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ON THREE FORMS OF THINKING: MAGICAL THINKING, DREAM THINKING, AND TRANSFORMATIVE THINKING

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The author believes that contemporary psychoanalysis has shifted its emphasis from the understanding of the symbolic meaning of dreams, play, and associations to the exploration of the processes of thinking, dreaming, and playing. In this paper, he discusses his understanding of three forms of thinking—magical thinking, dream thinking, and transformative thinking—and provides clinical illustrations in which each of these forms of thinking figures prominently. The author views magical thinking as a form of thinking that subverts genuine thinking and psychological growth by substituting invented psychic reality for disturbing external reality. By contrast, dream thinking—our most profound form of thinking—involves viewing an emotional experience from multiple perspectives simultaneously: for example, the perspectives of primary process and secondary process thinking. In transformative thinking, one creates a new way of ordering experience that allows one to generate types of feeling, forms of object relatedness, and qualities of aliveness that had previously been unimaginable.

Keywords: Forms of thinking, magical thinking, omnipotent fantasy, dream thinking, dreaming, transformative thinking.

In broad strokes, the current era of psychoanalysis might be thought of as the era of thinking about thinking. It seems to me that many of

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the most interesting and generative questions with which analysts are currently working have less to do with the symbolic content of dreams, associations, play, and other behavior, and more to do with what work we do psychically with our lived experience. In other words, our attention as analytic clinicians and analytic theorists has been increasingly focused on *the way* a person thinks, as opposed to *what* he thinks. To my mind, the two most important contributors to this movement in psychoanalysis are Winnicott, who attended more to the capacity for playing than to the symbolic content of play; and Bion, who explored in his writing the process of dreaming/thinking far more extensively than he discussed the symbolic meanings of dreams and associations.

In this paper, I will demonstrate some of the ways in which this shift in emphasis from symbolic content to thought process has altered the ways I approach my analytic work.

I conceive of the three forms of thinking that I will be discussing—magical thinking, dream thinking, and transformative thinking—as coexisting, mutually creating, preserving, and negating aspects of every experience of thinking. None of these forms of thinking is ever encountered in pure form.[1] Neither is there a linear relationship among these forms of thinking, such as a "progression" from magical thinking to dream thinking. Rather, I see these forms of thinking as standing in dialectical tension with one another, just as I view the relationship between the conscious and unconscious mind; the paranoid-schizoid, the depressive, and the autistic-contiguous positions (Klein 1946; Ogden 1989); the psychotic and the nonpsychotic parts of the personality (Bion 1957); the basic assumption groups and the work group (Bion 1959); the container and the contained (Bion 1970); primary and secondary process thinking (Freud 1911); and so on. *Moreover, none of these forms of thinking is a single, unitary way of thinking; rather, each "form of thinking" represents a rather wide spectrum of ways of thinking. The particular variation of the form of thinking that an individual may employ is always in flux and depends upon his level of psychological maturity, the intrapsychic and interpersonal emotional context of the moment, cultural factors, and so forth.*

[1] Of the inseparability of forms of thinking, Freud (1900) wrote: "It is true that, so far as we know, no psychical apparatus exists which possesses a primary process only [i.e., without secondary process] and that such an apparatus is to that extent a theoretical fiction" (p. 603).

The forms of thinking upon which I will focus by no means encompass the entire spectrum of ways of thinking. For example, I will not address operational thinking (de M'Uzan 1984, 2003), autistic thinking (Tustin 1981), psychic foreclosure (McDougall 1984), or "phantasy in the body" (Gaddini 1969), to name only a few.

In order to provide a sense of the trajectory of this paper, I will briefly introduce the three forms of thinking before delving into each clinically and theoretically. (In the tradition of Bion, when I speak of thinking, I am always referring to thinking and feeling.) I use the term *magical thinking* to refer to thinking that relies on omnipotent fantasy to create a psychic reality that the individual experiences as "more real" than external reality—for example, as seen in the use of the manic defense. Such thinking substitutes invented reality for actual external reality, thereby maintaining the existing structure of the internal world. Moreover, magical thinking subverts the opportunity to learn from one's lived experience with real external objects. The psychological cost paid by the individual for his reliance on magical thinking is a practical one: magical thinking does not work in the sense that nothing can be built on it except for additional layers of magical constructions.

I use the term *dream thinking* to refer to the thinking we do in the process of dreaming. It is our most profound form of thinking, which continues both while we are asleep and in waking life. Though it is primarily an unconscious mental activity, it acts in concert with preconscious and conscious thinking. In dream thinking, one views and attributes meaning to experience simultaneously from multiple vantage points, for example, from the perspectives of primary and of secondary process thinking, of the container and of the contained, of the infantile self and of the mature self, and so on (Bion 1962a; Grotstein 2009). Dream thinking generates genuine psychological growth. Such thinking may be done on one's own, but a point is inevitably reached beyond which one needs another person with whom to think/dream one's most deeply troubling emotional experience.

The third of the forms of thinking that I will discuss, *transformative thinking,* is a form of dream thinking that involves a radical alteration of the terms by which one orders one's experience: one transcends the categories of meaning that have previously been felt to be the only pos-

sible categories with which to organize one's experience. In transformative thinking, one creates new ways of ordering experience in which not only new meanings, but new types of feeling, forms of object relatedness, and qualities of emotional and bodily aliveness are generated. Such a fundamental change in one's way of thinking and experiencing is more striking in work with severely disturbed patients, but occurs in work with the full spectrum of patients.

In the course of the discussion that follows, I will present clinical examples that illustrate some of the ways in which conceptualizing forms of thinking in the ways I have described are of value to me in talking with myself—and, at times, with the patient—about what I think is occurring in the analytic relationship and in other sectors of the patient's internal life and life in the world.

MAGICAL THINKING

Beginning with Freud (1909, 1913), omnipotent thought has been a well-established concept in psychoanalytic theory. Freud (1913) credits the Rat Man with coining the term *omnipotence of thought* (p. 85). I will make a few observations that capture something of my sense of the differences between magical thinking and the other two forms of thinking that I explore in this paper.

Magical thinking has one purpose and one purpose only: to evade facing the truth of one's internal and external experience. The method employed to achieve this end is the creation of a state of mind in which the individual believes that he creates the reality in which he and others live. Under such circumstances, psychic reality eclipses external reality: reality is "the reality not of experience but of thought" (Freud 1913, p. 86). Consequently, emotional surprise and encounters with the unexpected are, as much as possible, foreclosed. In the extreme, when the individual fears that the integrity of the self is in danger, he may defend himself by means of virtually all-encompassing omnipotent fantasies that so disconnect him from external reality that his thinking becomes delusional and/or hallucinatory. In this psychological state, the individual is unable to learn from experience and incapable of distinguishing between being awake and being asleep (Bion 1962a)—i.e., he is psychotic.

To the degree that psychic reality eclipses external reality, there is a progressive deterioration of the individual's capacity to differentiate dreaming and perceiving, symbol and symbolized. As a result, consciousness itself (self-awareness) is compromised or lost. This leads to a state of affairs in the analytic setting in which the patient treats his thoughts and feelings not as subjective experiences, but as facts.

Magical thinking underlies a great many psychological defenses, feeling states, and forms of object relatedness. I will briefly discuss only three. Mania and hypomania reflect the hegemony of a set of omnipotent fantasies: the individual relying on the manic defense feels that he has absolute control over the missing object and therefore he has not lost the object, he has rejected it; he celebrates, not grieves, the loss of the object because he is better off without it; and the loss is not a loss because the object is valueless and contemptible. The feeling states associated with these omnipotent fantasies are concisely summed up by Klein (1935) as feelings of control, contempt, and triumph.

Projective identification is also based upon omnipotent fantasy: the unconscious belief that one can split off dangerous and endangered aspects of oneself and put them into another person in such a way that that aspect of oneself takes control of the other person from within. (The act of "containing" [Bion 1970; Ogden 2004a] a projective identification involves the "recipient's" transforming the "projector's" magical thinking into dream thinking, which the projector may be able to utilize in dreaming/thinking his own experience.)

Similarly, envy (which protects the individual from disturbing feelings such as abject emptiness and desolation) involves the omnipotent fantasy that one is able to steal what one lacks from another person and spoil what remains of what is envied in that person.

The qualities of magical thinking just discussed all reflect the use of omnipotent fantasy in the service of creating the illusion (and, at times, delusion) that one is not subject to the laws that apply to others, including the laws of nature, the inescapability of time, the role of chance, the irreversibility of death, and so on. One may speak cruelly to another person and then believe that one can literally "take back" the comment (re-create reality)—for instance, by renaming it a joke. Saying something makes it so. One's words are felt to have the power to substitute a newly

created reality for a reality that is no longer convenient. More broadly, history can be rewritten at will.

Magical thinking is very convenient—simply saying something obviates the need to face the truth of what has occurred, much less do anything about it. But as convenient as magical thinking is, it has one overriding drawback: it does not "work"—nothing can be built on it or with it except additional layers of magical constructions. Such "thinking" has no traction in the real world that exists outside of one's mind. Rather than constituting a form of genuine thought, it is an attack both on the recognition of reality and on thinking itself (i.e., it is a form of anti-thinking). It substitutes invented reality for actual reality, thus collapsing the difference between internal and external reality. The belief, for example, that one can use an indiscriminate "forgive-and-forget" approach to interpersonal experience serves not only to further blind the individual to the reality of the nature of the emotional connection that exists between himself and others, but also further blinds him to who he himself is. He increasingly becomes a fiction—a magical invention of his own mind, a construction divorced from external reality.

Nothing (and no one) can be built on or with magical thinking because omnipotently created "reality" lacks the sheer immovable alterity of actual external reality. The experience of the otherness of external reality is necessary for the creation of genuine self-experience. If there is no *not-I,* there can be no *I.* Without a differentiated other, one is everyone and no one.

One implication of this understanding of the central role of the recognition of otherness in the development of the self is the idea that, as important as it is for the analyst to understand the patient, it is equally important for the analyst to be a person who is different from the patient. The last thing in the world any patient needs is a second version of himself. The solipsistic aspects of a patient's thinking—the self-reinforcing nature of his ties to his unconscious beliefs—leads to a limitation of the patient's ability to think and to grow psychologically. What the patient (unconsciously) is asking of the analyst—even when the patient is explicitly or implicitly claiming that he has no need of the analyst—is a conversation with a person other than himself, a person who

is grounded in a reality that the patient has not created (see Fairbairn 1944; Ogden 2010).

A Patient Who Was Reduced to Omnipotence[2]

Ms. Q told me in the initial interview that she had come to me for analysis because "I am unusually talented in wrecking everything in my life—my marriage, the way I treat my children, and the way I do my work." Despite the intended irony of this statement, it felt to me to be more a boast than an admission of failure or a request for help. It seemed to me that Ms. Q was putting me on notice that she was no ordinary person ("I am unusually talented").

In the first week of Ms. Q's five-session-per-week analysis, something quite striking occurred. Ms. Q left a phone message saying that, due to a change in her work schedule, she was unable to attend the meeting we had scheduled for the following day, but she would be able to attend the session just after the one we had scheduled, i.e., she could meet an hour later. She ended the message by saying, "I'll assume that's all right with you unless I hear from you." I had no choice but to return her phone call. In my phone message, I said that I expected her at the time we had agreed upon. Had I not returned her call, she would have arrived at the same time as the patient to whom that later session belonged, which would have created an intrusive situation for the other patient and me when the three of us met in the waiting room.

The patient arrived twenty minutes late for the session she had asked to change. She offered facile apologies and explanations. I said to her, "It seems to me that you don't believe I've genuinely made a place for you here and so you feel you have to steal one. But I don't think that such things can be stolen." I strongly suspected that the fear of not having a place of her own had been a lifelong anxiety for the patient, but I did not say this to her.

[2] Bion once said to his analysand James Grotstein, "What a shame it was that you were reduced to omnipotence" (Grotstein 2001). The connection between shame and omnipotent thinking that Bion subtly makes in this comment is a highly significant one: unconscious, irrational shame is a powerful force impelling one to give up on the real world, and instead to create a world that is fully under one's control.

Ms. Q said that she did not think it was so complicated as that, and went on to tell me more about events at work. I said to her, "I guess I'm not to have a place here with you unless I fight for it." The patient behaved as if I had said nothing.

Ms. Q spoke in a rather flippant way about her life. In talking about her "formative years," she said that she had had a "perfectly normal childhood" and had "perfectly reasonable parents" who were highly successful academics. "I can't blame it all on them." I imagined that what the patient said was true in a way that she was not at all aware of. That is, she had been a "perfectly" behaved child (compliant, and fearful of her emotions), and her parents were "perfectly reasonable" in the sense that they were little able to be receptive to, or expressive of, feeling. This inference was borne out over time, both in the transference-countertransference and in the patient's accounts of her childhood.

Closely linked with Ms. Q's efforts to control me and steal from me and from my other patients was her belief that I had the answers to her problems—her inability to be a mother, a wife, a friend, or a productive member of her profession. My "stubbornness" in not giving her solutions to her problems puzzled and enraged her.

I gradually became aware of a way in which the patient had been relating to me from the very beginning of the analysis, but which had become less disguised and more provocative as time went on. The patient would regularly misrepresent feelings, behaviors, and events that had occurred either within or outside of the consulting room. This was most striking when Ms. Q distorted something that she or I had said in the current session or in a recent one. After almost two years of feeling controlled in this way, I said, "I think that by presenting yourself and me with story after story that you know to be untrue or misleadingly incomplete, you ensure that everything I say or think is of no interest or value to you. Reality is only a story that you create and re-create as you choose. There is no real me or real you that lies outside of your control. Since you can create any reality that suits you, there's no need to actually do anything to make the changes in your life that you say you want to make."

As I said this to Ms. Q, I was aware that I was angry at her for the ways she undermined me and the analytic work. I was also aware that

my pointing out that she was failing to conduct herself in a way that I approved of would likely force her into an even more highly defended state. (That is, in fact, what ensued.) But it was not my anger that was most disturbing to me at this point. I was speaking in a chastising way that felt quite foreign to me.

A few sessions later, I closed my eyes for a few minutes while sitting in my chair behind the couch (as I often do while working with patients in analysis). After a while, I suddenly became very anxious. I opened my eyes, but for a few moments did not know where I was, what I was doing, or whom, if anyone, I was with. My disorientation did not lift even after I saw a person lying on the couch. It took me a few seconds more to deduce where I was, who the person on the couch was, and what I was doing there (i.e., who I was). It took several more moments before this deductive thinking was succeeded by a more solid sense of myself as a person and as Ms. Q's analyst. This was a disquieting experience that led me, over time, to become aware of my own fears of losing myself in the psychological-interpersonal experience in which Ms. Q continuously reinvented reality and reinvented herself and me. It seemed to me that Ms. Q was showing me what she could not tell me (or herself), i.e., what it felt like to invent and reinvent herself, and to be invented and reinvented by another person. I was reminded of Ms. Q's parents' demand on her, and her own efforts to be "a perfect child," a child who makes no emotional demands on her parents, a child who is not a child.

I said to Ms. Q, "I think that your distortions of reality, and particularly your inventions of yourself and me, are efforts to show me what you don't feel able to convey to me in words. It seems to me that when you were a child, you felt you were the invention of someone else's mind, and you continue to feel that way. I think that you've been afraid to tell me or to tell yourself the truth because that would endanger what little you have of yourself that feels real. To tell me the truth would be to leave yourself open to my taking from you what feels most real about you, and replacing it with my own version of you." Ms. Q did not reflexively dismiss what I said with a sardonic quip or other form of contemptuous dismissal, as was her wont. Instead, she was quiet for the few minutes that remained of the hour.

In the following day's session, Ms. Q told me a dream: "I was playing tennis—in reality I don't know how to play tennis—and the ball rolled to a far corner of the series of courts on which we were playing. There was a kind of trough at the edge of the far court that was filled with brand-new tennis balls, but I didn't know how to take more than one or two with me. I can't remember what happened after that. I woke up in the morning feeling all right—not great, not terrible."

I said, "In telling the dream, you told me and yourself right away that in the dream you are playing tennis, but in reality you can't play tennis. It seems that it felt important to you that we both know what is real and what isn't. The ball rolled to a far corner where there's a trough. You find a great many new tennis balls in it—it seems like an exciting treasure, but you can only take one or two with you. On the other hand, the tennis balls that you already have are enough. When you woke up, you didn't feel cheated of a treasure, nor did you feel like a thief, as you have felt so often in the past. You felt all right."

Ms. Q said, "That's right, I didn't really care that I couldn't take all the tennis balls. I didn't want them or need them. Finding the tennis balls in the trough didn't feel like discovering a treasure, it just seemed strange. When I was a kid . . . actually I was in high school . . . I shoplifted things I didn't want and threw them away as soon as I got outside the store. It makes me feel queasy remembering that. I knew I didn't want the stuff, but I couldn't stop myself."

In the course of the succeeding year of analysis, Ms. Q's creation of her own reality greatly diminished. At times, when she was engaged in distorting reality, she would interrupt herself, saying, "If I continue talking in this way, it will be pointless because I'm leaving out an important part of what happened that I'm embarrassed to tell you."

In the portions of the analysis that I have discussed, the patient relied heavily on magical thinking in an effort to create (and destroy) reality, including herself and me. The alternative to creating reality, for her, was not simply an experience of helplessness, but a sense of losing herself, a feeling of having herself stolen by someone else. Moreover, she felt ashamed of not being able to hold onto a sense of herself that felt real and true to her.

The patient's distortions of reality (her magical creation of her own reality) angered me because of the way in which they contributed to what felt like a theft of meaning from the analytic dialogue and a theft of my sense of self. What I initially said to the patient regarding her magical thinking was excessively accusatory, and consequently, unutilizable by her. It was, however, of value to me in alerting me to the way in which I did not recognize myself in the way I was talking. This understanding, in turn, created a psychological space in which a reverie experience was generated (by the patient and me) in which I experienced a frightening feeling that I did not know who I was, where I was, or who was with me.

Talking with Ms. Q about what I believed to be her feelings of losing herself in her endless reinventions of reality provided an emotional context (a containing way of thinking) that allowed her to dream (with me) an experience of being herself in the world without the need for magic. The patient, both in the tennis ball dream and in talking with me about it, was able to be accepting of herself as she was. Reality was not a threat; it served as a grounding otherness. My otherness and the otherness of external reality were made more immediately present as I "retold" the tennis ball dream in a form that was other to her own telling of it. In hearing my telling of the dream, Ms. Q, I believe, saw something like herself (herself at an observable distance) in "my dream." The patient made use of the external reality (the otherness) of my version of the dream in a self-defining way, as reflected in her quietly correcting my version of the dream in places where she felt she did not recognize herself. For example, she told me that finding the multitude of tennis balls "didn't feel like discovering a treasure"; rather, she found it "strange" (that is, foreign to the person who she was becoming).

While this section of the paper has focused on magical thinking, the work of coming to understand something of what was occurring in the analytic relationship involved a good deal of dream thinking on both the patient's part and mine. I will further describe this aspect of the analysis in the next section of this paper. (As I mentioned earlier, one's thinking always involves the full spectrum of forms of thinking. What varies is the prominence of one form, or combination of forms, at any given moment.)

DREAM THINKING

Dream thinking is the predominantly unconscious psychological work that we do in the course of dreaming. We dream continually, both while we are awake and while we are asleep (Bion 1962a). Just as the light of the stars in the sky is obscured by the glare of the sun during the day, dreaming continues while we are awake, though it is obscured by the glare of waking life. Dream thinking is our most encompassing, penetrating, and creative form of thinking. We are insatiable in our need to dream our lived experience in an effort to create personal, psychological meanings (which are organized and represented in such forms as visual images, verbal symbols, kinesthetically organized impressions, and so on) (Barros and Barros 2008).

In dream thinking, we view our lived experience from a multiplicity of vantage points simultaneously, which allows us to enter into a rich, nonlinear set of unconscious conversations with ourselves about our lived experience. That multitude of vantage points includes the perspectives of primary and secondary process thinking; the container and the contained; the paranoid-schizoid, depressive, and autistic-contiguous positions (Ogden 1989); the mature self and the infantile self; the magical and the real; the "psychotic" and "nonpsychotic" parts of the personality (Bion 1957); getting to know what one is experiencing (Bion's [1970] "K") and becoming the truth of what one is experiencing ("O"); the "projector" and the "recipient" of projective identification; and so on. The multilayered, nonlinear "conversations" constituting dream thinking take place between unconscious aspects of the personality, termed by Grotstein (2000) "the dreamer who dreams the dream" and "the dreamer who understands the dream," and by Sandler (1976) "the dream-work" and "the understanding work." Such thinking would result in massive confusion if it were to occur consciously while one was attempting to go about the business of waking life.

The richness of dream experience and dream thinking is captured by Pontalis (2003) in his description of waking up from sleep:

> I must separate myself brutally from the nocturnal world, from this world where I felt and lived more incidents than anywhere

> else, where I was extraordinarily active, where I was more awake than one ever is in what we call the "state of wakefulness." [p. 15] . . . Dreams think and they think for me . . . . Waking up we would like to recover the beautiful, distressing, and disturbing images that visited us in the night and already these images are fading. Yet we also feel that what we are losing then is much more than these images; it's a realm of thought that progresses continuously. [p. 18] . . . [Dreaming—and, I would add, dream thinking] unfurl[s] in all directions [p. 50], . . . unaware of its destination . . . carried away by the sole power of its movement. [p. 19]

As discussed earlier, the problem with magical thinking is the fact that it does not work: it substitutes invented reality for the reality of who one is and the emotional circumstances in which one is living. Consequently, nothing of substance changes in oneself. The strength of dream thinking lies in the fact that it does work: it does give rise to psychological growth, as reflected, for instance, in the way one consciously and unconsciously goes about making changes in the way one relates to other people and in one's other engagements with the real external world. In this sense, I view pragmatism as a principal means of taking the measure of the value of any aspect of the workings of the mind (as is true of the workings of the body). A fundamental question regarding any given form of thinking is always: Does it work? Does it contribute to the development of a sense of an emotionally alive, creative, self-aware person, grounded both in the reality of himself and of the external world?

Beginning in earliest infancy and continuing throughout life, every individual is limited, to varying degrees, in his capacity to subject his lived experience to dream thinking, i.e., to do unconscious psychological work in the course of dreaming. When one has reached the limits of one's ability to dream his disturbing experiences, one needs another person to help one dream one's undreamt dreams (Ogden 2004b, 2005). In other words, it takes (at least) two people to dream one's most disturbing experience.

In earliest life, the psychological-interpersonal phenomenon that I am describing takes the form of the mother and infant together dreaming the infant's disturbing experience (as well as the mother's

emotional response to the infant's distress). The mother, in a state of reverie, accepts the infant's unthinkable thoughts and unbearable feelings (which are inseparable from her response to the infant's distress) (Bion 1962a, 1962b; Ogden 1997a, 1997b). The mother, who in this way enters into a subjectivity that is co-created with the infant (Winnicott's [1956] "primary maternal preoccupation"; Bion's [1962a] and Rosenfeld's [1987] intrapsychic-interpersonal version of projective identification; Ferro's [1999] "bi-personal field"; or what I call the "intersubjective third" [Ogden 1994a, 1994b]), brings to bear on the infant's unthinkable experience her own larger personality and greater capacity for dreaming. In so doing, she and the infant together dream something like the infant's disturbing experience. The mother communicates to the infant his formerly undreamable/unthinkable experience in a form that he is now more fully able to dream on his own. A similar intersubjective process takes place in the analytic relationship and in other intimate relationships, such as the parent–child relationship, marriage, close friendships, and relationships between siblings.

In saying that it takes (at least) two people to think one's most disturbing emotional experience, I do not mean to say that individuals are not able to think on their own. Rather, I am saying that one inevitably reaches a point in one's thinking/dreaming beyond which one cannot go. At that juncture, one either develops symptomatology in an (often futile) effort to gain some measure of control over (which is not to say resolution of) one's psychological difficulties, or one enlists another person to help one dream one's experience. As Bion (1987) put it, "the human unit is a couple; it takes two human beings to make one" (p. 222).

It must be borne in mind that not all forms of mental activity that appear to be dreaming—for example, visual images and narratives experienced in sleep—merit the name *dreaming*. Post-traumatic nightmares that are repeated night after night achieve virtually no unconscious psychological work, and consequently do not constitute genuine dreaming (Bion 1987). In other words, such "dreams" are dreams that are not dreams in that they leave the dreamer psychically unchanged. Again, the measure of whether a dream is a dream is whether it "works," i.e., whether it facilitates real psychological change and growth.

The Ordinary Rescued from the Magical

As I mentioned in connection with my work with Ms. Q, dream thinking was done at several critical points in that analysis. I will focus here on one of these instances: my use of my reverie experience that occurred during a session in which I listened to the patient while my eyes were closed. In that reverie, I was, in an important sense, dreaming *with* Ms. Q an experience that she had been unable to dream on her own (much less put into words for herself or for me). The reverie itself was a form of waking dreaming in which I not only lived the experience, but—even as I was in the grip of it—I was also able to form questions that addressed the essence of the emotional situation: Where am I? Who am I? With whom am I?

On "waking" from the reverie, I was able to engage in more conscious aspects of dream thinking. This involved my conceiving of my experience of having momentarily lost myself as constituting an unconsciously co-created version of Ms. Q's experience of losing herself as a consequence of her use of omnipotent fantasy to invent and reinvent herself and me.

The thinking I have just described involved apprehending and putting into words multiple levels of meaning that were alive in the emotional experience. I treated my reverie experience both as an experience of having co-created a dream with Ms. Q, and as an experience that had personal meanings that were unique to each of us. My own experience of the reverie was one in which I briefly lost touch with my sense of who I was, while Ms. Q's experience of losing herself was lifelong, and at times quasi-delusional.

As I have said, I view dream thinking as a form of thinking that is primarily unconscious, although it operates in concert with preconscious and conscious thinking. The co-creation of the reverie experience itself was principally an unconscious phenomenon that generated preconscious and conscious imagery (as is the case with dreams that one remembers after waking from sleep). In relating my reverie experience to Ms. Q's experience of herself, I was primarily engaged in conscious, secondary process thinking, but that type of thinking would, I believe,

have been stale and empty had I not been speaking *from* my experience as a participant in the reverie.

An important measure of whether or not the thinking that Ms. Q and I did was genuine dream thinking lies in the degree to which it facilitated the work of helping the patient become more alive and responsive to her experience in the real world, better able to accept herself as she was, and more capable of thinking and talking about her experience with herself and with me. It seems to me that my use of my reverie experience to talk with Ms. Q about *her* experience of losing herself reflected psychological change in me, i.e., in my own increased capacity to contain the patient's unthinkable/undreamable experience (as opposed to evacuating it—for example, in the form of a chastising intervention). My talking with Ms. Q about her experience of losing herself contributed, I believe, to her dreaming her tennis ball dream, a dream in which she had little interest in, or use for, magical thinking. Her psychological growth was reflected in her capacity to dream that dream and in her enhanced ability to talk and think with me (and herself) about it.

The type of dream thinking that I have described here involved a form of self-reflection in which I drew my own experience, and my conception of the patient's experience, into relation to one another, i.e., I made use of my experience of losing myself to make an inference regarding the patient's experience of losing herself. The category of meaning (the experience of losing oneself) remained relatively constant. As will be seen in the following section of this paper, dream thinking at times involves a radical shift in the structure of the patient's and the analyst's thinking. This form of dream thinking, which I refer to as *transformative thinking*, may precipitate what Bion (1970) refers to as "catastrophic change" (p. 106), a change in nothing less than everything.

TRANSFORMATIVE THINKING

The idea of transformative thinking occurred to me in response to a passage from the King James translation of the Gospel of John, which was discussed in an essay by Seamus Heaney (1986). I will treat the writing in that passage as a literary text, not a religious text, and as such, I will treat the figures and events depicted in the story not as expressions of

theological meaning, but as expressions of emotional truths arrived at by means of a particular form of thinking. Because the thinking is *in* the writing, I will quote the passage in its entirety:

> And the scribes and Pharisees brought unto him a woman taken in adultery; and when they had set her in the midst,
>
> They say unto him, Master, this woman was taken in adultery, in the very act.
>
> Now Moses in the law commanded us, that such should be stoned: but what sayest thou?
>
> This they said, tempting him, that they might have to accuse him. But Jesus stooped down, and with his finger wrote on the ground, as though he heard them not.
>
> So when they continued asking him, he lifted up himself, and said unto them, He that is without sin among you, let him first cast a stone at her.
>
> And again he stooped down, and wrote on the ground.
>
> And they which heard it, being convicted by their own conscience, went out one by one, beginning at the eldest, even unto the last: and Jesus was left alone, and the woman standing in the midst.
>
> When Jesus had lifted up himself, and saw none but the woman, he said unto her, Woman, where are those thine accusers? hath no man condemned thee?
>
> She said, No man, Lord. And Jesus said unto her, neither do I condemn thee: go, and sin no more.
>
> [Gospel of John (8:3-11)]

In this story, Jesus is brought into a situation in which a woman has been taken "in the very act" of adultery. He is asked whether he will obey the law (which demands that the woman be stoned) or break the law (by putting a stop to the stoning that is about to take place).

Jesus, instead of replying to the question, "stooped down, and with his finger wrote on the ground as though he heard them not." Instead of accepting the terms as they were presented (Will you obey the law or break the law?), Jesus opens a psychological space in which to think in the act of writing. The reader is never told what he wrote. Jesus's writing on the ground breaks the powerful forward movement toward action, and in so doing, creates a space for thinking both for the characters in the story and for the reader/listener.

When Jesus stands, he does not reply to the question that has been posed. He says something utterly unexpected and does so in the simplest of words—a sentence in which all but two of the fifteen words are monosyllabic: "He that is without sin among you, let him first cast a stone at her." Jesus does not address the question of whether to obey the law or break the law, and instead poses a completely different, highly enigmatic question: how does one bring to bear one's own experience of being human, which includes one's own sinful acts, to the problem of responding to the behavior of another person? And further, the passage raises the question of whether any person has the right to stand in judgment of another person. At the end of the passage, Jesus renounces any intention of standing in judgment of the woman: "Neither do I condemn thee."

The final words of the passage: "go, and sin no more," are tender, while at the same time, demand honest self-scrutiny. Language itself has been altered: the meaning of the word *sin* has been radically transformed in the course of the story, but into what? In relation to what moral order is sin to be defined? Is the woman free to commit adultery if her own morality does not deem it a sin? Are all systems of morality equal in their capacity to prescribe, proscribe, and take the measure of the way human beings conduct themselves in relation to themselves and one another?

My purpose in discussing this piece of literature is to convey what I mean by transformative thinking. It is a form of dream thinking that involves recognizing the limitations of the categories of meaning currently thought to be the only categories of meaning (e.g., obey the law or break the law), and, in their place, creating fundamentally new categories—a radically different way of ordering experience—that had been unimaginable up to that point.

The biblical story I have just discussed constitutes one of the most important narratives—and instances of transformative thinking—of the past 2,000 years. No doubt it would have been forgotten long ago had it been less enigmatic, less irreducible to other terms (such as the tenets of a new set of secular or religious laws to be obeyed or disobeyed), or even to abstract principles such as: no person has the right to pass judgment on another person. Had the story merely substituted one binary choice for another, or introduced a new prescription, the thinking achieved in

the writing would not have been transformative in nature and, I speculate, would not have survived as a seminal narrative of Western culture. The story, like a poem, cannot be paraphrased and mined for meanings that stand still.

We, as psychoanalysts, ask of ourselves and of our patients no less than transformative thinking even as we recognize how difficult it is to achieve. Our theoretical and clinical work becomes stagnant if at no point do we engage in transformative thinking. It is this striving for transformative thinking that makes psychoanalysis a subversive activity, an activity inherently undermining of the gestalt (the silent, self-defining terms) of the intrapsychic, the interpersonal, and the social cultures in which patient and analyst live.

Each of the major twentieth-century analytic theorists has introduced his or her own conception of the transformation—the alteration of the way we think and experience being alive—that is most central for psychological growth. For Freud (1900, 1909), it is making the unconscious conscious, and later in his work (1923, 1926, 1933), movement in psychic structure from id to ego ("Where id was, there ego shall be" [1933, p. 80]). For Klein (1948, 1952), the pivotal transformation is the movement from the paranoid-schizoid to the depressive position; for Bion (1962a), it is a movement from a mentality based on evacuation of disturbing, unmentalized emotional experience to a mentality in which one attempts to dream/think one's experience, and later (1965, 1970), a movement from getting to know the reality of one's experience (K) to becoming the truth of one's experience (O). For Fairbairn (1944), therapeutic transformation involves a movement from life lived in relation to internal objects to a life lived in relation to real external objects. For Winnicott (1971), crucial to psychological health is the psychic transformation in which one moves from unconscious fantasying to a capacity to live imaginatively in an intermediate space between reality and fantasy.

My focus in this section of the present paper is not on the validity or clinical usefulness of each of these conceptions of psychic transformation, but on the nature of the intrapsychic and intersubjective thinking/dreaming that mediates these transformations. As will be seen in the next clinical illustration that I will present, the achievement of transformative thinking is not necessarily an experience of a sudden break-

through, a eureka phenomenon. Rather, in my experience, it is most often the outcome of years of slow, painstaking analytic work that involves an expanding capacity of the analytic pair to dream aspects of the patient's formerly undreamable experience.

Transformative thinking—thinking that radically alters the terms by which one orders one's experience—lies toward one end of a spectrum of degrees of change-generating thinking (dream thinking). The clinical example that follows is taken from work with a patient who experienced florid psychotic thinking, both prior to the analysis and in the course of the analysis. I have elected to discuss my work with this patient because the transformative thinking that was required of the patient and me is more apparent and more striking than in most of my work with healthier patients. Nonetheless, it must be borne in mind that transformative thinking is an aspect of all thinking and, as such, is a dimension of my work with the full spectrum of patients.

A Woman Who Was Not Herself

Ms. R sat stiffly in her chair, unable to make eye contact with me during our first consultation session. She was well dressed but in a way that seemed artificial in its perfection. She began by saying, "I'm wasting your time. I don't think that what is wrong with me can change. I'm not a person who should be in an analyst's office." I said, "The first thing you want me to know about you is that you don't belong here. I think you're warning me that both of us will no doubt regret having had anything to do with one another."

Ms. R replied, "That's right." After a minute or so, she said, "I should tell you something about myself." I said, "You can do that if you like, but you're already telling me, in your own way, a great deal about who you feel you are and what frightens you most."

Space does not allow for a discussion of the initial years of analysis. In brief, Ms. R spoke with great shame and embarrassment about how repulsive she felt; she continually readied herself for my telling her to leave. As we talked about these feelings, the patient slowly became more trusting of me. In a very unassuming way, Ms. R revealed herself to be a highly intelligent, articulate, and likable person.

Toward the end of the third year of this five-session-per-week analysis, Ms. R said, "There's something I'm afraid to tell you because you might tell me that I'm too sick to be in analysis. But you won't be able to help me if you don't know this about me, so I'm going to tell you." Ms. R haltingly went on to say that she had had "a breakdown" when she was in her thirties while traveling in Europe. She was hospitalized for a month, during which she had a hallucination that lasted for several days. "In it, a string was coming out of my mouth. It's very hard for me to say this because I'm afraid of getting caught in it again. I was terrified and kept pulling on the string in order to get it out of me, but the string was endless. As I pulled, I found that my internal organs were attached to the string. I knew that if I didn't get this string out of me, I would die, but I also knew that if I pulled out more of the string, it would be the end of me because I couldn't live without my insides." Ms. R said that she had felt unbearably lonely during the hospitalization and was consumed by thoughts of suicide.

She and I talked at length about the hospitalization, the experiential level of the hallucination, and her fear that the hallucination would frighten and alienate me, and entrap her. I restricted myself to putting what she was saying into my own words in order to let her know that she was not alone now as she had been then. The hallucination seemed to me to be far too important an event to risk foreclosing it with premature understandings.

Ms. R also felt that I would have to know more about her childhood experience to be able to help her. She said, "I know I've been very vague in talking about my childhood and my parents. I'm sure you've noticed, but I couldn't bring myself to do it because it makes me feel physically ill to think about it. I don't want to get trapped there either."

Ms. R said that, as a child, she had "worshipped" her mother: "She was dazzlingly beautiful and extraordinarily intelligent, but I was as afraid of her as I was revering of her. I studied her way of walking, the way she held her head, the way she spoke to her friends, to the mailman, to the housekeeper. I wanted desperately to be like her, but I was never able to do it well enough. I could tell that she thought I was always falling short. She didn't need to say anything. It was unmistakable in the coldness of her eyes and in her tone of voice."

The patient's father was fully consumed with running the family business, and was at home very little. Ms. R recalled lying in bed trying not to fall asleep so she might hear her father's voice and the sound of his movements around the house when he got home. She did not dare get out of bed for fear of displeasing her mother by "tiring her father out after his long day at work" (as her mother put it). Gradually, in the course of growing up, the patient came to understand that her mother could not tolerate sharing her father's attention. Her parents seemed to her, even as a child, to have had an unspoken agreement that her father could spend as much time at work as he wanted to, and in exchange her mother would run the house and the family as she pleased.

In this period of analytic work, the patient's lifelong, visceral sense of disgust for herself as a person and for her body (particularly its "female excretions") became so intense that Ms. R avoided as much as possible being around other people for fear that they would be repulsed by her odor. Being in my consulting room with me was almost unbearable for her. As she spoke about her "repulsive body" during one of these sessions, my mind wandered to a book that I was reading in which the narrator discussed the odor that clung to his own body and those of the other prisoners in the concentration camp in which he had spent more than a year. I thought, at that moment in the session, that not to be stained by the odor would have been far worse than being stained by it because being free of the odor would have meant that one was a perpetrator of unthinkable atrocities. A prisoner's terrible odor obliterated his individual identity, but at least it served to mark the fact that he was not one of "them."

In talking with me about her revulsion for herself and her body, Ms. R gradually began to recognize the depth and severity of her mother's "distaste" for her. "It was as if being a child was an illness that my mother tried to cure me of. Only now do I see that her teaching me how to be 'a young woman of culture' was insane. I was able to convince myself that this was what mothers did. On my own, I learned how to rid myself of the [regional] accent with which the other children spoke."

When the patient's periods began at age twelve, her mother left a box of Kotex and a detailed letter about "how to keep yourself clean." Not a single spoken word passed between them on the subject. The pa-

tient's mother became significantly colder and more disapproving of Ms. R after the patient entered puberty.

After several more years during which the patient did considerable work with the understandings I have described, she began to experience left-sided abdominal pain that she was convinced was a symptom of cancer. When extensive medical tests failed to reveal a physiological source of the pain, the patient became extremely distressed and said, "I don't believe them. I don't believe their tests. They're not real doctors, they're researchers, not doctors." She, then, for the first time in the analysis, sobbed deeply.

After a few minutes, I said, "It's terrifying to feel that doctors are not real doctors. You've put your life in their hands. But this is not a new experience for you. I think that you felt you had a mother who was not a real mother, and your life was completely in her hands. Just as you feel you are a guinea pig in the so-called doctors' research, I think that you felt you were merely a character in your mother's insane internal life."[3]

Ms. R listened to me intently, but did not respond in words to these comments. Her sobbing subsided and there was a visible decrease in the tension in her body as she lay on the couch.

The succeeding months of Ms. R's life, both within and outside the analysis, were deeply tormenting ones. During this period, she was again preoccupied with the string hallucination. The patient said she continued to feel the physical sensation of having her mother (who was now indistinguishable from the string) inside of her, though the sensory experience no longer held the unmediated realness of a hallucination. Ms. R came to view her fear (and conviction) that there was a cancer growing inside of her as a new version of the string hallucination.

Also at this juncture in the analysis, Ms. R began to correct grammatical errors that I made—for instance, when I said, "people that" instead of "people who," or when I made an error in the use of the subjunctive.

[3] I also thought that Ms. R unconsciously experienced me as another doctor using her for my own purposes—perhaps using her as a subject for a lecture or paper—but I decided to wait to talk to her about that aspect of what I sensed was happening in the transference-countertransference until that set of thoughts and feelings was closer to her conscious experience of me. I believe that the patient would have experienced such a transference interpretation at that juncture as a substitution of my story for hers.

She subtly made her corrections by repeating the essence of my sentence, but with the error corrected. I am not sure whether the patient was at all aware that she was doing this. Ms. R openly complained about television news broadcasters and the *New York Times* "butchering the English language." I became highly self-conscious regarding the grammatical correctness of my speech, to the point that I felt tongue-tied and limited in my ability to speak in a spontaneous way. I was able, over time, to understand what was happening as the patient's way of unconsciously forcing me to experience something of what it felt like for her to have her imperious mother inside of her.

In a session in which Ms. R was feeling hopeless about ever being able to free herself of her mother's physical and emotional presence in her, I said, "I think that you feel today, almost as strongly as you did when you had the string hallucination, that you have only two choices: you can try to pull the string out of you—but that requires pulling out your own insides along with your mother, which would kill both of you. Or, you can choose not to pull out the string, which means giving up your last chance to remove her from you. You would be giving up all hope of ever becoming a person separate from her."

While I was saying this, I had a strong sense of emerging from a psychic state in which I had felt inhabited by Ms. R in a strangulating way. Something quite new, and very welcome, was occurring between the two of us at this point in the session, though I was unable to put it into words or images for myself or the patient.

Ms. R said, "As you were speaking, I remembered something that plagued me when I was in junior high and high school. I lived in a world of looming disaster. For instance, I had to predict exactly—to the tenth of a gallon—how much gas the car would take at the gas station. I was convinced that if I was wrong, my mother or father would die. But worst of all, there was a question that I could not get out of my head. I haven't thought about this for years. The question was: if my family and I were in a boat that was sinking, and everyone would drown unless one person was thrown overboard, and it was up to me to decide which one was to go, whom would I choose? I knew immediately that I would choose to throw myself into the water, but that answer was a 'wrong answer'—it was

against the rules. So I would begin again asking myself the same question, and that went on over and over and over, sometimes for months."

I said, "As a girl, you were too young to know that it was not the answer you came up with that was wrong or against the rules—it was the very fact that the question had to be asked that was 'wrong' in the sense that there was something terribly wrong going on in your life and in the life of your family. I think that you've felt virtually every moment of your life, from the time you were a small child, that you have to decide who to kill—yourself or your mother."

Ms. R replied, "It was too awful—impossible—as a child to allow myself to know any of this. It's been there as a feeling, but I didn't have words for it. I felt she was everything. I knew that if I got her out of me, it would kill her, and I didn't want that, but I had to get her out, I didn't want to die. I'm so confused. I feel as if I'm in a maze and there's no way out. I have to get out of here. I don't think I can stay."

I said, "The very first thing you wanted me to know about you in our initial meeting was that you and I didn't belong here together. Now I realize that, despite the fact that you couldn't put it into words, you were trying to protect both of us from yourself. If you allow me to help you, I'll be inside of you and you'll have to kill one or both of us. As a child, you were alone with that problem, but that's not true any longer."

Ms. R said, "There are times when I'm here that I know that there is a world made entirely differently from the one I've been living in. I'm embarrassed to say this—I can feel myself blushing—but it is a world in which you and I talk like this. I'm sorry I said it because I don't want to jinx it. I feel like such a little girl now. Forget I said anything." I said, "Your secret is safe with me." I had grown very fond of Ms. R by this point in the analysis, and she knew that.

It was only at this juncture, with the patient's help—her telling me she felt like a little girl—that I was able to put into words for myself something of the emotions I had sensed earlier in the session, and was now feeling with far greater intensity. I was experiencing Ms. R as the daughter I never had, a daughter with whom I was feeling a form of tenderness and a form of loss (as she grows up) that is unique to the tie between a father and daughter. This was not simply a new thought, it was

a new way of experiencing myself and Ms. R; it was a way of feeling alive both lovingly and sadly that was new to me.

In the next session, Ms. R said, "Last night, I slept more deeply than I've slept in a very long time. It is as if space has opened up in every direction, even downward in sleep."

As the analysis progressed, Ms. R was able to experience types of feeling and qualities of human relatedness that were new to her: "All my life I've heard the word *kindness* being used by people, but I had no idea what the word meant. I knew I had never felt the feeling they were talking about. I now know what kindness feels like. I can feel your kindness toward me. I cry when I see a mother tenderly holding her baby in her arms or holding the hand of her child as they walk." She said she cried because she could now feel how little kindness she had been shown as a child. But more important, she thought, was the terrible sadness that she felt about having shown so little kindness to her own children. Ms. R had only occasionally spoken of her children up to this point in the analysis, despite the fact that all of them were having emotional difficulties.

Over time, the psychological-interpersonal shift that I have described became stabilized as a way of being and perceiving for Ms. R. The stability of the change was reflected in the following dream: "I was returning home from somewhere and I found that people had moved into my house. There was a whole group of them and they were in every room—they were cooking in the kitchen, watching TV in the living room, they were everywhere. I was furious, I yelled at them, 'Get the fuck out of here! [I had never before heard Ms. R use profanity.] This is my house, you have no right to be here.' I felt good on waking up. In the dream I wasn't frightened of the people who had taken over my house, I was irate."

I said, "The house is the place in which you live, a place that is yours and yours alone." Ms. R and I talked about the way in which the dream reflected her growing capacity to firmly lay claim to a place in which to live that is entirely hers, a place where she need not choose between killing herself or killing someone else who is occupying her. "In the dream, the people who had moved into my house were not going to die if I sent them away. They would simply have to find another place to live."

Ms. R had been living in a psychotic world generated by and with her mother (with the help of her father), a world in which the patient was, at every moment, unconsciously feeling that she had to choose between killing herself (giving herself over to being a projection of her mother's feelings of her own vileness) or killing her mother by insisting on becoming a person in her own right (albeit a person who had no real mother and no world that held meaning for her).

The thinking that I consider transformative thinking in my work with Ms. R was the thinking that the patient and I did together in the course of years of analysis—thinking that eventually led to a radical transformation in the way the patient and I ordered experience, creating a gestalt that transcended the terms of the emotional world in which she and I had lived. Ms. R, in this newly created way of generating and ordering experience, was able to feel feelings such as kindness, love, tenderness, sadness, and remorse, which up to that point had been only words that others used to refer to feelings she had never been able to feel. The intimacy and affection that Ms. R and I were now capable of feeling were alive for both of us when she spoke of a world in which "you and I talk like this." Even Ms. R's use of the words "you and I" in this phrase, as opposed to "we," conveyed a feeling of loving separateness, as opposed to engulfing, annihilating union. So simple a difference in use of language is communicative of the radical transformation in the patient's thinking and being.

The fundamentally new emotional terms that were created did not derive from self-hatred and pathological mutual dependence, but from Ms. R's wish and need to become a person in her own right, a person who was able to give and receive a form of love that she never before knew existed. It is a love that paradoxically takes pleasure in, and derives strength from, the separateness of the other person. Separateness in this new set of emotional terms, this new way of being alive, does not give rise to tyrannical efforts to incorporate or be incorporated by the other person; rather, it generates a genuine appreciation of the surprise, joy, sadness, and manageable fear that derive from the firm knowledge of one's own and the other person's independence.

While I believe that transformative thinking in this clinical account was a product of the entirety of the work with Ms. R, I also think that

there were junctures in the work during which I sensed that Ms. R and I were engaged in something different from "ordinary" dream thinking. For example, as I have described, such a moment occurred in a session as I spoke to the patient about her hopelessness regarding the possibility of ever freeing herself of the need to make an impossible choice: whom to kill, herself or her mother? Though I could feel that a significant (and welcome) shift was occurring at that point, I was not able to attach words to, or even be clear with myself about, what I was feeling. As the session proceeded—a session in which a good deal of psychological work was done—the patient (unconsciously) helped me realize that I had come to experience her tenderly and sadly as the daughter I never had, and never would have. Paradoxically, in the very act of becoming aware of that emotional void in myself, I was experiencing with Ms. R feelings of father–daughter love and loss (separation) that constituted, for me (and I believe for Ms. R), a new way of being with oneself and with another person.

This transformative thinking was inseparable from another level of transformative thinking in which the patient and I were engaged during this session: Ms. R's coming to feel and understand at a profound psychological depth her self-imprisonment in a world cast almost exclusively in terms of the dilemma that becoming a person separate from her mother required either murder or suicide. The patient was able to begin to experience a way of being that was cast in radically different terms. She began to experience separation (becoming a person in her own right) not as an act of murder, but as an act of creating a place in herself (and between herself and me)—a place in which she was able to experience a previously inconceivable sense of who she was and who she was becoming.

CONCLUDING COMMENTS

The shift of emphasis in contemporary psychoanalysis from an emphasis on *what* the patient thinks to *the way* he thinks has, I believe, significantly altered how we, as analysts, approach our clinical work. I have discussed three forms of thinking that figure prominently in the portions of the two analyses I have discussed. The first of these forms of thinking—mag-

ical thinking—is thinking in name only; instead of generating genuine psychic change, it subverts thinking and psychological growth by substituting invented reality for disturbing external reality. The omnipotent fantasying that underlies magical thinking is solipsistic in nature and contributes not only to preserving the current structure of the unconscious internal object world, but also to limiting the possibility of learning from one's experience with real external objects.

By contrast, dream thinking is our most profound form of thinking. It involves viewing and processing experience from a multiplicity of vantage points simultaneously, including the perspective of primary and secondary process thinking; of the container and the contained; of the paranoid-schizoid, depressive, and autistic-contiguous positions; of the magical and the real; of the infantile self and the mature self; and so on. Unlike magical thinking, dream thinking "works" in the sense that it facilitates genuine psychological growth. While dream thinking may be generated by an individual on his own, there is always a point beyond which it requires two (or more) people to think/dream one's most disturbing emotional experience.

Transformative thinking is a form of dream thinking in which one achieves a radical psychological shift—a psychological movement from one's current conceptual/experiential gestalt to a new, previously unimaginable ordering of experience. Such movement creates the potential for generating types of feeling, forms of object relatedness, and qualities of aliveness that the individual has never before experienced. This sort of thinking always requires the minds of at least two people, since an individual in isolation from others cannot radically alter the fundamental categories of meaning by which he orders his experience.

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AN ELUSIVE ASPECT OF THE ANALYST'S RELATIONSHIP TO TRANSFERENCE

BY STEVEN H. COOPER

The author discusses the analyst's reactions to being the object of the patient's transference, noting that this topic has been somewhat neglected in the psychoanalytic literature because of the centrality of transference analysis to the psychoanalytic method. He identifies different dimensions of countertransference that relate to being a transference object and discusses these in the light of "objectionable" and "unobjectionable" transference. The analyst's relationship to theory is also discussed. To clinically illustrate his points, the author summarizes the case of a patient whose transference fantasies and attributions engendered quite contrasting reactions by two different analysts.

Keywords: Transference, enactment, analytic attitude, transference object, transference interpretation, countertransference, conflict, resistance, fantasy, analytic posturing, analytic theory, erotic transference.

Psychoanalysts are always in some kind of relationship with their patients and with the psychoanalytic process. While there are many elements of the analyst's object relationship to process (e.g., Parsons 2006), I will focus on one that is at the heart of method: his reactions not just to being a particular kind of transference object, but also to the fact of being a transference object. I choose this topic since its centrality to method makes it difficult to think about.

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There is reason to believe that, as individuals, we differ in our relationship to receiving and participating in the analysis of transference—that is, in how enthusiastically we embrace, feel gratified by, idealize, devalue, or in sum have conflicts about the psychoanalytic process that features the analysis of transference. We are all different in the degree to which we feel ourselves at home with being an object of transference or are alienated by the notion of transference, or locate ourselves at some point in between. Of course, there is also the general technical matter of whether we are more comfortable working with transference through displacement or taking it up more directly.

One reason that we have not vigorously explored the analyst's experience of being a transference object is our fear that, in doing so, we might undermine the method itself. If analyzing transference is our job, our medium—as well as understanding the countertransference—why would we legitimize thinking about how it feels to be a particular kind of transference object? Another reason relates to a figure-ground problem in distinguishing countertransference to the patient from countertransference to the method of analyzing transference. This is not unlike the joke about two fish swimming when another fish swims by and asks, "How's the water?" One of the fish looks at the other and asks, "What's water?"

We encourage patients to give themselves over to experiencing transference. As analysts, we learn about the value of surrendering to being transference objects. The act of relinquishing ourselves to receiving the patient's transference partly defines us as analysts, and shapes what it is we are trying to accomplish. When we work with our reactions and experiences about being transference objects within the particularities of any analytic dyad, we always run the risk of collapsing the patient's analytic space, taking away this precious opportunity to understand the patient's objects, the ghosts that haunt him and accompany him in the present. Unconscious enactments related to our feelings about being objects of transference, since this is the very stuff of analytic therapy—a lynchpin of technique—may sometimes be quite difficult to see.

Psychoanalysts have been more inclined to focus on the patient's resistance to the transference (e.g., Sandler and Sandler 1994) than on the analyst's resistance to observing the transference. Bird's (1972)

description of these forms of resistance in the analyst is an exception to this generalization, as are important contributions by Joseph (1985), Feldman (1997), and Smith (1990, 2000). The notion of the analyst's "being" a transference object does not imply that the analyst occupies a static, unidimensional form of object relating or a single affective experience for the patient as the patient expresses unconscious feelings for the analyst in the form of transference. In speaking of the analyst as "being a transference object," I am simply referring to the patient's conscious and unconscious experience and participation in that affective realm that patient and analyst try to recognize as a part of transference.

To be sure, our more general reactions to being a transference object often help inform us about the nature of specific transference and countertransference reactions with particular patients, just as these reactions are affected by the content of particular transferences. For example, the analyst may feel that he has only a distant relationship to the patient's attributions to him, or he may have an intimate experience of these attributions. This may be related to defensive aspects of how the patient is relating to the analyst or may relate to the analyst's particular kinds of experience in response to the patient. The analyst's wish for recognition may become prominent at various stages of analytic work (Steiner 2008), just as there are parts of the analyst that he may wish will not be recognized by the patient. It is easy for the analyst to attribute or consign disavowed parts of himself to the patient's "transference," or to be overly literal in failing to see as transference certain elements of the patient's perceptions of him that resonate with the analyst's perceptions of himself (Feldman 1997).

Experienced analysts have the opportunity over time to determine whether they tend to be more comfortable with elements of erotic transferences or hostile ones, and of course to observe whether they tend to experience one form of transference more frequently than another. Smith (1990) noted that three continuously interweaving strands—technical decisions, countertransference, and mutually evoked enactments—contribute to determining the analyst's participation in the analytic relationship.

I view it as axiomatic that the analyst is always in various degrees of conflict with the idea and experience of being a transference object,

just as he is in a state of conflict toward everything else in psychic life (Brenner 1982; Smith 2000). One part of the various sources of conflict and ways that conflict is expressed is the analyst's relationship to the analytic method of working with and experiencing the transference, notwithstanding our conscious dependence on and valuation of the transference in our work.

It could be said that we construct particular types of compromise related to being transference objects that involve occupying a position between a methodological ideal (i.e., what the analyst aims to receive and interpret about the transference) and a clinical reality (the analyst's constraint or limitations in interpreting particular clinical phenomena). When the analyst notices that he is in a kind of postured position with his patient related to this type of compromise, it is often a sign that he might benefit from trying to understand the relevance of this countertransference situation to the notion of an enactment. For example, our technical decisions not to address something may be born of enacted experiences between patient and analyst. The analyst might question how these compromises or postures on the analyst's part repeat the patient's previous object experience. Alternatively, it may be useful to consider possible enactments between analyst and patient that are related to new forms of object relating with the analyst.

Consider the situation of a male analyst who is aware of a possible erotic transference to a female patient, a transference that he is reluctant to interpret because he is uncertain about it and wants to listen further in order to learn more about what the patient might be expressing. Over time, he learns that the patient's father was shy and tentative in relation to the patient's emerging womanhood during adolescence. The analyst's compromise (actually a prudent and reasonable piece of technical decision-making) is nevertheless located at a particular point on the enactment spectrum, which analyst and patient may gradually become attuned to over a period of time.

This view is consistent with Feldman's (1997) description of the analytic situation as one in which the patient projects both a fantasy of an object relationship and a propensity toward action. Within this view, the patient is trying to reduce the discrepancy between an internalized object relationship and experiences in the analytic situation. If the ana-

lyst receives these attributions with too much of a sense of congruence between the patient's internalized object relation or fantasy and the patient's experience of the analytic situation, he is often unable to observe various modes of conflict and defense related to the meaning of these unconscious object relations.

