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# PSYCHOANALYTIC SUPERVISION: THE SUPERVISOR'S TASKS

BY OTTO F. KERNBERG

*This paper reviews key aspects of psychoanalytic supervision, including the capacity to combine a teaching function with an openly expressed evaluating one; communication of a clear, interpretive theory of technique, combined with an intuitive reaction to the totality of information gained in the supervisory situation; a combination of collegiality and honest communication with the candidate; and the awareness of reciprocal parallel processes. Reducing the influence of institutional dynamics, particularly those related to authoritarian pressures, is another responsibility of the supervisor. These tasks also involve discrete understanding and management of countertransference developments in both supervisor and supervisee.*

**Keywords:** Parallel process, authoritarianism, institutional dynamics, analytic theory, analytic technique, transference-countertransference, analytic supervision, analytic research, group supervision, videotaping, clinical formulation, intuition.

## THE TASKS OF THE PSYCHOANALYTIC SUPERVISOR

A review of the literature on supervision in psychoanalytic psychotherapy and psychoanalysis indicates that the major emphasis is on what the supervisee needs to learn, how this learning can be achieved and evalu-

Otto F. Kernberg is the Director of the Personality Disorders Institute at New York Presbyterian Hospital, Westchester Division, New York, and a Training and Supervising Analyst at Columbia University Center for Psychoanalytic Training and Research.

ated, and what problems the supervisee needs to face and resolve in order to achieve competency as a therapist (Arlow 1963; Blomfield 1985; Greenberg 1997; Junkers, Tuckett, and Zachrisson 2008; Martindale et al. 1997; Target 2002; Wallerstein 1981). In what follows, I would like to focus on the tasks of the supervisor, what should be expected of him or her, and the difficulties one finds with supervisors rather than supervisees. Jacobs, David, and Meyer (1995) included this focus on the supervisor in their broad, systematic approach to supervision across the spectrum of psychoanalytically oriented treatments. Here I wish to focus particularly on the specific tasks of the supervisor of psychoanalytic candidates.

Tuckett (2005) and Szecsödy (2008) have contributed significantly to a review of the criteria involved in evaluating a candidate's psychoanalytic competence. It is generally agreed that a supervisor's responsibilities are to transmit to the supervisee knowledge of the application of psychoanalytic theory to psychoanalytic technique, with particular reference to the skills required to carry out the technical requirements of the supervised case. It is commonly accepted that a collegial attitude should be stimulated and maintained, with the avoidance of an authoritarian ambiance that conveys a supervisor's sense of seniority or superiority to the supervisee.

The simultaneous function of teaching and evaluating the candidate requires, of course, an honest assessment of the supervisee's work. Some supervisors find it difficult to combine teaching within a collegial atmosphere while critically evaluating the candidate, and yet that is an essential task of supervision (Junkers, Tuckett, and Zachrisson 2008). This dilemma is sometimes masked behind the façade of an analytic attitude, whereby the supervisor communicates relatively little to the supervisee, expecting him to guess the supervisor's views through carefully formulated hints. That, of course, runs counter to the mutual sharing of experience implied in a collegial attitude in which both participants learn in the process of supervision.

Beyond these commonly accepted tasks, I wish to stress the importance of an integrated view, on the part of the supervisor, of the field to be explored, communicated, and shared, so that the supervisor's concrete recommendations about technical interventions should be embedded in

and reflect the application of his or her particular theory of technique. Some might argue, however, that an integrated theory of technique militates against free-floating attention and an intuitive response to the immediate situation that would capture the communication of unconscious meaning from patient to supervisee, from supervisee to supervisor, and from the supervisor to both supervisee and patient in terms of his or her countertransference reaction.

Nevertheless, I propose that there is no reason why such an intuitive process that absorbs, one might say, the total relationship of patient/supervisee and supervisee/supervisor could not be incorporated into a more general frame of reference that would permit the supervisor to transform an intuition into an interpretive remark. Such an implicit frame of reference, of course, is unavoidable as part of the selective focus of what the supervisor sees as essential at any point. The "selected fact" depends not only on immediate intuitive capture of the analytic situation, but also on the particular theory that orients the focus of the analyst's intention.

One can recognize psychoanalysts with different theoretical formulations in their apparently intuitive reaction to a supervisee's material. Intuition is a form of rapid processing of unconscious and preconscious components from within the theoretical frame of reference in which the supervising analyst has been trained. It might be argued that many supervisors have not formulated such an integrated view that underlies their own interventions, and some may even be reluctant to clarify such a view for themselves. My argument is that this formulation should become an ongoing task for the supervisor; carrying out such a task may become an important contribution to the supervisory process.

For example, a candidate whom I supervised presented a session with a narcissistic patient who had severe difficulties in his relationships with women, who were never good enough for him. In the first part of the session, the patient had criticized his girlfriend for her neglectful attitude toward her apartment, and what he considered her exploitiveness of him. Then he had talked in a desultory tone about a visit to a friend's house. His friend, he said, was happily married to a stupid woman and enjoyed a rather poorly paid job, but seemed happy with his lot. The

patient then described his serious doubts about continuing the relationship with his girlfriend.

My supervisee had interpreted the patient's suspicious attitude about his girlfriend as a projection onto her of his own exploitive feelings, and the devaluation of his friend's life situation as a defense against the patient's envy of the friend's capacity for a satisfactory life and love experience. And the patient had listened to these interpretations with his habitual signaling of acceptance of them, but without any further emotional elaboration of this material. To my supervisee, it seemed an empty session.

I explored with my supervisee his sense of the session's emptiness, as well as the patient's conveying both apparent interest in the interpretation and a lack of emotional reaction to it, and then I suggested that the patient had enacted his defenses against unconscious envy of the analyst in the transference. The unconscious aspects of the conflict with his girlfriend were being enacted in the transference. The patient had been "learning" the meaning of his associations, rather than using the analyst's comments as a stimulus for his own associative processes. I used this session to go beyond the concrete analysis of feelings of emptiness in the countertransference to the analysis of the patient's mechanism of intellectualization and "cognitive learning" as an "appropriation," in replacement of an authentic dependency on the analyst. To this narcissistic patient, dependency on the analyst meant to accept needing him, to accept the analyst's freedom to work, and to establish a trusting relationship—all of which would cause profound and, so far, probably intolerable envy to the patient.

From here, we went into a more general discussion of the importance of conflicts around unconscious envy in narcissistic pathology and its impact on transference developments. This supervisory instance illustrates, I believe, the shift from a concrete exploration of the immediate situation to the more general theory of technique on which a concrete interpretation would be based.

From the viewpoint of the supervisor's task, such an integrated frame of reference is not to be rigidly "superimposed" on his or her intuitive reaction to the material, but consciously elaborated and formulated in the supervisor's mind so that it can be called upon to "explain" the reasons

for the recommended intervention that, at first, seemed to be based on pure intuition. This integrated frame of reference requires knowledge and intellectual discipline, matched by an internal freedom for intuitive reaction to the material and its unconscious implications. Learning about the theory of technique that constitutes the organizing integration of the supervisor's intuitive listening and clinical formulations permits the supervisee to learn not only how to deal with a concrete situation, but also about the supervisor's way of thinking, the internal frame of reference from which he or she operates. This facilitates understanding not only of how to intervene in the concrete situation, but also of how to generalize that learning into a gradually expanding, integrated technical framework.

This viewpoint is critical of a not-too-infrequent situation in which the supervisor provides the candidate with wise comments or suggestions that seem to come from a position of profound understanding, without leading to the candidate's possibility of tracing such wisdom back to a general theoretical orientation from within which the concrete formulation would make eminent sense (although that theory might permit other interventions as well).

The supervisor's responsibility to articulate to the candidate his or her particular theory of technique may carry the risk, however, that the supervisor will end up presenting his position as "the only acceptable" one, or that, at any rate, the supervisee will reach such a conclusion—particularly if the supervisor's theory of technique corresponds to the dominant one at that training institute. The supervisor, while spelling out his or her personal views, should also keep in mind a responsibility to alert the supervisee of alternative ways of conceptualizing the issue under consideration, and related, alternative ways to intervene technically. In addition, the goal of stimulating the supervisee to explain his or her own ideas about how interpretations have functioned to move the analytic process forward should reinforce the supervisor's efforts to counter the authoritarian implication of imposing a particular theory of technique.

The supervisor's responsibility to articulate a clear, integrated theoretical foundation of his or her own requires active, ongoing work. It is a creative burden that forces the supervisor to critically review all inter-

ventions and recommendations made to the candidate, and to rework his or her theory of technique throughout time. I believe that the supervisor may be expected to grow and to continue developing a working understanding of psychoanalytic and psychotherapeutic techniques as supervisees present the infinite novelty of clinical situations that evolve in interactions between patient and candidate and between candidate and supervisor.

Related to this requirement is the importance of the supervisor's sharing with the candidate how the supervisor him- or herself would respond to the specific clinical situation being interpreted. While focusing on what the supervisor recommends that the supervisee do, the supervisor might often state what he or she would be thinking and doing under those same concrete circumstances.

## INSTITUTIONAL AGENDAS

Supervision takes place, usually, in the context of an organizational institution, be it a psychoanalytic institute, a university outpatient department, a private or public mental health clinic, or a hospital setting, all of which have their own structural characteristics, institutional biases, and realistic expectations of learning on the part of the supervisee, as well as other, "hidden" agendas. Hidden agendas usually relate to problems around authority within the institution, legal or financial requirements that determine the boundaries of tolerance of atypical treatment situations and risk aversion, and/or idiosyncratic rules and regulations of individual supervisors. It might be trivial to refer to this fact were it not that these agendas may powerfully influence the supervisory process—determining, for example, a treatment approach that might be less than optimal, because what would be optimal would run counter to the institution's financial and/or political constraints, or implicitly activate ideological struggles within it.

For example, if a psychoanalytic institute has a predominantly ego psychological approach, but a supervisee is particularly interested in applying a self psychology approach to a patient, the supervisor might support this, or not, according to the flexibility provided in the teaching programs of that institute and the supervisor's degree of willingness to

depart from his or her own theoretical beliefs. The practical implication of this issue is that a *parallel process* evolves—not only in terms of the supervisee's unconscious enactment of a role reversal of experienced but not understood problems in his or her relationship with the patient, but also in the sense that the same process may be activated by the supervisor's subjectively experienced, unresolved conflicts with the institution in which the supervision takes place. In the latter situation, the supervisor enacts the conflict with the institution in a corresponding role reversal with the supervisee.

An example of this type of parallel process was seen in the case of a Kleinian-oriented psychoanalytic institute in which an intersubjective/relational approach had been adopted by a significant group of "rebellious" faculty members. A hostile interaction developed between one of the Kleinian supervisors and a supervisee who was interested in the intersubjective/relational approach, so that the institutional dynamic was replayed in the individual supervisory relationship.

The phenomenon of parallel process illustrates, better than anything else, the activation of unconscious relations in the supervisory process (Baudry 1993; Kernberg 2006). Unconscious countertransference reactions of the supervisee, usually related to an unconsciously registered but not consciously elaborated aspect of the patient's transference, are enacted in the supervisory situation. Such reactions are then "discharged" with a role reversal in which the supervisee unconsciously identifies with that aspect of the patient, while projecting the corresponding countertransference reaction onto the supervisor. The supervisor's alertness to this development, on the basis of the diagnosis of a specific distortion in the supervisory relationship, may help clarify the meaning of this transference-countertransference bind; but this process demands an open, honest, collegial relationship.

I believe it is very helpful for the supervisor, aware of institutional conflicts that may be affecting his or her subjective attitude toward the supervisee, to bring this out in the open. At the same time, the supervisor should feel free to point out the parallel process in the supervisor–supervisee relationship as possibly influenced by an unrecognized or unresolved countertransference problem in the supervisee's relationship with the patient.

In a group supervision at a Kleinian-oriented psychoanalytic institute, a candidate presented a case to me by starting with a recent session. He provided a minimum of preliminary information about the patient's earliest life experiences and went on to read his summary of the session. I interrupted him to say that I was interested in the patient's present difficulties, and, particularly, in a brief summary of the patient's present problems in the areas of sexual love, work, or social life. The group reacted quite strongly in reminding me of the recommendation to analyze "without memory or desire." I acknowledged their reaction and expressed my admiration of Bion (1967), but also pointed to some differences in my approach, and wondered whether we could work together in sharing both similar and dissimilar ways of reacting to the material of the session. The tension in the group decreased noticeably, and I believe we were able to learn from each other; I had the opportunity to illustrate my view about the potential relationship between presently dominant life conflicts and the predominant transference development.

Such an open exchange in the supervisory process may bring about an honesty that reduces the highly prevalent paranoid fears of the supervisee, particularly in authoritarian organizations, and in turn fosters honesty of communication regarding the psychotherapeutic or psychoanalytic process, and facilitates countertransference analysis of the supervisee in a non-threatening, non-intrusive way.

## COUNTERTRANSFERENCE EXPLORATION

In this connection, the exploration of the supervisee's countertransference is an important yet delicate aspect of the supervisory process. I believe that it is very important to generate a collegial atmosphere in which the supervisee may feel free to openly explore his or her countertransference reactions, including those to the supervisory process of that particular patient. The supervisor may use countertransference analysis to explore aspects of the nature of the patient's transference that may have impacted the supervisee's subjective experience, but have not been fully understood and elaborated by the supervisee.

The analysis of how the patient contributes to the countertransference reaction of the supervisee is what is important here, while main-

taining a tactful respect for the boundaries of privacy regarding deeper aspects of the supervisee's conflicts that may have been activated in the supervisory situation. Supervision should not become a psychotherapeutic process; conflating the two usually leads to regression in the supervision, tends to blur the clarity of the supervisory process, and may interfere with the collegial aspects of the relationship. It may also foster transference displacement and acting out by a supervisee in relation to his or her personal psychoanalysis.

For example, I supervised a candidate for the treatment of a severely narcissistic patient who presented unstable object relations, sexual promiscuity, and an unconsciously envious and derogatory behavior toward women. After telling me that her patient had expressed sexual fantasies about her in a clearly seductive way, the candidate—a highly intelligent woman who was usually secure and open—told me that this had made her feel very insecure, and in fact she had difficulty dealing with the patient. We explored this further, and she finally said: "I have to confess that if I met this man one evening in a bar without any prior knowledge of him, I would be tempted to go to bed with him."

I commented that she was making it clear he was attractive to her as a man, but what was it in him that made her afraid of him? This led us into a discussion of the controlling aspects of his seductive behavior: his implicit attempt to undermine her authority as an analyst and to transform her into his image of a desirable and unavailable woman whom he would be tempted to "conquer," which was his usual behavior pattern—unconsciously motivated by envy and hatred of women, whom he perceived as teasing him. I expressed appreciation of the candidate's capacity to talk honestly about her feelings with me, but focused on the meaning of the patient's induction of those feelings, and I respected the candidate's privacy regarding the particular unconscious tendencies that might have made her feel particularly attracted to this man.

Some degree of idealization of the supervisor on the part of the supervisee is probably unavoidable under conditions of a good supervisory experience, particularly if the supervisee is simultaneously experiencing regressive reactions in a psychoanalytic treatment. The supervisor needs to keep in mind that, in all interpersonal situations in which there is a role distribution between one who "knows" and one who "needs to

know," an implicit de-skilling of the latter may occur, with the consequent attribution of all knowledge and skills to the supervisor and a self-devaluation of the supervisee. Efforts to maintain a collegial attitude through direct, open, "non-oracular" communication of the supervisor's knowledge and experience may modify the idealization into a creative, warm professional relationship, in contrast to an idealized one that fixates the supervisee's conviction that the supervisor will always know better and will always be superior, and a permanent hierarchy will remain in their relationship.

Such a negative fixation at an idealizing level is not infrequent, particularly in institutions with highly prestigious, powerful, and even guru-like figures, whose own narcissistic needs may foster a tendency to surround themselves with admiring students. The encouragement of mutual or peer supervision by groups of trainees who already have some years of experience is one helpful countermeasure; in the process of "intervision," in contrast to "supervision," trainees may become aware of possessing more understanding and skills than they have been conscious of in supervisions with revered elders.

## THE DYNAMICS OF GROUP SUPERVISION

This leads me to the process of group supervision, which may be very helpful in integrating the developing experience and knowledge of supervisees, while also providing them with a more realistic awareness of the limitations of the supervisor's knowledge. In a group situation, there is an opportunity to examine the clinical aspects of a case from many different perspectives, thereby providing a richness and diversity of understanding that does not privilege any one line of thought over another.

It is helpful for the supervisor to acquire a knowledge of group dynamics, which will permit him or her to utilize the supervisory group situation itself as a teaching instrument. I am referring here to the role distribution that automatically occurs in groups as an expression of the parallel process characteristic of the individual supervisory relationship. In practice, an unresolved transference-countertransference fixation in a case presented to the group may elicit a range of responses in the group—responses that correspond to conflictual or split-off aspects of

transference and countertransference in that case. Joint analysis by the supervisor of these different reactions to the material may provide an in-depth analysis of the dominant transference-countertransference situation that the presenter "discharges" in the group, without being fully aware of the issues that he or she is implicitly communicating.

Naturally, this process tends to be obscured when the supervisor acts as though he or she were the only source of knowledge regarding the problems presented in the case under review. In fact, such an assertion of the "last word" by the supervisor may inhibit communications in the group and, therefore, the learning process itself.

An interesting expression of institutional dynamics occurs when the members of a supervision group each have individual supervisors of the cases that they present to the group. (The same dynamics are also present in continuous case seminars in a psychoanalytic institute in which only one candidate presents a case in treatment—as long as that candidate's individual supervisor is not also the group leader.) Under these circumstances, significant differences in the approaches of the individual supervisor and the group supervisor may rapidly emerge to challenge the candidate—and the group supervisor—in many ways. Rivalries between the two supervisors may implicitly color group interactions, and the trainees' shared anxieties over these discrepant views may emerge either timidly or openly. This is an excellent opportunity to point out that to be exposed to different viewpoints has an enormous educational advantage, in that it forces the student to consider alternative frames of reference, compare them, and develop his or her own synthesis.

I supervised a candidate who presented a patient with a marked hysterical personality disorder and strong masochistic features, both in her relationship with her husband and in the transference. I helped the candidate see the patient's chronic fights with her husband as the unconscious expression of profound oedipal guilt and related submission to a dominant but also deeply frustrated mother, whose own marriage had been a very unhappy one. At one point, the supervisee presented the patient to a group supervision conducted by another training analyst at my institute. After a few weeks it became clear that, in that group, the patient's marital conflicts were seen as expressing the profound frustra-

tion of her oral-dependent needs in her relationship with her mother, now reenacted in her relationship with her husband.

The candidate was tense and troubled: she told me that the group supervisor had questioned her interpretive approach, and that much of what was being suggested in the group supervision made sense to her. My countertransference reaction included a sense of irritation with the candidate, a sense of competition with the group leader, and, as I also recognized, a complex condensation of my oedipal rivalry with the group leader with the candidate's enactment of her patient's masochistic pattern with me. And, at a different level, I was frustrating the candidate's dependency wishes on me . . . .

I decided to share with the candidate these interpretations of the institutional situation and their relevance to the understanding of her patient's transference situation. I invited her to elaborate this situation in her own mind while feeling free to discuss all of it with me, and to reach her own conclusions in further exploring her experience with the patient. I said that I felt "a lot of competition was in the air." Her presentation to the group, I noted, at first brought about a potential competition between her view identified with mine, and that of the group supervisor. Then she felt identified with the group supervisor and in competition with my view.

One might say that—leaving the objective analysis of the patient's treatment situation open—the candidate had been afraid to oppose the group supervisor, subordinated her view to his, and now was afraid of disagreeing with me, asking for my help in dealing with this situation. In fact, I added, I too had felt in myself a sense of competition with the group supervisor, and a slight sense of corresponding irritation with her (my supervisee). The situation could also reflect an institutional discussion, I commented, around the relative importance of oedipal and preoedipal conflicts. I thus replicated in my countertransference the same activation of feelings of the "danger of aggression" in this competitive situation, and I was running the risk of threatening the supervisee's helpful dependent relationship with me.

I wondered whether, if I was right, this entire situation might unconsciously repeat the transference-countertransference situation: the patient's inducing in the candidate-analyst a wish to respond positively

to the patient's demand for understanding and help in dealing with her "impossible" husband, while the analyst was struggling with confronting the patient with her provocative behavior toward her husband out of unconscious guilt over the "forbidden" sexual relationship with him.

My intervention, I believe, calmed the supervisee and opened the road to further exploration of her understanding and management of the treatment situation. She thoughtfully reflected on her internal conflict between her wish to assure the patient of her empathic understanding, and what she saw as a need to confront the patient about generating unwarranted fights with her husband, as though to maintain a good mother–daughter relationship at the cost of the marital one.

In fact, as has been pointed out by various authors (Galatzer-Levy 2004; Levin 2006; Shane and Shane 1995), the exposure of trainees to alternative viewpoints in the context of a non-authoritarian institution fosters the learning process as well as professional maturation. It may be argued that, to the contrary, exposure to such contradictory views may lead to chaos and confusion; this may be true, particularly when there is no forum in which different viewpoints can be aired and compared, and instruments provided to the students with which to arrive at their own synthesis. Psychoanalytic institutes today may be facing a major challenge in determining what basic "common theory of technique" may be available to provide a solid ground for students that will permit them to reach educated decisions regarding alternative approaches.

One test of the extent to which a trainee has achieved a reasonable ability to internally evaluate different viewpoints is to assess the trainee's ability to develop an integrated frame of reference for his or her own technical understanding and approaches. The trainee's understanding and approaches should not rely on a chaotic, eclectic mixture of different approaches in different situations that do not give evidence of a common, integrative framework as the basis for which a move into alternative techniques can be justified.

## PROFESSIONAL RESPONSIBILITY

An important issue that is often not fully clarified is the question of who carries the responsibility for the patient. The ideal situation between su-

pervisor and supervisee is one in which both parties are clear that the supervisee ultimately carries this responsibility. The supervisor has the freedom to recommend a way of handling a situation, while the supervisee has the freedom to accept or reject that recommendation, using his or her own judgment, with awareness that the ultimate professional, legal, and personal responsibility for the patient rests with the supervisee.

In many educational institutions, however, the ultimate responsibility may lie with the institution, particularly from a legal standpoint, and this then limits the degree of freedom that both parties have in relation to the treatment approach. When the supervisor, in representing the educational institution within which he or she supervises, carries the responsibility for the well-being of the patient, his or her responsibility to the patient, the supervisee, and the institution must all be carefully weighed. In most cases, this does not impinge on the supervisory process; but when there are serious problems in the functioning of a supervisee, or "impossible" clinical cases that create high-risk complications for the institution, the distribution of these responsibilities must be spelled out clearly and openly, with the understanding that the supervisee, under certain circumstances, may have to comply with the supervisor's instructions.

The extent to which this is a problem naturally depends on the particular ideological and legal culture in which the educational institution operates. In the United States, with its highly litigious culture, this issue becomes very important with problematic cases. My main point here is that the extent to which responsibility for the patient rests in one or another professional, or is shared by them and an institution, should be clearly communicated.

A psychoanalytic candidate treated a patient with a severe personality disorder in analysis as part of his practice within a university hospital. At one point, the patient became acutely suicidal. It seemed to me, the supervisor, that this suicidal tendency was not linked to a depressive reaction, but was part of a characterological pattern that needed to be analyzed rather than treated with a preventive hospitalization. However, I was concerned about who was responsible for making that decision. I could have documented the reasons for my recommended approach,

but the patient was not my patient. The candidate was part of an institutional system—the hospital—that had a very conservative view of such situations.

After clarifying the various responsibilities involved, the supervisee and I decided that he would consult with his administrative supervisor in the hospital on this case. The supervisee would then make the decision about the strategy to follow in the light of that consultation. I committed myself to helping him regardless of his course of action.

This leads to the issue of limitations in the candidate's professional functioning, and the responsibility of the supervisor in circumstances where this is problematic. The supervisor's honesty is essential with trainees who, for a variety of reasons, are not able to achieve the minimal level of skills required. Situations in which a supervisor internally gives up on a supervisee—without honest and courageous communication about it, directly to the supervisee—are not infrequent. The supervisor has a responsibility to the institution and the profession, as well as to the supervisee and the patient. Following are examples of cases in which such painful moments of truth emerge.

## CANDIDATES' PSYCHOPATHOLOGY

First, there is a great reluctance to acknowledge the possibility that—particularly at advanced stages of psychological and/or medical training—a supervisee who has been able to reach the point of specialization in psychotherapy or psychoanalysis may not have the intellectual capacities to carry out such work. It is, of course, difficult to differentiate a lack of emotional introspection or of awareness of the depth of human feelings as an expression of character pathology from cognitive factors per se, and the supervisor, without the availability of psychological testing or alternative sources of information, may not be in a position to make this differential diagnosis. The usual assumption is that the supervisee is *emotionally* incapable of achieving adequate competency. The safest way to reach such a conclusion, of course, is to provide the supervisee with ample opportunities to learn in the supervisory sessions, patiently repeating the same information while evaluating to what extent a learning process is taking place.

The supervisor is responsible for remaining alert to what happens to his or her contributions—to what extent they function as seeds planted that grow and flourish, or, conversely, whether they resemble young plants that perish in the desert. Individual supervisors may disagree on the length of time that is reasonable for a supervisee to begin to demonstrate certain core competencies, but there comes a point when a failure to learn may have to be addressed. When it becomes evident that repeated clarifications in the supervisory situation do not bring about change, and that the same problems emerge again and again, this should, of course, be shared openly with the supervisee.

The following case was one of the most painful experiences in my functioning as a supervising analyst. The candidate had been able to obtain a full education in medicine and psychiatry—helped to achieve this goal, it must be said, by the efforts of a particular agency, throughout her life. She was a warm, responsible, engaging person who was received with open arms at an international institution that was particularly interested in fostering the higher education of members of a minority group, including psychoanalytic training.

I was one of three visiting supervising analysts (from a different country) at the international institution that supervised the candidate's work, and my impression from her interaction with me was that she was not capable of achieving further learning. Although she had had almost two years of supervision, I felt that I had to repeat the same suggestions over and over again, and that, while she almost desperately tried to use what I had said in the following sessions with her patient, no long-term traces of our discussions were evident. I spoke with her openly about the situation, more and more frequently as time went on, and she was straightforward in conveying her difficulty in transferring general principles from one situation to another.

I could not identify any major characterological difficulties in the candidate, and after a time, I consulted with two other supervisors about her situation. All three of us had exactly the same experience: we all wanted to help her but could not. We studied her past records and discovered that she had had significant learning difficulties all along, and was able to reach this advanced stage of her professional career only through extremely hard and consistent work. She had a fine memory,

which had helped her through all her educational experiences, including medical school. Our conclusion was that she had some kind of cognitive limitation or impairment, and, finally, we recommended a shift in her career direction, as well as a neuropsychological examination if she were interested, and we suggested a suspension of her psychoanalytic training at that institution.

A frequently encountered situation that may lend itself to confusion with the previous one is the case of a candidate with significant narcissistic pathology who, although eager to learn whatever new knowledge is offered, soon becomes convinced that he or she has absorbed it all and that there is nothing new the supervisor can offer. This type of supervisee tends to show an excessive degree of idealization at the beginning, followed by subtle devaluation of what he or she has received. Such trainees seem to absorb what the supervisor offers as simple or clever formulas that are useful only as such, but lack the capacity to authentically expand the supervisee's own elaboration and development of the material.

Sometimes severe narcissistic pathology manifests in the form of an excessive enthusiasm for some new, "original" development that seems to be offered by a certain supervisor, but this is followed by the trainee's disappointment or disillusionment, and then by the search for another new, magical approach with someone else—leading to surprisingly radical shifts in approaches by the candidate that, in the end, reveal a superficial acquisition of each new theory of technique.

Supervisees with significant emotional immaturity, whose personal chaos not only distorts their capacity to listen to patients but also does not permit them to integrate new learning in a significant way, constitute another source of frustrating supervisory situations. However, the gradual resolution of conflict and personal growth achieved in the trainee's psychoanalytic or psychotherapeutic treatment may improve the supervisory experience significantly.

The key challenge in all limitations to learning is to determine the cause. To what extent is the supervisor, his or her attitude or approach, part of the problem? To what extent is the supervisee's personality or intelligence a significant factor?

We must acknowledge that significant psychopathology on the part of the supervisee may sometimes remain undetected even by very expe-

rienced supervisors. Simultaneous supervision of each trainee by several supervisors significantly improves the likelihood of diagnosing serious difficulties and resolving them in the educational process. Such an arrangement, of course, is not possible in the private supervision of an independent mental health professional by another one, but should be possible in institutional settings, particularly in departments of psychiatry—and even more so in psychoanalytic institutes, where the educational structure is so focused on supervision. Regular meetings of supervisors to discuss supervisees, particularly those who seem to present problems, may help clarify issues that, for the individual supervisor working alone, may take much more time to fully appreciate.

For example, I once supervised a fourth-year (!) psychiatric resident who was treating a very ill borderline patient. I found it impossible to get a clear view of this patient, in spite of the fact that the supervisee seemed very clear in what he was saying, seemed to have a good understanding, and was quite open. But the patient was getting worse by the day, with all kinds of complications emerging—in the patient's life, in the patient's relationship with the therapist, and in the therapist's relationships with other mental health personnel connected with the treatment. I was tempted to see the patient myself in order to find out what made it so difficult to get a live picture of the patient throughout the supervisory process.

I decided to discuss the situation with the supervisory group connected with this supervisee's progress. I found out that, not only did other supervisors have the same difficulties with him, but there were also very serious questions about his ethical behavior. In the middle of our discussions, this supervisee disappeared from the map, abandoning his functions as a resident without formal resignation, and had to be formally dismissed from the program.

Another fourth-year resident was invited to continue the treatment of the patient whose care I had supervised, and, after a few weeks of supervision with the new trainee, not only did I have a clear understanding of what kind of person the patient was and of the main conflicts to be explored, but all the complications in the patient's relationships with other professional staff and in the patient's life began to resolve as well. A transference-countertransference bond established with the new thera-

pist could now be meaningfully explored in the supervisory sessions. In short, I had missed the first trainee's severely antisocial features and his capacity to convey a pseudo-mature understanding that in fact reflected consistent distortions of the information I had been receiving from him.

## SUPERVISORY MATERIAL

It is helpful for the supervisor to show flexibility in letting the supervisee choose in which form he or she wishes to present case material to the supervisor, with the agreement that, in turn, the supervisory material selected can be flexibly chosen as well, incorporating information on tactical and strategic interactions and interventions.

In this regard, it is interesting to note that studies of a brief segment of one session, of an entire session, of a sequence of sessions, and of development in the treatment over a period of weeks typically reveal the same structure—in other words, the same transference-countertransference pattern and dominant defensive operations throughout those very different time spans. The macro cosmos of the session reproduces the micro cosmos of the interaction in a brief segment of it. The shift from studying segments of a session to studying what happens over weeks, and vice versa, provides a third dimension to the evaluation of the clinical material and of the trainee's learning process. Many supervisors insist on receiving no written notes, but only subjective information on the basis of brief summaries the supervisee has made for him- or herself, while other supervisors require detailed process notes of verbal interactions in their natural sequence. Again, flexibility and shifts in approach in this regard, over time, seem optimal.

Informal, verbal communication on the part of the supervisee provides rather imprecise information about the concrete therapeutic dialogue, but excellent information about the supervisee's general understanding, attitude, and parallel process. Detailed written material, drawn from written notes or audio recording during the hours, provides a more accurate reflection of the dialogue and of the therapist's interventions, but may miss some of the subtleties of emotional interactions that are communicated by means of the parallel process. Listening to audiotapes of sessions conveys more clearly the emotional interaction and gives a

very full sense of what has been happening in the session, but, because of the slowness of the process of replicating the timing of development in the sessions, it is usually necessarily limited to listening to segments of a particular session.

Viewing videotapes of psychotherapy sessions provides maximum information of content and attitudes, and permits judgments regarding transference and countertransference by means of the shifting nonverbal behavior of patient and therapist. A limitation, of course, is the difficulty of building videotaping into the therapy in a natural enough way so that it does not significantly distort the therapeutic process. Videotaping also reduces evidence of the parallel process in the supervisory sessions: the supervisee is cast into a passive spectator role. However, all in all, videotaping may be the best source of information about the overall functioning of the therapist, and often there are surprisingly marked differences between what the therapist reports and what one sees on video.

Perhaps the main problem with videotaping is that, in the case of psychoanalytic treatment, most of the information is gained through the patient's verbal communication of subjective experience, with relatively little nonverbal, visually observable interaction occurring in the sessions—which makes videotaped psychoanalytic sessions extremely boring to watch, to the extent that the supervision may become a self-defeating process. In contrast, in the case of psychoanalytic psychotherapy, particularly with severely regressed patients, where intensive behavioral, face-to-face interactions between therapist and patient are registered, videotaping—in our experience at the Personality Disorders Institute at Cornell University—is by far the most effective way of facilitating the supervisory process.

In this connection, it must be recognized that the bias against videotaping psychoanalytic sessions is so strong in many psychoanalytic circles that even the exploration of this medium as a potential contribution to the supervisory process may shock some psychoanalytic colleagues. This is not the place to address this issue in the contrasting light of experiences in various research-oriented organizations that have confirmed the feasibility of psychoanalytic work under such circumstances. But I will mention that, on the basis of clinical and research experience spanning thirty years, it is clear that patients quite readily accept ongoing video

recording if they have been appropriately informed and assured of the confidentiality of those recordings, and the psychotherapeutic process is remarkably little affected by such arrangements. In our experience at Cornell, therapists who are just beginning their professional careers have significant initial difficulty with video recording due to their own self-consciousness, but they, too, quickly forget that the camera is there.

## GENERAL CHARACTERISTICS OF COMPETENCE

A research finding regarding the competence of therapists carrying out psychoanalytic psychotherapy may be relevant. Although this finding applies to psychotherapy rather than psychoanalytic supervision proper, I believe it may also be relevant in the latter.

Our work at the Personality Disorders Institute at the Department of Psychiatry at the Weill Medical College of Cornell University and the Westchester Division of the New York Presbyterian Hospital has provided us with important learning regarding the overall desirable personality qualities of therapists and the development of therapeutic skills in psychoanalytic psychotherapy with severe personality disorders. In the present paper, I shall limit myself to pointing out our conclusion that four relatively easily evaluated qualities of therapeutic interventions in psychoanalytic psychotherapy define the quality of psychotherapeutic work on the part of our trainees (namely, third-year psychiatric residents and beyond, and first-year postdoctoral psychology fellows and beyond).

These four determining factors of therapeutic interventions are:

- the relevance of the therapist's comments to the dominant affective issue evolving in the session;
- the clarity with which interpretive interventions are formulated;
- the depth to which those comments penetrate into the patient's dominant conflicts, particularly the unconscious layers of defense and impulse involved in the conflicts activated in transference and countertransference; and
- the speed with which the trainee is able to carry out such interventions.

This last feature may seem surprising, but the dissociative nature of patients' communications in severe personality disorders, the prominent role of enactment and acting out in sessions, and the prevalence of nonverbal behavior over what is communicated verbally about the patient's subjective experience combine to bring about rapid shifts in the content of the hours. These shifts require correspondingly rapid interventions, rather than patiently waiting for the material to clarify itself over time.

When everything goes well, it should be possible, over time, for the supervisor as well as for the supervisee to construct in their minds an integrated picture of the patient's personality, including a three-dimensional awareness of the present vicissitudes of the patient's conscious and unconscious life experiences and his or her relationship to significant aspects of the past. Supervisor and supervisee should also be able to experience directly which areas that have to be approached are now affectively dominant in the sessions, and which areas of the patient's life experience are glaringly absent in the treatment situation and therefore require an active focus. Mutual learning may occur as supervisee and supervisor freely express their views and questions about the patient.

For the supervisor, seeing the supervisee's growing independence in doing good work, supported by his or her capacity to convey new information and to provide new leads to the supervisor, is a gratifying experience of knowing one has contributed to the supervisee's autonomous growth. I have found it very helpful to vary the intensity and rhythm of my contributions to the supervisory process, ranging from periods in which I might very actively try to convey information and influence the therapeutic process, to those in which I might sit back and position myself on the receiving end as I listen to what is going on with the patient, and to what new contributions the therapist may make.

Good supervision becomes an extremely interesting learning process for both participants; a supervision that is failing can be a trying experience for the supervisor, one to which he or she should not react masochistically (or sadistically!). Over time, it will become clear to what extent the trainee is developing his or her own frame of reference, integrating knowledge received from the supervisor without there being a process of "surface imitation" that is often misread as identification with the supervisor.

A senior candidate would present her case to me with general reflections about what struck her most in a particular session or over a particular period. She might reflect on alternative ways to handle the material that she presented, and she very openly expressed uncertainties or doubts. She was able, in looking back at a set of sessions over a more extended time period, to venture hypotheses about where the analysis was going, or in what way she was changing her view about a particular development.

I had the growing feeling during that supervision that an experienced colleague was presenting a case to me. Not infrequently, I was surprised and stimulated by the originality of her interventions. I was learning in the process, and I told her so. Not surprisingly, she wrote a series of papers on the technical issues this case presented, making an original contribution to our field.

Körner (2002) defined the objectives of psychoanalytic education as the development of candidates' knowledge, technical skills, and analytic attitude. All three can be observed over time in the course of the supervisory process, and they facilitate a realistic evaluation of that process—an evaluation that, as mentioned earlier, must be shared fully and openly with the candidate, and the supervisor must remain open to the candidate's reactions to the supervisor's views. The supervisor's self-reflective function may be shared with the supervisee to an increasing degree over time, so that the supervisor's speculations, uncertainties, and possible alternative formulations regarding the patient can be made available in more direct and open ways, facilitating the supervisee's identification with the supervisor's self-reflective attitude. Transmission of this attitude, in turn, broadens and deepens the supervisor's pleasure in the supervisory process.

Last but not least, the supervisor may convey to the candidate the need to be very patient in tolerating the repetition of severe problems again and again, and the same transference developments over time, without losing patience, while maintaining an attitude of alertness and therapeutic "impatience" in every session. And of course, this also holds true for the supervisory process: there is a need to be patient over time, but also to attempt to maximally utilize every supervisory hour, while

remaining alert to the defensive operations and obstacles that may block that process.

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*New York Presbyterian Hospital*
*21 Bloomingdale Road*
*White Plains, NY 10605*

*e-mail: okernber@med.cornell.edu*

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# THREE PSYCHIC ORGANIZATIONS AND THEIR RELATION TO CERTAIN ASPECTS OF THE CREATIVE PROCESS

BY RICHARD B. ZIMMER

*The author describes three different ways in which individuals in psychoanalysis may make use of the analyst. Each brings together affective and symbolic communication in a different way and draws the analyst into a different way of relating. It is suggested that these reflect three organizations of the individual's experience of the object and of himself in relation to the object. Though not encountered exclusively in creative artists, each of these organizations, which the author calls analyst-as-mental-function, analyst-as-medium, and analyst-as-audience/interlocutor, is related to a specific aspect of the creative process.*

**Keywords:** Analytic relationship, creativity, analytic interaction, affects, symbolism, analytic process, object relations, transference, projective identification.

Daniel, speaking of his frustrations in finding love, came to the end of a train of thought. He fell silent for a few moments before resuming his associations. "Ah, people!" he mused. "People who need people—they're the luckiest people in the world!"

Behind the couch, I smiled ruefully. Daniel was inviting me to play our game. In the game, I am being cued to say, in a tone of mock wisdom, "Yes. They're children . . . needing other children . . . ," to which Daniel would reply, in a tone of mock discovery and insight, "And yet . . . letting their grown-up pride . . . ," and so forth.

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Richard B. Zimmer is a Training and Supervising Analyst at Columbia University Center for Psychoanalytic Training and Research, and an Associate Clinical Professor of Psychiatry at Weill-Cornell Medical College.

The game, of course, is an enactment, and, like all enactments, serves many functions, including defensive and affect-modulating functions for both patient and analyst, as well as potentially communicative functions and the opening of new channels for exploration. I have come to understand that it plays an important role in Daniel's analysis and to embrace it; at the same time, I continue to seek opportunities to explore and understand its many functions.

The game provides a brief respite in the midst of a serious endeavor—from moments that are too intense or, more frequently, from times when the analytic process seems to simply hit a wall. In these moments, we step back and gently mock ourselves—and each other—for the intensity with which we pursue the analytic task. A playful note is struck. Our verbal exchange is scripted by the lyrics of familiar songs. Our affective exchange is a caricature of analyst and patient working together to make an emotional discovery.

Sometimes, in the course of the game, Daniel will hit upon a lyric that strikes a fresh emotional chord, and this will lead to resumption and deepening of his associations. At other times, it is merely an opportunity to segue to less threatening material. But as the "game" moments became a part of the analysis, I became intrigued by the creative leaps that, at least some of the time, these moments seemed to facilitate, and curious about how this worked.

The "game" with Daniel involves both analysand and analyst switching to a different state of mind, associated with a different way of relating to each other and a different form of thinking and communication. It involves Daniel making use of me as an object in a different way. I believe that the creative process is made up of many such shifts in states of mind, and that these shifts reflect changes in the relation with an internal object and the way that object is constructed. Because the analytic process, at its best, is a creative collaboration between patient and analyst, it provides a unique opportunity to closely observe these shifts, and these observations shed light on fundamental aspects of the creative process itself. Here, when I speak of the creative process, I am not exclusively speaking of the professional work of individuals engaged

in the arts, but also the more everyday forms of creative thinking that most of us do about our work, our lives, and our inner worlds.

The individual engaged in creative work or creative thinking (whom I shall call "the artist"—again, not because I intend to speak only about individuals in the arts, but for economy of expression) has an inner experience, affective and cognitive, which he endeavors to express. He seeks to convey to his audience at least some part of this inner experience; in this effort to communicate, there is a tension between an appeal to the mind of the audience through symbolic communication and an appeal to the body of the audience through more direct sensuous stimulation. Put another way, the artist wishes simultaneously to tell his audience a story and to stir that audience to have the affective and sensuous experience of having lived it.

## AFFECTIVE COMMUNICATION, SYMBOLIC COMMUNICATION, AND PSYCHIC ORGANIZATION

The affective and the symbolic are two separate, if intertwined, channels in all human communication. Each of these two forms of communication is associated with its own way of experiencing the object. While it may be overly schematic to put it this way, we might consider that, through the channel of affective communication, the object is perceived, to one degree or another, as a "part object"—specifically, a container of projected contents (as described by Bion [1962]) that may also be used to metabolize and transform these projected contents and imbue them with meaning (what Bion refers to as α function). Through the channel of symbolic communication, the object is more likely perceived as a "whole object"—separate, complexly elaborated, having an internality of its own, and capable of being hurt or lost.

In my thinking about these two forms of communication, I have found it useful to think of them not as particular to two "positions," one of which evolves from the other, and of which only one can be occupied at any given moment, but rather as pertaining to two different ways of constructing the object and relating to it, both of which are simultane-

ously present in every individual at any moment. Kernberg (1987) makes a similar point regarding these two forms of communication, but focuses on the varying admixture of the two in different levels of character organization, whereas I am focusing on shifts in the admixture within the individual. The two constructions of the object mutually interact over the course of time to affect one another's development, and are brought into contact with each other in various different ways.

For example, in my patient Daniel's "game," he makes use of affective communication with me, setting a playful tone, to induce me into the "game" frame of mind. When I join in, my symbolic communications of my own thoughts are completely placed on hold; my verbal interventions are limited to the scripted song lyrics, while affectively I join with him in setting and maintaining an ambiance that says, "Let's look at the commonplace in a different way and see if we can find something new in it." Daniel is thus free—and encouraged—to think about the lyrics (which, after all, were his associations) in a new way, while being protected from the intrusion of my interpretive efforts. He is making use of me in a particular way—and, momentarily, I allow him to do so—dividing me into an affectively holding and encouraging object and a cognitively interpreting object, embracing one and putting the other off. At the same time, his control of me in the service of this split, though mostly exercised through affective communication, is based on his knowledge of me and my attributes as a complexly understood whole object—not solely a container of his projections; he is aware of, and makes use of, my dry sense of humor, my ability to not take myself so very seriously, and my willingness to "take a break."

Within this model, I would see maturation not simply as a movement from one "position" to another, but as an increasing integration of the two constructions of the object. The paranoid-schizoid and depressive "positions" might, within the model, be seen as two hypothetical and asymptotically approached organizations at either end of a broad spectrum of organizations that combine features of each of these two in different ways, with, perhaps, affective communication predominating in the paranoid-schizoid position and symbolic communication predominating in the depressive position.

In this paper, I will describe three psychic organizations, each defined by a particular construction of the object, which represent three points along this spectrum. More accurately, each represents multiple possible organizations falling along three different sectors of this spectrum—the first, a sector in which the two basic constructions of the object are poorly integrated; the second, an intermediate organization in which affective communication is prominent but in which awareness of and concern for the whole object is stably in the background; and the third, an organization in which considerable integration of the two basic constructions of the object is achieved under the dominance of the whole-object/symbolic communication organization.

In this paper, with my focus on their relation to aspects of the creative process, I will call these three organizations *analyst as mental function, analyst as medium,* and *analyst as audience/interlocutor*—referring to the use the analysand tends to make of the analyst within each organization. Each has its characteristic way of bringing together whole- and part-object elements of the transference. These organizations differ in the degree of both elaboration and stability of the whole-object transference. More important, they differ with respect to the *quality* and *purpose* of affective communication that predominates in each organization.

What I hope to demonstrate in this paper is that the characteristic way in which the analysand attempts to make use of the analyst in each of these organizations corresponds to a different phase of the creative process. Awareness of these organizations may broaden the analyst's tolerance of being used by the patient in ways that do not feel consistent with the analyst's usual technical approach, but may nonetheless potentially facilitate the analytic process. And in individuals who are struggling with creative work outside of the analysis, the presence of conflict in any of these organizations may highlight and help clarify difficulties that the individual encounters in the corresponding phase of the creative process.

## THE CREATIVE PROCESS

The creative process is complex, and over the years psychoanalytic investigators have tried to examine it from many different points of view.

Though Freud considered the origins of the content of creative work (1908) and the energic functions of creative activity, particularly the importance of sublimation (1910), he despaired that the nature of creativity itself could not yield to analytic understanding, referring to the "unanalyzable artistic endowment" of the writer (1928).

Some analysts (Klein 1929; Riviere 1952) have followed Freud's initial focus on content and used creative works to exemplify an expanded vision of the contents of the unconscious. Others (Bonaparte 1933; Eissler 1963; Greenacre 1955) have used a psychobiographical approach in an attempt to understand the impact of specific artists' life experiences on the genesis of their creative impulse and the contents of their work. Ego psychologists have considered aspects of psychic structure and mechanisms that seem particularly prominent in creative individuals, and in so doing shifted the focus of attention to how the creative individual operates, rather than what determines the content of his work or impels him to creative activity (Gedo 1996; Giovacchini 1971; Kris 1952; Nass 1971; Noy 1979; Rose 1963, 1964; Weissman 1967, 1968).

Still others have approached the question of creativity by considering its links with various forms of psychopathology, including psychosis (Kris 1952; Rothenberg 1990; Segal 1974; Waelder 1926), imposture (Chasseguet-Smirgel 1984; Greenacre 1958), and perversion (Chasseguet-Smirgel 1984; McDougall 1980). An exhaustive review of this extensive literature is beyond the scope of this paper, though thoughtful overviews are provided by Fossi (1985) and Niederland (1976). While a nonreductive unifying theory of creativity will probably always elude us, it seems that detailed psychoanalytic consideration of isolated aspects of the creative process may still be illuminating.

My focus in this paper is on a relatively narrow sector of the broad sweep of the creative process. I believe the three organizations I am considering in this paper have particular relevance to a specific "moment" in the creative process, at the nexus of inspiration and elaboration. In this moment, the artist is inspired with a vision, an observation about his inner world, the external world, or (most probably) the interaction between the two, compelling to himself but not yet translated into rep-

resentational form. He wishes to express it, that is, to place it outside himself, to preserve it, to seek relief from its nagging internal presence, and to communicate it to others. He turns to his medium, and attempts to use this medium to represent some approximation of his vision.

Yet there are aspects of the vision that elude symbolic representation—affects and other aspects of the vision that, though having meaning, of course, and being themselves forms of representation, are closer to bodily experience and sensation. Here the artist must fall back on a different form of expression—*evocation* rather than *representation*—and use different aspects of his medium in order to achieve evocative as well as representational ends. He brings together these two forms of expression into a product that serves to communicate at least some of the experience of the vision, both cognitive and sensuous, in his audience.

I call this a "moment" in the creative process not because it happens in a brief instant of time, but because it is only one in a series of events, each with its own particular psychic organization and activity, which comprise the whole of the creative process. I am *not* addressing, for example, the complex processes of observation, fragmentation, and reintegration of the experience of the external world that lead up to inspiration, described by Segal (1991). Nor am I describing the moment of inspiration when the results of prodigious unconscious and preconscious processes coalesce and find their way to consciousness (with its own special organization of the experience of boundaries between self and object), as described by Kris (1952) and Rose (1964). I am also not considering the constitutional features or the experiences of loss or trauma that may contribute to the power of the creative impulse and predispose to the capacity for inspiration in certain individuals, as described by Lowenfeld (1941), Greenacre (1957), and Rose (1987). Nor am I turning my attention to moments further along in the creative process, where the artist's actual external product has begun to take shape and his relation to vision, product, and audience become considerably more complex and, to some extent, more dominated by whole-object transferences, as described by Britton (1994) and Kaplan (1995).

## THE PSYCHOANALYTIC PROCESS AS A COLLABORATIVE CREATIVE PROCESS

Still, the moment I am considering readily lends itself to close examination in the clinical psychoanalytic situation. An important part of the analysand's task in analysis is to communicate his conscious and preconscious mental experiences, along with their affective component, to an audience, the analyst. In turn, the analyst perceives something of the analysand's internal world, the relation of the analyst's internal world to it, and is "inspired" by an insight that he then attempts to communicate, with cognitive and sensual components, to the analysand.

Beres (1957) notes the parallels between communication in the creative process and in psychoanalysis. He emphasizes the importance of the evocation of an aesthetic experience in analysis in order to establish a sense of conviction about the contents of the unconscious. But for Beres, this aesthetic experience is one evoked *in the analysand, by the analyst.* Beres insufficiently addresses, I think, the *differences* between analysis and the creative process, particularly in terms of the locus of inspiration. This conceptualization, I think, can lead to particular tensions in analytic work, perhaps especially with creative individuals, as it relegates the creativity of the analysand and the aesthetic experience evoked in the analyst to a secondary position.

Beres and Arlow (1974), in a careful study on the workings of empathy, note the aesthetic quality of the operation of empathy and the ways in which communication between analysand and analyst resemble that between poet and audience. They emphasize the bringing together of affective, nonverbal communications of unconscious material with verbally expressed conscious material, and in so doing move the focus to the analyst's aesthetic experience of the analysand's communications. But their focus is on communications that occur in what I call the *analyst-as-audience/interlocutor* organization, and takes into account empathic moments that are equivalent to the moment of inspiration in the creative process; whereas I am also elaborating on forms of communication that may precede such inspirational moments and, though evoca-

tive of strong feelings, do not produce an aesthetic experience in the analyst.

Levine (2003) also notes the parallels between communication in psychoanalysis and the work of creativity, emphasizing the analyst's aesthetic pleasure in the analytic process itself or in the analyst's own functioning. Levine, like Beres and Arlow, does not really address the analyst's responses to pieces of the analysand's creative process that evoke emotional responses in the analyst short of a satisfying aesthetic experience.

Meltzer and Williams (1988) focus on the analysand's use of projective identification and the analyst's containing function in the analytic situation. They distinguish between two different types of projective identification, one of which allows for the operation of the analyst's α function, and the other of which overwhelms and destroys this function. This distinction is particularly relevant, within my model, to the *analyst-as-mental-function* organization, which I will elaborate momentarily. When the more benign form of projective identification is in operation, the analyst can find the affects evoked to be a source of inspiration for his own creative interpretive activity. But under conditions of more intense aggression, the latter form can have the effect of shutting down the analyst's creativity.

## THE THREE ORGANIZATIONS: CLINICAL FEATURES

### *Analyst as Mental Function*

In this organization, the relation to the object as whole object is tenuous; observable qualities of the external object are poorly integrated into the internal object image. Fantasy predominates. In the transference, the actual qualities or actions of the analyst are only thinly incorporated into the analysand's fantasies. When an analysand operates within this organization for extended periods of time, the countertransference experience may be a somewhat lonely one in which the analyst does not feel known by the analysand, even in his functioning as an analyst.

Communication through projective identification is prominent, and this communication tends towards affects that are intense but have a quality of being disconnected, or very poorly connected, to verbally elaborated fantasies in the analysand's mind.

When communicated through projective identification, these affects can have a sweeping, disturbing quality in the recipient. At their most extreme, they may set the analyst into a desperate scramble for some idea or understanding about the affect that will help him manage it, avoid acting out, and maintain an analytic stance.

I would posit that this form of projective identification calls upon the analyst to provide meaning to be linked with the affect; this hearkens back to the containing relation that Bion (1962) described between mother and infant and the α function the mother performs, modifying these projected affects and imbuing them with meaning through her reverie. Often in this organization, evacuation of unwanted psychic contents is the principal motivation for projective identification, and there are simultaneous aggressive attacks on the analyst's α function.

In this organization, whole-object transferences and part-object transferences are poorly integrated, so that the analysand may move—in a sudden and jarring way—from his efforts to remain connected to the thinly elaborated whole-object image of the analyst, to a position in which this relation is abandoned and the communication of intense, often negative, affects through projective identification takes over.

I call this organization *analyst as mental function* because the relationship here aims at the linking of affect and meaning, and, in the well-functioning artist, this is primarily an internal function that occurs within the artist's own mind.

### *Analyst as Medium*

In this organization, there is considerably more stability to the whole-object transference. An underlying positive feeling toward the analyst is generally maintained, even if the management of aggression in this context results in a somewhat masochistic adaptation. There is an acknowledgment and valuing of the analyst as a separate person. The

analyst, in turn, feels more known in a real way than in the analyst-as-mental-function organization.

The analysand utilizes this whole-object awareness, which includes his perceptions of the analyst's personal quirks, strengths, and weaknesses, to make use of the analyst in a particular way. Here, aspects of the analyst's affective experience, as well as his cognitive and perceptual abilities, are appropriated and controlled by the analysand so as to facilitate the analysand's expression of his inner experience. Put metaphorically, the analysand learns to "push the analyst's buttons" in such a way that he becomes a virtuoso player of the instrument of the analyst's countertransference experience.

Unlike in the first organization, here the analysand's inner experience has the quality of being composed of both affect and ideational content. But it is *communicating and being understood* rather than either *connecting affect with meaning* or *receiving a communication that deepens understanding* that the analysand is aiming at.

Though the analyst may have feelings of discomfort with being manipulated or with his interpreting function being pushed to the background for extended periods of time in this organization, there is often a playful, engaging quality to the analysand's efforts to manipulate and control the analyst's responses, and a sense of delight that the analyst is implicitly invited to share when these efforts hit their mark. Caper (1996) alludes to a similar form of projective identification that he associates with the ability to play and with creativity; and he notes its resemblance to the artist's relationship with his medium.

I call this the *analyst-as-medium* organization because, within it, the use that the analysand makes of the analyst closely resembles the artist's relation to and use of his medium. Like the analyst in this organization, the medium is taken as found in the external world, and it is molded, mixed, pummeled into shape, and otherwise tortured to serve the function of being turned into a thing that communicates something of the artist's inner world. In order to make his medium (and the analyst) maximally useful to this end, the artist must understand its qualities, its potentialities and limitations as a vehicle of the expression of his inner

experience in both sensuous and representational dimensions. Further, the conflicts that prevail for the analysand operating in this organization may have bearing on difficulties he encounters in the mastery of his medium in creative pursuits outside the analysis.

*The Analyst as Audience/Interlocutor*

In this third organization, the whole-object relation with the analyst moves to the forefront. Projective identification remains as an important channel of communication, but it serves to enrich or reinforce verbal communications of thoughts and feelings. Affective communication is well integrated with verbal communication, or there is a smooth alternation between the two, with each drawing upon the other in an unfolding way. The analyst is able to comfortably receive the projections and incorporate them into his formulation of interpretations, and the analysand is interested in the analyst's interpretive responses (not just his confirming or empathic responses), and makes use of them in his continuing creative efforts in the analysis. This mode of transference experience and its countertransferential correlative has been well described by LaFarge (2000).

I call this organization *analyst-as-audience/interlocutor* because, in it, the analysand's relation to the analyst resembles the artist's internal relationship with his audience as he presents or imagines presenting his creation to the external world. At the same time, I want to emphasize elements of this internal relationship that go beyond that of the audience as the passive target for the artist's exhibitionistic display. Indeed, I believe that the artist's internal relation with his audience, with his wish to engage, to have emotional impact upon, to be understood, and to be responded to in a way that confirms his impact, with evidence of having successfully evoked something *of* his audience *in* his audience, carries more of the sense of interlocutor than the word *audience* usually connotes.

I return now to my patient Daniel. The following material illustrates a regression from the analyst-as-medium organization exemplified by Daniel's "game" to the analyst-as-mental-function organization in the face of an emerging negative transference.

## CLINICAL EXAMPLE #1: DANIEL

Over the course of his analysis, Daniel, an advertising executive in his early forties, had achieved considerable success in his industry, but still felt dissatisfied with his work. He longed to break away from his agency, where he felt underappreciated and too subject to control by his superiors. In his personal life, Daniel had a large group of friends and a small number of close ones; but he was unable to fall in love.

Daniel was a musician *manqué*. As a younger man, he had attempted to establish himself as an independent producer in the music industry, and had failed. He remained a passionate lover of music of all kinds, and each Christmas he would put together an album for his friends consisting of cuts from his large music collection, complete with a witty and erudite commentary that highlighted the stylistic, tonal, and thematic linkages of the year's selections.

Daniel's analysis deepened slowly. As an analysand, he was variable. His discourse was lively, and he could be a keen observer of his own psychological foibles; there was a warm quality to his engagement, and he had a wicked sense of humor. At times he struggled courageously with painful aspects of his inner life. Yet he had great difficulty acknowledging any painful feelings—anger, longing, envy, or competitiveness—in the transference.

In the countertransference, I felt quite known—and loved, in a way—by Daniel, who was a keen observer of details of my emotional tone, working habits, and patterns of thought. Yet my sense that he was anesthetized to any pain I might cause him left things feeling a bit thin. He had difficulty working with dreams, treating them as harbingers of his psychic future, either "optimistic" or "pessimistic," while associating to their elements in an unimaginative, rote way. Although his descriptions of his relationships were lively, they often took on a sentimental tone, whereas when he talked about music, there was a level of awareness of emotional complexity and nuance that was often absent in his interpersonal interactions.

The following sessions occurred several years into Daniel's analysis. Daniel had recently broken off a relationship that he had initially hoped

would lead to marriage. In addition, his stepfather, H, had recently been diagnosed with a terminal illness.

*First Session*

Daniel began his Monday session by reporting some optimistic news in his work, which had been going poorly for a number of weeks. I was aware of something in the tone he was setting—still friendly, but less ingratiating than usual. He then said he had had a dream the previous night:

> It's one of those dreams of being in my apartment and finding extra rooms I didn't know existed. I'm sharing the apartment—I've just moved into it. I think it's with J's father. [J was Daniel's friend whose father had disinherited her.] The apartment is reminiscent of one I looked at once down the block from your office. There are big rooms on either side—there's an extra living room. I've had dreams like this so many times before. I'm trying to figure it out; obviously, since it's the apartment down the block, it must have something to do with here. Finding things in my head I didn't know were there. It's like mental space—something creating the idea of space rather than the experience of space.

I found myself momentarily inclined to point to an "optimistic" aspect of the dream—the quality of expansiveness of internal space—and then immediately felt irritated at myself for the stereotyped and sentimental quality of this intervention. I realized that Daniel—by alluding to the "dreams like this so many times before," and by beginning his session with "optimistic" news in his work—was cuing me to interpret this one in a similar vein, though everything else seemed somehow changed: I, rather than Daniel, wanted to see the dream as "optimistic," and Daniel's tone—and associations—had a discouraged, world-weary quality to them; it was the same old dream, creating an idea rather than an experience. In the dream, he shares the apartment—associated with my office—with a depriving, disappointing, and rejecting father.

Daniel continued, "Mental space is kind of the opposite of paranoia. In the dream, I'm pleasantly surprised by my mental space." I asked

Daniel how this related to his experience now in the analysis. "I'm obviously going through a lot of changes now, and I think there's some good things that are coming out of it all, but it's not happening without a fight," he said. "I've been very emotionally volatile for the last few weeks—depressed a lot of the time. I'm not engaging with the world; I'm trying to conserve my energy for when H [his terminally ill stepfather] dies. I've hung up a 'Gone Fishing' sign."

In a seeming non sequitur, he told me of an apartment he saw recently that was a very good value. I sensed he was suggesting I might be interested in it for myself; Daniel himself had recently moved into an apartment costing more than twice as much. He reported that his mother and stepfather had been quarreling about the stepfather's will. He then complained about a former subordinate, E, who was now making twice as much money as himself. Then he sighed. "Clowns to the left of me, jokers to the right; here I am—stuck in the middle with you!"

As Daniel continued talking, I found myself taking a deep breath. I felt as if I had been punched in the gut. It was clear that he was unaware of the hostile statement he had just made—disguised as "reciting" a song lyric. It was as if he were focusing on only the first two lines—clowns and jokers, beleaguered by frustrating, angering relationships, with subordinate, mother, and stepfather—and "stuck in the middle with you" was only the obligatory next line. Yet I felt contemptuously rejected, inadequate as both solace and help to him.

I wanted to show Daniel that his withdrawal was a way of placing distance between himself and potential sources of support toward whom he might feel angry or envious. "You're kind of spacing out," I said. "You've 'gone fishing'—it's a way you check out from people who might potentially—"

At this point, Daniel interrupted me. "Yes, it's the opposite of a roach motel. You can check out, but you can't check in."

"Like right now," I said, "you interrupted me in order to let me know that you understood what I was going to say before I even said it, and to make a little joke of it. It's engaging but distancing at the same time, and you wind up feeling I didn't give you anything you didn't already have, and in fact, you haven't given me the chance to say anything you hadn't already anticipated."

"Listen," he said. "I hear what you're saying. But you know, I don't really think of people as potential sources of support except for my failure to access them. I have a fundamentally more paranoid view than that. I don't know that you're wrong in what you say, but in my own mind I'm not cutting myself off from support, but holding threats at bay. You and my friend A are the only two people I come close to being able to trust as unalloyed sources of support—beyond that, it gets more problematic. And I don't really see how I'm closing myself off from you."

*Discussion*

In this session, Daniel presents a dream in which I appear as a depriving and rejecting father. He talks about a feeling of being disengaged and "spaced out." I attempt to interpret his disengagement as a withdrawal from potential sources of help and support, but he interrupts me and makes a joke of the interpretation before I finish. He goes on to say that he sees he may distance himself and cut himself off from sources of support, but sees people as threats rather than sources of support. Surprisingly, he then excludes me from this category, and says he doesn't see himself as distancing himself from me.

On the level of affective communications, I was aware almost from the beginning that "something was different." Then, in a verbal communication that appeared to be a non sequitur (though it picked up on the apartment theme of the dream), Daniel stirred in me feelings of envy of him and of being condescended to by him. This was a very different use of projective identification from that in the "game," one that aimed at making me feel something he himself did not wish to feel, rather than at controlling me to behave or relate to him in a particular way so as to enable him to pay a different kind of attention to his own associations.