For example, we hear many analysts who, in speaking of patients who see us in the transference as variously idealized objects, construe this as a form of "what the patient needs or needed during development." This particular form of congruence between what the patient projects and how well it fits the analyst should always be questioned as multiply determined and potentially fraught with other meanings. The patient may be inducing us to behave in certain ways (e.g., Sandler and Sandler 1994) or avoiding other ways of seeing us that create unconscious anxiety about hostile feelings or different kinds of longings than those manifested through idealization.

A blatant and crass example of my own experience of being a transference object occurred a number of years ago when I was consulting with a close colleague about a patient who was feeling particularly envious of me and angry in the transference. I was seen as a father who had much to give but who selfishly refused to do so, and instead decided to withhold love from him. My colleague also talked to me about some of his most challenging patients. At some point in our conversations, we humorously imagined a *New Yorker* cartoon depicting an analyst's office with a sign on the wall that read "Transference Costs Extra." When this joke about our method developed, I found it immediately helpful with regard to this particular patient of mine, as it seemed a rather obvious signal that I felt something was being extracted and stolen from me, something I was afraid of losing or wanted to get back. My vengeful thoughts about charging extra for transference seemed to relate to a fantasy in which the institutionalized methodology of psychoanalysis would change and conform to elements of my frustration with my patient, given that I had felt I was giving my all and it was not enough. Basically, my patient wanted me to change the inherent and institutionalized restraints of being an analyst so that I might spend more time with him. Interestingly, my vengeful fantasy reflected my actual inhibition about more actively

interpreting his feeling that not only was I not giving enough, but also that I *could* not give enough.

This example reminds me of Ferro's (2005) comment that he often learns about his patient through what he himself has said but not yet fully understood until he speaks. I have referred to this as a form of the analyst "working backwards"—discovering and hearing a new formulation that is implicit or embedded in a comment that the analyst has just made, either silently or to himself, or through an only partially formulated interpretation (Cooper 2010).

CONFLICT AND ENACTMENT EMBEDDED IN THE ANALYST'S ATTITUDE TOWARD TRANSFERENCE

I suggest that there are at least two dimensions of countertransference that specifically relate to being the object of the patient's transference. While they are not entirely separate from one another, it may be useful to tease them apart in order to illustrate how these dimensions may illuminate conflicts for the analyst in understanding enactments in relation to the transference. In particular, these dimensions of the countertransference exist in dynamic relationship to one another and are often embedded in enactments between patient and analyst.

The first is a level of more immediate experience, something that the analyst senses about the patient's way of seeing the analyst that includes perception and attribution. The other level is a technical ideal that we hold about how to use countertransference, which demands that we not consciously attribute negative or positive feelings too quickly or concretely, too categorically, or too simplistically to any particular meaning. Above all, this technical ideal emanates from a belief that the patient's transference helps the analyst understand elements of the patient's inner life and the inner life of the analyst as they are intertwined in various forms of enactment. Our technical ideal also holds that patients are always trying both to change and to hold onto their current self-organization in a way that creates conflict within the self and within the analyst.

Countertransference includes all feelings that the analyst holds toward the patient, including those stemming from his experience of being a transference object, his feelings about being a person in relation to the patient, and his responsibilities and technical ideals as an analyst. Yet the experiential level of countertransference to the patient's transference does not entirely overlap with a theoretical commitment to the proposition that all countertransference experience (like all transference) is complex and serves to both advance and limit analytic progress. In other words, we feel what we feel in the moment-to-moment experience of being an analyst. We use this level of feeling by incorporating it into our commitment to a kind of analytic ideal about understanding how our experiences help us understand the patient.

Within this experiential level, the analyst is to some extent at any given moment operating with a sense of what is an "objectionable" and "unobjectionable" set of feelings in relation to the patient's transference, regardless of his technical ideal not to think of any countertransference experience as technically "objectionable." The analyst may begin to experience something about the nature of transference as a binary (e.g., erotic or hostile, good or bad) as he begins to formulate the meaning of transference in language that gets at the "thickness" (Tronick 2003) of meaning. For example, a patient's lack of apparent progress is likely to feel more frustrating or problematic at one point than at another. With another patient, the analyst may gradually notice himself shifting in his experience of the patient's idealizing transference; he may note that in some respects, he finds this idealization impersonal and reflexive, or even hostile and patronizing. Like any other form of countertransference, this is partly unconsciously motivated, and might very well be more or less noticeable, or unobjectionable or objectionable, to another analyst.

But these experiences of what at any moment feels "different" or more noticeable in the analyst's reactions to the patient's transference are not objectionable at the level of being technically or analytically problematic. On the contrary, these shifts in the analyst's experience of the patient's transference are nearly always a sign of movement, a kind of tipping point, in trying to understand levels of enactment or mutually held forms of resistance within the analytic dyad. These are cues (Smith

1990) about a level of experience related to resistance or enactment that is becoming more conscious. Smith's (2000) explication of the *benign negative transference* demonstrates how many subtle experiences of the analyst may be more broadly applied in understanding levels of enactment and resistance in the analytic dyad.

It is important to emphasize that some analyses are compromised by the ways in which our technical ideals about welcoming and containing the patient's transference sometimes make us less attuned to the useful signals provided by our more immediate experience of being objects of transference. Other analyses may suffer from the opposite problem, one in which the analyst's affective experience about being the object of transference is valorized in ways that compromise his ability to contain and make use of more complex countertransference.

An area that is particularly important to explore is that we are also probably quite different from one another in terms of how we both metabolize and express affect. For some analysts, a change in countertransference may feel as though a switch has been turned on, while others are far more able to have a more continuous awareness of affects about the patient's transference. That is, some analysts become more aware and conscious of what they are feeling about the transference in a sudden way that may be more similar to the ways that dichotomies such as "objectionable" and "unobjectionable" describe experience. There are also differences in the promptness with which analysts initiate interpretations about enactment, experience, or conflict, with some taking up these matters gradually and others more abruptly. Some debates between various schools of thought about the use of countertransference are, at root, debates about to what degree the analyst speaks from "unformulated experience" (Stern 1983) or a personal register (Bromberg 1998; Cooper 1998, 2008), more than they are debates about how these experiences are ultimately conceptualized in clinical work.

My view of these levels of countertransference overlaps a great deal with Smith's (2000) view of the *benign negative countertransference*. Smith describes the analyst's awareness of subtle shifts in repetitive, but not always fully seen and enacted, elements of the transference. He would encourage analysts to more closely attune themselves to these kinds of experience in working with formulations about transference and enact-

ment. In my attempt to tease apart the analyst's initial, affective reactions as distinct from our technical dedication to working with these reactions, I am trying to highlight something that Smith called "a personal response from the countertransference" (1990, p. 223) that triggered his thinking about the complexity of enactment with any particular patient. Greenberg's (1995) notion of the *interactive matrix* is also relevant here, since he suggests that the analyst's focus on interpretation will depend on what is visible to him at any particular time—essentially, what is syntonic or dystonic.

While on one level it seems obvious to apply these notions about countertransference to the patient's transference, in fact, I believe that this is not so clear-cut. If we believe, as I do, that the patient's transference is to the "total situation" (Joseph 1985), then the patient will be reacting to everything that the analyst does from a total psychic organization. He will be responding to various elements of how the analyst responds to analyzing and expressing his reactions to the patient's transference, including changes in how the analyst responds to elements of the transference. The patient will also notice, sometimes without being conscious of it, that there is a difference between the analyst's affects about receiving the transference and his capacity to dedicate himself to working with it.

Also relevant to this discussion is Feldman's (1997) comment that, if the analyst feels his role is too congruent with the patient's internalized fantasy of an object relation, the analyst's ability to recognize the patient's unconscious fantasy is compromised. In the light of the two levels of theoretical discourse about our use of countertransference that I am highlighting here, Feldman is suggesting that, when the analyst feels the transference is concordant, he may sometimes fail to engage in the second level of work with the countertransference—in his terms, to explore an internalized fantasy, or, in my terms, to more fully investigate levels of enactment between patient and analyst that we may be alerted to through these experiences.

Put another way, the more immediate form of experience that Feldman is speaking of, and that I am describing as well, is another cue as to the nature of forms of resistance on the part of the analyst. Similarly, Mitchell (1991) proposed that the analyst changes in his experi-

ence of the arrangements of analytic work in ways that make him more or less likely to see and interpret particular types of clinical phenomena at various points in the work. These analysts suggest that whatever the analyst interprets is related to how psychic phenomena are juxtaposed in the context of the analyst's changing psychic reality.

It is likely that many analysts struggle with feelings about the transference being noxious, annoying, or unwelcome, given that we invite the transference—indeed, rely on it to do our work. Smith (2000) prefaced his discussion of the benign negative transference by saying that it may be "impolitic" to try to discuss this matter, while earlier in this paper, I referred to my imagined *New Yorker* cartoon as potentially crass. Yet I think that our patients sometimes have a realistic sense of our range of feelings about being transference objects, despite their awareness that we aim to work with and understand the complexity of these feelings.

Sometimes this becomes a kind of "before and after" situation for the patient: "How come you seemed to welcome my anger before, and now you see it as my blaming and avoiding taking responsibility?" Thus, many of our patients, fundamentally not interested in our technical notion of finding all levels of our own feelings workable, would describe our reactions to their transference in the binary of "objectionable" or "unobjectionable." For example, the patient might notice an instance when the analyst shifts his interpretive position in relation to the transference, perhaps partly because it has become painful or challenging for him to work with. In this sense, laments of "you used to love me," "you used to see my side more" (even when the patient consciously agrees with the analyst's interpretations) become defensive positions that are more comfortable to hold on to than it would be to entertain the complexity of new shadings and perspectives on the patient's conflicts.

A more accurate way of describing these various levels of countertransference experience is to say that we are always in a state of conflict with our patient that both advances and impedes progress in getting to know him. We are also in a constant process of change in our relationship to our patient's experience and our arrangements in working with him, as described by Greenberg (1995) and Mitchell (1991). For example, a patient's version of psychic reality in which he feels victimized by his parents in some way may be largely resonant with the analyst for

a period of time, until some later point when the analyst becomes more aware of the patient's identification with these hurtful others, or even of the patient's unconscious efforts to arrange for a repetition of these kinds of interactions or experiences with the analyst. In a sense, as the analyst gets to know his patient more and more, he changes in terms of how much and how deeply he *feels* different parts of the patient, and consequently his interactions with the patient may also change.

As analysis progresses, the analyst also (hopefully) feels a greater degree of freedom to think and to express his thoughts and perspectives to the patient (Bion 1967; Symington 1983)—what Caper (1997) referred to as the analyst "having a mind of his own." Some of the time, I suspect that our feelings about not wanting to accept particular forms of transference are important because they lead us to a further exploration and awareness of more comprehensive versions of the transference. At best, dichotomies such as unobjectionable and objectionable, or negative and positive, help the analyst locate his experience in order to understand new elements of transference-countertransference engagement.

Some analyses that tend to provide destructively false "alternative realities" do so by ignoring some of the analyst's realistic feelings about being a particular kind of transference object. What results is a tendency toward dichotomies about what the patient needs versus what the patient might understand about what he needs. Blatant examples involve the analyst's reluctance to interpret hostile elements of erotic transference, not only for fear of hurting a patient, but also because the patient's longings and attributions are congruent with either how the analyst feels toward the patient or wants to feel toward the patient, or how the analyst wants to be experienced by the patient. This is a place where rationalizations related to "needs" that the patient has to experience love, while partly true, may be valorized to the exclusion of more multifarious elements of transference (the mixture of loving and hostile feelings) that the analyst avoids taking up with the patient. Sometimes the analyst's tendency to idealize parts of the patient is an obvious example of those instances when positive feelings may potentially prevent him from observing and understanding his patient's conflicts.

I have worked with patients who had previously seen analysts for protracted periods of time in which the patient was feeling lost in an

erotically masochistic relationship to the analyst. Sometimes the analyst in these circumstances is afraid of hurting the patient by more actively analyzing the meaning and origins of some of these fantasies. Sometimes he is gratified by these fantasies and unwittingly blocked in making sense of them to his patient. The fear of hurting the patient through interpretation of these desires may lead to the analyst's concretization of these fantasies as "real" in the patient's mind, as a kind of object relation, instead of the analyst's working with the fantasies as complex expressions of affect and desire that can be investigated. The analyst may be blocked in his ability to think about his patient "falling in love" because he wants to welcome the patient's capacity to resume experiencing longed-for empathic objects, and thus at the same time may welcome unconsciously prescribed ways of behaving in response to the patient's inner life.

On the other side, however, the analyst's constraint in interpreting some of these fantasies can engender and catalyze the patient's fantasies/wishes about the analyst being in love with the patient. In this sense, interpretation always contains a component of rejection and repudiation of a patient's transference fantasies. It is an act of separating the patient's mind and the analyst's mind for a moment in time. Sometimes these moments occur very early on in treatment.

Consider the following clinical example as an illustration of how differently two analysts hear and understand elements of transference. I aim to illustrate a number of issues related to our varying feelings about being transference objects and what these feelings may tell us about the patient. I suggest that this dimension of analytic work may inform us about implicit and explicit attitudes embedded in our theory about how the analyst uses his experience of being a transference object, and about various forms of what I will refer to later in this paper as *analytic posturing*.

CLINICAL ILLUSTRATION: EDWARD

I saw Edward, a man in his mid-fifties, as part of a consultation process three months after he had begun an analysis with a female analyst, Dr. G. Edward had been in a previous analysis for three years with a different female analyst, Dr. H, until his move to a new city.

My initial impression was that Edward had developed what appeared to be a highly eroticized form of transference with Dr. H, his former analyst. He had enjoyed seeing her despite feeling that he had not really changed as a result of their three years of work together. I was struck by his appreciation for Dr. H, despite his stated frustration about his lack of apparent progress. According to the patient, Dr. H had not really offered any formulations of what these erotic feelings were about in dynamic or developmental terms, leaving him feeling that his erotic sentiments were "really just about being attracted to her and I think her being attracted to me."

I found this puzzling, and of course I considered whether Edward simply didn't want to hear or remember what Dr. H had said about his feelings. Yet I found his version of things plausible, particularly after a discussion with Dr. H.

Edward had grown up feeling that, although his mother showered him with praise, her observations and engagement with him were superficial. While his three-years-older brother felt envious of the flattery that Edward received from their mother, Edward envied his brother because "she was honest and direct with him like she was with my father, opinionated but engaged." He felt that his mother actually attended to his brother's schoolwork, critically evaluating both his athletic and academic performance. In contrast, Edward's mother reflexively praised his activities, he felt, in ways that began to enrage him during adolescence, making him feel unimportant to her and weak. In contrast, Edward trusted his father's evaluation of both his own and his brother's performance. He felt that while his father was supportive, "he could be honest, too."

Edward told me that he had ostensibly been seeing his former analyst, Dr. H, to improve his relationship with his wife. Yet it occurred to me in our several meetings that, unconsciously, he was seeing her at least partly in order to gratify some of the erotic needs and fantasies that he was unable to bring to his marriage. He found Dr. H very attractive and thoughtful, and the two of them lived together in his mind in an idealized marriage. Unlike his wife, Dr. H had been interested in him and had laughed at his jokes, Edward said, while his wife found his sense of humor "stupid and childish."

Edward said that his analysis had helped him stay in his marriage, but it was not clear whether this was because of what he had learned about himself or because the analysis functioned as a kind of adjunctive relationship that titrated his disappointment and anger with his wife. It also occurred to me that his analysis had functioned as a kind of compromise between staying with his wife in their relatively disconnected state and having an actual, secretive affair that would cause him more guilt than he was already experiencing. I had some sense that perhaps he had found another way not to need anything of an emotional or sexual nature from his wife.

Edward consulted with me only three months after beginning treatment with his new analyst, Dr. G, because of his concerns about her. During our consultation, I saw Edward alone for a few sessions and spoke with both Dr. G and Dr. H. In my discussion with Dr. H, the patient's previous analyst, it appeared that the analyst felt that Edward's experience of her was of a longed-for maternal object—a sense of loving and being loved that he could trust. I found Dr. H thoughtful but quite general in her descriptions of the analysis. She had found Edward appealing in his intelligence, and experienced him as quite lonely and unhappy in his marriage. She had been encouraged by his ability to give up a series of affairs when he began analytic work with her.

When I told Dr. H about Edward's statement that she "hadn't made interpretations about his affectionate and loving feelings for her," she was surprised, since she thought she had linked these feelings to the patient's wishes for a mother who would love him and engage with him. Yet she did say that she had been considerably less active with Edward than was her custom with most patients, and that his transference had been striking in how quickly it materialized and how homogeneously it was expressed.

My overall impression of this work was that Dr. H had been recruited through Edward's projections in ways that were relatively comfortable or congruent for her, but that she may not have been aware of his unconscious involvement in narrowing and delimiting what they would look into in important ways. I wondered more specifically about how the homogeneity of this transference, rather than involving primarily "loving" feelings, may have also incorporated elements of generalized, generic

loving, like that he had experienced with his mother—in contrast to specific ways of knowing and being known that he had longed for with his mother. That is, it occurred to me that Edward had partly re-created an old situation of feeling "loved" while not feeling very well seen or understood.

Within the first few months of his new analysis with Dr. G, Edward had developed very strong erotic feelings and fantasies toward this new analyst, not unlike what he'd experienced toward his first analyst, Dr. H. The new analyst, however, had begun to take a very different interpretive direction. Early on, Edward asked Dr. G how she felt about his having such strong and intense desires for her. Dr. G surprised Edward by telling him that she was puzzled by his feelings and intrigued by his question. She told him that she did not yet know what his desire might mean, and that she wanted to understand these feelings with him.

Dr. H had told Dr. G how she had viewed Edward's erotic feelings, and Dr. G thought that this formulation was partly correct. She also had the sense that Edward was trying to revisit the question of whether he could love and be loved in a way that would allow him to feel that his mother had been sincere and engaged, and that he could trust her in ways that he had never been able to feel. Dr. G came to this conclusion partly based on her experience of Edward's affect when he probed her about how she felt about his desire. His question seemed riddled with anxiety and had a demanding quality, as though he were attempting to lock in her affection and attachment to him. Since he was a man of some subtlety and nuance, the question also struck her as incongruent with his other ways of relating.

After a few months of work with this new analyst, Edward continued to ask Dr. G how she felt about his desire for her. At this point, she wondered with Edward about whether he was unconsciously avoiding or minimizing anxiety about his attachment to her, and in fact working hard to replace anxious feelings with feelings of desire. She told Edward that he might be hoping she would act and feel in ways that were not unlike what he himself described feeling in relation to what his mother had done to him—that is, his mother would often tell him how much she loved him, but he felt it was disingenuous and insincere. During his adolescence, Edward had felt guilty about not believing his mother,

and would sometimes criticize and attack her. Furthermore, he would at times feel "dropped" by his mother when she would seem to be close and then all of a sudden prefer his father or older brother to him.

Dr. G said that Edward's tendency to "fall hard" for Dr. H, his first analyst, and to so quickly fall for Dr. G herself, made her think that his desire was actually a request or demand for both analysts to be more trustworthy than his mother. In a sense, he was providing an apparent opportunity for a disingenuous form of engagement, probing Dr. G to determine whether she, like his mother, would offer meaningless expressions of love that he would then question (yet desperately continued to seek).

The patient came to me to talk about whether he should continue to see Dr. G. What did I think of his work with her so far? He was confused. He was puzzled and intrigued by this new analyst's having answered an important question (even though the answer was more of an interpretation about what Edward was seeking through asking the question). He had never asked Dr. H the question about how she felt about his desire, but he had nevertheless felt there to be a silent acceptance of it.

I developed the sense that, at least to Edward, he and Dr. H had seemed to live in a world outside of interpretation, and the analysis served to fuel Edward's fantasies about the two of them as objects of desire for one another. He thought that Dr. G, too, might be the right analyst for him, but he also felt threatened by her; he was concerned that she was "tough and rejecting."

In our three sessions together, I became convinced that Edward was beginning to experience his new analyst as rejecting in ways that he had experienced his mother, and that, while painful, this might be quite productive for him. I did not experience Dr. G as "tough," and in fact I had the sense that she was quite engaged with Edward, and that she was accepting of his desires while very much wanting to help him understand their complexity.

I think it was a useful consultation. Edward and I talked for a few sessions about his experience of Dr. G's interpretation. He spoke to me about how he had sought intimacy with women through a series of affairs, and said he felt hopeless about finding closeness and sexual gratification in his marriage. Edward was pleased that, during his earlier anal-

ysis with Dr. H, he had terminated his extramarital affairs. He agreed with my suggestion that, in his earlier analysis, he had to some extent enacted a compromise in which he found intimacy with a woman without having a real affair. Analysis had provided him with an opportunity to feel understood, but also with a way to reject his wife and mother. It had partly been a safe place to hide. He decided to take this on with his new analyst, agreeing that something in his question to Dr. G about her experience of his desire was a test. Of course, this was an adventurous interpretation made on a hunch by the new analyst, but it was offered with a considerable degree of modesty, warmth, and speculation, inviting the patient to discover his reactions.

What I want to explore for a moment is Edward's probing question to Dr. G about how she felt about his feelings toward her. Dr. G's response to him utilized her countertransference experience with considerable freedom. By her own admission, in this situation, she did not actually like being the recipient of these feelings so suddenly and without a sense of where the feelings had come from. She wondered whether her sensation of mild irritation reflected an inability to contain Edward's wishes and longings.

For good reasons, we are trained to be suspicious of our wishes *not* to receive or contain our patients' feelings and attributions before making use of them; it usually takes a while to get a sense of what these feelings are about. Dr. G told me that she was usually quite open to patients who express such feelings, and that she often found these feelings quite gratifying. But in this case she felt suspicious because she felt quite unknown by Edward; it was as if this "transference" had a life of its own. She also felt controlled by Edward, and this feeling of control led her to consider whether the patient was beginning to elaborate an internalized sadomasochistic object relationship; this relationship involved erotic feelings organized around submission to what he construed as a maternal lie.

The issues confronting Edward's new analyst were quite complex, and by no means can any aspects of technique be generalized from this consultation—particularly with reference either to the complexity of erotic and hostile transference, or the virtues or problems with early interpretations of transference. For Dr. G, Edward's new analyst, the early appearance of strong, nearly automatic erotic feelings became an occa-

sion for her to think more quickly, and perhaps more daringly, about some of the underlying transference phenomena than she would have done had these feelings of Edward's developed over time. She probably also benefited from knowledge about his previous analysis, its strengths and limitations.

What is most important to my discussion of the analyst's experience of being a transference object is the notion that Dr. G made more liberal use of her trust of what was "normative" in her experience of doing analysis. This resulted in her sense of questioning something about the complexity of Edward's experience, something at odds with the patient's psychic reality or conscious experience. This reliance on a kind of external reality (her perceptions of the patient's "desire") provided her with a pivot point from which to understand his unconscious expressions of desire, enactment, submission, and the attempt to secure an attachment.

It is important for many reasons to pay attention to our subtle reactions to being a particular transference object even in the context of our commitment to welcoming these reactions. This may allow us to better appreciate Edward's actual interest in his new analyst as an object external to the internalized fantasy he had held in relation to his previous analyst (Bromberg 1995; Feldman 1997; Winnicott 1969). He demonstrated this by asking Dr. G how she felt in response to him. In fact, Dr. G and I considered whether there were ways in which Edward might even be permitting himself a form of useful therapeutic regression by asking this question—a revisiting of the experience of betrayal with a difficult-to-read, often disingenuous mother. I also think it possible that Edward may have been responding to elements of Dr. G's attitudes, feelings, and reactions to him that were quite different from what he might have prescribed for her (Feldman 1997).

Analytic work and a commitment to the analysis of transference need not involve a suspension of the obvious reactions that our patients feel and that we feel in the countertransference (i.e., a kind of reality testing). When someone immediately feels "in love" with his analyst, and the analyst in turn acts as though this is immediately understandable in ways that it actually is not (once we integrate various countertransfer-

ence reactions), a particular kind of disconnected posturing on the analyst's part may be involved. On the other hand, we try to contain affects and attributions that we do not yet understand. This is not necessarily posturing, but involves an active process of trying to make sense of transference that requires time.

With Edward, Dr. G was prone to a particular kind of reflection that accompanied her receptivity; the transference felt distinct to her as something other than what Edward expressed it to be. I believe that this analyst, in a highly thoughtful and careful though daring way, was trying hard not to push Edward away from his feelings of love and attachment. Instead, she wished to show him, I think, how he might truck with erotic feelings that were far more complicated than he had let himself investigate in his previous analysis.

I find it interesting that Dr. G initially demonstrated a particular kind of questioning of the patient's attributions to her, or perhaps even showed a resistance to being the transference object Edward wished her to be. She felt unknown by him, made into a creation of an internal object in his mind. This is what she was beginning to try to analyze—that Edward subverted the reality and externality of the object in order to enact internalized scenarios in his mind. Dr. G decided early on to try to begin an analytic process by making it their project, in a sense, to look into and investigate that.

Dr. G made use of her countertransference to being a particular kind of object for Edward as a sort of signal of something problematic, or of what I have called a *disturbance in the field* (Cooper 2010). She experienced a particular kind of countertransference to being an unconsciously prescribed object involving Edward's unconscious transference of wanting her to submit to his demands to love him by "believing him." She learned that Edward had felt seduced and abandoned by his mother. Interestingly, Dr. G's method allowed her to make different transference interpretations to Edward; she could try to help him see why he needed to assign feelings to his analyst that might not be very related to what she really felt.

Edward's new analyst was much more focused on Edward's unconsciously embedded transference than Dr. H had been, and less focused

on his accessible awareness of his experience of the relationship. I very much agreed with Dr. G that, in this way, she helped him make contact with parts of himself that he was continually enacting through his adaptations, including in his enacted version of repetitive scenarios with his former analyst. This way of using a variety of levels or types of transference is to me a living example of the way in which Freudian, Kleinian, and relational versions of transference can find a home together.

If we frequently dismiss or override our reactions to being an object of transference in clinical work, then we are throwing out huge amounts of clinical data and opportunity. Another way to say this is to note that the interpretation of transference as a form of enactment has sometimes been a relatively neglected area of focus in analytic work, due to the fact that the interpretation of transference is one of our most important forms of interpretation. But it is no less likely to involve compromise formation, repetition, and enactment than other types of interpretive activity. Smith (2007) has put this well in saying that: "Moreover, if we accept that enactment is continuous, then all interventions are part of an enacted process. Whether we are interpreting conflict, self-object transferences, projective identifications, or relational configurations, every interpretation is made from within that process" (p. 1058).

Often a patient such as Edward thinks he is expressing feelings about the "transference" and concretizes these feelings, unable to experience a disavowed or dissociated opposition to another set of feelings. His "have erotic transference, will travel" modality constituted a way for him to repeat an ambivalent attachment to his mother and his accompanying servitude to her. It was also a way *not* to feel the desperate aloneness he felt in relation to his wife, and not to feel what it was that he needed from her or anyone else. Dr. G's attunement to her relatively routine negative countertransference was a clue to this defense, but in order to be most effective with Edward, she had to avoid her instinct to accept transference attributions instead of paying attention to this more commonplace reaction of a benign negative countertransference (Smith 2000). In the end, I imagine that this put her in closer contact with parts of the transference that were less apparent: the patient's feeling that if he did not manipulate and seduce his analyst with his submissive love, she would abandon him.

DISCUSSION

I think it fair to say that, since the process of psychoanalysis is so centrally defined by the analysis of transference, we have been prone to emphasize the analyst's attempts and wishes to bring the transference into focus. For example, Steiner (2008) provided a thoughtful examination of the analyst's experience of being an excluded observer in the transference.

Analysts have written less about the sense of alienation that can accompany listening to the myriad ways in which patients experience us in the transference. Sometimes I think of being a transference object as a kind of uprooting, of being an alien in a strange land—inhabiting a self as experienced by another who is sometimes unfamiliar and at other times uncomfortably familiar, in that the patient recognizes parts of us that we might wish were less recognizable. In our acceptance of this role as analyst—indeed, our invitation to work with transference without really knowing what we are getting into or how it will go—psychoanalytic treatment begins with an act of uncertainty and risk for the analyst, even if that risk may not be as great as the patient's. Sometimes I actively try to mentally, psychically disengage from my expectations about what I would naturally predict about transference so that I can think about this phenomenon as Joseph (1985) described it: as the "total situation."

To some extent, the analyst pushes aside his personal concerns about this risk in favor of his method, which he believes will be helpful to his patient. This pushing aside is based on a mix of investment in the patient and in the analytic process, and allows the analyst to retain potentially useful elements of information. An obvious caveat is the need for the analyst to first consider that his "objections" to being seen in the transference may involve any of a number of problematic features: a rejection of the patient's unconscious fantasy life; the analyst's need to be seen "as he is," rather than as an object in the patient's mind; the analyst's wish to dictate psychic reality rather than explore the patient's psychic reality; or a fundamental nihilism about the analytic process itself.

At the beginning of analytic work, there is a kind of pact involving the analyst's invitation for the patient to say what comes to mind. As

Philips (1993) characterized it, the patient is invited to say what comes to mind "without knowing in advance what he will say." I suggest that the analyst's stance in inviting the patient to say what comes to mind is always an adopted one that the analyst has not yet come to experience fully as his own position. He consciously wishes to extend the invitation because of his belief in the analytic process, but he does not yet know whether he really wants to hear what the patient has to say. At the very least, he knows that the new patient—a stranger, as it were—will be telling him the most intimate details of his life. What has prepared the two of them for this?

The postured part of the analyst's stance relates to the fact that the analyst commits himself to this process because he believes in it. But he is often filled with complex feelings that are sometimes not attended to and may be important. For example, his excitement or reluctance about this invitation is often important to consider in regard to elements and patterns of enactment of transference in the early stages of treatment. A patient who is prone to impulsiveness or disinhibition will induce quite different feelings in the analyst than will an inhibited patient for whom the invitation feels more consonant with the psychic project of augmented expressiveness. The analyst might ask himself questions like: Why am I reluctant to ask the patient to say what comes to mind? What am I excited about in asking this particular patient to say what comes to mind?

Ogden (1994) seems to implicitly address this complexity in outlining his wish to let his patients know that they, like he, may also want to retain some privacy. With this statement, Ogden may in effect be making an interpretation about the analyst's countertransference to his method; he seems to be noting that there may be a particular kind of enactment in our usual invitation in that it does not pay enough attention either to our lack of certainty about what we want, or to the need for privacy in the dyad as well as expressiveness. He is implying the presence of a kind of posturing, perhaps even an enacted and institutionalized posturing, in the analyst's invitation.

I want to emphasize that I do not believe it is possible or useful to achieve an analytic stance that is "without posture." We are human beings with limited emotional and intellectual abilities to dedicate to the

understanding of another person. I am trying to bring into focus that at the outset, we do not yet understand how we have become implicated in the patient's inner object world, nor how we will contain, enact, and analyze this inner world with its attendant feelings. This lack of personal and emotional experience and knowledge with and about the patient often makes it difficult to understand our participation in the analysis as it begins, except to somehow consign it to the "unobjectionable."

Yet I am persuaded by the writing of Joseph (1985), Symington (1983), and Feldman (1997) that some of our experiences that seem most congruent with the transference attributions conveyed by our patients are nevertheless fraught with a complexity that requires us to be suspicious of the "unobjectionable," and to aim at offering a potential for growth (we saw an illustration of this in the differences in stance associated with Edward's two analysts). At the level of a theory of technique, I agree with Smith's (2007) suggestion that interpretation is born of an enactment that analyst and patient may or may not eventually understand in more detail. Hoffman (1996) seems to imply something similar in his redefinition of analysis as not so much the process of analyzing free association as analyzing a series of transference-countertransference enactments occurring as analytic work progresses.

This invitation by the analyst is, of course, far more than postured. His genuine concern for the patient is quite important in his understanding of his countertransference to method. I imagine that for most analysts, there is a period of time, a transitional time, during which there is a need to translate the method of listening that we use outside analysis, to the ways in which analysts listen in order to understand transference. For example, I notice various forms of constriction in listening when I begin working with a new patient in analysis. I often have an initial intensity of focus that unwittingly limits my experience of my own reactions. I would say that I am less "adrift" in my own associations and reverie as I try to simply learn about the patient and get the "facts" surrounding his actual life, not only his psychic one.

It is more common in this early stage for me to see things in a way that is largely congruent with the patient's view of psychic experience. It is as if I am psychologically devoted to seeing things as he does, colonized in an easy and seamless way by the patient's sensibility and concerns, and

some other part of my mind is either constricted or on hold. While this empathic capacity is always a valuable, necessary analytic function during all phases of work, I usually find that it is not sufficient in and of itself.

Over time, my mind becomes freer to work and function as a separate entity in analyzing transference phenomena. I can observe how I view the patient more distinctly from how I believe that the patient sees things. My dedication to the analytic task includes a more distinct sensibility within myself that can move back and forth between immersion in the patient's psychic reality and my own version of his psychic reality. In a sense, during this early process, I have shut down a part of my mind that would think more about the transference, and would do so in a more complex and supple way, because at some unconscious level, I do not feel comfortable thinking in that way with someone whom I do not know very well. We are taught not to talk to strangers, particularly about something as private as the ways in which one of us has managed conflict. Of course, these are generalizations, and one of the features that makes analytic work so interesting is the wide variation in the analyst's listening and participation.

Sometimes the line between posturing and our actual view of therapeutic action is a blurry one. For example, Hoffman's (1996) explication of the analyst's "intimate and ironic" authority presupposes that we can never fully analyze the patient's predilection to view us as authority figures. He suggests that these idealizations are part of what fuels the process of analysis and our own power to influence. I disagree with Hoffman in his de-emphasis of the attempt to analyze the patient's experience of idealizing his analyst as much as possible. In fact, I would say that, if anything, idealization is usually as destructive as it is constructive in growth and development during analysis. However, I appreciate that Hoffman is essentially exposing his awareness of a kind of posturing intrinsic to his own notion of the method of the analytic process.

I have heard some patients complain that the analyst loves his technique more than he loves the patient. To some extent, of course, this is an epic battle for each patient as he tries to get the analyst to love him, while the analyst's job is to understand the patient and the meaning of his transference in order to help the patient understand himself. However, there is some validity in the idea that if the analyst is too absorbed

in his expectations of how the transference will be expressed—too much in love with the notion of the transference as an object, as it were—then he may not see the shifts in how the patient expresses new feelings and conflicts and how the analyst engages in new forms of enactment of those conflicts.

A common example of this, one related to expressions of negative transference, occurs when the patient responds to an interpretation of negative transference—e.g., "I think that you felt criticized in this way by your father"—by pointing out to the analyst that the patient was unable to talk about this with his father. In making such a comment, the patient may want to divert the analyst away from the patient's negative feelings in the paternal transference, but he may also be trying to express his relief and gratitude for the ways that the analysis and the analyst are different, and to recognize that this is partially a new experience. Smith (2004) has written about the tendency of every theory and every analyst to espouse a kind of idealized patient, and, in the context of this discussion, the ideal patient would no doubt be one who affirms our ways of thinking about ourselves as transference objects. Analysands often learn about the analyst's predilections to see particular versions of transference over the course of the work.

Our technique or theory about transferences that usurp our formulations, interpretations, and participation in the analytic process differs from our technique pertaining to transferences that facilitate these features. Being too in love with method is a kind of degradation of the psychoanalytic process—which is, after all, a technique that is supposed to allow us to intimately and uniquely understand each of our patients. For example, there can be problems if the analyst is too attached to being seen as a transference object closely tied to the patient's conscious perceptions and fantasies. Feldman (1997) expressed this well when he commented on the problematic nature of a "comfortable, collusive arrangement, in which the analyst feels his role is congruent with some internal phantasy" (p. 238). Feldman noted that what is projected into the analyst by the patient is a fantasy of an object relationship that "evokes not only thoughts and feelings but also propensities toward action." Feldman stated that the analyst may feel "more or less comfortable with this projection or he may be prone to enact" (p. 238).

If, as Feldman suggested, the patient projects partly in the service of reducing the discrepancy between internalized object relationships and what the patient experiences in the analytic situation, the analyst is likely to enact from within his comfort zone by implicitly not seeing those determinants that lead the patient toward particular kinds of recruited action with the analyst. The enactment may represent the analyst's attempt to restore a less disturbing fantasy to the forefront of the interaction. Feldman seemed to imply that there is an optimal level of receptivity to these projections in which the analyst will not be prone to restoring or revising the patient's attributions.

While I agree with the notion that there is an optimal level of receptivity to the patient's projections, I also believe that the analytic pair is always in one or another form of enactment (Mitchell 1991; Smith 2000). I tend to think that, whether or not the analyst is comfortable with these projections, he is positioned in a particular form of enactment relative to the unconscious processes of both patient and analyst, a form that he may or may not discover. But I find quite useful Feldman's notion of thinking about this in terms of the projection of a particular kind of object relationship that evokes or recruits particular kinds of actions (Sandler and Sandler 1994). This leads the analyst to consider more specifically how he feels about being pointed in particular directions by the patient and how this differs from the patient's earlier propensity for action.

Along these lines, Caper (1997) cogently argued that when the analyst identifies too much with the patient's projections, he is unable to survive these projections and cuts off access to those of his internalized objects that allow him some interpretive purchase. The analyst must try to differentiate his need to identify with the patient's inner world (obviously necessary in order to make contact with the patient) from his identification with his own inner object world.

My own orientation is overlapping but also distinct from Caper's in this regard. I appreciate Caper's focus on the need not to be subsumed by the patient's unconscious wishes to create too much receptivity to the patient's projected internal world. Caper may be implying that the analyst's comfort level with transference attributions is likely to be somewhat revealing in terms of the recruitment of the analyst into particular

roles and attributions that compromise his ability to observe the transference. Yet I also try to be attuned to the ways in which the analyst's inner object world is experienced by the patient, and to remember that we cannot always conclude that the analyst's "receptivity" to the patient is simply "the analyst's identification with the patient's projections as a form of pathology of his receptivity to the patient." In my view, there are elements of reciprocal exchange between each participant's inner object world and ascriptions of external fantasy objects (Cooper 2008). Edward, for example, may well have been reading something in his new analyst's response to him that made him raise questions with her about the meaning of his erotic feelings.

The language we use in thinking about transference may often attune us to enactments of the kind I am describing. We live in our language. For example, a patient treated by an analyst in supervision with me, Dr. J, had cared for her rather infantile father after her parents separated when she was ten years old, and she pleads with Dr. J to provide her with direction because she feels "lost without his input about what she should talk about." In supervision, Dr. J tells me that the patient was used to adapting to both her parents' needs, particularly her father's, and that she now experiences this need with her analyst in her search for direction. Dr. J is convinced that, while she pleads for a different kind of paternal experience, the patient's transference involves finding and refinding an unavailable other.

Dr. J is also aware that this patient unconsciously creates an experience in which she has to do what is expected of her, collapsing the potential "freedom" of the analytic experience to be herself into one that is familiar to her in that she is told what to do. Dr. J describes feeling pressured, and says that when he interprets elements of this transference, he is, in his words, "hoping that I can interpret it away." The analyst is able to think about the incongruous nature of the patient's wish to forgo her freedom to think and feel and instead to subjugate herself in relation to an analyst who will tell her what to do. Dr. J's fantasies of "interpreting the transference away" are a clue to him that he may be enacting her fantasy of externally controlling what she says (by interpreting away feelings and needs), or at least that he is being pulled partly in this direction. Such a view may allow him to consider other elements of transfer-

ence that are less exclusively related to the patient's prescription (e.g., that she may feel that she is to disappear or "go away" through being told what to do).

Other familiar, degraded forms of the analyst's experience of the transference are those related to rather concrete versions of therapeutic action in which the analyst focuses more exclusively on "what the patient needs." Sometimes the espoused views of what the patient needs involve elements of what the analyst needs. We are all likely to have a particular area in which we are more comfortable being seen, whether it be one of being idealized or of being depriving.

We need to expect that the analyst is all too likely to become too attached to, or to fall back on, encrusted ways of being observed and experienced by the patient—ways that in turn become sources of resistance to analytic work. The process is memorialized through previously offered interpretations of transference, rather than given life in the form of curiosity and exploration. This dependence on an "overvalued" interpretation (Bion 1967; Britton 2003; Cooper 1996) is not unlike what occurs when writers refer to their "precious darlings"—the words and phrases that they struggle against letting go of, but ultimately need to let slip away.

It can be tiring to be stuck in places of transference-countertransference entanglement that are difficult to change. Often, as patient and analyst get engaged with the patient's most refractory conflicts, the two of them fall into habits, if you will, related to this transference-countertransference engagement. As one of Samuel Beckett's (1953) characters said: "Habit is a great deadener" (p. 82). I think that every dyad, including in analyses that are productive, gets habituated to transference and stuck in particular places that involve acclimating to each other, for better and sometimes for worse. For the analyst to get habituated to the patient's perceptions and experience is likely, if not inevitable, and seems as potentially problematic as the patient's getting habituated to the analyst's limitations. At first, transference is new and in some sense unfamiliar: *unheimlich*. Over time, the very nature of transference as unfamiliar may change and become part of our habitual modes of relating to each other—which is itself often a defensive or enacted form of unconscious engagement between patient and analyst.

CONCLUSION

The interpretation of transference as an action or a form of enactment has been neglected in analytic work because the interpretation of transference is among our most revered forms of technical activity. Various types of collapse are occasioned by the analyst's ways of creating distance from being a transference object (either through unwittingly collusive agreement with the patient or unwitting inability to understand transference phenomena) or by the patient's dissociation within an embedded and repetitive transference experience. But transference is no less likely to involve compromise formation, repetition, and enactment than other forms of activity. Smith's (2000, 2007) dedication to this observation is helpful in demanding the analyst's continuous scrutiny of this fact of psychoanalytic life. Analyst and patient alike can retreat from the daunting uncertainty of new and spontaneous interpersonal relatedness by viewing each other, over extended periods of time, in the familiar safety of mutually agreed-upon transference-countertransference understandings. This retreat may be thought of as a kind of interpersonal compromise formation (e.g., Cooper 2010) and often takes one form or other of analytic posturing.

Highly experienced analysts who are immersed in psychoanalysis day after day may have become so acculturated to the method that they can lose touch, at least partially, with just how subversive the analytic situation really is. Students of psychoanalysis are sometimes closer than more experienced analysts to the radically different nature of what we do in treatment relative to what we learn, culturally, as citizens. The novice often keenly appreciates the leaps we ask our patients and ourselves to make, and he is generally far less familiar than is the experienced analyst with the powerful and extraordinary ways that productive analytic regression can allow people to get in touch with affects and fantasies that had heretofore been less available. Yet in a sense, students are quite conscious of the radical shifts accomplished by the analytic method in relation to the conventions of other types of discourse and treatment. Nowhere is this more apparent than in our experience of working in the transference.

The beginning analyst, indeed, has much to learn about analyzing specific elements of transference and regression, and particularly about bearing and being curious about levels of transference intensity. Nevertheless, I conjecture that the relatively less-experienced analyst may sometimes be less dissociated from his experience about being an object of transference, in contrast to those of us who have worked for many years with patients and the nature of their transference to us. To be sure, I believe that there are relatively normative, inevitable levels of dissociation and disconnection from our feelings about being transference objects that, if attended to, can be of interest.

Perhaps we should consider whether we have experienced an institutionalized distancing from our very particular reactions to this aspect of the process, leading us to espouse to our students a rather automatic and potentially superficial receptivity to the patient's transference. In this sense, we might ask ourselves whether we sometimes unwittingly advance an attitude of dissociation toward the transference in our necessary commitment to teaching students to be its recipients. By keying into the complexity, subtlety, and diversity of our emotional reactions to being transference objects, and in dedicating ourselves to analyzing these reactions, we may facilitate a greater understanding of the patient's complex unconscious conflicts and their enactment. These experiences may be profitably worked with and explored over the course of a psychoanalytic career.

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ON THE WISH TO BE INVISIBLE

BY ARNOLD GOLDBERG

This paper is a reverie on the wish to be invisible and how it is played out in psychoanalysis. Beginning with a brief clinical case and its countertransference manifestations, the paper touches on invisibility in various aspects of analysis, ranging from publication to supervision. It emphasizes the unconscious determinants of the wish to be invisible.

Keywords: Invisibility, telephone analysis, anonymity, publications, medications, supervision, exhibitionism, neutrality, interpretation, insight, placebo effect.

As a little boy who avidly read the comic strips, one of my favorites was one called "Invisible Scarlet O'Neill" (or at least that is the name I remember). The heroine of this illustrated fable was a beautiful young woman who could become invisible by pressing a vein in her left wrist. Despite numerous efforts to emulate this feat, I myself seemed destined to a life of visibility. The veins in my left wrist did the work that I later learned was the activity demanded of all veins and never went beyond that very limited scope. Once again, anatomy was destiny.

The appeal of invisibility, I am sure, is a universal one and serves to explain the popularity of Scarlet O'Neill. Of course there are a host of fictional works on this phenomenon, ranging from *The Invisible Man* (Wells 1897) to Wonder Woman, but the present essay is launched by this particular comic strip. Likewise, the literature on other aspects of invisibility, such as invisible playmates, is also not considered here. I sus-

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pect that part of the appeal of invisibility lies in the consequent ability to sneak in on the unsuspecting and to see and overhear what others are saying and doing. An analyst might readily propose some variant of looking in on the primal scene without personal exposure. All sorts of scenarios can develop if one's imagination is given full rein, but one thing that seems to remain with me in my remembered relentless pursuit of Scarlet O'Neill's prowess was that there was simply no downside to invisibility; it promised only rewards. One could see and hear things, get away with all sorts of behavior or misbehavior, play all sorts of pranks, and never get caught. Of course Scarlet O'Neill used her power to fight evil, but I suspect most readers saw a greater potential in this feat of invisibility.

What may seem apparent to some but was insignificant in my own musings about invisibility was revealed (a most appropriate word) to me during the course of an analysis of a patient who announced his persistent, lifelong wish to be invisible. This wish was always with him, and he yearned for this power to be his.

CASE REPORT

The patient was a young professional in analysis who had recently been promoted to a somewhat more prestigious job than the one he had previously occupied. This new position involved a bit more exposure in the sense of his having to frequently speak before various groups. This sort of public speaking was something that he was quite proficient in doing, as well as a task he usually enjoyed. However, he soon associated to his intense dislike of meeting people in very casual encounters at work on his way to his office. My ears perked up at what sounded to me like a contradiction, especially when he said that he wished he were invisible during these morning journeys and thus able to avoid any confrontations whatsoever.

The problem with these confrontations, usually with friends and fellow employees, was that he was often at a loss as to what to say, i.e., to participate in what he labeled "small talk." When pressed about the discomfort associated with small talk, he said he greatly feared looking and sounding foolish, and so invisibility would be a wonderful method

of avoidance. The contradiction that I noted was of a person who had no trouble in speaking in front of large groups, but who also dreaded impromptu, casual conversations. The explanation seemed simple. In the former, he was in charge, while in the latter he had no clear script to follow. He feared being caught without competence. He would then suffer the label of looking the fool.

This patient's childhood was characterized by his being the only boy, with two older sisters, a doting mother, and an ineffectual and depreciated father. He was felt to be a very special and very bright child, and this specialness and brilliance carried over to his school, both in scholastic performance and with his peers. He reported that he felt this specialness was always precarious, and he clearly recalled a rebellion by his schoolmates that consisted of his being put in his place. He insisted that he felt he was but "a king in exile" during this period, and so his specialness was never in jeopardy; the feared state of being what he called "a loser" never came about.

Focusing on his anxiety in the above-noted casual confrontations, the patient claimed that he felt a need to be interesting, humorous, and exciting, along with a host of other desirable qualities, in each and every encounter. Being invisible would allow him an escape from having to display this very burdensome, self-assigned list of personal qualities. After each of these unavoidable meetings, he would carefully chronicle and grade his performance with the underlying fear of exposure of his inadequacies. There was a clear connection to his ineffectual father, whose fall from greatness was primarily remembered with a firm resolve on the patient's part to "never be like him." In the transference, I was treated as an admirable but also completely ineffectual person who had accomplished absolutely nothing of benefit for the patient throughout the analysis. I was just as good as invisible.

My countertransference to being seen as someone incapable of accomplishing very much was initially to chalk up his unwillingness to recognize my worth as emanating from a severe and somewhat intractable resistance on his part. However, as we both became captured by this newly brought-up issue of invisibility, I began to feel a modicum of value in my being able to make a contribution. Behind the patient's fearfulness of being thought a fool, hand in hand with the dread of being dismissed,

his constant companion to the fear of being laughed at was that of being applauded. And so it was true of my personal function as an analyst. The flip side of not mattering much is always that of being terribly important. I struggled with my not amounting to much of anything to my patient, and I so wanted to really matter. As the analysis proceeded, we realized how much we wished to conceal from one another. In a sense we both struggled with wanting only certain things to be exposed while others remained hidden.

THE ANALYST'S INVISIBILITY

A moment's consideration of the analytic situation—as opposed, let us say, to most psychotherapeutic ones—reminds us that the analyst is not visible to the patient. A number of explanations have been given as to why Freud chose this particular arrangement, but it has become the classical position, no matter the number of individual exceptions who prefer or insist upon a face-to-face confrontation. The invisibility of the analyst is disrupted by "interpretation," which for some is felt to be disruptive or even traumatic (Kohut 1971).

I recall a case conference that I attended in which the presenting analyst (a candidate) made an interpretation to the patient and told those of us in attendance that the supervisor of the case said: "Don't you think that the patient could have reached that conclusion without your having to say it?" Muteness, restraint, and forbearance were considered optimal in the stance that saw the analyst as the midwife who needed only to watch as the patient delivered the hoped-for insight. To interfere was to disrupt the process.

The very word *insight* suggests that the patient should see what is internal and not be waylaid by what may be offered by the presence and action of another. Thus, the analyst must maintain not only anonymity, but also invisibility in order to allow the process to proceed.

The candidate who speaks too quickly, the analyst who gives advice, along with the one who decides to share his or her personal feelings, are considered suspect, and perhaps—as with the above patient—need to be put in their place. This virtue of invisibility is in stark opposition to the sin of having to talk, having to take a stand, having to be recognized.

That sin is one of allowing oneself to matter. Perhaps psychoanalysis should rethink the unconscious forces that are at play with the supposed need for the analyst's invisibility. It may facilitate certain things, but it also takes a toll on the analyst. A rethinking required of all of us would examine the positions that are often taken for granted. The invisible analyst is struggling with his or her own wish to matter. The face-to-face therapist struggles with a wish to stay hidden. There need not be an exclusive virtue to either position, but they certainly merit inquiry. Indeed, we routinely attribute propriety and even moral correctness to positions that are really ones of comfort.

The invisibility of the analyst extends to his or her muteness and to the blank screen so championed by many classical portrayals of analysis. One patient reported to me that he had terminated his analysis without his analyst saying one word to him. The patient was convinced that, despite or because of this caricatured portrayal of analysis, the analyst disliked him. It is difficult to tease apart the patient's fantasy about this supposed feeling toward his analyst from the reality of the truth about the analyst. Rather than a blank screen or a nonresponsive, neutral analyst, we have constructed an analyst in hiding.

TELEPHONE ANALYSIS

Perhaps a more perfect route for the analyst to achieve invisibility is that of therapy or analysis by telephone. The new popularity of this form of treatment allows the analyst to almost completely disappear, and so to read or eat or write while the patient goes on with the assumption that he or she has the complete, undivided attention of the listener. Some analysts (Slochower 2006) seem to feel that a lack of undivided attention is a form of transgression or misdemeanor, i.e., something the analyst should feel guilty about. Such a stance is reflective of the myth that analysts or therapists can be—indeed, should be—totally focused upon the patient. Aside from the possible restlessness that is endemic to many analysts, the assumption is that of a person with no other interests than that of the patient. The unreality of this posture is pushed aside, but the invisibility achieved by the telephone seems to allow the humanness of the analyst to emerge, while in reality it may only be disguised.

AND ANONYMITY

A close companion to the wish to be invisible is the wish to be anonymous. That state involves one's not having any features or factors that might distinguish one person from any other. Of course, presence is no sure indication of invisibility, since sometimes a person's absence stands out and serves to call attention to him or her.

A patient of mine who was a reformed alcoholic said that he always looked for Alcoholics Anonymous groups to attend in which he would know no one. He did not want to be recognized, nor did he wish to recognize anyone. He was especially loath to speak up at meetings, but after many years of silence, he now forced himself to talk. He did so with the fervent hope that none of the assembled group would be moved or even interested enough in what he had to say to want to speak face to face with him after the meeting had adjourned. Rather, he wanted to slip away from the crowd and so be indistinguishable from everyone else. He felt secure in the spirit of AA, which stressed anonymity, and he insisted that striking up friendships or even casual relationships dishonored that spirit.

More to the point, this patient felt that any form of exposure of himself to another might lead that person to initiate a relationship, and this was what he most dreaded. He wished to reveal nothing about himself, nor was he interested in learning about others. Such incipient relationships that might occur when the group was disbanding and exiting were experienced as burdensome and to be avoided at all costs.

Of course, most analysts maintain some form of anonymity along with invisibility. They prefer to remain ciphers who reveal nothing and so are available for the patient's projections. Such a stance that borders on the mysterious, i.e., the mystery of the unknown, is hardly a neutral one, since it so deviates from most normal relationships. The patient asks where you are going on your vacation and the ensuing silence does not necessarily bring forth a host of fantasies as much as puzzlement as to why you are so secretive. If you preface your need for anonymity with a caution about the greater importance of learning about the patient's fantasies, often the wish for a response is merely delayed. No doubt over

time, patients learn the peculiarity of the situation and stop asking such intrusive questions. But that does not make it any less strange.

In contrast to my patient who wished to slip away unnoticed are those who yearn for contact and remain open to the development of relationships. So, too, are there therapists who regard the anonymity of analysis to be unrewarding, and so see the analytic relationship itself as both necessary and welcome; however, one must question that perspective as well. It may well be true that those who wish to be unnoticed are matched in number by those who wish to be noticed. Anonymity stands in contrast to recognition and even notoriety.

It should be clear that there can be no optimum posture for analysts and therapists that completely avoids the poles of the demand for attention and the equally strong wish for secrecy. Behind anonymity are unconscious fantasies that seem to clamor for being seen and listened to. Similar fantasies may be expressed and rationalized under the guise of a need for relationships. It is foolhardy to believe that one can dictate a set of proper procedures for the conduct of a treatment, inasmuch as our personal needs often conflict with our functioning according to the needs of patients. Some of us want to slip away unnoticed, while others need to stand out. We cannot be sure which is the better. We need to recognize that neither is better. We necessarily operate in a space of tension.

CALLING ATTENTION TO ONESELF

To return to the case conference in which the analyst was cautioned by the supervisor to refrain from making a comment, and so to allow the patient to arrive at the hoped-for insight on his or her own, it may be profitable to consider the tensions or conflicts experienced by the novice analyst. The wish to speak up with an opinion or conviction of one's own must be tempered by the wisdom offered by the seasoned therapist who recommends silence. Indeed, a good deal of analysis is devoted to keeping quiet and remaining as unobtrusive as possible. Many analysts advise the beginner to abjure the drinking of coffee in sessions lest it arouse an oral drive in the patient. Taking notes becomes a hotly contested issue in some case discussions, with those advising abstinence

claiming that the sound of writing serves as an interference to the patient's free association. Without taking a stand as to the value or folly of this accumulated advice, I think it is worthwhile to consider what it means to put the analyst or therapist into a state similar to frozen animation—i.e., in which the analyst is someone who is both there and not there—and what that does to the analyst.

In contrast to the silent and unmoved analyst is the therapist who speaks his or her mind, up to and including personal thoughts and feelings stirred up by the patient. This position is regularly rationalized as one closer to the truth and so properly reflecting reality. Such a stance allows for expression that eschews anonymity and invisibility, and literally calls attention to the therapist or analyst. Here, too, one must consider the implications of a treatment that, although surely intersubjective, can be seen as interfering.

We have no easy way to judge the effectiveness of invisibility versus exhibitionism. The crucial variable may lie in the particular patient and the needs of that patient. It does seem to be the case that one size does not fit all, in terms of either analysts, therapists, or patients.

SOME EXAMPLES

Publications

Publication of one's therapeutic work gives rise to an interesting example of the tension between anonymity and notoriety. Most authors delight in seeing their names in print, but are quite intent on not revealing the identity of their patients. Often they go to extreme efforts to disguise the patient, or to show the patient the finished product and obtain permission for publication, or even to use other therapists' patients.

No one doubts the need to protect the patient from being recognized, although no one has ever gathered much evidence to demonstrate the deleterious results from such recognition. It has become a fact of life in publication: the patient must be disguised or protected from being identified. Although I personally have been asked by patients whom I have seen to be included in my papers or books, this is usually felt to be a reflection of the patient's wish to be noticed. Once again, hiding seems to take the moral high ground over revealing.