Talking about his frustration with mother and stepfather, and envy of his former subordinate, Daniel quotes a song lyric that ends with "stuck in the middle with you." Unlike his customary use of lyrics in the analysis, I am not invited to join in "the game" on this one. "Stuck in the middle with you" (which in the game would have been my line to recite and tag—by my tone and inflection—as dense with meaning) is given the tone—through Daniel's inflection—of an irrelevant throw-away. My

awareness that I have not only been excluded (as I am in the game), from *assigning* meaning, but have now also been removed from my position of tagging a lyric as *having* meaning, heightens my awareness of the meaning of the words; I feel both excluded and demoted by Daniel's actions and declared a useless albatross by his words.

*Second Session*

Daniel began his next session saying he had thought a great deal about what I had said in the previous session, but had not completely understood it.

> I know what you mean by my "checking out"—I'm there, but not there. And when I'm in that state of mind, I'm spaced out—my mind dilates. I'm aware that I can't concentrate well in that state, but I think you were saying that it's something interpersonal I'm doing as well. With you . . . . You've taken away my denial about a lot of things—so when there's tension or stress, I use the dilation to kind of short-circuit it. And maybe what you were saying was that that comes at the cost of closeness with people when I most need it.
>
> On my way to the session today, I noticed the fruit vendor at the corner stooping to give a plum to a child. I'm removed from close interpersonal connection because of my paranoia, but it doesn't make me unaware of the existence of warmth and kindness and closeness. In a way, it almost makes it easier for me to see it, not just between other people but with myself. I'm aware if someone extends me an unexpected kindness, and I appreciate it, but somehow I don't connect to it personally; I don't take it in. In my darkest moments, I think of my friend A, whose life is rich with these moments of warmth and connection that flow from a bedrock that he got growing up. I feel it's impossible that I'll ever have that. When I think about what's impossible for me to have, I plummet into despair, and it's that despair that makes my mind dilate. I see there's a self-fulfilling prophecy here.

"With A, and with me as well," I said, "you feel touched by the offer of closeness, but you despair that you could have it. You envy that we have rich stores of it to give freely; you feel there is some condescension

in the offer of it, that we stoop to offer it to you like the fruit vendor, and you withdraw from it."

"It's a tragic choice I make," Daniel said. "I may not know what I want, but I know what I don't want. My father foists his neediness onto unsuspecting victims all the time. He's pathetic and infuriating. I'd much rather be the charming, well-dressed person with the quick wit. It's like that song—'I believe that since my life began, all I have is a talent to amuse. Hey, ho. If not for that, I would be lonely.'"

"You use that talent to place yourself at a distance from people," I added, "and I do that, too. In fact, we get into it together when we play 'the game.'"

"I see that, yes," Daniel replied. "But that's a kind of closeness, too, and you shouldn't apologize to me for it. I value it tremendously. Yes, I see that we use it to ward off another kind of closeness—a more painful closeness that feels dangerous to me. But it's more complicated than that, because in a way, the game catches me off guard, it frees me up, it makes me feel safe, and often I find myself going to places in it I wouldn't ordinarily go. But I also understand that if the loneliness is so painful I can't bear to talk about it, it will elude the kind of connection with you that might possibly help it."

I responded, "It places you at kind of a middle distance—close enough to feel connected, but not so close that it threatens to be painful—or, alas, to give you what you need. And then, there you are, stuck in the middle with me."

*Discussion*

In this session, there is a reduction of the disruptive, aggressive use of affective communication. Daniel struggles to gain understanding of the previous day's interpretive line. He acknowledges that there is an interpersonal component to his "spacing out," distancing himself from people when he most needs them. He speaks of the fruit vendor stooping to give a child a plum, and his envy of his friend A (associated with me in the previous session). I interpret that when people offer him closeness, he envies their capacity to offer it and feels "stooped down to" as it is offered. He talks about his intolerance of his own neediness, and his

use of wit as a means of avoiding the pitfalls of emotional need. I point out that he and I collude in "the game" in using wit to avoid closeness. Daniel acknowledges the defensive function of the game, but eloquently states how it has enabled him to explore aspects of his inner life with a sense of safety. I bring this form of compromised closeness back to his sense that, when he is beleaguered, he is "stuck in the middle with me."

*Third Session*

Daniel began the following session by complaining that his irritable bowel was acting up. He then reported a conversation he had had with his mother about his stepfather's will. The stepfather had intended to sell off some assets in order to buy her a house to live in after his death, but she felt it would never happen; he hadn't investigated the details of the real estate. Daniel became furious; his mother, about to be the widow of a wealthy man, was arranging to be left homeless. "I wanted to tell her, don't just sit by, feeling sorry for yourself! Take some responsibility and make it happen! But when someone has spent their life stifling their emotions, how do you give them the opportunity to not stifle their emotions?"

I said, "I'm wondering if you're not also talking about yourself here."

Daniel snapped back, "I'm talking about my mother!" Though I was a bit taken aback by Daniel's open hostility toward this intervention—which was unusual for him—I persisted. "I didn't say you weren't—I said maybe *also* yourself." "Yes, yes," Daniel replied impatiently, "I see it. My sense of despair, the self-fulfilling prophecy of it . . . . It's the same thing." He fell silent.

After a few moments, I asked him what he was thinking. He laughed and answered:

> Actually, I was thinking—I can't believe it! You overruled me! How dare you! But what were you saying? You were saying, "Listen to me—I'm not going along with you here, you're not being your own friend." With my mother, my initial impulse is to side with her sadness and self-pity. The last year she gets to have her garden. But then I thought—wait a second. The sad thing here is not about her garden. It's that H is dying, she hasn't

gotten everything she wanted from him but a whole era of her life is ending, and even though neither wants to acknowledge it, she has to plan her life to make it bearable when he's gone, and she needs him to do that with her. So maybe that's where I am with you.

[He fell silent, then resumed.] I'm trying to figure out about the IBS. Why now? [His associations went to his dissatisfactions with his work.] And I keep coming back in my mind to E [his former subordinate]. The idea that he's going to out-earn me again this year feeds into the despair. How does it happen? Why don't I do better? E is talented, but no more than me. It gnaws at my gut . . . .

*Discussion*

Daniel begins the session reporting a somatic symptom, and not surprisingly he seems cut off from his own affect. He associates to his mother's inability to deal with his stepfather in terms of providing for her after his death, and then about her being disconnected from *her* emotions. He wonders if it is helpful to get someone who stifles their emotions to feel them. When I interpret that he may also be talking about himself, he angrily rejects the interpretation.

Here, I think, we see an escalation of an attack that began with Daniel's "stuck-in-the-middle-with-you" session. Having been eliminated, first as an interpreter of meaning and then as an indicator of the meaningful, I have had the audacity to continue to interpret, "overruling" his efforts to paralyze me in this function. Specifically in my interpretive function, I am experienced as a persecutory threat to be fought off.

Then, when Daniel is able to retreat from this position and to experience me as somewhat more benign and helpful ("But what were you saying? 'Listen to me . . . . You're not being your own friend'"), he returns to his mother's dilemma with her dying husband—and sees in H's impending death a harbinger of termination with me ("and maybe that's where I am with you"), then to his affect cut off from meaning (the bowel symptoms), and finally to his envy of E, which "gnaws at his gut." He is beginning, then, to bring together the strands of his disavowed feelings of envy and aggression, need, and anticipation of loss of me,

and to imbue his affect, experienced as somatic symptom, with psychic meaning.

In summary, then, in the context of his stepfather's impending death and a disappointment in his romantic life, a negative paternal transference begins to emerge in the "whole-object" realm. As this brings to the fore affects that have been strongly kept out of awareness in the transference (aggression, envy, dependence, and fears of loss), Daniel's use of projective identification changes from one characterized by controlling me to function as an optimal holder and recipient of his communications, to one that aims at evacuating unwanted mental contents into me, and at attacking, as dangerous and persecutory, my function of imbuing these evacuated experiences with meaning.[1] As the aggression abates somewhat, Daniel is able to utilize me in this function to connect affect (bowel discomfort) with meaning (envy gnawing at his gut).

In my second clinical example, a bulimic woman establishes a stable transference relationship with me within the analyst-as-medium organization. Psychotherapeutic work in which active interpretation played a relatively minor part enabled her to move into the analyst-as-audience/interlocutor organization, with a corresponding change in the quality of our work together.

## CLINICAL EXAMPLE #2: LISA

Lisa, a 19-year-old art student, had been bulimic for over two years. Her nightly purges were ineffective, however, in controlling her weight. Shortly before beginning treatment with me, she had begun investigating a radical form of cosmetic surgery that involved breaking both legs and then resetting them, for a gain of perhaps an inch in total height.

[1] Rosenfeld (1971), in a paper on psychotic states, notes the appearance in psychotic patients of violent destructive impulses and intensification of projective identification as they begin to experience themselves as separate from their objects, and he attributes this to intense feelings of envy. In nonpsychotic patients such as Daniel, I believe primitive defenses such as omnipotence and projective identification may be mobilized regressively in psychic situations other than that of nascent feelings of separateness, if affects that are stirred are particularly intense, and/or if there is poor affect tolerance—for instance, in traumatized patients.

In her work, Lisa had already achieved considerable recognition for her art, both at school and in the larger world, but she felt left out of what seemed to be an exciting social life at the school. She was fearful of approaching her fellow students outside of class, and felt shunned and humiliated when she dared to do so.

Lisa and I met three times a week in face-to-face psychotherapy. She had consulted me reluctantly at the insistence of her family, and I was somewhat surprised that she rapidly developed a positive feeling toward me and her treatment. She seemed to look forward to her sessions, arriving early, smiling and looking pleased to see me when I greeted her in the waiting room. Once in the office, she would smile nervously and fidget, somehow managing to look like a small child sitting in a too-large chair. She would report some slight or humiliation that had happened at school. There was a vaguely paranoid flavor as she imagined her fellow students talking about her and laughing at her. The sessions had a repetitive quality, and I began to wonder how I would be able to move Lisa toward a more productive use of her treatment.

Several weeks into her treatment, I noticed that I habitually had a headache after Lisa left my office, and one day I found myself massaging my eyes and temples for a bit of relief. I realized that my habitual headache with Lisa was eyestrain. An image of myself flashed into my head, sitting at a table on which had been spilled a vast number of tiny colored beads; I was trying to sort the beads by color with a tweezers. I made a mental note to see if I could determine the source of my eyestrain the next time I met with Lisa.

Over the next few sessions, I became aware of something that had been going on at the edge of my consciousness. Lisa's fidgeting at the beginning of her session actually subtly directed my attention to some piece of clothing or accessory she was wearing; I would register my response to the item with my eyes, then they would quickly dart away, as if we were both observing some rule that I was to neither look at nor talk about her body.

I was aware as well of feeling a particular need to address this discovery with Lisa in a way that did not inordinately embarrass her or bring the transference into our discourse in an artificial or intrusive way,

and I felt uncertain as to how to do that. I decided to begin by making our subliminal exchange more explicit.

One day, I said simply, "That's a nice scarf. Is it new?" Lisa's face lit up. It was an old scarf, she explained, though it was new for her, and she told me about her pleasure in browsing at thrift shops for the occasional treasures one could find there. She took off the scarf and handed it to me so I could look at the pattern, and as I did so she pointed out the unusual colors that had originally attracted her attention to it. I was aware that I was being drawn into an enactment, but because (as with Daniel), it was centered around Lisa's chosen mode of artistic expression, and seemed to open up a fresh line of inquiry, I decided to see where it might take us.

After this, the explicit discussion of Lisa's clothing, accessories, or jewelry became a common event in our sessions. In the end, the focus always came down to color. Lisa began to identify some colors as "Lisa colors," colors that did not necessarily complement her hair, eyes, or complexion, but seemed to resonate with who she was and what she felt like inside. Over the course of the next several months, I found myself—not only in the sessions with Lisa but outside as well—exquisitely attuned to fine shadings of difference between colors in a way I never had been before. And, almost as if by magic—it was only partially through Lisa's instruction—I developed a color vocabulary which, up until that point, I had been unaware of having. Salmon, coral, and apricot were suddenly three distinct colors to me, though before I knew Lisa, I would have identified them all as orange. Gradually, I learned to identify "Lisa colors" without her assistance.

From time to time, Lisa would bring in her art work to show me as well. I could see that it was her use of color that gave her work a special sense of excitement and aliveness. In one picture, a sky shot through with shades of dusky pink and orange over a meadow the color of egg yolks gave a palpable feeling of heat, and the surrounding dense foliage in deep shades of green and purple hinted at a hidden, voluptuous sexuality that belied Lisa's physical awkwardness and somewhat childlike manner. I realized, though I had previously been aware of the discussions of color as providing a forum for the discussion of Lisa's body that

felt lively but quite desexualized, that on another level Lisa had successfully engaged me in paying close attention to her body in a way that might be either consciously or unconsciously sexually exciting for her, though I was consciously unaware of any reciprocal feeling.

One day, Lisa came to her session wearing a necklace made of polished stones of different colors. The central stone picked up the color of her eyes. "That's a pretty necklace," I said. "It calls attention to your face." Lisa smiled at me with pleasure, then looked down; her smile changed, as if she was now enjoying a private joke of which I was not a part. "Well," she said with a touch of hesitance, "it draws the eye upward."

I was taken aback. In the mildest way, Lisa had corrected me, something she almost never did. Was there a touch of contempt in that smile? It was as if something in her tone said, "You rube, you've fallen for the oldest trick in the artist's book."

Another vivid visual image flashed through my mind. It was an advertising poster for Lisa's school, which I had seen years before. In the poster, a smiling clown looks up with a dreamy expression at the sky. Three stars point to a crescent moon at the top of the poster. The viewer's eye follows the eye of the clown to the moon in the upper right-hand corner of the picture. Tied around the clown's waist is a sash with a large pom-pom hanging from the bottom. Through a trick of perspective, the viewer feels he is standing at the feet of the clown who towers over him. The legend in the poster alludes to daring to dream, focusing the viewer's mind on the eye of both viewer and clown fixed on the stars, and leaving the large, looming phallic sash to make its impact subliminally.

I asked Lisa what, other than drawing attention to her face, was being accomplished by drawing the eye upward. She responded that it made her look taller. I was reminded of her wish for height-enhancing cosmetic surgery. What would it be like, I asked, to be seen as taller?

This question opened up a line of exploration that went on for several weeks, as Lisa described to me the body she wished to have and the impact it would have on men. Tall and slender, with breasts that were not flat but did not define her figure; the look would be one of a narrow cylinder. She would have long, straight, shiny blonde hair that would give further emphasis to the cylindrical shape of her body. This was the

kind of body that men would be helplessly attracted to and worship. Possessing such a body would give her power over men; she would be able to make them give her what she needed and wanted from them, including the satisfaction of a voracious kind of sexual hunger.

The revelation of this fantasy was accompanied by a number of other changes in the sessions. Lisa's apparel continued to be a focus of our attention, but now, instead of just color, she focused on pattern, texture, and structural elements of the apparel, and she spoke in detail about the visual effect she was aiming at in making use of these elements, and how it related to her fantasied self-image. The quality of Lisa's moment-to-moment relatedness shifted, so that in the countertransference I was now much less struck with the forcible recruitment of my visual capacities and stretching of my visual perceptual skills than I was by a broader range of emotional responses to Lisa and an awareness of her emotional complexity.

Though I had come to enjoy my education in color (and in Lisa's inner world as expressed through color), I felt liberated from its constraints, relieved to be in the world of verbally expressed fantasy, more able to formulate interpretations, and more confident that I was expressing them to a receptive audience. Though Lisa's playful quality persisted, I was now more aware of alternations between her approaching me with her ingratiating, childlike appeal, and moments in which her sense of power, deriving from her talent and growing technical proficiency in her work, came more to the fore; then she assumed, with pleasure, a sense of dominance and being able to take the lead in our work together. Though it was understated, there was also a more palpably flirtatious quality to her playfulness.

*Discussion*

The session with Lisa's necklace marked a shift, I believe, between a phase in which her mode of relating was primarily in the analyst-as-medium organization to one in which the analyst-as-audience/interlocutor organization prevailed. In the former, my predominant experience of being with Lisa was of her active recruitment of my visual perceptual apparatus in the service of her efforts to communicate. The content of

what was communicated, through color, was relatively raw and unelaborated aspects of Lisa's affective experience.

One striking manifestation of this recruitment was the appearance at crucial junctures in the treatment of two vivid visual images. For me, the visual image is a relatively rare form of countertransference experience. Each of these two visual images, the one with the beads and the tweezers, and the one with the skyward-looking clown, condensed several important emotional currents, and presaged the appearance of these currents in the oncoming phase of treatment. Some of these currents came from Lisa, and were communicated through projective identification—for example, the feeling of fragmentation represented by the tiny beads, and the use of color as a way of organizing and consolidating this fragmented experience. Some arose within myself—for example, the experience of a forced hypercathexis of my visual apparatus and my resistance to it; still others were of uncertain or mutual origin, as, for example, the sense of a large and painstaking but finite task ahead.

In the latter, analyst-as-audience/interlocutor phase of treatment, the communicated content (that is, the fantasy of the narrow, cylindrical phallic body and the associated fantasy of being a dominating, demanding, phallic woman in relation to men), rather than the means of communication, was at the forefront of my awareness, and these contents were more elaborated, both visually and in terms of interpersonal fantasy, than the primarily affective and sensuous contents of the earlier phase. Symbolic communication through verbal description was more integrated with affective communication through projective identification, with a smooth, nondisruptive back and forth between Lisa's description of her fantasies of phallic dominance over men and the clear but relatively unobtrusive enactment in which she alternated between playing the ingratiating clown and seizing the position of dominant senior creative partner in the treatment. Here projective identification served an important but secondary function of exemplifying, emphasizing, or deepening my experience of the fantasies that were being verbally communicated, as well as the unspoken conflicts that these fantasies attempted to resolve.

*Defensive and Communicative Functions of the Analyst-As-Medium Organization*

Lisa's initial move into the analyst-as-medium organization was a movement away from a whole-object transference experience in which both libidinal and aggressive wishes were too powerful and disorganizing for Lisa's fragmented self to manage. Lisa simultaneously, but in a split-off way, wanted me to look at her as both an appealing but desexualized mélange of color and as a sexual object. My eyestrain was a symptom of conflicts in the countertransference that were largely stirred by her transferential conflicts and attempts to resolve them; particularly the impulse to look at her clothing and body, and a powerful sense of prohibition in acting on or even acknowledging this impulse. Other countertransferences I had at the same time gave hints to the nature of some of Lisa's specific fears that made her shy away from her wish to exhibit her body to me—my fear of humiliating her or being painfully intrusive to her with my interpretations.

But, technically and theoretically, I think it would be a mistake to focus only on what Lisa moved away from, without looking at what she moved toward, which is remarkable in a different way. In the analyst-as-medium organization, Lisa was able to maintain, through inhibition of her libidinal and aggressive impulses, a positive connection with me as a well-elaborated whole object. This enabled her to observe with considerable detail aspects of my cognitive capacities, my affective responses, and interpersonal style, and to make use of these observations to actually mold and shape me and to stretch my capacities, largely through the devices of projective identification, so as to become a more ideal recipient of her communications through a channel that was well-known to her—that of color.

The joint task of discovering the palette of "Lisa colors" became a mode of discovering and consolidating a vision of Lisa's inner life; in fact, the "Lisa colors" captured her qualities of warmth, sensitivity to nuance, earthiness, naturalness, intensity, boldness, and capacity to surprise—much more vividly than the words I use here to try to capture

the same qualities. As this inner world was elaborated and Lisa, through her observation of my growing capacity to independently identify "Lisa colors," became increasingly confident that I grasped, appreciated, and respected this inner world, she felt sufficiently safe from the dangers of her own sexual and aggressive impulses, as well as what those impulses might stir in me, so that she was able to move to the more fully whole-object-dominated, analyst-as-audience/interlocutor organization. She was thus able to talk about her feelings and fantasies in a way that allowed us to work in a mode in which interpretation played a more central role.

The work I describe here concerns Lisa's body image and her attempts to manage and control it; it is clearly related to her bulimia. It represents Lisa's taking of both the therapy and her own body as objects of her creativity. I should add, however, that this was only the very beginning of our work on this most entrenched of her many symptoms. It was not until years after the work that I describe here, when she had been able to make many other positive changes in her life and her bulimia had been addressed on many different levels, that Lisa finally began to be able to relinquish her pattern of bingeing and purging.

## THE THREE ORGANIZATIONS, CREATIVE ANALYTIC WORK, AND CREATIVITY OUTSIDE THE ANALYSIS

The psychic organizations I am describing in this paper are of course not exclusively observed in creative individuals. In fact, they are observable in most patients in one form or another. Their close relation to mental activities that are an important part of the creative process highlights them, and gives them special clinical significance in analytic work with creative individuals, and I would suggest that even in individuals of more ordinary talent, these activities are integral to the capacity to think creatively within the analysis itself. For those individuals who are struggling to do creative work outside the analysis, the working through of specific conflicts that arise within each of these psychic organizations may facilitate that work.

Nevertheless, not every patient who tries to do creative work does so successfully, even if conflicts in the areas I discuss are successfully worked through. The ability to do creative work rests on a variety of factors, including constitutionally based perceptual-cognitive and integrative capacities. Analysis may enhance the capacity for both symbolic representation and channels of affective communication that are complex and nuanced, and may lead to the internalization of integrative thought processes that heighten a capacity for inspiration, but these may still not be sufficiently keen or sufficiently supported by other ego functions to enable the individual struggling with a creative impulse to turn out a product that meets the test of public criticism.

Nonetheless, the individual difficulties encountered within each of these organizations, as well as in the vicissitudes of transitions amongst the organizations, as observed in the transference, are reflected in the strengths, weaknesses, and inhibitions in the individual's creative work. Lisa, for example, who for an extended period of time remained stably in the analyst-as-medium organization as a regression from intense conflicts in the analyst-as-audience/interlocutor organization, and who developed an effective way of utilizing me in the former organization, was, in her work, extremely effective in the use of color, but unable to talk extemporaneously about her work or to effectively write artist's statements describing her work when applying for grants or in attempting to have her work shown.

Daniel, though probably less basically talented as a musician than Lisa was as an artist, was a master anthologizer and commentator, using the completed artistic works of others as his medium. This probably was reflected in the clinical prominence of Daniel's use of the analyst-as-medium organization less as a regression from higher-level conflict than as a compensation for deficits at the level of the relationship with the containing and meaning-giving object in the analyst-as-mental function organization. Daniel's inability to experience certain intense affects as linked with meaning, leading to his experience of them as somatic rather than psychic contents, probably contributed to his inability to compose his own music, or even to play an instrument sufficiently effectively for

public performance, though indeed he played a number of instruments with some measure of technical proficiency.

## SUMMARY AND DISCUSSION

Each of the three psychic organizations I have described represents a different level of integration of whole-object relatedness and part-object relatedness and their respective modes of communication. In terms of the "moment" in the creative process that I have described, each of these three organizations is associated with particular psychic activities that comprise this "moment." The analyst-as-mental-function corresponds to the bringing together of inchoate affective and cognitive experiences, which constitute the creative impulse leading into a moment of inspiration, which constitutes the creative vision. The analyst-as-medium organization corresponds to the artist's turning to a medium and gaining mastery of it in such a way that its usefulness as a tool of the expression of his creative vision is maximized. The analyst-as-audience/interlocutor organization corresponds to the artist's formation of a product that condenses communication on symbolic and sensuous levels and his offering up the product to the world.

Though this moment of the creative process aims toward the attainment of the final organization—that of the relation with the audience as a whole object with whom the artist must communicate across interpersonal boundaries—the process cannot go forward without contributions from the first two organizations and, ideally, the artist must have the capacity to move back and forth with fluidity amongst the three organizations, while retaining his focus on the completion of his product in the final configuration.

It may indeed be that, with the creative individual struggling with creative work, the analyst needs to keep in mind as a goal not only the maximization of functioning in the final organization, but also the capacity to move back and forth amongst the organizations, while not getting stuck too long in either the first or the second organization. (Of course, though achieving this fluidity of movement in the artist's work should promote the same facility in his interpersonal relations, any individual may attain a capacity for functioning within the third organization

in one realm of activity to a greater degree than in the other; being able to turn out successful creative work by no means guarantees a capacity for object love.)

In an analysand for whom creative work is less a central issue, a more exclusive movement toward the third position may be more optimal, and is more conducive to the emergence of the psychoanalytic process as we are used to thinking about it, with the analyst's interpretive activity at its center, and other forms of the analyst's activity being seen as subordinate to or in the service of interpretation.

That said, this way of thinking about the psychoanalytic process may pose an ideal that carries its own potential for countertransferential interference with our work with certain kinds of material; this may be particularly true of work with creative individuals when they are in one of the first two psychic organizations. Smith (2004), discussing the analyst's fantasy of the ideal patient, notes that this fantasy is connected as well with a fantasy of an ideal form of free association, and a fantasy of the analyst's own ideal mode of functioning as an analyst. For many analysts, the "ideal analytic patient" is one who is in the analyst-as-audience/interlocutor organization, which allows the analyst to function as he ideally wishes.

When an analysand is in one of the other two organizations, the analyst needs to tolerate a form of free association in which actions and affects are louder than words, and in which he allows himself to be made use of for purposes beyond his interpretive function. The analyst is used to analysis being his own creative work with the analysand as his medium, and analytic theory and technique as his tools. But when the analysand is in the analyst-as-medium organization, the analyst is called upon to function as a tool of the analysand's self-expression, and to some extent, it is necessary for the analyst to set aside his own style of thinking and working (and often his active interpretive function) so that he can perform this function for the analysand.

Though ultimately the analyst returns to "analyzing as we are used to thinking about it" when the analysand returns to the analyst-as-audience/interlocutor organization, competitive tensions for ownership of the treatment and intolerance of being placed in a passive position may

interfere with the analyst's capacity to be receptive to affective material being communicated in the analyst-as-medium mode.

The analyst-as-mental-function organization poses a different set of countertransferential pitfalls. While in the analyst-as-medium organization, inspiration is primarily the analysand's, and in the analyst-as-audience/interlocutor organization, inspiration moves back and forth from analysand to analyst as each stimulates the other with their communicated visions, in the analyst as mental-function organization, the analysand provides primarily the sensuous experience and the analyst provides the processing leading to insight, so that inspiration occurs *between* analysand and analyst, sometimes with a measure of confusion as to the source of the vision.

In the analysand who is struggling with creative work outside the analysis, this kind of confusion may manifest in struggles over a sense of originality, and conflicts over ownership of creative work, or in concerns regarding appropriation of ideas or plagiarism. In such situations, the analyst may feel under subtle pressure to reassure the analysand of his creative capacities, but in fact, individuals who wish to be creative but who lack the special perceptual, cognitive, or integrative abilities to turn out actual creative work can easily fall into this mental organization in their analysis.

On the other hand, analysands with actual talent may slip into this mental organization for extended periods of time and appear as if they have little creative ability, while in fact they are in a regressive retreat from higher-level conflicts with internal whole objects, or struggling with some measure of frustration to find expression for some experience that taxes but ultimately does not exceed their capacities for symbolic representation. Taking a stand one way or another on the analysand's abilities beyond what has actually been demonstrated in the external world becomes an enactment that stands in the way of exploring the analysand's conflicts both with the containing part object and with whole objects.

The psychic activities associated with each of these mental organizations may also give rise to particular aspects of the aesthetic impact of the artist's product. Activity in the analyst-as-mental-function organization, for example, may evoke in the artist's audience its own creative impulse as the artist excites his audience with sensuous stimulation that

evokes some affective aspect of the artist's experience, but leaves the full processing of this to the audience. Activity within the analyst-as-medium organization evokes in the audience a sense of being able to perceive or understand the world in an expanded, richer way, as the artist literally stretches the capacities of the audience beyond its accustomed limits in order to enable it to more adequately receive his vision. This is reminiscent of my experience in Lisa's treatment of being more aware not only of subtle differences in color, but also of the ways in which color functions to convey nuances of affective experience.

Regression—even prolonged regression—to either or both the first two organizations I have described is not only inevitable, but probably necessary as analysands struggle with creative work, as each mental organization is associated with psychic activities that are central elements of the creative process. Awareness of these organizations not only gives us a clearer understanding of some of the potential interferences with the creative process that the artist may encounter; it also enables us to work more effectively with creative individuals by protecting against potential countertransference interferences that their emergence might evoke, and allows us to understand more fully with our analysands the joy and the pain of the creative process as it unfolds.

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*1148 Fifth Avenue*
*New York, NY 10128*

*e-mail: rbz1@columbia.edu*

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# ENDINGS AND BEGINNINGS

BY SIRA DERMEN

*The author postulates that challenges related to ending an analysis may reflect the fact that the analysis has never truly begun, in the sense of achieving a true analytic engagement, one that can lead to psychic growth. Patients who are unable to achieve an emotional experience thus highlight the problem of interminability as one of how to begin. The author describes the model of reification of experience and presents aspects of the analysis of a perverse patient, the case of Mr. C, to illustrate the usefulness of this model in understanding how this patient defended against experiencing his emotions and the ensuing transference-countertransference difficulties.*

**Keywords:** Termination, reification, perversion, analytic engagement, instrumentality, emotional experience, sexualization, sadomasochism, deception, guilt, interpretation, analytic relationship.

## INTRODUCTION: NO ENDING WITHOUT A BEGINNING

In the seventh year of his weekly treatment at the Portman Clinic in London,[1] Mr. A, a transvestite patient, ended his therapy as follows. In

[1] The Portman Clinic is a public-sector outpatient clinic in London that specializes in offering psychoanalytic psychotherapy to patients who suffer from perversion, delinquency, and violence. It is part of the Tavistock and Portman National Health Service Foundation Trust.

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Sira Dermen is a Training and Supervising Analyst of the British Psychoanalytical Society and is Hon. Senior Consultant at the Portman Clinic, London.

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mid-session, he said, "I'm sorry, but I have to do this," got off the couch, and walked out of the consulting room.

It was not wholly out of the blue. We had been talking about ending for some two years, but when he ended in this singular manner—*doing this,* as he called it—I was dismayed, though I knew he was telling me he could not "end" in any other way.

After some weeks, Mr. A contacted the clinic again, requesting to see me. In this last meeting, I commented that he had to come back to check that I was alive: ending his therapy had not killed me. I did not hear from Mr. A for the next ten years. Then, in the very month that I was retiring from the Portman Clinic, he was referred back to the clinic by the same agency that had originally referred him eighteen years earlier.

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Ms. B was a private patient in five-times-per-week psychoanalysis—an accomplished professional woman, in a stable marriage, with two children. Yet after ten years of analysis, an ending was nowhere in sight. She would, from time to time, raise the question of ending in the form of how much longer "this" would last. By contrast, my preoccupation was not with an ending, but with a beginning. Despite diminution of her psychosomatic symptoms, despite substantial improvements in family life, especially her relationship with her children, despite positive developments in her career, I felt little had changed in her mode of engagement with herself or with me. She remained dissatisfied and demanding, controlled and controlling, and there was a cold, calculating quality in her attitude toward me, as if her eye were constantly on a narcissistic balance sheet.

Beneath the veneer of psychological formulae she had acquired, Ms. B remained untrusting, ever-vigilant, and un-free to associate. She felt she had been helped by her analysis, but it seemed that analytic engagement was still as alien to her as it had been at the start of our work together. True, needing analysis was now less of a narcissistic blow to her, so she felt less belittled and more tolerant of interpretation, but her attitude toward insight remained what I came to think of as *instrumental.*[2]

[2] Roth (2009) addresses a recognizably similar clinical phenomenon from a different angle. She conceptualizes it as the *commodification* of the object.

In this she had something in common with Mr. A: they were both preoccupied with *how to do it.*

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Mr. A treated insight as a formula, a prescription. He told me that, as he was leaving a session in which he had been struck by an interpretation, he said to himself: "Do this and you will never feel anxious ever again." He had been bitterly disappointed because it had only worked for a few days. It took me some time to understand how he had turned the interpretation in question into a "do this"—a formula.

With all her sophistication, Ms. B carried out a version of the same thing. It was only when I started addressing the *instrumentality* of her mode of engagement with me that an area of resistance came to light. To give an example: I had often interpreted her envy of those she saw as capable of *doing* whatever she felt she could not do—and this ranged from her husband's capacity to simply pick up the phone and make social arrangements, to my capacity to analyze her. Ms. B could now reveal that she felt entitled to dismiss any interpretation that made her feel "uncomfortable." Her hitherto-silent, dismissive response of "How is that supposed to help me?" could find voice. We could now put into words her belief that it was my job to give her the tools to get whatever she wanted while simultaneously relieving her of all "discomfort," especially any feelings remotely approaching depression or guilt.