It may be worthwhile to examine and evaluate a host of concepts and procedures that seem to exist as though beyond question. Is the elimination of identifying material about a patient always crucial? And if so, why? We should be wary of fixed rules by which to live.

Medications

The waning popularity of psychoanalysis is often connected to an upsurge in the prescription and use of psychopharmacology. The cost of psychoanalysis and psychotherapy is often cited as responsible for the shift to psychotropic drugs for most if not all psychological maladies. As these drugs have become more widely advertised, they have been dispensed more and more by physicians who are not trained psychiatrists or mental health professionals, but are primary care physicians, internists, or just about any doctor who can prescribe. The companies who make and advertise psychotropic drugs are eager, of course, to trumpet the essential and unmistakable fact that improvement seen in patients is due to the medication, no matter who dispenses it.

The clinical trials conducted by these companies, trials designed to compare drug effectiveness, were always conducted with a control group that received some form of medication that looked like the one with the active ingredient, but was essentially composed of inert substances. Drugs had to outperform these "dummy" pills in order to be promoted, and stories abounded of highly valued drugs that failed these clinical trials because of what was universally called "the placebo effect." This is no more than the recognized phenomenon that most people have some sort of reaction to the mere act of taking something they feel is medicinal. This reaction has been confirmed by brain PET scans and seemingly cannot be totally eliminated.

The placebo effect is said to work by way of expectation, i.e., through the activation of a series of memories of someone who actually did help in the past (Hedges and Burchfield 2005). If one matches the placebo effect of a clinical drug trial with actual psychotherapy, in terms of a treatment with the same number of sessions and duration, the effects of the two modalities are no different (Baskin et al. 2003). If one imagines an invisible therapist, the result seems to be the same as with his or her presence.

One effort to partially eliminate or minimize the placebo effect is that of removing the psychological impact of the relationship that develops between the patient and the person offering the medication. If the psychiatrist, for instance, says something hopeful and reassuring to the patient as the prescription is tendered, then the efficacy of the medication could theoretically be enhanced. Ideally, the person giving the medication should be invisible.

Invisibility—along with its cousin, muteness—is an essential component in determining the therapeutic action of a psychotropic medication, because of the need to eliminate the patient's possible reaction to being given a pill by someone who could stimulate something significant in the patient. The power of the prescriber must be removed in order to properly evaluate the power of the prescription.

Supervision

Some years ago, I attended a workshop on supervision in which a senior analyst presented his experiences as a supervisor who literally attended the analytic sessions with the supervisee and the patient. This analyst claimed that it was very important to him to see the particular layout of the candidate's office, as well as to observe the conduct of the analysis. In terms of the former, he described one office that featured crossed swords over the couch, and he thereby justified his ability to judge the character of the candidate through office furnishings. In terms of the latter, he insisted that he would sit quietly in the corner after the supposedly unsuspecting patient would enter the room and be apprised of his presence. He insisted that the disadvantages of his actually being in the room were negligible.

My reaction to this description was that this was supervision with a vengeance, since supervisors are supposed to be invisible. Of course, some control cases are informed of the existence of a supervisor, and many patients have a number of fantasies about the particular role of the supervisor, but I feel that invisibility is an essential requirement. Both students of analysis and experienced analysts may tell of imagining the presence of a supervisor during the course of an analytic hour and using this imagined presence as some form of assistance, either as a control-

ling superego or a comforting ego. However, these imaginings allow the invisible (often miniaturized) supervisor to appear and disappear at will.

It seems to me that the existence of a supervisor should surely disappear over time, arising only at certain crucial moments in an analysis. I cannot imagine how the actual living presence of a supervisor in the room could possibly be reckoned with over time. It would seem that the grandiosity of a supervisor in the room would not allow him or her to be invisible. So, too, this form of infantilization of the beginning analyst would not allow him or her to become an independently functioning analyst. Here invisibility is essential.

DISCUSSION

Perhaps somewhere in the literature on the normal development of children there are statistics on the prevalence of the fantasy of being invisible. I have always felt it to be universal, and routinely assumed it to be equivalent to a desire not to be caught at something. However, Freud (1921; see footnote, p. 79) alerted us to the coexistence of opposites, and I somewhat belatedly recognized that the wish to be invisible was companion to a simple but often repressed equivalent desire—i.e., the wish to be visible.

Rethinking the tried and true procedures of any enterprise is difficult and considered necessary only if these procedures are felt to be no longer effective. Although norms of psychoanalytic practice are regularly challenged in terms of frequency of appointments, use of the couch, and requirements for graduation or certification—i.e., in terms of practical effectiveness—they are not usually examined in terms of unconscious motivation. Ethical standards are one example of the set of tried and true positions that are felt to be beyond debate. The reasons for taking on these standards in terms of personal needs is felt to be beside the point because, by definition, these are standards of correct behavior (Goldberg 2007).

So, too, the question of the analyst's or therapist's taking a position that involves being noticed or not is usually framed pragmatically—i.e., "is it good or bad for the patient?" Although that is and will always be an important consideration, it may be of equal moment to ask what it

means to the therapist. A working conclusion is one that dispenses with any form of generalization about the proper procedure for conducting an analysis or a psychotherapy, and so deals concurrently with the needs of the analyst or therapist. Such needs should not be subordinate to the "right way of doing things." The invisible and anonymous analyst is no more a caricature than the open and relating therapist.

To restrict the evaluation and consideration of the analyst to assessing the degree to which he or she is neutral or invisible or without influence on the patient's productions, versus how much he or she is a meaningful presence, is to look at only one half of the situation. An experiment was conducted years ago by a therapist who instructed patients to talk to a hidden therapist behind a curtain. The patients were then asked to tell the researcher what they thought of the therapist-in-hiding who in truth was non-existent. The patient's ideas were then reported as constituting his or her pure projections. Indeed there was a good deal of difference in the reports, and this was seen as buttressing the conclusions about projection. However, not surprisingly, the experimenter left himself out of the equation. Projections or not, there is a good deal more going on in this sadistic set-up in which the patient is essentially a patsy in the mind of the researcher. The presence or absence of a real therapist is simply not the whole story, any more than is the visibility of the analyst.

The theory behind relational or interpersonal analysis or therapy posits the analyst in a particular position, just as does the theory insisting that we serve only as a silent screen. Being bound to one or another theoretical stance may deprive us of a more careful investigation of why we want to matter most when we may not, and why we want to seem to matter least when we so want to matter more.

SUMMARY

What may seem obvious in retrospect often requires a good deal of analytic work to rise to the level of recognition. My own memory of a childhood comic strip was reawakened in response to a patient's ever-present fantasy of being invisible. I joined in this fantasy with the implicit assumption that invisibility safeguarded freedom from exposure. Further

analytic work, especially directed to my countertransference, revealed that behind—or perhaps better said, accompanying—the wish to be invisible was its more significant counterpart. Perhaps what best characterized my own and my patient's unspoken plaint was reminiscent of that wonderful line in Arthur Miller's play *Death of a Salesman,* as Willie Loman's wife Linda cries out: "Attention, attention must finally be paid to such a person!" (Miller 1949, p. 40).

The grandiose, exhibitionistic fantasy of recognition is the primary unconscious force that is defended against by invoking the desire to be invisible. The same fantasy encourages the need to be open and to share personal feelings with patients. Willie Loman's success as a salesman is also a sad truth in the play, inasmuch as it is a tragedy, which by definition is a narrative about the downfall of greatness.

Psychoanalysis exists in the arena of conflict, and one significant conflict that we all experience is that between concealing and revealing. It would be foolhardy to favor one over the other or to assign therapeutic correctness to one or the other. The solution of invisibility is best seen as an illusion.

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AFTER HOURS: TEMPORAL DEVELOPMENTS AT THE EDGE OF THE ANALYTIC SESSION

BY MOSHE HALEVI SPERO

The author presents case material of a rigid, schizoid patient who at some point during his treatment began to come late for sessions. He once missed an entire session only to appear at the door after the scheduled hour had passed; this "timing" was evidently intentional. Discussion centers upon the meaning of this kind of phenomenon; it seemed that this particular patient was trying to remold the analytic frame, and the analyst's temporal experience, in accordance with a deeply primitive experience of the "shape" of time, and thereby carve out a sanctuary into which he could sequester his idiosyncratic sense of nontime until circumstances enabled further progress toward more mature symbolization of time.

Keywords: Time, analytic frame, object relations, countertransference, timelessness, personality disorders, cancellation of sessions, enactment, *après-coup,* dreams.

> What makes experience endurable, or otherwise, has at least something to do with knowing that there will be a time to it.
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> —Boris (1994, p. 301)

Most patients in analysis arrive on time for their sessions, while many others arrive early, late, or not at all. Among the nonpunctual group,

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some are sporadically so, or solely during a particular phase of work, or chronically. Still other patients arrive or leave their sessions on time as judged by the clock, yet within their hours an uncanny subjective quality of time begins to unfold that somehow makes the objective onset and end of the session, and the duration in between, all but lose their reliable characteristics. Such patients may eventually imbue us with a sense that they "never arrived" for or "never left" their sessions, despite all physical evidence to the contrary.

These phenomena present a well-known dilemma, though it has been difficult to establish a general explanation for them. We try to learn as much as possible from each idiosyncratic context and refine what implications we can for the management of the analytic frame specifically, and the meaning of time generally (Meissner 2006, 2007, 2008; Sabbadini 1989; Spero 1998, 2008).

Works of art and prose often help us capture the paradoxical and otherwise elusive qualities of time, providing a unique specimen or sample suitable for scientific scrutiny. In that spirit, I offer a self-critical lament from St. Augustine's *Confessions* (c. 397 A.D.)—a gem of psychological deliberation as well as of theological reflection—that portrays, during the period of life he is recollecting, the paradoxical eddying of time in the presence of intense ambivalence and psychic standstill. Ensconced for years in a deathlike state, and tormented by the voice of an other whose presence is still too frightening to acknowledge, Augustine sought to move beyond apathy, yet found himself forestalling the future as long as he could. At some point, he observed:

> I had no answer to Your calling to me, "Awake, you who sleep, and arise from the dead . . ." On all sides, You did show me that Your words were true, while I, convicted by the truth, had nothing at all to reply but the drawling and drowsy words, "Presently, presently; leave me alone for a little while." But "Presently, presently" had no present, and "leave me alone for a little while," went on for a very long while. [Book VIII, chapter 5:12]

"'Presently, presently' had no present" (*modo et modo non habebant modum*)—or, in more vernacular English, "'By and by' never arrived."

It is important to note that Augustine is not just describing frozen time per se. He is describing a frustrating aspect of what seemed like

a perpetually unrealized *relationship with* an other and the malaise of a temporal limbo or gap paradoxically imbued with the presence of this absent relationship. In such states, it is not just *time* that fails to become present; it is a relationship between a self and an other whose mutually experienced presence fails *to achieve presentness.*[1] As a *result*, time seems to have stood still.

Augustine's deeply aggravated sense of an about-to-happen that never happens—the wish for a "presently" that persists in happening-never-to-arrive!—articulates an experience shared by psychoanalysts and analysands during a great number of treatment hours. Moreover, Augustine may have anticipated a particular quality of the temporal dimension of object relations that the psychoanalyst experiences in an exceptionally sharp way during the idiosyncratic kinds of countertransference that tend to be evoked by patients who, owing to primitively regressed or arrested development, project stultifying temporal states into the analytic framework.

From a psychoanalytic point of view, we know that in addition to the time of the patient and the time of the analyst, there is the time of the analytic session itself, which emanates from the deep developmental background of the temporal dimension of the analytic frame (Bleger 1967). As a dynamic hedge between the unconscious and conscious and their mutually exclusive modes of operation, the frame houses intensely paradoxical states. Among the key paradoxical developmental elements of time inherent in the frame is the fact that the original sense of time of which the self can be aware must be *its own,* even though it is also *already* the time of the mother, or breast, and of the father, or the lawful elements of phallic time. The structure of time—and the rhythm it lends to the impulses, needs, and wishes it transports and mitigates—are to a large degree internalized from the outside, and yet the infant cannot experience "belonging" without first adopting such structures as its own, and then creatively adjusting these structures to his individual needs.

[1] The manner in which Augustine expresses his anxieties at this stage of his life—against the background of his broader preoccupation with the concepts of memory, repetition, and time—seems very close to the "someday" and "if-only" attitude or personal myth (Akhtar 1996), a conflict-ridden form of immature "hope" that reflects a deep temporal discontinuity in the self, often becoming a bulwark preventing change, as it does during psychoanalysis as well.

Within the analytic frame, time and timelessness, "internal" time and "external" time, the time-restricted session versus the unbound analytic process, *Nachträglichkeit* and *Neiderschrift* coexist as variations of the archaic dialectic from which the self gradually emerges, to which it is bound, and which it is always punctuating and repeating (Arlow 1986; Fiorini and Canestri 2009; Freud 1916; Green 2002; Hartocollis 1983, 2003; Meissner 2007). Thus, the temporal dimension of the session from beginning to end ensconces the universal developmental history of the temporal dimension of the psyche, and, ideally speaking, it is able to contain the paradoxical characteristics of time (Bleger 1967; Goldberg 1990; Namnum 1972; Waugaman 1992).[2] Nevertheless—and prior to the added impact of neurotic conflict or personality disorder—every perception of time within the analytic session is potentially able to evoke an experience of familiarity as well as estrangement, and a sense of paradox that can be fruitfully navigated primarily by a symbolically oriented psyche (in which oscillation and dialectic are more tolerable than sheer splitting and isolation).

Since circumstances within analysis are generally not ideal, we anticipate that the dividing line between the beginning and end of the session may appear unclear. Generally, the paradoxical characteristics that the analytic couple begins to experience *within* the hour actually derive from the intrapsychic and intersubjective dynamics taking place both within the analytic hour and *from certain dynamics taking place outside the analytic hour.* The greater the degree of paradox within the temporal dimensions of the clinical phenomenon that appear in the analytic hour and at its margins, the greater the strain upon all attempts to capture and articulate such paradox in logical, coherent, or convincing form without losing sight of these paradoxical qualities.

CLINICAL MATERIAL

I offer here a snapshot of a single temporal moment that served to awaken an analytic process that had gotten stuck in the doldrums, al-

[2] Arvanitakis and Kafka (2005) reiterated the special suitability of psychoanalysis for studying the inherent temporal uncertainty of all cultural frames and their contents: "The analyst is a condenser and a dilator of time, attaching unusual meanings to sequences, paying strict attention to the beginning and ending of sessions, yet living in a 'loose' temporal world which seems most peculiar to the patient" (p. 531).

though this transformation could only be fully appreciated in retrospect. I intentionally use the term *moment* in deference to that small, underappreciated, utterly common unit of time, a Janus-faced entity that straddles the formal end of a session and all that might follow it. It was a dramatic moment, chosen by the patient—a moment that belonged outside my analytic range, as it were—that creatively filled the absence or emptiness that had characterized many of his sessions up until that point, especially the fifty unused minutes of one particular analytic session, linking these to a new kind of mental space and sense of time.

This *single temporal moment* occurred in the psychoanalysis of Sol, a very schizoid man in his twenties, unmarried, who was brilliant, regressed, peculiar, angry, supercilious, almost friendless, and isolated yet lonesome. Sol was diagnosed by a psychiatrist as possibly schizophrenic, though he demonstrated no psychotic behavior or formal thought disorder either then or later. Sol might be viewed as an Asperger's-type character, yet his carefully protected awareness of inner turmoil and conflict, the look of pain at his emotional frustrations, and the wish for deep relationships, though carefully masked, spoke otherwise. He refused medication and, for a long time, any kind of psychotherapy.

A clinical psychologist who was friendly with Sol's family and had undertaken a circumscribed period of successful supportive work with the young man quickly recommended that he strongly consider more intensive treatment—specifically, psychoanalysis. In his odd way, Sol expressed "some curiosity" about such therapy and, after two sessions with me, was willing to acknowledge intellectual interest in the kind of work analysis might entail—"a chance for a meeting of minds," as he put it, adding dryly, "if I can spare the time." It did not take long before I learned that this statement was more than merely ironic.

At the time of writing, Sol has been in analysis for almost three years, three sessions per week, and the development I now report comes from the end of the second year. When Sol came to analysis, he was still participating in some of his study classes for a few hours every day, under great parental pressure, but almost as soon as the analysis got under way he abandoned these classes and spent most of his day sleeping, while wandering about aimlessly at night. After the first three months of working together, something in our relationship became engaged: Sol began to sleep less and came to sessions attentively and punctually—we will return

to this below—yet it seemed to me that he had not yet achieved, or was not yet ready for, full wakefulness. He was depressed, sullen, and tired, with his eyes always either downward-turned or half-closed.

Sol spent a great deal of time creating a kind of ritualized order of daily activity, with elaborate planning of interlocking events that would enable him to get to and from our sessions without having to consult a clock. These ritualized and repetitive activities struck me as similar to complicated Rube Goldberg-type mechanisms that in some way facilitated Sol's intuitive sense of cause and effect, sufficient to enable a basic relationship with the real world (i.e., arriving at my office door on schedule) without his having to become fully conscious of time.

The few other activities in which Sol engaged were all characterized by a certain compulsive mode of remaining somewhat dissociated and disconnected from the fullness of the rich world around him in which he now intentionally chose to find himself. For example, in his occasional visits to the yeshiva in which he was formally enrolled, he spent most of his time cataloguing books in the vast library, often getting "lost" in one or another tome while leaning against a small window near the stacks all night long. Nevertheless, as I gradually understood from Sol's carefully parsed hints, he was evaluating time in a clandestine manner through variously combined rhythms of page turning, ambient noises, the rising and falling shadows on the pages of the tomes, and so forth.

He would attend two movies per week at a set time on a certain day, purchasing tickets to both movies playing simultaneously, and would walk in and out of the two theaters, interpolating in each case the material he missed during the intervening moments. Here again, it seemed that Sol was preserving some kind of internal rhythmic counterpoint, but it was a semi-somnolent, darkened, and secretive dimension. The same applied to the manner in which he would walk in and out of various halls of museums (that opened at such-and-such a time and closed at such-and-such a time), shopping malls, and the dark alleyways of flea markets—with his eyes half-closed, all the while preserving subtle relationships with sensory stimuli that enabled him to divide up the day.

Regarding all these paradoxical activities, Sol explained, "I need the stimulus but I am not enjoying it and don't want the sense of entering the dimensions of time and space that normal social symbols invite me to." His methods were bearable because they signaled "pure time," as he

called it—or, in a more clever way of putting it, as Sol spelled it: "prema*turn*al turning."

Some of these tendencies had been noted during his high school years, but became more aggravated as Sol faced the large expanse of post-high school study, the dispersal of his few relationships, and, inevitably, his compulsory induction into the army. Regarding the latter, Sol expressed interest in basic training but also intense anxiety, and was deeply embarrassed that he might need to seek deferment. Neither physical exertion nor military risks frightened him. Instead, Sol was entirely obsessed with stories he had heard about the arbitrary schedules and ad hoc surprises of life in boot camp and what these must do to a soldier's sense of time, and he was afraid that he might not be able to bear the tension in his current state. At Sol's request, his physician arranged for Sol's service to be delayed indefinitely, which enabled our analytic work to get underway undisturbed, and at some point further on from the events to be described below, Sol voluntarily enlisted, completed an alternative form of basic training, and began to work in a competitive area of computer science.

Sol is Israeli-born, the child of American parents, professional people who practice a somewhat rigorous, heavily traditional form of religious orthodoxy. Although Sol is fluent in Hebrew, he preferred that the analysis be conducted in English. In fact, Sol expresses himself well and has an excellent vocabulary, though his way of speaking is sprinkled with peculiar pronunciations and intentionally odd word usage not attributable to his being bilingual. He regards these oddities as deeply humorous, though he has never laughed, and when he commits these malapropisms he will turn his head around on the couch or pause to sense whether I have caught his irony.

But there are other tributaries to his odd speech. In part, as Sol has slowly revealed—through both the specific associations and memories he brings in and the manner in which he speaks—his family's discourse and behavior have been laced with anxiety-provoking traces of unspoken secrets and blank spaces rooted in transgenerational Holocaust trauma. These lacunae have infiltrated Sol's own way of conveying thought and feeling, and as he speaks, he incipiently brings these absences into the analytic space, paradoxically representationalizing the incomplete representations that carry these absences. Also, as already described, Sol

lives within a clandestine dimension of time, and he evidently uses the cadence and tempo of his talking as another method for maintaining the idiosyncratic and partly concrete "shape" of his own internal state of temporal suspension.

The early months of treatment were difficult. Sol was always punctual, standing for a moment or two with his feet and face almost against the door (as I could sense from his shadow beneath the door) until he knocked a single, measured, timid knock. On cue, he would enter, recline and say very little, and then, at the end of the session, would melt off the couch in an unfeeling way. As he left, he would turn around eerily, look at me quizzically, turn again, and leave.

He had little trust in anyone, and mocked God and religion because he felt that his parents' fanatical preoccupations had vitiated his own existence. He loathed the sense of "religious time" upon which he had been raised—time to pray, time to be too late, time to be too early, time between meat and milk products, hours of inert time (as he viewed Shabbat and holidays), unclean and clean time.

In one session during this period, Sol delivered his own cynical rendition of King Solomon's ancient wisdom:

> Turn, turn, turn!
> There is a time to be born and a time to be unborn;
> There is no time to be reborn.
> A time to die and *more* time to die;
> Too much time for time;
> Why, there is an unbearable, freakin' time for every goddamn thing under my mother's heavens!

To be sure, Sol was aware that other people led deeply enriching lives through and within time, but, as happens to the good breast spoiled by poor timing, uneasy duration, and premature withdrawal, time for Sol had become a "bad," dead medium, obscuring all contents and sensations that it might otherwise convey. And so he needed to divest or disconnect all things from their natural time frame.

Session after session was suffocated under Sol's autistic-like defenses, and he seemed quite unsure what it meant to articulate a feeling or a thought, or even to be in a room for very long with another person who was not providing him with bread and board, making demands of him,

or merely tolerating him. Divested of a sense of past and future anticipation, there often seemed to be little sense of "history" within any session or among them. I experienced these hours as excruciatingly vast, seemingly unending, and inspiring little hope.

After about a year of work, Sol, still punctual, began to talk throughout most of each session with longer reflective pauses, working as steadily as he could bear with the ever-increasing surfacing of human feelings, interest in relating, and conflict. Against the backdrop of a modicum of trust and caring that began to take hold, Sol's hours felt less like a concrete block of Sol-being-present and more like a working experience. In the first two years of work, only toward the last two months could Sol snicker at something objectively humorous, and even laugh normally, though with intense embarrassment. In the transference, I was either his unbearably imposing and interfering mother—evoked whenever I made an occasional interpretation or comment—or, on another level (thus far), his more loving yet silent father, about whom he felt intense anger for not sufficiently defending him against his mother's intrusiveness.

Gradually, "regressively" positive developments began to occur in the form of new symptoms that, while peculiar—and not likely to win him friends in the outside world—seemed very much to represent an effort to bring more of his painful self into our little world. For instance, alongside a budding interest in employment (though in this regard he confined himself to his cavelike room at home, where he sat in front of a computer, but for which he was well reimbursed because he was good at what he did and consistent), the patient grew his hair and beard so long and thick that it was actually difficult to see much of his face. I assumed this was a shield/skin that enabled him to negotiate an increasingly difficult-to-deny or occlude real world, both inside and outside.

At the same time, while Sol was quite hirsute, his mouth and eyebrows were neatly trimmed, and he attended to his overall hygiene. Sol had never worn anything to his sessions other than one specific, dark-colored shirt and pair of pants, though these were always clean and not particularly rumpled. More conspicuously, his shoes were frayed and almost completely de-soled (de-souled?), and the loosely connected leather flapped noisily when he walked, his bare toes in plain view when he lay down.

As is typical of the asymptotic nature of analytic progress, the course of work was uneven. There was still something not quite right about the quality of time we shared, or, more accurately, as Sol himself expressed it, "an experience of et cetera, et cetera, et cetera" permeated the room. This was conveyed in subtle ways. Sol began to dream, though much of each dream was reported as forgotten, the retained images fragmentary. The main themes in his dreams concerned corpophagic zombies that continuously chased him (he played both roles in these scenarios), eating him and regurgitating him repeatedly—which he described in gory, perversely appetizing detail—even as he seemed in these dreams to remain intact and unendingly, agonizingly unchanged.

Here, too, it was possible to expand our understanding a bit, as Sol made some associations to additional, exaggerated representations of his mother's appetite and excessive talkativeness, but we did not have a convincing sense that this was the most meaningful maternal dimension coming to life through the dream. Such insights as Sol occasionally had during this period could then be followed by four sessions of almost no work on the preceding insight or any other topic.

After several months of such sessions, the regressive developments deepened and new phenomena became noticeable. Sol began to occasionally miss a session, about one in six. When he did come to sessions, he continued to arrive in his usual punctual manner, but I began to sense, somewhat outside my line of direct awareness, an increased quality of lifelessness in the hour. We attempted to discuss this phenomenon, but nothing meaningful arose. He acted as if he were unaware of having missed a session; rarely, he would allude in a subsequent session to the waste of money entailed, but not to the loss of time.

I became aware of a powerful temptation to interpret this phenomenon in terms of what the two of us knew thus far about Sol's conflict-ridden feelings about time, such as a passive-aggressive attack upon the tormenting time frame and the parental representations to which the frame corresponded. While this kind of dynamic was no doubt pertinent on some level—cutting out a session is certainly an aggressive enactment—it was quite clear that these themes were not focal, nor would they provide a sufficient net of meaning for him. In fact, it seemed very clear to Sol that I was aware his absences were not simply incidents of wanton acting out.

As I considered the overall flow of things, it seemed to me that interpreting Sol's missed hours as aggressive *at this juncture* would be perceived as counteraggression on my part, and a failure of containment. But *what* was I being asked to contain? Ought I to insist upon absolute obedience, or should I ignore his absences? Could I tolerate his absences, and would Sol himself be able to tolerate them? Most intriguingly, were Sol's absences truly episodes of *absence*—or perhaps, against all reason, were they some kind of development that was taking place, as St. Augustine might have said, "by and by"?

As this new de-synchrony continued, I began to feel that the time within each of Sol's sessions was becoming pressurized or condensed in some strange way. Even when he was present, Sol's monologue became more stale and inert than ever before—his voice monotonous, his silences elongated and unreflective. In response to this, evidently, I experienced a variety of aberrations in my own sense of time. In one session, in a moment of countertransference-"inspired" lassitude, I had been attending to Sol's breathing and suddenly came to the objective conclusion that the hour had reached its end. As if a refreshing sea breeze had blown through the room, I moved ever so slightly in my chair and was about to utter my customary "Well, we'll pause here for today," when I instinctively glanced at my watch, and noticed to my shame that a mere five minutes had passed since the session had begun.

As I resigned myself to my fate, sheepishly adjusting my composure, I could hear Sol clearing his throat with an uncharacteristic, slightly artificial "ahem!"—had he sensed something?—and he began speaking again of the zombie theme. Now, however, instead of repetitively describing the zombies' ghoulish behavior and depravity as he had during the preceding phase of work, Sol pointed to their mindless way of subsisting, enjoying nothing yet compelled to suck out life from whatever source they could.

In the next session, after itemizing yet another zombie dream fragment, Sol lapsed into forty minutes of silence, and then exclaimed:

> If they don't even envy the living, what *drives* them?! How can they discriminate one need state from another? How is one moment different from the next or from the one that came earlier?!? Maybe they eat and eat just to pass the time of their unending existences?!

I readily understood that Sol was now alluding to his own autistic-like time-keeping functions and their deeper link to the wider range of trapped existential needs, appetites, and wishes. But with my previous countertransference enactment as an added guide, I suddenly felt that Sol's zombie preoccupation had become palpably real for me, something I could now interpret from closer range. It was not their avaricious and gory cannibalism as such that generated anxiety in Sol, but rather their mindlessness, their unending captivity in a timeless state, and the sense that, without time frames, self- and object representations tend to merge, creating tremendous anxiety at the boundaries between self and other.

After some reflection, I said to Sol:

> I don't know much about zombies in movies, but from what I know about the creatures you have conjured up in your dreams, it may be that you find their lack of envy, their motivational emptiness, more frightening than any other element. If they have no sense of time, then whatever they do is an unending torture. The zombie-like person must attach himself to some kind of stereotypical behavior that allows him to somehow establish what one might call a sense of time, and yet, to add to the frustration, he doesn't seem to gain anything from what he's taken in.

Sol was visibly satisfied with this interpretation and relaxed back into his silence. However, this kind of interchange was not common during these months, and the dullness, though a bit lighter, prevailed. I longed for his cynical wit or even his anger, yet he seemed not to be hiding or denying his anger; rather, he had simply "lost" these elements.

I hope I have conveyed a sufficiently accurate picture of the circumstances of our work leading up to the point when the following incident occurred. Its utter brevity is its genius. It took place after the hour just noted in which we had talked about zombies. And although some time has passed since this incident, I think that usage of the present tense is the best way to portray the unfolding of these developments.

A Pivotal Moment

It is Friday morning, fast approaching 11:00 A.M. My 10:00 patient's session, quite productive, has just ended in a reasonable manner, and

I feel unpressured and thoughtful. Two analytic appointments remain today: I am to see Sol at 11:00, and then one last patient at noon.

At 11:00, Sol is not punctually standing with his nose to the door, as he usually is. In an atypical bit of immediate reverie, I feel that the space under the door seems unusually bright, and I "already" feel a distinct hole in my mind where I was anticipating Sol's signature knocking to be. As things tend to work in this domain—or, at least the way they work in *my* mind—I develop the powerful conviction only a few seconds after 11:00 that he will not be present *at all* for today's session.

Given recent developments, I feel surprisingly calm about this, even somewhat pleased. After all, Sol's absence—a schizoid's version of reverie, perhaps—seems to fit in well with the new degree of depth that we have recently shared in his discussion of death, absence, and cannibalized time. I have some other thoughts as well. Not to be ignored, I have just been out of the country for four days, followed by a Jewish religious holiday, which has caused us to miss three analytic sessions. In the first of the two sessions since my return (the latter of which was the "zombie" session), Sol was able to speak about what he had been doing during the hiatus, though he did not speak about what he thought I might be doing during that time. In fact, he allowed for no sense that he was truly aware that *I had been absent.*

So now I begin to wonder whether Sol is perhaps reacting to my earlier absence. Then again, this pattern of not appearing every so often began well in advance of my brief trip. Finally, I think to myself, if Sol's absence and my absence have become enmeshed in some way in his mind, then today's absence would be a watershed, if only because it evokes within me a significant amount of intersubjective reflection, hopefully in parallel to something equally creative and empowering within him.

My intuition that today's session will be an absolute no-show gathers confirmation as the minutes pass. Unlike in the earlier phase of our work, I do not feel suspended in some kind of null state, nor do I feel that our hour is being wasted. It is true that I am no longer anticipating Sol's arrival, which feels oddly relieving, yet I miss him, thinking that he must be doing something else with the time. Put differently, I do not feel that I am floating inertly in some kind of temporal limbo; rather, I

feel enriched by hybrid states of aloneness, emptiness, fullness, presence, and a sense of longer-range anticipation (the "next" session).

I walk around the room cleaning up some dust that has settled during a recent heat wave, read a professional paper, and fuss a bit with an off-center picture frame. It becomes obvious to me fairly quickly that these activities are minor, creative displacements of some mild anxiety having to do with my analytic frame, though no sharper focus comes to me.

By 11:45 A.M., I was no longer thinking consciously about Sol or anything else, and at 11:50 I began to entertain an image or two of my 12:00 patient.

However, at 11:51, one minute after the end of our analytic hour, there is a single knock of unmistakable timbre on the door, and a familiar shadow darkens the space below it. It is Sol. Following his customary knock, he enters quietly, with a hint of hesitation. It seems very clear to me—uncannily so, without words—that Sol has no intention of being belligerent, nor has he appeared now in order to protest his prerogatives or to violate my time constraints. He is aware that his hour has passed; he is aware that another patient will soon arrive. More curiously, I feel none of the tension one might expect of an analyst under such circumstances.

I meet Sol's look with a welcoming glance. With no more than a millisecond of apparent deliberation—perhaps there actually was none!—Sol saunters toward the couch, his soles flapping, and sits on it, looking straight ahead. Remarkably, I have not deliberated much either about the legitimacy of welcoming him in during this rapidly diminishing transitional period of time.

"There's not much I can do since the hour is over," Sol states in a matter-of-fact way, peering at me sideways.

"Perhaps," I answer honestly.

"Then why did you let me come in?"

"You *came,*" I replied, "in a manner that brought you in. That's what happened, I think. You might not have come at all. But, more important, it now seems that you have been here the entire time."

"Hmmm," Sol murmurs, half in mildly ironic imitation of me, but thoughtfully.

The room seems to expand with residual time, even as the seconds pass. Sol lies down on the couch and says he wants to say only one more thing. He has noticed something novel about the zombie dreams we have been discussing in the previous sessions. He was stunned by my interpretation, so much so that he felt would be wrong to simply "consume" yet another hour of our time in his compulsive manner of late. This morning, he needed to be with this new idea, and with me, *during the time* we usually meet, but, at least for one dramatic episode, quite by himself.

"I held my session in two locations, at one and the same time," he says. He has come here now, though late, in order to tell me that even a zombie might get tired of being frightening and invincible. He adds:

> I have a sense of time, I have a sense that my being here and *not* being here has come to matter to me. And that rhythm gives me some structure with which to hold my pain. I can afford to be less ritualized—I don't have to cannibalize my own mind just in order to have a sense of time.

After a pause, he concludes, "Mortality might have its merits."

I nod and say, "Though I prefer to see you for a full hour, I think we did as much today in five minutes. You proved that the therapy hour is simply mortal; it *can* be frightening and evoke ritualization, but it also permits life. By restoring its time value, you gave it life."

"I think so," Sol agrees, looking straight ahead. He strokes his beard, collects himself, turns around for a quarter view at the door, and walks out in his usual methodical matter.

Aftermath

Sol arrived punctually to the first session of the new week. After a moment, he thanked me for the Friday session. "Was that a full session," he asked without irony, "and when did it *really* begin?" After all, he had arrived at the Friday session at 11:51 A.M., on *my* time, trusting that he could build something sturdy against the edge of our hour, and thereby reclaimed the *concept* of the analytic hour, and the sense of *our* time.

After a long silence, he continued as follows.

> I was not happy about those sessions I missed. I *needed* them, because I cannot always handle the *pressure* that our work creates. It is *good* pressure—I sense that now, somehow—but I cannot absorb it like normal people do. So when I am not here in the room, it is not really like I am *simply* not here; I am "not here *trying to find ways to be here.*" To do that requires mental space, and I was not always able to do that. Last Friday, I tried to bring my *non-sessions* back *into* the room by arriving, by being present, only during the time that I would ordinarily *not* have been present. It worked. I liked that.

Sol elaborated that he felt somewhat more able to transform this blunt "pressure" into a "symbolic pulse," in his words—a more truly mental sense of the passage and fullness of time. He continued to speak about his difficulty pacing things and containing events within time, but now, after the dramatic episode of absence, he felt able for the first time to actually think about the nonnegotiable density he identified with his mother's mental states. It was not that mother had no sense of time, Sol added thoughtfully, but more that her mental density defeated time: "turned it against itself, consumed it, and exploded it." After a few moments of silence, he elaborated, "The sense of time I think I got from her could only enable the kind of clocks you see in that famous Dalí painting—melted, falling all over the edge, wobbly, unreliable."[3]

Sol then reported that he had had a dream, the first relatively detailed one in our experience together:

> I am sitting on the edge of a rock-like structure, maybe like the edge of a beach, though it had an exaggerated quality to it. I could sense every one of hundreds of nooks and crannies along the edge of this mass. These were exquisite, not simply geological imperfections; they were evidence of purposeful design that can only be inferred by imagining the appearance of the complementary piece of rock that had broken off long ago.
>
> I am sitting at this edge, half off and half on, and there are bits of rock crumbling under me, though I am able to keep shifting myself backward, all the time feeling safe, curious, as these bits fall off. And I am crying. I don't get the feeling that

[3] The floppy soles of his shoes perhaps foreshadowed this conception.

I am unhappy, but that I am feeling remorse; maybe I've lost something? I don't know why.

Although we worked with this dream for several sessions following, the ideas that emerged within this hour were already very significant extensions in the direction of recent developments. Sol's initial associations led him to focus on details at the edges of the rock and on fractal patterns, which reminded him of the rhythmically moving patterns that he loved to watch for hours on his computer. These were soothing, he felt, and brought up many childhood sensations that he believed existed prior to maternal (what he called prema*turn*al) time.

Sol was impressed with his own new openness to the complexity of time and with his capacity for curiosity about the gaps and spaces that had been so anxiety-provoking to him until now. When he said this, I thought to myself that it was also possible Sol was preparing to not only look *at* "the mother of time"—still cast somewhat concretely as the "flat plane of time"—but also to begin to enjoy exploring her internal space, without fear of getting lost within it. But I did not interpret this to him yet.

As the session moved toward a close, Sol said he was fascinated (not an emotion he had ever expressed before) by the "rock-like structure" that appeared in his dream. He felt it represented the analysis itself and its boundaries, whose significance, as emphasized in the dream, lay in their double-edged quality and in their relationship to other patterns that were no longer in evidence but could be inferred and experienced. In the same vein, the dream replayed Sol's having taken the chance the previous Friday to straddle that boundary creatively. I said, "Against your increased comfort with that border, you seem able in the dream to move backward in time as well, not without an awareness of danger, but calmly, with curiosity."

Finally, Sol admitted that he was still troubled by the "bits falling off" in the dream, sensing that his crying had something to so with them. He felt he was crying not out of panic or abject misery, but rather owing to a sense of guilt about having possibly taken something from me, from my time. Perhaps it was right, he thought, to have experimented with the hour, crumbling off bits of *our* structure, but in some ways it was prob-

ably not right to have taken away pieces of *my* structure. I did not take up this conflict directly in that hour, but it was a touching expression, I felt, of Sol's concern for both my professional time and the integrity of my internal objects, as well as their newfound importance to him.

DISCUSSION

H/Our Analytic Time

The psychoanalytic process can be characterized by a temporal topography marked by graded prominences, plains, and trenches. This topography—with its rich, lolling valleys, hidden culverts, confusing thickets, and dreadful bogs—is generally contained *within* the domain of the analytic hour. Occasionally, the topography extends beyond the domain of the hour into the wider temporal fields that surround it, where the transformations of clinical interest emerge in the crossover between the two topographies, generally in paradoxical ways.

Such temporal paradoxes are not just a matter of the nature of the *content* of an hour (i.e., the patient's expressed views or memories regarding the topic of time), but of the dynamic processes within the frame of the hour itself. Psychoanalytic time is unique in many ways, a chronology unto itself, comprised of a paradoxical admixture of strict temporal elements, on one hand, and the emergence of indeterminate, timeless elements, on the other hand. These are the conditions that comprise *analytic freedom* (Sabbadini 1989, pp. 306-307), and most analysands perceive it that way.

Generally—though, of course, dependent upon individual dynamics and developmental conditions—the tension between these varied temporal paradigms might be expressed in highly symbolized form, readily amenable to metaphoric/metonymic interpretive hermeneutics, as is characteristic of intrapsychic conflict in the classical sense. Yet for patients whose personalities have been built upon defective or degenerate symbolized structures of time, there will be many occasions where the struggle *against* time takes place *outside or alongside* the boundary of the analytic frame itself, in vague, sharply split, and concretized form, acted out rather than expressed through fantasy.

But the matter can become even more complex. In his introductory remarks to a new collection of essays devoted to the topic of time, Smith offers the following deliberation (see also Smith 1988, pp. 75-76):

> To one extent or another, patients always actualize their wishes at the same time as they agree to analyze them—in fact, actualize them with the only things the analysand has at her disposal, her very words and behavior. In pursuing their wishes, patients disavow the work, and in doing the work they disavow their wishes. I know no other way to address this double disavowal than to analyze it as it is happening in the real time of the hour [Smith 2006], even though we can be sure that its analysis is simultaneously being incorporated into the very enactment we are analyzing. [Smith 2009, p. xix]

Applying Smith's idea to the case of time, when the time of the analytic process itself is the topic of analysis—and I think this is the case much more often than we think, as it was with Sol—the analyst must be aware that this "double disavowal" itself may need to take place twice. First, it is dimly expressed within a temporal sphere that is, strictly speaking, outside the real time of the hour, from which position the boundaries of the analytic hour are perceived in the distance, as it were (e.g., the appointed hour that the patient has chosen to miss). Second, this interaction is lent further meaning by its unfolding within the analytic frame itself, and by the double disavowals that now gain deeper definition through analytic time proper.[4] Ultimately, it is the analytic hour that enables us to bestow potential meaning, retroactively, upon what would otherwise remain an external event.

Time, Countertransference, and Enactment

In practice, a patient who is chronically late, misses sessions, or manages in other ways to distort the analyst's sense of time within sessions may, at some level of mental operation, be acting out in a passive-aggressive way, seeking to keep the analysis outside of time (as Meissner emphasizes [2006, p. 624]). However, when deeply primitive levels of

[4] This interaction, then, is the ultimate extension of the concept of "aftereffect," retroaction, or *après-coup* in psychoanalytic therapy (see Birksted-Breen 2003).

mentation hold sway—which typically foster characteristically uncanny and intense forms of countertransference experiences—a patient may be desperately trying to bring a warped or perverse but essentially archaic sense of time into the space of his analysis, and into the temporal experience of the analyst. The unconscious intention would be to carve out a sanctuary of sorts into which the patient might sequester his sense of non-time, or extraneous time,[5] until circumstances enable the analytic couple to make some sense of things and to undertake further progress toward a more mature symbolization of time and the conflicts surrounding it. It may take a long while before the analyst can assimilate such a time warp, emotionally and conceptually, and this warp will remain almost impossible to articulate verbally during the early phases of that period of suspension.

In fact, if, as Bion supposed (1962), the rudimentary perceptions of time are first registered during the meanderings of the mother's reverie, then Sol's impact upon my own sense of time, though initially taking the form of countertransference enactment, was a crucial induction to restore that initial experience of "losing track of time and refocusing," through the temporary loss of my own containing reverie and its reinstallation.

Space does not permit greater discussion of this important point, but I wish to add, briefly, the following. My experience and that of others suggests that when disturbances in the time frame are of a "higher," neurotic quality, repression-formatted, and linked strongly to networks of symbolic meaning, then the emotionally relevant meanings of such things as forgotten sessions or morbid lateness usually gain satisfactory expression through the patient's language, metaphors, and dreams,

[5] Some readers may prefer the expression "*external* to the hour" in order to designate all that is simply not included within the analytic frame or hour. However, I have intentionally used the term *extraneous* in order to distinguish between events or concepts that are external to the frame *in the absolutely exclusive sense* implied above, and those that are external to the frame *in a partial or fluid sense.* The latter sense allows us to imagine the thin edge or moment in which the end of the hour and the beginning of "outside time" are still intimately linked in a back-to-back manner. Distinctions of this kind are discussed by Gaddini (1976), and also by Lacan (1957, p. 436; 1959–1960, pp. 71, 139; see Evans 1996), who might have referred to Sol's appearance at 11:51 A.M. as "extimate" to the hour itself; that is, external to certain normative markings on the clock, yet also intimately part of the fifty minutes of the hour.

without the need for especially dramatic countertransference-type dynamics.

However, when primitive faults within the patient's personality become aligned with the analytic framework's own inherent sensitivity to such states, the experience of lateness will emerge more subtly but no less forcefully through mechanisms like projective identification. Under these circumstances, the analyst is likely to encounter the strange temporal mode that Green calls *anti-time* (2002, pp. 44, 127). Anti-time refers to a culvert that can only be described by default: a blank, timeless, stultifying, negative hallucination that replaces or masks a normal sense of time—a world of chronicity as opposed to symbolized chronology. When time aberrations stem from such primitive mental states, the psychoanalyst needs to anticipate invasive countertransference activity, such as the experience of temporal confusion or of being suspended in time, the feeling (or fantasy imagery) of having somehow become the perpetual mourner (guilt-ridden or ashamed) for some turgid, conservative, autistic, moribund, frozen, or deceased object representation or self-representation of the patient, or of becoming preoccupied by omnipotent reveries involving timelessness.

CONCLUSION

Dealing with the countertransference caused by a patient who manipulates the analyst's sense of time is a step-wise process, as always, but more important, it requires that we allow our range of vision to be transitorily commandeered by the patient's impulses. In the case of my patient Sol, it required that I allow myself during the hour to take in the "after hour."

In the clinical vignette offered above, my experience within the session, up to the critical "moment," was heavily influenced by an exaggerated sense of dead time and of having lost the sense of time, but also by a mental impression of the patient as being *not present* even when he actually was present. At a subsequent point, when the patient dared to actually be absent, I regained a sense of presence and of time restored. This development was the result of a process, to be sure, and it might have had no value outside the context of the analytic developments that preceded it—which included, of course, an intense transference-countertransference experience.

The key moment was not a moment that I would have predicted. It took form at the horizon between time inside the analytic hour and time outside it, and it drew its meaning not from the clock but from the way in which the horizon was amplified by the superimposition of an even thinner margin, stemming from the mind of the patient, between "dead" or frozen time and a dim sense of the dawning of time.

The patient's intuitive use of an extra-analytic moment to revive the "stuck clock" of the analytic hour itself was what we might refer to as an "edge" phenomenon, an element of that world of strange, often creative occurrences that take place in the world of horizons, barriers, and boundaries that surround the psychoanalytic process. The use of the term *edge* here is not simply a metaphor. Boschan (1990) argued that alterations in time may serve as a *protective barrier* (after Freud), for example—a barrier against excessive stimuli that regressed or primitive-type personalities cannot otherwise deal with. This point augments the idea I have put forward here, for I am suggesting that when the formal analytic threshold has become unbearable, especially in regard to the dimension of time, the patient's time distortions—whether within the hour or of the more concrete form reported here (and by Meissner [2006])—may be serving as an alternative or atavistic temporal margin.

Moreover, the dimension of the analytic edge in and of itself—if we can imagine it as enlarged under a microscope—can also perform a primitive type of containing function, different than the more highly symbolized containing capacity of the interior of the analytic frame. This containing function would by nature seem better suited to more fragmentary, poorly internalized, and preverbal aspects of ego functioning, such as, precisely, the deepest infrastructure of the sense of time (Rhode 2003a, 2003b). I believe that this is why the ephemeral, temporal nature of the edge or barrier—and the lateness, preemption, and absence that it highlights—is so especially attractive to the archaic, not-fully-symbolized modes of intersubjective communication that are preferred by patients with so-called primitive personality disorders.

And it is along margins such as the temporal threshold of the analytic hour that the countertransference experience proves its value in sharpening the analyst's sensitivity. While I comprehended many things about Sol's feelings and ideas without special appeal to projectively induced aberrations in my own listening apparatus—and I have indicated

in my vignette which these were—a great deal of what he needed to import into the room regarding time was not fully stored in semantic, propositional form and could not be articulated until I myself had partaken of the maddening sense of temporal discontinuity that characterized Sol's mind on a general basis. In the case of time—partly because it is a rudimentary ego function, so basic to the development of the individual mind as well as to the architecture of the analytic frame—the analyst may become preoccupied with some peculiarity within his own sense of time, yet this primes the analyst's receptivity to what the patient may be trying to articulate (Boschan 1990; Sabbadini 1989; Spero 2008)—long before the specific conflicts and object representations pertaining to the patient's crises can be recognized and addressed.

The blunt "pressure" that Sol initially described was sufficiently effective for creating a semi-concrete culvert or space in my mind, in our experience of the analytic hour, that could *signal* the patient's literal absence or presence. Paradoxically, the predominant feeling state within the countertransference was of being unpleasantly too similar to the patient. However, when the patient came to feel more as if a "symbolic pulse" (his words) had been generated, launched by our work with the zombie-like dimension of his self and his creatively "missed" session, he gained the use of thoughts, fantasies, and dreams contained within a span of time. Now the space of the hour could *represent* Sol's sense of absence or presence. Paradoxically, the predominant feeling state within the session was less that of countertransference, and a more pleasant sense of shared independence with the patient.[6]

By bringing his rigid, zombie-like, dead time-at-the-edge *into* the margin of our analytic hour—after sufficient progress had been made

[6] Maiello (2001), speaking of the failed sense of time in autistic children, notes: "It is important to distinguish between rhythmical and stereotyped activities. Formally, they may appear similar, but stereotypes stir countertransference sensations of boredom, exclusion, or irritation, whereas the initial rhythmical expressions of a formerly [completely] autistic child are among the initial promising signs of relational awareness" (p. 189). Maiello's view is quite pertinent to the views expressed here. My sole qualification of this statement, based on my experience with Sol and other patients, is that the stereotypical dimension of speech and behavior, with its deeper attenuated or corrupted maternal and paternal endowments, may induce variable countertransference states, as opposed to singular or one-dimensional states, wavering between experiences of atemporality and momentary episodes of temporal hypersensitivity.

enabling him to do so—Sol took a giant leap toward containing that rigid edge within the frame. Put in somewhat different terms, he seems to have taken grasp of what he once called "the experience of et cetera, et cetera, et cetera" that had effectively neutralized true time—as was the case with St. Augustine's "'presently, presently' that had no present"—and enabled this to evolve into a deeper sense of shared time.

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SOME NOTES ON THE EPISTEMOLOGY OF EMPATHY

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The nature of the knowledge base in empathy is explored. The presumption is that empathic responses are active in both analyst and analysand. The variety of meanings of empathic experience is reviewed and aspects of its implementation discussed. Reservations regarding the accuracy, certainty, and limitations of empathy are considered. The subsequent analysis focuses on empathic affective attunement. The role of underlying mechanisms, both neurophysiological-nonconscious and psychological-unconscious, are explored. An attempt is made to integrate contributory functions of these processes in a provisional model of empathic attunement and its differentiation from countertransference responses in the analyst.

Keywords: Empathy, countertransference, trial identification, projective identification, self-representation, object representation, introjection, internalization, self-image, narcissism, mind–brain relationship, mirror neurons.

The role of empathy in clinical terms has been a pervasive theme in psychoanalytic literature from the time of Freud. It is one of the basic sources of analytic information about the patient's inner mental state, and from the perspective of the patient, it offers a channel of important information about the analyst. The clinical applications of empathy have been exhaustively explored, but little progress has been made regarding the mechanisms and psychic processes that bring it about.

In this essay, I am interested in exploring the integration of mental and neuropsychological processes contributing to the experience of empathy. Kakar (2003) poses the problem clearly, as follows.

> One person's capacity to partake of the inner experience of another through unconscious attunement [empathy] skims over the underlying mystery of the process. In other words, how does our normal unempathic state, a state of self-experience with thoughts that are usually self-related, change into a state in which we can transcend the boundaries of the self to share the conscious and unconscious feelings and experiences of another self? [p. 115]

I propose to approach this problem by discussing first some of the meanings and nature of empathy, followed by a review of the physical, neurophysiological, and psychological processes that may contribute to empathic experience. I will conclude by attempting to reconstruct a model of how empathic experience can arise and find expression in the analytic dialogue. I will *not* discuss the clinical vicissitudes of empathy, which I have addressed at length in other contexts (Meissner 1996a, 1996c, 2003a). My purpose here is to examine the nature of empathic knowledge and to describe, insofar as possible in terms of current research and technology, how it works.

THE MEANINGS OF EMPATHY

The nature of empathy has been discussed by many authors (Basch 1983; Beres 1968; Beres and Arlow 1974; Buie 1981; Greenson 1960; Kohut 1959, 1971, 1977, 1984; Lichtenberg, Bornstein, and Silver 1984; Olden 1953; Schlesinger 1981; Shapiro 1974, 1981). In addition to an unconscious[1] process of transient sharing of another's affective experi-

[1] Throughout this paper, I use the terms *unconscious, preconscious,* and *conscious* in the usual senses. Thus, *unconscious* refers to aspects of affect and cognition that are repressed, not conscious, and belong to the usual dynamically and defensively motivated meaning of unconscious processes familiar in psychoanalysis. Such unconscious elements can become conscious, but are prevented from being so by dynamic and defensive psychological processes. The term *nonconscious,* in contrast, derives from cognitive and neuropsychological usage, and refers to processes that are operative physiologically or neurophysiologically without ever becoming conscious, and that by their nature are not capable of becoming conscious. Thus, later in this paper, I will refer to aspects of embodied cognition as *nonconscious,* meaning that they are never conscious because of their nature, not because they are defended against or dynamically motivated and thereby excluded from consciousness.

ence, empathy has been described by these authors as also related to cognitive and intellectual aspects of the analyst's experience, as in generative empathy (Schafer 1959), coenesthetic communication (Spitz 1965), vicarious introspection (Kohut 1959, 1965), emotional knowing (Greenson 1960), resonant cognition (Kelman 1987), and even as a form of projective identification (PI) (Ogden 1979; Tansey and Burke 1985, 1989).

It is generally agreed that empathy is not based on observation, although it may complement or intersect with observational data. Rather, it seems to involve other forms of communication, both conscious and unconscious, between analyst and analysand.

Trial Identification

With antecedents in Freud (1912–1913, 1915), *trial identification* is regarded by many analysts as the basic mechanism of empathy enabling the analyst to directly understand the patient's subjective experience (Basch 1983; Beres 1968; Beres and Arlow 1974; Fliess 1942; Greenson 1967; Levy 1985; Olinick 1969, 1975; Olinick et al. 1973; Reich 1966; Schafer 1959; Weigert 1954). Fliess asked:

> On what does the so-called born psychologist's keenness in sizing up his object's utterances depend? Essentially on his ability to put himself in the latter's place, to step into his shoes, and to obtain in this way an inside knowledge that is almost firsthand. The common name for such a procedure is "empathy"; and we . . . should like to suggest calling it trial identification. [p. 681]

Fliess took the analyst's identification with the subject (he "identifies with the subject" and "becomes this subject himself" [p. 683]) to mean that the analyst becomes both object and subject of the striving, i.e., that the patient's striving has in some sense become the analyst's striving. Subsequent to this trial identification (referred to as a kind of "tasting"), when the striving is reprojected back to the patient, it "presupposes its having been kept free from admixtures . . . . We have been able to guar-

antee that no instinctual additions of our own distort the picture after the reprojection of the striving into the patient" (pp. 686-687).[2]

The emphasis in trial identification falls on the identity of subject and object; as Jacobs (2007) emphasizes: "He [Fliess] stressed the fact that for a period the analyst must *become* the patient; emotionally, he *is* the patient, and thereby is subject to all the turmoil and all the pain that the patient feels" (p. 722, italics in original).[3] As Tansey and Burke (1985) pointed out, this trial identification can be understood as synonymous with Racker's (1968) *concordant identification* (see below).

In the present reconstruction of empathic processing, I will argue that if such trial identification is possible, the proposed empathic model does not require it (see below). We can question first whether the mechanism is that of identification or not, and then whether any such form of internalization is involved at all. If identification connotes a form of internalized structural modification in the self-organization (Meissner 1981; Schafer 1968), empathy would be a phenomenon of a different order.

Empathy, in my view, is a cognitive-affective form of experiencing that attunes the subject to communications from another person, leading to some intimation of the state of mind or inner experience of that other. Does this require internal reorganization of the subject's self? I would think not. In this sense, as a complex form of affectively at-

[2] As to difficulties in the concept of trial identification, Schafer (2007) comments that, in Fliess's view, "boundaries between self and object are sharp and secure. The analyst's ego undergoes no changes in response to the analysand's projection and manipulations. What the analyst observes and 'tastes' is the real thing and is not influenced by his predilections. Through the quick and certain 'taste' achieved via trial identification, the analyst is thought to experience the analysand's state *exactly*, and so to know just what that emotional experience *is*" (Schafer 2007, p. 708, italics in original). As he notes, such assumptions of a lack of subjective influences would fall short of current understandings of introjective and projective interchanges and irreducible subjectivity in analysis.

[3] In similar terms, Poland (1974), following Racker's (1968) view of concordant identification in empathy, concluded: "The wish to understand the patient leads to the analyst's readiness to 'put himself in the patient's shoes.' With this sense of 'I am like you,' the analyst tends to identify part for part with the patient, e.g., 'My urges are like your urges, my ego like your ego, my superego like your superego.' It is this quality which is referred to as concordant identification" (pp. 285-286).

tuned perception and awareness, it does not imply any structural change or anything necessarily internalized in the subject. Thus, the proposed integrative model of the empathic process cannot exclude the possibility of trial identification, but also has no need for it. If there is no need for any "trial identification," the need for an assumed identification would have to be questioned.

The Introjective Model

Controversy over the role of trial identification directs our attention to the manner in which the self-as-object is structured. This understanding is critical to clarifying the meaning of *trial identification* and will be central to the discussion below of the mechanisms of empathy. The problem is this: if empathic moments of attunement involve identifications, what do they mean and how are they engaged in the subject's sense of self? If they do not qualify as identifications—that is, as integrated functional aspects of the self-structure as the source of agency and subjectivity—there may at least be reason to think of them as transient modifications of how I experience myself as object, that is, as forms of introjection,[4] and thus transient components of the self-as-object (Meissner 1996b).

We ordinarily think of our self-knowledge as mediated by self-representations, but since in my view self-representations are cognitive acts ("self-representings"), I use the terms *introjection* or *introjective configuration* to suggest possible objects for self-representational knowing and a more objective perspective on the structural organization and meaning of the self-as-object. Obviously, the objective view of how I experience myself can include any attribute or quality that I can apply to myself—whether based on my own observation or the observations of others.[5] I may think of myself as sexually endowed, handsome, witty, athletically

[4] My analyses of the nature and forms of internalization and the distinctions between introjection and identification can be found in Meissner (1981, 1994, 2009a).

[5] The influence of the attitudes, responses, and observations of others on one's self-image is related to the *self-as-social* (Meissner 2003b), which I would distinguish from the social activist's concept of the *social self.*

gifted, well read, a boring speaker, a poor conversationalist, overweight, and so on.[6] The self-as-object includes the sum total of the rich complexity of natural endowment and developmental vicissitudes processed and integrated through a lifetime of lived experience.

As far as I can tell, these qualities do not become pathogenic unless and until they become entangled with aggressive or narcissistic introjective influences. Narcissism and aggression are basic forms of primary motivation that can be attributed to the self. I have selected these from among other possible introjective components as related to basic, psychoanalytically relevant motivational patterns and as most directly implicated in self-based psychopathology. Accordingly, the subject's affective self-experience is related to the organization of these introjective configurations. In practical terms, I have found it useful to think of them as organized primarily in patterns of polar opposition: in aggressive terms, they are composed of the aggressor and victim introjects, and in narcissistic terms, of the superior and inferior narcissistic introjects.

The superior narcissistic form is expressed in attributes and fantasies of superiority, grandiosity, specialness, entitlement, pride, being an exception, or in manic symptoms; the inferior form can give rise to a sense of inferiority, worthlessness, devaluation, lowered self-esteem, shame, depressive affect, and inadequacy. On the aggressive side, the aggressor introject finds expression in destructive behaviors or fantasies, sadism, domineering and controlling behavior in personal relations, and hyperindependence, while the victim introject is associated with weakness, vulnerability, hyperdependence, powerlessness, passivity, masochism, help-

[6] The question inevitably arises as to the role of sexuality in this context, as an important component of my self-image. The question specifically centers on what role sexuality plays in my sense of self. Certainly, I can experience myself in sexually related terms, but the motivational dynamic of sexuality is directed to objects, not to the self; to the extent that I may have a libidinal investment in the self, that motivation would be considered not as object libido but as narcissistic. See my discussion of narcissism as motive (Meissner 2008). These attributes of the self-concept can gain emotional and motivational power intrapsychically through being affiliated with the prevailing introjective configurations organized in aggressive and/or narcissistic motivational terms. The Don Juan sees himself as a sexual aggressor or predator; the masochist sees himself as a sexual victim; the narcissist as God's sexual gift to womanhood; and the depressive as sexually inferior and worthless. However, sexual motivation as such is cast in terms of object libido.

lessness, hopelessness, and so on. These can be organized in any pattern or degree of combination; in pathological configurations, one or another or some combination of them can prevail and determine the sense of self, internally, and the patterns of behavior and relationship, externally. While these configurations reflect the individual's developmental and previous experiential history—particularly of object relations—they remain open to continual reshaping and reconfiguration from current patterns of interpersonal relatedness and the changing vicissitudes of life experience.

These introjective configurations assume importance both as derived from significant object relations and as sources of pathogenic distortions of the self-concept, and by providing the bases for projection. The individual's self-representations are cast in terms of the mix and balance of these components, in which one or another aspect can predominate; in healthier and more mature personalities, the oppositional components tend to balance or neutralize each other, allowing for a more harmonious and adaptive integration. However, these components, when activated, can serve as the basis for projections that may be involved in both empathy and countertransference responses, as we shall see. In this proposed model, the introjective configurations of both parties involved in the empathic relation serve as the central focus in the self, where empathic affects can be experienced consciously or unconsciously.

Other Views

Not unlike the advocates of trial identification, Kohut (1975) summarized his view of empathy in three propositions:

> (1) Empathy, the recognition of the self in the other, is an indispensable tool of observation, without which vast areas of human life, including man's behavior in the social field, remains unintelligible. (2) Empathy, the expansion of the self to include the other, constitutes a powerful psychological bond between individuals which . . . counteracts man's destructiveness against his fellows. And (3), empathy, the accepting, confirming, and understanding human echo

> evoked by the self, is a psychological nutriment without which human life as we know and cherish it could not be sustained. [p. 355]

As Ornstein and Ornstein (2003) emphasized:

> Empathy is the only method that gives us direct access to the patient's subjective inner experience . . . . [namely] the idea of *feeling oneself and thinking oneself into the inner life of another*, which is the current definition of empathy. [pp. 162-163, italics in original]

Expanding the self to include the other seems to reflect Kohut's understanding of the self-object concept. This language opens the way to problematic considerations of the role of projective identification (PI) in empathy, and it raises questions of merging between self and other and the possible crossing of boundaries.[7] I would prefer a language of similarities and relatedness in which I can recognize that the other is in some way like me and in some ways not, and that empathic attunement creates a unique relationship between my self and the self of the other, even as I recognize the separateness and difference between my self and the other's.

Empathy is also thought to play a vital role in development, buried in the preverbal affective attunement between mother and child (Basch 1983; Harris 1960; Stern 1985; Winnicott 1971). In the psychoanalytic context, analogously to the exchange between mother and child, analyst and patient develop a private language of allusions, cryptic references, symbolic gestures, and other forms of privileged communication,

[7] Gunther (1976) commented: "Certain aspects of analytic experience can be perceived only through the use of this capacity to merge temporarily, selectively, and at some depth of regression with another psyche *in order to feel with* someone else" (p. 217, italics in original). I question whether empathic attunement—feeling with someone else—necessarily requires merger with the other; I have no doubt that in some cases that happens, but I do not know whether it has to happen for the analyst to be empathically attuned to the patient's feelings. Nor do I think that regression is required to be emotionally attuned to the other's feelings, any more than regression is required for me to have my own feelings.

to which outsiders have no access, and that become reflections of increasing mutual adaptation (Schlesinger 1994).[8]

I would add that developmental contributions to the capacity for empathy are not limited to infantile forms of emotional attachment and attunement, but also encompass the full range of developmental achievements. Preverbal attunement must be complemented by further developmental attainments from other levels, including oedipal and post-oedipal phases—not only as a basis for establishing the capacity for empathic resonance with later developmental dimensions of the other's psychic experience, but also as a necessary contribution to the capacity for connection-and-separation in self-object differentiations and the development of object relations.

However, a degree of caution is called for in order to avoid overstating the case. In my view, my state of empathic attunement with my patient is not synonymous with any experience of myself as simply like the patient, but rather involves a more complex sense of myself as like but also unlike the other. Empathic attunement requires a capacity for self-decentering that allows one to be open to and receptive of the expressions of the other's experience. I would suggest that concordant attunement runs a greater risk of seeing (or mis-seeing) the other as like me than of seeing myself as like the other.

Likewise, viewing empathy as involving a form of projection or PI (Auerhahn and Peskin 2003; Beres and Arlow 1974; Berger 1984; Tansey and Burke 1985, 1989), despite its antecedents in Freud (1905; see also Pigman 1995), has its difficulties. I will say more about this below, but briefly, to the extent that it is projective, from the perspective of the projecting subject it is not empathic; rather than attuning oneself to the self-experience of the object, it tends to envision the object in terms of one's own self-experience. The reliance on overblown assumptions of

[8] Likewise, Olinick (1969, 1976; Olinick et al. 1973) connected the psychoanalytic work ego with empathy. He (1976) noted the synchrony between patterns of movement and articulated speech, exemplified in the research of Condon and Sander (1974). Olinick commented: "The studies made by Condon and Sander have given support to what practicing analysts have intuitively known: that among the effective stimuli of their empathic processes are sublimated actions on the part of the patient" (1976, p. 94).

our empathic astuteness is not only risky, but is also an open invitation to countertransference distortions, particularly of a narcissistic variety, as Langs (1976) emphasized.

EMPATHIC EXPERIENCE

It seems evident that there are variations and degrees of empathic experience. How empathic experience takes place is not simply a matter of perception and/or identification. True empathy can attune to the experience of another and recognize similarities with one's own subjective experience, while keeping adequate perspective on differences (Treurniet 1983). Apparently, the more closely aligned analyst and patient are—biologically, psychologically, and culturally—the more likely it is that their unconscious affective communications will be mutually attuned and responsive (Basch 1983). As Tuch (1997) elaborated, empathy requires

> . . . knowing not just how but *why* others feel as they do. It accordingly requires that one understand enough about the individual's situation (the context in which the affects arise) in order to *comprehend* how such feelings fit into that person's life and make sense, given the individual's personality and past. [p. 264, italics in original][9]

Highlighting the complexity of empathic experience, Buie (1981) described four subcategories of the analyst's experience of empathy in the therapeutic interaction: conceptual empathy, self-experiential empathy, imaginative-imitative empathy, and resonant empathy. *Conceptual empathy* arises from experiences either with others or within oneself, as well as from more general experiences related to the creative symbolism of myth, art, and religion. It involves integration of specific self- and object representations: the analyst may construct a conceptual model of the patient that includes a more elaborate, accurate, and individualized impression based on data gathered in the course of analysis (Greenson 1960, 1967; Kernberg 1993; Peterfreund 1975; Tansey and Burke 1989).

[9] See also Tuch (1999).

Self-experiential empathy, in turn, derives from the analyst's memories, affects, feelings, impulses, superego, and other complex expressions of the analyst's inner world. These provide the basis for empathic attunement to the inner world of the patient—particularly affective dimensions of the patient's experience.

Empathic attunement in the *imaginative-imitative* form can arise from imitative use of the analyst's imagination, yielding a vicarious experience derived from sympathetic and imitative responsiveness to the patient's description of his own experience. Similar forms of empathy come into play in attending a moving drama or movie or reading an affectively charged work of fiction or poetry. I regard these forms of empathy as expressing aspects of the inferential process, based on and related to a primary affective resonance.

Empathy can also be based on *affective resonance*, described as a "primitive form of affective communication . . . in which a strong affect in one individual simply stimulates the same affect in the others" (Furer 1967, p. 279). This form of empathy is related to forms of unconscious communication. Freud (1915) related empathy to unconscious communication between analyst and analysand: "It is a very remarkable thing that the *Ucs.* of one human being can react upon that of another, without passing through the *Cs.* This deserves closer investigation . . . but, descriptively speaking, the fact is incontestable" (p. 194). And further, Freud (1933) compared such thought transference to telepathy: "Mental processes in one person—ideas, emotional states, conative impulses—can be transferred to another person through empty space without employing the familiar methods of communication by means of words and signs" (p. 39). To which Beres and Arlow (1974) added: "A measure of the analyst's empathic capacity lies in his ability to be stimulated by the patient's unconscious fantasy when the analyst himself is not yet aware of the existence or the nature of the patient's unconscious fantasy" (p. 45).

As far as I can see, one need not interpret Freud's expression to mean that there is a direct communication from one unconscious to another. Whether communication takes place unconsciously or consciously, it involves a complex process of interpersonal cuing and metacommuni-

cation. It may reflect forms of nonverbal communication, more affective than cognitive, including more or less nonconscious, unconscious, and conscious components, combining to provide a form of affective attunement.[10]

D. Stern (2005) also notes the diversity of meanings ascribed to empathy, and particularly the tensions involved in its usage, some of which are antithetical—active versus passive, rational versus mysterious or intuitive, as an aspect of art versus science, emotional versus propositional, a way of listening versus therapeutic technique, etc. Stern tends to absorb empathy into the overriding meaning of intersubjectivity as he conceives it. Interpersonal relatedness, in his terms, involves two levels of interaction, one conscious and verbal as part of conscious declarative knowing, and the second unconscious, rooted in empathy, and constituting the context of implicit relational knowing. In this schema, empathy becomes the foundational component of intersubjectivity (Boston Change Process Study Group 2007; D. Stern 2005; D. N. Stern 1985; D. N. Stern and Boston Change Process Study Group 2004; D. N. Stern et al. 1998). As Monti (2005) explicates:

> In this perspective, the therapeutic action of psychoanalysis manifests itself through a *binary form*: on the one hand, at the level of explicit declarative knowing (as described by a theory about cure based on the prominent role of interpretations); and on the other hand . . . at the level of implicit relational knowing, which remains mostly unexpressed, and without becoming necessarily accessible to awareness. [p. 1025, italics in original][11]

[10] D. N. Stern (1985) distinguished between affect attunement and empathy, designating attunement as automatic and unconscious, while empathy requires more complex cognitive processing associated with the acquisition of language. However, for Kohut (1984), empathy encompasses both unconscious and nonverbal elements, as well as verbal and conscious ones. As Wolf et al. (2001) note, the distinction is difficult to make since the development of empathy leads from early infantile attunements to the emergence of symbolic capacities that enhance empathic capacities. As far as I can see, taken in the sense of affective resonance (Buie 1981), empathy and emotional attunement are synonymous.

[11] I have previously voiced my difficulties with these formulations (Meissner 2006): the glaring omission in them is the lack of any consideration of the therapeutic alliance, which overlaps many aspects of implicit relational knowing.

The important note for our purposes is that empathic attunement is relatively unconscious, or at least the basic mechanisms by which it is realized are unconscious, though this does not necessarily exclude conscious awareness.

Empathic attunement has been compared to intuition as one of the nonverbal ways in which the analyst can come to know the patient. Arlow (1980) spoke to this issue eloquently. "Intuition," he observed,

> . . . consists of being able to organize silently, effortlessly, and outside of the scope of consciousness, the myriad of observations, impressions, facts, experiences, in a word all that we have learned from the patient, into a meaningful pattern without any sense of the intermediate steps involved. [p. 201]

And further:

> The patient uses several modes of communication with the therapist. He expresses himself verbally and nonverbally. Mode of behavior, facial expressions, body posture, different gestures, all transmit meaning which augments, elaborates, or sometimes even contradicts what the patient articulates verbally. The timbre of the voice, the rate of speech, the metaphoric expressions, and the configuration of the material transmit meaning beyond that contained in verbal speech alone. All of these are perceived sometimes subliminally and are elaborated and conceptualized unconsciously, i.e., intuitively. [p. 201][12]

Although empathy is usually described as extending from analyst to patient, there is also a countercurrent from patient to analyst (Auerhahn and Peskin 2003; Meissner 1996a, 1996c, 2003a). The analyst may emit a variety of subtle and unconscious cues to the patient that contribute to the patient's empathic attunement with the analyst. Silverman (1988) made the following suggestion.

[12] Similar views were expressed by Reik (1948) and Bucci (2001). A cautionary note also came from Paniagua (2003), who observed that the analyst's reliance on intuition tends to limit the patient's role in interpreting and discourages patient collaboration.

> The analyst might have conveyed gross or subliminal cues to the patient, e.g., general appearance, facial expression, particular mannerisms, posture, movements, greetings, etc., before the patient lay down on the couch; or thereafter by sounds of all kinds, even changes in breathing patterns, or some other sensory perceptions picked up by the patient. [p. 290]

This approach raises the question of whether the analyst's countertransference in any way contributes to his empathic attunement. Customarily, empathy and countertransference are opposed. Based on Racker's (1968) distinction of concordant and complementary identifications, empathy has been thought to derive from concordant identifications, and countertransference from complementary ones. However, as Tansey and Burke (1989) argued, assuming the role of PI in both empathy and countertransference, an empathic response or countertransference may result from either form of identification. The difference, I would assume, lies in the degree of impact that the projection (e.g., of the patient) makes on the projectee's (e.g., the analyst's) introjective configuration.[13]

Along this line, Sandler (1976) suggested that the concordant form related to empathy was based on identification with the other's self-representation, and the complementary form—usually found in countertransference reactions—on identification with the object representation into which disavowed aspects of the self had been projected. As Smith (2005) comments, in explaining concordant identification:

> Sandler seems to suggest that in all cases of concordant identification the analyst, appearing to identify with the fantasied self-representation of the patient, in fact identifies with the fantasied object representation of the patient into which the patient has projected aspects of his or her self-representation. This would lead us to the intriguing conclusion that, given the ubiquity of projective identification, all identifications are fundamentally identifications with object representations, which may secondarily contain "projected aspects of the self." [p. 227]

[13] I am anticipating here the argument developed in what follows on the mechanisms of empathy.

This adds a further wrinkle to Racker's original description of concordant identification in empathy as a straightforward identification with the patient's self-representation, and contributes the additional note that all such identifications rest on an initial PI from patient to analyst.[14] As Smith notes, Sandler's focus was on the empathic identifications of the analyst; the empathic identifications of the patient were not addressed.

RESERVATIONS

While advocates of the utility of empathy have not been lacking, there are others who emphasize the uncertainty and potential for error in empathically based conclusions about another's experience. Alexander (1948) expressed what he saw as sources of error in the understanding of the mind of another person, including deception on the part of the patient, self-deception on the part of the analyst, errors arising from individual differences between observer and observed, and the existence of blind spots and unacknowledged motives in the observer that could interfere with accurate assessment.

Ferreira (1961) likewise expressed dissatisfaction with the intuitive, amorphous "quasi mystical halo" associated with empathy. He defined it as "an ability correctly to perceive non-verbalized feelings and moods" (p. 91). But he dismissed Reik's third ear and Ferenczi's dialogues of the

[14] Smith (2005) also noted that including the analyst's self-representation into the equation, as Sandler suggested, could lead to difficulties. If the analyst identifies with the patient's fantasy of an object representation, he must really identify with his own fantasy, since he has no way of perceiving the patient's fantasy directly. Smith wonders: "How could there ever be a direct identification with the patient's fantasy, any more than there ever could be a direct projection into the external object of the analyst? . . . Putting all this together, the process of projective identification takes place solidly in the realm of fantasy, specifically the patient's fantasy of an object representation (or more accurately a mix of self- and object representations) that the patient projects and to which the analyst responds, producing a representational fantasy of his or her own making with which the analyst identifies" (p. 229). This seems to pose the further difficulty of what the relation might be between the analyst's representational fantasy and the patient's projected object-representational fantasy. If the analyst is really identifying with his own fantasy, how does that connect with the patient's fantasy?

unconscious as no more than impressionistic descriptions of phenomena for which we have no adequate theory.

A more recent complaint came from Bucci (2001):

> The psychoanalytic explanations of unconscious communication have grown increasingly abstruse. The emphasis on projective identification and related concepts has deepened the epistemological mystique surrounding the question of how the analyst can "know" the patient's experience and further widened the gap between psychoanalysis and scientific psychology. [p. 41]

And again:

> The inner experiences of other people, conscious and unconscious, are intrinsically unobservable events that require some sort of theoretical network to be understood. All individuals constantly make inferences to the inner experiences of other persons, within the frameworks of their largely implicit, working theories of emotion and mind, to enable their day-to-day interactions. [p. 45][15]

Bucci also emphasizes the need for verification of such empathic inferences and concludes with a caution: "The analyst may tend to make inferences from his own experience without recognizing the various sources of informational uncertainty that apply; this represents a problem for clinical work as well as for the development of psychoanalytic theory" (p. 67).

These questions seem to raise the problem of how one could know or enter into the subjective world of another as stipulated in identificatory and self psychological views on empathy. Empathy in these terms seems to require a series of inferential processes, analyzing and interpreting the data of experience, in order to conclude with the analogous affective resonance. Freud (1915) spelled this out explicitly in the following passage.

[15] Pally (2007) addresses similar inferential processes as forms of prediction.

> Consciousness makes each of us aware only of his own states of mind; that other people, too, possess a consciousness is an *inference* which we draw by analogy from their observable utterances and actions, in order to make this behaviour of theirs intelligible to us . . . . The assumption of a consciousness in them rests upon an *inference* and cannot share the immediate certainty which we have of our own consciousness. [p. 168, italics added][16]

This approach resonates with Renik's (1993) approach to the inevitable subjectivity of the analyst in that an individual can construct his view of the world and reality only in terms of his own subjective organizing principles. There is no guarantee that my organizing principles are identical or synonymous with anyone else's.[17]

Along the same line, as Buie (1981) thoughtfully cautioned, empathically derived affective experience may not mirror the inner experience of the object. The inherent limitations of empathic understanding do not prevent its serving as an invaluable guide in the work of therapy, but it cannot be relied on without some degree of verification from other analytic data. Absolute verification is impossible, but consistent efforts to sharpen and confirm empathic impressions can significantly improve the accuracy and effectiveness of empathic understanding (Adler and Bachant 1996; Buie 1981; Meissner 1991, 1996c).

There is always the question of whether and to what extent the analyst might project his own thoughts, feelings, or fantasies onto the patient in his empathizing (Wasserman 1999). Should that happen, it would amount to a form of countertransference[18] reaction rather than empathy. Widlöcher (2001) made a similar point, noting that the "imag-

[16] Along similar lines, Sawyier (1975) noted: "Inner states (at least those of others) are inferred and therefore hypothetical. They need, as Wittgenstein (1953) remarked, outer criteria" (p. 38).

[17] Jimenez (2004) pointed out the importance in perversions of such disparities in how analyst and patient view the world.

[18] Rangell (1980) argued emphatically that countertransference and empathy should not be confused.

inative construction of another's subjective experience requires the development of inferential processes" (p. 255).

Bucci (2001) also pointed out that a double set of inferences are involved in understanding another's mental state:

> The analyst first connects her own inner subsymbolic experience to its symbolic meaning—images and words. While the analyst's subsymbolic knowing of her own experience is direct, the symbolic interpretation and derived meanings are variable; the first stage of uncertainty occurs here. The analyst also makes inferences from her experience to the patient's; the possibility of variable interpretation is significantly broader for this inferential leap from one's own experience to the subjectivity of another person. The analyst must understand the patient in the context of the analyst's own unique emotion schemas. [p. 64]

We might take these cautions as indicating that any empathic reading of another may be open to distortion because of the impossibility of knowing the experience of another as it is experienced by that other. Any empathic conclusion can only be drawn by some form of inferential process that, regardless of the mediating and communicating mechanisms, can in varying degrees be valid or invalid.[19]

These caveats and skeptical approaches to empathy alert us to the uncertain quality of our empathic attunement. Whatever the mechanisms that underlie and give rise to empathic experience, they remain open to the ambiguities of the connection between and communication from one subjectivity to another. While empathy remains an invaluable and important source of information about other persons and our relations with them, there is no guarantee that my empathic intuition about the thinking or feeling of the other is in any sense accurate and valid. It may be, but then again it may not be. The reasons lie in the nature of the underlying mechanisms, particularly those mediating unconscious communication.

[19] A similar conclusion was drawn by Saxe (2005).

MECHANISMS

Neurophysiological Mechanisms

The recent discovery of the mirror neuron functions has added a new and important dimension to the understanding of the communication between one subject and another, whether consciously or unconsciously.[20] First of all, mirror neurons are activated by the perception of motor activity in an object. When a motionless monkey sees the experimenter put some food in his mouth, similar motor neurons are activated in the monkey as would be involved in his performing the action himself (Brothers 1989). As Olds (2006b) puts it: "In the experience of viewing a motor event of another, there seems to occur a *virtual premotor-cortical* event in the viewer. The same cells fire that would fire had the observer performed the same action" (p. 862, italics in original). And further: "When one perceives another's affect, a similar virtual manifestation occurs in one's brain. It is speculated that one experiences a mild form of the other person's affect; that could help us understand something about empathy" (p. 862). He goes so far as to say: "To make a bold claim, we might say that this research finding reveals the intense *interpenetration* of subjective beings who are in personal contact" (p. 862, italics in original).

Further, there is evidence that similar mirror responses[21] can be identified in relation to verbal action-related sentences (Gallese, Eagle,

[20] The argument connecting mirror neuron activity with empathic attunement requires caution, since—as Vivona (2009) recently pointed out—direct connection of mirror activity with mental processes involved in empathy have not been demonstrated, so that any such constructions must be regarded as more assumed or hypothetical than demonstrated.

[21] Gallese, Eagle, and Migone (2007) provided an extensive review of studies related to the functioning of the mirror neuron system as it is involved in and reactive to multiple sensory and other stimulations, including aspects of language, especially in relation to nonconscious transmission and reception of emotions. Embodied simulation mechanisms, of which mirror neurons form a significant component, operate more or less automatically as part of the neurologically mediated processes in the nonconscious aspect of the mental processing involved in unconscious emotional transmission, thus serving as an important fundamental underpinning for all externally provoked affective experiences, both conscious and unconscious. See also Vivona (2009).

and Migone 2007), suggesting that nonverbal communications accompanying some forms of linguistic expression—perhaps not only those regarding actions, but also those in relation to affects—can serve a mediating function in interpersonal discourse.

In exploring multiple functions of the mirror neuron system, Gallese, Eagle, and Migone (2007) summarize:

> In all the above domains—of actions, intentions, emotions, and sensations—perceiving the other's behavior automatically activates in the observer the same motor program that underlies the behavior being observed. That is, one internally simulates the observed behavior, automatically establishing a direct experiential line between observer and observed in that in both the same neural substrate is activated. Although we may and do employ more explicit hermeneutic strategies and argument by analogy to understand another, embodied simulation—we propose—constitutes a fundamental basis for an automatic, unconscious, and noninferential understanding of another's actions, intentions, emotions, sensations, and perhaps even linguistic expressions. According to our hypothesis, such body-related experiential knowledge enables a direct grasping of the sense of the actions performed by others, and of the emotions and sensations they experience. [p. 144]

I would conclude, on these terms, that the mirror neuron system is a fundamental part of a more comprehensive neural organization involved in the perception, reception, recognition, and initial responsiveness to sensory and emotional stimuli. But the process in mirror neurons as such is *not* in itself inferential, and the "understanding" attributable to mirror neurons themselves is limited only to knowing and recognizing that a stimulus of a certain quality has been experienced as coming from the object. Contrary to Gallese, Eagle, and Migone's (2007) assumption of an automatic, unconscious, and noninferential understanding, it seems to me that any further understanding would require an inference or interpretation based on the presumed analogy between my inner experience and that of the other. It would be important to remember that in this realm of mental processing, events remain unconscious, so that

the basic inferential process[22] would itself be unconscious and almost instantaneous. This level of unconscious informational processing would correspond, as far as I can see, to Bucci's (2001) subsymbolic processing system.

Responding to claims that operation of the mirror neuron system allows for direct, accurate, meaningful, and unconscious sharing in the other's internal experience, Vivona (2009) focuses on three assumptions underlying such conclusions.[23] The *correspondence assumption* holds that when the mind is active, so is the brain; but, conversely, we cannot assume that when the brain is active, so is the mind, she notes. Many patterns of brain activity do not give rise to mental activity—certainly, not conscious mental activity. Thus, we do not know what mental activity, if any, corresponds to mirror neuron activation.[24]

The *shared experience assumption* suggests that similar patterns of brain activation enable a subject to share in another's internal experience. Vivona contends that there is no evidence to support this assumption, and that the mirror neuron system in itself can reveal nothing about the emotional meaning and motivation of perceived actions.

Finally, the *directness assumption* states that an observer can understand the meaning of an actor's internal experience in virtue of automatic brain mechanisms and emotional simulation that stimulate the same internal experience in the observer—independently of any subsequent cognitive processes that might occur. Current models of empathic resonance allow for inferential processes in various degrees. Vivona's ob-

[22] It may also be worth noting that such inferential processes do not take place in a vacuum. The inferential process is embedded in the full complexity of the analyst's experience with the patient or the patient's experience with the analyst, extending over a lengthy period of intense interpersonal relating and interacting. We can assume that both analyst and patient learn a great deal about each other, much of which may remain on an unconscious or implicit level, but which, conscious or unconscious, can play an important role in determining the direction of inference.

[23] See also the response to Vivona's critique by Eagle, Gallese, and Migone (2009).

[24] But, as Olds (2006a, 2006b) points out in reply, this assumption is generally accepted among neurobehavioral scientists. In this essay, however, I am suggesting that the conjunction of mental processes with brain activity is more than correspondence, and that the brain is actually producing such effects. See my discussions of mind–brain integration (Meissner 2006, 2009b).

servations are congruent with the model I am proposing here, assuming neither shared nor direct experience, but attempting to integrate mirror neuron activation with other inferential brain actions within an overriding psychological construction.

Gallese, Eagle, and Migone (2007) call attention to the fact that automatic simulation can also involve parallel inhibitory mechanisms that can allow for mitigating influences, such that variations in understanding others would be due to interfering processes on other levels of neural processing, possibly related to defenses that interfere with preconscious access to and the capacity to reflect on inner cues generated by the mirror neuron and embodied simulation systems. Or, variations in empathic ability may be due to subtle variations in the mirror neuron system from developmental deficits and traumas or from tendencies to assimilate new experiences to preexisting schemas.

I would add that these interferences can arise in whatever mental processing takes place in the wake of mirror neuron responses, that is, in what I have referred to as inferential processes. In other words, these inferential processes are also operative as an inherent part of the empathic process itself, leading to the conclusion that what the other is experiencing is similar or analogous to something I have experienced or am experiencing, but not necessarily identical.

Some have attributed to the mirror neuron system the capacity not only of emotional attunement, but also of recognizing the subjective intentionality of the other and of involvement in identificatory processes. Wolf et al. (2001) suggested that mirror neurons are not only responsive to observed actions of the other, but are also sensitive to the meaning of those actions, insofar as they enhance the observer's capacity to recognize the intentionality of the actor.[25] And, further, Scalzone (2005) suggests that the automatic, involuntary, and nonconscious responses of mirror neurons may be involved in the also unconscious and involuntary imitative processes, especially in the early preverbal and sensory mother–child interaction, that may serve as the primitive roots of internalizations and identifications.

[25] See also Jacoboni et al. (2005).

These claims, I suspect, may overstate the case, attributing more to mirror neurons than they actually effect; but mirror neurons may have a valid role, nonetheless, as part of the initial response in which outside stimuli are received, registered, and partially encoded, and thus they provide the initial phase of a more complex response involving other aspects of the neurological net that eventuate in empathic experience.

Similarly, there also seems to have developed a tendency, especially among intersubjective theorists, to overload the functional significance of the mirror neuron system. D. N. Stern and his associates (2004) make the following claim:

> One crucial finding is the discovery of *mirror neurons*. These provide possible neurobiological mechanisms that underpin the following phenomena: reading other people's states of mind, especially intentions; resonating with another's emotion; experiencing what someone else is experiencing; capturing an observed action so one can imitate it; empathizing with another and establishing intersubjective contact; identification; and internalization (Gallese et al. 1996; Gallese and Goldman 1998; Rizzolatti and Arbib 1998; Rizzolatti et al. 2001). [p. 643, italics in original]

Gallese, Eagle, and Migone (2007) recently pointed out that if one sees someone grasping a cup, the corresponding mirror neurons are very likely activated in the observer's brain, but "the direct matching between the observed action and its motor representation in the observer's brain, however, can tell us only what the action is (grasping) and not why the action occurred" (p. 135). They further indicate that, when actions were observed in their related and meaningful contexts, signals were also produced in the posterior part of the inferior frontal gyrus and adjacent ventral premotor cortex, where hand actions are represented. They comment: "Thus, premotor mirror areas—areas active during the execution and observation of an action—are actually involved as well in understanding the 'why' of action, that is, the intentions promoting it" (p. 136).

Some caution seems advisable here. I suggest that the inclusion of context provides additional evidence for a further inferential pro-

cess that does not take place simply in the mirror neurons, but may be triggered by or automatically associated with stimulation of the mirror neuron system. The authors are careful to say that mirror neurons are "involved in" the interpretive process, but I submit that other aspects of the neural net would be required in order to elaborate the interpretive associations for inferring the intentionality of the other. This added elaboration may be the aspect of the process that can easily lead to potential misinterpretations, as well as to accurate interpretations.

Gallese, Eagle, and Migone (2007) add another point that touches on issues related to trial identification. They point out that one person's simulation of another's behavior can never be exact

> . . . insofar as there are two different people or two different brains involved. A's simulation of B's behavior is filtered through the former's past experiences, capacities, and mental attitudes. In the context of empathic understanding, what is important is that A's simulation needs to be sufficiently accurate to generate responses congruent with or attuned to B's behavior and experiential states. [p. 151]

Thus, empathic understanding does not consist in "imitation or duplication of another's behavior, but rather in congruent and attuned responses, including complementary or modulating responses" (p. 151). To which they add:

> The mere existence of such a mirror system, while necessary for attunement, is not sufficient to guarantee it [empathic attunement]. For although the mirror system and embodied simulation may be hard-wired universal processes, we know that there is a wide range of individual differences in people's capacity to understand and empathize with others. [pp. 152-153]

Gallese, Eagle, and Migone conclude that

> The term *mirroring*, as used in the psychoanalytic literature, is misleading insofar as it implies that the observer's . . . response is a replica or imitation of the observed's . . . behavior. We suggest that the term be replaced with such locutions as *attunement*

> or *congruent response*. Or at least it should be emphasized that mirroring should not be (and cannot possibly be in nature) a perfect reproduction of the other's mental states. [p. 152, italics in original]

One can argue that there is a degree of congruence between the PI model of empathy and the embodied simulation model. As Gallese, Eagle, and Migone (2007) suggest, the current of emotional attunement passes back and forth between patient and analyst in the course of therapy. The analyst's simulation of affective stimuli from the patient and the resulting attuned response can be reciprocally received by an embodied simulation in the patient, with the potential of clarifying and further modulating the patient's own emotional state. This sort of back-and-forth dialogue of embodied simulations strikes an analogous chord with the mutual exchange of projections and introjections involved in PI. But, on the other hand, while the PI model implies a complex process of introjection based on the projective content (that is, an aspect of the projector's self) and subsequent reprojection (on the part of the projectee), which involves complex dynamic and defensive issues on the unconscious level, the simulation model is automatic, hard-wired, and operates nonconsciously, exclusive of dynamic or defensive motivations. Motivational issues would presumably arise subsequent to embodied simulation in the inferential stages of an empathic experience.[26]

In further processing affective stimuli, other areas of the brain are active. A. R. Damasio (2002) pointed out that the neural basis for empathy includes regions of the parietal association and prefrontal cortex; he also (in Anderson et al. 1999) relates the medial and orbital prefrontal cortex to regulation of interpersonal relationships, social cooperativeness, and moral behavior. Focal prefrontal cortical lesions in adults result in deficits in empathy (Eslinger 1998). Further, damage to the right somatosensory cortices impairs the ability to imagine the feelings being experienced by persons exhibiting certain emotional facial expressions. A. R. Damasio noted that, in a study by Adolphs (2002), it

[26] I will argue in what follows that mechanisms of PI can in certain cases complement the effects of emotional attunement and simulation.

was noted that when a task was essentially visual, it was not impaired by damage to the visual system, but it was impaired by damage to the right somatosensory system.

Similarly, prefrontal cortex lesions (H. Damasio 2002) interfere with a patient's capacity to sense the feelings and moods of others. These circuits may also be involved in mentalization and empathic responsiveness (Fonagy and Target 2002). Fonagy (2003) noted that optimal prefrontal cortical functioning is essential for mentalization, and that it is specialized for processing social information.[27] Patients with similar lesions display a psychopathic-like syndrome, showing little empathy or remorse, with difficulties in social relationships and deficits in moral reasoning (Anderson et al. 1999).

Similarly, Pally (2001) pointed out that right-brain hemispheric lesions could impair the ability to interpret nonverbal cues. Also, damage to the right hemisphere can impair comprehension of the affective components of language (Ross 1981). Areas of the temporal cortex, especially regions of the fundus of the superior temporal sulcus, are responsive to facial stimuli and connect through the amygdala with limbic structures mediating affective responses and autonomic reactivity through brain stem and hypothalamic connections (Brothers 1989). Other studies, of responses to pain (Singer et al. 2004), indicate that bilateral anterior insula (AI), rostral anterior cingulated cortex (ACC), brainstem, and cerebellum were similarly activated when subjects experienced pain themselves and when they witnessed a painful stimulus administered to a loved one. The experience of pain also activated areas of the posterior insula and somatosensory cortex and caudal ACC as additional parts of the pain mechanism, but this did not occur when the subject witnessed pain in another. Thus, mechanisms involved in affective responsiveness (AI and ACC) were thought to be specific for pain-related empathic responses, and not the related sensory mechanisms. These wider effects

[27] See also Emde's (2007) comments on these findings and Gabbard's (2005) comments on these aspects of the mind–brain relation in the study of personality disorders. Additional discussion of the functions of the brain in subserving forms of social interaction can be found in Cozolino (2006).

in the central nervous system would be over and above inputs from the mirror neuron system.[28]

Psychological Processes

Weigert (1970) pointed out the importance of various forms of nonverbal communication that allow the participant observer "to say, 'I know exactly how you feel,' even before any verbal reporting takes place" (p. 92). Subsequently, Basch (1983), rejecting the notion of trial identification, wrote:

> A given affective expression by a member of a particular species tends to recruit a similar response in other members of that species . . . . This is done through the promotion of an unconscious, automatic, and in adults not necessarily obvious, imitation of the sender's bodily state and facial expression by the receiver. This then generates in the receiver the autonomic response associated with that bodily state and facial expression, which is to say the receiver experiences an affect identical with that of the sender. [p. 108]

While I might question the assumed identity of affect, the emphasis on unconscious and nonverbal communication is important. Writing after another score of years, Pally (2001) made the same point:

> Nonverbal communication includes cues of behavior, facial expression,[29] gesture,[30] tone of voice, and the visceral changes of

[28] Earlier, Brothers (1989) suggested the possible role of some of these deficits in infantile autism and even alexithymia.

[29] While facial expressions may have a hard-wired connection with internal states, Ekman and Friesen (1975), in addition to demonstrating this connection—along with others—drew attention to the rules for masking this connection as a way of concealing the true internal state and deceiving observers. I suggest that if such is the case for facial expression, it may well be the case for other channels of affective expression as well.

[30] Fonagy and Target (2007) point out the emergence from gestures of symbolic communication, as proposed by Mead (1934): "The communicative gesture is condensed action and is only partly performed; the intended action is hinted at. The action is represented by communicative gesture in a more condensed form, according to the pars pro toto principle, by parts of the body, both conspicuous and mobile, such as the arms and hands" (pp. 433-434).

> blushing, pallor, and sweating.[31] Perception of these nonverbal cues relies on the peripheral sense organs, predominantly the eyes and ears, and the "internal sensory" channels of the body's visceral organs . . . . While nonverbal signals enhance and clarify spoken exchange, they also can operate relatively independent of language and consciousness. [p. 72][32]

She noted that each affect has unique patterns of expression involving combinations of facial expression, muscle tonus, gesture, posture, and vocalization. Arnetoli (2002) also stressed the importance of nonverbal communication, emphasizing that

> Verbal language cannot be separated from nonverbal or analogue language (Scheflen 1973), and that the latter conveys information which is fundamental for the understanding of verbal language, as well as for the affective definition of a relationship (metalinguistic and pragmatic functions). It is the metalinguistic messages, in analogue and nonverbal form, that contextualize verbal language and that inform us as to the intentions and affective state of the other party to the dialogue. [p. 743]

To begin with, emotions are related to unique patterns of facial expression that are linked to specific autonomic nervous system (ANS) responses (Ekman 1992). In experimental situations, when subjects voluntarily adopt facial expressions corresponding to specific emotions, they tend to feel that emotion; and even imagining situations of emotional

[31] Fonagy and Target (2007) also stipulate the communicative value of tone of voice; as they put it: "Similarly, intonation may have a shape that reminds the listener of a gesture. But we shall see that gestural language exists at all levels of language: phonetic, syntactic, and semantic rule transgressions are evocative because they are not products of a deficient output but are governed by a universal iconic apparatus of gestures or actions, of a primordial grammar that enables the speaker to express preconscious and unconscious mental contents. Fonagy maintains that this is a primary code for nonconscious communication and carries information that could not be conveyed by means of the conventional grammar of any language. Secondary messages generated by the primordial grammar are integrated into the primary grammatical message" (p. 435).

[32] Muller (1996) cited the work of Haviland and Lelwica (1987) on facial mirroring in the first six months of life. The infant's facial expressions can mirror the mother's affective appearance—a form of *coerced empathy,* in his terms.

experience tends to elicit the corresponding affects. As Pally (2001) observed, the patterns of ANS activity that distinguish among emotions are relatively specific to that emotion. Hurlbut (2002) commented in this regard:

> These studies suggest an innate hard-wired connection between the subjective feelings, the motor and the visceral components of emotions, leading to an integrated psychophysiological state. The conclusion is that there are no subjective (psychological) states without visceral and postural correlates, and there are no body actions without psychological correlates. Thus emotions are simultaneously both inward and outward realities; they are intrinsically bodily based and have visible expressive manifestations which can be drawn on in the communication process. [p. 315]

I would emphasize that these reactions can also occur unconsciously. Recent discoveries that the mirror neuron system is involved in responsiveness to facial expressions add another dimension to the neurologically hard-wired aspects of emotional experience (Gallese, Eagle, and Migone 2007).

Olds (2006a) cites the perception-action model of empathy of Preston and de Waal (2002), who describe their model in the following terms: "According to the perception-action hypothesis, perception of behavior in another automatically activates one's own representations of the behavior, and output from this shared representation automatically proceeds to motor areas of the brain where responses are prepared and executed" (pp. 9-10, in Olds, p. 34). And as Merkur (2001) noted: "Empathy may . . . be resolved into two components: (1) an *imaginative construction* of the subjective feelings of another person, (2) . . . together with *introspection* concerning one's own feeling in response" (p. 68, italics in original).

One important line of thinking about the mechanism of empathy, occurring largely among Kleinian theorists, appeals to PI as the fundamental process underlying empathic attunement (Auerhahn and Peskin

2003; Beres and Arlow 1974; Berger 1984; Ogden 1979; Tansey and Burke 1985, 1989). Tansey and Burke (1985, 1989), for example, argue that PI is always involved when there is any question of empathic contact; thus, an empathic response in the therapist is always the result of a PI from the patient. In their view, the so-called trial identification of empathy not only involves concordant identification—that is, identification with the other person's self-representation—but can also result from complementary identification, in which the identification takes place with the other's projective object representation. In the therapeutic context, this identification is transiently integrated into the therapist's self-representation.[33] Tansey and Burke envision these identifications taking place in the context of a creative regression in the therapist that makes the empathic trial identification possible, although it is still controlled and temporary. This identification results in arousal of signal affects (Beres and Arlow 1974; Emde 1980, 1990; Olinick 1969; Schafer 1959), alerting the therapist to the inner feelings of his patient.

In Tansey and Burke's (1989) approach, empathy involves a complex interaction between therapist and patient that is initiated by a PI from the patient. If what is projected is based on the patient's self-representation, the resulting identification in the therapist would be concor-

[33] I have some difficulties with the Tansey and Burke construction. Focusing projective effects in terms of modifications of self-representations in empathy (à la Sandler) is clarifying, but most of the description is cast in interactive terms without explanations of how the interactive effects take place. One difficulty is that the interactive dialogue seems to call for an almost unrestricted disclosure of countertransference effects from therapist to patient. I have expressed my reservations in this respect elsewhere (Meissner 2002). Also, the description throughout makes it difficult to determine what in the process is unconscious and what is conscious. For the most part, the descriptions are cast in terms that sound conscious rather than unconscious. The ambiguity on this account resonates with their totalistic perspective on countertransference, according to which all reactions of the therapist to the patient, conscious or unconscious, are regarded as countertransference. My supposition is that PI is essentially an unconscious process. Even if one acknowledges that the empathic experience is fundamentally unconscious but can resonate at a conscious level, as I do, the underlying mechanisms—including PI, if it is such a mechanism—would remain unconscious. A further limitation is that their description applies only to the therapist; nothing is said about the action of the patient in the supposed interaction, although Tansey and Burke note that this is an aspect of the overall process requiring further exploration and elucidation.

dant; if it is based on the projectively modified object representation, the resulting identification would be complementary. It is also possible, they hold, for the projection to have both concordant and complementary effects. The therapist integrates the effects of the patient's projection with other sources of information about the patient to form a model of the patient in the context of the therapeutic interaction. Thus, the analyst's concordant identification serves as the basis for empathic attunement; if the identification is complementary, the therapist identifies with the patient's disavowed projective image.[34]

The masochistic patient, for example, would project his sadistic impulses into an object representation that he attributes to the analyst, leaving his sense of self as masochistic intact. The analyst is then assumed to internalize that image, resulting in a complementary identification (with sadistic aspects of the patient's projected image). But when both elements are in play in the projection, Tansey and Burke argue that the analyst may also be influenced to resonate with the concordant aspect of the patient's sense of self as masochistic victim. If, for example, as they put it, a masochistic patient "transiently assumes the sadistic role in the therapeutic interaction, the therapist's temporary masochistic identification awakened by the pressure of the interaction is both complementary with the patient's immediate sadistic self-representation, and concordant with the patient's prevailing, longstanding experience of self-as-victim" (1989, pp. 94-95).[35]

Subsequently, alerted by the resulting signal affects, the analyst can process the effects of the internalization and communicate this to the patient as a model for more benign reintrojection by the patient. In ei-

[34] Elsewhere (Meissner 2009b), I have proposed a neuropsychological model of PI, integrating neurobehavioral and psychological perspectives. A question left unanswered in prevailing accounts of PI pertains to how the supposed projection of aspects of the self-image to an object representation in the mind of the subject can be internalized (introjected) into the mind of the object. The suggested model offers one possible answer.

[35] This model assumes that the therapist's masochistic stance is due to a temporary ("trial") identification with the patient's object representation. In the present model, as discussed in what follows, the therapist's stance reflects an introjective configuration already present and active in his self-as-object.

ther case, whether concordant or complementary, rather than empathy, the introjection can result in a form of countertransference—more or less automatically in complementary identifications, or by some form of excessive reaction in concordant identifications. The therapist, for example, may overidentify with the patient or may defensively nullify a concordant response, thus undermining empathy.

My first question pertains to the proposed temporary identification. Tansey and Burke (1989) offer the example of a therapist who feels saddened in response to the intense grieving of his patient. As they put it, he begins to "feel some of the patient's sense of sadness" and then recalls his own experience of loss and sadness in the past. They add:

> The therapist may feel quite sad as he briefly relives his own experience of loss in reaction to the patient's material. The therapist . . . is certainly undergoing an identificatory experience . . . . The stimulation of the patient's presentation of grief has evoked an introject within the therapist that was formed long ago, apart from the present therapeutic relationship. [p. 55]

They would regard the therapist's reaction as evidence of a concordant identification with the grieving patient.

Undoubtedly, this therapist is empathically attuned to the patient's grieving affect. As a result, he feels sad—but I would argue that what he is feeling is his own sadness, not the patient's. In the moment of reacting, is he identifying with the patient or simply feeling his own pain? At some further point, may he have the sense that he and the patient are experiencing something similar? If so, then where is the identification? My sense that you and I are alike in some manner does not constitute grounds for claiming internalization. In this account, the therapist's response relates to and resonates with his own introjective configuration of himself, let us say, as the pained, abandoned, and grieving victim of the loss and deprivation in his own life. This does not involve any current internalization from the patient; rather, the internalization has already taken place at some other time in the therapist's past and lives on in

memory as an aspect of how he experiences himself and his life experience. I find it interesting that Tansey and Burke (1989) make this very point themselves.

I conclude that empathic attunement and experience need involve no trial or concordant identification. The therapist, provided he has a degree of self-autonomy and has not regressed into some form of merger with the patient,[36] has a clear sense that he is not the patient and that his grief is his and not the patient's, and that the patient's grief is the patient's and not his.

A further question is whether the process involves PI, in this case coming from the patient and inducing an empathic response in the therapist. The projective component is a fantasy product occurring in the patient's mind, assigning some disavowed aspect of the patient's self to the fantasy object, namely, the image of the therapist. I would argue that this process can set up a dynamic within the patient that generates certain signals (discussed in more detail further on) communicating the affective tone of his residual sense of self, and calculated to induce a corresponding response in the therapist to confirm or reinforce that projectively modified self-image—namely, the self-representation that results after the undesirable elements have been ejected by means of the projection to the fantasy object.

The outcome can then take two predominant forms: the projection can result in a complementary response in the therapist or a concordant response. If complementary, as when the analyst identifies with the sadistic aspect of a masochistic patient's projection, this can be accompanied in the PI model by actions of the patient putting pressure on the therapist to assume a complementary role, that is, to become more sadistic or victimizing. If concordant, he would be more likely to respond empathically with the patient's masochistic self-image.

[36] I recognize that some, even many, analysts would hold just this—that empathy involves some form of regressive merger. Tansey and Burke speak of a *creative regression*—but I do not find their arguments persuasive. There may be room for such regressive involvement in some forms of treatment of psychotic patients, but I think this is not the case in the ordinary run of analytic experience.

To return to the process of empathic attunement, what decides the outcome, in my view, is the prevailing quality of the therapist's extant introjective configuration.[37] If his aggressor-victimizer introject prevails, the masochistic posturing of the patient will serve as a stimulus and an invitation for the aggressive and victimizing tendencies in the therapist to be activated. If the victim introject prevails, the therapist is more likely to respond with a degree of empathic attunement with the correspondingly victimized patient. I note that, in this sense, there is no putting of something from the patient into the therapist, and there is no internalization of something in the therapist that has come from the patient. It is, as far as I can see, entirely a matter of external stimulation activating relevant aspects of the projectee-therapist's already extant introjective configuration.[38]

In related terms, Gallese, Eagle, and Migone (2007) make a salient point:

> What is to be especially noted here is that according to the theory of embodied simulation and related findings, the therapist is likely to experience feelings and emotions similar to the patient's, quite apart from questions of the patient's projections and quite apart from the patient's interpersonal pressure (i.e., the patient's unconscious attempts to induce certain emotions in the therapist). Although interpersonal pressure may intensify this process, the findings reported here suggest that the process is an automatic and ubiquitous one that occurs independently of projective identification. [pp. 148-149]

[37] This aspect of the process speaks directly to the importance of the analyst's inner experience and subjectivity in the analytic process. Some object to the self-referential aspect of this account, implying that these processes take place in the analyst without reference to or consideration of the patient. If so, any semblance to true empathy would seem spurious and without the depth and feeling of true empathy. This seems to ignore the interpersonal context of the process and that both analyst and patient are involved in it. There is no process unless there is some form of affective communication coming from the patient, and, whatever psychic processing goes on in the analyst's mind, the result is an affective connection and involvement with the patient.

[38] The point here is not whether there is any trial identification involved, but that in this reconstruction there is no need for it.

I will suggest (see below) that one possible connection is that the induced emotional response may serve a signal function that would resonate with the preexisting introjective configuration in the receiver, thus activating certain aspects of his introjective organization. This effect may be integral with the sense of similarity and serve as the basis for analogous inferences.[39]

A MODEL OF EMPATHIC EXPERIENCE

Based on the above findings and perspectives on empathy, I would like to suggest a tentative model of how empathic experience, specifically in terms of affective attunement, might be produced. The model, as it takes place between analyst and analysand, involves the integration of complex processes on both a neurological-neurophysiological level and on a psychological level, centering on the nature of the introjective configurations in both parties to the process. Similar mechanisms are involved in both empathic and countertransference responses in the analyst, so that the model should have analogous application to both outcomes.

Also, the model applies to empathic responses from both sides of the analytic relation: from analyst to patient and from patient to analyst. In terms of levels of nonconscious communication, as outlined above, patterns of nonconscious as well as unconscious communication are flowing back and forth between the two of them, activating the corresponding affective responses on both sides of the dialogue. For convenience of exposition, I will describe the process primarily from the perspective of the analyst, noting parallels in the patient where indicated.

The model can be articulated in the following steps.

[39] As Gallese, Eagle, and Migone (2007) point out, the mirroring effect does not rule out PI as a possible mechanism of empathy, but any such claims would require evidence to substantiate the effects of projection and pressure over and above the effects of embodied simulation. As they note: "The mere fact that the therapist's experiences are similar to the patient's does not itself suffice as such evidence" (p. 150). Further, I suggest that we could use a better understanding of the relation between the nonconscious, automatic, hard-wired transmission of affect and the role of unconscious mechanisms like projection and introjection.

(1) The analysand, at least unconsciously but possibly also consciously, experiences an emotion.

(2) On the level of nonconscious neurophysiological processing, synchronously with the occurrence of the emotion and as part of the emotional process, neurophysiological processes in the analysand are automatically set in motion, triggering a pattern of physiological and neuromuscular effects that are actuated in facial expression, gesture, posture, autonomic reactivity (resulting in blushing, pallor, sweating, changes in heart rate, etc.), changes in vocal tone and expression, and other physically mediated subliminal cues corresponding to the nature of the emotion in question.

(3) On the psychological level, affect is related to, or actively expresses, an aspect of the sense of self that may or may not reach awareness; if conscious, it is experienced subjectively as *my* feeling, or, if unconscious, as belonging to my unconscious sense of self, therefore reflecting and expressing some aspect of my self-as-object, specifically the introjective configurations that are central to the motivational and emotional experience of the self. The experience of fear,[40] for example, is not fear in the abstract, but fear in the concrete as not only my fear, but fear as reflecting my sense of self as vulnerable and victim—an expression of the victim introject. In this sense, both the neurophysiological patterns and the activation of the sense of vulnerable victimization are correlative and integrated in the same experience.

(4) On the other side of the analytic relation, on the level of nonconscious and basic communication, the analyst in turn perceives, receives, and registers the pattern of cues generated by and being received from the analysand. This immediately triggers a neurological response in his mirror neuron system—a reaction to the pattern of emotion being communicated, simulating a corresponding pattern of low-

[40] It should be said, even though it seems obvious, that I am using fear as related to the victim introject, both here and in the following discussion, as an example to illustrate the working of empathic processes. This does not exclude from consideration a range of other introjective configurations, both aggressive and narcissistic, as well as the myriad forms of combination that can characterize individual differences in self-experience.

level, subliminal, nonconscious emotion in the analyst that is analogous to the emotions being experienced by the analysand.

(5) This pattern of mirror neuron emotional activation gives rise to a corresponding pattern of unconscious signal affects that induce a further level of processing of the stimulus in other related brain areas, different for different emotions. This more complex processing results in an inferential process that concludes with the sense that the analyst is responding in an emotionally analogous way to the emotion communicated from the analysand. The inferential process is carried out in entirely unconscious terms and relies on other informational-processing capacities of the central nervous system; it may take place almost instantaneously in real-time terms.

(6) This pattern of affective neuronal activation resonates with some aspect of the analyst's own introjective organization that informs his sense of self (self-as-object). I note that this model does not call for any new internalizations (*trial identifications*) for these effects to be realized, but what is required is that elements of previously acquired introjective configurations be extant and open to influence in the analyst-object's self-organization. Depending on the configuration of these introjects, the analyst will respond accordingly to affective input from the analysand. In the fear example, if the analyst's introjective configuration is predominantly organized around a victim introject, he is more likely to respond in terms of his own fearful vulnerability and weakness. Insofar as this allows the analyst to be more responsive to the fearful aspect of the analysand's victim introject, however defensively denied, the response can be more empathic. However, if the analyst's aggressor-introject predominates, he may respond in more aggressive terms and become more of a victimizer to the patient's victim—a form of countertransference.

(7) This pattern of neuronal activation can result in an empathic response in the analyst that may operate entirely unconsciously, and thus find expression indirectly in forms of em-

pathically attuned behavior without ever rising to the level of conscious awareness. In later stages of the processing, however, when more complex cerebral activity becomes involved, it may attain a level of more or less conscious awareness of being empathically attuned to the analysand. I would add that, thus far, the process of emotional communication and attunement is carried on in nonconscious terms, mediated by automatic mechanisms of perception, whether subliminal or conscious, neurophysiological and autonomic activation, embodied cognition and embodied affective simulation.[41] No motivational or dynamic psychological processes are called for at this level. But these mechanisms may be and often are combined in more complex dynamic and defensive psychological processes arising in the interaction between analyst and analysand. Further steps in the empathic process may involve projection or PI on the part of the analysand, resulting in further interactions.