This realization paved the way to analyzing the particular form of dependent relationship in which Ms. B engaged with me, wherein she felt she owed me nothing, as well as the wishful fantasies sustaining it, which up to then she had silently gratified. Her certainty that she knew what constituted real help arose out of her need to obliterate any *emotional experience* of being helped by me. Reluctantly, she came to think that maybe she should "consider" some of the uncomfortable things I said because they *might* help her.

For my part, I could appreciate what uphill work analysis was for Ms. B, as she had no natural bent toward inwardness, no acceptance of the necessity of learning from experience—the opposite of the instrumental approach—without which there is no true psychoanalytic engagement.

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To follow up these opening remarks, I will state my theme in the present paper. There is no ending without a beginning. Patients who cannot end analysis are patients who, like Mr. A and Ms. B, have not begun, because their approach to analysis is to evade the give and take of *emotional experience*. Having managed to get by in external life, they are thus reinforced in the instrumentality of their approach to psychic life.

Of course, Ms. B was doing better than merely getting by; viewed externally, she was far less disturbed than Mr. A. Ms. B had a richer life, except that her demands and complaints precluded her from inhabiting her life—and, equally, her analysis. It is telling that for years she referred to her analysis as "this." In short, psychoanalytically, both she and Mr. A fell within the broad diagnostic category of narcissism.

## EXPERIENCE AND ITS MODES: REIFICATION

Emotional experience is the medium through which we apprehend the clinical situation. It is also the medium of self-awareness. Whatever psychoanalytic understanding we have reached, our concern is to convey this to the patient in a way that will resonate with his emotional experience. The locution "the patient's experience of the analyst" is the commonest, the most natural form of words in conveying the analyst's sense of the manifest transference.

But, unlike transference, *experience* is not a technical term, so it does not claim our attention. We are not inclined to say, "It depends on what you mean by *experience,*" as we might of a theoretical term, which may have acquired different meanings with the development of psychoanalytic theory. It seems obvious that we all mean the same thing by *experience,* that *experiencing* itself—as opposed to its content—refers to one and the same phenomenon, that it is the inevitable and irreducible aspect of being a sentient creature. To have sense perceptions and feelings is to have the potentiality to have an experience.

Yet my clinical work with perverse patients, and some narcissistic patients, has forced upon me the realization that I cannot take for granted that experience is a unitary phenomenon. It appears to have modes, some of them pretty strange. I have already alluded to one such mode:

an instrumental approach to psychic life. Instrumentality is entirely appropriate to acting upon an object, with behaviorism as its background theory. But acting is not the core of experiencing. Instrumentality is inimical to the enterprise of psychoanalysis.

The psychoanalytic setting enables the gradual unfolding of an experiential process, lived and meditated upon, all in the service of learning. Beyond instrumentality, there is a more extreme deformation of experience that defies our implicit understanding of the concept in that it is denuded of emotional qualities. The patient is always observing himself from a distance. He is never *in* his experience. He brings to his experience of himself a mode of apprehending more appropriate to an inanimate object. So what kind of "experiencing" is this? Tentatively, I call it a *denuded experience*.

Characteristically, experience is a two-way process—active and passive, operational and receptive, with the emphasis on the passive and the receptive. Typically, the two directions are going on at the same time. Above all, it cannot be controlled. It is *given*—and one has to be open to it. For this reason, *undergoing an experience* is a better choice of words than *having an experience*. We could call this *ordinary, rich, saturated experience*—experience fully lived—in contrast to the denuded experience of a patient who is always at a distance, observing himself.

Patients who do not actually begin analysis despite turning up five times a week are trying to avoid the two-way movement of full experience. Acquiring knowledge from a book, or the analyst-as-book, is considered not only preferable to learning from the analyst-as-human-being, but even the ideal kind of relation. The advantage of a book is that it does not talk back. But knowledge so acquired changes nothing, as we know. I propose that analytic engagement on this basis is a nonbeginning. I also suggest that such a nonbeginning can last for years.

Optimally, the psychoanalytic process has two components. On the one hand, the patient has to allow himself to be *in* his experience, yet over time he has to learn to stand back sufficiently to join the analyst in reflecting upon it. This is not easy, but managing this tension is one of the capacities that grows in an analysis in which growth is happening. This capacity for self-observation is an indicator in assessing the patient's readiness to end analysis. Where emotional experience itself is evaded,

there can be no true self-observation either. Instead, there is a great deal of self-absorption, rumination, and vigilance that are believed to yield truths about self and object—convictions sometimes of a delusional quality—but there is no self-observation.

So far I have put things in black and white—to indicate that experience is not a unitary phenomenon. However, it is more fruitful to consider deformations of experience as residing along a continuum. At one end we have full experience, the capacity to be *in* one's experience. At the other end is what I shall describe as the *reification of experience*, a deformation so extreme that it moves into a different dimension.

Along this continuum, we can place patients who frequently gravitate toward *the observer* position. Clinically, it makes quite a difference whether or not the move to the observer position is a tendency only—a position to which a patient resorts defensively in identifiable emotional situations, while having the capacity for full experience. I would place Ms. B somewhere about here.

However, when the observer position is essential to the patient's central defensive structure, and therefore has become the *only* mode of experiencing, we are in a qualitatively different situation. We encounter this situation with perverse patients, where we are confronted with the startling human capacity to treat not only the object and the body, but even the mind, as inanimate. This extreme state of affairs is the most intractable obstacle I know of to psychoanalytic engagement, to initiating the psychoanalytic process. Every hint of a beginning is nullified through the reification of potentially full experience. The essence of the defense of reification is the turning of a live experience into a dead thing.[3]

## CASE PRESENTATION: MR. C

I turn now to a more detailed case presentation: that of Mr. C, a perverse patient who was seen five times per week. In this analysis, after the well-known aspects of the perverse transference—sexualization, sadomasochistic relating, and deception—had been sufficiently analyzed, there emerged a puzzle: something silently undermined every insight, every new beginning. I will describe how the solution to this puzzle

[3] *Reification* comes from the Latin *res,* a thing.

hinged upon identification of the defense of reification of experience. I will then discuss the usefulness of this understanding in opening up the analytic process. I will go on to examine how these openings led to a fuller appreciation of the power of this defense to nullify every potential beginning.

Mr. C was a 50-year-old, single man when he started analysis. The reason he gave for seeking analysis was that he wanted to get married and have children. But he had a problem: whenever he started a relationship with a woman, his eyes began hunting for another woman. This identified his perversion: voyeurism.

By the end of the consultation, Mr. C was able to sum up his predicament as "I cannot love or be loved." He arrived for treatment with an arsenal of analytic jargon, a bastion against the analytic process. Any interpretation could contribute to pseudo-talk. If I took up what I *supposed* was his anxiety, he would go along with it, but the nature of engagement did not change. (He secretly believed himself to be immune to anxiety. It took us three years to reach the point at which he could say, "I live outside the perimeter of anxiety.") Technically, here-and-now interpretations posed a particular danger: it was a game whose rules he thought he knew and could play with great skill. On the other hand, what I took to be a free association would turn out to be in reality a mental action—for example, taking himself out of the room, absenting himself. He believed he could use even his dreams to defeat and trick me.

Mr. C was tall, lean, and muscular, yet came across as effeminate. He was tricky and passive, controlled and controlling, and expressed absolutely no affect. He would offer a well-scripted "thought" and then fall into a dead silence. On the couch, he lay like a corpse. His early communications were of himself as "neither dead nor alive," but leading the halfway existence of a "zombie." Nothing touched him; he existed "behind a glass wall."

The pathos of this state of affairs remained obscure to others and to Mr. C himself, as he perpetually engaged in seduction—of everyone. The transference was sexualized, dominated by sadomasochistic dynamics, with the patient initially firmly entrenched in the masochistic position. Deception in the transference was ever present, a source of erotic and narcissistic gratification.

Mr. C found extremely difficult his perception of me as someone whom he could not easily seduce, but he came to appreciate my efforts *not* to be seduced into pseudo-analysis. This meant I could stand not being appreciated, and I could bear to know his secret denigration of me. With time he could be more honest, less dedicated to conscious deception. The relief he reported was one of feeling less fraudulent, less alone with his lifelong sense of being bad and/or mad.

He began to join me in attempting to discriminate pseudo-contact from real contact, and to articulate how impossible it was for him to be a patient on the couch. He could not say what was on his mind, as his mind was dominated by the part of his personality that he came to call *the observer*, the one who scrutinized my every move to find out what *I* required of *him*. Mr. C could thus be in control of the proceedings by *appearing* to give me what he believed I wanted, while secretly withholding. Frustrating me was exciting. As *the observer,* he was in a superior, unaffected position; he watched and controlled all interactions between us, literally from a great height, wholly *dissociated* from his body, the seat of his emotions.

On those rare moments when the patient was actually *in* his body—when he was not the observer—he felt profoundly disturbed, on the edge of breakdown. Emerging from such a state, he said: "My whole life is organized around never feeling loss." I would add only that loss—to the extent that it can be represented—is always a betrayal; at a deeper level, it is bodily disintegration (what Mr. C later came to call "chaos").

During the first three years of Mr. C's analysis, there were changes in two areas: his aggression, and the narcissism of the object. He began to own his hostility toward me and the whole analytic endeavor. His belief system could now be expressed. *The observer* was his true protector. The observer was all powerful and all knowing, anti-dependent and anti-analysis. Without the observer, to be a patient was to be in my power. He began to ask why he came to analysis five times a week if he was so determined to defeat me. And how could I stand him, such an unrewarding patient?

Mr. C could see a link between his punishment of me and his hatred of his mother. He began to take some interest in his dreams, which at this stage featured repetitive images of robbers, criminals, and terrorists.

Something had changed. Nevertheless, I felt that something else, something not yet identified, quietly undermined every insight we reached. Every session started as if there had been no previous session: with lifeless statements—minimal, scripted offerings called "thoughts."

A change in the countertransference was that I no longer felt the same pressure of frustration. I felt, rather, that if something were to happen, the onus of creativity had to be entirely on me; I must be the sole bearer of the wish for meaningful contact. I must not count on any collaboration from the patient; I must keep alive the hope that, at some unpredictable moment in the session, I *might* get through to him in a way he *might* then appreciate. Which left me with a puzzle: what had happened to his experience of moments of real contact?

One day, there came a clue. Having done some productive work, Mr. C said, with anguish in his voice: "I wish I could say that I have had an experience of being understood by you—which I have—and that this will make a difference. But I know it won't." There was masochistic defiance here. But what was *new* was the anguish. This alerted me to the fact that, during this moment of real contact, something was happening to the *experience of being understood.* That he routinely edited me out of the process, so that the understanding became his creation, was not new. Nor was it new that he fed his grandiosity and obliterated any awareness of dependence on me; such emotional stealing had been a familiar part of the work. The new insight concerned the silent dynamics of *reification* of his experience of being understood by me.

Mr. C abstracted the *understanding* from the *experience of being understood.*[4] This is *the observer* in action: the patient removes understanding from its living context, which alone gives it meaning—gives it life. Denuded of the shared experiential context, understanding becomes a *thing* that can be possessed by the patient and stored in his mind. (This is Bion's [1962] knowledge as possession, as opposed to the emotional experience of coming to know and be known.) Reification transforms insight into artifact, understanding into information. Thus, instead of understanding living and growing in Mr. C's mind, his mind came to

[4] Joseph (1989) makes the identical distinction between the experience of being understood and "getting understanding" (p. 79).

possess a collection of things called *understandings*. These were filed, classified, reclassified: this was what he called *thinking*.

When this dawned on me and I could interpret it, Mr. C's confirmation was unequivocal. He said with unprecedented conviction and vehemence: "I don't want the living context! I don't want to experience!" The energy in his voice was singular: he had really come to life—at the very moment that he was rejecting life.

How does this help? First, the concept of reification illuminates the recalcitrance to internal transformation of perverse patients. Second, it is salutary to realize that the mere occurrence of emotional contact between patient and analyst can be overvalued in work with perverse patients. Not that emotional contact never occurs, but rather that, even as the analyst is moved, and is having an experience and believes herself to be sharing the experience with her patient, the patient has already silently destroyed the moment of real give and take.

Clinically, this conceptualization not only enabled me to analyze the reification in the moment, but also allowed access to the hitherto hidden, split-off, mad parts of Mr. C's mind, an area ruled by delusional beliefs, such as: "I am the only boy-man in the world." Work could then follow on his confused gender identity: his overt passivity equated with femininity and his hidden masculinity equated with exciting delinquency and violence. His sense of himself was as everything: girl, boy, man; and yet as nothing: not-girl, not-boy, but a "zombie."

Mr. C would occasionally express the hope of coming alive, or some concern over wasting his life and his analysis in the ceaseless vengeful triumph over his mother and me. Yet what he called "hope" could now be seen to be a manic, omnipotent state of mind—and despair, when it emerged, was suicidal in quality. Moments arose when his terror of utter helplessness could be touched on. We now had a real word for anxiety—his word: *panic*. Any hint of dependence on me led to the panic of disorientation—the terror of leaving the consulting room and experiencing the world as *chaos*.

While the understanding of reification opened up the analysis and made for some movement, again, it felt like nothing was changing. The old problem of *no experiential continuity* was still there, dressed in new clothes. At this point, I noticed something: although understanding was

growing in *my* mind, something different was going on in *his* mind—an accumulation of disconnected pieces of knowledge, but no growth. I now felt the full force of the concept: reification precludes the growth of true understanding. *Things* cannot grow. They can only be put together into lifeless aggregates, or kept apart, assembled and disassembled, and all this with no effect upon the one in charge of the activity. My patient treated his mind as a cabinet of curiosities.

But what is it that reification defends against? What is so terrifying about being alive that live objects are treated as inanimate matter, and experience itself is treated as a thing that can be operated upon?

*The Tantalizing Mother: The Genesis of Reification*

Over the years of Mr. C's analysis, an unvarying situation changed in one respect only: it became more overt. Every time I gave the patient the dates of an incipient break, weeks of silent hostility were ushered in. The patient grew as dead as it was possible to be, essentially walking in and out of the consulting room and breathing on the couch. He spent considerable time sleeping on the couch. When awake, he lay absolutely still and silent.

In every session after my announcement of a break, Mr. C uttered one or two carefully scripted sentences, never in response to anything I had said, but merely to prove that nothing I said had any impact on him. Even if occasionally there was contact, the following day it was as if there had been none. Over the years, I offered many interpretations at such times, including the dual aspect of his sleeping: to obliterate all awareness, and to be at one with me forever. In practice, I found interpretations of his sadism and his unquenchable thirst for revenge to be the most accessible to him; I had to realize that I had committed an unforgiveable crime for which my punishment was lifelong torture. But interpretations that linked his revenge to the approaching break were not convincing—not to him, and increasingly not to me; the nature of my crime remained unknown.

On one particular occasion, after many weeks, there came an opening. Near the end of a session, out of the blue, the patient asked himself a question: "Why do I hate my mother so much? What she did to me was not *that* bad."

This led, in subsequent sessions, to work on identifying her original crime. I condense here the image of the *Tantalizing Mother,* which emerged gradually as a result of collaborative work, but the words and phrases I use are his. She could not get enough of him; she fussed over him, could not leave him alone; he was all she wanted. He fitted in with her, gave her everything she wished for. He was not a child—he was a grown-up, the one whom mother desired. Then, suddenly, she wanted to be with father, and he was told to leave her alone. When she had her husband, she became haughty; she treated him like a child—to be seen and not heard, to be told off: "Stop being such a baby!"

This was the pivotal moment: the moment of betrayal. We had been there before, but never accompanied by a current of such strong affect. Mr. C's violent rage now found words appropriate to the maddening frustration: "*You complain about the thing you made me into!*"

This was a deeply moving moment. And there was no question that the patient was reliving his unbearable experience. But in subsequent work, I had to learn, yet again, that what *I* learned from my clinical experience with Mr. C and what *he* made of it were discrepant. *I* felt he had been disinherited; his childhood had been taken away from him. I suspect it was the empathy he picked up from my tone of voice that he could not stand. Coldly, he disagreed with me and informed me that he *loved* being a grown-up, and that he looked down on children; what he hated was his mother's treating him like a child.

And of course, this was timelessly true. In the analysis, he hated my treating him as a patient. Taking this up enabled him to spit out at me: "I'll tell you how it makes me feel! It makes me feel *profoundly unimportant*!" He could then acknowledge his conviction that, were he to allow himself to stay with his fury for more than a moment, I would be in danger of being murdered. To come alive was to kill me. Being in his experience was to plunge into a psychotic transference where I *was* his mother. He evaded the dilemma and settled for a war of attrition. The episode ended with his declaration to me: "If I am to be *real* with you, I will have to dispute *every single thing* you say."

Mr. C kept his promise. He did dispute what I said. And this, of course, had the potential for a real beginning. Except that there wasn't one. Instead, I was told by the patient: "You have to understand that

there is an ever-present background against which I hear everything you say. You are cold, harsh, and critical." There were variations on this theme (he "knew" that I hated him); and he could develop imagery suggesting that I was not so much hating of him as *indifferent* toward him: me the surgeon operating on him, me dedicated to psychoanalysis but not to *him*.

One might think these images to be full of potential—a surgeon operates on an anesthetized patient, psychoanalysis and I as the parental couple—except that they proved not to be. The characteristic of all Mr. C's statements about "the background" was that they were presented as unnegotiable reality—as dogma. It was in this new era of his freedom to be overtly critical of me and to tell me how he "experienced" me that the problem about the quality of his "experience" came to the fore. It became clear that, when the patient told me I was cold, harsh, and critical, he was not communicating his experience to me as a human analyst who might receive the communication and understand it. Rather, he was telling me who I was; he was telling me this was his reality, and even to allow for any other possibility was for him to comply with my requirements, and therefore to be driven to deception, which he was no longer willing to do.

Thus, Mr. C's newfound capacity to be more outspoken, which one might think he owed to the analysis, became an instrument to defeat the analysis. Quite a conundrum—but it did have the merit of putting center stage the issue of deception.

I will return now to the Tantalizing Mother. This material suggests a construction: a hypothetical moment in which the patient initiated and instituted the reification of experience, which henceforth became his main mode of psychic being. The image of the Tantalizing Mother condensed the maddening emotional experience that could not be lived because it led to murder, yet it was reenacted within the mode of reification. The solution (the defense) was for Mr. C to vacate his experiencing, bodily self and become the observer of his own experiencing. The gain was to preserve the needed object. The fantasy was that, from the observer position, whatever was needed to sustain life could be extracted from the object, with no regard for what was being done to it.

He, the observer, was entirely immune from being affected by it, a thing. Any emotional experience of give and take was dispensed with.

The catch in this solution was that an awareness remained that the object would *hate* being so treated, as a thing to be used, so that deception of the object was imperative. A pretense of caring was substituted for real caring. Deception was instituted at the same moment as reification. That the reification did not obliterate all awareness of feeling—hatred aroused by being treated as a thing—was the only tribute paid by this solution to the truth of the original experience. It lived on as the ever-present threat of the object's hatred of him, the subject, should she get to know what he was really doing under the facade of seductive care.

While such reification ensures survival, it does not obliterate guilt—in fact, guilt becomes a conviction of irremediable badness. There is a vicious circle here. By putting himself outside the human condition (through reification), the patient also puts himself beyond the reach of what he most comes to need, the mitigation of his guilt. Guilt cannot be mitigated without the intervention of a *live* object capable of offering him understanding of his predicament, which could lead to forgiveness—first and foremost of himself. But the only way he knows to make contact is through seduction and deception. The vicious circle is lived out in the analysis.

The model of reification is exactly that, a model, and not a historical reconstruction. The model hypothesizes the experience of being tantalized and treated as a thing, as the central experience defended against through reification. I do not claim genetic primacy for this experience. Historically, a great deal had happened before the period from which this memory comes; it is not from infancy.

Interestingly, Bion (1962, chapter 5) hypothesizes a disturbed early feeding situation in which the infant's solution to irreconcilable fears—fear of aggression, his own or another's, on the one hand, and fear of death through starvation, on the other—is to create a distinctive form of splitting between "material and psychical satisfaction" (1962, p. 10). This enables the infant "to obtain what later in life would be called material comforts without acknowledging the existence of a live object on which these benefits depend" (p. 10). Bion also connects this "enforced splitting" with the destruction of alpha-function, and with the distinction

between knowledge as possession and knowledge as a process of coming to know. With such patients, the paradigmatic psychoanalytic relationship of the analyst getting to know the patient, and the patient getting to be known by the analyst, cannot be realized. In Bion's (1962) words:

> The patient . . . does not feel he is having interpretations, for that would involve an ability to establish with the analyst the counterpart of an infant's relationship with a breast that provides material wisdom and love. But he feels able only to establish the counterpart of a relationship in which such sustenance can be had as inanimate objects can provide . . . . The patient uses equipment suited for contact with the inanimate to establish contact with himself. [pp. 11-12]

It appears that Bion (at least in this text) is according ultimate explanatory status to the split he postulates between material and psychological/immaterial satisfaction, with its correlate in contact with inanimate versus animate objects, a sort of bedrock of the patient's being. Interestingly, though Bion's concern here is with thought-disordered patients, in my experience, it is remarkably illuminating of something fundamentally intractable that one comes up against in the analysis of perverse patients.

That there may be a close link between what we call *disorders of thought,* on the one hand, and *perversion,* on the other, raises many questions. At the most abstract level, it raises questions of nosology/classification: whether perversion can be placed on a continuum extending from psychosis to neurosis. Glover grappled with this question and reached a negative conclusion. (For his alternative classification of a "parallel series," see Glover 1956, p. 226.)

I do not as yet feel in a position to grapple with the role of psychic temporality and causality—the Freudian *deferred action*—in this material.[5] The model of reification brings together meaningful things Mr. C has said in seemingly unconnected contexts, separated by long periods of time. To take only two examples: in his view, there was a point at which he stopped caring and started to pretend to care, the point at which he

[5] Perelberg (2008) suggested an answer to this question: in killing experience, the patient is killing time and space. With the collapse of time, there is no *après-coup.*

said—in his mind—to his mother: "You are *nothing* to me!" At another point, the patient said that the woman he had sexual intercourse with was not a person, but a "bundle of flesh." What I claim for the model is that it addresses my persistent clinical puzzles and struggles, as well as my failures to speak to the patient in a way that ameliorated his underlying sense of isolation, despair, and guilt.

The model illuminates why Mr. C's *experience* of his mother in the transference remained so inaccessible to analysis. The purpose of reification is to render the self immune to being affected by the object—in other words, to obviate the need to *experience* one's self as linked to the object. It is this which was repeated in his analysis. The patient was voicing the truth when he said to me, "Nothing you say will make any difference to me," and equally so when he said, "You are cold, harsh, and critical."

But the truth lay in the service of *doing* something to me—making me a thing, repeating and reinstating his defense. I might understand him to be saying, "Nothing you do will ever take me there, where I feel, where I am subject to the maddeningness of true experience." But the clinical problem remained: that is, how was I to convey this understanding to him?

Since he had to reinstate the defense, he could not allow my words to resonate with the needy, vulnerable, human part of himself. And even if there were a stirring of an emotional experience, within a matter of seconds, reification would occur. The situation was greatly complicated by sexualization, so that there was triumph in this, and sadistic gratification. More than gratification, it was the only counter to Mr. C's deadening reification; it was his only avenue to life—life as triumphant excitement. But the fact remained that, in doing it, he was halting the possibility of revisiting the maddening original situation in the presence of a new object, his analyst.

So when I conveyed to the patient my understanding of what he was defending against, he might go along with me, but we ended up having a theoretical discussion about him. If I addressed his defense and took up his indifference to me, I had to address the fact that indifference was his ultimate revenge against me. At a certain point, he could acknowledge such interpretations intellectually, but this did not help his guilt—

at best, it became a piece of dead knowledge, and at worst it became sexualized and experienced as my weapon to make him feel even worse about himself than he already felt. His guilt could never be mitigated—he had placed himself outside human intercourse.

A model I have found *not* to illuminate clinical facts is one based on the assumption of the patient's identification with his mother. The clinical facts suggested, rather, that the mother was lodged and kept inside Mr. C as an *introject*, an alien other who had to be kept *doubly alien*—she was a thing, and she was a not-him-thing. This was the only way he could say no to her (and to me). His whole being and energy were devoted to keeping her at arm's length, keeping her as a thing to be acted upon: imprisoned, punished, extracted from ("I force you to care for me"), and denied life, save for the bare minimum of sensual contact when the need arose ("All I know is to pleasure the woman, service her, and get pleasure back"); the need to deceive was unmitigated. This at least explained my conundrum that, even though *I* might think he had a sustained experience of me as someone whom he did not have to deceive, *his* psychic reality was that he had no such experience.

Another merit I claim for my chosen model is that it helped with my countertransference. Frustration ceased to be the main problem. The greater danger was my indifference, an indifference born out of my repeated experiences of sheer outrage and disbelief as I listened to what Mr. C did with the insights we had reached with such painstaking work, moments I found so moving. He rendered them lifeless things, which he himself learned to call "just words," "empty words," "meaningless words," or "just theory." And not only this; he also took credit for the fact that, in saying they were meaningless, he was being honest. His capacity to turn any gain in the analysis into a weapon against me was limitless. The twists and turns of deception were extraordinary, and disentangling what was genuine from what was false, what was in the service of revenge, or what expressed his profound despair could feel like an impossible task—and yet it was the main task. My countertransference problem was: how could I maintain empathy rather than resort to interpretation as a mechanical procedure?

It was not difficult to attribute the function of deception to the patient's observing self. In a productive session, he was able to say: "When-

ever I am approaching really feeling something . . . like now . . . it's like I am reaching out to put my hand into the fire. The observer says, 'It isn't real,' and I draw back . . . and then *it isn't real any more.*" We could then see that the observer, held in place as Mr. C's true protector, was in fact a deceiver—he "protected" him by telling him that what was real was not real. In time, the observer became a bit less reified, became acknowledged as part of the patient himself, and with this came some capacity to own and to take the measure of his confusion about what was real and what was not.

Here is a brief excerpt from a session. The issue here was the ever-present me in "the background." On this occasion, the cold me was elaborated as *deaf to him.* This arose out of my taking up Mr. C's habitual gesture of forcefully poking his ear with his index finger, as a communication of his experience of my emotional deafness to him. The patient then talked as though he believed I had spoken to him in an unemotional tone of voice. Since this was not convincing to me, I addressed his defense.

ANALYST: I think you edit out any emotion you hear in my voice because it's dangerous. It could affect you.

MR. C: [immediately] I don't think you have any emotions.

[The patient stopped and fell into a dead silence. He was not to be contradicted. By this point, I had learned that when he made such a statement in such a tone, he was not communicating his experience of me in any ordinary sense of that word. But he was doing something very familiar—making me into a thing. I chose not to interpret this as it felt repetitious and mechanical. As the silence continued, I associated to words we had recently gotten to—in a tiny opening, after his sustained indifference upon returning from the break, and after he had sufficiently impressed upon me the fact that the problem was not the break itself because, break or no break, the situation was always the same for him: he felt "incredibly bad, ugly, and frozen out." If anything, he had said, the break was a relief for him because he could at least distract himself. Now, "frozen out" was pretty close to what *I* was feeling. Having gotten to this

point, I no longer felt frozen, and it felt all right to remain silent.]

MR. C: You are emotionally deaf to me. [This was my interpretation of his experience of me—now issued as his, and as fact! I felt that directly interpreting this was likely to draw me into an all-too-familiar sadomasochistic enactment—would close rather than open a space for experience. I remained silent.]

MR. C: [After a long silence, he spoke in a different, more reflective tone.] Maybe *I'm* emotionally deaf. [Silence]

MR. C: [He spoke with a hint of distress.] Maybe I'm deaf to my own emotions.

[Another long silence followed. The patient started rubbing his forehead with his fist; there was a sense of struggle.]

MR. C: I'm confused. I can't work it out . . . . I can't work out whether I am really emotionally deaf and pretend to be hearing . . . or whether I pretend to be emotionally deaf and I can really hear . . . .

ANALYST: You can't work it out without help from me, an analyst able to hear you emotionally. You did away with that analyst the moment you said, "You have no emotions." You made it real for yourself that I am emotionally deaf to you.

## CONCLUSION

I hope I have illustrated the problem of interminability with a patient with whom what it is to have an emotional experience cannot be taken for granted, and also that the problem of interminability is one of how to begin. At least it was so in this case. It is said that, in the legal arena, hard cases make bad law; in psychoanalysis, by contrast, hard cases are revelatory. What we learn from hard cases illuminates dynamics with a wider range of patients.

I will end with a further clinical vignette from the analysis of Mr. C. It occurred at the end of a week in which he had given evidence of having derived some benefit from a session, and then proceeded to

show me that he could not tolerate this being acknowledged. On Friday, there was a surprising development. He said: "As you were talking, my thoughts went to yesterday's session . . . and I thought, *you accept* that there are *some* sessions I benefit from, and others I *don't* benefit from." This was offered as a revelation. He went on: "You are not trying to control all the time . . . . It felt like . . . I don't know how to describe it . . . . It felt like a very grown-up position."

I found myself saying: "I accept my limitations." His revelation was matched by my own; I felt I had spoken out of a sense of my own fallibility and mortality.

After a silence, the patient said: "So much of my thinking is done from the observer position that when I begin to think from another place . . . inside . . . it is freeing, but frightening, because there is chaos."

* * * * * * * * *

In sum, we all have to face our terrors. We believe analysis offers the patient the opportunity to face them in the presence of an analyst who is prepared to accompany him on a journey, wherever it leads, and who can, over time, transform such stuff of raw experience sufficiently to make it bearable. For some patients, defenses obliterate any awareness that there is a journey to be undertaken—in psychoanalysis as in life. And so they do not begin.

Perhaps we continue working with such recalcitrant patients not only because of what we learn about the complexity of the human mind, but also because they teach us to realize our limitations—and our mortality. It is paradoxical that being confronted with an interminable analysis should connect us with the unalterable fact of life, that it ends. If we do not believe in forced terminations of analysis, the option of giving up is not available. This may sound like an excess of therapeutic zeal, but for some considerable time, I have grounded myself in Bion's (1965) dictum: "Psychoanalysts do not aim to run the patient's life but to enable him to run it according to his lights and therefore to know what his lights are" (p. 37).

I discovered that working with Mr. C made me more deeply alive to the pain and the beauty of the following couplet by Shakespeare (1623).

Golden lads and girls all must,
As chimney-sweepers come to dust.
[IV:2:325-326]

The lights by which Mr. C lived his life rendered him immune to pain, but, sadly, also to beauty. For him, everything was merely as dull as dust. It was this, his ultimate sense of isolation in his reified world, that I had to stay with for as long as it took.

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*16, Hungerford Road*
*London N7 9LX*
*United Kingdom*

*e-mail: siradermen@blueyonder.co.uk*

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# POSSESSIVE OBJECTS AND PARALYZING MOODS

BY DAVID POTIK

*This article focuses on unique being states of mental and physical paralysis among schizophrenic patients. These paralyzing moods derive from continuous extractive introjections, in which anything alive in the patient is sucked out, as it were, by an internalized possessive object. Continuous extractive introjections early in life constitute attacks on authentic expression of the child's subjectivity, and prevent the development of his idiom and the unthought known. A clinical vignette is presented to illustrate certain movements both in a progressive direction (i.e., in psychoanalytic treatment) and in a retrogressive direction (in the formation of the original psychotic pathology).*

**Keywords:** Projective identification, internalization, paralyzing moods, extractive introjection, psychosis, schizophrenia, possessive object, parasitic transference, nameless dread, selected facts, attacks on linking.