(8) This part of the process can involve the following steps. As a result of the introjective activation in the patient, the affect may be experienced in different ways, either as self-syntonic (as a characteristic, typical, or relatively nonconflictual aspect of the sense of self) or as self-dystonic (as a disturbing, distressing, painful, repulsive, shameful, self-devaluing, or conflictual aspect of the sense of self that can motivate the rejection or elimination of this undesirable or unbearable element). Dystonic affects can call into play defensive responses of splitting and projection familiar in descriptions of PI. Thus, if only splitting and projection are involved, the offensive element is rejected, disavowed, and projected onto a fantasy object—namely, in the usual transference context, the object representation of the analyst. The projection remains entirely intrapsychic and unconscious, so that in the mind of the analysand, the analyst-object is portrayed as embodying the undesirable trait or quality as the basis for a projective transference. To stay with the fear example, the analysand's defensive

[41] I have previously reviewed aspects of unconscious emotional simulation, along with other neuropsychological factors that contribute to the mechanism of PI (see Meissner 2009b).

response may take the form of a split between the fearful victim-introject and the fearless aggressor-introject (both aspects of the analysand's self-as-object) and projection of the fearful victim image onto a fantasy object, while the subject's self-image, now distanced from the fearful sense of victimization, can adopt a more fearless and aggressive stance. While either self-syntonic or self-dystonic affects can produce corresponding patterns of neurophysiological expression, only when the affective experience is self-dystonic in some way does the projective defense come into play.

(9) When the affects are sufficiently intense and conflictual, activation of the introjective configuration in the analysand may stimulate a defensive response leading not only to projection of any threatening aspect of the introjects onto the object image of the analyst—in the fear example, projecting the sense of fearful victimization onto the object representation of the analyst—but also to PI. PI will result in the patient's further efforts to interact with the analyst in terms dictated by the projection, that is, in which the projection is accompanied by a behavioral repertoire mobilized unconsciously and motivated by the need to bring the analyst into conformity with the projective demand, that is, to draw him into a degree of role responsiveness that will accommodate to the projected image. The analysand might thus adopt a more aggressive or sadistic stance toward the analyst's presumed fearful sense of victimization. The analysand's projection of this fearful aspect requires some form of fearful response in the analyst corresponding to and reinforcing the aggressor-introject and the defensive and aggressively motivated fear-denying stance of the analysand. If successful, these pressures, largely unconscious for the analysand and unconsciously received and registered by the analyst, can interact with the predominant victim motif already extant in the analyst, thus drawing him beyond mere empathic resonance and into a form of countertransferential role responsiveness enacting the role of vulnerable victim of the analysand's aggressive and victimizing attacks. To the extent that these pressures do not succeed, or that the analyst is able to resist or circumvent them and to see through them

to the underlying defensive need, the response can be more empathic.

The difference in the analyst's response again reflects the organization of the introjective configuration in his self-as-object: if the victim-introject predominates, the analyst is more likely to respond via some form of victimized countertransference reaction; if the aggressor-introject prevails, the analyst would be better able to attune more empathically with the defensively adopted aggressive aspects of the patient's sense of self. Thus, in both cases, the difference between empathic attunement and countertransference enactment is a function of the quality of the introjective configuration in the analyst's self-as-object, in conjunction with other aspects of the analyst's capacity for autonomy and resistance to being drawn into countertransference enactments.

Imbalances in the introjective configuration, however, can leave the analyst vulnerable to countertransference pressures and can thus undermine empathic capacities. There is, then, no projection of the victim aspect from patient *into* analyst, as in PI; rather, the victim configuration is already present and available for activation in the analyst's self-as-object. At the same time, the more balanced the analyst's integration of introjective elements, the better able he is to maintain empathic contact with both aspects of the analysand's self-conflict—with both the projected sense of fearful vulnerability and the defensively maintained stance of aggressive and counterphobic empowerment.

CONCLUSION

In concluding this discussion, some qualifying comments are in order. First, the neurological, neurophysiological, neuromuscular, and autonomic mechanisms are hard-wired, operating automatically and nonconsciously. They provide an operational physiological basis for the generation and unconscious communication of affects. They play a fundamental role in affective experience and communication, both in terms of the subtle physical expression of affective states in the one experiencing the emotion and of the perception, reception, registration, and internal

processing of one observing the emotional state of another. They are an essential part of any form of empathic attunement and response.

Second, in this model, the affects expressed by these mechanisms automatically resonate psychologically with the introjective organization of both the one experiencing the emotion and the one observing. There is no question of anything *transferred* from experiencer to observer, no projection of parts of the self *into* another, no merging, no question of one subject becoming another, no *trial identification.* Rather, the affective resonance of the analysand's (usually unconscious) self-experience is communicated unconsciously to the analyst in whom it is received and registered. Insofar as the analyst's own introjective configuration features elements of an introjective alignment similar to the patient's, his affective response will tend to be more in tune with the self-experience of the analysand. This basic process would be reinforced by whatever behavioral cues the analysand would generate to communicate this internal stance.

The link between the analysand's projection and the analyst's introjection involves *no transmission or projection of anything into the analyst,* no unmediated or unexplained *unconscious communication;* rather, it is simply a matter of the already existing quality of the introjective organization in the participants. Thus, in an analysand's enactment of a masochistic stance, what the analyst receives can resonate with the masochistic aspects of his own personality organization as centered in his own victim introject, and can result in an empathic response. Thus, the organization of the introjects is pivotal. If, for example, the aggressor-victimizer introject has a more prominent role in the analyst's self-as-object, he would be more likely to respond in those terms. The victimized stance of the analysand, for example, is an open invitation and stimulus to the potential aggressor to become more aggressive and victimizing. The result in the analyst would, of course, take the form of countertransference rather than empathy.

Third, there is the question of what and when any of these complex processes become conscious. Presumably, on the neurological, neurophysiological, and autonomic level, these processes are inherently nonconscious and remain so. But their effects can be registered and become

to some degree conscious—for example, through blushing, sweating, or heart rate. The affect itself can also become conscious and be experienced with any degree of intensity. As long as the affect remains unconscious, its presence can be detected only by autonomic or behavioral concomitants. In the process of empathic attunement, the affective resonance with the feeling state of another presumably becomes available to conscious awareness and processing only in the latter stages of the progressive development of the response when the neurological processing involved in the inferential process has reached a certain point of elaboration. Before that, whether the expression and reception of emotion involve projective devices or not, the affective component remains unconscious.

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ON THE FANTASY OF DECAPITATION OF WOMEN AND DENIAL OF THEIR CREATIVITY

BY EUGENE HALPERT

Using material from the analysis of a male patient, the author examines the meanings of the decapitated body of a woman in various religious and cultural beliefs and myths, including those represented by the image of the Hindu goddess Lajja Gauri, and the relevance of these to male denial of creativity in women. Material demonstrating the relationship between feelings of loneliness and the urge to create is also presented.

Keywords: Decapitation, fantasy, women in society, creativity, Hindu mythology, Hindu art, male envy of procreation, misogyny, sexuality, sibling rivalry, fertility, incest.

Across time and geography, various writings from archeology, art, history, myth, and religion give evidence both of fantasies about decapitation and of its reality. For example, the pre-Columbian Moche people of Peru had a god called the "decapitator" by archeologists. He was depicted as part man and part spider, holding a decapitated head in one hand. In Western art, decapitation has often been depicted in the context of a religious story or mythological event; David with the head of Goliath, Salome with the head of John the Baptist, and Judith with the head of Holofernes have been repeatedly painted. That the image of decapitation has been so widespread and varied is indicative of the intensity of the emotions and complexity of the fantasies attached to it.

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One image from among multiple ones of decapitation will be explored here (see Figure 2, p. 482). It is the image of a decapitated woman that came to play an important role in the analysis of a male patient. In addition, this patient also became preoccupied with a four-headed figure of the Hindu god Brahma (see Figure 1, p. 475).

One of the most familiar variants of the image of the decapitated woman is that of Medusa, one of the Gorgons, the three monstrous sisters of Greek mythology. The hero Perseus cut off her head and gave it to the goddess Athena, who wore it on her shield. Freud (1922) interpreted that this monstrous head with snakes for hair unconsciously represented the female (maternal) genitals displaced upward. Freud (1923) added, "What is indicated in the myth is the mother's genitals. Athena, who carried the Medusa's head on her armor, becomes in consequence the unapproachable woman, the sight of whom extinguishes all thought of a sexual approach" (p. 143). Despite some disagreements with or additions to this viewpoint, all writers who have commented on it, both psychoanalytic ones (Balter 1969; Ferenczi 1923; Miller 1958; Reik 1951; Seelig 2002) and nonpsychoanalytic ones (D'Angelo 1995; Delaney 1995; Doniger 1995; Eilberg-Schwartz 1995; Lang 1995; Levine 1995), have agreed that the head was unconsciously equated with the female genitals.

Freud (1916) explored another Greek legend in which a woman was symbolically decapitated. In it a woman named Baubo tried to amuse the goddess Demeter by lifting her dress up to cover her head and expose her genitals. Freud noted:

> During the excavations at Priene in Asia Minor some terracotta figures were found that represented Baubo. They show the body of a woman without head or chest and with a face drawn on her abdomen: the lifted dress frames this face like a crown of hair. [pp. 337-338]

Lubell (1994), in an extensive work on Baubo and Baubo-like figures, focused solely on her exposing her labia by lifting her skirt. Lubell traced this gesture through many different cultures and epochs dating from prehistoric times, and concluded that exposure of the labia was indicative of the worship of female sexual, procreative power. This au-

thor also felt that Medusa represented a degradation of Baubo and of feminine sexual power under later male influence.

That the image of a decapitated female body (with or without a head drawn on it) is enduring is further indicated by its persistence into modern times. The surrealist artist Magritte painted Le Viol (*The Rape*), which depicts a woman's torso as a head on a neck with long hair where the neck should be, the breasts as eyes, the umbilicus as nose, and the groin and external female genitalia as a bearded mouth.

Nor has the fantasy of the decapitated woman been expressed only in the visual arts. For example, Benjamin Franklin (1745) advised a young friend to take an older woman as a mistress and to cover her head with a basket during intercourse. Franklin explained that, with her head covered, it was impossible to tell an old woman from a young one. Franklin's fantasy of symbolic decapitation of women continues to be verbalized by American men who say of women whom they find unattractive, "I'll just put a flag over her face and head-fuck for Old Glory."

CLINICAL MATERIAL

The ending of an analytic session has meanings for all patients. It is most meaningful for those in whom issues of abandonment, loneliness, and separation are particularly acute. These meanings are often expressed behaviorally rather than verbally. Some patients fall silent at the end of sessions; others speak more rapidly. Some get off the analytic couch slowly, while others do so with great rapidity.

If and when these behaviors become the focus of direct analytic attention, some patients will speak of feeling "cut off" or "castrated." I have had three patients who said they felt "decapitated." That was how decapitation entered into the analysis of a man, Mr. L, whom I saw five times a week. He persistently fell silent at the ends of sessions. After seven months of treatment, this pattern was called to his attention. In reflecting on it, he said he would rather end the session himself than be "cut off . . . . When you end the sessions, it feels like you are cutting my head off or castrating me. It feels as if you are treating me like a woman, someone whose words are unimportant and don't matter." There was then a long silence followed by the barely audible words: "Like I was a dumb cunt."

Mr. L had been born and raised in a rural area, the fourth of nine children and the first male child in a white, fundamentalist Christian family. At the time of his birth, his oldest sister was seven and a half, and the sister born immediately before him was eighteen months old. He was two when another sister followed him and eleven when his last sibling was born. The last four children were all boys. His mother had therefore been pregnant and delivered a child nine times in nineteen years. Each delivery took place at home with a midwife in attendance. The family was poor and the house was small. Often there were two or more to a room and sometimes to a bed. Under these conditions, the patient was repetitively exposed to the sight of his mother's abdomen swollen with yet another child; her breast-feeding his younger siblings; his sisters' breasts, pubic hair, and menstruation; and his brothers' genitals and masturbatory activity. The sounds he was exposed to included those of his parents' sexual activity and those of his mother during childbirth.

Arrayed against the plethora of stimuli and the temptations, fantasies, and conflicts they stimulated were his parents' preoccupations with hellfire and damnation as punishment for what they considered sexual sins. Their church had itinerant preachers, and sometimes Mr. L's father took that role. In contrast to the bodily exposure the patient experienced at home, his father and the church preached extreme modesty in dress. This was taken to such an extent that the boys on the basketball team in the "Christian" school he attended wore long pants rather than shorts.

As he recalled this childhood milieu, Mr. L's deep underlying sense of sadness, fears of abandonment, and longings for closeness and praise emerged more clearly in the transference. Seeds of these feelings were present in our very first meeting. When I went into my waiting room that first time, I found him standing and staring at two antique illustrated Indian Hindu manuscripts that hang on one wall. It is relevant to note that he is the only patient in the thirty-six years that they have hung there who ever did this. He even began that first session by saying, "Those are curious paintings. Are they Persian? Or Indian? Or Tibetan?"

While at the time I noted his behavior, I did not fully appreciate its meanings or significance. I thought to myself that Mr. L's interest in the manuscripts was a displacement of his curiosity about the analyst—the

stranger whom he was about to meet—and his anxiety that I would be too distant, foreign, or strange to understand or help him. While these first speculations proved valid, they were not the entire story.

Both paintings contain figures with unusual heads. In one, the Hindu god Brahma, the creator and progenitor of all mankind, is depicted with four heads (see Figure 1 below). In the other, the god Ganesa, the creator and remover of obstacles, is shown. Ganesa has a portly man's body and an elephant's head. At that time, I had no reason to suspect that these particular images would be of special interest to this patient, nor did the patient consciously know why he was so interested in them. As indicated by his initial questions, he had no knowledge of or familiarity with Hindu religion or art.

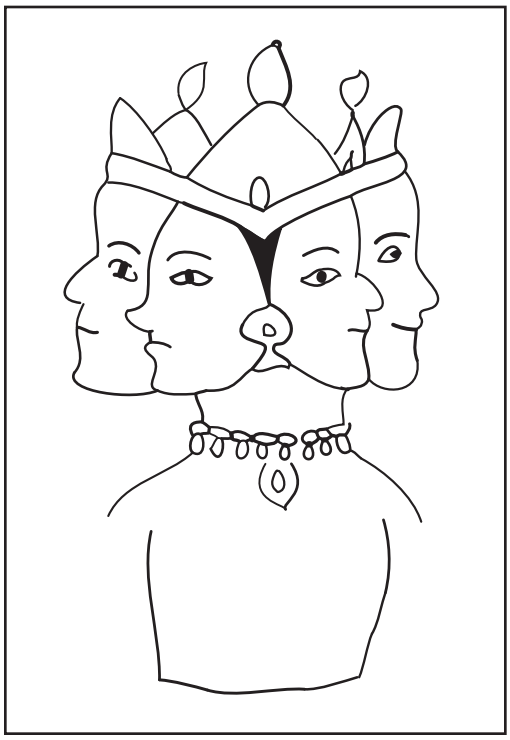

FIGURE 1: The Hindu God Brahma
(drawing by Eugene Halpert)

However, six months into the analysis, Mr. L became preoccupied with these images hanging in my waiting room. He did some research and correctly identified the figures with the strange heads. He did not stop at that, but continued to read about Indian art and religion and to visit museums that displayed such art.

Simultaneously, Mr. L began to express ever more open hostility toward women. Since coming to the New York City area, he had lived in a world very different from the one he had grown up in. He had given up the religious beliefs and practices of his childhood. His New York world was one of the sophisticated, educated, financially elite. In this world, he had had multiple brief sexual experiences, but no emotionally meaningful relationships with women. In the session after he told me that when I ended a session, he felt as if I had dismissed him as a "dumb cunt," he spoke of a woman whom he had had intercourse with. He said, "I can't tell one woman from the other—they are a blur, as if they all had the same face. But I can't tell you what that face looks like. They even all sound the same: dumb. They just chatter on as if they didn't have a brain in their head. But who cares? All I think of is what they have down below and getting into it."

Analysis of these misogynistic feelings revealed a decapitation fantasy. Since all women's faces and heads were the same and could not be described, it was as if they did not have a head. A series of memories, fantasies, and feelings were condensed in this image. The most easily accessible of these were memories of his father's preaching that women were weaker, less intelligent beings who existed only to serve men's needs. His father would invoke scripture to support these ideas by saying that Eve had been brought into the world from a useless part of Adam.

The patient had readily taken in this contemptuous attitude toward women. As a longed-for son, he had been overly valued by his parents, while his sisters had been devalued. In essence, the unconscious, shared belief was that if you have a penis, you are worth something, and if you don't you are not. This was, via displacement upward, one contribution to Mr. L's fantasy of the decapitated woman.

However, hidden behind his demeaning, dismissive, angry attitude toward women was a longing for closeness to an idealized mother. In time, this longing became manifest in the transference. When the pa-

tient first saw the two framed manuscript pages, he thought (correctly) that such strange images must be of interest to me. My awareness of my heightened curiosity about this man who came from such a different background than my own (city-bred and Jewish) and any of the other patients I was seeing at that time alerted me to my vulnerability to his attempts to secure the undivided, loving maternal care and attention that he yearned for by appealing to my interest in the strange and foreign.

The idea that I was interested in and accepting of strange things was reassuring to Mr. L, since he felt he was strange and came from a strange background. He unconsciously fantasized that if he learned about those images, he would thereby show me how smart and knowledgeable he was, and he would become my favorite and ultimately my only patient. In this way, he imagined he would undo the feelings he had experienced with the births of his four younger brothers—feelings of abandonment and loss of status as the only son. This narcissistic mortification contributed to his rage at his mother for her reproductive capacities and at his siblings for existing. This display of knowledge to the analyst would also, he unconsciously felt, fulfill his wish to be that powerful, creative, and desired mother whom all envied. His feelings that women were "dumb" and "empty-headed," and that "nothing important comes out of their mouths," were displacements upward of his envious wishes expressed via reversal. These feelings also expressed his wish to empty his mother's womb and dismissively destroy his siblings.

These wishes emerged from the analysis of extra-analytic as well as analytic transferences. At his workplace, the patient had climbed the ladder of power and responsibility by defeating a series of competitors in a very large organization. His associations to these competitions, as well as to his ambition to defeat all his competitors and become the head of the organization, led back to his unconscious childhood wishes.

For example, in one session several years into the analysis, Mr. L said:

> My family was big like the company, and I had to work hard to get noticed. The babies could wail and get noticed, held, and fed. My mother decided who got taken care of. It made me furious when I was too old to wail, but I tried to pretend I didn't care. I felt like smashing them all, my brothers and sisters. And

> my mother, too—not only for bringing them into the world in the first place, but for having the power to decide who got responded to. Often not me. I was talking to my oldest sister recently, and she told me that, when I was three and a half and Ma was noticeably pregnant again, I ran into her belly on two or three occasions. At this point in my life, I've smashed a lot of people, and I have the power to decide who gets what for a lot of people.

As noted above, similarly, Mr. L unconsciously wished to eliminate all my other patients, and in so doing to become my "only child." This was evidenced early on by the derogatory and belittling comments he made about the patients who came before and after him. His early transference to me as an idealized, creative person upon whom he lavished praise and admiration reflected his early childhood awe of his mother's procreative abilities. His competitive envy of these abilities expressed itself in the transference as an element in his curiosity about the figures on the wall of the waiting room and his research into them and the Hindu religion. He would make comments such as "I'm learning about this stuff and maybe someday I'll know as much as you do about it."

Further along in the treatment, these comments were more along the lines of "Maybe I now know as much as you do, and someday maybe I'll even know *more* than you." His competition and identification with me reflected his unconscious, early, conflicted, frightening competition and identification with his mother and her power to create. The castration anxiety accompanying this feminine identification led to his disparagement, denigration, and "decapitation" of women.

One way this emerged in the transference was in Mr. L's reflections on my name, which occurred several years into the analysis. The first time he spoke of my name, he said, "I don't know if I ever mentioned it before, but when Dr. X referred me to you, he called you 'Gene.' I wondered whether it was *Gene* or *Jean*—whether you were a man or a woman—and I asked him. I only wanted to see a man . . . . I wonder how often you were teased as a child. You know, by being called 'Jeanie.'" He also wondered whether "other patients" might have teased me about my name. The analysis of these projections and displacements of his own

feminine identifications, envy, and sadism played a prominent role in the treatment.

In addition to this unconscious identification with his mother, the patient had sexual longings for her. These longings emerged most clearly in memories of his oldest sister, who had begun caring for him when he was two and she was ten. Though he had told me of his research on the figures in the manuscript pages as soon as he had discovered their identity, he did not report what else he had learned about them or his reaction to his new knowledge until more than eighteen months later. At that time, he accurately recounted how both Brahma and Ganesa had gotten their unusual heads, saying:

> They each had a head cut off. Brahma, who created all people and everything in the universe, originally had five heads. He sprouted them so that he could always watch his first creation, a goddess whom he lusted after. He had created her out of loneliness and longing by splitting himself in two. To help Brahma control his passions, Shiva wrenched off one of his heads.
>
> The story about Ganesa struck me as similar [the patient continued]. The goddess Parvati became very lonely when her husband Shiva was away for a very long time. Out of her loneliness, she created a son to protect her and to keep her company. She rubbed oil on her skin, and out of the material of the rubbing, she created Ganesa. She made him the guardian of her bath and told him not to let anyone in. While standing guard, he occasionally peeked at her. When Shiva finally came home, Ganesa refused to let him in to see his wife. Shiva became enraged and, not knowing that he was Parvati's son, decapitated him. Parvati was overcome with grief and rage and said that, unless Shiva gave him a new head, she would destroy the universe. Shiva told his servants to bring him the head of the first creature they saw, which turned out to be an elephant. Shiva put the elephant's head on Ganesa's body, revived him, and then adopted him.

The meanings of these stories for Mr. L became clearer over the next several months. He noted that in them the wish for a child arose out of feelings of loneliness, and that sexual intercourse did not play a

role in the creation of the child. As he related this, he recalled his own loneliness as a child. He said:

> It might seem strange that I could feel lonely since there were so many of us. But you know, I think we were all lonely to some degree because it wasn't ever possible to just have one special person to yourself. My mother was always worn out and preoccupied with the one who was most recently born. Sometimes I'd watch her with the baby, whatever baby it was, and envy the baby and sometimes even my mother. If she got lonely, she could always have another baby and have that special close relationship to it. Even Ginny [the sister who took care of him[1]] had interests other than me. By the time I was twelve, she was out of the house, married and pregnant. If I were a man like Brahma, I could have created my own child and could have had that special kind of relationship. [In fact, Mr. L felt that he had been like Brahma and Ganesa in some ways.]
>
> I think they show Brahma with four or five heads, each pointing in a different direction,[2] because we are all curious and want to see everything. He, being a god, could do that. He could always have his eye on whomever he desired. That was me with Ginny: always swiveling my head around to catch her in the bath—like Ganesa, I guess. Or with her boyfriend, or getting dressed or undressed. When I was real little, maybe four or five, she used to take me into the bath with her. I always looked even though I knew I wasn't supposed to. And thought of touching her and doing other things. I knew it was sinful and that I was going straight to hell. Later on, I would pretend to myself that she wasn't my sister so that it wouldn't be so bad looking at her body. [Laughter.] Maybe I was expecting Shiva in the form of my father to come and cut my head off for having such thoughts!—or my balls.

In the context of these associations, Mr. L's inability to remember or recognize the faces of the women he had sex with was interpreted as a

[1] This sister's name, Ginny, was similar enough to mine, Gene, that it became one of the bridges over which the patient's transference traveled—especially his transference to me as the longed-for mother/sister who would cherish, appreciate, and care for him above all else.

[2] See Figure 1, p. 475.

way of decapitating them. This both expressed and avoided his guilt and fear of castration for his incestuous desires for his sister/mother. Whenever he saw a woman's face, he would imagine seeing her body, in effect blanking out her face or conflating it with her genitals.

As this work proceeded, the patient began one Monday session by reporting that he had once again visited the Asian collection at New York's Metropolitan Museum of Art. In it he had seen a small stone figure of a naked woman that he had not noticed before (see Figure 2 on the following page). He said:

> There she was. Sitting or lying there, I couldn't be sure which, with her legs spread wide apart so you could see her crack. But she didn't have a head. It wasn't broken off, because instead of a head, she had a lotus flower. The sign said "Lotus-Headed Fertility Goddess. India. Seventh Century." It didn't give her a name. On the one hand, she is showing you—I mean me, or whoever looks at her—everything she has between her legs, but is hiding her head. That is, a flower has replaced her head. What is ordinarily hidden is shown and what is ordinarily seen is hidden. I knew you would wonder what it meant to me. I wondered myself. I know some of it has to do with what I've been talking about: wanting to see my sister—to see between her legs, to get between her legs. Am I really saying this stuff? Do I believe it? Do I expect Shiva or you to rip my head off? I am beginning to believe that I really do blank out women's heads and faces, because to recognize them and have feelings for them would be like seeing my sister and desiring her.

When he spoke of the lotus-headed figure in a later session, I asked Mr. L if he was aware that he had not said anything about her being a fertility figure. He responded with two interrelated trains of thought. One was: "Whenever I don't say something but keep it to myself, and you say something like you just did, I wonder if you said it to really help me know myself, or because you are just curious and get some kind of pleasure out of trying to see inside my head. Or is it both?" The other train of thought was: "Fertility figure? My mother?"

Over time, the exploration of these two interrelated thoughts led to his admiration and envy of me for what he saw as my "creative and

open mind . . . . your receptivity to ideas and the ideas you come up with." Mr. L had projected and reversed these feelings in the transference. In doing so, he had unconsciously assumed the role of the creative mother/woman giving birth to admirable ideas/babies, and cast me in the role of the curious, awestruck child trying to look inside his sister's/mother's head/body to learn the secret of her creativity.

THE INDIAN GODDESS LAJJA GAURI

Art historian Bolon (1992) provided the following description of the lotus-headed goddess, most often called Lajja Gauri (depicted in Figure 2 below).

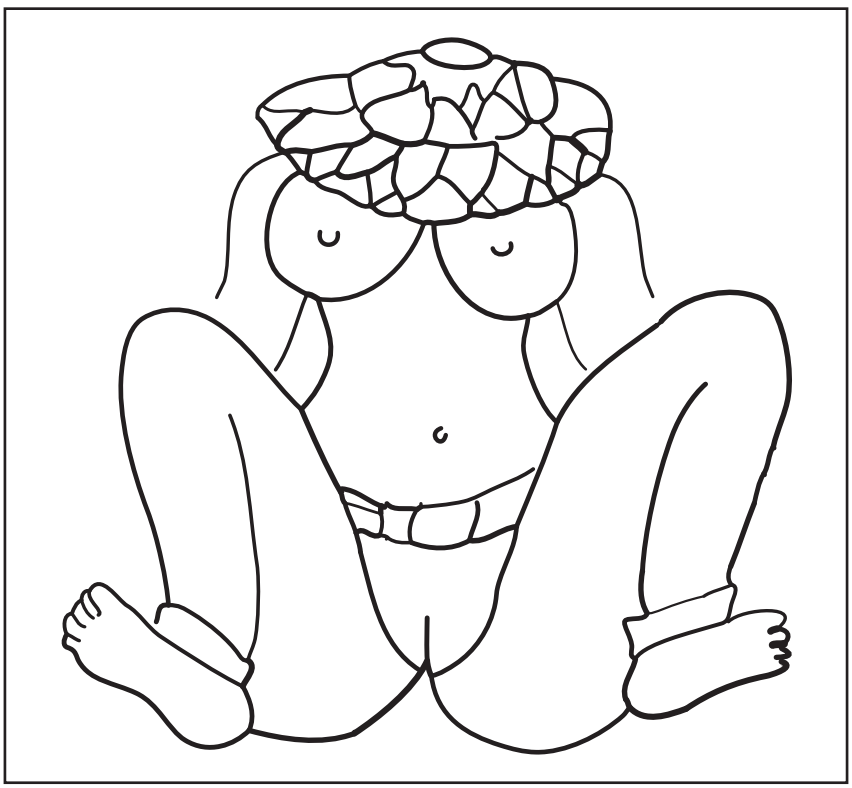

FIGURE 2: The Goddess Lajja Gauri
(drawing by Eugene Halpert)

> Striking images of a certain Indian goddess have been variously referred to as "The shameless woman," "the nude squatting goddess," or, because her historical name remains unknown, by more than twenty-five names . . . . The best-known images of this goddess have a female torso and a lotus flower in place of a head, while her legs are bent up at the knees and drawn up on each side into a pose that has been described as "giving birth" or "self display" . . . . [p. 1]
>
> Lajja Gauri is almost always made to lie on her back, supine. The toes of the recumbent figure are tensely splayed as if she is in the act of giving birth, yet there is no indication of pregnancy. Some scholars have concluded, however, that the goddess is simply indecent, shameless, and that the pose indicates sexual receptiveness. Nevertheless, it should be noted that, although some do give birth miraculously, Indian goddesses are never pregnant in imagery or myth. The pose of Lajja Gauri is ambiguous, but probably intentionally so since the pose of sexual receptivity and the pose of giving birth are the same. The human form and the intercourse/birth pose are used as a metaphor for creation. [p. 5]

This spread-leg pose is called the *uttanapad* pose in Sanskrit. Bolon noted, "The word *uttanapad* exactly explains this image. In Rg Veda it is said that the earth sprang from the Uttanapad, the Creative Agency or Productive Power. Uttanapad in Sanskrit means 'one whose legs are extended in parturition'" (p. 6).

Bolon concluded:

> The essential nature of this goddess is not as Universal Mother, Divine Mother, Personified Womb, or Mother Goddess, although she encompasses all these. More properly she is the essential source of all life, animal and plant, and thereby the source of all Fortune. She personifies the sap of life, which in Indian philosophy is considered to be the vivifying element embodied in water, the support of all life. That she is creative power personified is apparent from the symbols employed in her form and their deep cultural and artistic significance. [p. 6]

Among those symbols, the lotus is most prominent. It is the sacred flower of India, symbolizing fortune, fertility, and reproduction. As such, it is found in Hindu, Buddhist, and Jain art.

Quoting Bolon again:

> The lotus floats upon the water, as it was conceived by Indian mythologists, the earth floats upon the waters and thereby the lotus is also a symbol of the earth, source of all life and fortune . . . . The lotus symbolizes, thereby, both the potency of life-giving water and the earth. [p. 52]

DISCUSSION

While one may question some of the meanings offered by Bolon of the iconography of Lajja Gauri, the degree of agreement between this art historian's examination of the spread-legged, lotus-headed figure of the goddess and my patient's associations is striking. Both saw the goddess as basically the most creative, generative figure imaginable.

In addition, Mr. L's associations indicated that the figure's decapitation and replacement of her head with a lotus flower might originate in several interlocking conflicts and fantasies. One of these is the displacement upward of castration anxiety. While in the Medusa image, snakes replace the absent penis, in the image of Lajja Gauri, a long-stemmed flower replaces it. The lotus head may also both represent and defend against incestuous desires. The patient had in effect unconsciously decapitated women and made their individual faces "a blur," lest he see his sister/mother in his mind's eye; it is the same with the lotus-headed figure of the goddess, since one lotus head looks like another.

Furthermore, when Mr. L found a woman's face attractive, he undressed her in his mind and imagined her genitals. The same idea is represented in the Lajja Gauri image by both the lotus head (the lotus and flowers in general are common symbols of the female genitals and generation) and the open view of the external genitalia. The most striking features of the goddess, visually, are her legs spread apart to reveal her genital slit and the absence of her head, which is replaced by a lotus. This represents and emphasizes the unconscious equation of one with the other.

The hostility expressed in the decapitation of women derives from the unconscious awe and envy of the creative power of women. While that awe and destructive envy were unusually intense in this patient

whose mother had given birth nine times in nineteen years, it is universal. Horney (1926) noted the universality of this awe and envy when she wrote:

> But from the biological point of view woman has in motherhood, or the capacity for motherhood, a quite indisputable and by no means negligible physiological superiority. This is most clearly reflected in the unconscious of the male psyche in the boy's intense envy of motherhood. We are familiar with this envy as such but it has hardly received due consideration as a dynamic factor. [p. 330]

Chasseguet-Smirgel (1976) wrote along much the same lines. For example:

> Freud attributed to man a "natural scorn" for women. This scorn originated in the lack of a penis. My experience has shown me that underlying this scorn one always finds a powerful maternal imago, envied and terrifying . . . . The need to detach oneself from the primal omnipotent mother by denying her faculties, her organs and her specifically feminine features, and by investing in the father, seems to be a need in which both sexes share. [pp. 283-284]

Seelig (2002) reviewed the Greek myth in which Zeus swallowed the goddess Métis, who was pregnant with his child, because of the prophecy that the child would be very powerful. Seelig stated, "In this sequence, male fear and envy of women's procreative powers leads to incorporative and aggressive action" (p. 899).

We are aware that the wish to be and have everything is part of infantile narcissism. When an infantile wish is denied—be it the wish to have a penis, to be able to have a baby, or for anything else—rage is inevitable. Since this is as true of the female as the male, and a little girl cannot become pregnant or give birth any more than a little boy can, one wonders about her feelings and thoughts in this regard. The figure of the Indian goddess Lajja Gauri suggests that women also unconsciously decapitate women. She is, after all, a fertility goddess who is prayed to by female worshippers when they wish to become pregnant.

Balsam (1996) drew attention to the neglect in the psychoanalytic literature of the effect on the little girl of her pregnant mother's body image, and stressed the importance of the changing size and shape of the mother's body on the little girl's gender identity. It should be noted that the case of the male patient presented here indicates that the changes in the pregnant mother's body have no less important effects on the psyche of the male child. How the effect of the mother's bodily changes during pregnancy is the same or differs in children of either gender, and/or of different ages, awaits further psychoanalytic material and observation.

Does a Hindu woman praying to a decapitated goddess to grant her a pregnancy unconsciously think of the goddess and of herself only as a generative vessel whose power to create shows in her face and her head as much as in her genitals? How much would such a woman's feelings about her mother's fertility and creative power be similar to, and how would they be different from, those of a man? Would any woman anywhere, wanting to become pregnant and fearful that she might not be able to, unconsciously create images similar to those worshipped by followers of Lajja Gauri? Answers to these questions, once again, await further analytic material and exploration.

It has frequently been observed that men often undress women with their eyes. What has not been appreciated is how often such undressing may express an unconscious decapitation fantasy. Nor has it usually been understood that these decapitation fantasies may form an unconscious element in societal contempt for and prejudice against women. Many persons, particularly in light of recent world events, may think only of fundamentalist Muslim societies as practicing symbolic decapitation of women via veiling and the denial of voting privileges, education, and the ability to work outside the home. However, as some scholars have demonstrated, it is far more widespread (though often not as blatant) than that.

For example, D'Angelo (1995) wrote:

> For early Christian men, as it seems for men in antiquity in general, women's heads were indeed sexual members, and at least two of these men, Paul [the apostle] and Tertullian [a third-century ecclesiastic] expended much thought and no little ink to enforce the sexual character of women's heads. [p. 131]

To illustrate this assertion, she quotes from Paul's sermon to the Corinthians as recorded in 1 Corinthians in the New Testament of the Holy Bible.

> 11:3, But I want you to know that the head of everyman is Christ, the man the head of woman and God the head of Christ.
> 11:4, Every man praying or prophesying with his head covered shames his head.
> 11:5, But every woman praying or prophesying with her head uncovered shames her head; for it is one and the same thing with a shaven woman.
> 11:6, For if a woman does not cover herself, let her also be shorn. But if it is shameful for a woman to be shorn or shaven then let her be covered. [quoted by D'Angelo 1995, p. 132]

In short, as D'Angelo noted, Paul argued for the veiling of women, or shaving their heads, because in his mind a bare-headed woman was sexually exposing herself and her husband. His belief that women cannot think and need a man to do so for them was another expression of decapitation: in effect, he thought of them as headless. A little further on in 1 Corinthians, Paul, like my patient Mr. L, expressed the wish to deny women their creativity and appropriate it for men:

> 11:8, For a man is not from woman, but woman from man.
> 11:9, And man was not created on account of the woman, but woman on account of the man.

While D'Angelo made the same observation—"Paul's use of the Genesis texts not only removes the woman's ability to act as head, but also robs her of her role as a source of life" (1995, p. 134)—she did not attempt to provide motivation for his need to deny women's creative capacity. I suggest that the Genesis story of the derivation of Eve from Adam that Paul relies on—a prime creation myth of Western civilization—contains within it the same unconscious male envy of women's creative abilities, and appropriation of them, that Mr. L demonstrated. It also suggests an emotional link between loneliness and creativity: Eve was created as a solution to Adam's loneliness, just as Mr. L wished that he could give birth like his mother did so that he would never be lonely, just as Brahma and Parvati gave birth as a solution to their loneliness.

Suffice it to say that Tertullian, in a third-century tract entitled "On the Veiling of Virgins," was even more explicit and virulent about the symbolic decapitation of women, openly expressing the upward displacement of the female genital to the head: "Impose a veil extrinsically on her who has a covering internally. Let her whose lower parts are not bare have her upper parts likewise covered" (Tertullian quoted by D'Angelo, p. 146). Tertullian also stressed the erotization of looking as a reason for veiling: "Such eyes wish a virgin to be seen as has a virgin who wishes to be seen. The same sorts of eyes mutually desire each other. It is of the same lust to be seen as to see" (quoted by D'Angelo, p. 145).

CONCLUSION

Having explored the image of the decapitated woman as it arose in Mr. L's analysis, including his interest in the image of Lajja Gauri, and having noted how common this image is, I cannot but suggest that the fantasies condensed within it play a role in broader, shared unconscious fantasies that underlie various societal prejudices toward women. Some of these prejudices have been expressed in the history of Western society through the denial of women's capabilities in various creative fields, be they in the arts or sciences. Women have often been denied access to training or education in these fields. These prejudices may be understood as the expression of a shared unconscious wish to decapitate women by not recognizing them and enviously robbing them of their creativity.

Like my patient who could not distinguish one woman from another and hostilely felt that all of them were empty-headed, as an expression of his awe and envy of their ability to create life, to give birth, so males in general have often expressed the wish to deny women the capacity to create artistically, as their way of saying, "It is we who can create and give birth and not you." In so doing, society merely recapitulates the fantasy that Adam gave birth to Eve, a tale repeated by Paul to the Corinthians and by my patient Mr. L's father to Mr. L himself.

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THE LOGIC OF PSYCHOANALYTIC INTERPRETATION

BY DAVID H. KLIGMAN

The importance and difficulty of validating psychoanalytic interpretations at the time they are made led the author to propose an existential hypothesis method, which involves formulating fundamental psychoanalytic theories as existential hypotheses (i.e., hypotheses that claim the theories are true at least for one case but not necessarily for all) and using a form of deductive reasoning (disjunctive syllogism) to validate interpretations. The method is illustrated by applying it to two interpretations, one of which is rejected and the other accepted. Some questions and criticisms are addressed.

Keywords: Interpretation, validation, suggestion, analytic theory, analytic technique, Sigmund Freud, analytic construction, transference, association, psychic determinism, unconscious conflict, compromise formation.

THE IMPORTANCE OF VALIDATION IN PSYCHOANALYSIS

A good deal has been written about the epistemic status of psychoanalysis since Freud claimed—first implicitly (Freud 1900) and then explicitly (Freud 1913b, p. 207)—that it is both a form of therapy and a source of knowledge about the mind. Epistemic questions continue to be important today. Our means of verifying psychoanalytic theories, how we

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know when our clinical interpretations are correct, whether it makes a difference if they are—and even what *correct interpretation* means—should concern psychoanalysts, not only because an interest in such questions characterizes self-critical, knowledge-seeking disciplines, but more specifically because they are fundamental to the claim that clinical psychoanalysis can provide knowledge about the mind. This claim will be the focus of my presentation.

Unfortunately, the epistemic debate about psychoanalysis has focused excessively on the high-level problem of whether or not it is a science, as Freud (1933, p. 158) claimed. Until recently, too little attention has been paid to the ground-level question of how—if at all—we are able to validate individual psychoanalytic interpretations, i.e., to establish that they are likely correct.

We are familiar with the notion that psychoanalytic interpretations are conjectures; however, another term for conjecture is *hypothesis* (Belsey 1995). One way of systematizing our understanding of hypotheses is to treat them as logical *propositions;* that is, expressions that are capable of being true or false (Copi 1979, p. 2). Hempel (1945) did precisely that with respect to empirical hypotheses, i.e., those that can in principle be found true or false on the basis of experience. Since, from its inception, psychoanalysis has rested on observation and inference (Freud 1914, p. 77), we have good reason to expect that an analysis such as Hempel's will be applicable to the validation of psychoanalytic interpretations, understood as complex empirical hypotheses. We are justified in calling such an approach *the logic of psychoanalytic interpretation.*

The pairing of logic and interpretation may seem odd and perhaps even offensive to some analysts. Aren't psychoanalytic interpretations supposed to be guided by the analyst's use of his or her own associations to the patient's productions (Arlow 1979)? Do we not risk turning an intuitive and empathic human endeavor into a sterile exercise if we then bring logic into the picture?

Certainly, the image of a well-analyzed analyst resonating with an analysand, and introspectively using that resonance accurately to diagnose the analysand's unconscious motivations from moment to moment, is an appealing representation of a worthy ideal. However, until such time as analysts are perfectly analyzed, we will need—at a minimum—

some error-detection technique that does not assume a psychoanalyst's perfect knowledge of anything.[1] Once we have accepted this, we are in the business of validating our interpretations, an activity that belongs to the realm of observation and reason (Arlow 1979), where it is not what we think we know that counts, but only what we can show likely to be true. Although this validation constraint applies equally to any psychoanalytic approach, my discussion focuses on interpretations in classical psychoanalysis and its descendants, such as modern conflict theory (Brenner 1982).

THE CONTEMPORANEOUS VALIDATION OF INTERPRETATIONS

The techniques that psychoanalysts commonly use to validate their interpretations fall into three groups. I shall not elaborate on the problematic claim, referred to above, that an analyst's attunement to his patient's unconscious permits the *immediate validation* of interpretations (i.e., without the necessity of reflection). Neither will I address the important controversy about Freud's logic of *ultimate validation* (e.g., Grünbaum 1984). While the ultimate validation of a line of interpretation depends on "the further course of the analysis" (Freud 1937, p. 265), it is obviously also desirable to validate an interpretation at the time we make it, so that we can pursue correct interpretations and abandon those that are incorrect. Here, I shall focus exclusively on attempts to validate psychoanalytic interpretations by some reflective procedure at the time they are given, i.e., on methods of *contemporaneous validation.*

Before proceeding, I must clarify what I mean by *a correct interpretation,* as there is at least the possibility of ambiguity. For purposes of this discussion, a correct interpretation explains whatever is being in-

[1] There is also a deeper problem here, in that the claim that correct interpretations are those given by well-analyzed analysts rests on analytic authority. As such, it invites the question of whether the well-analyzed analyst's interpretations are correct because she is well analyzed, or whether we regard her as well analyzed because her interpretations are correct. The point is that in neither case is the claim at all informative about what makes a correct interpretation correct. This is a variant of Plato's "Euthyphro problem" (Matthews 1995), which similarly undermines ethical theories that rest on moral authority rather than on arguable moral principles.

terpreted by attributing to the patient unconscious motives that he or she actually harbored and that came into play just as stated in the interpretation. It is literally correct. Some analysts, taking an instrumental approach, regard any intervention that advances the therapeutic aims of an analysis as correct. On this view, an intervention might be judged correct if it made the analysand feel better, elicited important information, or brought about a beneficial change in the patient independently of its literal correctness or lack thereof. The knowledge value of this approach is limited to inferences about the kind of mind that would produce the responses that the interventions elicit.

There are two general approaches to the contemporaneous validation of interpretations. *Pre-validation* involves accumulating confirmatory or disconfirming clinical evidence prior to the giving of the interpretation, while in *post-validation,* the patient's response to the interpretation is used as an indicator of its likely correctness.

Freud's Response Indicators

Freud argued for his response indicators, a form of post-validation, in "Constructions in Analysis" (1937). Although he referred throughout the paper to *(re)constructions* of his patients' childhood psychology, analysts writing since then (e.g., Glover 1955, p. 131; Greenson 1967; Harrison and Carek 1966; Langs 1974; Wisdom 1967) have generally applied these indicators to interpretations of the patient's mental life in the present. Freud did this, too, when he acknowledged that the confirmatory response, "'I didn't ever think' (or 'I shouldn't ever have thought') 'that,'" is heard more often in response to interpretations than to constructions (1937, p. 263).

Freud (1937, pp. 262-265) cited four responses as sources of reliable (but not conclusive) indirect confirmation of a construction:

(1) conscious assent followed immediately by memories that amplify the construction;

(2) a response of the general form of "I didn't ever think (of) that";

(3) an association in response to the construction that is similar or analogous to it, especially when such an unconscious

"yes" repeats the essence of the construction, simultaneously contradicting a conscious "no"; and

(4) in cases where an analysand habitually manifests a negative therapeutic reaction, a worsening of symptoms in response to a construction.

Intuitively, we might think that the unconsciously self-impeaching testimony of the third indicator appears to provide the strongest confirmation, because we hold that the unconscious always speaks the truth; but unconsciously speaking the truth about an interpretation is not as straightforward as it sounds.

In characterizing his response indicators as "indirect forms of *confirmation*" (1937, p. 263, italics added), Freud claimed that an analysand's unconscious acceptance of an interpretation indicates its literal correctness. This leaves us with two questions: first, was Freud justified in claiming that these indicators denote the unconscious acceptance of an interpretation? And second, does unconscious affirmation indicate the literal correctness of what it affirms?

I am prepared to accept that Freud's response indicators generally denote unconscious acceptance of an interpretation, because they correspond to everyday forms of agreement. On the other hand, I cannot accept that unconscious affirmation entails the literal correctness of what it affirms, unless we revert to an archaic understanding of what *unconscious* means.[2] If "the unconscious" consisted of repressed, veridical memories of past events, as Freud believed for a time in the 1890s (1896, p. 211); and if a correct interpretation breached the "repression barrier," allowing otherwise inaccessible material to become conscious; then if a construction elicited further details from the past, that response might imply the literal correctness of what it affirmed.

The most compelling contemporary view of repression, however, is not of a barrier that is removed by correct interpretation; not only can repression facilitate drive gratification on occasion, but what is repressed

[2] There is much in "Constructions in Analysis" that strikes me as a throwback to the heyday of the topographical theory that Freud had rejected for such sound reasons fourteen years previously. The emphasis on recovering repressed childhood memories (Freud 1937, pp. 267-268), reference to "the 'upward drive' of the repressed" (p. 266), and the bypassing of the complexities of the unconscious are three instances of this.

regularly gains access to consciousness as part of a compromise formation (Brenner 1982, p. 113). Moreover, one of the reasons that Freud rejected the topographical theory was his recognition of the heterogeneity and complexity of that which can be designated "unconscious" (1915, pp. 192-193; 1923, pp. 17-18), including highly organized, secondary process fantasies (1915, pp. 190-191). When we consider Freud's response indicators in this light, their problematic nature becomes apparent, for these complex unconscious fantasies, especially those that are of central importance to the individual, readily assimilate the analyst, becoming in that way transference fantasies. So, when a patient responds to an interpretation with an unconscious "yes," unless we can rule out the possibility that the response was produced by an unconscious transference wish to please the analyst, we cannot infer that the interpretation is confirmed.

Consider the following example.

Example 1. After several years of analysis, Ms. B complained one day that men had been favored over women in her family and in society generally while she was growing up, with the result that she had allowed herself to be talked out of her chosen profession. When her analyst commented that she seemed to feel she had been short-changed by being denied the badge of male privilege (i.e., a penis), she was quick to assert that she didn't believe in "all that penis-envy stuff"; however, after a pause, she allowed that her analyst had read the rows and rows of books lining his office walls, while she had read only one small book on psychoanalysis. Because Ms. B consciously repudiated "all that penis-envy stuff," but then seemed to express unconsciously an analogous sense of being intellectually stunted compared to her male analyst, this would appear to be an exemplary instance of an analysand consciously responding "no" but unconsciously responding "yes" to an interpretation, thereby confirming it.

At this point in their work, Ms. B challenged her analyst at every opportunity; however, as the analysis progressed, she gradually relaxed her defenses against the wish to find a loving and protective parent-substitute in him, one she hoped would make everything all right if she were a good girl. In this later phase of the analysis, the wish to please that had been unconscious at the time of the "penis envy" interpretation became

overt, leading the analyst to question the apparent confirmation of his earlier interpretation. He could now appreciate that Ms. B's response to the interpretation had probably combined two wishes: first, to gain his approval by being a good girl who agreed with everything he said (reflected in her comment about the books); and second, to defend herself against the perceived risks of the first wish by fighting with him and repudiating his conjecture. In that case, neither her conscious "no" nor her unconscious "yes" could be taken as evidence bearing on the literal correctness of the analyst's "penis envy" interpretation, as *both* were motivated by transference wishes.

In sum then, Freud's indirect response indicators likely do indicate unconscious agreement; however, the further inference that unconscious agreement entails the literal correctness of the preceding interpretation or construction is not supported as a general claim because:

(1) we now understand that what is unconscious is not homogeneous;

(2) on the contemporary understanding of conflict and compromise formation, repression is not a barrier that is removed by interpretation; and

(3) the possibility that suggestion has played a significant role in determining the apparently confirmatory response is now taken into account.

These considerations cast a veil of doubt over any clinical findings based on Freud's response indicators and on any theoretical inferences (e.g., a theory of the mind) drawn from those findings.

Post-Validation by Wisdom's Response Indicator

Wisdom (1967) based his response indicator on the criterion that an interpretation is corroborated if the analysand's response to it, except for the defense, can be interpreted by the same hypothesis that generated the interpretation. Recognizing the risk that suggestion might lead to false confirmations, Wisdom advocated discerning whether the analysand manifests a trait of suggestibility by assessing his or her assent or dissent to a meaningless interpretation, possibly followed by a further "interpretation" that would hurt the patient only if it were true.

Today most analysts would probably object to Wisdom's procedure on ethical grounds. He also owes us an account of just *how* his criterion supports an interpretation's correctness; unfortunately, he leaves us in the dark on this essential question.

Glover's Pre-Validation of Interpretations

A critical examination of Freud's response indicators shows that post-validation is vulnerable to the influence of suggestion precisely because it relies on the patient's response to the analyst's statements. Glover (1955, p. 119) advocated waiting to hear whether the analysand's further associations confirm an interpretation before giving it, citing a case in which the patient reported a fantasy that exactly replicated the proposed transference interpretation.[3]

Despite possessing some advantages over Freud's response indicators, Glover's method is also problematic, at least because instances in which subsequent associations are identical to an unverbalized interpretation are probably rare. More commonly, the associations will require some theory-based interpretation to achieve a match. But, since the theory we turn to for this help derives *its* authority from other interpretations of broadly similar clinical material earlier in the history of psychoanalysis, what is our warrant for accepting *those* interpretations? Surely, we cannot say that they were validated in the same way as the current interpretation, because that would raise the same question about yet an earlier generation of interpretations—and we would quickly find ourselves spinning in the kind of repetitive and futile search for solid ground that philosophers call a *vicious regress* (Blackburn 1994, p. 324).

Finding ourselves in difficulty, we might be tempted to argue that our theories have been substantiated by numerous instances of ultimate validation or by extraclinical evidence. This is not the place for a detailed examination of either of these important claims. Here, I will

[3] Calling this "Glover's method," as I do, suggests something more elaborate than a single sentence in a 400-page book. However, Glover described and illustrated quite succinctly the practice of waiting for confirmation before verbalizing an interpretation. Inasmuch as I have not found this common psychoanalytic practice recommended in either Freud's relevant papers on technique (1911, 1912a, 1912b, 1913a), Fenichel's *Problems of Psychoanalytic Technique* (1941), or Lorand's *Technique of Psychoanalytic Therapy* (1946), the credit for first publishing it probably belongs to Glover.

simply note that Freud's method of ultimate validation has come under serious attack by Grünbaum (1984), so that it is not immediately obvious that we can resort to it in defending Glover's method; and that, while extraclinical evidence has supported such psychoanalytic doctrines as the causal power of unconscious motives (Brenner 1973, pp. 10-11), most of our theoretical ideas have not been conclusively tested extraclinically.

Glover's method thus trips over the fallacy of begging the question—that is, of assuming the truth of the very thing one is attempting to prove (Govier 2001, p. 439). In this case, showing that an interpretation is correct assumes the truth of theories that are based ultimately on the unproven correctness of interpretations just like the one in question. That being the case, "confirmatory" associations do not in general have the power to confirm our conjectures, even those we have considered silently.

SUGGESTION AND COMPLIANCE

If begging the question is one important obstacle to validating interpretations at the time they are made, we have seen that suggestion is another. Auchincloss (Colombo 2008, p. 614) defined suggestion as the ability to influence another by means other than an appeal to reason, and we might define compliance (in the sense that is of interest to psychoanalysts) as a patient's acting either consciously or unconsciously under such an influence.

It seems to me that there are three forms of compliance risk:

(1) the risk that even adopting the model we work within will skew our patients' ways of thinking about themselves (*ontological compliance*);[4]

(2) the risk that, if we rely on such methods of post-validation as Freud's response indicators, patients will compliantly affirm our interpretations (*response compliance*); and

[4] Ontology is "the branch of metaphysics that concerns itself with what exists" (Blackburn 1994, p. 269). Although I cannot develop it here, I believe that an argument can be made to the effect that the various psychoanalytic models are in fact divergent ontological positions about the mind: is mind fundamentally conflict and compromise formation, internalized relationships, a self in the context of its selfobjects, or something else? Hence, I call compliance with the analyst's model of the mind *ontological compliance*.

(3) the risk that, once our patients understand which ideas we find interesting or useful, they will unconsciously tailor all their subsequent associations to some degree in accordance with those ideas, excluding potentially contradictory information (*compliant filtering*).

Every psychoanalyst must work within some model or other, and ontological compliance is relatively benign epistemologically, as long as we avoid claiming that we can find out everything about the mind within one model. So let us acknowledge that ontological compliance is unavoidable and set it aside for purposes of this discussion. We have also seen that response compliance can be avoided by adhering exclusively to pre-validation.

Clearly, then, compliant filtering is the really hard problem of suggestion. For instance, Glover's method of pre-validation would falsely confirm an interpretation if the clinical material that suggested it and the subsequent associations that seemed to confirm it were both the product of a patient's having unconsciously filtered his or her thoughts in accordance with the analyst's previous comments. Similar considerations apply to other methods of validation, including the one I am about to present. I do not know of any reliable procedure for determining the extent of compliant filtering in a given case, but this does not mean that one could not be devised.

Freud—incorrectly, I would now say—minimized suggestion as a potentially important contaminant of his response indicators (1937, p. 262). Grünbaum (1984) drew a conclusion diametrically opposed to Freud's, arguing that all psychoanalytic clinical data (p. 277)—and, in consequence, the psychoanalytic theories they are alleged to support (p. 167*ff.*)—are contaminated by suggestion. These days, psychoanalysts struggle to reconcile the validity of psychoanalytic knowledge with the ubiquity of suggestion (Colombo 2008), and this burden is not lightened by experimental work in social psychology that demonstrates how readily suggestion can occur and how durable its effects can be.

Loftus (1979, summarized by Stich and Nichols [2003]) showed that false statements by participants at the time of an event, or leading questions by investigators, can plant incorrect information in the memories of eyewitnesses; and Nisbett and Ross (1980, summarized by Stich

and Nichols [2003]) reported that subsequent debriefing failed to undo subjects' false beliefs that they possessed such traits as "suicide-proneness" or "latent homosexuality" that had been implanted by bogus psychological tests.

THE EXISTENTIAL HYPOTHESIS METHOD

Since it is desirable to evaluate interpretations at the time they are made and current methods of doing so have various limitations, I now propose an alternative form of pre-validation. This method has two main features, each of which will require considerable explanation and justification.

First, psychoanalytic theories are formulated as existential hypotheses, which is a departure from our customary way of stating them as universally true. And *second*, the proposed method is argument-based in that candidate interpretations are each treated as the conclusion of a chain of deductive reasoning applied to the relevant clinical material. I hope to show that this *existential hypothesis method* avoids some of the problems that beset Freud's and Glover's approaches to contemporaneous validation.

I begin with a detailed presentation of the existential hypothesis method, following which I show how it can reject as incorrect an interpretation for which adequate evidence is lacking, and can validate one for which it is available. I want to state clearly, however, that these examples are intended to be illustrative rather than probative, merely demonstrating that the method can work at least some of the time and on a certain kind of clinical material.

Psychoanalytic Theories as Existential Hypotheses

Hempel (1945, pp. 39-40) described four kinds of empirical hypotheses, and the three that concern us are ordinary quantified propositions (Copi 1979, p. 63*ff.*) with empirical content. A hypothesis may be *singular* (referring to an individual) or *general* (referring to a group). "The object hidden under that cloth is black" is a singular hypothesis. Two subtypes of general hypotheses are of particular relevance to the logic of psychoanalytic interpretation: *universal hypotheses* are claimed to be true without exception (e.g., "All ravens are black"), while *existential hypotheses*

claim only the existence of a certain entity for which they are true (e.g., "Some ravens—at least one—are black"). Although the existential claim is weaker than the universal one, it includes the possibility that all ravens are black.

Hempel (1945, p. 39) also distinguished two degrees of support for an empirical hypothesis: *confirmation* describes the support of a hypothesis by a favorable experiment or observation that falls short of conclusive *verification; disconfirmation* and *falsification* are the respective opposites of confirmation and verification. Hempel noted the impossibility of verifying universal hypotheses by confirmatory evidence since, no matter how many confirmations we have in hand, a single disconfirming instance (which would falsify the hypothesis) may someday be found. For similar reasons, existential hypotheses can be verified by a single confirmation and can never be falsified. Singular hypotheses can in principle be either verified or falsified.

The major theoretical positions of classical psychoanalysis are usually stated as universal hypotheses; for instance, *psychic determinism* is taken to mean that psychological forces determine every psychological act or experience (Moore and Fine 1990). I believe that this approach is problematic if we are to claim—as we do—that psychoanalysis is an empirical discipline, in which theories are shaped and tested by experience. To formulate our theories as universal empirical hypotheses requires that we state under what conditions we would consider them to be falsified (Hempel 1945, p. 40; Popper 1957).

However, a number of our most important theories do not lend themselves to falsification: the claim that all mental acts and experiences necessarily involve an unconscious component (Boesky 1991) is a case in point. What conceivable clinical datum would we accept as conclusive evidence that a given mental act or experience had no unconscious roots? What falsifiable prediction relevant to this thesis would we ordinarily make in psychoanalytic practice, where we rarely if ever make predictions? And if we were to designate the absence of confirmatory evidence in any single case as sufficient to falsify one of our general theories, we would always be able to vitiate the condition of falsification by claiming that confirmation would have appeared in time, or that the patient's resistance prevented its emergence. It is therefore preferable to formulate

psychoanalytic theories about the mind in the weaker form of existential hypotheses.

One important consequence of formulating our theoretical positions as existential rather than as universal hypotheses is that we thereby surrender the claim that they are universally true. I do not regard this as a major drawback for three reasons. First, among the main virtues of such universal hypotheses as scientific laws are prediction (Papineau 1995) and its close relative, explanation (Hempel 1948, pp. 247-250)—neither of which is useful to us clinically, since we and our patients have to discover explanations anew in every analysis if they are to be therapeutically beneficial. Thus, testing our hypotheses every time we invoke them demands nothing from us that we were not already doing. Second, we may still be able to establish by suitable data collection and statistical analysis that our existential claims are confirmed in the vast majority of cases. And third, there is the possibility of testing our theories extraclinically.

Recognizing that they do not exhaust classical psychoanalytic theory, I offer eight existential hypotheses for consideration. In contrast to Rapaport and Gill (1959), who sought a minimal set of assumptions from which all of psychoanalytic theory could be derived, the following empirical hypotheses have to be validated anew by logical inference from clinical data each time they are invoked as explanations. I have tried to frame them in language that neither rules out nor assumes the universal truth of any particular psychoanalytic theory.

First, some human behaviors and experiences are motivated (psychic determinism). The doctrine of determinism, which claims that every event has a cause (Blackburn 1994, p. 102), i.e., that none are random, is a universal claim that has been called into question by certain discoveries of quantum mechanics, namely, that laws concerning events at the most fundamental level of matter are irreducibly statistical rather than deterministic (Rosenberg 2005, pp. 9-10). It is thus possible that my desk could levitate—not through the causal agency of an external force, but due to the random circumstance that all of its vibrating molecules happen to shift upward simultaneously. Since the probability of this sort of thing ever happening is very close to zero, macroscopic events appear to occur deterministically (Weatherford 1995).

Fortunately, it is not necessary to derive psychic determinism from universal determinism, as Freud sometimes did (1916–1917, p. 28). By definition, a pattern is not random, so it has a cause. Thus, when we discern patterns in our patients' behaviors or experiences, we are quite right to invoke psychic determinism—i.e., to seek psychological causes—because the patterns are psychological in nature. Each pattern expresses a patient's disposition to react in an individually typical way under certain circumstances. Clinically, we encounter patterns in symptoms, character traits, attitudes, transference reactions, and the way that unconscious fantasies color subjective experience; so the restriction of psychic determinism to psychological patterns imposes little or no practical limitation on the psychoanalytic inquiry into mental causation. However, when it comes to discerning patterns, we can never be completely certain because the very next observation may frustrate our expectations; so we must always be prepared to modify our conceptions of specific psychological patterns and to revise our causal interpretations accordingly.

I will mention two philosophical debates concerning psychic determinism in order to set them aside by establishing that, in each case, my claim is supported by one of the contending positions. First, whether causes can be mental at all is an open question in philosophy (Heil 2004, pp. 170-176); however, my approach accords with Davidson's (1963) position that giving reasons (we might say "exploring unconscious motivations") is a kind of causal explanation.

A second debate arises from the philosophical worry that applying determinism to human action negates freedom of the will. Freud observed that people consciously accept the psychic determinism of their important decisions, but feel that they could have acted otherwise in regard to the trivial ones, because in those instances the determinism remains unconscious (1901, pp. 253-254). A number of philosophers, including Hobbes, Locke, Hume, and Ayer, have asserted that freedom of the will and determinism are compatible (Davidson 1973, p. 63) by claiming, for instance, that people are not free just to the extent that they are prevented physically from acting as they choose. I use the concept of psychic determinism in this "compatibilist" sense.

Second, some mental causes of human behavior or experience are unconscious (unconscious mental causes). By *conscious,* I mean "an object

of immediate experience," where *immediate* means taking place without the mediation of reflection (cf. Freud 1923, pp. 13-14). All mental acts, dispositions, properties, events, and processes that are not conscious are unconscious. To demonstrate that the motive of a particular behavior or experience is unconscious, it is necessary to show only that the behavior or experience being interpreted is motivated, and that the individual is not consciously aware of the motive on that occasion. This can be accomplished either by the analysand's credible admission that she does not (consciously) know her motives or by the falsification of her claimed explanation.

Third, some unconscious mental causes of human actions and experiences can only be discovered indirectly by inference (indirectly discoverable unconscious mental causes). Unconscious mental contents can be divided into two groups: those that can be accessed merely by focusing attention on them, which Freud (1923) called descriptively unconscious, and those that can only be inferred indirectly, under which Freud (1915) included the repressed unconscious, along with the defenses and some highly organized secondary process fantasies. For purposes of this discussion, I shall call the former *directly discoverably unconscious* and the latter *indirectly discoverably unconscious.*[5] In some cases, where there is evidence strongly suggesting the presence of an unconscious motive but none indicating what it might be, we may be forced to conclude that an unconscious motive exists, but that we do not know what it is and may never know.

Fourth, some human behaviors and experiences are caused by multiple motives (plurality of motives). In demonstrating that a particular behavior or experience is plausibly caused by multiple motives, we proceed to show that it is unlikely that a single motive could fully account

[5] Within his topographical model of the mind, Freud equated the descriptive unconscious with the preconscious (1923, p. 15). While he consistently maintained that there is a repression barrier or censorship between the unconscious and the preconscious (e.g., 1916–1917, pp. 295-296), he sometimes (e.g., 1900, pp. 617-618) invoked a second censorship between the preconscious and the conscious. In using such terms as *preconsciously* and *directly discoverably unconscious,* I simply mean *having all the attributes necessary to be conscious except currently being an object of attention.* I do not subscribe to the double censorship model; for those who do, the application of the existential hypothesis method is complicated by the question of whether the same logic of validation applies to descriptively unconscious mental contents as to those that are dynamically unconscious.

for it. Of course, we cannot examine all possible motives, and so we restrict ourselves to those that are relevant to what we are trying to explain (cf. Williams 2001, pp. 45-46).

Fifth, some human behaviors and experiences are caused by conflicting motives (conflicting motives). Conflicting motives (e.g., wanting to attack someone and fearing the consequences), if each were fully expressed, would necessarily dispose to different actions or experiences (i.e., attacking and not attacking); while compatible motives (e.g. wanting a glass of soda and wanting to be cooled by standing in front of an open refrigerator) can, in principle, be fully expressed by the same behavior. Two motives can only be either compatible or conflicting; there is no third alternative.

Sixth, some human behaviors and experiences are caused by conflicting motives that are simultaneously but incompletely expressed (i.e., blended) in such a way that they become compatible with a single behavior or experience (compromise formation). Although this hypothesis and the one immediately preceding it seem quite different from the detailed model of conflict and compromise formation with which we are familiar, the latter should emerge as a plausible explanation of the clinical data in specific cases.

Seventh, some attitudes toward other people are at least partly based on experiencing them as though they were someone toward whom the reacting individual held that attitude in the past (transference). In order to demonstrate that a particular attitude is an instance of transference, we would have to show three things: (a) that the attitude cannot be fully explained as a reaction to the actual behavior of its object; (b) that those aspects left unexplained on this basis are fully accounted for by the assumption that the reacting individual is experiencing the object of the attitude as though they were someone toward whom the reacting individual held that attitude in the past; and (c) that this last assumption is rendered plausible by some subjective similarity in the reactor's mind between the past and present objects of the attitude.

And, eighth, some ideas are caused by a blend of the cause(s) of the immediately preceding idea and some new factor (association of ideas). Clinically, we base our conclusion that two successive ideas are associated on some similarity between them, and from this we infer the likelihood of a corresponding similarity in their causation.

The Role of Disjunctive Syllogism in Validating Interpretations

If there are a limited number of different statements about a situation, one of which must be true, and we are able to rule out all but one, we are justified in accepting the truth of that final alternative. Although this kind of reasoning is so basic that we all perform it preconsciously many times a day, the logic upon which it is based has a formal name: *disjunctive syllogism* (Copi 1979, p. 34).[6] It is not always possible to establish that there are only a limited number of possibilities, but our task is simplified when we can be certain that our alternatives concern a property and its negation—"conscious" and "not conscious," for instance—because between them they exhaust all the options. We are also justified in concluding that, if one of two alternatives is very unlikely, the other is very likely.[7]

Freud's argument for the necessity of postulating an unconscious (1915) is an example of a disjunctive syllogism. An unstated premise is that the sequence of our thoughts, when properly understood, makes sense. The disjunctive syllogism is that either there is an unconscious or there is not. Freud observed that, if there is no unconscious, the trend of our thoughts often does not make sense. Since this contradicts the unstated premise that they do make sense, if we accept that premise, it follows that there must be an unconscious.

Another example is to be found in Freud's use of the Wolf Man case (1918, pp. 53-54) to rebut Jung's thesis that the childhood experiences and fantasies reconstructed by the psychoanalysis of adults are really only regressive adult fantasies. The only possibilities are that childhood events and fantasies structure an individual's mental life, including ill-

[6] The basic form of the disjunctive syllogism is: (1) either *p* or *q* is true; (2) *q* is false; therefore (3) *p* is true, where *p* and *q* are declarative sentences. More complex cascades, in which alternatives are ruled out until only one is left, can be built up from this basic prototype.

[7] The more "likelihoods" we conjoin, the more we diminish the overall likelihood of the conjunction, just as when we multiply probabilities. An event with a probability of 0.85 is quite likely to occur, but if a particular outcome rests on five events, each with an individual probability of 0.85 occurring consecutively, its probability is $(0.85)^5$ or only 0.44. This constraint comes into play when, in support of our interpretations, we build complex arguments that depend on multiple concurrent likelihoods: e.g., to prove that *D* is likely, we first have to prove that *A, B,* and *C* are likely.

ness (Freud's hypothesis), or that they do not (Jung's hypothesis). Since Jung's theory cannot account for a symptomatic infantile neurosis such as the Wolf Man's, Freud's theory is supported. Thus, my use of disjunctive syllogism in a psychoanalytic argument is not novel.

For each of the eight existential hypotheses that I have based on fundamental psychoanalytic theories, there is a corresponding disjunctive proposition comprising two or three alternatives, one of which must be true:

(1) *(Psychic Determinism)* Every human behavior or experience is either motivated or unmotivated;

(2) (*Unconscious Mental Causes)* A mental cause of a human behavior or experience is either conscious or unconscious;

(3) *(Indirectly Discoverable Unconscious Mental Causes)* An unconscious motive is either undiscoverable, directly discoverable, or indirectly discoverable;

(4) (*Plurality of Motives)* Every motivated human behavior or experience is either caused by a single motive or by multiple motives;

(5) *(Conflicting Motives)* Pairs of motives for a given behavior or experience can only be either compatible or conflicting;

(6) (*Compromise Formation)* Multiple conflicting motives can only be expressed either in different behaviors or experiences; or in a single, complex behavior or experience that blends them, where *blending* is the simultaneous, incomplete expression of two or more conflicting motives, so that they become compatible with a single behavior or experience;

(7) (*Transference)* Every attitude toward another person is either (a) fully justified by that person's behavior; (b) a reaction based exclusively on experiencing that person as though he or she were someone toward whom that attitude was held in the past; or (c) a blend of the two; and

(8) *(Association of Ideas)* Every idea is motivated either (a) in exactly the same way as the immediately preceding idea; (b) entirely by some new factor; or (c) by a blend of the two.

If we construe quantitative (economic) changes as new factors, then it seems almost certain that (8a) describes an empty set for, if there are neither qualitative nor quantitative differences between the causes of an idea and those of the immediately preceding idea, they will be the same idea. Determination of an idea entirely by some new factor might occur, for instance, if a person were walking in unfamiliar surroundings in the dark when a sudden flash of light revealed imminent physical danger.

The foregoing disjunctive propositions are not intended to summarize the psychoanalytic theories to which they relate, but only to indicate, for each corresponding existential hypothesis, the full range of possibilities. For ease of reference, the eight theory-bearing existential hypotheses and their corresponding disjunctive propositions are presented in tabular form in an appendix (see p. 519).

In testing an interpretation by the existential hypothesis method, an attempt is made to construct a *cogent argument,* i.e., one that gives sufficient grounds for its conclusion (Govier 2001, p. 81). At each step of the argument, a disjunctive proposition corresponding to one of the theory-bearing existential hypotheses is brought into play.

Suppose that the interpretation being tested states that some conjecture *C* is true of the analysand. If the corresponding disjunctive proposition states, "Either *A* or *B* or *C* is true," that is because *A, B,* and *C* are the only possibilities. If another possibility, *D,* were excluded from the proposition, the argument based on it would be fallacious (Govier 2001, p. 441) and thus incapable of validating the interpretation. The critical issue is whether the clinical material makes every alternative but *C* extremely implausible. If that is the case, then the interpretation is likely correct.

In the course of validating an interpretation, some existential hypotheses (psychoanalytic theories) are thereby also confirmed *for that particular case.* We may then say that those theories *apply* to that case. Theory-bearing existential hypotheses and their corresponding disjunctive propositions are related as follows. The existential hypothesis claims that one particular alternative in its corresponding disjunctive proposition is true in some cases. For instance, the hypothesis that some motives of human behavior or experience are unconscious corresponds to the disjunctive proposition that a motive for a human behavior or experi-

ence is either conscious or unconscious. So, to the extent that we rule out conscious motivation for a motivated behavior, we are able to affirm that it is motivated unconsciously, thereby also verifying the existential hypothesis that some behaviors are unconsciously motivated by providing the required instance.

At this juncture, I want to emphasize that, although the existential hypothesis method makes use of Hempel's (1945) classification of empirical hypotheses, there are important differences between his logic of scientific confirmation and my proposed logic of psychoanalytic interpretation. In Hempel's system, an observation statement (prediction) is deduced logically from a hypothesis and then confirmed or disconfirmed by experiment. In the existential hypothesis method, an interpretation arrived at by the psychoanalytic method is evaluated by attempting to build a cogent argument for it, consisting of a cascade of disjunctive syllogisms, each like a fork in the road. As we have seen, one path at each junction or node is a singular hypothesis derived from one or another psychoanalytic theory-bearing existential hypothesis, while the others at that same node exhaust the remaining possibilities, so that one of the alternatives at each node must be true. If the existential hypothesis claims, "*Some* motives are unconscious," the singular hypothesis states, "*In this case*, the motive was unconscious."

REJECTION OF AN UNSUPPORTED INTERPRETATION

The existential hypothesis method rejects any interpretation for which a cogent argument cannot be constructed.

To see how this works, let us revisit Example 1, in which the analyst's belated appreciation of Ms. B's initially disguised compliant attitude led him to reject the "penis envy" interpretation that he had originally accepted on the basis of a Freudian response indicator. Regarding the interpretation itself, I cannot find sufficient grounds in the preceding clinical material on which to base a cogent argument. While penis envy (or, more accurately, an unconscious fantasy of being castrated) may have led to Ms. B's comments about the favored position of males, there

is nothing in the comments per se that requires us to postulate such a cause, since her complaint that males were favored and she was discouraged from pursuing her preferred career may simply have been true. That being the case, the interpretation could easily have arisen from a theoretical presumption on the analyst's part.[8] He may have been correct, but we cannot show that likely to be so on this occasion.

When we turn to the analyst's further (unvoiced) interpretation that Ms. B's reaction to his first interpretation confirmed it, several features stand out. She first repudiated "penis envy" and then surrendered her repudiation, deferring to the analyst's allegedly superior knowledge, symbolized by his books. This development can be understood as an association *both* to her original comments and to the analyst's interpretation: the former accounting for the aspect of deferring to a male, and the latter for the sense of relative inferiority (*Association of Ideas*). Since there was nothing in the reality of the situation that compelled her to defer to her analyst, her deference likely was a reaction to his trying to teach her (by interpretation), which entailed her experiencing him as though he were one of the authoritative men she had learned to defer to as a child (*Transference*). This provides no support for the analyst's second interpretation.

For those who may wonder how this rejection of the "penis envy" interpretation in Example 1 relates to the rejection I arrived at in my initial presentation of the example, let me say that, previously, I argued that even if we take psychoanalytic theory as a given, there is reason to doubt the correctness of the interpretation. Here, on the other hand, I do not take psychoanalytic theory as a given, and reject the interpretation because I cannot construct a good argument for accepting it.

VALIDATING THE INTERPRETATION OF A PARAPRAXIS

The following clinical vignette illustrates how the existential hypothesis method can be utilized to establish that an interpretation is likely cor-

[8] See Grossman and Stewart (1976) for an illuminating discussion of this kind of misinterpretation.

rect. I have deliberately chosen an ordinary interpretation of the kind that analysts frequently make. In this instance, the interpretation helped establish the dynamics of a particular characterological symptom.

Example 2

Mr. D, a middle-aged man who had been in analysis for several years, found it very difficult to assert himself, a symptomatic pattern. Sometimes he would feel attacked and not be able to respond; on other occasions, he would describe an angry feeling without sounding angry.

One day, Mr. D began his analytic session by describing an incident in which a homosexual acquaintance said to an informal gathering at which the patient was present that the worst kind of people were those whom you could only describe as "nice." The patient volunteered to his analyst that he had been offended, since he felt that this description fit him, and might indeed have been directed at him. Then he made a slip of the tongue, referring to the acquaintance who had made the offending remark as "she."

When the analyst pointed this out and wondered aloud what had led to the slip, Mr. D asked whether the analyst felt that slips of the tongue always meant something. The analyst replied that this had to be decided in each case. On this occasion, the analyst asked, since Mr. D knew that the man who hurt him was homosexual, did it make more sense to believe that his slip was random, or that he was retaliating by verbally castrating him—i.e., calling him a "bitch" behind his back, hitting him where it hurt?

The patient responded that he could believe the latter of someone else, but found it hard to accept in himself. The analyst added, "Because it's not nice, which provides the motive for doing it without being aware of the intent."

The analyst's interpretation to the effect that, despite his unwillingness to admit it, Mr. D had unconsciously acted with the intention of hurting his acquaintance *in absentia* is supported by the following argument. Mr. D's slip was almost certainly motivated because it occurred in the retelling of an incident that conformed to his pattern of being

unable to express the anger he felt. On the reasonable supposition that, in retelling it, he reexperienced some of his anger, the retelling without consciously expressing the anger also corresponded to the pattern. Since a pattern is, by definition, not random, the retelling, including the slip, was not random; thus, it was caused. And since the slip was a mental event, it is legitimate to seek a psychological cause for it.

Mr. D's slip was unconsciously motivated, since if a mental cause of a human behavior or experience is not conscious, it can only be unconscious; and Mr. D was not consciously aware of any motive for the slip. Furthermore, since he did not become aware of a motive on reflection, the unconscious motive was indirectly discoverably unconscious, authorizing us to resort to indirect, inferential means of establishing his motive(s).

In the absence of a single motive that could fully account for the slip, we are entitled to look for multiple motives, possibly including conflicting ones. First, however, we must consider a possible single motive: the "her" might simply have referred to some female person. In this case, a likely candidate would be Mr. D's mother, who had frequently and hurtfully admonished him not to think too much of himself. However, even if the slip referred to his mother, that alone could not fully account for its emergence in the current situation in the absence of something similar in his reaction to his homosexual acquaintance. Thus, it would be an instance of transference, possibly expressing the equation, "You are belittling me, just as *she* did." This is plausible as far as it goes but, as a complete formulation of the slip, it leaves us uninformed about how Mr. D could have said he felt angry at his acquaintance without showing any signs of anger; more significantly, it also leaves unexplained why the protest would have come out as a slip.

Lacking a single satisfactory motive for the slip, we have to consider multiple motives; and here, since Mr. D was hurt and angered by his acquaintance's comment, the motive to retaliate is strongly suggested. Since he did not in fact retaliate, and said he felt angry but showed no anger in retelling the event, the presence of a second motive to restrain his aggressiveness is also strongly suggested. Since neither was fully ex-

pressed in his slip, but the partial expression of both fully accounts for it, the interpretation of the slip as a compromise formation is supported.

The interpretation of the parapraxis provided confirmatory support for the hypothesis that Mr. D's symptomatic pattern of unassertiveness and difficulty expressing anger was based on his refusal to accept that he was capable of deliberately attacking someone. This illuminated the dynamics of his symptom and provided an explanation for his inability to act in spite of acknowledged angry feelings or the wish to assert himself. At the same time, the interpretation also offered limited confirmation of a number of psychoanalytic theories, expressed in the form of existential hypotheses, by providing a credible instance of their applicability.

QUESTIONS AND DISCUSSION

I will now turn to some questions and criticisms that have been suggested by my own reflections or by the comments of others.

Question 1

We have seen that question begging and suggestion/compliance are important obstacles to the contemporaneous validation of interpretations. How well does the existential hypothesis method meet these challenges?

The best initial approach to this question is to compare the existential hypothesis method with Freud's response indicators and Glover's method. All three are equally prone to compliant filtering, but Freud's indicators are also subject to response compliance, while the other two methods are not. Thus, on an initial appraisal, it appears that the existential hypothesis method is roughly equivalent to Glover's.

However, I contend that, for most interpretations, Glover's method will likely require the analyst to rely on psychoanalytic theory as a *given;* and this leads to serious epistemological difficulties because we are attempting to decide whether we can *derive* such knowledge of the mind from interpretations in clinical psychoanalysis. The existential hypothesis method, on the other hand, does not begin by assuming the correctness of any theory, but adds confirmation whenever a theory is required

to play a role in building a plausible interpretation. In this regard, it is preferable epistemologically to Glover's method. However, the example of the parapraxis shows that the existential hypothesis method is painstaking and time-consuming, requiring the analyst to adopt, for an extended period, a different frame of mind from the evenly hovering attention within which interpretations are generated.

Question 2

This last-noted feature of the existential hypothesis method means that using it during an analytic hour would impose a burdensome alteration of psychoanalytic technique. What role might the method play in psychoanalytic practice?[9]

The existential hypothesis method could be used in a retrospective evaluative exercise performed outside the analytic setting, along the lines of my examination of the interpretations in the two clinical examples I have presented. If the method is found to be useful and interesting, its approach to validation might be assimilated gradually into the interpretive work of some analysts.

Alternatively, familiarity with it may reveal some fatal flaws or remediable problems. The description of this method of validating interpretations could also encourage colleagues to devise better approaches. It might even become clear that many analysts have been using something like the existential hypothesis method to check their interpretations informally (and perhaps preconsciously) all along.

Question 3

If the existential hypothesis method is to be used retrospectively, how can it be a method for pre-validating interpretations?

If an analyst employs the existential hypothesis method to evaluate an interpretation and utilizes only those facts that were known to him or her at the time the interpretation was made, then the actual timing of the evaluation should not matter. It is still a pre-validation (albeit a

[9] I am grateful to Henry F. Smith for suggesting the approach I have adopted to this question.

non-contemporaneous one), in that it is not based on the patient's subsequent behavior or associations.

Question 4

Since suggestion and compliance are ubiquitous in psychoanalyses, how can any method validate our interpretations and our theories?

This is the major obstacle facing the claim that clinical psychoanalysis can provide knowledge about the mind. Although I do not have a solution to the problem, I think that refining our concepts of compliance might make it possible to find one. For instance, it might be an epistemologically benign form such as ontological compliance that is ubiquitous, and the more pernicious forms such as compliant filtering may be clustered in the analyses of certain kinds of cases, in particular phases of analysis, or in the presence of certain styles of interpretation. If that proved to be the case, we might be able to base our knowledge claims selectively on clinical material that is relatively free of compliant filtering.

Question 5

What about the fact that the clinical examples lack the complexity of psychoanalysis as we know it in our practices?

Minute amounts of a substance may appear quite different from very large quantities: we should not expect atoms of gold to be shiny and yellow. In beginning to study a new method of evaluating interpretations, it is best to use simple clinical material, or one will very quickly be lost in a sea of complexity. For this reason, I chose the smallest units of interpretation I could find, the simplest conjectures worthy of being called interpretations: atoms of interpretation. The resulting absence from the reported material of personal history, resonance of the interpreted theme in the transference, genetic reconstruction, and working through admittedly gives the vignettes a fragmentary, somewhat flat quality.

Question 6

Given that there are a number of incompatible psychoanalytic models, is it not possible that analysts will obtain incompatible results

by using the existential hypothesis method to confirm interpretations within their respective models?

Let us construe compatibility narrowly as *consistency,* a relation among two or more declarative sentences such that they could all be true (Blackburn 1994, p. 78). Omitting the difficulties of determining whether an incompatibility actually exists, we have two main points to consider.

To begin with, some psychoanalytic models may not be amenable to the existential hypothesis method. What are the implications of this? At the very least it means that, in order to claim credibly that their theories constitute clinically acquired knowledge of the mind, the proponents of such theories have to explain how they can validate their interpretations while managing to avoid the problems of immediate validation that I referred to at the outset, as well as the pitfalls of question begging and response compliance.

Second, because of the weakness of its claims, the existential hypothesis method cannot produce inconsistent results, although it can be shown that, if it could and did confirm inconsistent theories, the fault would lie with one or more of the theories rather than with the method, which is based on a valid form of argument. It might appear that this limitation disqualifies the existential hypothesis method from detecting false theories. However, the method only confirms a theory as applicable to a particular instance when the theory participates in validating an interpretation as the most plausible alternative generated by a particular psychoanalytic model. If a theory is never confirmed in this way, supporters of the model that it forms a part of will eventually have to question its knowledge value.

The existential hypothesis method is weak in two distinct ways, which I will call *weakness of generality* and *weakness of certitude.* Its weakness of generality lies in the fact that, unlike universal claims, existential claims need only apply to one case in order to be true. Thus, any two existential hypotheses will be consistent as long as neither is self-contradictory.

Suppose, however, that we ask two analysts who utilize different models to interpret the same segment of clinical material (the "comparative interpretation problem"), and that they both use the existential hypothesis method to validate their interpretations. In the comparative

interpretation problem, the singular hypotheses derived from two competing, theory-bearing existential hypotheses could, in principle, be inconsistent if they were expressed as unqualified truth claims. Here, it is the weakness of certitude of the existential hypothesis method that prevents it from certifying inconsistent claims. The method can only validate interpretations and confirm the applicability of theoretical existential hypotheses as "likely correct" or "plausible," a degree of certitude that falls far short of "true" or "correct."[10]

Multiple claims of plausibility may be consistent even if the alternatives would be inconsistent as unqualified truth claims. For instance, "The market will rise next and the market will fall next" asserts inconsistent claims, but "Plausibly, the market will rise next and, also plausibly, the market will fall next" is indeterminate but innocuous. In the comparative interpretation problem, subsequent events may make one interpretation more plausible than the other, or the indeterminacy may persist.

CONCLUDING COMMENTS

In conclusion, the box score for the existential hypothesis method comprises a short list of merits and a somewhat longer catalogue of faults. On the positive side, it has a rational basis and appears to be an improvement on Freud's and Glover's methods of contemporaneous validation in that it avoids both response compliance and question begging. However, it is cumbersome, limited to validating the plausibility of interpretations, and—worst of all—just as prone to compliant filtering as its competitors.

Whatever strengths the existential hypothesis method possesses derive at least in part from the weakness of its claims. Some psychoanalysts might argue that a retreat from the strong claim that our theories are well-established, universal truths about the mind surrenders too much ground and is thus far too modest. However, in matters pertaining to the validation of our interpretations and theories, we have very good reasons to be modest.

[10] However, this tentativeness characterizes most of what passes for knowledge in everyday discourse (Russell 1912, pp. 139-140).

Appendix: Corresponding Theories, Disjunctive Propositions, and Existential Hypotheses

Theory	Disjunctive Proposition	Existential Hypothesis
Psychic Determinism	Every human behavior or experience is either motivated or unmotivated.	Some human behaviors and experiences are motivated.
Unconscious Motivation	A mental cause of a human behavior or experience is either conscious or unconscious.	Some mental causes of human behavior or experience are unconscious.
Indirectly Discoverable Unconscious Motivation	An unconscious motive must be undiscoverable, directly discoverable, or indirectly discoverable.	Some unconscious mental causes of human actions and experiences can only be discovered indirectly by inference.
Plurality of Motives	Every motivated human behavior or experience is either caused by a single motive or by multiple motives.	Some human behaviors and experiences are caused by multiple motives.
Conflicting Motives	Pairs of motives can only be either compatible or conflicting.	Some human behaviors and experiences are caused by conflicting motives.
Compromise Formation	Multiple conflicting motives can only be expressed either in different behaviors or experiences, or in a single, complex behavior or experience that blends them.	Some human behaviors and experiences are caused by conflicting motives that are blended.
Transference	Every attitude toward another person is either (a) fully justified by that person's behavior; (b) based exclusively on experiencing that person as though he or she were someone toward whom the attitude was held in the past; or (c) a blend of the two.	Some attitudes are at least partly based on experiencing a person as though he or she were someone toward whom the attitude was held in the past.
Association of Ideas	Every idea is either motivated in exactly the same way as the immediately preceding idea, or entirely by some new factor, or by a blend of the two.	Some ideas are caused by a blend of the motive(s) that produced the immediately preceding idea and some new factor.

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BOOK REVIEWS

INTERPRETATION AND DIFFERENCE: THE STRANGENESS OF CARE. By Alan Bass. Stanford, CA: Stanford University Press, 2006. 216 pp.

Freud struggled with what he evocatively named the "daemonic" power of repetition—intense but uninterpretable transference reactions to the analyst. This paradox inhabits psychoanalysis. As Alan Bass puts it in his new book, *Interpretation and Difference: The Strangeness of Care*: "Demonic repetition haunts the concept of transference itself: transference can be the possibility and impossibility of analysis." (p. 142). Traditional psychoanalytic interpretation often seems not to unravel these knots, which provides a motive for examining and perhaps reframing the problem.

Bass departs from this aporia toward the three philosophers he uses in his book—Nietzsche, Heidegger, and Derrida—to read from each of them theories of interpretation that, successively and cumulatively, replace the causal/historical theory of interpretation developed by Freud and followed by most analysts today. Though models differ and ramify, each shares in treating the resistances of what Bass calls "concrete" patients as primarily resistance to "difference." Bass has produced for the committed reader a powerful work of theoretical integration, pursued at the highest level.

The titles of each of the three chapters begin with the names of philosophers. Yet Freud is the protagonist of the book. It is apparent that Bass's goal in many places is to bring others to Freud to illuminate penumbral or latent elements of Freud's theories. But he does not use these three philosophers merely to explain or complete Freud; Freud is also, if not equally, brought to them. For example, Bass suggests that Heidegger's dismissal of drive theory as a merely causal—"metaphysical"—explanatory device may not give Freud's concepts of primary narcissism and the history of the body—"nonmetaphysical" concepts, in Bass's view—sufficient notice (p. 83). In another example of bidirectional ex-

position, Bass uses Freud's theory of primary human bisexuality to challenge Heidegger's assertion that *Dasein* (human being) is sexually neutral, something that might be seen as a limitation of Heidegger's phenomenology (p. 128).

There is a paradox in resistance to difference—as there is more broadly in all defense—that resistance to difference in the form of disavowal implies at the same time a registration of difference (discussed at length in Bass's earlier companion volume[1]). Bass traces the idea of a paradox in Freud's model of the origin of thinking. Though feeding is satisfying and tension reducing for the hungry baby, the experience of feeding and its subsequent recollection is tension increasing: tension reduction rests upon tension increase. This is implied in Freud's model, but not elaborated. Bass looks to other thinkers to clarify and develop this and related "difficult inferences" (p. 15) from Freud's theories.

In relation to this paradox, Bass extends Freud's theory of sexual fetishism into a general model of defense. The sexual fetish provides a fantasy defense against the anxiety of castration. But this is a fantasy built upon a fantasy. Primarily, difference between the sexes is disavowed and replaced with the theory of phallic monism, yielding a simpler view of people as existing in either castrated or noncastrated states. More generally, then, disavowal of the truly different meanings in an interpretation reveals the registration of this difference, and manifests itself as the substitution of concretely—objectively—held realities. For example, in a fetishistic transference, analysands may "view the analyst as an object who makes good an objective lack within themselves" (p. 41). Interpretations of this defense, rather than focusing on the genetics of the formation, would instead aim to illuminate substitutions of fantasy for reality, and of simplifying oppositions such as phallic/castrated rather than even more unsettling differences such as male/female.

Bass begins with Nietzsche in his first chapter and picks up a limitation of drive theory, which is the implication that the tension-reduction model reveals at the center of human being a wish to avoid all sensation, all tension, all trauma, all life. Resistance in analysis reflects an

[1] Bass, A. (2000). *Difference and Disavowal: The Trauma of Eros*. Stanford, CA: Stanford University Press.

existential resistance to irritation, to the confrontation with something non-identical with our needs. Alternatively, the *active interpretation* that Bass finds in Nietzsche would aim to open human beings to irritation, complication, and activation. This method rebels against "metaphysics" (more on Bass's use of this term later)—first, the ontology of Plato, and later the ethics of Christianity—both of which seek, from Nietzsche's view, to kill the liveliness of body and mind and minimize the destabilization of difference. Bass provokes the reader, and exemplifies the activity he writes about, when he says, "In fact, a case can be made that much contemporary psychotherapy, including psychoanalysis, operates in just this way" (p. 12). Active interpretation, on the other hand, seeks to expand the tension-raising, traumatizing, interconnecting recognition of profound differences.

What would active interpretation look like as technique? This is not made very clear, though to be fair the book does not profess to be a treatise on technique, or even a book primarily for psychoanalysts (p. ix). Bass suggests: "'Active' interpretation does not discover facts or objective truths . . . . It opens the differentiating unconscious realities inevitably repudiated because of their pain" (p. 30); interpretation "gives a name to a process . . . introducing truth, as a *processus in infinitum*, an active determining" (Nietzsche quoted by Bass, p. 32). Bass elaborates: "The function of (active) interpretation is to reopen such closed systems in the act of giving a name to this process [of introducing truth]" (p. 33). One might infer, more prosaically, that interpretations of resistance to differences between the analyst's and analysand's thoughts, and so particularly in the transference, might be prominent in a technique derived from this theory.

Heidegger, in Bass's second chapter, provides another "nonmetaphysical" model for interpretation—*descriptive interpretation*, a theme that provides the subtitle for the book and points toward an "existential analysis" (p. 47). Two connected and primary evasions of *Dasein* are avoidance of authentic concern and insistence on the objectivity of the manifest. "Concrete" patients, as Bass refers to them, may present with persistent, transference-driven demands for the analyst to "leap in for them," rather than being able to use the independence-promoting "care" of the psychoanalyst, in Heidegger's terms. Bass observes:

> The clinical literature on such patients is full of accounts of endless, stalemated analyses, in which the patient feels hopelessly dependent and the analyst hopelessly despairing. In Heidegger's terminology the patient would be insisting that inauthentic concern simply *is* concern. [p. 41, italics in original]

Partly, this evasion comes about through a particular kind of concreteness or "objective literalness" (p. 52) of patients, in which their own perceptions are seen as objective and immutable and analysts' as merely subjective and dubitable. Bass argues that concrete patients' resistance is not due primarily to unconscious contents, but rather to a metaphysical "entrenchment in objective presence, in everydayness" (p. 43). Such patients suffer, by this formulation, from a more rigid version of *Dasein's* general aversion to confronting its own being, preferring to interact with "things that are there *now*, as beings" (p. 37).

A nice demonstration of Bass's method of descriptive interpretations is one he gives of the concrete patient's relationship to time and the consequences of this in analysis:

> Conscious time is also the dream time of hallucination . . . . A patient's resistance to interpretation becomes an insistence on infinite repetition of objective perceptual identity: I *am* defective *now and now and now;* you *are* a jerk *now and now and now;* I control the interpretive setting by ending the session *now.* [p. 73, italics in original]

Here the patient insists upon what is real and unchanging. I wish there were more of this in Bass's book (as I wish there were more of this in Heidegger). This is a very different way to think about patients who are more usually described as having psychotic transferences, being borderline, narcissistic, prone to splitting, paranoid-schizoid, or having mentalization deficits, to name a few current alternatives. Here particularly, the psychoanalytic reader may want to bring Bass's new thoughts into a wider context. He refers in this chapter to the conceptions of Abraham, Klein, and Winnicott, making cross-theory links with Heidegger's concept of *concern,* for example; however, placing these philosophical conceptions prior to all the rest, as fundamental or primary in distinction to the (merely) psychological ones, may raise doubts among readers who

do not immediately see the priority of the philosophical, or who perhaps even see the priorities as reversed.

A key Derridean term that Bass examines, in the third, longest chapter, is *différence*—Derrida's word, a play on words, for "a simultaneous process of differing and deferring" (p. 97)—and the resistance of patients to it. The term leads in many directions, including Freud's concepts of deferred effect (*Nachträglichkeit*), repression, memory, and trauma—routes that Bass follows to varying distances. To encounter trauma, the memory of traumas deferred, to relinquish repression, one must become vulnerable to difference: "To be in the analytic setting is automatically to register the pain of opening, the ultimate narcissistic wound and threat to mastery" (p. 144).

As part of Derrida's critique of the "metaphysics of presence"—continuing the work of Heidegger—one can see defense against difference as aimed at making the transference the objective present, and so closing off the interpretation of transference as the past in the present:

> Freud knows that a patient may defensively repeat painful experience with the analyst as if it were objectively, uninterpretably present, but he does not know that the patient does so in order to repudiate the pleasurepain [sic] of interpretation as differential relation. [p. 147]

It is questionable, as in this example, whether these alternative models of interpretation—which turn on concepts like repetition, past, present—entirely eschew the causal-historical, "metaphysical" aspects of traditional interpretation. However, in Bass's account of what he calls Derrida's *spectral interpretation*, the aim is avowedly not to tie present and past into a causal nexus. Rather: "Interpretation of defensive determinism [concreteness, objectivity of self and subjectivity of other] involves interpretation of defenses against fictiveness, against the uncanniness of psychic reality" (p. 151). Spectral interpretation is disruptive, not equilibrating, and combines the paradoxical qualities of separating and binding together. An interpretation does not even aim at immediate action on the person (just as effects of the early traumata of life may be deferred). Spectral interpretations are, as Bass puts it—borrowing from Derrida—"postal": "a sending without assured arrival at a destination" (p. 147).

Where Nietzsche, Heidegger, and Derrida all conflict most pointedly with Freud is in their approach to metaphysics. Freud, Bass argues cogently, was mostly committed to the metaphysics descended from Kant and embodied in the methods and dreams of scientific rationality. When Bass writes about *metaphysics,* he tends to use the term in this narrow sense; for example: "Nietzsche, Heidegger, and Derrida all explain how and why metaphysics cannot encompass the most radical implications of difference" (p. x); and "metaphysics sees truth as identity in order to decrease tension and avoid pain" (p. xi), among many other instances. Traditional psychoanalytic interpretation is "metaphysical" interpretation: as criticized from Nietzsche's perspective, it is reactive, tension reducing, slavish.

In contrast, "nonmetaphysical interpretation is actively differentiating—it opens up the unconscious realities that metaphysics avoids . . . . As nonmetaphysical, it has to operate without the usual categories of subject, object, causality, and opposition" (pp. xi-xii). Freud, causal-historical interpretation, and consequently the majority of current psychoanalytic approaches and psychoanalysts are faulted for complacency about metaphysics.

There is a broader sense of metaphysics unhidden but left to the side so far. A metaphysics, as Bass writes, is a body of work that offers "a statement about the being of beings" (p. 84), or even more broadly, about what there is and how it hangs together. Any metaphysics will take some stand, even if an antithetical or deflationary one, about concepts such as subject, object, causality, time, identity, and so on. Nietzsche, Heidegger, and Derrida, as much as Plato, Aristotle, and Kant, are metaphysicians in this wider sense. These are all thinkers who were irritated by the ancient problems of being. Heidegger, in particular, was truly possessed by the importance of these problems and has arguably produced the most rich and subtle modern analyses of human beings in their being. If anything, Freud is less a metaphysician than Heidegger in this wider sense, for we might say he scratched only the itches of consciousness and rationality.

People who are impressed by Heidegger's analyses will think that not scratching the rest of the itches means missing something indispensable. People who are perhaps more impressed by other thinkers—such as the later Wittgenstein and his successors—may want to help these others to

stop itching. People whose thinking formed outside these philosophical ideas will not even itch, and may want to know why they should start scratching. This is probably the greatest task for a writer developing this ancient subject for a modern audience, even a curious, patient, and scholarly one like the ideal psychoanalyst. Part of the work of doing so would entail an effort to include more links from theory to technique, and then some evidence that the technique works—if not better, than at least as well—with daemonic transferences.

There are, of course, many more ways to think about interpretation. Another approach that is interested in differences between speakers and interpreters—and also treats psychoanalytic interpretation, like existential analysis does, as one member of a larger class—is perhaps less metaphysical still, seeing resistance to interpretation as a matter of norms rather than of ontology. It adds an undeniable complication to interpreting the speech of another if we cannot make use of the everyday norm of "first-person authority" described by Davidson[2]: the usual assumption that *I know what I mean.* If we cannot turn to our interlocutor to tell us what he or she means as we refine our moment-to-moment theory for interpreting his or her speech, we are left with a more challenging task—like asking someone for directions in a foreign city but meeting another tourist—although not a new task; it is still possible to find one's way.

This is the case, more or less, when speaking with anyone. However, when talking with patients who see the therapist—rather than themselves—as insisting on "always being right," or who take anything other than their own words (sometimes even those) as "putting words in my mouth," one especially notices how this norm is asserted as if the patient had nothing else to lean upon. We know there is more freedom in being able to relax this principle than in binding oneself to it. Speaking to the relentlessness of this binding and its consequences may be another way to loosen these knots. In the last analysis, though, whether any one method of understanding and speaking to daemonic repetition is better than another remains an empirical question.

JASON A. WHEELER VEGA (NEW YORK)

[2] Davidson, D. (1984). First-person authority. *Dialectica,* 38:101-111.

FREUD'S TRAUMATIC MEMORY: RECLAIMING SEDUCTION THEORY AND REVISITING OEDIPUS. By Mary Marcel. Pittsburgh, PA: Duquesne University Press, 2005. 221 pp.

The aim of this slim book is summarized in the title and subtitle: the author, who is a teacher of rhetoric, takes as the nodal point in Freud's early career his abandonment of the seduction theory and adoption of the Oedipus complex, and seeks to explore and explain this puzzling, radical shift.

Factors considered are Freud's own molestation as an infant by his nursemaid, the unwelcome reception by the Vienna medical establishment of his paper on the etiology of hysteria in 1896, the prevalence of infantile sexual molestation at that time, and Freud's skewed, incomplete reading of the Oedipus myth. As suggested by the word *reclaiming* in the subtitle, the book laments the abandonment of the seduction hypothesis, and the default background position is Judith Herman's work from a feminist perspective on the diagnosis and treatment of sexual and domestic abuse.[1]

Some chronology: from October 1885 through February 1886, Freud was in Paris studying with Charcot and the French forensic medical establishment. In the etiology paper presented in Vienna on April 21, 1896, Freud, drawing on eighteen cases, took the position that all cases of hysteria were caused by infantile sexual molestation. (His insistence on sexual seduction as the only cause of later hysteria, and the elimination of all other causal factors, distinguished his 1896 position from his earlier work with Breuer.[2]) Marcel is harshly critical of his presentation and conclusions: "On the basis of eighteen cases, he will assert 'universal validity'. . . . He offered his conclusion in advance of giving any evidence, any case studies" (p. 69). Marcel invokes the term *rhetorical fallacy:* that is, without the presentation of any evidence to contradict him, Freud is automatically right.

Through his self-analysis after the Vienna rejection, Freud wrote to Fliess of what was "slowly dawning on me" as he contemplated the

[1] Herman, J. (1992). *Trauma and Recovery.* New York: Basic Books.

[2] Breuer, J. & Freud, S. (1895). *Studies on Hysteria. S. E.,* 2.

etiology of hysteria. By September 21, 1897, he reported his revised thinking: child sexual abuse was not as widespread as he had thought, and he had no therapeutic cures with his technique; he was now ready to give up both the expectation of complete resolution of the hysterical neurosis, and his insistence on childhood etiology.

> The continual disappointment in my efforts to bring a single analysis to a real conclusion . . . the absence of the complete successes on which I had counted . . . then the surprise that in all cases the father, not excluding my own, had to be accused of being perverse—the realization of the unexpected frequency of hysteria, with precisely the same conditions prevailing in each, whereas surely such widespread perversions against children are not very probable. [Masson, p. 264][3]

Two weeks later (in a letter of October 3 and October 4, 1897), Freud, continuing his self-analysis, recovered his infantile seduction by his Czech nursemaid: "I can only indicate that the old man plays no active part in my case . . . . The 'prime originator' was an ugly, elderly but clever woman" (Masson, p. 268). In the same letter, Freud reported that his libido toward his mother was "awakened" during an overnight trip that apparently included some maternal nudity.

After relating some details of the nursemaid's seduction, he wrote a detailed and complex letter dated October 15. The initial segment clarifies, via his analysis of a dream and some information from his mother, that it was the nursemaid, not he, who was a thief and was imprisoned for it. The next part reported his detailed memory of crying with despair over his absent mother, with his brother Philipp trying to pacify him, including opening a closet at his request to look for her. In the next paragraph, Freud writes that

> A single idea of general value dawned on me. I have found, in my own case too, of being in love with my mother and jealous of my father, and I now consider it a universal event of early childhood, even if not so early as in children who have been made hysterical. [Masson, p. 272; see footnote 3]

[3] Masson, J. M. M., ed. (1985). *The Complete Letters of Sigmund Freud to Wilhelm Fliess*. Cambridge, MA: Belknap Press.

Thus, within a month, Freud writes of his doubts about the etiology and treatment of hysteria; recovery of the memory of an early seduction by his nurse at age two to two and one-half; arousal of his "libido" toward his mother; recovery of his memory of inconsolable longing for her; and his conviction of the universality of what he would call the Oedipus complex.

Troubled by Freud's abandonment of the infantile seduction theory, Marcel continues her critique with Freud's technique. Citing Herman's work (see footnote 1), Marcel notes that by 1896, Freud was more concerned with etiology and method, less with affect and technique.

> The work of psychoanalysis was just that: analysis, breaking into smaller pieces the rough stone of the unconscious. Perhaps his medical and scientific training had become a block to empathy. Here was Freud the dissectionist, the objective investigator . . . in treating the patients' unconscious as a site to be excavated, [overlooking] the distress that such opening to the light of day would cause them. [p. 82]

Noting that many of his patients fled treatment, Marcel believes Freud's method was inadequate to the therapeutic task at hand; he might not have fully understood the magnitude of the problem. "Freud was oblivious to, or not culturally conditioned to notice, his patients' distress and attend to it as a legitimate emotional process necessary to their healing" (p. 91). Herman writes about recovery in traumatized patients occurring in stages, as well as the advisability of a lone therapist having a support system in order for the therapist to be able to absorb and integrate the massive amounts of affectively charged material, but Freud is faulted on both these counts. For Marcel, "in abandoning the early techniques without attempting to improve or refine them, Freud condemns himself to an ever-returning plague of psychological pain and ineffective therapeutic nostrums" (p. 155).

With the metaphor of the recurring plague, Marcel revisits Oedipus and the problem of adult transgressions. Puzzled by Freud's abrupt shift to the Oedipus myth and his discovery of infantile sexuality, she sees this as consistent with his abandonment of the seduction theory: it was not the perverted adult who abused the child, but what happened was the child's own responsibility. External causation is replaced by internal.

Consistent with this is her focus on Freud's incomplete citation of the Oedipus myth, which omitted the role of Oedipus's father Laius, further evidence of Freud's pullback from the adult transgressor line. Laius, in the myth now well known, was cursed as punishment for his seduction/rape of the Greek youth Chrysippus. This was not in itself a taboo, for man–boy relations were common and accepted in Greek life. But Laius's failure to obtain permission for this affair from Chrysippus's father and his attempt to continue the affair beyond the acceptable brief timetable were cultural transgressions, and Laius's punishment was to be murdered by his son. When the son was born, Laius tried to avert actualization of the curse by exposing him to the elements to die, but the baby was rescued and survived, raised by foster parents, and he later "unwittingly" killed Laius and married Jocasta.

Freud cites Laius in two places. First he notes that Laius was warned that his son would be his murderer, but does not mention the reason for this curse.[4] Later, Freud writes that it makes no clinical or theoretical difference that Oedipus did not know that the man he murdered was his father, or that his own wife was also his mother, citing the poetic handling of this mythological material: "The ignorance of Oedipus is a legitimate representation of the unconscious state into which, for adults, the whole experience has fallen."[5]

To Marcel, Laius is the perverse adult whose own behavior, not Oedipus's, triggers the tragedy. Freud's incomplete reading of the myth diminishes adult blame and dilutes the importance of the seduction theory. Since most sexually abused children are girls, and Freud emphasized the child's responsibility instead of the adult's, this indicates to Marcel an anti-feminine polarization. But while Freud was moving away from the totality of the seduction theory by 1897, and described the unreliability of memories by 1899,[6] his balanced view is more explicit in later writings, such as when he notes:

> Childhood experiences constructed or remembered in analysis are sometimes indisputably false and sometimes equally cer-

[4] Freud, S. (1900). *The Interpretation of Dreams. S. E.,* 4, p. 261.

[5] Freud, S. (1940). *An Outline of Psycho-Analysis. S. E.,* 23, pp. 191-192.

[6] Freud, S. (1899). Screen memories. *S. E.,* 3, p. 301.

> tainly correct, and in most cases compounded of truth and falsehood. Sometimes, then, symptoms represent events which really took place and to which we may attribute an influence on the fixation of the libido, and sometimes they represent phantasies of the patient's, which are not, of course, suited to playing an aetiological role.[7]

The criticisms of Freud and psychoanalysis presented in this book, set against the background of recent thinking and writing about sexual and domestic abuse by Herman and many others, are not claimed as new or original. Marcel's original intent is to link the abandonment of the seduction theory and the expounding of the Oedipus complex to "Freud's traumatic memory": how Freud was affected by and managed knowledge of the early sexual seduction by the Czech nursemaid. Marcel says her research indicates that, although this material has been known since the publication of these letters in 1985, it has largely been ignored. "This book takes the analysis of Freud's anti-female animus one step further by examining Freud's own experience of seduction, prior to the age of three, by his Czechoslovakian nurse in Freiberg," Marcel writes; with it, she believes, "we will uncover perhaps the deepest evidence regarding both Freud's humanity and the limitations worked upon it by untreated psychological trauma" (p. 8).

First described to Fliess in the letter of October 3 and 4, 1897, the nursemaid was a "prime originator" of Freud's infantile sexual exposure, his

> . . . teacher in sexual matters [who] complained because I was clumsy and unable to do anything. Neurotic impotence always comes about in this way. The fear of not being able to do anything at all in school thus obtains its sexual substratum. [Masson, p. 269; see footnote 3]

Further on in the same paragraph, Freud reports a dream to which he associates the nurse's asking him to steal money for her—"the old woman got money from me for her bad treatment"—with "today I get money for the bad treatment of my patients."

[7] Freud, S. (1916–1917). *Introductory Lectures on Psycho-Analysis. S. E.,* 16, p. 367.

Marcel notes:

> Freud rewrites his sexual molestation at ages prior to two and a half as if it were a teenage boy's first visit to a prostitute . . . . What exactly is a one- or two-year-old boy supposed to be able to do to satisfy an adult woman? . . . nothing. And yet Freud, thrust back into the humiliation of being unable to perform what he could not perform, tries to rewrite the scene as a precocious sexual initiation at which he failed. [p. 18]

In the etiology paper, his sympathies had been with the child victim. In recollecting his own life, however, he harshly internalizes the feelings of failure. He relates his infantile incapacity to his current impotence as a therapist. Marcel describes the transformation "from the doctor in 1896 whose sympathies lie with his patients sexually abused in childhood, to the confused victim of 1897 whose failings as a therapist he identifies as rooted in his childhood sexual abuse" (p. 16). There is no surprise or outrage at the demands made by this presumably trusted adult:

> The clarity with which he had set out the sad and damning picture of the damaging effects of the premature sexualization of a child by an adult in the Aetiology lecture is here smudged and made over by his internalization of the demands of his abuser . . . and his failure to fulfill them. [pp. 15-16]

Marcel believes Freud mastered this unhealed wound—to a degree—by denying its power over him, and by internalizing it via the discovery and development of the Oedipus complex, thus denying the effects of molestation and making the child (himself) responsible.

This book is provocative and thought-provoking. Though highly critical of Freud, it provides a platform from which to examine certain aspects of early psychoanalysis not usually discussed in this light, particularly the fate of the seduction theory. However, it suffers from its tilt, and is therefore less convincing, sometimes resorting to strained connections and distortions. Marcel asks, "What child of two fears castration because his mother is in his presence naked?" (p. 25). It is now common knowledge that children become aware of sexual differences by the end of the first year, so the concern of a little boy in this regard is not so far-fetched.

The attempt to tie the aspects of the case against Freud together seems too one-sided, sweeping, and forced. Freud's lone-ness in treating hysterical patients is echoed in his aloneness, having no one to turn to for help, after the infantile sexual trauma, having no one to help him through the healing. Whatever the poignant parallels here, the lugubrious theme of alone-ness—including his rejection by the Vienna medical establishment, and even dying alone—seems something of a packaging stretch:

> If generations of therapists, family members, and society as a whole rejected such violent and ugly truths in the lives of children, we may perhaps pause to consider Sigmund Freud, a victim, a patient without a physician, unable, alone, to face it for himself. [p. 181]

After making and re-making the case against Freud and Oedipus, Marcel reaches a hyperbolic conclusion that reflects the polarized tone of the book:

> In a real sense, the courts, the mental health system, and public opinion in the west by now have rendered the Oedipus complex largely obsolete. We no longer judicially or socially accept the rape or molestation of girls or boys . . . . The testimony of women and children is no longer held to be legally suspect on its face. [p. 181]

DANIEL A. GOLDBERG (NEW YORK)

UNDERSTANDING DISSIDENCE AND CONTROVERSY IN THE HISTORY OF PSYCHOANALYSIS. Edited by Martin S. Bergmann. New York: Other Press, 2004. 396 pp.