> This breast is an object the infant needs to supply . . . with milk and good internal objects.
>
> —Bion (1962, p. 34)

## INTRODUCTION

Wilfred Bion is one of the most prolific and interesting analysts, whose contributions in many areas of psychoanalysis have shed light on com-

David Potik is on the staff of the Department of Psychiatry, Tel Aviv Sourasky Medical Center and Tel Aviv University, and is also on the staff of the Miriam and Sheldon G. Adelson Clinic for Drug Abuse, Treatment, and Research of Tel Aviv Sourasky Medical Center, Tel Aviv, Israel.

plex mental disorders. His intriguing and original writing about primitive mental processes was drawn from wide experience of the analysis of psychotic patients, and led to important findings about psychoanalytic theory and the treatment of schizophrenia (Bion 1959, 1962).

One of his most important discoveries about the psychotic mind relates to the destructive *attacks on linking* that the patient makes on anything felt to have the function of linking one object with another (Bion 1959). These attacks are related to a "certain state of mind in which the patient's psyche contains an internal object which is opposed to, and destructive of, all links whatsoever, from the most primitive to the most sophisticated forms of verbal communication" (p. 108).

Bion's descriptions of this particular state of mind can be related to Bollas's (1984, 1989) concept of moods, which are complicated self-states that create a remembering environment in which one reexperiences former infant and child experiences and states of being. The revelation of moods in analysis is valuable, since self-experiencing and meaningful events from the patient's personal theater throughout life are expressed through moods. Bollas's writing does not focus on psychotic processes as much as Bion's writing does, but Bollas's unique therapeutic comprehension helps broaden our understanding of the patient's unconscious self-experience and evasive being states.

Bion (1959) writes that "the nature of the external object which is internalized and is opposed to all links is left for further investigation" (p. 108). The main objective of the present article is to further our investigation of the nature of this object and its continuous influence on emotional experiencing in life. In the first part of this article, I will focus on different forms of projective identification and its importance in creating the first link with the psychotic patient. Then I will discuss some unique being states of mental and physical paralysis among schizophrenic patients—*paralyzing moods* that derive from continuous extractive introjections, in which anything alive in the patient is sucked out, as it were, by an internalized possessive object.

I will try to demonstrate that, through the transference, the patient can bring back lost mental elements and draw progressively closer to his authentic feelings. Exploration of these authentic feelings is related to the rediscovery of unique being states by patient and analyst during an

analytic journey whose vicissitudes I will present along continuums. In the second part of this article, I will elaborate on some of Bion's and Bollas's ideas about emotional growth. Clinical material will be presented, taken from two years of intense psychoanalytic psychotherapy sessions with chronic schizophrenic patients residing in a board-and-care home.

## PROJECTIVE IDENTIFICATION AND EXTRACTIVE INTROJECTION

Projective identification has been the subject of many conceptualizations and interpretations since its introduction in 1946, and many psychoanalysts and theoreticians on both sides of the Atlantic have dealt with this important concept, which is one of the building blocks of early emotional development. I will not attempt to review the entire literature on this challenging concept, but rather will focus on three major theoretical contributions that can be located along a mental health continuum.

Klein (1946) initially used projective identification to describe the infant's two main lines of destructive attacks against the mother's breast: fantasied oral attacks aimed at robbing the mother's body of its good contents, and anal and urethral attacks aimed at expelling dangerous parts of the self into the mother. These onslaughts on the mother afford the infant only a temporary relief, since there is a concomitant fear of retaliation by the external omnipotent object. Klein emphasizes that the persecutory fears arising from oral impulses to rob the mother's body of its good contents, and anal impulses to put excrement into her, play a major role in the development of schizophrenia.

Bion (1959, 1962), an analysand of Klein, distinguishes between *normal projective identification* and its pathological form. Normal projective identification is a means of communication and a vital component of early child–mother interaction. The infant lacks the ability to contain emotions, and the mother must serve as a container that will transform the infant's unbearable material (ß-elements) into bearable material (α-elements) through a function of reverie and alpha-function. The concept of the *container-contained* emphasizes the importance of the infant–environment relationship and the necessity of the mother's adaptability to her infant's needs.

Bion (1959, 1962) also discusses the concept of *excessive projective identification,* which relates to the infant's attempts to rid himself of sensory impressions (ß-elements) and painful mental contents when the mother denies the infant's projected material or is not available for reverie. These maternal failures enhance *nameless dread* and lead to frequent use of excessive projective identification, as the baby attempts to rid himself of ß-elements (Bion 1962). This pathological form of projective identification leaves the infant with overwhelming anxiety, which might result in the denial of reality. These maternal failures might also lead to developmental failures of normal thinking processes and eventually to psychotic disorders.

The third contribution to the subject that I would like to highlight is Bollas's (1987) concept of *extractive introjection.* Extractive introjection is an interpersonal, violent process in which, for a certain period of time, a person steals elements of another person's psychic life and appropriates them. Bollas (1987) considers such multiple extractions to be a "serious deconstruction of one's history" (p. 66), but does not discuss the vicissitudes of these processes among psychotics. He notes that extractive introjection and projective identification are two different defense mechanisms that act in a parallel manner, with interplay between them, but he does not further elaborate on this interplay.

In the continuum below, the interplay between these three conceptualizations is presented in relation to early mother–infant relations:

| **normal projective identification** | **pathological projective identification** | **extractive introjection** |
|---|---|---|

**mental health . . . . . psychopathology**

This continuum of relative mental health refers to the vicissitudes of projective identification during early development and during the analytic process. Transitions from one point on the continuum to another derive from failures in normal projective identification during early emotional development, which have an enormous influence on the mental development of both mother and infant. First I will describe normal projective identification and then refer to pathological variations.

The left side of this continuum is the location of Bion's (1959) concept of normal projective identification. These harmonious projective-introjective cycles between mother and infant have the quality of a play wherein the infant projects, and the mother receives, refines, and projects material back into the infant in a digestible form.

Maternal failure of reverie is actually a failure of the whole process of projective identification, since its essence is adaptability to the baby's needs. Therefore, maternal failure of reverie, and the resulting unmetabolized material, shifts the mother to the right on the continuum, toward pathological forms of projective identification located at its center. One of these pathological forms is *reversed projective identification,* which occurs when the mother projects her depressive anxiety and internal deadness onto the child. The mother's impoverished psyche lacks the capability to intuit the child's needs and may lead to extraction of the infant's mental elements, as a way for her to quell her own internal deadness. Extractive introjection might then appear next to reversed projective identification, if the mother both projects her anxieties onto the child and simultaneously extracts the child's aliveness and vitality.

Maternal failure also shifts the infant toward the right side of the continuum, in the direction of pathological projective identification, since he is overwhelmed by ß-elements that cannot be contained without developed mental functions. Excessive projective identification, a pathological mode of projective identification, occurs when the infant (or the psychotic) attempts to rid himself of sensory impressions, painful mental contents, and interpretations by evacuating the mind, since the mother is not available for reverie or denies the infant's projected material (Bion 1958). Failures in adaptation to the baby's needs enhance nameless dread, a state of mind that is not thinkable (Bion 1962), and lead to frequent use of excessive projective identification as an attempt to get rid of ß-elements. Repetitive and aggressive attempts at evacuation of the mind might also result in emptiness, since they leave the baby mindless and element-less (bereft of vital mental elements).

Extractive introjection is used by the baby as a means of survival and as the only way known to obtain aliveness from objects in the environment. It is necessary for survival since the unbearable emptiness and the experience of an endless void drive the baby to fill that void. In

these states, a smile or a pleasant touch or voice are not experienced as simply good but as necessities. Such natural gestures composing an integral part of normal development are experienced by the victim of extractive introjection as *vital supplies for survival*. If extractive introjection is repetitively used by the mother, this becomes a normal means of communication with the environment.

Pathological development characterized by extractive introjections leads to the creation of a vicious circle of excessive projection of ß-elements, unbearable feelings of emptiness, and repetitive attempts at extraction of lost mental elements. This endless search for objects is characterized by greed, envy, and an intense desire to rob the object of its contents (Klein 1946). Attacks of greed and envy on the source of nourishment, the breast, and the source of relating, the environment, are actually attacks on life itself, carried out in order to achieve a minimal sense of containment and wholeness.

Movement on the aforementioned continuum is evident during psychoanalytic therapy of patients suffering from schizophrenic and other severe psychotic disorders. The following is a clinical illustration of transitions along this continuum.

## CLINICAL MATERIAL

George, a 41-year-old, single male, has lived in a board-and-care home for two years. It is populated by chronically psychotic patients who have spent large parts of their lives in psychiatric hospitals. The home's rehabilitative orientation emphasizes the goal of functioning in the community through encouragement and guidance in carrying out daily activities, such as independent preparation of meals and doing laundry. Physicians monitor medical health, and counselors (without formal training) help patients in the performance of daily duties.

Until my arrival, psychological treatment was not an integral part of this board-and-care home, although counselors were encouraged to create meaningful relationships with residents. I was appointed as a therapist after the director of the board-and-care home had concluded that the residents' functioning was not improving, despite the rehabilitative orientation. At the time of my arrival, George rarely left his room, and

most of his relations with the external world ended in arguments with the psychiatrist about dosage changes in his antipsychotic medications.

George had been diagnosed as paranoid schizophrenic. He had been admitted more than twenty times to psychiatric hospitals, with one hospitalization lasting ten consecutive years. He was the only son of Holocaust survivors who did not hide from him the fact that he had been unwanted. His development was characterized by emotional abuse and much ridicule from both parents, who had met after the Second World War. Like many survivors, they had entered quickly into a loveless marriage in the hope of rebuilding a stable family life as quickly as possible.

George's mother had received medical treatment for depression and anxiety. She was described by George as a nervous woman who had never accepted him as he was and who always pushed him beyond his abilities. She was not satisfied with his achievements in school, although he had not been such a bad student, and she habitually demeaned his accomplishments. She also interfered in his social functioning, demeaning his friends and the girls and women in whom he was interested. Often George was upset by her criticisms and shouted at her, but she reacted by running away and locking herself in another room, later reproving him for his behavior. Many times, he had hidden knives, screwdrivers, and other sharp tools with the intent of killing his mother, but had never actually attempted it.

George's father was described as a downtrodden man who had worked from dawn till dusk to support the family. He typically spent no time with his son, and George remembered being the victim of physical abuse when his father was upset. Any memories of love, intimacy, compassion, or affection between the parents were completely absent. George's most prominent memory was of an empty home without many visitors, since friends were not welcomed, and most of the relatives had died in the Holocaust. His mother mourned the dead, but his father did not mention them.

George's strange behavior had started in adolescence and first manifested in constantly checking behind doors. His parents made nothing of this other than to ridicule his behavior. When George was eighteen, a psychotic episode occurred, inaugurating his history of treatment in psychiatric hospitals. Between admissions, he made many unsuccessful

attempts to participate in rehabilitation programs. During vacations, he would lie in bed, listen to music, and refuse to go out of the house. George was interested in women, but his mother always had something negative to say about his interpersonal relations.

For many years, George's primary complaint had been of attacks in which he would reportedly fall onto the floor, seemingly passed out, and feared death. He tried to cope by looking for gymnastics exercises that could prevent his falling. He also tried to stave off attacks by calming himself through looking at magazines or eating candy. When he had "been attacked," as he thought of it, he would lie down with a frightened look on his face until the episode passed.

George was very hostile and paranoid toward both counselors and other patients. Counselors described him simply as untreatable since he often collapsed on the floor and refused to stand up or to perform any tasks. In the past, he had been to a social club a few times, but now spent most of the time in his room. He was afraid to go out due to persecutory delusions about people outside the board-and-care home who wanted to kill him. The counselors' offers to help George were met with refusal, and logical attempts to persuade him of the transience of his "attacks" were made in vain. The counselors' frequent complaints about his behavior became a routine feature of weekly staff meetings.

For two years, I met George three times a week for psychoanalytic psychotherapy in this board-and-care home. Our first meeting took place before my formal introduction as the new therapist. I was sitting in my office when George appeared and asked to come in. He was a thin man, a little pale, and wore mismatched clothes. His behavior was agitated; he spoke quietly and quickly. I responded positively and he entered, saying he was not feeling well. He sat quietly for a few minutes and asked if I knew any physical exercises that could help prevent his attacks, adding that other therapists had given him exercises.

I asked George to describe his attacks, but he refused and repeated his request for exercises. Suddenly, he began to assume my sitting position, saying that it helped him feel better. After a few seconds of silence, he left the room, noting that he felt improved. The meeting left me confused about his needs and his use of me as an object.

In our subsequent meetings, George's imitation of my sitting postures and of my movements was frequent, accompanied by his questions

about a relationship between postures and the prevention of his attacks. I asked what he felt when he sat in certain ways, and he replied that he felt better, again asking me for exercises. Between our scheduled sessions, he often looked for me and would rush into my office with intensified demands for exercises to stave off a forthcoming attack. I invited him to sit and noticed tension in his body, which I tried to mirror, saying, "It looks like you are a little bit tense." He immediately answered that he was having an attack. When asked to describe his feelings during the attack, George said that he had a terrible fear of falling and of an inability to get up. Suddenly, he started to weave in different directions, repeatedly asking if I knew of any exercises for him; I said that I did not, but added that I would assist him if he fell.

During these sessions, I sat across from George and asked myself what the analytic setting and I could offer him. I struggled with uncertainty and powerlessness about his mental malaise; it was the first time I had met with such a phenomenon. I felt limited to providing empathic listening and constancy, and I wondered whether that was enough.

After a month, George started to ask the other counselors what day I would arrive. When we saw each other, his imitation of my posture and movements stopped and there was a slight decrease in his delusions, but his requests for exercises intensified, as he would storm into my office claiming to be in the throes of a forthcoming attack, obsessively looking behind my office door. He continued to say that other therapists had given him exercises.

I was a little bit frightened when George arrived in such a frenzied state, but I kept telling him that I would see him whenever he would like to talk, and I added that he was always welcome in my office. Privately, I considered responding positively to his concrete requests for physical exercises that would diminish his anxiety. But after much consideration, I told him that I did not know any such exercises, though I again emphasized my readiness to see him often.

He replied that he felt attacked, and he looked behind my office door and then leafed through some magazines. I noticed his fear of unseen objects in my office.

Two weeks later, I heard screaming from George's room. He had started to clean it, as required, under the supervision of a young female

counselor when he suddenly stopped, saying he was tired. The counselor asked, "How can you be tired when you haven't even started to clean?"

I entered the room just as George started to shout that he was doing the best he could. The counselor said that George always complained of tiredness but performed his assigned tasks anyway. George advanced toward the counselor, became pale, and started to shout: "What do you want from me? I'm a sick man! I'm doing the best I can."

In my mind, I could see George's mother standing in the room, saying that he did nothing except sit around all day. My thoughts were interrupted when George suddenly raised his hand and advanced toward the counselor in a threatening manner, implying an intent to hit her.

He looked in my direction, appearing pale and excited. I said that it seemed he was angry and even a little afraid. I added that sometimes we experience frightening sensations, and that there are different ways to express this. He looked at me, lowered his hand, and resumed quietly cleaning. His requests for exercises and his imitation of my movements virtually disappeared after this incident.

The focus of our next sessions was the investigation of unclear feelings and aggression that had been directed toward the counselors, especially during task performance. Our mutual work focused on emotional recognition of bodily sensations and aggressive impulses in relation to specific events, as I tried to help George translate raw material into digestible emotions and words. Most of these sessions dealt with two themes: aggression that arose when the counselors demanded that he carry out his duties, and primary envy and greed toward younger counselors and the aliveness they represented.

## THE RECOURSE TO PROJECTIVE IDENTIFICATION AND PARASITIC TRANSFERENCE

Movement on the continuum presented earlier occurred after the aggressive incident, which opened a new channel of communication for George. Attempts at extractive introjection, imitation, and frequent requests for physical exercises—in order to obtain mental elements that in George's fantasy were linked to mental equilibrium—were less prevalent

during the next sessions. The incident in regard to cleaning his room enabled the renewal of an old and natural form of communication, projective identification. He had a convincing experience that the object (me) was not destroyed by his projected aggression and raw material, nor did the object retaliate or change his attitude (Winnicott 1969). The survival of the object and the returning of raw material as food for thought opened a new channel of communication for George. The analytic setting provided a potential space (Winnicott 1971), which contained the opportunity of learning to name unnamable and dreadful experiences.

Patients re-create their infant life in the transference and present parts of their parents in a way that invites us to learn how the child of such parents feels. Patients watch to see whether we will turn into the mad parent, reacting in the same manner and preserving the object relation (Bollas 1987). The scene in George's room was doubtless very similar to scenes that took place in his home. But in contrast to past situations and to his mother's or other counselors' reactions, here the powerful transference of dreadful ß-elements was now processed into α-elements (feelings of anger and aggression) that could be incorporated.

George's near-constant search for me between sessions could be likened to the arousal of premature and intensely dependent transference relations appearing in analysis (Bion 1956). The patient imagines that all that is life enhancing resides in the analyst (Bollas 1987), and he clings to the aliveness that the analyst represents; the patient wishes to extract and appropriate mental elements and therefore searches for the analyst. The search is intended to bring back lost emotional elements, since the victim of extractive introjection does not hide from paranoid objects, but searches for external objects to continue the extractive process. This unconscious search is aimed at recovering parts of the personality lost through violent intrusion and theft (Bollas 1987). Therapeutic relations take on a dependent tone, since clinging and constant attempts at extraction are actually the only form of communication the patient knows.

The formation of parasitic transference and the analyst's willingness to bring back affects and mental contents enable the patient to use the analyst as a unique object unlike any other object usage in his life.

During George's childhood, his mother had not served as a container and had denied his projective material. Extractive introjection had been used as a normal form of communication because of her own traumatic life experiences. In this continuing process, not only were ß-elements not contained, but extraction of naive, vital, and childish elements of the personality also occurred. The mother's psychic deadness was fed by the child's aliveness, and her desire to possess vitality and spontaneity led to intrusive evacuation of mental elements. Perhaps the extraction (origin) of the movement toward excessive projective identification and extractive introjection are best depicted in Winnicott's (1947) observation that "the mother hates the baby before the baby hates the mother and before the baby can know his mother hates him" (p. 200).

Children of Holocaust survivors, referred to as the second generation, can be deeply affected by the horrific events their parents experienced. The intergenerational transmission of trauma (Sigal and Weinfeld 1989) has two prominent aspects: first, the background story tends to be either a stifled mystery or overflowing with traumatic information. Therefore, emotional growth in the shadow of psychic conflicts stemming from bereavement, mourning, guilt, and anxiety can lead to annihilation anxiety and nightmares of persecution. Second, intergenerational transmission of trauma creates increased vulnerability to stressful events in the second generation, as well as unresolved conflicts around anger complicated by guilt (Kellermann 2001).

In George's family, overwhelming traumatic memories and constant mourning were prevalent alongside a draining of emotional life. One of George's most prominent childhood memories was of his mother's screams at night during nightmares, and of her crying on awakening. The Holocaust constituted a unique experience of nameless dread for the mother, a psychic catastrophe, and assumed a nonverbal presence in George's home. The mother did not have adequate α-function to process her own ß-elements, and her way of coping with the unbearable experience was to cast out powerful, unwanted emotions and mental contents. She used projective identification in the Kleinian sense as a defense mechanism against her own deadness. Her wish to survive and to attain aliveness led to violent attacks that impoverished the child's personality, since deadness, despair, aggression, confusion, emptiness, and

fear became the primary affective experience. This process calls to mind the brutal maternal decathexis that the child is unable to understand and that turns his psychic world upside down in the situation of the *dead mother* (Green 1986). The defenseless child is driven to identify with the aggressor, and the result is murder of the psyche.

In such a situation, maternal negative emotions prohibit any expression of aggression, which would risk augmenting the maternal detachment. This silent destructiveness demolishes the child's ego and his ability to establish object relations. The child grows up with a dull psychic pain and the incapacity for minimal cathexis with an affective object in the environment, since the omnipresent internal object does not allow the reestablishment of any relations. Hatred is as impossible as love, and the affective internal world vacillates between indifference and terror.

In George's therapy, intensified requests for physical exercises were accompanied by repeated checking behind my office door, since dangerous mental elements, such as hatred, envy, and aggression, were being split and projected into the room. These fragments were sought out because the patient was afraid the projected material might retaliate mercilessly (Bion 1957a). Excessive use of projective identification forced the patient to deal with unbearable emptiness, resulting in his search for external objects with which to continue the extractive process. My refusal to give him exercises led him to seek concrete objects (candy and magazines) that might represent food and aliveness with which to fill the endless void. Here the patient was not able to extract mental elements and so looked for items in the object's environment that contained aliveness.

I wondered many times if I were perpetuating the repetition compulsion by not letting in the hated parts of George's personality. The amount of unmetabolized material (aggression, greed, and envy) present in the room hinted at an enactment, and made me wonder whether I was acting like his mother. Many times, I pondered whether George's repetitive requests for exercises were actually requests for a transitional object (Winnicott 1971) that would represent me in my absence and would help him cope with dreadful anxiety. I remembered Bion's (1962) words that the ability to bear frustration is an achievement leading to mental

growth. But I worried that perhaps I was frustrating the patient too much or inadvertently preserving the object relation with his mother. My internal conflict between more directly effecting a possible diminution of the patient's anxiety and bearing both his and my frustration was resolved in favor of the latter, based on an enhancement of the parasitic transference.

When the counselors told me that George looked for me frequently and waited for my arrival, I understood that a link with the patient had been created. These dependent relations were evidence for the director of the board-and-care home and for the counselors that George was not a lost cause. Their reports that he fell on the floor less frequently helped me continue to bear my frustration with him. The episode that arose in relation to cleaning his room signified a valuable progression toward normal projective introjection, and demonstrated how the analytic setting can enable a patient to experience nonmalignant forms of projective identification that contribute to the incorporation of different object relations.

The analytic process involves the recovery of mental elements such as affects and mental processes, and ultimately of psychic structure (Bollas 1987). During this prolonged process, the patient is enabled to experience different physical sensations, to acknowledge and to name them. He learns not to fear new experiences or emotions in relation to objects and to contain these emotions. Victims of extractive introjection can begin to discover a new range of self-experiencing.

Just as previously discussed in relation to early mother–infant relations, the inverted journey in analysis, toward normal projective introjection, is described on the following continuum:

| **normal projective identification** ← | **pathological projective identification** ← | **extractive introjection** |
|---|---|---|
| **mental health** | ..... | **psychopathology** |

Intriguing analytic investigations of patients who have been victims of extractive introjection often reveals the patient's belief that "something hostile 'out there' has taken something valuable from within" (Bollas 1987, p. 168).

## PARALYZING MOODS AND POSSESSIVE OBJECTS

George's fear of falling and his worry about walking and other movements has some similarity to Bion's reports of patients' feelings of being imprisoned and unable either to escape or to get out of a certain state of mind (Bion 1953, 1956, 1959). This state of mind might be related to Bollas's (1984, 1989) concept of complicated self-states that create a remembering environment in which one reexperiences former infant and childhood relationships and states of being (Bollas 1984). Fear, horror, and terror are prevalent moods among schizophrenic patients experiencing persecutory anxiety from external objects. However, I would like to focus here on feelings of fear and horror that may be related to internal objects that terrify patients to the point of mental and physical paralysis. Such terrorizations are not panic attacks, since there is an absence of the physical symptoms that characterize this disorder, such as palpitations, sweating, shaking, nausea, or chest pains (American Psychiatric Association 2000). Delusions, hallucinations, and other psychotic symptoms are also not reported or evident.

Instead, the main complaint in what I am describing is a unique feeling of unexplained primeval horror. In the grip of this horror, patients are not simply frightened but terrified due to a nameless dread that finds a physical expression. A common clinical picture is of physically falling or of collapsing on the ground without the ability to move or to get up. Sometimes patients simply sit or stand motionlessly, like statues, reporting physical paralysis. These states of mind could be named *paralyzing moods* because of the mental and physical experience of paralysis.

George was always pale and frightened when he reported his own feelings of paralysis and his inability to move or to walk. Another patient would lie down on the floor and say that he could not see. When asked to describe his feeling, he answered that he "wanted to scream." He was invited to scream, whereupon he shouted for a few seconds and then stopped. When invited to continue to shout, he refused, saying he was calmer and did not need to shout any more. A possible explanation

for this is that the gesture or readiness to enable projective identification resulted in a psychomotor venting. However, I believe that the main issue in such cases is the origin of the nameless dread that cannot be contained and must find expression in order to leave the psyche, and also—and especially—the nature of the internal object that prevents this.

Bion (1959) mentions a "certain state of mind in which the patient's psyche contains an internal object which is opposed to, and destructive of, all links whatsoever" (p. 108). I believe that these experiences of imprisonment in a threatening state of mind and the experience of paralyzing moods are significantly related to the existence of an object with distinct features inside the psyche. Moods typical of a person's character frequently conserve something that *was* but *is no longer,* and they are occasions for the expression of a conservative object—that is, that internal self state that has been preserved intact during childhood, often upon some breakdown between the child and his parents (Bollas 1984).

The origin of paralyzing moods is a possessive object housed in the psychotic's psyche that prevents any expression of subjectivity. The possessive object is the internalized representation of the mother or the environment that took possession of the child's psyche. It acts, sometimes in a parallel manner, in two modes of action: through prevention of the experiencing of or manifestation of genuine emotions, and through attacks on the analyst or on his containment ability. It screens out any improvement in the patient's mental state and halts any advancement in analysis. The origin of the possessive object lies in continuous processes of extractive introjection in which the child's naive, vital, and childish parts have been robbed and appropriated. These destructive processes expose the child to despair and the burden of emotions that cannot be contained. (This same process is liable to occur in traumas such as incest, sexual assaults, and relational traumas.)

References to the possessive object's antecedents can be found in Bion's writings. For example:

- [an] internal object whose origin was an external breast that refused to introject, harbor, and therefore modify the baneful force of emotion, which is paradoxically felt to in-

> tensify relative to the strength of the ego; emotions in opposition to the ego then initiate the attacks. [Bion 1959, p. 108]
>
> - [a psychosomatic breast that is] an object the infant needs to supply . . . with milk and good internal objects. [Bion 1962, p. 34]

I believe that these descriptions relate directly to the refusal of the mother or the environment (the internal object that in its origin was the external object) to contain the infant's emotions. This refusal leads to intensification of the emotion (it does not enable projective identification), until it is experienced as a deadly force beyond the infant's control.

As the extractive attacks continue, the infant becomes afraid to allow himself to have feelings, since internal attacks on emotion and on the right to express subjectivity might follow. This continuous co-opting of genuine emotions, of vitality and spontaneity, actually amounts to a suctioning of aliveness. It prevents the emergence of playing and creativity, since the child lives in a frightful world full of omnipotent objects that attack playfulness. Bollas (1987) uses the verbs *to appropriate* and *to arrogate* to describe the actions of the person responsible for the extractive process. I believe that the adjective *possessive* better represents the nature and action of the extraction, as well as the lifeless relation to the child as property and as an object, literally.

The evacuation of mental elements vital for maturation is in effect the evacuation of the personal idiom and of subjectivity. Transitional phenomena (Winnicott 1971) cannot be successfully carried out since the child cannot be freed from the grasp of the omnipotent possessive object. This is not the shadow of the object that fell upon the ego and caused melancholia (Freud 1917), but is rather a very strong grip on the subject. It is a metaphorical constriction of the child's subjectivity and an evacuation of aliveness. The unwanted emotions and thoughts stemming from the possessive object are constrained, and so the range of the experience is limited. After numerous and continuous extractions (and violent attacks), the possessive object is internalized in the child's psyche, and external attacks are transformed into internal attacks on genuine affects, thoughts, and other expressions of subjectivity.

## FOLLOW-UP TO THE CLINICAL MATERIAL

After two months of therapy with George, I suddenly realized that his attacks and paralyzed moods were the only themes of our sessions, and I began to wonder what he was trying to tell me. I noticed that he did not mention any pleasant experiences, and I decided to mirror this tone in the next session. He looked at me for a while and then said (as always) that he did not know how to deal with his attacks. He started to talk again about these attacks and about new physical exercises that he had learned to cope with them.

I noticed his evasion and decided to come back to my point, but he ignored it and carried on talking about exercises. I interpreted his behavior to myself as resistance to the creation of a link between the two of us through conversation. I started to feel despair, and thought to myself that probably we would always talk about exercises. I stopped thinking and contained my frustration silently.

George suddenly stopped talking about exercises, was silent, and looked at me. I felt that this was a special moment of tacit lucidity, and after a few seconds, I said that maybe it was more comfortable to talk about familiar things than about painful ones. George did not speak for a few minutes and moved uncomfortably in his chair. Then we spontaneously spoke together, both of us saying, "Probably."

This vignette illustrates the patient's fear of involvement in the analytic process, which might lead to enactment or reconstruction of an early catastrophe that the patient was trying to avoid. This was not merely a resistance, but also an important attempt to maintain homeostasis and self-existence. The analyst was conceived as a threat that might smash the patient's homeostasis (with his psychosis) to pieces, exposing him to a fear of death.

Possibly, this vignette supports Winnicott's idea that some patients have a need for the analyst to "know and tell them what they fear. They themselves know all the time, but the thing is that the analyst must know and say it" (1947, p. 237). Although the origin of George's fear was not defined or processed, this important session ended with a common understanding and a recognition of the existence of dreadful material

that was not being spoken about. I believe that our joint comment—"Probably"—created a link of intimacy and understanding in a sea of mistrust and fear. The creation of such a link contributes to the apprehension of the analytic situation and the analyst as less dreadful objects.

I kept silent many times when George rushed into my office complaining about his attacks, and my only intervention was often to simply mirror his physical and emotional expressions of fear. Subsequent hours were more stable since George was less anxious, and the parasitic transference had weakened. He did not search for me between sessions as before, and he complained less about paralyzing moods. He began to come out of his room more, working in the occupational club and even helping the counselors. Our sessions concentrated on his genuine expression of emotions in various situations toward different people throughout the day. Usually, he showed physical discomfort or ignored my words, but I did not interpret this. I was less frustrated and in fact was encouraged since the counselors reported improvements.

At this point, my objective was to facilitate George's experience of authentic feelings without external persecutory attacks. When some containment ability was achieved, emotions were expressed without the fear of external attack that might result in splitting and projection. George started to be more talkative, and he expressed verbal anger without checking behind the office door. In addition, he joined a jogging group outside the board-and-care home. Improvement was also manifested in his participation in therapeutic groups and skill acquisition programs.

Our next sessions were dedicated to exploring the origin of the paralyzing moods. George talked about his parents and the invasive atmosphere in his home. In his family, neighbors were criticized without reason and were called crazy, and every one of George's friends had been examined under a microscope. George's decisions, feelings, and behaviors were usually ridiculed and were never recognized as legitimate.

I said that it must be very difficult to grow up in such a restrictive environment where his choices were not accepted. George became angry and responded quickly that he was having an attack, and that his decisions had no importance since his mother knew what was best for him.

After a few moments of thundering stillness, he asked if I were angry with him. I told him that perhaps the expression of emotions was not

welcomed in his home, and said that here he could act freely, without fear of injury or death. I added: "You can express anger and nothing will happen. I will still like you." George looked surprised, and I saw the frightened expression of a little child. He kept silent for a minute and then asked incredulously, "I *can*?"

After this interpretation, George's attack passed, but a headache appeared. I said that perhaps he was confused and surprised that his anger was accepted as a legitimate emotion that did not kill anyone. He looked at me with some amazement. I did not speak for a few seconds, and I saw curiosity on his face. I added that perhaps he was surprised that the current environment encouraged the free expression of feelings, in contrast to his usual environment, and noted that perhaps he did not know how to function in this new environment. He said this was nonsense and that he had a headache because of bad neck movements.

I felt that George wanted to continue this joint exploration despite his resistance, and I said that it looked like he was surprised his emotions had been expressed without causing destruction.

The next day, George was frozen, pale, and barely moved. His paralyzing dread intensified such that admission to the psychiatric department was considered. He sought me out and asked me to hold him so that he would not fall from the attack he could feel coming on. This regression and search for the analytic setting lasted a month; during this time he asked counselors when I would arrive a few times a day. I believe that the parasitic transference emerged here again because of George's fear of death, which was triggered by the discovery of his authentic feelings. The return of a parasitic transference is similar to a baby's resumption of sucking and clinging to the mother after a new discovery that cannot be processed alone.