The centerpiece of this book—an edited volume on dissidence in psychoanalysis—is a long review essay by Martin Bergmann. From his own unique vantage point, Bergmann charts the chief dissident voices over the past psychoanalytic century. The advantages of Bergmann's history, maturity, and perspective are enormous. He knew and studied with some of the main characters, and lived through most of the periods of contro-

versy after Freud's death. He has long had a keen historian's eye directed toward psychoanalysis. The experience of reading his chapter is very particular: you are taking a slow, careful walk through many ideas and time periods, examining different networks of colleagues and wary competitors. I never felt I was being told how to think on this journey, but rather given various tools with which to think. At the same time, Bergmann has a point of view; we know what he thinks and why, and we can come to our own conclusions.

What makes this review essay so potent, in my mind, is not simply its breadth, or the personal links to authors and ideas, but rather the radical agenda Bergmann sets for considering dissidence. Taking not only a historical approach but also a dynamic and nonlinear one, Bergmann sees the history of dissidence as integral to the development of psychoanalysis. He watches as ideas are jettisoned and rejected in one period, only to reappear in another period, as altered forms within the canon in ways that renew and deepen the central projects of psychoanalysis. As mentioned, Bergmann's sense of history is nonlinear, as though psychoanalysis is moving and evolving through a series of instances of *nachträglichkeit*—moves that alter past as well as present.

This approach has many advantages. Eschewing the approaches of others, such as Wallerstein (a homogenized, common-ground approach) and the more strictly boundaried approach of Green, Bergmann's strategy keeps difference and convention in constantly renewing tension. Bergmann is free to have opinions, to value particular combinations over others—and he is knowledgeable about the bloodiness of some of these conflicts. Alliances and conflictual struggles, betrayals and misunderstandings, come and go over a nearly century-long period. In this essay, making a place for dissident ideas is never a form of airbrushing difficulty or reducing the complexity of differences among analysts. This is a developmental story with destruction, re-alliance, and renewal.

Bergmann advances an important hypothesis, namely, that dissidence during Freud's lifetime was different from dissidence afterward. Almost half our history has been lived in the context of Freud's life and his relation to the institutions he formed and fostered. It is interesting to link these ideas to the conception of dissidence that Otto Kernberg proposes in his chapter of this book, where institutional and oedipal dy-

namics intersect and co-mingle with different implications after Freud's death. But, interestingly, in Kernberg's way of thinking about dissidence, dynamic conflict seems to bear a more central explanatory weight than cultural or historical forces.

The first response to Bergmann's position paper is André Green's. In both tone and agenda, these essays could not be more different. Green is resolute that what is needed to discuss dissidence is first an agreement on core theory. He seems to be rather concerned about keeping psychoanalytic theory in a pure environment in which clearly articulated principles can be identified. He refers to theory's unassailable Freudian core, assembled between 1895 and 1912, and centered on a one-person system in which the intrapsychic, the unconscious, and the centrality of the drives—sexuality and aggression—are not merely the core of the theory, but also its components.

Interestingly, in Green's view, psychoanalytic technique is still a work in progress. In privileging metapsychology, he seems to feel that any ideas outside it are dissident and therefore anti-psychoanalytic, in his sense.

Prominent in this essay is Green's well-known disagreement with those who support psychoanalytic experimental and empirical work. Green's criticism of attachment and infancy studies has often centered on the work of Daniel Stern and others. In this essay, in defining a central core to psychoanalysis around unconscious process and sexuality, he dismisses a significant amount of contemporary psychoanalytic thinking with a comment: "But not motivation, please, that's a concept good for rats" (p. 118). He means, of course, laboratory animals, but it is hard not to take the remark personally. Bringing observation, empirical preoccupations, and extended ideas about motivation into psychoanalysis seems, in his view, to be a messy, American weakness.

Green is rightly revered and well known for an incredibly important position he has taken in defense of psychoanalysis as a theory of the unconscious and a theory of sexuality. To me, there is something crucial and correct about his concerns that the revolutionary edge of psychoanalysis could be lost to attachment, mentalization, motivation, and intersubjectivity. But in defense of this core idea, I wonder whether something too

unbalanced comes into play here. When looked at more closely, Green's problem with concepts like attachment and motivation seems as much aesthetic as substantive. The words seem too mild—lacking force, not just drive. Romeo is "attached" to Tybalt, Green notes, quite amusingly, but for Green it is the passion of Romeo for Juliet that requires terms that have force and intensity, terms like *drive*. In demanding that analysts attend to their own fears of the unconscious and of sexuality, Green strikes me as too reckless in what must be sacrificed in the name of this theoretical purity. Fear of the unconscious seems to have been replaced by fear of history, of social forces and observation.

Empirical strategies have been central to psychoanalysis from Freud onward. Inference and observation are often—indeed, usually—interwoven. Nonetheless, the sole theorists in Green's pantheon with an approved sociohistorical perspective seem to be Puget and Berenstein, submitted here for our consideration but without reference or elaboration.[1] I find this a disservice to two remarkable theorists who are able to coordinate intrapsychic, intersubjective, and historical forces with great subtlety.

From all the authors in this book, we see many interesting angles of thinking about the agenda of Freud, his followers, and the dissidents. Matters of ideology, politics, and allegiance appear and reappear in this story. In a wonderful and subtle chapter on Ferenczi by Harold Blum, the familial and oedipal dynamics with Freud, and a tragic incestuous scene involving Freud and Ferenczi at familial, conscious, and unconscious levels, are viewed as productive of Ferenczi's ideas at both their most genius and their most regressive and unbalanced. The interweaving of conflicts between these two giants affected theoretical work on trauma, abuse, technique, and on the very status of reality within psychoanalytic theory.

I would venture that, throughout this volume, Ferenczi often carries great weight as the totemic dissident, the totemic oedipal son, and

[1] Puget and Berenstein are discussed in: Cairo, I. (2004). *Psicoanálisis:* Revista de la Asociación Psicoanalítica de Buenos Aires. *Psychoanal. Q.*, 73:863-887. See also: Puget, J. (2006). The use of the past and the present in the clinical setting. *Int. J. Psychoanal.*, 87:1691-1707.

the passionate wise baby. In doing research on Ferenczi, I have recently had occasion to read the correspondence with Freud while Ferenczi was teaching in New York in 1926. The two plot various battles in support of lay analysis, plan for critiques of Rank, and gossip over friends and family. The tone in Ferenczi's letters is warm and confident. Six years later, the terrible break over the "Confusion of Tongues"[2] paper has occurred, and a little later Ferenczi is dead and effectively erased from serious attention within the field for decades. The mix of hate and love and vehemence is astonishing and dramatically fast-paced.

The other essays in this collection take very particular and individual perspectives, representing less a survey of landscape and more a close look at particular problems and persons—some lost, some recovered, some still in question. Read across these essays, the accounts of dissidence and controversy are painful, occasionally funny, sometimes awful, and in the slow unfolding of our psychoanalytic story, we can see the preoccupations with intensely difficult problems. Who is treatable? What is technique? How is psychoanalysis mutative? Who should do analysis? What is the nature of mind and of the unconscious? What is social, what is psychic, and how are they linked?

These are the questions that define most psychoanalysts' primary concerns in regard to theory and clinical life. The book is thus focusing on issues that are remarkably current and important. If nothing in the rest of the book quite lives up to Bergmann's inaugural essay, this is somewhat a matter of scale. Running to nearly ninety pages of the volume, his is an ideal text for teaching the history of psychoanalysis, being both capacious in its range and deliberate in its judgments.

One powerful distinction among the speakers/writers in this book is the degree to which they deploy a psychoanalytic method of analysis of their topic. For Bergmann, issues of character, the fates of disrupted or incomplete analyses, powerful forces of resistance and transference—all are actively present in the production and fate of controversy. I feel quite compelled by Bergmann's insistence that controversies in psychoanalysis

[2] Ferenczi, S. (1932). Confusion of tongues between adults and the child. *Int. J. Psychoanal.,* 30:225-230.

have some particular burdens and characteristics, and by his clarity in using psychoanalytic ideas to argue this point. The centrality of character and dynamics also plays a central role in Kernberg's treatment of the appearance and function of dissidence.

It seems inevitable that the conditions and quality of personal analysis shaped a number of dissident efforts in the period during Freud's lifetime. Here, for me, Ferenczi is the poignant exemplar: knowing his limits in relation to his analysis, and functioning as loyal son but also as internal saboteur. Ferenczi often introduced subtle differences into theory while loyally declaring himself Freudian. His work on introjection and internalization genuinely seems a departure from Freud, though it was written as a loyal subject. Perhaps we need a category of secret dissidence and faux loyalties.

The crucial vector in the long half-century since Freud's death, very much the focus of Kernberg's concerns, is the power of institutions and psychoanalytic education and transmission. The practice of various forms of domination in so much of training has been of concern to Kernberg in a number of recent papers.[3] Here dissidence and resistance become shaped by the social and sometimes historical forces shaping institutional life, but—for Kernberg—they are always hosted by the dominant elements of character, domination, and authority within an oedipal constellation.

I want to credit Kernberg with an insight that I think is spot on and very rarely articulated. Theories and innovations and alternatives, dissident and mainstream, do not remain in isolation. Influences and ideas creep from one rivalrous theoretical position to another, mostly unacknowledged. The interpenetration of often very conflictual ideas and concepts goes on, almost underground, all the time. The evolving work on countertransference might be such an example at present, with ideas circulating among neo-Kleinian, intersubjective, relational, and object relational perspectives.

[3] See Kernberg, O. F. (2004). Discussion: "Problems of Power in Psychoanalytic Institutions." *Psychoanal. Inquiry,* 24:106-121; and Kernberg, O. F. (2006). The coming changes in psychoanalytic education: part I. *Int. J. Psychoanal.,* 87:1649-1673.

Additionally and importantly, from a number of different speakers and perspectives, dissidence can arise in the context of work with disturbed and unusually ill patients, work that pushes the envelope of technique and metapsychology. Some of these matters were at play in Freud's lifetime (Tausk's influencing machine seems to have been an idea stemming from work with trauma and psychotic process). Many of the concepts emerging from work with very ill and psychotic patients surfaced later on. Dissidence arises from the radical edge of clinical life. Perhaps this is a phenomenon seen in many areas and disciplines of healing: that is, new ideas arise from the edge of what is knowable and bearable.

The last third of this book contains the transcript of two days of psychoanalytic meetings in 2003, in which conference presenters considered in greater depth the issues raised in precirculated papers. To my surprise, I found this section very interesting. Sometimes contentious, often erudite, and containing several moving personal accounts of migration, exile, and professional difficulty (Kernberg's and Green's), the verbatim reports of the meeting are fascinating. The transcript retained all the little spats, enactments, and competitive scenes, large-scale and small. I often had the experience of thinking, "Thank God I wasn't there"—but really, how wonderful to read this material.

Several general ideas emerged for me from this section of the volume. One could see *in vivo* how such vehemence is a part of the play of ideas in psychoanalysis and the negotiation of what dissidence is, what internal conflict is, and what still lies beyond the pale. The vehemence on display in this discussion was considered to have various sources: oedipal dynamics, powerful differences about the relative importance of history and context in considering metapsychology, fear of the unconscious, fear of history, fear of sexuality—all seem at play here.

I am left with the question of which dissidence is still kept outside the canon. Who is missing from this book? At a certain moment in the discussion, Jill Scharff is positioned as the most outsiderly of the speakers. She is representing Fairbairn and object relations! But shortly after her work is considered, many people climb on board that—surely centrist—wagon. Dissidence is still alive, and judging from this volume, there are still some unspeakable or inaudible phenomena. The political ideology

at work here is at best centrist and at worst highly conservative. Outsider, outlaw status seems only to cleave to the relational and interpersonal perspective. Feminism and contemporary work on homosexuality are also, in this volume, invisible. These omissions mean that a century of evolving theory and clinical work on sexuality, gender, gender variance, and homosexuality are virtually absent from anyone's considerations in this volume. Some feminist ghosts hover around Young-Bruehl's fascinating account of Ian Suttie, but the presence of any gender-driven critique remains spectral.

I come back to rats. As everyone with a relative under ten knows, the delicious Pixar animation *Ratatouille* concerns a rat, Remy, who becomes a chef, aided by an extended rat family and by the illegitimate son of a great chef, who democratically proclaims that "anyone can cook." This is anathema for the tall, elegant, French critic who serves as arbiter of all things French and gastronomic. The film ends with the triumph of the rat with fabulous taste buds. Remy has charmed the critic by reinventing one of the culinary classics, ratatouille, sending him into a preoedipal, primary-process swirl of pleasure. Suffused in reverie over the classic cuisine of his childhood, the critic, whose name is Ego, finds delight in the nouvelle cuisine of the rat, announcing that "not everyone can cook, but anyone can cook."

In that spirit of inclusion, where rigor and invention synergize, I would like to thank Martin Bergmann for his magisterial essay, for his role as historian and guide within our field, and for his continually renewed appetite for this work. *Bonne anniversaire, cher maitre.*

ADRIENNE HARRIS (NEW YORK)

INTERNATIONAL DICTIONARY OF PSYCHOANALYSIS. In three volumes. Edited by Alain de Mijolla. New York: Thomson Gale, 2005. 2,196 pp.

The text presented here is the result of impressive work, realized under the guidance of psychoanalyst and psychiatrist Alain de Mijolla, founder and president of the International Association for the History of Psycho-

analysis. Originally published in a French version in 2002, which has been very well received,[1] the *International Dictionary of Psychoanalysis* is an excellent English translation.

The editorial committee in Paris—made up of Sophie de Mijolla-Mellor, Roger Perron, and Bernard Golse—has found a comparable counterpart in the American team that was responsible for the care and translation into English of this essential reference book: Rachel J. Kain, Rita Runchock, and Patricia Kamoun-Bergwerk, with the editorial support of Edward Nersessian and Paul Roazen (who reviewed all the entries). The work of translating the three volumes was conducted by, among others, Nellie Thompson and Matthew von Unwerth. It is important to stress that this was not simply a work of translation, but something much more complex, given the different geographical, cultural, and scientific backgrounds of the many authors who contributed. This involved, for example, the need to delve into the specific points of view of the authors and editors of every single dictionary entry, including a consideration of each author's professional affiliation and the specific subject assigned to him or her in the context of the *Dictionary*—a point recalled by Nersessian in his introduction to the English translation.

In perusing the items in the *Dictionary*—which, despite its refinement, should be considered a reference work that has drawn on well-known past theoretical and scientific dictionaries and biographies, as well as others less known but of considerable interest[2]—it is possible to appreciate the tremendous impact that psychoanalysis has had in the world. This is true not only in terms of its basis in scientific thinking and its application as a discipline, but also in regard to its status as a global force that has permeated the cultures, art, and thought of the twentieth century.

[1] See, for example, Parsons, M. (2003). Book review of *Dictionnaire international de la psychanalyse,* ed. Alain de Mijolla. Paris: Calmann-Lévy. Pp. 2017, 2002. *Int. J. Psychoanal.,* 84:472-474.

[2] See, for example, Skelton, R. M., ed. (2006). *The Edinburgh International Encyclopaedia of Psychoanalysis.* Edinburgh, Scotland: Edinburgh Univ. Press.

De Mijolla, in his preface to the English-language edition, takes the opportunity to criticize the pharmacological treatment of mental suffering, initially perceived as an overall solution to the problem of mental illness (de Mijolla refers here to the experience of Jung and Bleuler at Burghölzli) and subsequently resulting in a widespread attitude of disappointment.

It has been noted that the *Dictionary* reflects its French origin, being rich in concepts and biographies of French analysis and analysts, which proves "how alive and fertile psychoanalysis is in France, compared to its almost moribund condition in the USA."[3] Indeed, this work seems to demonstrate not only the historical development of psychoanalysis in about fifty different national contexts, but also the interplay of psychoanalysis with other disciplines, covering the main concepts based on Freudian psychoanalysis, Jung's analytical psychology, and Kleinian and Lacanian theories, among many other subspecialty areas.

Written by an international team of 460 authors, the 1,569 dictionary entries—which include 360 biographies of leading analysts—combine to form a comprehensive work in which it is easy to follow the numerous cross-references. It should be noted, however, that, although care has been taken to present the biographies of an exhaustive list of analysts now deceased, some important analysts of the present time have not found a place in the *Dictionary*.

At the end of the work, there is a chronology that begins with December 18, 1815 (the birth date of Sigmund Freud's father, Jakob), and runs through August 2004. There is also a glossary of terms and concepts in five languages (French, German, Italian, Portuguese, and Spanish) and a detailed bibliography.

In essence, the text edited by de Mijolla is an important cultural operation. The dissemination of this work in the English edition should be encouraged in major libraries of psychoanalysis, psychology, and psychiatry in all the English-speaking countries in the world.

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[3] Chessick R. D. (2006). Book review of *International Dictionary of Psychoanalysis*, ed. A. de Mijolla. *J. Amer. Acad. Psychoanal.,* 34:570-574; see p. 570.

THE UNCONSCIOUS: FURTHER REFLECTIONS. Edited by Jose Carlos Calich and Helmut Hinz. London: International Psychoanalytical Association, 2007. 252 pp.

This volume contains a foreword, prologue, introduction, and epilogue, each of which introduces and provides commentary on a collection of eight authors' conceptions of the unconscious. The fact that a full third of the book consists of commentary about its body hints at the complexity, the intellectual pleasure, and occasionally the frustration of reading this collection of disparate renderings of a central psychoanalytic concept.

To my reading, the most impressive efforts in the volume are those in which the author locates his or her vision of the unconscious in a clear and systematic way, and delineates how it may differ from, agree with, or add to previous conceptualizations. Not surprisingly, the essential differences among the pieces stem from the authors' views of the extent to which bodily experiences and contributions from the aggressive and sexual drives are viewed as central, from their attempts to locate the role of the other in the structuring of the unconscious, and from differences among the authors regarding unconscious structure itself—that is, what it includes, how it is structured, how it works.

I will address first the chapters that offer the most comprehensive descriptions of the possible structure of the unconscious and how one might come to know it. For me, those are the chapters by Jean Laplanche, James Grotstein, and Rene Kaës. Other chapters offer different delights and challenges, and all address some aspect of the central differences outlined above.

Jean Laplanche ("Three Meanings of the Word 'Unconscious' in the Framework of the General Theory of Seduction") critiques modern schools of psychoanalysis that to him have lost the central importance of the role of infantile sexuality in structuring the unconscious. He adds two concepts, however, that dramatically alter the classical conception. One is his view of the *fundamental anthropological situation,* in which the asymmetrical communication between parents, who have language, and infants, who do not, is complicated by the parents' unconscious (sexualized and pregenital) communications and the child's consequent confu-

sion. The enigmatic message, couched in a code that the infant is not able to understand, is "inscribed or implanted" (p. 35) and only later reactivated from within, an "internal foreign body that must at all costs be mastered and integrated."

Thus, the other's role in structuring the child's unconscious begins with the infant's registration, though not translation, of the adult's unconscious, sexualized communications, according to Laplanche. These enigmatic messages become reactivated at various stages of life, including during adolescence, with the emergence of the sexual instinct. Laplanche contends that, during adolescence, "The sexual *instinct* . . . has to catch up with the *drive* of intersubjective origin, which has developed autonomously over a long period" (p. 34, italics in original). He thus does not accept the notion of a "primordial id" at the origin of psychic life, nor of infantile sexuality as deriving from the infant himself, but rather from the versions of sexuality transmitted to him via maternal and paternal objects.

The second central difference from, or addition to, classical theory is the importance of translation in the formation of the unconscious itself. For Laplanche, the preconscious is established by the child's attempts at translation of the enigmatic parental messages, with the unconscious constituted by untranslatable residues, particularly sexual ones, since the latter is inevitably contained within the adult's unconscious communication. The contents of the unconscious, then, consist of that which has escaped from the construction of meaning and has been repressed.

Laplanche favors Freud's topographical model, though he revises it to contain the repressed unconscious of the neurotic, constituted of partially translated messages and in dialogue with the preconscious, and an additional "subconscious enclave," maintained by a "thin layer of conscious defense" (p. 37)—that of disavowal—and disconnected from the preconscious. "Radically untranslated" messages stagnate here, including some messages from the superego. Subjects in which this area of the unconscious is predominant may have severe borderline or psychotic psychopathology.

Laplanche feels that the child's innate mechanisms of communication and attachment are not adequate to the task of decoding parental messages, but that children are helped in this effort by cultural narratives

containing resonant symbolic messages. These mytho-symbolic codes are seen as repressing forces, however.

I agree with the statement of Helmut Hinz, one of the book's co-editors, that Laplanche turns Freudian conceptions of sexuality on their heads; in his theory, it is the adult who is active and polymorphously perverse, not the child. While Laplanche refers to the child's innate decoding capacities, there seems little room in his rendering for the child's active desires or for the ways in which these intersect with contradictory messages that must be deciphered—messages coming from the parents, from within the child's own body, and from other sensory data as well.

Child observation demonstrates the fluidity between primary process thinking and secondary process thinking in children. Affective states, bodily perceptions, and social interactions are perceived and organized in a manner in which fantasy meanings coexist with other attempts at translation. These observations are not explicitly addressed in Laplanche's model, which as a result seems limited. Furthermore, the technical application of this model runs the risk of analyst and patient feeling that they are capable of translating the content of the parental unconscious. While some aspects of the parents' apparently unconscious conflicts are often provisionally inferred within analysis, the degree of distortion created by the analysand's affective responses, misunderstandings, and desires inevitably makes these surmises hypothetical at best, and analysand and analyst run the risk of creating a *folie à deux* of mistranslation.

James Grotstein's "'Through the Unknown Remembered Gate': The Unconscious Reconsidered—An Essay" is a fascinating effort at fashioning a theory of the unconscious that combines knowledge from multiple disciplines: primarily philosophy and religious studies, but also the arts and mathematics. For Grotstein, the unconscious "constitutes an ineffable holographic mystery. It is unified and paradoxically consists of many entities at the same time" (p. 90). These entities include:

(a) *the unrepressed, a priori, or pre-reflective unconscious,* which contains "formatting" capabilities within the brain that prepare us to perceive and decode, within the narrow range of our perceptual/receptive capacity, the data of the senses and of encounters with the object world;

(b) *the repressed or dynamic unconscious of Freud,* which Grotstein views as depersonalized, dominated by the drives, unorganized, and primitive;

(c) *the preconscious,* likened by Grotstein to the cinematographic "mixing room" of the psyche, and to the "search engine" for the unconscious. He sees this as the domain for unconscious thought, planning, creativity, fantasy, illusion.

Additionally, however, Grotstein uniquely identifies the preconscious as comprised of perception, feeling, thinking, and creating that occurs *between two subjects:* one understood as the personal, secular, historical *subject of experience,* and the other as the *ineffable, phenomenal subject.* The latter, exquisitely sensitive, points the experiencing subject toward Bollas's idea of the *unthought known* (a self who is unconsciously suspected) or Winnicott's *true self:* essentially, toward the knowledge of a truth that is sought, but for which the historical subject has no words. Grotstein links this phenomenal subject to Bion's "O": "the ground of being"—the search for self-revelation and for Platonic forms, for "unconcealment" (p. 80), for truth.

Grotstein also notes the simultaneous existence of

(d) the *cognitive unconscious,* in his rendering tied to Bucci's concepts of subsymbolic and symbolic processing, similar to primary and secondary processes;

(e) the *emotional or affective unconscious;*

(f) the *mystic-religious unconscious,* suggested by the fact that all cultures seem driven to find a deity, a phenomenon that can be experienced under certain highly stimulating situations such as temporal lobe epilepsy, states induced by certain drugs, ritual ecstatic dancing, or psychosis; and, finally,

(g) *the cultural-linguistic unconscious* of Lacan, in which the individual is linked to historical experience via the translation (or not) of historical, intergenerational experiences through language.

The concept of unconscious as holograph is fascinating, and seems to me to correlate well with current neuroanatomical findings of mul-

tiple associative pathways linking many different areas of the brain that operate outside of consciousness, often simultaneously. Grotstein also avoids reducing the infant's active role in communicating about and receiving translations of stimuli. In fact, he explicitly extends Bion's model of the infant's projection of primitive, disorganized beta elements into the mind of the mother, who receives, contains, translates, and organizes them into alpha, "thought" elements. Grotstein includes more recent neurolinguistic findings about infants' innate "hard-wired" communicative capacities, and imaginatively reconfigures the mother–infant communication as a two-way, sending-receiving one, albeit characterized by the need for the parent to decode preverbal messages from the infant. This seems to me to link with the work of Fonagy et al.[1] on the parents' capacity for mentalization and its role in attachment and affective regulation, a capacity that involves the parent's registering and responding to the child's active and preverbal communications, as well as, later on, to verbal ones.

I enjoyed Grotstein's fascinating attempt to define an aspect of the unconscious that may embody the human search for truth, synthesis, affective wholeness. Perhaps this multilayered capacity might be embodied in other aspects of the a priori unconscious, whose functioning, discerned within the preconscious, is *experienced as that of another subject,* rather than actually *being* another subject. It would make sense that the highly complex human mind, which is capable of learning to decipher the hidden meanings of social interactions (other highly social primates, such as chimpanzees, have evolved this capacity[2]) and of seeking to solve a myriad of puzzles about our existence, our internal and external realities, might have evolved the capacity to nudge us toward seeking language adequate for such syntheses. Although I disagree with Grotstein's mystical rendering, I applaud the attempt to include in the model of the unconscious that ineffable presence within us that seems to seek truth while connecting us to the deepest sense of mystery and awe, toward an apprehension of the yet undiscovered, as in the Lacanian Real and in Bion's O.

[1] Fonagy, P., Gergely, G., Jurist, E. & Target, M. (2002). *Affect Regulation, Mentalization, and the Development of the Self.* New York: Other Press.

[2] De Waal, F. (1998). *Chimpanzee Politics.* Baltimore, MD: Johns Hopkins Univ. Press.

I find Grotstein's reading of the dynamic unconscious as envisioned by modern analysts operating within a classical understanding to be surprisingly reductive, however, especially given the complexity of his thinking. Rather than depersonalized and primitive, essentially made up of id, the unconscious is viewed by many modern analysts as an ever-changing and immensely powerful force in which multiple defenses (as a priori processes of the unconscious mind) become simultaneously mobilized *within an individual,* against desires that are subjectively registered and experienced as dangerous *within the context of specific, complex relationships.*

Also apt to be repressed or dissociated are the individual's unique affects and fantasies in relation to conflicted desires and to objects. Once repressed, these affects and fantasies are further disguised by encoding in the primary process operations of the unconscious mind. This model of the unconscious is a complex one that encompasses in a different configuration some of Grotstein's multiple coexisting unconscious minds: his affective unconscious, the a priori unconscious (which many analysts would name the *cognitive unconscious* and would include in it, for example, procedural memory, attachment capacities, facial recognition, emotional recognition, and nonverbal communicative capacities), and a repressed unconscious structured by primary process encoding.

While Grotstein contributes to our understanding of the structure of the unconscious with his use of the holographic image and his inclusion of the unknown known, Kaës adds a framework that uses data from the psychoanalytic study and treatment of groups and families. This author is clear that his vision of the unconscious involves an extension, not an overturning, of previous models of the unconscious. For Kaës, the psychoanalytic method establishes boundaries that allow an exploration of the mind of a single subject, and thus cannot gather data about other situations in which the unconscious may be manifest.

With the concept of projective identification, however, Klein anticipated a situation in which unconscious messages might be projected and then acted upon by another, an insight developed by Bion and others as a basis for studying the power of group fantasy organizations on their individual members. Kohut's concept of the selfobject also introduced the blurring of psychic boundaries between the nascent self and the at-

tachment object who helps it find language and, ultimately, a sense of differentiation. I was surprised, in this otherwise comprehensive chapter, not to see mentioned these early suggestions of an interpsychic space, derived from the analytic process itself.

But this is quibbling with an otherwise fascinating paper. Kaës demonstrates evidence of not only the intrapsychic space of the individual subject, but also of an interpsychic space among groups and families and a trans-psychic space extending through the generations. He is careful to distinguish between private, common, shared, and different psychic spaces. Kaës's private space is the "individuated psychic space" that contains a subject's history, instinctual organization, fantasies, defense mechanisms, repressed or split-off "contents," identifications, and object relations. This space is never simply lost or collapsed. However, individuals are also united in groups and families by "the common": joint fantasies, desires, identifications, ideals, unconscious alliances.

> That which is common requires the abandonment or the loss of the individual limits of the subjects who are bound together, a certain lack of differentiation, but there is also the basic psychic material necessary for the subject to emerge in his singularity. [p. 99]

The "shared"—to my mind, not perhaps the clearest descriptive—connotes the role played by each subject within the group or family: for example, as an active or passive actor in a group's shared fantasy, or as an observer of the psychic action or entanglement. Each subject holds his own place that singularizes him within the shared fantasy. The "different" demonstrates the gap or discontinuity between and among members of a group, and it is through encountering the otherness of other members that one comes to understand what is one's own private space, and to realize that the "other" cannot be reduced to an internal object.

Kaës contends that within these different spaces, a shared psychic life is created that is not the sum of individual spaces, but that presents instead a new kind of psychic reality. In group life, he sees the "common" and the "shared" as being organized *before* the individual or the differentiated. Group or family structure calls for the emergence of certain figures: leader, hero, go-between, scapegoat, spokesperson, bearer of

ideals, bearer of symptoms, etc. These roles impose certain constraints on individual members for the benefit of group formation: "constraints of belief, representation, perceptive norms, adherence to ideals, and common sentiments" (p. 103). In many ways, this concept is not so different from Lacan's Rule of the Father, though it is located in quite a different vision of the unconscious mind.

Groups may combine in different arrangements: in an isomorphic mode, in which private space and group space are imagined to be identical. This is a psychotic mode of group functioning. By contrast, the homomorphic modality is established with an understanding of the similarity but also of the difference between psychic spaces; this allows for the possibility of metaphor and symbolization. A third mode, the "whirlpool," is characterized by "a chaotic instability of the tuning of minds" (p. 103). "It is as though the participants cannot agree with each other at any level and so are unable to establish any stable relationship between their internal space and that of the group," states Kaës. Any reader who has experienced such a group situation will recognize the description and be intrigued by its interpretation.

Kaës observes that good leadership can contribute to the stabilization of the group, but there must also be "urgent identifications," which contribute to "the sense of belonging upon which the 'We' rests" (p. 104). This presumably includes "like-me" or, alternatively, admired objects, but also ideals and ways of interpreting reality that help the group cohere. This is a welcome addition to Kernberg's and the Tavistock group's primary emphases on leadership, task, and role as preventing group regression.

Unconscious life for individuals in groups is characterized by Kaës as consisting of alliances and pacts that express "the essence of the *process* whereby psychic reality is forged and organized in the group" (p. 105, italics in original). Within such pacts, symptoms may be formed and maintained in order to keep alive a link with another. Primal narcissistic contracts, such as those forged by parents with their children, are based on an investment with the child who will become a vehicle of continuity for the family, as well as for the parents' unfulfilled wishes and dreams. One can also imagine such a contract between teachers and the students who they hope will carry on their work.

The secondary narcissistic contract involves a renegotiation of the original contract, as the individual enters into conflict with it; for example, this may occur when he forges extrafamilial ties or begins to think differently from his role models. Both of these are aspects of grouping in the service of life. The narcissistic *pact*, on the other hand, is the "result of an immutable assignation to a location of perfect narcissistic coincidence. It is deadly" (p. 107). Parents who can tolerate no individuation, and totalitarian regimes allowing neither dissent nor difference, exemplify this type of pact.

Kaës discusses such aspects of group life as the "return of the repressed" and the denied within group structures. In the former, he observes the living out of the returned repressed within the transference, for instance, while the latter results in projections, splitting, and rejections, and eventually becomes "encysted in negative pacts, communities of denial, and perverse contracts" (p. 111).

Finally, Kaës offers his idea of the *polyphony of dreams,* in which dreams, in addition to their function as described in the classical understanding, are also inscribed in an intersubjective, common, and shared dream space. A clinical example might have been quite helpful here for the reader to comprehend this concept. Luckily, Antonio Alberto Semi (whose comments are discussed below) offers one in the chapter that follows Kaës's. In sum, Kaës offers a view of the topographical unconscious and of poly-topographical unconscious "spaces." This construction seems to avoid many of the reductions of the radical co-constructionist analysts critiqued by Charles Hanly (also addressed in what follows).

Antonio Alberto Semi ("Eulogy of Surprise") and Rivka Eifermann ("On the Inevitable Neglect of the Unconscious") lament in different ways the mechanical, logical, or reductive renderings of the unconscious in many modern theoretical formulations. Both plead for the understanding that the unconscious, by its very nature, is enormously difficult for the conscious mind to apprehend, and note that one can render only approximations at best. Semi notes the surprise, constantly disavowed, about how little, in fact, we can consciously know about *what* or *how* we know. For Semi, it is essential for the analyst to approach his work with an awareness of not knowing, and he reminds us of how difficult it is not to unconsciously discourage the transference. The transference, he

contends, is violent in the sense that it feels as if "'someone' is thinking inside us, using our representational material and emotions to construct their pathway" (p. 127).

Semi offers an intriguing and detailed clinical example of an attuned analyst feeling his way in attempting to understand resonances from the patient's unconscious in their work on a dream, and the confusion facing him as he seeks to unravel his own associations:

> Is it a thought of mine, one that is independent of what the patient is thinking, or is it an unconscious thought the patient has transmitted to me, using elements of my unconscious, taken from my background, moving within me and making me think about something? [p. 130]

This description, I think, offers a sense of what Kaës refers to as *dream polyphony*.

Rivka Eifermann focuses on attempts in modern theory to exclude or reduce the unconscious, which she sees exemplified in Hartmann's "autonomous ego," Guntrip's emphasis on "material reality"—for instance, on whether the mother was "really" cold—the focus on deficit through maternal deprivation rather than conflict, self psychology, and the reduction of the unconscious by American relational analysts to that which is "exclusively interactive." She is especially concerned with the jettisoning of the role of free association as a method and with the criticisms by Spezzano and Renik of analysts who work to expand analysands' awareness of their unconscious mind at the expense of their achieving more satisfying emotional and relational experiences.

While her technical points are well taken, I think that, within a historical context, Eifermann herself reduces the value of these critiques of a kind of sterile, bloodless, and concrete analytic process—in which, for example, none of Semi's surprise at the mutual influences between analyst's and analysand's unconsciouses could occur. I believe that Hartmann was, in Grotstein's terms, emphasizing the difference between the repressed and the a priori unconscious, discrete but interacting processes within the unconscious, mutually influential but not identical. Further, isn't there theoretical value in attempting to understand the influence of, for example, a "psychically dead" mother on intrapsychic develop-

ment, as in Green's work, or of the parents' unconscious communications to their child in Laplanche's? I think that a distinction needs to be made here between the workings of theory and a potential compromise of technique.

Charles Hanly, in "The Unconscious and Relational Psychoanalysis," offers a deftly stated view of modern concepts of the unconscious from analysts operating within the classical tradition. He also skewers the "vertiginous" logic of the most radical "co-constructionists," who would view the unconscious as *only* relational/interactive, and would thus exclude from their framework of understanding such phenomena as the symbolic content of private reverie, the private experiences and fantasies about bodily illness, and the oedipal fantasies described by Hanly in a patient's immediate and interconnected fantasy reactions to two different analysts' offices—one belonging to a male, another to a female analyst. Again, the work of Kaës seems to me to offer a considerably less reductive version of the "radical co-constructivist" argument.

I find Hanly's use of *radical co-constructionist* as synonymous with *relational analyst* to be somewhat problematic. In the American relational group, Donna Orange and Robert Stolorow would most resemble those whose work Hanly refutes. Jody Davies, however, offers case material that reveals a respect for the individual unconsciouses of analyst and analysand as gradually discovered through work in the transference-countertransference. Philip Bromberg, while holding a radically different vision of the unconscious than Hanly, also describes unconscious communication between individuals in a way that is not co-constructed in the more radical sense. Bromberg has made quite interesting observations of the activity of dissociated, unconscious self-states within an individual that are revealed through enactments within deepening analytic treatments.

A skillful presentation by Viviane Mondrzak and several co-authors, "The Unconscious in the Perspective of Complexity and Chaos,"[3] suggests the potential usefulness of chaos theory, and of Matte Blanco's use of the theory of infinite sets, to describe something of the *process and action* of the unconscious, rather than its *space*. For these authors, the

[3] Mondrzak's co-authors are: Aldo Luiz Duarte, Alice Lewkowicz, Anna Luiza Kauffmann, Eneida Iankilevich, Gisha Brodacz, Gustavo Soares, and Luiz Ernesto Pellanda.

unconscious may be best described as operating according to the principles of chaos theory, which articulates the workings of complex and open systems in which unpredictability and indetermination are more commonly observed than simple cause and effect.

The authors also see the unconscious as organizing the data of experience simultaneously at different levels, according to principles of symmetry and propositional logic, on the one hand—equivalent to primary process thought—while the mechanisms of asymmetrical logic, or abstract reasoning, predominate in secondary process thought (p. 179). Symmetrical logic demonstrates many of the properties that we connect to the primary process: no distinction between time and place, internal or external reality, the mechanisms of displacement and condensation, the lack of the negative, and the recognition of classes rather than individuals. For these authors, primary process, or symmetrical logic, registers and organizes emotions.

It seems quite possible that these interlocking models may help analysts more clearly envision how the unconscious might encode and process experiential material, and therefore this chapter is a welcome conceptual addition to our field. Many questions arise in reading it, however, which it would have been helpful for the authors to address. For instance, they write that primary process serves to register and process emotions. Is this true if we adopt a broad definition of emotion—to include, for example, subtle types of confusion (such as the child's response to receiving Laplanche's enigmatic message from the parents, which may not even be a conscious affect, but rather a registration of dissonance)? Can the model also apply to a manner of processing those fantasies that specifically attach to a child's affectively tinged sexual explorations—for example, the fantasy that boys are disgusting and will harm one via penetration, or that girls might urinate on the boy's penis or cause it damage?

Dream analysis demonstrates the existence of complexly symbolized fantasies and of defensive operations mobilized by unconscious conflicts. Are these also potentially encoded, according to the model described by Mondrzak et al.? How would the fluid interplay between primary and secondary process thinking be conceptualized, as seen in reverie, artistic creation, the analytic process, and in children's play? Hinz offers addi-

tional concerns about what might remain unaddressed in such a model (pp. 219-221), such as the complex interweaving of transference-countertransference, on the one hand, and the blockage of oscillation, as well as the paralyzed fluctuations of psychopathology and of the repetition compulsion, on the other.

Finally, Jose Milmaniene, in "The Freudian Unconscious Nowadays: A Lacanian Look," offers a view of the unconscious from a Lacanian perspective. His paper describes the analytic project as making available the space

> . . . for the subject to recover his freedom, by acknowledging, with his own signification, the traumatic message originating from the enigma that binds him to the Abyssal desire of the mother in its failed metaphorization of the significant of the Name of the Father. The subject of the unconscious shall be split between the words of the Other and the jouissance of his bodily objects, marks and residues of the primitive maternal eroticization and its mythical libidinal history. [p. 151]

Similarities to Laplanche's thinking are evident from this quotation, which also describes the desires of the mother and the Name of the Father as part of a narrative about the temptations of eroticized symbiosis with either parent, as well as about the necessity of the move to triadic relationships. When the role of the Father (symbolizing the third, that which draws the infant out of a solely dyadic relationship and into the realm of the social-cultural, and of the law) is foreclosed or disavowed, symbolization and repression cannot adequately occur, and instead one sees evidence of a foreclosed unconscious, similar to Laplanche's subconscious enclave. Milmaniene describes the kind of "perverse" and narcissistic psychopathology that can result, in which metaphor and symbol cannot function, and the individual ignores the role of history, culturally interpreted reality, and individual limits.

Using this perspective, the author offers interesting interpretations of phenomena as disparate as terrorism, body piercing, and pornography. At times, his viewpoint is reductive, however, as when he criticizes "artistic proposals that aim to raise excremental anal objects to the category of works of art" (p. 158)—showing, he feels, a lack of sublima-

tory capacity on the part of artist and the culture. Here Milmaniene fails to appreciate the fact that, in at least some of the art work to which I believe he is referring, a sublimation occurs that intertwines symbolic commentary with quite rigorous standards of visual beauty (though not necessarily classical ones).

Milmaniene's language is poetic and revealing, but also quite frustrating in the context of a volume intended to accomplish an interpretive task—that is, of making one's thinking clear to others unfamiliar with one's approach. Given that he represents a theory dedicated to language and translation, this author's difficulty in finding a way of speaking to those not part of his group seems to me an enactment: a failure to register difference, to recognize the existence of other myths, other metaphors, other ways of making sense of intrapsychic and interpsychic reality. The Name of the (intercultural, interdisciplinary) Father would seem to require an effort to translate concepts in a less circuitous and enigmatic fashion. Perhaps Milmaniene is encouraging the reader to decipher his own enigmatic message, with all its resonances. Nonetheless, this essay is worth the effort it exacts in allowing the reader to achieve a deeper understanding of the Lacanian view of the unconscious.

Overall, I find this book a welcome addition to any psychoanalytic library.

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THE UNSUNG PSYCHOANALYST: THE QUIET INFLUENCE OF RUTH EASSER. By Mary Kay O'Neil. Toronto, Ontario, Canada: Univ. of Toronto Press, Toronto, 2004. 250 pp.

In this unusually conceived and constructed book, Mary Kay O'Neil pursues two projects at once. The first is an effort to reconstruct Ruth Easser's development and impact as a psychoanalyst from her personal history; from the progression of her thought in the papers she presented and published; and from the memories of those who knew her—as family member, friend, colleague, teacher, supervisor, or analyst. The second is to explore, through the lens of Ruth Easser's life, what it might mean for anyone to live and work as a psychoanalyst.

These two projects intertwine around a personal mission that becomes explicit at times: "Indirectly," writes O'Neil, this book "is the author's own story of becoming and living life as a psychoanalyst" (p. 11). Easser's death—of cancer, at age fifty-three, in 1975—"was a great loss" to O'Neil, who was in treatment with her when she died; "this book is the author's response" to that loss (p. 11). In the concluding chapter, O'Neil characterizes her work on the book as "a form of post-termination contact" and as a "reawakening and reworking of mourning" (p. 203). Her experience in writing about Easser, she adds, "has deepened my conviction of the truth of internalization and the mutative impact of identification."

What O'Neil presents as the story of analysts-and-analysands-in-general is perhaps best understood as the story of her own professional development (with "we" standing in, as it often does, for "I"). By weaving that story together with Easser's, she has created a hybrid entity; part Easser and part O'Neil, this book binds together the identities of the author and her analyst/subject. It conveys O'Neil's effort to continue forging her own identity, as analyst and as person, in the context of an ongoing internal relationship with an analyst who died much too soon.

Ruth Easser, born in 1922 in Toronto, completed her medical degree at the age of twenty-three. To meet the country's wartime need for doctors, medical training was condensed to four and a half years after secondary education (Ontario's Grade 13); and like many of her classmates, Easser enlisted as an officer in the Canadian Women's Army Corps reserve. Yet Easser was unique, even among pioneering peers. In 1946—at age twenty-four—she left Toronto for New York to begin analytic training at the fledgling Columbia University Psychoanalytic Clinic for Training and Research. She was among the first few women graduates to join Columbia's faculty, and the first to become a training analyst.

Easser, whose mature work combined Columbia founder Sandor Rado's adaptational perspective with ego psychology, was also the first Columbia graduate chosen to present the prestigious Rado Lecture. A quietly confident approach to patients and colleagues—firm but noncombative, thoughtful, direct, and clear—enabled Easser to "form bridges"; at a time when Rado's defection from the New York Psychoanalytic Institute still cast the Columbia Institute under a cloud of suspicion, Easser was

among the first of its graduates to enter the inner sanctum of the American Psychoanalytic Association, where she sat on the Board of Professional Standards (1960–1970).

Beyond the Columbia Institute, Easser is perhaps best known for her co-authored publications on hysterical personality, one of which is generally recognized as a classic. In "Hysterical Personality: A Re-Evaluation" (1965),[1] Easser and Lesser observe that "symptoms alone do not reveal the underlying personality structure"; so some patients who employ hysterical mechanisms "should not be classified as hysterics" (quoted by O'Neil; p. 159). Another seminal paper[2]—from a series written in the early 1970s on narcissism and empathy—takes the technically consequential position that narcissistic patients do not lack "empathic capacity"; rather, "potential empathic capacity is present but inhibited and defensively blocked" (quoted by O'Neil; p. 192).

Easser's scholarship also included collaborative research on amenorrhea, which produced two publications in non-analytic journals[3, 4]; and on Columbia's "adaptive balance" project, which yielded a multidimensional assessment of ego strength.[5] By O'Neil's reading, Easser's published works—like her clinical approach—have a "prescient" quality, prefiguring later developments in our field (toward the intersubjective and a two-person focus, for example).

Soon after she finished analytic training, Easser married Stanley Lesser, a psychiatrist and psychoanalyst who also trained at Columbia and went on to join its faculty. Five of Easser's published papers were co-authored with her husband. Together, Easser and Lesser also raised four children: two daughters, adopted during years when Easser and Lesser were unable to conceive; and two biological sons born several years later.

[1] Easser, B. R. & Lesser, S. R. (1965). Hysterical personality: a re-evaluation. *Psychoanal. Q.,* 34:390-405.

[2] Easser, B. R. (1974). Empathetic inhibition and psychoanalytic technique. *Psychoanal. Q.,* 43:557-580.

[3] Easser, B. R. (1954). A case of amenorrhea showing psychohormonal interrelationships. *Psychosomatic Med.,* 16:426-432.

[4] Kelley, K., Daniels, G. E., Poe, J., Easser, B. R. & Monroe, R. (1954). Psychological correlations with secondary amenorrhea. *Psychosomatic Med.,* 16:129-147.

[5] Karush, A., Easser, B. R., Cooper, A. M. & Swerdloff, B. (1964). The evaluation of ego strength. 1: A profile of adaptive balance. *J. Nervous & Mental Disease,* 139:332-349.

(The matter of their infertility and its eventual resolution may raise questions in readers' minds that are not addressed in O'Neil's book.)

In 1970—when Easser was forty-eight years old and very much in the prime of her career—she and Lesser left New York for Easser's native Toronto, in search of living conditions congenial to family life. The move meant forfeiting professional status, influence, and a nurturing professional home at an institute that was by then well established; leaving patients to start a new practice; and establishing a foothold in the newly formed Toronto Psychoanalytic Institute. It was there in 1973 that O'Neil met the subject of her book.

"Surprisingly," writes O'Neil, Easser and Lesser "were ambivalently received by the Toronto institute, which was tightly controlled by a small group of comparatively inexperienced training analysts" (p. 185). However, many colleagues, patients, and candidates—O'Neil among them—were "eager to work with the newcomers." In the book's introductory chapter, O'Neil writes that she was "in a training analysis with Easser at the time of her death" (p. 11). In a more declarative restatement of this fact near the end of the book, the shortness of O'Neil's time with Easser becomes poignantly clear: "In September 1973, I began a training analysis with Ruth Easser. In September 1975, she died of cancer" (p. 202).

There is no reason to think that Easser knew she was ill (or about to become ill) when she returned to Toronto; but her illness became known—and must have been evident to her patients—for some time before she died. Surely, it must have shaped O'Neil's painfully abbreviated contact with Easser. In what *might* be a personal account of her own treatment (it is written in the third person, but conveys the intimacy and passion of first-person experience), O'Neil writes:

> An analysand married a widower with children around the time Easser's cancer recurred . . . . Although obviously ill (her legs were bound because of edema), she was able to resume work for three weeks before her final summer break. During one of their last sessions the analysand was speaking about her experience in becoming a stepmother. Easser said emphatically, "The children's first mother has died. You are not their stepmother, you are now their mother." The analysand responded with intense feeling and awareness of the possible tragedy of her analyst's

> death, "It is possible that your children might be needing a new mother." Ruth Easser responded simply, "Yes, that is right." [p. 197]

Holding fast to these words—and so to Easser—"sustained [the analysand] through the vicissitudes of new motherhood," even as she felt "freed to get on with her life, independently from Ruth Easser's tragedy." O'Neil continues:

> The analysand could identify with their similarities—they were both mothers—without being burdened by the unfortunate differences in their fate. At least for this analysand, Ruth Easser achieved an optimal balance with her simple acknowledgment of her own fate. That she continued to work to the very end was of enduring importance to the analysand and, for Ruth Easser, an affirmation of herself both as a person and a psychoanalyst. [pp. 197-198]

Whatever the source of this recollection, O'Neil invokes it to illustrate qualities she values in Easser: "her capacity to meld the *personal* and *professional* aspects of life, to resolve the incongruities of *attachment* and *autonomy,* and to harmonize the *similarities* and *differences* in self and others" (p. 197, italics in original).

In O'Neil's appraisal (p. 190), Easser was not a Kernberg nor a Kohut; even if she had lived longer, she might not have become widely known. But she was reasonably well published and quite highly regarded within analytic circles. The facts of her professional life suggest she was not so much "unsung"—i.e., anonymous, underappreciated—as cheated by untimely death of decades of professional productivity.

Whence, then, the idea of the "unsung" analyst? In part, O'Neil means to capture the private, unreportable, unreproducible aspects of any analyst's daily work; she emphasizes that most of what transpires between analyst and analysand—the "intensely lived experiences . . . the moments of exchanging knowledge, of mutual enlightening, of change, and growth" (p. 8)—remains unspoken outside the consulting room. However, in choosing what is both a title and an organizing motif for her book, O'Neil also seems to comment on an element of Easser's character: a personal reticence that allowed her to be politic (hence, perhaps, her

success in bridging then-renegade Columbia with the American Psychoanalytic Association), but kept her influence "quiet"—and also, perhaps, made it hard for others to get to know her in certain ways.

The closing chapter of *The Unsung Psychoanalyst* (epilogue, pp. 199-207) is rich in reflection on O'Neil's experience of learning and writing about the analyst she lost. Here, she explains that she deliberately decided to tread lightly around Easser's personal life, including "only those aspects of her family background pertinent to Ruth Easser's life as a psychoanalyst, as well as those relevant aspects of her relationship with her children and her husband as her main support and her closest analytic collaborator"; because "this book is not a history, nor a biography nor a psycho-biography, to have included other personal material would have been an invasion of privacy, unnecessary for the purposes of the project" (p. 205). Ideally, this guiding principle might have been stated in the book's opening chapter; even then, however, the reader might question what O'Neil has chosen to include and what she has omitted. In the end, it is hard to say where respect for Easser's privacy ends and O'Neil's reticence—as former analysand looking into her lost analyst's personal history—begins.

There is a notable discrepancy between the level of detail lavished on Easser's prehistory, childhood, and passage into young adulthood and comparatively scant treatment of significant aspects of her personal life in adulthood. We learn a great deal about each of Easser's parents, including the vagaries of personal history that brought them together and forged their "social democratic, internationalist, non-Zionist, non-religious, Yiddish household" (p. 21). About Easser's mother, Sarah, we are told—significantly—that she "never bent to anyone"; she was "a strong woman with a forceful personality" who learned from *her* mother (Ruth's maternal grandmother) to "walk tall" in the face of adversity (p. 20). Sarah Easser put this principle into practice as a political activist, through union-based assistance work for Jewish refugees from war-torn Europe.

Together with Easser's father, Sam—presented here as a man whose "integrity and vision" strongly influenced Easser (p. 27)—her mother encouraged and supported her education. From O'Neil's interviews with Easser's surviving siblings, we learn that "Ruth was Sarah's prize," and

that "vicariously, in many ways, Mother attempted to live through Ruth." For example, "it would not have been unusual if Mother joined Ruth and a friend to go to a movie" (p. 28). Set in the context of this relationship, Easser's pursuit of professional training—which took her far from home (and into a personal analysis) in early adulthood—can be seen as both compliance with her mother's high expectations and as a means to escape her domination. O'Neil writes, "Ruth's struggle between stooping to her mother or walking tall her way seems central to her inner development and influential to her motivations underlying her life choices. Psychoanalysis became her way of walking tall" (p. 30).

Given this history, Easser probably experienced some degree of conflict around becoming a mother herself; but O'Neil's account thins out around this aspect of her adult personal life. Where Easser's motherhood is concerned, O'Neil privileges her subject's privacy over our understanding of how her personal and professional development intertwined. Easser's first published papers (cited earlier in this review)—written when she was in her late twenties—were about psychological correlates of amenorrhea. From 1948 to 1953 (during her late twenties through early thirties), Easser served as psychiatric consultant for obstetrics and gynecology at Columbia Presbyterian Hospital; during those years, she worked on studies (unpublished) of "habitual abortion, hyperemesis in pregnancy, the effect of the unconscious meaning of pregnancy on its course, and subsequent attitudes to the mother role" (p. 154). The vagaries of feminine reproductive physiology and psychology might capture the interest of any young woman in our field, and Easser's analytic lineage traced back just one generation—through her analyst, Fanny von Hann-Kende—to Helene Deutsch, whose focus on the psychology of women may have influenced her. But research in this domain must also have reverberated with events in Easser's personal life, as she encountered struggles of her own around childbearing and motherhood.

The reproductive timeline in Easser's family of origin is laid out quite clearly, early in O'Neil's book; we learn Easser's age in relation to both an older half-brother and a younger sister, and we know that her mother "had some difficulty with pregnancy and had lost at least one baby" (p. 21) some time between Easser's birth and her sister's. By contrast, the arrivals of Easser's children are presented so elliptically that

the reader cannot easily map them onto her professional development. In the introductory chapter, we learn that Easser was "mother to four children, making her one of the early role models as a woman analyst who combined her work with marriage and a family" (p. 9). Later (in chapter 3), we learn that, though both she and Lesser wanted children, Easser "had some difficulty becoming pregnant"; and that the couple therefore adopted one daughter in 1953 and another in 1956 (p. 73), when Easser was in her early thirties.

But just where we might expect to read something about Easser's reactions to motherhood, O'Neil turns, instead, to a personal friend's comments on "Stan and Ruth as individuals and as a couple" (p. 73). A paragraph later, she turns away from Easser's personal life altogether. "What of Ruth Easser's early development as a psychoanalyst?" (p. 74), she asks—and she proceeds to address this question without reference to Easser's experience as either a woman struggling with infertility or an adoptive mother.

For some time, the reader is left to wonder: what about her other two children? About ninety pages separate O'Neil's brief mention of Easser's adopted daughters from the first mention of her two biological sons. In a segment of the book that falls midway (in terms of pages, not chronology) between these events, O'Neil discusses the mutual influence of "psychoanalysis and family life," which "impinge on each other" but "also inform one another" (p. 126). She describes the difficult position of the child whose psychoanalyst parent works in a home office, as Easser did for some portion of her career: "This nearby parent, attending to patients, is not readily available" (p. 122). O'Neil remarks that "being a psychoanalyst does not necessarily make one a better parent" (p. 122), and she acknowledges that Easser "struggled to be the involved psychoanalyst, to teach, see patients, do supervision, and to be the involved mother" (p. 122).

O'Neil's account hints at some degree of inhibition in Easser's capacity for emotional intimacy with her own children; a close friend remarks that she was "not demonstrative . . . . I never saw her being warm, cuddly with the children" (p. 124). Easser once confided to this same friend that she felt "she was being too strict with the children, as a way of compensating for feeling out of touch with their daily activities." In

her friend's view, Easser sometimes "applied too much psychoanalysis to some of the actions of the girls, perhaps not always acting first as the mother. She was the disciplinarian" (p. 124); yet—perhaps speaking from personal experience—Easser had the perspicacity to tell a candidate, who "never forgot" the comment, "You are speaking about your son as if he were a patient" (p. 125).

Lesser may have been a warmer and more demonstrative parent than Easser but he could also disengage, leaving Easser to put out fires (quite literally once, when Lesser remained "oblivious" to a blaze the children had set in a wastebasket). A family friend put it this way: Lesser "could sit and read and the house could fall apart" (p. 124). Late in her life, Easser's close friend and confidante asked, "Would you have married Stan if he came around now?" To which Easser replied: "I would have married him but I might not have had children with him" (p. 127). Whether her conscious reservations pertain to his fathering or to her experience as a mother—or both—is ambiguous.

Three years after the couple adopted their second daughter, "Ruth became pregnant for the first time, at the age of thirty-seven, and she gave birth to their first son" (p. 163). O'Neil does not comment on how pregnancy became possible for Easser (improved infertility treatment? Some shift in physiology and/or psychology?). A personal friend recalls that she had a difficult delivery, and that from the start, she and Lesser "felt something was wrong and didn't really know what" (p. 163). When their son was about three and a half years old, extensive testing at last yielded an accurate diagnosis: he was profoundly hard of hearing. Easser's friend remarks that "a new problem arose because Ruth spent a lot of time with him to develop his speech" (p. 163).