My next sessions with George began to focus more on separation from his mother and his release from the grip of the possessive object. He gradually became less frightened, saying that he did not think about the things I had said about his mother a month earlier.

A week later, he said: "I still do not think about the things you said about my mother." Although I feared another regression, I decided to continue since I believed that George's recent searching for me was aimed at bringing back lost emotional elements.

Following is a brief excerpt from a session during this period.

THERAPIST: It looks like the last sessions have aroused some things inside of you.

GEORGE: [closing his eyes] No, they didn't arouse anything.

THERAPIST: Your closing your eyes is an attempt not to hear my words and not to let them in because they bring up unpleasant emotions.

GEORGE: This is nonsense! I have no emotions.

THERAPIST: You do not want to feel any emotions because you do not want to feel any pain.

GEORGE: [shouting] That isn't true! I want to break a window in this room!

THERAPIST: This sort of talk brings up a lot of aggression, which is hard to handle and seems to hurt. Your mother didn't allow you to express these emotions, and now they arise with great intensity.

GEORGE: [shouting] Don't talk like that about my mother—she's a saint!

During this session, I decided to use more direct interpretations to help George recover lost parts of the personality that had been robbed by violent intrusion and theft. I felt that a strong link with the patient (the therapeutic alliance) was being created. This link symbolized an indestructible relationship in which one side did not terrify or attack the other. George's request for physical holding during his paralyzed mood symbolized the creation of basic trust and a willingness to carry on together in our journey.

The following sessions were dedicated to an investigation of the nature of George's attacks and their relationship to his difficulties in expressing his subjective experience. Here is an excerpt from our dialogue.

GEORGE: I want to talk with you, but not about the stupid things you usually say.

THERAPIST: You mean about emotions?

GEORGE: [exclaiming] Tell me, are you crazy? Do you listen to the words coming out of your mouth?

THERAPIST: You're angry. There is an accumulation of anger and aggression inside you, and you're afraid to let it out because of its destructiveness.

GEORGE: Do you know that other people could kill you for your words?

THERAPIST: You have a wish to kill me since I arouse feelings of anger and aggression that you want to avoid.

[Suddenly, George rushed out of the room, returning after a few minutes.]

GEORGE: I am calm now.

THERAPIST: You felt that your aggression could burst and kill me or shatter the room to pieces, so you left quickly because of the fear of your own aggression.

GEORGE: You cause me to have unpleasant feelings! I hope you know what you're doing.

I was concerned that I sounded too decisive in this session, and that perhaps my interpretations frightened George. His aggression and destructiveness were mobilized, serving as a ruthless link to other unpleasant emotions.

During this period, in the intervals between sessions, psychotic symptoms appeared frequently and hinted at the resistance and the fear of incorporating live fragments with dead ones. The incorporation of life and death is a threatening experience for patients whose internal world is characterized by chaos, where any attempt to loosen the grip of the possessive object is conceived as mutiny that might result in destructive vengeance. After the initial incorporation of live fragments, the patient must continue to incorporate more aliveness in order to loosen the possessive object's grip.

The reemergence of the parasitic transference signals the patient's growing need of an object that contains aliveness and can supply it. It gives an indication of the power and vitality required in the struggle against the possessive object, which aims to conserve a link-less existence both in the patient's mind and in regard to the patient's relations with the environment. The analyst must be ready to add extra sessions or

to speak with the patient outside the analytic setting, since additional holding and containment are frequently required.

The conflict between life and death can sometimes be resolved through enhancement of the parasitic transference. The patient's search for the analyst and the analytic setting intensifies due to their quality of lessening the patient's nameless dread. The patient's experience is similar to that of the baby who experiences a fear of death through starvation, which compels a resumption of sucking. In adulthood, the patient tries desperately to create a continuous link with everything that represents aliveness whenever internal dead objects again come to the fore.

These ineffable experiences were described well by George when he and I took a walk outside the board-and-care home. He saw a cat and wondered aloud how it might cross a busy street. I asked him to elaborate, and he said that many cars were driving very fast. When I asked what could happen to the cat, he replied that it could be squashed. He appeared frightened and I could see his identification with the cat. This emergence of symbolic thinking was a good sign, and I decided to try an interpretation. I linked his remarks to the previous session in which he had said that I caused him to have unpleasant feelings, and added that perhaps he saw himself as a cat facing deadly experiences during our sessions and trying to reach a safe haven. He accepted this interpretation, adding that his attacks were now less terrible.

In between sessions, George began to visit a grocery store and a shopping mall alone. The counselors reported that he was not as paranoid as before and was more collaborative. In the next two sessions, George left the room in critical moments to urinate, so as to feel calmer. I interpreted the difficulty of containing these feelings and the need to split and dispose of them in urine. He denied this, as usual, but smiled for a change (something he had not previously done in response to interpretations).

Another advancement occurred when he brought in a dream after many reports of an absence of dreaming. In his dream, he saw two people having sexual intercourse. The dream was not recounted with any associations, nor was it possible to foster any form of processing.

Although working through was not possible, the dream represented an important milestone in George's release from the grip of the posses-

sive object. The dream implied an unconscious thought generated in response to lived emotional experience, as well as the patient's ability to use unconscious psychological work (Ogden 2004). Furthermore, the dream was evidence of an apprehension of two separate individuals who were linked in a way that was not experienced as dreadful. Dream-work and the containment of linking without waking up in a horrible state represented the beginning of the creation of α-function.

After a few more sessions, the number and intensity of George's attacks decreased significantly. Psychotic symptoms lessened, alongside the appearance of more friendly behavior toward other residents and counselors. George reported his success with various assignments despite the attacks, and even tried to establish a relationship with a woman. His work in the board-and-care home's occupational club had improved, evidenced by his election as employee of the month. He started to visit a social club across town, together with other residents; a counselor reported that, despite having once missed the group's transportation to the club, he arranged to arrive independently by cab—thereby astonishing all the staff, including the home's skeptical director, and me as well.

At this point, the whole staff was acknowledging George's achievements, and the psychiatrist began to reduce the dosage of his antipsychotic medications. George still exhibited psychotic symptomatology, but significantly less than before. After almost two years of treatment with me, he was able to take an active part in his rehabilitative program.

## DISCUSSION AND CONCLUSIONS

This article has focused on the analyst's clinical journey with a patient suffering from psychotic disorders. This was a journey of investigation of the patient's psychotic emotional experience, entailing the discovery of evasive and unique being states. The process demanded courage since the enormous and continuous influence of former destructive objects on the patient's present life led to painful revelations.

Such a journey with a psychotic patient has general phases that might be depicted along the following continuum:

**–K → nameless dread → unthought known**

The left side of the continuum incorporates the patient's preference not to feel any of the pain involved in emotional growth. This position at –K calls to mind the blind Tiresias of classical mythology, who warned Oedipus against knowing the truth. Tiresias represents a false hypothesis, "maintained to act as a barrier against the anxiety anticipated as a concomitant of any hypothesis or theory that might take its place" (Bion 1963, p. 48). The analyst who encounters a psychotic patient in the –K phase might observe the patient living in equilibrium with delusions and hallucinations. According to Schneider (2005), not knowing can be a means of safeguarding one's existence, and when the very continuity of being is at stake, one acts in a mode fraught with panic and cannot make use of the other's projective identifications.

However, not knowing as a means of coping is phase specific. The psychotic experience of –K is characterized by fragmentation of the personality and a lack of continuity of being. Not knowing protects the psychotic person from the emotional pain involved in bringing back and containing affects and other mental elements. In such cases, the experience of continuity of being is linked to fear, panic, and early being states in which a psychic catastrophe occurred. Stupor allows psychotic patients not to "know" the nature of the avoided pain with the meaning of K, although there is some understanding that an encounter with pain is being avoided.

In the classical myth, Tiresias's blindness prevents him from knowing the truth; in lacking sight, he lacks the α-function that would allow him to know (K) the truth. Tiresias experiences the truth in visions that are actually sensory impressions (ß-elements) of mental reality. Knowing the truth in the sense of K involves physical feeling and the emotional experience of truth in the flesh.

The road to K is quite long and has significant phases. The analytic journey toward K begins when projective identification is renewed as a means of communication and when the parasitic transference is established. The patient is awakened from his deadness in the presence of the analyst's aliveness, and the struggle between life and death begins. The link between projective identification and parasitic transference furthers a curiosity that drives the patient to join the analyst in beginning the journey.

According to Bion (1957b), the analytic process is a discovery of curiosity—perceived as an internal component—for a past psychological catastrophe. The analyst's presence and his encouragement of curiosity spur unconscious conflict in the patient's mind. The next phase of the analytic journey requires that the patient face nameless dread, that is, his fear of experiencing and expressing subjectivity, which intensifies as the patient confronts two different object relations that cannot be integrated or contained. That is, the patient's internal theater is characterized by persecutory object relations even though the external theater does not put forth invasive relations; the patient lacks α-function and so does not have the ability to contain and integrate these two different mental realities. In addition, the analyst and the analytic setting are two objects that arouse hatred, since the link to these objects is bound up with mental pain. Therefore, the patient's preference to avoid the unbearable mental reality of this phase might lead to a regression toward –K, as indicated below.

**–K ← nameless dread**

The behavior of chronically ill psychotic patients in psychiatric facilities and board-and-care homes illustrates this phase. Silent patients who lack much facial expression are a familiar sight to analysts and therapists who work in such settings. The prevailing mood is one of deadness and despair that emanate from multiple projections of the patients' being states. This mental death is –K, the ultimate regression toward the abyss of lethargy that severs any link with living objects.

The analyst's emotional link to the patient plays a crucial role in processing nameless dread. Gradually, the analyst becomes less frightening and is conceived as the object that can dissipate the unbearable flood of unmetabolized material, while the analytic setting becomes a haven. Nevertheless, the patient might try to destroy objects outside his area of omnipotent control, and the analyst must survive attempts at extractive introjections and attacks of unprocessed aggression, greed, and envy. The object's survival of the patient's destruction signifies the beginning of separateness and the development of the patient's autonomy.

The *selected fact* (Bion 1962)—the emergence of an idea that brings order out of chaos—also contributes to successful passage through this

phase. The patient is more aware of specific components of nameless dread that terrify him, and he begins to relate to his experience with these components. In the aforementioned clinical example, the chosen fact was a common acknowledgment of the existence of a terrifying possessive object. This mutual discovery enhanced the therapeutic alliance and helped release the grip of the possessive object.

Differentiation enables the creation of vital object relations in the external environment. New object usage and playfulness might appear, since the patient no longer feels as threatened as previously. In this phase, the analyst's readiness to bring back lost mental elements and affects enables the patient to reconstruct the psyche—an imaginative elaboration of somatic parts, feelings, and functions.

Mental elements of a dynamic nature have a somatic equivalent (Winnicott 1949). The psyche is physical aliveness that cannot be differentiated from emotional aliveness; both make up the psychosomatic experience. The link between these two forms of aliveness gives birth to playfulness, spontaneity, and vitality. A new form of knowledge that has not been available, even though it exists within the patient, is now redeemed. This form of knowledge is the *unthought known,* and the measure of usefulness of this knowledge to the subject's being depends entirely on the nature of the child's experience with his parents (Bollas 1989).

Bion (1953, 1957a) refers to improvements in the patient's life during analysis. I find that improvements appear following the revelation of the unthought known, since the reappropriation of mental elements leads to a rediscovery of personal subjectivity and of the environment. The discovery of affects and abilities, and the appearance of new object usage and relations, is the essence of the analytic journey for many patients. This phase is characterized by the appearance of curiosity regarding external objects, a decrease in psychotic symptoms, and improvement in the patient's functioning in many areas of life. New object usage and the development of new object relations in the surrounding environment enable the discovery of abilities and skills. These "awakenings" in the chronically schizophrenic patient often astound those in the patient's external life, and call to mind Sacks's (1990) reports of "awakenings" among his post-encephalitic patients.

The long journey toward K has many withdrawals and regressions, and both analyst and patient are required to bear uncertainty and frustration along the way. K is an achievement that requires tolerance of various and (sometimes) opposing affects and mental contents. It constitutes achievement of the depressive position, since it involves the creation of a new container capable of containing the painful affects that appear following the discovery of truth.

In Oedipus's story, the aggression that appeared after the discovery of truth was turned against the self because, on reaching K, Oedipus could not bear it. The enormous power of knowledge (K) blinded him and returned him to the beginning of the journey—a state of being that prevents the subject from experiencing K.

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*Tel Aviv Sourasky Medical Center*
*Department of Psychiatry*
*6 Weizmann Street*
*Tel Aviv 64239*
*Israel*

*e-mail: dpotik@gmail.com*

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# WHEN THEORY PAINTS A PICTURE: A CLINICIAN REFLECTS ON PIERA AULAGNIER'S METAPSYCHOLOGY

BY ERIC GLASSGOLD

*The author discusses a patient who, while not frankly psychotic, was prone to states of disintegration marked by fragmented thinking, retreats into extreme isolation, and an idiosyncratic relation to language that manifested in his speaking without seeming to communicate. The analyst used his own forms of dreaming and reverie, including looking at pictures, to help him understand the patient's unique forms of self-expression. The metapsychology of French analyst Piera Aulagnier was particularly useful to the analyst in conceptualizing the patient's experience and understanding his reactions to interventions.*

**Keywords:** Analytic theory, visualization, associations, poetry, borderline pathology, Piera Aulagnier, *pictogramme,* representation, language, disintegration, dreaming, transference.

In this paper, I write about the early phase of psychoanalysis with a patient named Eli. As I listened to Eli, I found myself at a loss for words but in touch with inchoate feelings and images. I tried to make sense of what he was communicating but could not until I drew on my experience looking at picture books, something I routinely do to relax and rest my mind between sessions with patients.

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Eric Glassgold is a faculty member at the San Francisco Center for Psychoanalysis and an Associate Clinical Professor of Psychiatry at the University of California, San Francisco, School of Medicine.

With Eli, I did a kind of reverse dreaming: Rather than Eli's finding the "right" words to fit the images from a dream, I seemed to be finding the "right" images to embody his words. My action, finding images, was a form of associative linking or interpretation that allowed me to think about and understand Eli's attempts to express himself (Ogden 1997a, 1997b). As de M'Uzan observed after sitting with a deeply dissociated patient, "I dreamt *for* the patient *her* own dream" (2000, p. 143, italics in original).

This essay inquires into the ways turning to pictures deepened my understanding of Eli. It takes me in two directions: First, I turn to a theoretical description of the French psychoanalyst Piera Aulagnier's (2001) concepts of the *pictogramme* and the *originaire* to help describe a form of thinking that allows a narrative to emerge from elemental representations of somatosensory experience. Second, I argue that paying attention to the way this *originary* level of thinking was communicated as a bimodal identification in the transference helped me to make sense of and to describe my reactions in words.

## CLINICAL ILLUSTRATION

Eli sought treatment because of recurrent breakdowns in his friendships and a relationship with a girlfriend. He would become claustrophobic in their company. Shut away in his room, he refused visitors or phone calls. After a few days, he went to the airport and bought a same-day ticket to the East Coast, where he found refuge in his mother's home. While away, he lost all connection with his friends and girlfriend. He felt "eerie, like they never existed." Weeks later, he returned and picked up as though nothing had happened.

Eli was the second of five children born to immigrant parents in a large midwestern city. His mother was a stay-at-home mom, but she often withdrew into a frozen paralysis and was effectively unavailable. His father had a blue-collar job that kept him out of the house overnight, and he slept much of the day. Eli said he was a "macho man" who was given to storms of anger. When the storms came, Eli, his brothers, and his sisters hid under the tables and in the closets. Although Eli avoided being

hit, he was unable to avoid seeing his father beat up his older brother several times.

As the patient grew up, his father mellowed slightly but would still provoke arguments. There seemed to be no easy way to disengage. Consequently, Eli spent most of his time outside school hours at the nearby homes of his aunts, uncles, and grandparents.

Eli's presentation collated elements of the emotional rhythm of his father and his mother (Khan 1979). At times, he would engage in debate with a friend or colleague, gradually becoming more and more provocative, until he became enraged to the point of violence. Afterward, he disappeared into bed, paralyzed.

Eli seemed to fit the classical definition of a borderline patient. He presented with neurotic conflicts but sometimes entered a mode of quasi-psychotic functioning. Although he did not display symptoms of psychosis such as hallucinations, his associations periodically lacked richness and were difficult to track. At these times, he explained situations in a self-referential and paranoid way. But then the rhythm would suddenly change, and all his connections appeared restored.

Early on in treatment, Eli told me that his real refuge was poetry. He sent off poems to magazines but expected rejection letters because "no one understands them." With this introduction, Eli pulled out a notebook and asked me if he could recite his poems. He was inviting me to become one of the "no ones."

Eli's poems were filled with "POMO speak": terms drawn from writings in cultural studies. The language was neither lush nor sparse, neither ironic nor plain-spoken, neither comforting nor frustrating. I tried to situate my feelings on a spectrum (good/bad, warm/cold, open/closed, soft/hard, happy/unhappy), but my only association was "nowhere." Eli recited, it seemed, without pausing to breathe. He did not acknowledge me or that I would want to stop, reflect, and take it in. I tried to orient myself as the words rushed by, but I found no signpost, whether internal or external, to guide me. I searched for something I could identify with in his work yet found only what was unfamiliar and alien.

I thought about my first time reciting poetry. As a student new to a school in a non-English-speaking country, I did not understand the

poems I had to memorize. I remembered them from the sound and appearance of the words alone. I succeeded because these childhood poems followed convention. They rhymed, had meter, and had an internal structure recognizable from simply reading them aloud. Like a landmark on a hiking trail, this internal structure helped me remember how the poem should go.

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Eli's dream life also revealed his internal disorganization. He dreamt of fragmented body parts. His neck and mouth were cut into pieces. Trying to cope with disturbing residues of these dreams during the day, he braced himself against a terror of disintegrating.

He felt stymied when talking about this experience in sessions. When I tried to draw him out, he reacted angrily. Everyone he knew, he complained—including me—pressured him to tell them how he felt, but "they only want to force me to speak *their* language." Failing to find his own words to voice his feelings, he yelled citations from the writings of Karl Marx and other social critics. He flooded me with words.

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Piera Aulagnier, who worked and wrote about patients with psychotic problems, coined the term *conflit identificatoire* to describe the psychic activity underlying such manic behavior and fragmented thinking.[1] Aulagnier tied this conflict to the formation of subjectivity in infancy. For Aulagnier, psychic life begins with feeding, and specifically with contact between the sucking mouth and the breast—what she called *la rencontre* (the meeting). Aulagnier (2001) wrote:

> At the moment when the mouth meets the breast, it meets and swallows a first mouthful of the world. Affect, meaning, and culture are co-present and responsible for the taste of those first molecules of milk that the infant takes into himself: the food element is always duplicated by the swallowing of a psychical food, which the mother will interpret as the swallowing of an offer of meaning. [p. 15]

[1] *Le conflit identificatoire* is literally translated *a conflict in identification.*

The pleasurable experience of this "meeting" is encoded in neural circuitry: neural excitation is linked to an internal representation that Aulagnier called the *pictogramme*.[2] The *pictogramme* takes shape in one of two possible forms: the *pictogramme* of conjunction or the *pictogramme* of rejection. The *pictogramme* of conjunction is a multisensory representation of the object, such as a breast, fitting in tandem with a complementary zone, such as a mouth, combined with the satisfying feeling that arises when both the infant's biological needs and desire are fulfilled. This ever-more-pleasurable feeling of continuity with the object evokes an illusion of the object as truly part of the infant. In spectral representations of such somatosensory experiences, the subject and the object seem to be parts of each other. This early stage of experiencing oneself as having a place in the basic organization of another person is the basis for future identifications.

When the breast is empty or absent or when it fits poorly, this representational function creates a ghostlike image of absence. The infant wants a not-there breast. She reacts to its absence and the possibility of dying of starvation by trying to eliminate wanting. She faces an irresolvable paradox, "a desire for no desire."

To resolve the paradox, she attacks herself—or, as Aulagnier (2001) puts it, she "auto-mutilates" (p. 7). The infant reflexively destroys her representational function. The *pictogramme* of rejection memorializes the fear of immanent bodily fragmentation plus the consequent destruction of the capacity to represent it. It is a painful image of falling apart.

* * * * * * * *

In Aulagnier's theory, the *pictogramme* of conjunction and the *pictogramme* of rejection are basic elements of a vocabulary. These *pictogrammes* are continually shifting, and such shifts correspond to representations of *originary* relations. A sense of continuity with an object links with states of pleasure and contentment. A sense of premature separation from an object links with states of pain, frustration, and fears of disintegration.

[2] The term *pictogramme* derives from Freud's term *Bilderschrift* in *The Interpretation of Dreams* (1900, pp. 277-278). *Bilderschrift* literally means *writing/image* and has been translated as *rebus*. Aulagnier modified the use of the term.

The flow of movements between these two states constitutes a mode of thinking Aulagnier called the *originaire*, sometimes translated as *the originating process* (Oliner 1988) or *the primal process* (McDougall and Zaltzman 2001). Aulagnier further proposed that the *originaire* or primal process is a metapsychological level distinct from the primary and secondary processes. In work with primarily neurotic patients, the originating process may be much less apparent than primary and secondary process thinking—except, perhaps, in accounts of intense sexual, religious, or aesthetic experiences. (For example, a viewer may perceive himself inside the frame of a painting and entirely at one and continuous with the work of art.) Among patients with severe psychopathologies, however, alternation between a feeling of presence and satisfaction on the one hand, and of disintegration and disarray on the other, will be much more pronounced.

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In the moment-to-moment of our sessions, I continued to experience the confusion of Eli's being "nowhere" (Muller 1996, p. 97). Initially, I responded to his emptiness by trying to bring some order to the psychic field. I became a zealous note-taker, writing down almost every word Eli said, and at the same time, adding an element of linearity to his thinking that covered up the raw, disorganized experience of being with him. I was making the "nowhere" of his words disappear.

Witness the following notes typed for a consultation:

> I have such a crush on Caroline. I hated her for a while, but now I'm back to loving her. We can't talk directly to each other. What's that about? It's tension, that's what it is. There is this really interesting thing . . . this warm/distant thing. I'm not sure what it is.
>
> [Pause inserted in the typed notes to slow down the pace] When we are in a room together we can talk, but I get the feeling she doesn't like me. Sure, I don't know about that, but I'm not sure if I weird her out . . . . I like her a lot, but I don't want to be *with* her. I had this dream with her in it . . . . There's something important I should know . . . or something to celebrate? Really it's nothing. Yet it felt like I found insight.

> [Pause inserted in the typed notes] Why doesn't she tell me how smart and quick I am? When I was fourteen years old, that's how I got a girl's attention.

When I compare these notes with my handwritten notes from the session, I see that I have introduced affective tone and intonation into the patient's relatively flat and clipped telling of the story, tied together missing connections between fragments of speech, clarified confusion between past and present tenses, and filled in or given new referents to pronouns where Eli had dropped them. Here is a transcription of the corresponding section of my handwritten notes:

> I have such a crush on Car. I hated her for a while . . . now loving back . . . can't talk directly . . . to each other. What's that? It's a tension . . . . That's what it is. This really interesting thing . . . this warm thing . . . this distant thing . . . I'm not sure what, I'm not sure what . . . . In a room together, we can talk . . . gets feeling . . . . She doesn't like me, but don't know . . . not sure if I weird her . . . like her . . . don't want to be . . . her. I had this dream with her . . . something important, I know . . . should know . . . celebrate? It's nothing, really . . . but it feels like it's in sight . . . . Why doesn't she tell me how smart and fast I am? When I was fourteen years old, that's how I got it.

Aulagnier's concept of the *porte-parole*—literally translated as the *word bearer* or *word carrier,* and colloquially as the *representative*—helps clarify the pull I felt to impose a greater level of organization on Eli's experience. The *porte-parole* highlights the mother's presence as a mediator between the coded symbolic systems of the social order and the child's developing but idiosyncratic use of symbols in his inner world. The primary caregiver responds to her child's behavior in a libidinal language of relative pleasure or relative frustration. She may hug him at one moment and punish him at another. Through the feeling tone of her words, voice, language, attitude, and intuition, the primary caregiver offers an interpretation of the world and how it works when she teaches her child how to speak his mother tongue, and simultaneously how to behave "appropriately" in a social world. The caregiver unconsciously makes exceptions about how much of her idiosyncratic use of codes of

speech and behavior, how much of her own distance from the social order, to pass on.

When the mother responds to her child's crying by curtly saying "he's hungry!" she simultaneously explains his behavior to the world by assigning a motivation to him, and offers a *schema*—a tracing within a symbolic space—as an interpretation of his desire. Not only does she recognize what passes within him, but by naming it with words that have established meanings, she gives him the message that his experience has been named, known, and understood in the past. By building a bridge between imaginary and symbolic modes of experience, the mother/analyst helps the infant to see beyond himself and his immediate experience of the present and to feel anchored in an ordered system for representing himself in relation to the external world and its history (Scarfone 2006).

Over time, the patient accumulates experience connecting with these anchor points, signifier/signified pairs that tie him to external objects and events. These experiences accumulate and gradually create a reservoir of representations of connection, a surplus of the *pictogrammes* of conjunction—what Aulagnier call the *fonds représentatif*.[3]

Sometimes the caregiver will falter or fail in her role of the representative. When the gap between the primary caregiver's fantasy of the child and the child's own experience is large, the child will be unable to find a reflection of his experience in the caregiver's representation of the outer world. The triadic link between internal experiences, words, and their referents becomes fragile. The child is left holding a kernel of confusion, an element of experience that he can neither understand nor find comfort in. He will develop his own idiosyncratic idea of cause and effect and of the origin of things and relationships (Tysebaert 2003, pp. 125-126; Zaltzman 2001, p. 60).

The child's response is auto-mutilation of the apparatus for making representations, and this repeated auto-mutilation gradually erodes the surplus of meaning accumulated in the *fonds représentatif*. When such

[3] *Le fonds répresentatif*—literally translated as a *font* (as in a baptismal font)—is a reservoir of representations.

failures continue, the child will find the world increasingly empty and depleted of meaning. Trauma effectively separates him from the bases of identification and disrupts his capacity for symbolic functioning. In the clinical encounter, traces of such trauma may first become apparent through idiosyncratic ways of speaking and using grammar or vocabulary (André 2006).

As I sat with Eli, taking my careful notes and then presenting him to colleagues and consultants, I tried to play the role of *porte-parole*. I bore Eli's words to the world, interpreted him to outsiders, and gave him back a picture of how he might be seen. But by leaving out his most painful side—the profound isolation he experienced as a result of psychotic disorganization—I smoothed things over. Eli could not find himself represented in the picture I painted and presented. Consequently, he found my attempts to describe his experience constraining and even violent. Aulagnier termed the formation of psychic structure through interactions with a caregiver who constrains the child's idiosyncratic use of symbols *the violence of interpretation* (Aulagnier 2001).

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One summer morning, Eli came to his session more agitated than usual. He immediately started talking about a "crisis" at his workplace. Eli worked as a financial analyst in a department of a large corporation that was known for recruiting "creative" types. His most talented classmates from university worked there. He felt proud to belong to an "elite team."

Eli also felt ashamed of how he measured up to his co-workers. During the long stretches when he would shut down emotionally, telecommuting had allowed him to hide his irritability while maintaining his professional relationships. Yet he was anxious about the way his physical absences were perceived. He looked for evidence that his colleagues questioned his ability to pull his own weight.

A rivalry with a new colleague further complicated the picture. The newly recruited trainee depended on him for support and guidance, which Eli believed he offered in a brotherly way. Even so, this new trainee claimed as his own the knowledge and experience Eli had offered him.

According to Eli, at the prior day's staff meeting, his supervisor had deferred assigning a job until the new employee, who was absent, could be consulted. No one seemed to listen when Eli protested he had first dibs on the job. He felt sure this was a sign his boss preferred his junior colleague. He wondered aloud what could be going on between them. Eli seemed furious and raised his voice when he said that they must both be "closeted gays."

Feeling myself pulling back, I responded: "It's hard when you feel that you can't find a way to speak so other people can hear."

Eli was quiet for a few minutes, but eventually, in a wounded tone, he said, "I don't understand. You don't usually talk about *other* people."

He was right. I usually spoke to him more directly and personally. He heard what I had *not* said: "It's hard when you feel that you can't find a way to speak so *I* can hear." I had spoken from the side of other people who did not take into account his feelings and preferences. I had underlined the difficulty: that he could not speak *their* language—the language his boss, co-workers, and much of the rest of the world spoke. I had failed to hold a place between his idiosyncratic experience and a more conventional form of self-expression.

In retrospect, there were many "better" things I might have said. I might have reflected internally on his telling me about rivalries with another man for a third man's attention and his wanting approval and admiration but getting rejected. I might have wondered if wanting that contact with me aroused a fear of being penetrated and taken over. I might have put some of these thoughts into words.

When I was in the session, I felt that what I said had "just happened." I was sitting right there next to Eli, but I felt as if someone else were speaking. I had entered a *passage à l'acte* (Dean 1992, p. 40; de M'Uzan 2003; Simpson 2003). It was as if I were "not me" and "not there," or *no where* (Laplanche 2005; Pontalis 2003).

Eli had overloaded me with a tidal wave of words and feeling. Although I found it difficult to listen to the meaning of the words themselves, a few did penetrate. The phrase *closeted gay* in particular seemed to have a double meaning. One was the fantasy Eli had in its manifest form: his boss and his co-worker had a secret bond that went on be-

hind Eli's back. Derivatives of a primal scene fantasy and their potential meaning in the transference were yet to be explored in the analysis.

The second meaning pointed to the function of the consulting room, the doctor's "cabinet," as a closet. I was closeted in that I was routinely unrevealing of my life, plans, or interests outside the treatment. The asymmetric position of analytic neutrality left it to Eli to surmise things about me. But when I made a slip and identified with his boss and co-worker—an identification that I myself was largely unaware of—I brought into the room and expressed my discomfort with the sides of Eli that were undeveloped and psychotic. The wound in his voice let me know that he had accurately grasped this much. I had indeed spoken to him as if I were someone other than the analyst he knew (Laplanche 1999).

After my slippery interpretation, Eli began interrupting himself. His sentences fragmented, and I found his words hard to make out. After a long pause, he mentioned a dream he had had the night before. Although the dream preceded the hour, *his telling* me the dream at that point in the session conveyed just how much fear my comment had evoked in him.

In the dream, Eli was being followed down a dark, winding street. He could not see the figure behind him. He picked up his pace and could keep just enough distance to maintain a margin of safety. He ducked around a corner into the stairwell of an abandoned building. Then he escaped up the stairs. Everything was dark and disorienting there. He could not move lest he be discovered.

When Eli returned the next morning, he was agitated. He told me he had spent the night before shut up in his room with his poems. I mentioned what Eli and I had established long before: that his room and poems were a refuge he could escape to when he felt pursued by unbearably painful feelings. I added that my comment from the day before seemed to have aided and abetted the pain's overtaking him (like the man in the dream).

Eli surprised me by responding directly and clearly. The loud, quick execution of his statements and the fragmented silences of the day before were gone. He said he felt we were like magnets that attracted or

repulsed each other, depending on which sides faced the other. This statement seemed to have many potential meanings. It acknowledged that each of us had more than one side, and that each had the potential to become someone else in the transference.

Later in the session, the patient mentioned the melting pot of New York City, and the way in which Jewish and Italian sensibilities were once too edgy to fit in, but over time became assimilated and valued because they were overflowing. In that moment, he seemed able to represent the experience of discordant parts in a less threatening, even meaningful and constructive way.

Ironically, Eli had disappeared into his room with poems exactly when he was least able to find succor in language. When he emptied words of their meaning, they became vessels simply for transmitting energy, and his recitations modes of pure physical discharge. Since he could not find a way to represent his experience, discharge of excitement was the only option. He resembled what de M'Uzan (2003) called a "slave of quantity" (see also Simpson 2003). These waves of pure discharge would eventually give way to other experiences—such as the present one—when there were fertile connections, and he and I could make links between multiple layers of experience.