Meanwhile, demands on Easser increased again as she found that she was pregnant, at age forty, with her second son. This "didn't make her happy at the time" (p. 163), her friend recalls. Though born without incident and an otherwise healthy baby, Easser's second son was later found to have "some perceptual problems due to poor eyesight" (p. 163). Easser, already a busy, working mother, now faced both the added strain of her sons' perceptual impairments and her older, adopted daughters' reactions to their parents' biological children.

Easser and Lesser co-authored one published paper and two unpublished manuscripts on the psychological organization and treatment of "perceptually handicapped" children (appendix 1, pp. 212-213). O'Neil writes appreciatively about the adaptive and mutually supportive nature of this scholarly collaboration. However, she says little about how Easser's experience of both circumstantially induced stress and internally generated conflict might have affected her development as a mother—and as a psychoanalyst. In fairness, it seems that Easser did not make this aspect of her adult personal life a matter of public record through publication; and O'Neil undoubtedly took care to protect the confidentiality of her children (three of whom are listed among Easser's interviewees, in an appendix). But it would be helpful to the reader if she had explained directly, early on, how she had decided to limit her inquiry and/or her reporting in this important area. And though discretion might well limit commentary about Easser's experience of motherhood, it need not make reporting of the basic facts—the timing and nature of each child's arrival in the family, and the chronological relationship of these events to Easser's professional development—as murky as it is.

Would an author who had not been in treatment with Easser—one for whom writing this book was not, as O'Neil points out, a form of post-termination contact—be as circumspect about Easser's experience of motherhood? In her epilogue, O'Neil writes, "Through this process, I have experienced a wide range of emotional reactions around both wanting and not wanting to know about my psychoanalyst" (p. 204). Though she does not say so, it seems quite possible that O'Neil struggled with some inhibition around learning about—and/or reporting on—what might have been an area of personal sensitivity (though perhaps also a source of analytic inspiration and competence) for Easser.

O'Neil cites Easser's family life as a kind of rate-limiting factor in her scholarly output, and explains her eventual return to Toronto as an effort to meet her children's needs at some cost to her career. As analysts, we know that major life decisions are *always* multidetermined. Yet O'Neil cites two of Easser's colleagues uncritically, in asserting that concern for her children was the sole motivation for her move. Easser and Lesser "felt the New York environment . . . was too difficult for their children," says one colleague; "they had no other reason to leave" (p. 183). An-

other colleague concurs: "That is why she moved. It was tough to raise kids in New York," which is "certainly not habitable for children" (pp. 182-183). Many parents would disagree with this remark; and though life may well be simpler in Toronto, it is also possible that New York became the villain that Easser and Lesser blamed for the experience of conflict between work and family life (though conflict of this sort is always multiply determined, and can express an uneasy sense of self-as-mother or self-as-father).

For Easser, the move to Toronto also meant a return to the city of her childhood and to her domineering mother's orbit. The intensity and entrenched nature of conflict around dependence on her mother comes across in O'Neil's account of her last days. "As her illness progressed, she was confined to home and bed. Despite her weakened state, she continued to supervise." A supervisee and a friend who saw her often during this period described Easser's "insensitivity to her mother and her stubborn refusal to accept her mother's help"; in facing her own death, she was "unashamedly distant and self-sufficient," until—one day—"all that abruptly changed. Easser expressed a loving warmth towards and need for her mother not seen previously during her illness. That same evening Ruth Easser died" (p. 197).

Themes of personal autonomy in the context of female sexuality and motherhood were very much on Easser's mind in the last year of her life. In a presentation on "Womanhood" at the American Psychoanalytic Association in May 1975[6]—just a few months before her death—Easser said, "A woman is a complete individual even when not involved in heterosexual relationships or in a pregnant state or in the act of mothering"; and "if sexuality or motherhood are sought primarily as modes of self-completion, this will result in disappointment, lack of fulfillment, and further lowered self-esteem" (quoted in O'Neil 2004; pp. 195-196).

In her introductory chapter, O'Neil acknowledges an "obvious pitfall" of her project: a tendency toward "idealization . . . cannot be denied," she writes.

[6] See Settlage, C. F. & Galenson, E. (1976). Psychology of women: late adolescence and early adulthood. (Report of a panel presentation at the May 1975 meeting of the American Psychoanalytic Association, including Easser's paper on womanhood.) *J. Amer. Psychoanal. Assn.,* 24:631-645.

> Nor should it be . . . . A positive, even idealized transference is also a prime motivator: there is little reason to commemorate a person towards whom one feels negatively and much incentive to remember and understand a loved person. [p. 11]

But the act of creating an idealizing portrait may also serve to manage troubling affects: competition with the lost analyst as scholarly rival; anger at being abandoned; guilt over that anger; and the potentially complicated sense of privilege in receiving what Easser *did* give to her patients, even as the time available to her for both work and family life grew short.

In what is perhaps a particularly telling description of Easser, one colleague recalls that in general, "She was not overflowing with outgoing warmth"; yet when she interviewed patients,

> . . . her manner changed dramatically. Her voice became softer, she leaned forward to the patient with a motherly attitude about her that I didn't ordinarily see. There was an extraordinary change when she was talking to a patient. She was a wonderful interviewer . . . . I used to debate with myself which was the real Ruth. [p. 80]

Both, of course. Perhaps for Easser (as for many of us?), a life's work in psychoanalysis allowed for a comfortable experience of warmth and interdependence, in the context of a professional identity that brought some assurance of personal competence and autonomy. O'Neil was, it seems, among the fortunate beneficiaries of this adaptation. In this loving tribute to her former analyst, O'Neil has given us a compelling view of the life of an esteemed colleague—and much to consider in our own personal and professional lives.

JENNIFER STUART (NEW YORK)

PSYCHOANALYSIS, CLASS, AND POLITICS: ENCOUNTERS IN THE CLINICAL SETTING. Edited By Lynne Layton, Nancy Caro Hollander, and Susan Gutwill. London/New York: Routledge, 2006. 228 pp.

This study addresses how issues of politics, class, and the environment both impact and occur in the therapy situation, and it further attempts

to demonstrate how clinicians may be made aware of the complex interplay of psychic and social reality. The work emerged from the contributions of Section IX ("Psychoanalysis and Social Responsibility") of the Division of Psychoanalysis (39) of the American Psychological Association. Most of the contributors to this volume are members of Section IX.

Not unlike most edited books, and particularly ones in which the majority of papers have been previously published (such as this one), the contributions are uneven and in some cases not well integrated with the topic. It was conceived as a direct result of 9/11, a historical event that has clearly had an impact on all patients. Its usefulness is intended for instruction in treatment centers and institutes, as well as for therapists' use. The editors wish to raise our awareness of class and politics, something they feel has been neglected with the censorship of left-leaning émigrés from Europe following World War II.

The first chapter, by the noted Jungian analyst Andrew Samuels, is very good; his 1993 groundbreaking book was one of the first to demonstrate the importance of politics and class as therapeutic issues.[1] Samuels reports an earlier study in which he sent a questionnaire to 2,000 therapists in fourteen professional organizations in seven different counties. When issues of gender, the economy, race, national politics, and violence were brought up in treatment, 78% of the therapists understood that this referred to reality. Over 50% of the therapists said that they discussed politics with their patients. The study was undertaken around the time of the Gulf War, and one can only speculate on the results in a post 9/11, Iraq War period.

An interesting 1994 paper by Muriel Dimen on love, money, and hate explores the financial needs of the analyst and the denial of this need, and introduces money and class as countertransference issues. She writes: "Consider, for instance, that instant when you learn that your four-times-a-week analytic patient has been fired and will have to discontinue treatment. That first dip on the Cyclone at Coney Island has nothing on it" (p. 37). Money is part of the history of psychoanalysis. Recall Freud's many financial concerns as revealed in his letters and biographies.

[1] Samuels, A. (1993). *The Political Psyche.* London/New York: Routledge.

A paper by Lynne Layton with the unusual title "That Place Gives Me the Heebie Jeebies" reveals how awareness of social class is an everyday occurrence, particularly for the middle class. And a paper by Rachel Peltz on "our manic society" suggests that our frenzied capitalist society does not offer a facilitating environment or a degree of positive containment.

Nancy Caro Hollander and Susan Gutwill, in two not previously published papers, explore political themes that have emerged in our traumatized society, and note that after the despair of 9/11, a new sense of hope has emerged. Other previously unpublished papers by Lynne Layton and Gary Walls present relevant clinical material, and a paper by Maureen Katz shows how the impact of the beheading of Nicholas Berg, the events of Abu Ghraib, and 9/11 have impacted American consciousness. The role of the bystander, who employs defenses of denial and disavowal during times of terror, is explored by Hollander, with particular reference to the so-called Dirty War in Argentina.

A round table discussion entitled "Is Politics the Last Taboo in Psychoanalysis?"—with Neil Altman, Jessica Benjamin, Theodore Jacobs, and Paul Wachtel, as well as discussions by Muriel Dimen, Andrew Samuels, Cleonie White, and Amanda Hirsch Geffner—concludes the volume. For Jacobs, the obstacles to political discussion represent a fear of entering into an area of strong and perhaps irrational feelings between patient and analyst, while Benjamin notes that her patients are familiar with her published political views and thus often feel they share a similar worldview. The fact that patients know Benjamin's views is a reminder that in the age of Google, therapists are hardly unknown to patients.

Samuels expresses an interesting opinion in his discussion: "The question will soon cease to be: 'Why did you get involved in that political discussion?' . . . [and will instead become] 'Why did you collude in evading the political discussion that the patient was seeking?'" (p. 207). And Dimen comments: "I don't agree that analysts are sometimes political and sometimes they are not. We are always political beings, as much as we are all creatures of need, desire and consciousness" (p. 199).

Perhaps a future panel about our political psyches at a meeting of the American Psychoanalytic Association would continue the beginning started in this volume.

JOSEPH REPPEN (NEW YORK)

PREVENTING BOUNDARY VIOLATIONS IN CLINICAL PRACTICE. By Thomas G. Gutheil and Archie Brodsky. New York: Guilford Press, 2008. 302 pp.

This book contains a wealth of clinical wisdom for beginning as well as experienced clinicians. The many examples and dilemmas proposed become stimulating opportunities to grapple with the complexity and meanings of the therapeutic frame. The examples serve as reminders of mutual vulnerabilities that emerge in the multilayered therapeutic relationship. The format and discussions provide stimulating teaching opportunities that illuminate supportive protection for both psychoanalytic candidates and patients. Wide-ranging situations involving money, services, gifts, out-of-office contact, self-disclosure, clothing, and physical contact are discussed.

Gutheil and Brodsky have written a comprehensive review of boundary issues in a tone that emphasizes curiosity about dynamic meaning and context. Protecting both patient and therapist by maintaining a clear but not rigid, humane frame is stressed in a variety of real and believable clinical situations. Boundary deviations are presented as full of complex dynamic ramifications that need to be understood in their many layers of multiple meanings in order both to further the treatment and to prevent slipping into boundary violations. Boundary violations and boundary deviations, though connected, are clearly delineated as different. Exploration of dilemmas that involve the dyad in deviations always has as its background aim the understanding of psychodynamics, while the wish to facilitate growth and spontaneity, and also to protect both parties in the therapeutic dyad, is kept in mind as well.

The inevitability of boundary deviations occurring in the intimacy and intensity of the therapeutic dyad is acknowledged, and there is a discussion about processing these with the patient so that the available multiple meanings emerge, and then, hopefully, understanding and trust are deepened. Consultation with supervisors and colleagues is also stressed as helpful in guarding against being drawn into harmful boundary violations. The authors emphasize behaving in a professional, respectful, humane manner. A discussion of awareness of cultural differences, and the consequent possible differing meanings of "ordinary" behavior, high-

lights how the commonplace can reverberate with layers of meaning, evoking different reactions and issues in patients that will be influenced by context and personal history. For instance, shaking hands or helping a patient on with her coat could be perceived as seductive, respectful, intrusive, or insulting. Using or not using first names can evoke various reactions from patients—coldness, warmth, seductiveness—depending on previous histories. In a more complex example, a 1994 article is summarized that describes how boundary crossings thought to be helpful by the therapist were experienced in one case as a frightening, seductive boundary crossing, and in another as life-saving support.[1]

Each chapter ends with a summary of key ideas and concepts to mull over. While the summaries may seem simplistic at first, they can be read as highlighting guidelines for professional conduct, as well as attempting to build a protective signal anxiety function. "Don't worry alone"—instead, discuss and consult—is a constant emphasis (p. 20). The authors discuss a wide range of mental health professionals who function in various settings; they make it clear that, regardless of the particular theory a given therapy utilizes, the therapeutic relationship sets up an expectation for receiving help—sometimes magically (p. 33), in the patient's eyes—and an ethical responsibility in the therapist to protect the patient. The wishes stirred up by the relationship and its reverberating, unspoken symbolism are most effectively explicated and explored in a psychoanalytic setting, but the authors emphasize the need for all mental health professionals to be aware of the dynamics that are inevitably aroused, and to reflect on how they are being expressed.

The book's introduction is an excellent summary, with examples—elaborated in later chapters—of the clinical, ethical, and legal ramifications that can evolve from boundary violations. Throughout, implicit in these examples is the power of unconscious fantasy and the pressure for reenactment from both members of the therapeutic dyad. An ample number of examples are given of the devastating consequences that may result when the powerful early wish for magic, elicited in any therapeutic relationship, combines with naiveté, misdirected wishes to help, omnipo-

[1] See Waldinger, R. J. (1994). Boundary crossings and boundary violations: thoughts on navigating a slippery slope. *Harvard Rev. Psychiatry,* 2:225-227.

tent wishes, and the special life situations that foster the therapist's vulnerability, such as loss, illness, and aging.

While the authors make important distinctions between boundary deviations and boundary violations, they underline the many ways that the intimacy of the therapeutic relationship creates unexpected situations requiring clinical judgments in which spontaneity and humanness may need to take precedence over usual treatment formalities, in order to protect the relationship and the patient's narcissistic vulnerabilities. Focusing on the rules and what is usual can at times result in narcissistic injury, unintended humiliation, and damage to the relationship. However, the spontaneous solution of the moment must be reflected upon and processed by the analyst, both with the patient and with him- or herself.

The emphasis then, is always on exploring meaning with the patient and seeking consultation for the therapist. Countertransference and the analyst's utilization of it on behalf of understanding both patient and self, while implicitly acknowledged in this book, is not the author's focus, but repeatedly, the need for the therapist to reflect on and process countertransference meanings in spontaneous boundary crossings is advised.

The evolution of the focus on boundary violations is put into a historical context beginning with Freud's warning regarding transference love, and then moving into the 1970s and the revelations of sexual misconduct that emerged as a result of Masters and Johnson's research. There are descriptions of some famous cases that have a witch-hunt quality, but out of this era came realistic and grave concerns about harm done to patients by therapists, which then led to the research of the 1980s and '90s. Data and acknowledgment by therapists of sexual attraction to patients, sometimes reflected upon and sometimes harmfully acted out, has led to deeper dynamic understandings. The intensity of the repetition compulsion in survivors of sexual abuse is now acknowledged, better understood, and helps underline the need for all of us to reflect and consult.

The authors point out how public opinion has influenced cases of boundary violation that are brought to ethics boards and into the legal system. Clinical understanding of transference, countertransference, and the unconscious are often overlooked or not understood when ren-

dering decisions that affect the therapist's professional reputation and livelihood. There are many horrifying examples of patients using the legal system to express hatred, revenge, and disappointment that was stirred up but not adequately contained and analyzed in the treatment. Situations in which therapists have ended sexual involvement with patients are understandably acutely explosive, and even situations in which patients have imagined sexual involvement, with little basis in reality, have been occasions for accusations and legal action. The book's many examples serve to caution analytic candidates, who often underestimate pathology or make judgments based on therapeutic enthusiasm. But all clinicians—even the most experienced ones—need to be reminded of the importance of accurate assessment, consultation, exploration of multiple meanings, and documentation of concerns. This last factor, documenting concerns, is a protective endeavor for all therapists, whether they work in institutions or in private practice.

The chapter on "Vulnerabilities" reminds us again that "to analyze the patient's contribution to the dynamic interaction is not to blame the patient for conduct for which the therapist bears sole ethical responsibility" (p. 219). This chapter enumerates some of the known qualities that seem to constitute the "bad-apple" therapist who misuses the patient because of a narcissistic or sociopathic personality disorder. Several relevant articles are noted, including Gabbard and Lester's (2002),[2] with its list of common issues often associated with therapists who act out sexually with patients.

The main emphasis in this important chapter on vulnerabilities is, however, not "the bad apple," but the therapist who, because of certain life factors—age, illness, or loss, for example—begins to use patients to bolster the self. The therapist who has attained high professional standing and is vulnerable to the illusion of being beyond accountability, the therapist who is known to have difficulty letting patients go, the aging therapist who encounters a "special" situation and seems to lose judgment and restraint—these are just a few of the many situations noted. That "clinicians would do well never to underestimate their po-

[2] Gabbard, G. O. & Lester, E. P. (2002). *Boundaries and Boundary Violations in Psychoanalysis*. Washington, DC: American Psychiatric Publishing.

tential for self-deception" (p. 229) is an important reminder for all of us. Absent from this noteworthy chapter is any mention or discussion of the painful and complex ethical issues that arise for friends, colleagues, and analytic training institutes in dealing with such situations.

This book is addressed to a wide range of mental health professionals working in differing settings that do not have the complex admissions procedures of psychoanalytic training institutes, nevertheless, though we know that psychoanalysis is a powerful, life-changing treatment, it is also not to be overidealized as a cure-all by eager institute admissions committees. Even in times when potential candidates are not flooding the gates of training institutes, this chapter is an important reminder not to minimize applicants' grandiosity, superego disturbances, or sadomasochistic conflicts, which may not shift during a training analysis and could lead to later misuse of patients.

This is a particularly important book for beginning analytic candidates, as it stimulates awareness and discussion of the multiple meanings of the therapeutic frame, and vividly presents the serious challenges and responsibilities of helping patients to reflect and process complex psychic reality situations and past confusions. The importance of clear boundaries and the safety of structure in this endeavor is elucidated in a manner that is almost always complex and engaging.

ELLEN R. HIRSCH (NEW YORK)

THE INTERNAL TRIANGLE. By Lucy Holmes. New York: Jason Aronson, 2007. 149 pp.

The intent of Lucy Holmes's book is "to enrich [psychoanalytic] theory about female development in a way that focuses on women, not on the ways they are different from men" (p. 6). While confirming the value of oedipal theory, including the concept of penis envy, for understanding and predicting behavior of girls and women, Holmes emphasizes the hegemony of Freud's phallocentric theory, up to the present day, and its limitations for a valid understanding of female psychosexual development. In the past thirty years, she says, feminist psychoanalysts, attempting to develop new theories to correct the "deficit model" of female develop-

ment, have failed to develop a coherent theory of female maturation and development rooted in the unconscious and drive theory.

While Holmes acknowledges the influence of early theorists of female psychology (e.g., Bonaparte, Jones, Horney, Klein), she says she was motivated to develop her theory of the internal triangle because "psychoanalytic theory . . . offered no account of the psychosexual development of women other than a negative one" (p. 3). She suggests that Freud's "dark continent" has retained some of its arcane character.

In order to provide access to understanding the internal life of girls and women, Holmes posits "new theories of female development" based on over twenty years of clinical work with women. Her central metaphor is the internal triangle; it serves as an organizer for her theories of psychosexual development of women, feminine character, personality, and morality.

Citing the influence of Benjamin and Chodorow, Holmes sees this triadic construct, consisting of a maternal imago, paternal imago, and self-representation, as a unique solution to the girl's challenge of separating from early parental objects and developing a sense of mastery and control. This triangle functions for the girl like a penis does for the boy. Faced with the task of separating from the mother of infancy, who is also the object of identification, the preoedipal girl gains power through a primitive incorporation of the phallic mother. Later, when the oedipal girl's efforts to gain father's love/child and phallic power are disappointed, she finds a solution through introjecting the father, identifying with his power, feelings, and behavior. This identification entails submission and passivity; the self is subordinated in the triangle, which is dominated by its own identifications. The triangle serves as a filter for all subsequent relationships.

The internal self and object constellation shapes the female personality and influences the concept of femininity. The triangle, with its continual shifts and interplay among the various internal objects, depicts an ever-expanding inner space where rich multiple perspectives are considered, a range of intense feelings are expressed, and complex dramas are played out. This structure also accounts for distinct female morality based on the capacity to weigh ethical issues from a variety of viewpoints, rather than from more clear-cut, "masculine" rules and logic.

Major developmental crises—e.g, menarche, pregnancy/childbirth, and menopause—create intense physical and psychic disequilibrium, as well as favorable circumstances for reconfiguring the object representations of the triangle in ways that reflect and promote the authority of an enriched, higher-functioning self. Each crisis of female development is a confrontation with the original mother. Holmes credits her own experience of pregnancy and childbirth with the genesis of her hypothesis of the internal triangle. She is particularly interested in the unconscious identifications, both aggressive and regressive, that are activated during childbirth and the opportunities for intersubjectivity, as the mutual recognition of sameness and difference between two subjects is played out.

Holmes offers clinical illustrations to describe multiple projections stimulated by the fetus/neonate, the association of childbirth with death and loss of self/object, and the high level of individuation and autonomy that may ultimately result from working through former unresolved conflicts reanimated with the shifts in identification.

The second part of *The Internal Triangle* is more focused on particular clinical issues and technique. The role of the analyst, for example, is to accept the inevitable dyadic transference projections of the introjected *toxic mother*. The goal of treatment is to free the patient from the unconscious maternal imago, i.e., *the mind of the mother,* which has limited the patient's options. Articulation and transformation of the reexternalized object are the work of analysis. The analyst also "provide[s] a corrective emotional experience" (p. 135) by demonstrating that she is a good object with whom to identify.

Holmes advocates single-gender (i.e., women's) groups for "the traditionally 'feminine' woman, that is, the woman who has a rather impoverished sense of self in terms of her internalized objects," because of "the feminine tendency to become diffused in identifications [which] sometimes results in women feeling overpowered in mixed-gender groups" (p. 7). Fantasies and projection are explored in the group "play space," where inner reality is tested against shared reality. Holmes is most engaging when she describes her clinical material.

While Holmes is correct that we do not have an integrated theory of female psychology, she fails to pay sufficient attention to the exceedingly innovative and extensive post-1970s psychoanalytic literature pertaining

to female psychosexual development and functioning.[3] She would find her quest more fruitful were she to further explore the writings of contemporary psychoanalytic scholars and practitioners. Examples might include some of their influential ideas, such as distinct female genital anxiety, inner genital space in men, the impact of the pregnant body on self-representation, female gender identity as shaped by conflict and compromise, and a more extensive notion of what constitutes femininity in general.

With more consideration of the rich contributions of other psychoanalytic theorists of female psychology, Holmes could potentially expand her theory of the internal triangle and thereby further enrich the understanding of female developmental challenges, wishes, fantasies, and conflict, and how these are negotiated throughout the life cycle.

AIMÉE NOVER (BETHESDA, MD)

[3] For example, the *Journal of the American Psychoanalytic Association* published a supplemental issue devoted entirely to the psychology of women; see Richards, A. & Tyson, P. (1996). Acknowledgments. *J. Amer. Psychoanal. Assn.,* 44(suppl.):ix.

UNDERSTANDING ADDICTION AS SELF MEDICATION: FINDING HOPE BEHIND THE PAIN. By Edward Khantzian and Mark Albanese. Lanham, MD: Rowman and Littlefield, 2008. 157 pp.

This book is an excellent review of a lifetime of contributions by Edward Khantzian and his collaborator, Mark Albanese. Khantzian in particular has been a pioneer in the psychological understanding of addictions since the 1970s, and was one of the first modern psychoanalysts to take an interest in this often-overlooked area. His committed focus on the self-medication hypothesis of drug addiction over the years has been a significant factor in its current wide acceptance.

This book carefully demonstrates the *self-medication hypothesis* (the authors abbreviate it as SMH) with numerous case examples. This hypothesis is fundamentally a statement that drug use is an effort to seek relief from emotional suffering. Through many case examples, Khantzian and Albanese show people who become excessive drug users how to manage, at least temporarily, feelings such as worthlessness, loneliness, and confusion.

Central to the self-medication idea is that addiction is a disorder of emotional self-regulation. The authors particularly note this in drug use by people who are alexithymic or who have a deficit in *self-care functions*—a concept to which Khantzian and John Mack were early contributors. These self-care (ego) functions include vigilance about one's own safety and recognition of dangerous situations, including dangerous relationships, and the capacity to take appropriate action to protect oneself. The authors believe that people with such self-care deficits are particularly vulnerable to drug addiction.

Khantzian and Albanese also reassert one of the earliest concepts of the self-medication hypothesis: that a person's "choice" of drugs is determined by the ability of that drug to address his or her deepest emotional pain. Thus, those with depression, and those who are what the authors call "low-energy individuals" (p. 25) are drawn toward stimulants, while people who the authors describe as tense and anxious might seek sedatives such as alcohol to loosen their defenses and allow access to feelings and to others. The authors do not comment on the limitations of this idea, such as the fact that a very large number of people suffer from alcoholism—i.e., have made the same choice of drug—but their characters, defensive styles, and psychodynamic issues run the gamut of psychic possibilities.

Understanding Addiction as Self Medication is not entirely focused on the self-medication idea in its usual form, interestingly. One chapter is devoted to the psychological gain of "perpetuation of suffering" (p. 69) as a basis for addiction, an idea that Khantzian has written about over many years. This idea is summarized in a description the authors cite from a drug-abusing patient: "At least it was a misery I produced and I controlled." Addiction is here seen as a repetitive way for the individual to achieve a sense of control over his or her otherwise confusing and desperate life, even if through suffering. This mechanism is therefore distinguished from masochism.

As elsewhere in the book, the authors emphasize the role of alexithymia as a chief factor in the need to create an understandable and controllable existence. Without a doubt, people with alexithymia fit this model especially well. However, the idea of alexithymia as a factor in addiction, introduced by Henry Krystal forty years ago, was initially based

on the study of a population who especially suffered from that disorder. Many would now question whether a significant percentage of people with addictions are alexithymic.

The book very helpfully contests the widely accepted but false idea that addiction is a neurobiological disorder (a "chronic disease of the brain," according to proponents of this view). Khantzian and Albanese note that no matter how much is known about drug effects on the brain, these cannot fully describe the role of the "person" (they might have said "mind") in addiction. The authors' ability to cite and discuss numerous references to current neurobiological research lends impressive weight to their critical review of the "brain disease" idea.

At the end of the book, the authors touch on treatment. They review nonpsychodynamic approaches and very briefly summarize the group approach they have developed, which they call *modified dynamic group therapy*. They list the primary qualifications for any therapy as "kindness, empathy, instruction" (p. 108), among others, echoing Khantzian's work earlier in his career on the need for a therapist working with quite troubled people to provide more active intervention than would be the case with healthier patients.

The main criticism one might make of this fine book is not the fault of the authors, but a problem inherent in the self-medication hypothesis itself. Its great power as an idea, and what made it the wellspring of modern psychoanalytic thinking about addiction, is its simplicity. As much as psychoanalysts take for granted that symptoms entail defensive functioning, little of this was in our literature about addiction before the late 1960s. Addiction was often seen as a direct expression of drives accompanied by an absence of adequate ego function. With the self-medication hypothesis came the idea of addiction as defense—as a way to relieve distress—opening the way to further advances in understanding the psychology of addiction, while at the same time changing the tone of discussion about addiction among both professionals and the public. It is the profound simplicity of this idea that also limits it as a topic of discussion.

The authors have done a masterful job of describing the self-medication hypothesis, and consequently this book will be of considerable value to the general public. Psychodynamically oriented therapists may find it

more familiar territory. The book would have been enhanced if it had moved beyond the self-medication idea to discuss in greater depth subsequent advances in psychodynamic and psychoanalytic views of addiction.

There are a couple of quibbles. Throughout the book, the authors speak of SUDs (substance-abuse disorders), and nearly the entire book is about drug addiction. It is only toward the end (chapter 11 of 14) that they consider non-drug addictions, such as compulsive gambling and sexual addiction. When they do address these conditions, they rightly conclude that the self-medication hypothesis applies just as well to them. But I think it would have been preferable to emphasize the psychodynamic sameness of drug and non-drug addictions from the start, rather than segregating SUDs as though they were a meaningful, separate category.

A second issue is the perplexingly significant and uncritical place given in the book to Alcoholics Anonymous. The book's first page, before the table of contents, presents a quotation from "Bill W.," one of the founders of AA. Several illustrative examples unnecessarily add that these patients benefitted from attendance at AA meetings, although this is not relevant to the point of the case. The organization of AA itself is praised as having "proven to be an extremely effective intervention" (p. 106)— a highly contestable statement (only about 10% of people who attend AA become sober members). In presenting AA in a purely positive light, the authors treat it with less psychological acuity and critical mindedness than they bring to the rest of the book. Given the extraordinary (and I would say unjustified) acceptance of AA as the primary treatment for addiction in our society, it would have been helpful for readers to know not just the positives, but also the limitations and negatives of AA.

These quibbles are, however, just that. I highly recommend *Understanding Addiction as Self Medication,* both for therapists interested in addiction and for patients who are hoping to understand themselves better. Its authors are to be congratulated. This book is a fitting culmination of decades of inspiring and groundbreaking work by Khantzian, in particular, to whom all clinicians interested in addiction—and several generations of patients—owe a lasting debt.

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ABSTRACTS

PSICOANÁLISIS: THE JOURNAL OF THE ASOCIACIÓN PSICOANALITICA DE BUENOS AIRES (APDEBA)

Abstracted by Irene Cairo

Volume 28, Number 2 – 2006:
"Psychoanalysis in Times of Terror"

Against a sociocultural background of severe hardship, psychoanalytic groups in South America have been forced to pay attention to issues seldom addressed in the North American psychoanalytic sector. This issue of APDEBA clearly illustrates this phenomenon.

There is a need in psychoanalysis for a specific approach that takes into account the constitution of the social subject. Produced on the thirty-year anniversary of the military coup that installed Argentina's dictatorship, this issue is aimed at creating an articulation between context, culture, creative history, and personal history. Part of the background to the ideas expressed here is the notion that in extreme social situations, analysts are faced with a choice between neutrality and solidarity, a conflictual ethic that serves as an ideological framework.

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Representation and the Impossible. By Fethi Benslama, pp. 247-273.

The author gives a context to his ideas by referring to Primo Levi's statement that the Shoah needs to be thought from a psychic point of view. In his prologue to *If This Is a Man,*[1] Levi stated that his purpose was to provide documentation for a "calm" study of some aspects of the human soul. Benslama attempts to situate himself vis-à-vis Levi's exhorta-

[1] Levi, P. (1947). *If This Is a Man* and *The Truce,* trans. S. Woolf. London: Abacus, 1991.

tion. He reflects that he is writing fifty years after the infamous words *hier ist kein warum* were uttered,[2] and he tries to approach the subject from two aspects: the relationship between affect and drive, and the implied change of perspective required in approaching this material. Definitely, there is a brutal transition from the experience in the camps to a testimony like Levi's, and to the thinking process about those testimonies.

Against the backdrop of a comment of Freud's in *Civilization and Its Discontents* (1930)—that when we are confronted with extreme suffering, we set in motion specific protective mechanisms—the author sees a basic "clumsiness" in our capacity to think about the Holocaust. There is a breakdown of what is called "a common view." Where does that breakdown fall in terms of representation? How does representation appear in its passage from experience (or *imperience*, a neologism the author creates, since he believes there will be a permanent imprint) to reflection and witnessing? How do we name the result of the crumbling of what was previously thought of as commonly human—the *inhuman,* the *nonhuman,* the *a-human?*

The author emphasizes the difference between denial and disavowal, noting that the mind cannot find the means to represent what is inhuman. Human existence is marked by a link or by a pause, space, or lack, which is both identity and difference. What Benveniste called *dialectical coexistence* is at play between the real, the symbolic, and the imaginary, where the relation between the identity and difference of a man in relation to other men is what makes for the uniqueness of each subject.[3] In Greek mythology, this is what allowed Ulysses to escape the Cyclops by answering that he is "nobody." (In French, *personne* means both *person* and *nobody;* in Greek, *nobody* is *Oudeis* or *Outis,* a slight distortion of *Odysseus.*)

What had to be exterminated in the Holocaust was the Jewishness of Jews. But that target, the object of extreme cruelty, escaped localiza-

[2] In a revealing comment, a Holocaust prisoner, thirsty, picks up a piece of ice outside the bars of his confinement. The guard takes it away and the inmate asks "Why?" The reply is "*Heir ist kein warum*" ("Here there is no why").

[3] Benveniste, E. (1966–1974). *Problems in General Linguistics,* trans. M. E. Meek. Coral Gables, FL: Univ. of Miami Press.

tion in a single register; the process of *perverse apprehension*, then, is the attempt to apprehend in a man what cannot be apprehended. The representation of that perverse apprehension is made possible only through witnesses. The destructivity of the camp splits the individual into various fragments; seemingly, the testimonial process later achieves their unification, or at least ensures that they are not ignored.

It is clear that the survivor is wounded by the testimony, since the affects related to *imperience* are overwhelming: the victim had to preserve his identification as a victim, as the inhuman residue that he was supposed to be. Self-preservation forces self-hatred as a means of maintaining the image of being "killable," which in turn allows thinking about escape. Benslama gives the name *testimonial reversals* to the process by which a person tears up what it was necessary for him to adopt in order to survive.

From a psychoanalytic point of view, a system of ethics of representation of the Shoah would test the demands that are imposed by putting the experience into words. From his experience of the transformation necessitated by surviving the camps, Bruno Bettelheim extracted a model for infantile autism, the author notes; Bettelheim compared the autistic child to a figure in the camps called "The Muslim."[4]

The Shoah challenges the capacity to represent. With its perversity, genocide threatens to go beyond its own actions. The question is: how can man resist its destruction, at which point does he become not a man, where does this possibility come from, and what does it mean? There is a statement in Robert Antelme's book, *The Human Race*[5]: "Nobody here will become his own SS." But dehumanization is spoken about by all authors writing about the camps. It is powerfully evocative to note that the titles of at least two books by survivors, Levi's *If This Is a Man* and Antelme's *The Human Race*, allude to this near destruction and then to the affirmation of humanity.

[4] Bettelheim, B. (1960). *The Informed Heart: Autonomy in a Mass Age.* New York: Free Press.

[5] Antelme, R. (1957). *The Human Race,* trans. J. Haight & A. Mahler. Marlboro, VT: Marlboro Press, 1992.

Central to Benslama's philosophical reflections is the work of Giorgio Agamben,[6] especially in regard to that figure called "The Muslim" (in quotation marks). These are men who march and work in silence and have "extinguished in themselves the divine flame"; one cannot call them alive or dead. Numerous definitions and statements about this figure emerge in the works of both Agamben and Levi. Agamben sees this figure as a sort of *avant premiere* produced in the camps, a modern-man transformation that results in a man who eventually is only biological.

Benslama investigates the origins of "The Muslim" from several perspectives. This "no-man" man is the part of a Jewish man who has been forced to separate from his murdered self and to self-mutilate in imagination, in order to survive. This imaginary presentation is an equivalent of Ulysses's answer "nobody" in the Greek myth: an imaginary self, cast away, put forth as an illusion, with the goal of survival. The imaginary "Muslim" thus constitutes a rhetoric of survival, Benslama concludes—a maneuver that names in order to survive.

What and How Can We Think, as Psychoanalysts, about What Is Called "Terrorism" and "Terrorist"? By APDEBA's Department of Couples and Families, Isidoro Berenstein, Sara Berenstein, Julio Moreno, Janine Puget, and Sonia Kleiman, pp. 275-284.

This work was prompted by an invitation from the International Psychoanalytical Association to think about the subject of terrorism, resulting in a series of articles published in the "Focus" section of the IPA's newsletter (Volume 11, Number 1, of 2002). A common term used by the respondents was the *mind of the terrorist,* linked to other concepts, such as: trauma, identity, resignification, dissociation, projective identification, individual and social ideals, and the death drive.

The authors of this article observe that the presumed psychoanalytic notion of the *mind of the terrorist* explicitly expresses an ideology. Thus, to think as analysts about terrorism requires us to approach and define issues that refer to the constitution of the social subject. The authors then observe that in many descriptions, reference to *the mind of the ter-*

[6] E.g., Agamben, G. (1998). *Homo Sacer: Sovereign Power and Bare Life,* trans. D. Heller-Roazen. Stanford, CA: Stanford Univ. Press.

rorist implies that terrorist behavior is a symptom, later situated in a type of mental structure.

The authors address first the terrorist act. In the newsletter articles and in other papers, it is described in terms of self-destructiveness, identification with the lost object, early mental deficits that are replaced by a charismatic leader, etc. But the authors refer instead to Baudrillard, who addresses the terrorist act as the use of an absolute weapon because it is utilized against a system that lives on the exclusion of death, a system that has the ideal of "zero death."[7] Nothing can be used effectively as a weapon against an enemy who transforms his own death into the ultimate counteroffensive.

The authors point out that different models have been alluded to:

1. The connection of the suicidal act to an early object tie, within the mother–baby relationship.
2. Consideration of the way in which the social realm forms the subject, supplementing earlier ties.
3. The notion that the relationship of the subject with the social world has its own conflicts, especially in regard to the alien quality of different worlds, a fact that evokes terror.

The question, then, is: under what conditions of sociocultural conflict does the emergence of that figure, *the terrorist,* occur? The sociocultural conditions surrounding individuals form a practical network that produces both social logic and subjectivity, the authors note. Certain figures and concepts in our social world seem acceptable in a way that does not require further exploration, such as the *mind of the soldier.* Currently, to think about the *mind of the terrorist* gives the illusion of an identifiable face, when actually we are being confronted with great uncertainty and anxiety. Philosopher Gilles Deleuze and psychoanalyst/political activist Félix Guattari wrote about the process of obtaining a uniform face connected with the abstract machinery that produces terror and with the power structures that require such production—a "poster picture."[8]

[7] Baudrillard, J. (2001). The spirit of terrorism, trans. R. Bloul. http://www.egs.edu/faculty/jean-baudrillard/articles/the-spirit-of-terrorism.

[8] Bogue, R. (1989). *Deleuze and Guattari.* London/New York: Routledge.

The frequent response to the news of a terrorist act is: "I can't believe it." This suggests that if the ego cannot imagine something, that something cannot exist. Feelings of vulnerability, incredulousness, impotence, and confusion seem to require the naming of concepts, as if they were clear.

Many articles refer to *indoctrination*. The authors suggest that this is part of an ideology as well, since indoctrination is not thought of as a phenomenon that affects other agents of destruction—bomber pilots, for instance, or the Crusaders of the Middle Ages, who also considered their endeavor a holy war against evil. Perhaps we always think indoctrination is what *others* suffer; *our* world, in contrast, is the right one and should not be questioned.

The authors suggest that it may be useful to think about current events not in terms of *terrorist minds*, but as evidence of the difficulty of living with different cultures. They think our "established psychoanalytic mind" may actually be an obstacle to overcome in order for us to think meaningfully about these events.

"To Survive Genocide . . . and Then?" By Lucian Hounkpatin, pp. 285-305.

This paper is the result of research on the trauma suffered by inhabitants of the region of the Great Lakes in Africa and on the psychotherapeutic attempts by a French group to work with the victims. This broadly interdisciplinary group tackled a region that had suffered terrible wars, with instances of gang rapes, child murder, and the widespread destruction of life and of ways of life. The brutality of genocide did not allow survivors any tools with which to think about the events. Therapists first tried to address the traumatic events in consultation, in a sort of deconstructive procedure, later followed by a reconstruction of the events that contributed to the survivors' particular circumstances.

It is necessary to take into account the fact that these patients rejected the idea of intrapsychic illness. If the disorder cannot be attributed to the nature of the patient, but only to interaction with the aggressor, how do we construct our therapeutic propositions? These pa-

tients are attached to their language, geographical location, and culture, which draws on rituals, alliances, and particular reparative processes.

A clinical example is offered: the case of Flora, a 17-year-old Burundian girl who is almost mute and has episodes of unexpectedly falling down as a result of the traumatic experiences she lived through at the age of eight. A group experience is organized in which two people describe the horrendous experiences they themselves suffered. One of them is Flora's older sister, who remembers having had to go through horrific events and witnessing the trauma of others, including Flora's. In listening to their very terrible descriptions, Flora becomes slightly animated; the authors then reconstruct the meaning of her symptomatology.

Thus, therapy consists of reconstructing the unconscious theory that underlies the symptoms. A fundamental step is the articulation between personal and collective histories. In short, the therapeutic method developed here consisted of a first step in which the "word group" provided "a third" to offer a mediation to the experience, so that representation might become possible.

A second step was based on the physical symptom Flora suffered: her inability to support her own body weight. To treat this condition, a therapy called "packing" was employed in which the women in the group covered Flora with sand and then removed it, on a daily basis, and did the same with a wet sheet. In a final step, the women told Flora stories—narrations offering a link to their culture.

The author highlights that each situation requires a different prescription, a fact that demands great creativity from the therapist.

Curative Factors in the Psychoanalysis of Children of Holocaust Survivors, Before and After the Gulf War. By Ilany Kogan, pp. 307-326.

The author starts by addressing some of the questions Israeli psychoanalysts faced during the Gulf War: What is the task of the analyst involved in the same situation as her patient? Does analysis make sense in such situations? The answer for the author is that, as important as insight is, it is the task of containment that is essential at times of existential threat.

Kogan begins by highlighting the tendency of Holocaust survivors to concretize, and she emphasizes that the same tendency is present in the children of survivors, re-creating the parents' experience. This is the result of superego pathology shared by the survivors and their children. The author refers to the work of Maria Bergmann,[9] Ilse Grubrich-Simitis,[10] and Judith Kestenberg[11] for their definitions of this pathology.

The goal of obtaining insight for the children of survivors is obvious: to help them leave concretization and develop the capacity to verbalize. Yet during the Gulf War, the impact on the children of survivors was so great, and they reacted with such feelings of impotence and terror, that the emphasis of treatment shifted to strengthening ego forces. Many times, therapists had to rely on more personal communications, revealing to their patients some of their own feelings.

These ideas are illustrated by two clinical vignettes. The emphasis is on relational factors as the most crucial. However, the author also reflects that these are difficult to assess if this connection with the past occurs only in the second generation. She adds that many Israelis who had no personal Holocaust trauma reacted concretely during the Gulf War, linking it to the Holocaust. On that basis, Kogan speculates that perhaps "we are all second-generation survivors."

Comments about the Paper "Curative Factors in the Psychoanalysis of Children of Holocaust Survivors, Before and After the Gulf War," by Ilany Kogan. By Carlos Moguillansky, pp. 327-330.

The author comments appreciatively on Kogan's fruitful exploration of the subject of intergenerational transmission, the boundaries of semantic interaction, and its role in symptom formation. Moguillansky notes that this document emphasizes the value of the family's mnemic

[9] Bergmann, M. V. (1982). Thoughts on superego pathology of survivors and their children. In *Generations of the Holocaust,* ed. M. S. Bergmann and M. E. Jucovy. New York: Basic Books, pp. 287-309.

[10] Grubrich-Simitis, I. (1984). From concretism to metaphor. *Psychoanal. Study Child*, 39:301-319.

[11] Kestenberg, J. (1982). A metapsychological assessment based on an analysis of a survivor's child. In *Generations of the Holocaust,* ed. M. S. Bergmann & M. E. Jucovy. New York: Basic Books, pp. 137-155.

reservoir. However, in regard to the traumatic past of the Holocaust, he cautions against the apparent certainty of the presumed connections described by Kogan. He also reaffirms the exclusive capacity of psychoanalysis to challenge inconsistencies and to reveal intense affects or overvalued ideas.

Moguillansky then addresses another focus of Kogan's article: the technical problems of conducting psychoanalysis in conditions of war, suggesting that it may not be possible to do so except through intense dissociation. However, he affirms, if psychoanalysis is possible in war conditions—as the British authors of World War II suggested—then why resort to what may amount to self-revelation in order to affirm the reality of the patient's fear? A shift in meaning is inherent in the operation of the unconscious on any trauma, and the analytic method can give an account of that process.

"Silence Is Health": Trauma in the Analyst. Considerations Derived from Consultation with a Young Girl. By Ana Rozenbaum de Schvartzma, pp. 331-346.

This paper is an attempt to create an articulation between an individual consultation and collective history. During the 1980s, the author, working in Buenos Aires under the military dictatorship, saw a young girl in consultation who was "approximately" four years old, according to the referring pediatrician. This was a curiously vague statement by the referring doctor. Presenting symptoms were delayed development and problems with verbal speech. The history of her mother's pregnancy and delivery and of the child's early development was allegedly normal but equally vague. The parents complained that "everything" had been chaotic. During the consultation, the child spoke in repetitive phrases and became very distraught when a ball drifted away; this was viewed as a response to separation. Therapy resulted in improvement of speech and symptoms, and she was able to return to school.

After a few years, the parents, who periodically returned for follow-up, disclosed that the child had been adopted. They manifested an obvious suspicion by its negation, saying, "she's not the child of subversives." This revelation had a traumatic effect on the analyst, since she

realized that the little girl may indeed have been snatched from her parents during the dictatorship. Reviewing the entire process, the analyst recognized clear signs of the child's having been adopted, which she had not been able to consciously acknowledge. She reflected that the child's mutism, the secretiveness of the parents, and the "deafness" of the analyst all reflected the social reality in which words were "closed."

The author quotes Aulagnier[12] in describing alienating states, and Braun and Pelento[13] in talking about a conspiracy of silence. She then recalls an ominous slogan that was popularized through posters, radio, etc., during the dictatorship: "Silence Is Health."

Round Table Discussion: Thinking about State Violence from the Perspective of Psychoanalysis. By Elizabeth Tabak de Bianchedi, Janine Puget, Julia Braun, and Vicente Galli, pp. 349-377.

Eliana Tomaszewski, coordinator, opened this round table discussion by stating that APDEBA (the Asociación Psicoanalitica de Buenos Aires) had invited several prominent psychoanalysts to reflect on state violence on the occasion of the 30-year anniversary of the military coup that installed state terrorism in Argentina. She asked the participants specific questions. One addressed the term *desaparecido*[14] and its implications for the collective psyche. Another question dealt with the consequences of the amnesty given to perpetrators, and a third pertained to modifications in analytic technique that the panelists deemed necessary for the treatment of victims—particularly regarding neutrality and abstinence.

Julia Braun gives a title to her comments: "The Involvement of Psychoanalysts During the Dictatorship." She refers to Primo Levi's reflections on the meaning of memory—*memory so that others not forget*—and remembers her own statement, made earlier with Janine Puget, that the most prominent carriers of memory, the victims, are subject to what they call *forced memory*.

[12] Aulagnier, P. (1979). *Les destins du plaisir: aliénation, amour, passion.* Paris: PUF.

[13] Braun, J. & Pelento, M. L. (1991). Las vicisitudes de la pulsión de saber en ciertos duelos especiales. In *Violencia de estado y Psicoanálisis*, ed. J. Puget & R. Kaës. Buenos Aires, Argentina: Centro Editor de América Latina, pp. 79-91.

[14] Although it means simply *disappeared,* the original Spanish term has acquired political meaning internationally.

In trying to give a constructive cast to memory, Braun highlights that each epoch poses its own questions about the past. She recounts the efforts that were necessary to continue practicing psychoanalysis during the dictatorship. Speaking about the present time, she reflects on the traumatic impact of social vulnerability, the demand on analysts to acknowledge a form of collective trauma, the dependence of analytic work on sociohistorical processes, the fall of the dictatorship, trials and amnesty and their ramifications, the awareness of real risk, and the painful recovery of the capacity to condemn. Here Braun refers to Amati Sas, who observed that analysts had to maintain their capacity for indignation as an ethical principle, and not as a violation of the rule of abstinence.[15]

Tabak de Bianchedi reveals her great difficulty in preparing notes for this round table. She reports that she surprised herself with her internal monologue: "me too, me too, I too worked with the Grandmothers of Plaza de Mayo," and similar statements. Why such affirmation, she wonders? Then—she asks—as psychoanalysts, how do we think about state terrorism? We have to think about the collective psyche and about social subjectivity. She reflects on the subject of terror and relates it to Bion's description of nameless dread.[16]

Social violence implies physical violence, economic violence, ideological violence, and transgressive violence (corruption, lies, illegal pardons). These are all perversions of human rights. Tabak de Bianchedi emphasizes the importance of containment when addressing such experience.

Vicente Galli refers to the recent evolution of social awareness and of jurisprudence, with the recognition of so-called crimes against humanity. Crimes against humanity are not proscribed; thus, the legal maneuver to give amnesty to torturers has crashed against demands for justice and truth that naturally emerge.

Galli focuses on two particular aspects of state terrorism: *desaparecidos* and torture. In regard to the former, he highlights that the process of mourning is prevented by the status of the disappeared. Regarding torture, he notes that this has a devastating effect on the basic constitu-

[15] Amati Sas, S. (2004). Traumatic social violence: challenging our unconscious adaptation: an urgent psychoanalytical concern. *Int. Forum Psychoanal.,* 13:51-59.

[16] Bion, W. R. (1962). *Learning from Experience.* London: Tavistock.

tion of the self. In the context of these reflections, Galli adds that the recent nullification of amnesty laws and pardons is having new effects on society, as yet not fully processed.

Janine Puget reflects on how the recent past has been inscribed in personal, family, and collective memory. Does psychoanalysis offer new insights? Is it only the theory of trauma that can be utilized? Or, as Badiou thinks, is this an "evenement" (event) that requires specific theoretical resources?[17]

Comments on the Round Table Discussion, "Thinking about State Violence from the Perspective of Psychoanalysis." By Silvia Resnizky, pp. 379-384.

The author reflects that the phrase *from the perspective of psychoanalysis* is meaningful as part of this discussion's title, as it reflects the fact that participants offer not only their psychoanalytic ideas, but also their testimony—as citizens, victims, and as recipients and transmitters of collective memory. She quotes Puget in affirming that societies supporting "lethal utopias" reject memory and the capacity to historicize. She speaks of the possibility of "a dialogue between memories," in contrast to the limitations of totalitarian societies, where all memories must coincide.

Resnizky stresses the goal outlined by Braun and Galli: "to treat the untreatable, to represent what is not representable." Current theories are inadequate to that task; we require different perspectives. We search for a transmission of meaning that refers to the symbolic level.

Resnizky observes that some writers have referred to a *totalitarian temptation.* Primo Levi and later Tzvetan Todorov[18] stated that the carriers of evil are not radically different from ourselves. In highlighting Tabak de Bianchedi's contribution, the author adds that all forms of inviolence are a perversion of human values. She notes that Julio Moreno coined the concept of *the inadmissible,* connected with not having a place

[17] Badiou, A. (1988). *Being and Event,* trans. O. Feltham. New York: Continuum, 2005.

[18] Todorov, T. (1991). *The Morals of History,* trans. A. Waters. Minneapolis, MN: Univ. of Minnesota Press, 1995.

in the mind in which to lodge those events that are beyond accepted ethics.[19]

Finally, Resnizky refers to the euphemisms used by the regime—a practice that allows the perpetrator to disavow his own crime at the same moment he commits it.

Psychoanalytic Reflections on Times of Terror. By Norma Slepoy, pp. 385-397.

The author refers to her own prior work on the way that totalitarian structures can function within democratic institutions. She has immersed herself in the study of the work of Agamben. From this philosopher, she highlights the notion, based on Freud, that the antithetical meaning of primal words allows us to think about the sacred character of life, while at the same time ruling its extermination (the root *sacer* means both *sacred* and *impure* [20]).

Slepoy then distinguishes terror in a dictatorship from terror in a democracy. She describes in detail the now-public "ruling" by the Argentine military known as "psychological operations." Induced terror has had such an effect that it has contributed to an arrest of thinking. The author quotes diverse statements, both from prisoners and from allies of the ruling power structure, which show the difficulty in comprehending the enormity of the violent reality and the imposition of violence.

Slepoy insists on the specific meaning of the word *genocide,* which denotes that the state is functioning in a criminal way. In describing "the other terror," she contrasts two radically different ways of thinking about how the subject is constituted—one of which sees the individual as an island-universe, with only tangential relationships with the outside. This philosophy permeates modern law; it contains a possessive individualism. In the second way of thinking, described in the work of Rosenzweig and

[19] Moreno, J. (2002). *Ser Humano: La Inconsistencia, Los Vinculos, La Crianza [Human Being: Inconsistency, Links, Raising Children].* Buenos Aires, Argentina: Libros del Zorzal. See also Cairo, I. (2007). Review of *Ser Humano: La Inconsistencia, Los Vinculos, La Crianza. J. Amer. Psychoanal. Assn.,* 55:1064-1073.

[20] Agamben, G. (1998). *Homo Sacer: Sovereign Power and Bare Life,* trans. D. Heller-Roazen. Stanford, CA: Stanford Univ. Press.

Levinas, the subject *requires* that an other be constituted.[21] Within democracy, there is terror, and there are hierarchical relationships that are totalitarian, which are often manifest in an empty discourse about freedom. Subjected to institutional rulings, individuals do not have the chance to symbolize.

Referring to a previous paper, the author establishes a continuum throughout the century between different times and places of genocide. She believes this continuum casts doubts on our culture's possibility to recover.

Finally, Slepoy refers to analytic practice, highlighting that our task always involves delineation of the superego. She believes that in the particular analytic link between analyst and analysand, a clear aspect derives from superego constellations. She has observed the way in which moral imperatives create obstacles to analysis. She distinguishes positive transference from sublimated transference, with the latter being the one that establishes a link with an absent object, the unconscious, thus making symbolization possible.

Whereas there is agreement on the need to suppress superego objections to free association, less attention has been paid to the need to do the same with the analyst's free-floating attention. Many times, the terror connected with moral imperatives is what creates obstacles to association and to interpretation. Slepoy refers to Meltzer's distinction between "routine" interpretations, which have a didactic character, and "inspired" interpretations, which have a creative character.

Elegy for the Humanity of the Enemy. By Marcelo Viñar, pp. 399-419.

The author ponders what vertices the psychoanalyst might utilize to think about terrorism. How does his knowledge articulate with that of other disciplines? He points out that many analysts declare that the right position is to abstain from any opinion, stating that psychoanalysis is not the right tool to evaluate such ideas. This, the author believes, is a dangerous position, which alienates us from our world and makes us abdi-

[21] See Cohen, R. A. (1994). *Elevations: The Height of the Good in Rosenzweig and Levinas.* Chicago, IL: Univ. of Chicago Press.

cate our creativity. But a simplifying discourse makes the enemy a different individual—an alien figure—and this, Viñar believes, is also dangerous.

Quoting Manuel Castells, he reflects that the reverse of globalization is the ascendance of ethnic and religious fanaticism.[22] He affirms that in our midst, public events shake the privacy of our task. He supports himself by drawing on the Freud of *Totem and Taboo* (1912–1913), *Group Psychology and the Analysis of the Ego* (1921), *Moses and Monotheism* (1939), *Civilization and Its Discontents* (1930), and *The Future of an Illusion* (1927). (These works were characterized by Laplanche as the sociopolitical axis of Freudian reflection.) The author feels he is allowed a different perspective; Hannah Arendt, Serge Moscovici, Tzvetan Todorow, and Manuel Castells have contributed to amplifying his capacity to listen. He reminds us that Freud drew on anthropology, and that he established a dialogue with Gustave LeBon.[23]

Psychic experience begins with absorbing the good and expelling the bad, and this principle forms the root of seeing what is different as alien, aberrant, something to expel, to cast away. Naturally, we need to understand, as analysts, the etiology of cruelty. But as our discipline grows and becomes clearer, our borders also expand, creating new and as-yet obscure frontiers of vast areas where we see with humility that we do not understand enough.

Thus, we need to appreciate the input of other avenues of scientific discourse—e.g., sociology, economics, politics. Dialogue with other disciplines will enrich our understanding; analytic listening alone is not enough. The inertia of our discipline makes dialogue difficult, but we must make the effort.

[22] Castells, M. (1997–2000). *The Information Age: Economy, Society, and Culture.* Oxford, UK: Blackwell.

[23] LeBon, G. (1896). *The Crowd: A Study of the Popular Mind.* Atlanta, GA: Cherokee Publishing, 1982.

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