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Aulagnier's theory of the *originaire* and the *pictogrammes* helped me understand that Eli and I were reopening an *originary* relation in the transference. Hard as it was to bear the feeling of fragmentation and of being nowhere that Eli aroused in me, I had to find a way to accept and even welcome the psychotic elements of the transference. Aulagnier's metapsychology—the language of the *pictogramme*, the alternating yet discontinuous feeling of continuity and comfort followed by separation and disintegration—helped me to begin to identify a narrative line within Eli's experience. Looking at pictures, simply laying out images in a line, and making a first story from these building blocks helped me to soothe my feeling of disarray and to restore a creative link in the face of Eli's disintegration.

Such reflective activity helped me to recover my place in a world of symbolic functioning, or to reclaim what Aulagnier termed the analytic

function of the *porte-parole*. I could then begin to more accurately translate Eli's fragmented experience into words, painting for psychoanalytic consultants and for Eli himself a picture that felt more complete and consistent with his internal experience.

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*3530 Sacramento Street, No. 6*
*San Francisco, CA 94118*

*e-mail: ehgsfpsa@yahoo.com*

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# PSYCHOANALYSIS AND ART: ARTISTIC REPRESENTATIONS IN PATIENTS' DREAMS

BY ADOLFO PAZZAGLI AND MARIO ROSSI MONTI

*The authors explore the psychic passages that were opened up within a patient, Ada, thanks to her contact with two works of art, Signorelli's frescoes in Orvieto and Picasso's painting La Nageuse—their themes, formal structures, and the conventions governing their creation.*

*A work of art can be considered as a kind of window that allows one to look upon the imaginary world created by the artist. One can peer out of this window from the other side, permitting a look at the viewer (the patient), who is caught in a web of associations that are yet to be explored.*

**Keywords:** Art, dreams, painting, frescoes, imagery, artist, creativity, film, play, Signorelli, Picasso, emotions.

## PSYCHOANALYSIS AND ART: A TENTATIVE MAP

Art historian Ernst Gombrich (1963) imagined the strange realm of art as a completely mirrored hall or as a tunnel in which the weakest of sounds are perceptible at a distance. Every form and every sound is capable of evoking a myriad of memories and images. As soon as an image is consigned to art, Gombrich explains, a new system of relationships is created, into which that image or sound is inserted, so that it becomes an integral part of an established order. Each of these images

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Adolfo Pazzagli is a member of the Associazione Italiana di Psicoanalisi and a professor of clinical psychology at the University of Florence, Italy. Mario Rossi Monti is a member of the Società Psicoanalitica Italiana and a professor of clinical psychology at the University of Urbino, Italy.

and sounds, whether large or small, is amplified and reflected in the mirrored walls, giving rise to a play of lights, images, and sounds. What comes out, then—as from a kaleidoscope—are images that may differ very strongly one from one another, but that will always have been subjected to a common transition: that of having *passed through* a work of art. We propose this metaphor as background to the line of reasoning we intend to follow as we delineate just one of the innumerable lines of refraction that become possible when one comes into contact with a work of art.

Seen from this perspective, art takes the form of a great system of amplification, a resonance chamber in which a variety of things reverberate—things placed, however, within a framework that sets limits and creates relationships. The resonance is to be found in the internal world of the artist, but also in the way the artist fits himself into a community of artists. It is also to be found, of course, in the viewer.

The history of the relationship between psychoanalysis and art is dominated by the certainty that artists have something fundamental to say to the psychic world, and *about* the psychic world, and no less evident is the aspiration on the part of psychoanalysis to say something fundamental about art, about the artist and the work of art. It was, of course, Freud who started this intellectual quest, though he maintained a fundamentally prudent (if not ambivalent) stance, probably related to a fear that these sorties could expose him to accusations of improvisation or amateurism. Freud's hesitation is evidenced in many ways: his anonymous publication in the journal *Imago* of his first studies in applied psychoanalysis (*Totem and Taboo* [1912–1913] and "The Moses of Michelangelo" [1914]); in his description of his work on Leonardo as a *non-psychoanalytic creature* or a *half-fictional fantasy;* and in his warning that we should not forget we are actually working only with analogies, and that it is dangerous to tear not only people but also concepts from the sphere within which they were born and have evolved (Freud 1930).

Nonetheless, once this initial hesitation was abandoned, after Freud's time, the application of psychoanalysis to history, art, and literary criticism, and to the biographies of poets, artists, and literati, has grown to the extent that an attempt has been made to develop a psychoanalytically grounded aesthetics. Kris (1952) is very clear in distinguishing

three different problems that psychoanalysis has helped to investigate in the field of art: (1) the ubiquity of certain themes drawn from the individual's fantasy life; (2) the relationship between the artist's biography, in the psychoanalytic sense, and his work; and (3) the study of the artist's imaginative activity and creative capacity.

Within this panorama, however, it is our intention, rather, to speak of the stimulus that the sight of a work of art may exert on the analytic process when it appears in the patient's associations or dreams. We wish to recover, that is, the specificity of psychoanalysis within the psychoanalytic setting and consider the appreciation of works of art as one of the elements susceptible to analysis in the setting. However, this is one such element whose powerful evocative powers give it a privileged status.

The approach we propose to follow takes as its model a very common situation: what happens when, in a session, a patient talks to us about a film. What we listen for is not so much the content of the film—the plot, for example, or, to be sure, how the film reflects the director's psychology. Rather, our director is here before us, before our eyes and, especially, within speaking range. What interests us, then, is the investigation and exploration of the psychic passages that have been opened up in that person, thanks to his presence at the movie theater and to his contact with that particular film, with its themes and the formal structures that present those themes. What has the film jogged in the patient's mind? What areas of his psyche have come to life or encountered something new in their dynamic interaction with certain aspects of the film?

As early as 1914, Rank noted that the cinema—which in many ways recalls the mechanism underlying dreams—is capable, by means of a readily comprehensible figural idiom, of expressing certain psychological phenomena that poets cannot put into words. Likewise, one may reasonably believe that the appreciation of a work of art can act in the same way, mapping out or even opening up sometimes unanticipated psychic pathways. Through art, these psychological phenomena may find their way to the surface, or even reach their full-blown form.

Di Benedetto (2000) effectively illustrated the *anticipatory character* of works of art. The instantaneous views of the internal world that they furnish can prefigure a mental or verbal formulation. In this sense, he concludes, art offers everyone pre-logical structures for developing sym-

bolic and linguistic skills with which to communicate internal experiences. Moreover, as early as the 1920s, Baudouin (1929) observed the way that works of art can forcefully stimulate associations due to their ability to induce dreaming. A work of art does not contain a dream but, potentially, various dreams, and its most important characteristic, Baudouin emphasizes, is that it preserves them in their potential state, as though they were "imprisoned dreams" before which the viewer may experience a precarious balance—but also a perpetual give and take—as a fantasy takes shape but is at the same time always about to vanish.

In a particular sense, then, works of art are privileged stimuli to free association and the unfolding of the analytic process. With their communication of both forms and powerful implicit emotional charges, they open channels in the patient's mental life, potentially giving him access both to specific unconscious material (which is not, however, identical to the unconscious material of the artist) and to the capacity for play. Recently, Nagel (2008) discussed the role of another form of art in providing privileged access to a patient's unconscious life; she noted that if dreams, with their visual content and verbal analysis, can be considered the royal road to the unconscious, "the qualities of *music itself* provide important *points of entry* into unconscious processes" (Nagel 2008, p. 513, italics in original). In this view, music can act as an aural stimulus within the psychoanalytic setting. We argue that, probably, art of any sort might provide such access.

We abandon the illusory hope of developing a genuinely psychoanalytic aesthetics based on the *theory of resonance*. This theory rests upon the assumption that, in a work of art, two identical psychic configurations meet and commune with each other or are actually superimposed: on the one hand, the internal world of the artist as it is expressed in his work, and, on the other hand, the set of fantasies, emotions, and thoughts the work arouses in the viewer. This model has found expression primarily in Kleinian psychoanalysis. Segal (1952), for example, wondered what it is that makes a work of art so gratifying for the public. Enjoyment of art stems from identification with the work of art as a whole and with the whole of the artist's internal world as represented in the work; from Segal's point of view, all enjoyment of art implies an unconscious reliving of the artist's creative experience. Moreover, even Freud, in "The Moses

of Michelangelo" (1914), writes that what the artist aims to do is arouse in us the very psychic pattern that shaped the work.

This isomorphic model, based on experiential mirroring, is precisely what is criticized by Gombrich (1963), who exposes its *postal connotations*. The idea that the emotional configuration underlying a work of art is "sent" to the *sensitive viewer*—rather like a posted parcel, to be unwrapped in order to bring out the emotions packed therein—has generated a great deal of confusion. The point, for Gombrich, is that *structure gives form*, imposing a set of constraints on the initial message, and he emphasizes a fact that is well known to those who have studied the history of painting: most pictures owe more to other pictures than they do to nature. What is important for us to emphasize is that the viewing, the appreciation, the aesthetic enjoyment of a picture on the part of the viewer is not merely a photocopy of the emotional configuration of the artist, but the expression of a much broader and more complex system than that of a package mailed some time earlier.

From this perspective, we present *scenes* drawn from the clinical case of Ada to illustrate how the work of analysis led this patient to the possibility of translating into a dream her feelings of being lost—experienced before a work of art to which she had become receptive. As Rose (2004) stresses, an individual grasps in a work of art what he feels to be most consonant with himself, rewrites it in his own mind, and thus becomes its co-creator. The analytic work related to Ada's dream represents a fundamental step in her therapeutic itinerary.

## THREE SCENES FROM THE CASE OF ADA

### *Background*

Ada is a 40-year-old woman. She is small and gives an impression of rigidity and hardness. She seems above all tense, hypersensitive, and vulnerable. Brusque and apparently detached, she simultaneously seems to be always on the lookout for the smallest sign of acceptance or rejection. Even the clothes she wears, which are modest and somewhat masculine in style, appear to convey the carelessness of someone who wishes to go unnoticed.

The youngest of many children, Ada was born while her father was away for several years. Her father's absence had left her mother alone in the home of an authoritarian mother-in-law, who took it upon herself to look after both the family business and the family. The mother's relationship with this youngest child thus became the mother's only outlet for feelings of tenderness, and came to represent, in very real terms, her reason for living and her chance to develop an emotional bond—consolation, but also narcissistic gratification. This period, which the patient herself defined as "paradise," was abruptly interrupted by a veritable "expulsion" from her earthly paradise with the sudden return of her father.

After this, the patient avoided relating to adults other than her mother—from whom, however, she resentfully isolated herself. Ada described this period as one of "playing dead," a way of surviving rather than living, which extended to her relationships with peers and to her scholastic performance. She manifested serious learning disabilities, isolation, and anomalous and adversary attitudes. Her adolescence was marked by a new traumatic event: sexual relations with several unruly and maladjusted youths: "rape only in that I was a minor," the patient would later say. This initiation was followed by deeper self-isolation from social relations and strange behavior (she would wander alone about the countryside with only animals and plants for friends, for example).

Ada seemed not to take into consideration the existence of her body, probably because of the traumatic circumstances of her life: the later incident of her "rape," as well as her earlier trauma. The latter had been provoked by the return of her father, who had evicted her from the paradise she had inhabited with her mother. In that paradise, Ada had had many pleasures, but only as an object for, and of, her mother, and not as a subject in her own right. As a result, she had not only withdrawn from relations with other human beings, but had also begun to ignore her body, its demands, and its needs. For example, she claimed that she did not feel hunger and that she fed herself only in emulation of others, filling her plate with the same amount of food she saw taken by others at the table. Though with some difficulty, she obtained a high scholastic degree and undertook professional activities that reflected a desire to be creative, especially in relation to nature; these, however, were severely limited by her inhibitions, which often led to failure.

Ada entered psychoanalysis because of a constant, overall sense of uselessness and isolation, which was accompanied by a forced and inconclusive manner. The earlier phases of analysis were characterized by prolonged silences, with the analyst hard pressed even to catch her words and grasp the meaning of what was often mumbled; they seemed to be words that she expelled from herself. This was a patient who persistently signaled, even in olfactory terms—through careless grooming and personal hygiene as well—a sort of anal level of communication, as a compromise between a desire for social relations and some need to keep her thoughts to herself. This desire for, and coercion of, meaningful affective relations with the analyst expressed a very intense transference over which, however, hung the constant threat of a breakdown provoked by the patient's fear of those relations. The analyst thus saw the transference as dangerous, to the point that, at times, the patient seemed to be actively trying to blind him, which in the countertransference was apparently the patient's way of making the analyst relive her terror of abandonment, flight, and the breaking off of relations.

In fact, Ada could not stand separation. Weekends were filled up with her participation in unsatisfying social events. Work on the material she reported was possible only in mid-week sessions because, after periods when our work together yielded even slight progress—perhaps on certain aspects of the nature and origins of her vulnerability, or on her fear of becoming close to others and thereby risking abandonment again—as the weekend drew near, Ada would announce that since this was now understood, the analysis could be interrupted. She would nonetheless return the following Monday, maligning analytic technique but differentiating the analyst, as a person at once desired and feared, from a technique that kept him at a distance. Never once in the first years of analysis did a vacation begin or end as planned, due to changes in the patient's work commitments or to her vacations being out of phase with those of the analyst.

The first few years of work brought appreciable improvements in the organization of Ada's life and in her professional activity, but the analyst still perceived their work together as consisting largely of the construction of a shared theory. This shared theory was an abstract one, oriented primarily toward analyzing the past, but through work shared on an af-

fective basis. Hence there was a feeling of building something together while nevertheless maintaining an emotional distance, out of the constant fear that our coming together might bring suffering by enabling further separations and breakups.

In the week preceding Christmas vacation in the fourth year of analysis (the first vacation that would begin and end as agreed), the patient told—initially with satisfaction—of having spent a nice weekend with friends, a weekend in which she was less isolated, less bizarre, and more involved than she typically had been in the past. She had not felt well, however, during a visit to a chapel of the Cathedral of Orvieto; she had actually had to leave, in fact, and wait outside for her friends. Just after this, she remembered, again with pleasure, some work she had done some time earlier at a home for troubled youths, where she had tried very hard to bring order to the spaces they lived in, "so that they could feel at ease even with their thoughts."

After the first sessions of that week came sessions that seemed to portray three distinct scenes, each of which developed from the patient's contact with a work of art. The entire sequence unfolded around two works of art: the frescoes by Luca Signorelli in the Cappella di San Brizio in the Cathedral of Orvieto; and the painting by Pablo Picasso entitled *La Nageuse.*

*Scene One*

In the sessions that followed, Ada explained that while visiting the Cappella di San Brizio, frescoed by Luca Signorelli, she had felt overwhelmed at the sight of the flesh, the mêlée of white bodies, and the violence conveyed. Whereas the lower register of the frescoes was "lovely, calm and decorative," Ada had found the upper part "upsetting": "bodies dressed in colorful clothes, then naked figures, then white and dusty souls." This description recalled her previous remarks about her disturbing experience in the chapel and the orderliness, like that seen in the lower register of the frescoes, that she envisioned a well-organized space would bring to the minds of those afflicted youths. Exhausted and weakened by her strong emotional reaction to the frescoes, she had had to leave the cathedral.

At that moment, the analyst had only a faded memory of the Cathedral of Orvieto and the Cappella di San Brizio within it, but, convinced that his job was to try as hard as possible to see and understand things through the patient's eyes, he did not refresh his memory, as he could easily have done. It may nonetheless be worthwhile to note some of the characteristics of the spot where Ada was so powerfully overcome.

The upper part of the Cappella di San Brizio bears seven monumental scenes executed by Luca Signorelli between 1499 and 1504 (to complete the task that Beato Angelico had abandoned in 1447). These are:

The sermon of the Antichrist
The end of the world
The resurrection of the flesh
The damned enter Hell
The crowning of the chosen
Hell
The blessed enter Paradise

One of these scenes, the resurrection of the flesh, is shown in Figure 1 on p. 745. Details of this fresco appear in Figures 2 and 3, p. 746. The scene of the blessed entering paradise is shown in Figure 4, p. 747, with details in Figures 5 and 6, p. 748.

The monochrome register below the seven monumental scenes bears portraits of Dante, Statius, Virgil, Lucan, Ovid, and Cicero, along with scenes from their works. The chapel itself occupies the end of the left arm of the transept. The Cathedral, or Duomo, of Orvieto is immense and bare. Art historian and critic Jonathan Riess (1995) gives a precise description of the passage from the great open space of the Duomo to the small, oppressive space of the chapel, as follows: After walking slowly across the vast airy expanse, within the Cappella Nuova one seems to find oneself in another world, a world subject to radically different laws. Here all available space has been occupied, and swarms with people to the point of being saturated with a clamorous crush of images. Upon entering the chapel, one's first sensation is a feeling of insecurity; one does not know where to start looking, because the figural opulence of this ambitious pictorial set piece, grandiose to the utmost, tends to overwhelm the viewer. Wherever one looks, the eye is drawn

upward. The celestial hierarchy is constantly within one's field of vision . . . . Everywhere one senses this ascending movement. Both visually and iconographically, there is a strong upward pull. Then, as one acquires a broader, more relaxed view of the space, one's attention is drawn to the left, and here one enters the realm of the Antichrist and undertakes a journey in time which leads one forward all the way to the end of the world, a dream-like journey toward what awaits us after death.

What we see illustrated before us is a prophecy of the end of time and an exploration of the world of the dead. This, Riess (1995) tells us, is the most complete presentation in all of Italian art of eschatological doctrine—that is, the doctrine concerned with the end of time (death, judgment, paradise, hell). Taken together, the scenes delineate a change, a passage, a transit: we are faced with an absolute dichotomy, a place where the road inexorably diverges, separating the chosen from the damned, with God on one side and evil on the other. One world ends and another begins.

The Last Judgment is a point of no return. Before this most drastic of alternatives, people are crowded together in a confused mass, a tumultuous throng of bodies, a slaughterhouse. They form a sort of foam, like water before the prow of a ship. The dreadful side, that of damnation, is distinctly emphasized in Signorelli's picture—suffering, despair, sin, and punishment—while the beatitude of the chosen is hidden. These frescoes were to be a warning: men of faith can change their destiny, and the threat of the Apocalypse must summon them to observance of the great dogmas of the faith. Those dogmas were at that time under attack from the Catharite heresy, which denied the resurrection of the flesh, and against which the pope had ordained a crusade a few years before, the only crusade launched against a Western country (Gottlieb 2005).

This detailed observation offers us a good description of what the patient Ada must have experienced, and the analyst might have been influenced by these facts if he had had a more clear recollection of a space that he had not visited for decades. At the same time, the patient's account left him feeling very tired and anxious to move on, in a sort of alliance with Ada as she continued with her excursion into looking deeper, but without "stripping herself" and without expressing desires or feelings.

Thus, the analyst proceeded on the basis not of his recollection of the chapel and its frescoes, but of the subsequent development of the material reported by the patient, who later recounted some dreams. This was in itself a novelty in that, in the first four years of analysis, Ada had reported very few dreams, often muttering that she had had a dream, but adding that she did not remember her dreams or that she did not tell them because they were insignificant.

*Scene Two*

In the session that followed, Ada returned to the subject of the frescoes. She had learned that Freud had discussed Signorelli, and she wished to know more. This aroused a desire in the analyst (which he did not enact) to show how well informed he was and to tell her what Freud had written. During her visit to the cathedral, the patient had felt tired, weak, and—despite being among friends—alone. Ada's comments on what she had experienced upon seeing the Signorelli frescoes left the analyst at once pleased and apprehensive—aware of new possibilities for their work, but afraid that in the course of the session he might share with Ada emotional experiences that the two of them would not be able to face.

The night before, the patient had had a dream:

> I was with my brother and sister in a modern restaurant, an elegant but rather unfriendly place that one entered by going down steps, as in an amphitheater. It was a strange restaurant—modern, uncomfortable, and crowded with throngs of skiers.
>
> I left and found myself in the garden at the home of a friend and colleague, B, who is very successful and for whom everything always goes well. He was showing me the latest improvements in his garden, which was full of pools, water and hedges. The house was also full of things.
>
> I could tell myself that B brags too much about what he does, that he "makes too much noise," that he really goes too far. But the truth is that I *really* envy him . . . whether I'm dreaming or awake . . . . I'd like to have a garden too, where I could let myself go and go too far, fantasize and play.

The first part of this account brought to the analyst's mind the rigid and intellectualized period of the patient's analysis, whereas the second part suggested feelings that were repressed but also feared. The point was not just to imagine a sort of paradise lost, for which Ada felt a constant and consuming nostalgia, but also, she was careful to explain, to be free to imagine a part of herself that was joyous and playful, finding fun even in her work.

The crowded and uncomfortable scene in the restaurant reminded the patient of Signorelli's frescoes with their crowds and bodies. She also spoke with a certain aristocratic disdain for the throngs of people whom she had met on ski trails. All of this also brought to her mind her childhood home, a house too crowded with brothers and sisters, and, like the restaurant, elegant but uncomfortable, too crowded and unfriendly. Her friend B, too, tended to make her feel stifled, with all the things he did, things that filled his garden and his life. Ada wondered how she might "slip in under" that long period of her life when she had been "playing dead." How could she learn to gain access to her fantasies? Maybe if she eased up at work a little more—which might even improve her performance.

Perhaps, the analyst commented, Ada was afraid of being hidden or lost in the crowd and of suffering when exposed to an excess of stimuli, as happened before Signorelli's frescoes. "If I give in to the pleasure of fantasy and play," Ada said, "then it might just make it all the more painful to be abandoned." The Christmas holidays were approaching. Could one live with this feeling of being alone?

Ada remembered something the analyst had said some time earlier: that somewhere, after all, there must have been a suffering little girl Ada to explain her present unhappy state. Perhaps the false memory of an earthly paradise was a way to avoid recognizing just how bad things had been for her, as her comments might suggest: "I didn't remember—this is the first time I remember—just how bad things were when I was little, that I really suffered a lot; that's just the way I felt, alone, isolated, never unique for anybody, not even for my mother, who used me so that *she* wouldn't feel alone."

In her dream, the patient seemed to be taking up and reelaborating some of the features of the Signorelli frescoes that had struck her in Or-

vieto. Finding herself in contact with that seething mass of bodies—and under the pressure of the fresco that almost forces the viewer to follow the path leading to the Last Judgment—Ada felt all the weight, exhaustion, and passiveness induced by these somewhat dead aspects of herself ("playing dead"), beneath which she had hidden for so long. This initial anguish, however, was not an end in itself. It had set something in motion, something that reemerged in the dream in which Ada did not slip into those chaotic and confusing aspects of the throng of brothers and sisters in order to continue using them for aggressive and self-destructive ends. On the contrary, her annoyance with, disdain for, and envy of those who could enrich and fill their own lives, as they did their own gardens, was replaced by the desire that she, too, could express her potential for imagination and play. Nonetheless, Ada also expressed a fear that sharing such feelings could be dangerous—to the point, even, of imagining that the analyst was suffering from an illness, which she asked about at the end of the session ("But you have a cold, don't you?"), though he was actually fine and even felt relieved at the emergence of this vital part of the patient through their relationship.

It was as if a way to move ahead that the patient had never thought of suddenly opened up before her very eyes: a way that entailed "slipping herself in under" her "playing dead" for such a long time—slipping herself in under the envy and reemerging with the capacity to play with her imagination. She, too, could thus try to enrich her garden and her life.

Much that is explicit in the frescoes seems to return in Ada's dream and in her associations: the amphitheater-like setting, the press of the crowd, the paradise lost. And in moving beyond these concrete aspects, it would seem that Ada was finally able, through her dreams and through analysis, to deal with the frescoes and, above all, the implications for her of looking out of Signorelli's window: the opportunity to make contact with her internal world, its denizens and their relationships. She had previously been unable to do so. These frescoes, she reported, are "so powerful and so violent that they make the viewer feel impotent." She continued:

> Once a friend of mine who is very sensitive to the beauty of art invited me to see these frescoes with him while they were being

> restored. I didn't go. Hearing his excellent comments enhanced by his psychoanalytic insights was like being in a nightmare. He's so good . . .

She had not been able, that time, to "slip in under" the envy that still oppressed and confined her. It was almost as if she had now managed to accept the element of division and separation lurking in Signorelli's depiction. On the one hand, the crowded scene crushed, killed, and led to damnation; on the other hand, she could draw on other potentialities within a dimension characterized by greater freedom, more play, and heightened creativity. It was as if she had felt she was faced with the dichotomy of her own Last Judgment. Two roads had diverged, and the choice of which one to abandon became ineluctable.

Furthermore, it was as though for the first time Ada had been able to see this photograph, so to speak, of her current condition, and was thus locked into making the dramatic choice between life and death, one might say. It may be that Ada could not actually "see" all this, but she could certainly feel the weight, the anguish, and the oppression of a dimension characterized by a confusing and destructive crowding, which had alienated her from life in general and from her own psychic life in particular. It was as though the fresco had acted as a sort of slide that permitted her to "slip in under" this slaughterhouse—to grasp its horrifying, but also dreadfully challenging, aspects, and to reemerge a more vital person. She was no longer boxed into a sort of sarcophagus. She had come to sense that her analyst was a necessary partner in breathing life into her affective life. There was a risk, but only that of a slight and transitory illness.

*Scene Three*

In the next session, Ada—who never had many dreams to report—told of another dream. This dream illustrates how the process underway since she had seen the frescoes by Signorelli had truly unleashed new potentialities in her. She could now begin to see things even "under water" (as in this second dream) and to move in all directions above and below the water's surface. The previous analytic work had placed these potentialities, so to speak, at her disposal, but the painting had enacted them in

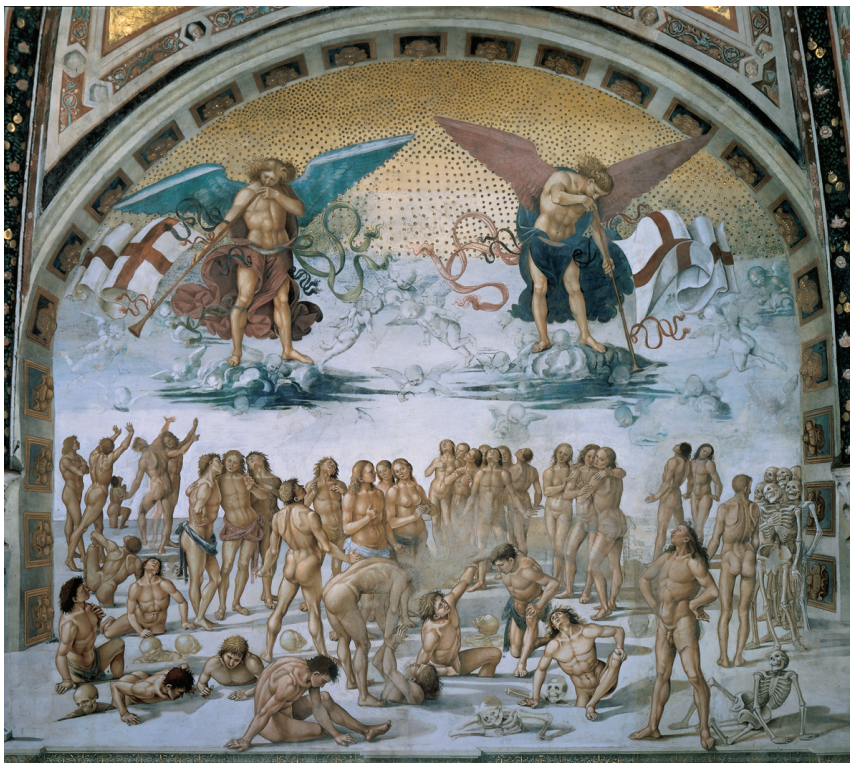

FIGURE 1: The Resurrection of the Flesh
By Luca Signorelli
Cappella di San Brizio, Cathedral of Orvieto
(circa 1499–1504)

FIGURE 2

FIGURE 3

FIGURE 4: The Blessed Enter Paradise

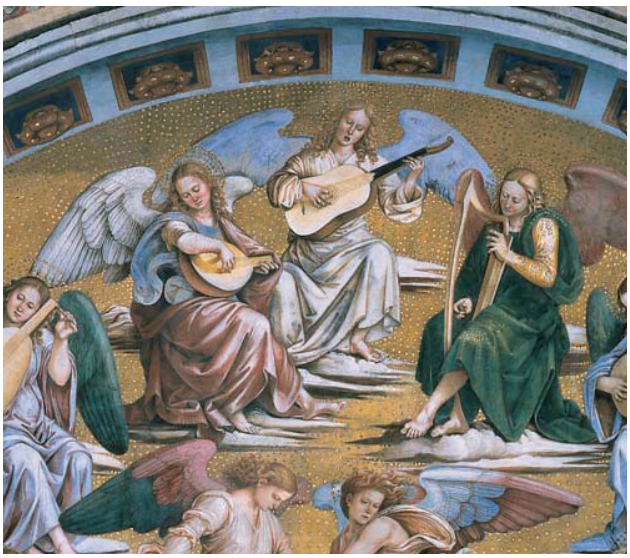

Figure 5

Figure 6

an animated way. This next dream was long and pleasant, a dream that took place on the water—on the water of the sea, in fact, but with seawater as calm as fresh water. Her older sister was there, and some friends, and there was a boat and a picnic excursion.

> Then [she reported], they put me on a boat of my own and told me I could get back to the shore by myself . . . but there were no oars . . . panic . . . . Then I put a hand into the water and saw that it was going fine . . . . I could see under water, lovely! I got off in a living room. Three of my brothers were there, along with you and me. They wanted to talk with you [the analyst], ask you questions . . . . You started to say really technical things. They said, no, we don't like that; it's the same old story.

The analyst commented that, rather than a Last Judgment, this was a judgment passed on the technical banality of the analyst: what both analyst and patient had felt to be necessary in the first stage of analysis. That voyage had led to a point where we could deal directly with Ada herself, without the mediation of brothers and sisters or of technical considerations, but looking beneath the surface.

Ada responded to my comments by recalling a painting by Picasso, *La Nageuse*: "Just as in a painting by Picasso, maybe the one I like the most—a dark blue one called *La Nageuse*. It depicts a woman who moves in all directions in the water, not just above the surface but also underwater, and she can go in all directions, anywhere," she explained.

Quite a contrast with the Ada who had played dead!

## CONCLUSIONS

Just as the temptations offered by a play on words can sometimes bring to light an aggressive thought that would otherwise be left unexpressed, so the possibilities offered by the stimulus provided by a work of art can sometimes bring to light feelings or experiences that would otherwise lie dormant in the patient. In fact, the viewer can grasp many more strings than actually exist in a painting or other work of art (Gombrich 1966); he may even perceive aspects not actually visible in the picture. Furthermore, a multitude of factors ties every work of art to the past, to the present, to the artist's cultural context, and to the perceptions of the

viewer as imagined by the artist; at the same time, all works of art reach out and resonate within a system of associations that is distinct from that of the artist, and in some ways highly idiosyncratic—namely, the internal world of the viewer.

Art thus becomes a sort of parlor game between artists or, as Dissanayake (1992) argued, the celebration of a shared invention with important implications for the very survival of the human race. As Trevarthen (1995) wrote, the beauty of art is a fundamental part of human communication since it proves the existence of universal parameters for the operation of the mind that must be, to some extent, "contagious" in order to favor the sort of understanding that fosters cooperation. These considerations call to mind Brenner's (2004) conclusion that it is not only the person who makes something new who is creative, but also the one who is considered so by the community. In this sense, a work of art derives from a negotiation between individuals. The psychoanalytic setting and the psychoanalytic relationship are, in turn, specific loci of this negotiation, areas where aspects of the process can be studied almost microscopically.

We believe we have illustrated the potential clinical significance of the stimulus represented by the sight of Signorelli's frescoes in a particular clinical situation and under the circumstances specified. More generally, this clinical significance must be considered in terms of its two aspects: the aesthetic experience, and the affective configuration of the patient at that point in his or her analysis. These two elements fit together like a key (the aesthetic experience) in a lock. The construction of the lock, as it were—that is, the desire and opportunity to open the door—are the result of analysis. If this process occurs in the interplay of artist and viewer through the mediation of a work of art that acts as a transitional area, this very interplay becomes problematic in persons whose psychopathology has stunted the capacity for play, as we believe may be said of the case presented earlier.

In the case of Ada, then, the evolution of the analytic process seems to have opened the possibility of "play" for the patient; but it was seeing Signorelli's work, with its specific contents, its formal characteristics, that suddenly opened up the dizzying prospect of this "play" in the patient's mind. This undoubtedly happened through her dreams recounted in

analysis and to the extent that it was possible to grasp the meaning of the malady she had experienced in the Cappella di San Brizio.

As Winnicott (1971, 1974) observed, psychoanalysis takes place where two persons play together. When one of the two is incapable of playing, an objective of analysis is to enable him to do so. A work of art may become a sort of epiphany, making manifest this newfound capacity. The aesthetic experience appears to be a necessary and specific element, though only within these particular circumstances. Art can thus function as a privileged stimulus that is in some instances necessary in bringing about changes in the psychic world within the framework of an analysis.

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*Mario Rossi Monti*
*Via Luca Landucci 10*
*50136 Florence, Italy*

*e-mail: rossimonti@tin.it*

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# DEAD OF NIGHT

BY LEON BALTER

Dead of Night, *the first psychoanalytic horror film, was produced in England in 1945, immediately after the end of World War II—that is, after the English population had suffered systematic Nazi terror from imminent invasion, incessant aerial bombing, and rocket-bombs. This film continued the prewar format of horror films based on themes of the supernatural and the hubris and excesses of science. However, it introduced psychoanalysis as the science in question. The film is structured on two levels: a genteel English country weekend to which witty and urbane guests have been invited; and five horror stories told by the guests. Psychoanalytic insights into this film structure are used here to explain how the film induces horror in the audience.*

**Keywords:** Film, horror, terror, nested ideation, World War II.

## INTRODUCTION

Before the Second World War, there was a plethora of horror films produced in many countries. The genre was extremely popular and the films were extremely varied. However, two particular themes among them are of interest here: the supernatural (epitomized by *Dracula* and *The Wolfman*) and the arrogance and excesses of science (epitomized by *Frankenstein* and *Island of Lost Souls* [also known as *The Island of Dr. Moreau*]). And these exemplars spawned a special wave of horror films as their continuations, elaborations, combinations, and imitations.

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Leon Balter is a Training and Supervising Analyst at the New York Psychoanalytic Society and Institute, and an Associate Clinical Professor in the Department of Psychiatry at Mount Sinai School of Medicine.

At basis, the two themes were essentially identical. For the horrible supernatural, harking back to the past was an explicitly direct derivative of the demonic and diabolical superstitions of the European Middle Ages—the suppressed and degenerate remnants of the old pagan, animistic religions of pre-Christian days. The arrogance of present and future science was embodied in a form of science fiction. It expressed the often-explicit and always-implicit warning that probing Nature's secrets and exploiting Nature's powers were intrusions into domains best left to God.

Thus, both supernatural and science fiction horror films constituted cautionary morality tales bolstering the prevailing religious and cultural ethos. They were modern forms of myth (Arlow 1961). Implicit in the supernatural's sacrilege and in science's hubris lay the temptations of illicit sexuality—most often *perverse* in nature.

After World War II, these themes still persisted. But, in postwar horror films, there appeared to be an accentuation of severe sadomasochistic psychopathology seen from a remarkably sophisticated psychoanalytic perspective. The acme of this particular variant of the horror film was Alfred Hitchcock's *Psycho*. It became the model for this very special kind of psychological horror film. But *Psycho* was by no means the first such postwar film.

The very first was *Dead of Night*. It was made at Ealing Studios in England in 1945, immediately after the war, and its actors were very familiar staples of British cinema. During the war, England, the island fortress across the narrow channel from Nazi Europe, had been constantly and systematically terrorized by the threat of imminent invasion, and then by the Blitz and "buzz bombs." For the duration of the war, British film censors made a correlation between the incessant anxiety provoked by the Nazi menace and the anxiety produced by horror films. They prohibited the making of horror films and banned their importation from abroad.

*Dead of Night* was the first burst of the new psychological genre upon the conclusion of the war. Probably, it influenced all later developments; certainly, it anticipated in so many ways the nature of things to come. The film is about *both* the supernatural *and* the hubris of science. Thus, it harks back in a general way to the old prewar themes. But now *psychoanalysis* has become the arrogant and presumptuous science, and is pre-

sented as such. But also the mind itself, with its dangerous unconscious impulses and its painful and grotesque conscious symptoms, becomes the vehicle for the inducement of horror in the audience. With *Dead of Night,* the horror film took a direction from which it has never turned back.

This psychoanalytic discussion will attempt to elucidate and explain the use of anxiety and its mobilization in this particular horror film, *Dead of Night.* A basic premise is that its manifest plot—*if accepted by the viewer as his or her own conscious fantasy*—will evoke and stimulate specific *unconscious* fantasies, which in turn will endow the film's manifest action with personal emotional significance. Accordingly, in order to reliably produce emotional effects in the viewer, relatively common—even universal—fantasy structures must inhere in the film's plot. And common conflicts mobilized by those common fantasies and common defenses, also inherent in the film plot itself, will be seen to be involved in the emotional effects achieved. The following discussion will attempt to elucidate how this is accomplished in this horror film.[1]

Of particular interest in *Dead of Night* is the fact that a major vehicle for mobilizing horror in the film is the rendition of multiple psychopathological phenomena from a psychoanalytic perspective. This makes for a fairly direct portrayal of anxiety-provoking fantasy structures as such. And, in case the viewer is not so psychoanalytically knowledgeable, the film comes equipped with an arrogant and irrepressible (if somewhat boorish) psychoanalyst, Dr. Van Straaten, who provides (often very valuable) explanations.[2] What makes *Dead of Night* a horror film and not a set

[1] See Balter (1999) for a more elaborated description of this strategy of aesthetic analysis. This strategy, based on the analysis of fantasy structures, certainly does not imply that other anxiety-producing techniques of the cinema are not relevant here. *Dead of Night* uses dramatic and dramatizing background music, eerie lighting, sudden facial close-ups, and distortions of perspective achieved through unconventional camera angles and special lenses, to name just a few of such techniques.

[2] Dr. Van Straaten is never called a *psychoanalyst* in the film; he is termed a *psychiatrist.* However, the good doctor himself is not shy to explain to his interlocutors that he is quite capable of psychoanalyzing people. Also, his formulations are purely psychoanalytic. His name is actually Dutch; but he has the middle-European accent commonly associated, in this professional context, with Vienna and Berlin. Recent wartime politics explains the national transposition. The actor, Frederick (previously, Fritz) Valk, though born in Germany, was Czechoslovakian. He then went to England and became a British citizen.

of psychoanalytic clinical cases is its depiction of a set of frightening—possibly supernatural—events that befall common, ordinary people in common, ordinary circumstances.

The film's plot line is unconventional. Part way through it, there is a radical discontinuity in its very content, its structure, and its relation to the audience. That discontinuity is crucial to the evocation and psychological manipulation of anxiety in the audience. Accordingly, this psychoanalytic explication of the film and its emotional effects will be directed first to the film *before* the discontinuity and then to the film *after* it.

## THE COUNTRY WEEKEND

*Dead of Night* opens with the protagonist, Walter Craig, in a car approaching a farm house, which has been converted into a country home by Eliot Foley. Craig, an architect, has been invited for the weekend to look over the house for possible renovations. On arriving, Craig has an intense, uncanny experience of déjà vu. The house, Foley's architectural concerns, and the other guests seem very familiar to him. He believes he has seen all this before in a dream or a series of dreams. He is at first in an intense daze, an altered state of consciousness. Upon coming out of it, the first person he recognizes is the psychoanalyst, and Craig greets him by name: Dr. Van Straaten. With some animation, he says: "[In my dreams,] you always treat me! You'll treat me now, won't you?"

Van Straaten does not believe Craig has dreamt of him. He suggests Craig may have seen his picture in the newspapers. But the other guests are fascinated and captivated by Craig's exotic experience, and immediately believe and support him. Thus, an intellectual battle develops between Van Straaten and Craig (with all the other guests supporting the latter). The doctor, in an irritatingly supercilious and pedantic manner, asserts that Craig's subjective experience of familiarity derives psychologically from unconscious associations, mobilized on the spot, and has no factual basis at all. This provokes the guests, one by one, to tell their own stories of strange experiences that cannot be adequately explained by the science of psychoanalysis; that is, they were *supernatural* occurrences. And thus begins the telling of five stories.

Accordingly, the first part of the film's plot (before the discontinuity begins) takes place on two "tiers": that of an English country weekend,

and that of the five stories told *within* the course of the country weekend. (This device of a group of stories told within a containing story is, of course, very old—e.g., Boccaccio's *Decameron*, Chaucer's *The Canterbury Tales*, and Cervantes's *Don Quixote*.) The lively and initially witty conversation of the country weekend pivots around the question of whether Craig's uncanny experience of familiarity is due to supernatural causation, as he maintains, or to purely psychological causes, as Van Straaten insists.

It is important that each of the stories told is rendered in flashback format. They thus constitute nested stories—separate, integral, and demarcated from the film as a whole. In effect, they are short films in themselves; and the film's introductory credits indicate that each story had its own separate director.[3]

An important element in the drama of the country weekend is what may be considered the obverse of Craig's contention that his déjà vu experience is of supernatural causation. That is, not only does he believe he has seen all this in the *past;* he also experiences premonitions of what will occur in the *future*. The premonitions are based upon snatches of memories that come to him about his dream. Indeed, upon first coming into the farmhouse but before meeting the other guests, he already *knew* that they were about to have afternoon tea. His prediction that Van Straaten, the psychoanalyst, will "treat" him seems quite farfetched . . . so far.

But on coming upon the guests assembled in the living room, Craig makes a comment about the six people he meets there. He is corrected; there are only five. But he then predicts that an attractive, dark-haired woman will arrive and will say something about not having any money. And, sure enough! After the next story is told, the dark-haired wife of one of the guests, Hugh Grainger, the ex-racing car driver, arrives by taxi and asks her husband to pay the fare as she has already spent all her money. The fulfillment of this prediction confirms for Craig his assertion

[3] The nesting/nested structure in works of art, and also in dreams, is strongly correlated with "the problem of reality": the problem of determining what is real or what is true (Balter 2005, 2006). In the present context, the problem of reality is whether Walter Craig's déjà vu experience is supernaturally caused or purely a mental aberration.

of having dreamed all this, and it also solidifies the collective convictions of the other guests (with the dogged exception of Van Straaten).

Later, Craig predicts that another guest, the adolescent girl Sally O'Hara, will leave the company. But then, he remarks, that does not make sense, because another premonition indicates that Craig himself will "hit Sally savagely, viciously." The sprightly, elderly hostess, the mother of Eliot Foley, then proposes that Sally stay for dinner, so that this will "break the spell" of Craig's premonitions. Everybody is charmed by this suggestion. But almost immediately, Sally's offensively intrusive mother arrives and demands that Sally come home. As the romantic Sally protests that she must stay because Mr. Craig has dreamt that he will "hit her savagely," her importunate mother remarks that she is sure Craig can find someone else to hit. She then whisks Sally off, thus confirming at least one part of Craig's prediction.

And Craig has another premonition. It was brought to mind by Van Straaten's constant handling of his thick glasses—very often to emphasize some pedantic point he is making. With some excitement, Craig tells of his dream-based premonition that entails the doctor's glasses:

> It's later on. We're having drinks. You break those glasses of yours. Then, quite suddenly, the room goes dark. Then, Foley, you say something. Something about the death of a man I've never heard of. That's when my dream becomes a nightmare . . . a nightmare of horror . . . . I feel my will power draining away. I feel I'm in a grip of a force that's drawing me toward something unspeakably evil.

As the country weekend's conversation goes on, as story after story is told, Walter Craig becomes progressively more worried about his premonitions coming true. (Not accidentally, his expectant anxiety is analogous to that of the British people over the previous six years. See below.) After the third story, his anxiety is very intense, and he wants to bolt and leave the house immediately. But Van Straaten passionately advises him to stay and see it through; he should not give in to his "obsession." The reality cannot be as terrible as his imagination has painted it. Craig responds as follows.

> My recurring dream isn't just a meaningless trick of the mind. It was sent to me as a warning, a warning against the terror that's waiting for me in this house . . . . I am going to act on the warning. I'm going to leave here now, this instant . . . . There's something horrible waiting for me here, perhaps even death itself . . . . Every minute brings the horror closer.

But Eliot Foley, rising to his role as host, persuades Craig to stay by telling a humorous ghost story, which calms him. Challenged by Craig to tell a story in which the supernatural may have been involved, Van Straaten then tells his own story. Upon its completion, the company is having drinks when Van Straaten's glasses are suddenly knocked out of his hand and break. Immediately afterward, the lights dim and go out. Foley, the host, exclaims, "Blimey! George is dying on us!"

Walter Craig becomes terrified that this is, indeed, the actualization of his premonition: something horrible is about to happen. He is *almost* reassured by the explanation that "George" is not a person at all, but rather Foley's power plant that now needs attending.

The fulfillment of his premonitions is Craig's vindication and triumph over Van Straaten's psychoanalytic explanations—indeed, a triumph symbolized by the doctor's broken glasses. Craig states that he must be left alone with Van Straaten. The doctor agrees: "Perhaps that's best." He asks Grainger to bring his spare glasses from his room because "I'm lost without them." And Van Straaten admits defeat, stating, "I accept your dream." He and Craig proceed to unconsciously fulfill Craig's earlier-stated premonition: that the doctor will "treat" him. With everyone else now absent, Craig and Van Straaten effectively set up the privacy and technique of the psychoanalytic situation.

Van Straaten then says: "Now my task is to listen; and yours to talk. Just let your thoughts run on. Speak them aloud. Say everything that is in your mind." But the distraught Craig is impelled by an inner force beyond his control. He tells the helpless, blind, "lost" psychoanalyst that he must kill someone, someone who only wishes him well, who has not harmed him in any way. Craig undoes his neck tie and, walking around Van Straaten, garrotes him from behind. In agony, Craig mutters: "Oh, doctor! Why did you have to break your glasses?"

This murderous behavior by the timid and consistently frightened Craig is the beginning of the film's radical discontinuity. While it is uncharacteristic of Walter Craig, it is not completely unprecedented in the film. As may now be demonstrated, the five nested stories have already paved the way for Craig's murderous tendency.

## THE FIVE NESTED STORIES

*The Racing Driver's Story*

The first story recounted during the country weekend is about a racing car driver, Hugh Grainger, and he himself tells it. The story revolves around his hospital stay while recuperating from a near-fatal crash on the racetrack.

Certain things are shown about Grainger. Most important in terms of the rest of the film and the rest of the discussion, Grainger is anxious and guilty about possibly having killed another racing driver—a rival, someone like himself, an *alter ego*. While in the hospital during a posttraumatic delirium, Grainger keeps reliving the car crash and is agonizingly worried that both he and the other driver may be killed. Only when he is assured that the other driver is safe does Grainger finally calm down to sleep relatively more peacefully.

However, a possible supernatural dimension of this story is evidenced in a vision Grainger sees out of his hospital window one evening. Anachronistically, the scene seems to take place at 4:15 P.M. on a bright afternoon. He first *hears* the whoosh of a racing car and then *sees* an old-fashioned horse-driven hearse below his window. He then sees the coachman look up at him and hears him say, "Just room for one inside, sir." The driver nods back to the coffin-containing carriage, indicating that Grainger himself should be the occupant. He steps back in horror from the window, which then returns to the evening vista.

Later, upon leaving the hospital, Grainger queues up at a bus stop on a bright afternoon, learns that the time is 4:15 P.M., and when the bus comes, the conductor (*the same man whom he saw in his "vision" at the window!*) says, "Just room for one inside, sir." Grainger draws back

in terror and watches as the bus proceeds to careen out of control and crash, presumably killing everyone inside.

Just as Craig stated that his dream is a "warning" of impending doom, so also Grainger construes the "vision" at the hospital window as a supernatural "warning" about the fatal bus accident. However, though it is not spelled out in so many words, Grainger's strange experiences during and immediately after his hospital stay may very well be explained on the basis of a *traumatic neurosis*. In fact, this is the stated view of the psychoanalyst Van Straaten. The vision that Grainger saw out the window is a form of traumatic repetition—homologous to his post-traumatic dreams and delirium, though much more attenuated in severity. As with any traumatic dream, the vision at the window referred to his recent trauma, the crash at the racetrack, which he barely survived. For he heard at the window the sound of a racing car passing; and, furthermore, in both a hearse and a racing car there is *room for only one person inside*.

Grainger's actual state of mind during the vision is not clear. Was it a hallucination? Or was it a supernatural warning? Whichever it was, the postdischarge episode at the bus stop may be seen as a phenomenon related to his near-death experience—that is, a visual residue of the traumatic neurosis—only now in even milder form, as would be expected in a progressively resolving traumatic condition. Van Straaten quite directly suggests that the experience of common identity between the hallucinated hearse driver and the "recognized" bus conductor, along with the identity of the hour and time of day, are retrospective distortions, analogous to secondary revision in dreams or to rationalization. In other words, they are the defensively motivated products of Grainger's own mind, reassuring him that there is a special supernatural force in the world protecting him.

Indeed, the average film viewer may well suspect that racing car drivers like Grainger make a profession of cheating death—that is, they express what Fenichel (1939) called "the counter-phobic attitude." A near-fatal racing accident would very probably shake the confidence of the most courageous driver. And so Van Straaten's formulation of Grainger's need to feel specially protected makes considerable psychological sense.

This episode has an emphatic sexual dimension, and it is crucial to the story. At the time of his crash, Grainger is a bachelor. Racing drivers are dashing, masculine sportsmen, and the driver in this story is a bachelor who flirts outrageously with his nurse after calling out the name of *another* girl during his delirium. In other words, the conventional iconography of the phallic-oedipal hero who faces danger and woos the woman is present. But here the working out of the traumatic neurosis and Grainger's becoming a domesticated, loving husband are two sides of the same therapeutic coin.

The instigator of this therapeutic triumph is the hospital doctor, Dr. Albury, who inadvertently utilizes the triangular, oedipal transference that the driver-patient has established with him and Joyce, the nurse. This is made explicit in the film, though it is cloaked in flirtatious banter. Grainger jokes about his nightmare that Joyce turns down his marriage proposal and marries Albury instead. But Joyce (a truly loving nurse) reassures him: "Oh, you needn't worry. He has a wife and three children." Then Grainger proposes to her, saying her marrying him will cure him of his traumatic neurosis. So, in cryptic terms, Grainger states that an oedipal victory will reassure him that he will not die.

Using reverse psychology to get Grainger through his traumatic anxiety, Albury challenges the professional sportsman. He *bets* Grainger that he will be out of the hospital in a week. The patient accepts the doctor's challenge—in effect, betting against himself. And, as Grainger himself puts it in proper oedipal fashion: "If I lose, I win." And then, referring to his quick recovery after the bet, he states: "As a matter of fact, I won. That is, I lost, if you see what I mean."

This is a mildly masochistic solution around the overwhelming anxiety his trauma has generated in him. Being defeated by the ministering doctor, he is reassured that he will neither be killed by a more lethal rival nor suffer the guilt due to killing *him*. Grainger regains his courage and wins the doctor's nurse in the process. For Joyce, the nurse, enters the country weekend house a little later as Grainger's wife, stating she has no money to pay the taxi driver ("the penniless brunette" whose presence is predicted by Walter Craig, the protagonist). Grainger's marriage to the doctor's nurse, like an arranged marriage of ancient times, ensures the

amity between otherwise rivalrous parties. Achieving a condoned and forgiven oedipal victory over a paternal rival, paradoxically by masochistically submitting to him in a sporting bet, makes his cure permanent, as Grainger himself puts it.

Dr. Van Straaten, of course, termed the post-hospital apparition of the hearse driver as the bus conductor to be Grainger's personal reassuring superstition: that a supernatural agency is looking out for his safety. And, from the point of view of the audience, this appears plausible.

*Sally's Story*

The next story is told by the adolescent girl Sally O'Hara. Like the previous story, this one is about the narrator's own experience. Just as Grainger's story describes his transition from bachelorhood to marriage, so Sally's story takes place during her transition from asexual latency to sexual adolescence. This is shown graphically when she and a boy her own age attend a children's Christmas costume party, held the previous year in the boy's own home. She and the boy are markedly older than the other guests and obviously already pubescent. As the narrator, Sally states this explicitly, and there are symbolic allusions to her sexual interest in her friend.

For example, in the game of Blind Man's Bluff, she (blindfolded) holds the boy's nose and pronounces it both his and (in adolescent fashion) "silly." And, in case the audience fails to see the boy's nose as a phallic symbol, the elongated nose on his upturned mask points upward at an extremely suggestive angle.[4]

The children decide to play a game called "Sardines," in which Sally hides and those who find her are to hide with her, thus gradually cramping the hiding space. (This is an echo of "Just room for one inside, sir.") She is found by her friend in a small curtained window seat. Now cramped beside her and expressing their new sexual maturity, he makes a pass at her. The juxtaposition of the asexual group games of latency

[4] For the phallic significance of the nose, see Abraham 1927; Brunswick 1928; Jones 1916.

and the sexual couple games of adolescence marks Sally's developmental position at that time. And the camera does, in fact, show her in both roles: as an asexual latency girl, and also as an extremely attractive, and slightly arch, young woman.

But Sally's boyfriend also tells her of a murder that took place many years before in that very house. A girl strangled and then slit the throat of her younger half-brother. Validating Freud's (1905, pp. 204-205) contention that fright may be sexually exciting, the two very young adults titillate each other with ghastly and ghostly elaborations on the template of the haunted house story. And, because of the sexual excitement this generates, the boy again makes a pass . . . and Sally bolts. Her running away from the associated sexual excitement indicates that she still has some way to go to integrate her already mature sexuality with her still-lingering latency morality.

However, crucial to the story, in her running away from this invitation to adult sexuality, *she runs back into the world of children.* But this world of children—sequestered in a hidden bedroom—is not like the one she has just left. It is solitary and isolated . . . and cruel. She meets a much-younger little boy, Francis Kent, who is dressed in nineteenth-century style and sobbing quietly. He tells her of his sadistic and menacing older half-sister, Constance—who is the same age as Sally herself—with whom he shares the bedroom. In contrast to the boy's half-sister, however, Sally treats him very lovingly. She soothes and reassures him. She tucks him in bed and sings him a lullaby.

When Sally rejoins the children's party, she comes to realize that the younger boy she has just met in the hidden bedroom was, in fact, the one murdered there so many years before. It is important to note that Sally's reaction to her discovery is *not guilt* because she might have saved him—but rather *anxiety.* In her agitation, she repeatedly exclaims: "I'm not frightened! I'm not frightened!" and then collapses, crying, into the reassuring embrace of her friend's mother.

The insights of psychoanalysis may well explain what has happened to this charming early-adolescent girl. Deutsch (1944), in her classic study on the psychology of women, described how early-adolescent girls often express their ambivalent, but definitive, renunciation of their in-

fantile masculine strivings through the formation of *a typical fantasy*. The content of the fantasy is that the girl once had a younger brother or male companion . . . who died. The imaginary brother or friend, and the pathos of his death, may be so vivid as to achieve the illusory or delusional status of a bona fide memory. Deutsch explained this fantasy as follows: The dead brother or friend represents the girl's own preadolescent masculinity, which she has to renounce as she assumes the adult feminine identity. Thus, the imaginary brother or companion is the girl's *alter ego*. Renouncing him through his (fantasized) death may entail actual work of mourning. But the renunciation of that early masculine self may also be experienced masochistically as a murder, with all the accompanying guilt and sorrow. Sally's intense solicitude toward little Francis Kent, her *masculine alter ego*, is thus an expression of narcissism, in addition to masochism.

In Sally's story, it is no accident that the vivid "actualization" of this typical fantasy comes immediately after Sally has been sexually stimulated in a manner she cannot yet accept in herself. The most probable conclusion is that this supposedly supernatural experience expresses her wish to eradicate from herself her own boyishness—and so to become a woman. The partial decapitation of the boy is, of course, a symbol of her own *fantasized* castration. Thus, the murder in that hidden bedroom constituted for Sally her own castrating aggression against herself—a disguised form of masochism, in the service of her developing adult heterosexuality. It is something that would, indeed, evoke castration *anxiety* and *not guilt*—which explains Sally's anguished exclamation: "I'm not frightened! I'm not frightened!"

On hearing Sally's story, Dr. Van Straaten barely suppresses, in that genteel adult company, his understanding that Sally has experienced the sexual conflicts of adolescence. Instead, he alludes to the fact that in the Middle Ages, young women such as Joan of Arc and Saint Teresa of Avila (the latter famous for her blatantly erotic mystical experiences) had remarkably similar vivid, hallucinatory experiences. Nevertheless, he cannot resist mentioning that their "visitations" were of a particularly "tangible" nature—implying that Sally has had a modern version of the same thing. Although Van Straaten tactfully does not elaborate along

sexual lines, behind these remarks, he is stating that Sally was caught in the grip of adult femininity and sexual stimulation, and that she has experienced a transient hysterical dissociative episode with hallucinatory features.

In any case, the extraordinary coincidence between the content of Sally's private experience and the history of Francis Kent's murder seems just too remarkable. Was it supernatural? Maybe.

*The Bride's Story*

While the previous two stories could be considered, from a psychological point of view, as entailing temporary aberrations in otherwise mentally healthy people, the next story is about a man, Peter Courtland, who by all common standards would be considered seriously and profoundly mentally ill. Here, unlike the first two stories, the narrator is not the main character. Any narration by Courtland would naturally be suspect. Accordingly, he is not even present at the country weekend. But his spouse is, and she is the story's narrator. An important character in the story in her own right, she is instrumental in Peter's cure. This is very much like the first story of the racing driver, whose nurse-wife promotes *his* cure.

This story is also about a bachelor, "the man who has everything" (as his wife retrospectively termed him), who renounces his single state for the fulfillments of marital life. Thus, like the first and second stories, it takes place at a time of transition in life. However, as the next step in life—marriage—comes closer and closer, Peter becomes more irritable, distant, internally preoccupied, and particularly hostile toward his betrothed. And, after they marry and enjoy a short period of marital happiness, he lapses into a *paranoid delusional psychosis*, accusing his wife of infidelities and of plotting to kill him. Finally, he attempts to murder her. Thus, his marriage was not only a fulfillment of heterosexual love but also a misogynous catastrophe that he could not mentally bear.

If this were all there was to the story, it would make eminent sense, even to a layman. However, what is inexplicable—perhaps even supernatural—about the story has to do with *a mirror* that was a gift from his

wife before they were married. The room in which he sees himself in the mirror is not the bedroom in which the mirror hangs, but another bedroom. Peter's ever-increasing fascination and preoccupation with himself in the hallucinated bedroom in the mirror is an important symptom of his psychosis. But he also experiences its fascinating and enthralling quality as *horrible*.

His preoccupation with the mirror leads to his progressive withdrawal of interest from the world around him and parallels the intensification of his paranoid jealousy about his wife. It is she who discovers that the mirror came from the bedroom of another man—an invalid, Francis Hetherington, who in 1836 suffered the same paranoid agonies that now delusionally afflict her husband. The first man strangled his wife out of paranoid jealousy and then, in front of the mirror—*that* mirror—he slit his own throat. (This act of partial decapitation, seen in the previous story as one of fratricidal murder, has in both instances the symbolic meaning of castration—in fact, *auto*-castration [Lewin 1933].)

Viewed from a *supernatural* perspective, Peter's preoccupation with the hallucinated bedroom in the mirror is really his preoccupation with that unknown dead man—or, what is the same thing, that dead man's preoccupation with Peter. The unconscious misogynous trend within Peter and the supernatural character of the mirror's bedroom are thus "two sides of the same mirror" (so to speak). Viewed psychoanalytically, Peter's hallucination of himself in the mirror's bedroom is at the center of his unconscious, homosexually based antipathy to marrying his wife. First, he tries to use this as a pretext to postpone the wedding. Second, the bedroom in the mirror is associated with his own desires. For he says:

> In a queer sort of way, it fascinates me. I feel as if that room, the one in the mirror, were trying to . . . to claim me, to draw me into it. It almost becomes the real room, and my own bedroom imaginary. [Then he uses almost the same words that Walter Craig used to describe his expectant anxiety about remaining in the house during the country weekend.] And I know there's something waiting for me on the other side of the mirror, something evil, monstrously evil. And if I cross that dividing line, something awful will happen.

Third, the mirror excludes Courtland's bride from the hallucinated bedroom, even when she stands in front of it with him. In the mirror and the bedroom, there is no place for her, just for Courtland alone (in another echo of "Just room for one inside, sir"). But when she insists that they are a couple—a heterosexual couple standing together in front of the mirror and holding each other's hand tightly—only then does the other bedroom in the mirror disappear from Peter's view and the normal one reappear, with both shown in it together.

Fourth, when his wife, in effect, "abandons" him and goes off for the weekend to see her mother—that is, when negative feelings toward her are called up, without her countering them—does the hallucinated bedroom again appear in the mirror. Without the immediate and insistent love of his wife, Courtland cannot surmount the mirror's hold over him; or, what is the same thing, his hostility toward his wife overwhelms his love for her. At that point, in his paranoid jealousy—in effect, a projection of his fear and hatred of her—he tries to kill her by strangulation. As Walter Craig would garrote Van Straaten in the framing drama of the country weekend, so Peter Courtland tries to garrote his wife from behind, using the sash of his house coat. This is the "monstrously evil" thing that he feels awaits him on the other side of the mirror.

What is occurring here—from a supernatural point of view—is possession: that is, the spirit of a dead person enters and takes over the body and mind of a living one. In Caribbean voodoo, in the European-Jewish *Dybbuk*, and in other popular superstitions, this frequently happens psychologically through a living person's appropriation of a dead one through massive identification—and, paradoxically, the living person becomes the *alter ego* of the dead one. But, just as Sally O'Hara did not know of the long-dead Francis Kent before she met him, so also Peter Courtland, the possessed person, knew nothing about Francis Hetherington, the previous owner of the mirror. But Courtland does not believe in spiritual possession, a supernatural superstition; in fact, he consciously adheres to a purely *psychological* explanation of his vision in the mirror—namely, that he is going mad.

It is Courtland's wife, on discovering the mirror's provenance, who immediately sees his trouble in the *supernatural* terms of possession. She

herself believes in such magic instantaneously. But, of even greater importance, in the murderous struggle that ensues between Courtland and his bride as he tries to garrote her, *she actually sees in the mirror the other bedroom, too, and herself in it.* That is, Courtland's bride is allowed into the mirror and into the bedroom only as his murder victim. *She is thus an eyewitness to the existence of supernatural forces* that wantonly attack and destroy the happiness of innocent people. (As is explicitly noted in the country weekend, by contrast, in the previous two stories, there were no eyewitnesses to corroborate the strange, possibly supernatural, occurrences recounted.) On thus accepting the supernatural, and not the psychological, nature of his illness, Courtland's wife shatters the mirror . . . and thereby cures him.

To be sure, the psychoanalyst Van Straaten has his own scientific explanation for the wife's "vision" of the bedroom in the mirror. And, consistently, his explication comes from the realm of psychopathology—this time, the wife's own. According to him, she allowed herself to become a participant in a *folie à deux.* Though we are spared Van Straaten's psychodynamic formulation, it would plausibly go as follows: Under the impact of her husband's murderous attack on her, she massively identified with the aggressor (A. Freud 1936) and, quite literally and concretely, *saw things his way.* Thus, she maintained her loyalty to him when she would be most prone to hate, reject, and lose him; and also, in entering into his psychotic delusion, she could destroy it, so to speak, "from within"—that is, as a loyal fellow adherent of the supernatural.

This explanation of Van Straaten's has some internal consistency. For it was just such a partnership *à deux* that suppressed for Courtland, at least temporarily, the hallucination in the mirror. The bride successfully used it before, and thus it makes sense that she would employ the same strategy again.

But was it simply a matter of coincidence, and not of the supernatural, that her husband suffered a torturing mental illness so similar to that of the previous owner of the mirror? That is the question provoked by the story and the reason it was told. And one for which there is no definitive answer . . . except for some credence given to the supernatural.

*The Host's Story*

Both dramatically and socially, the progressively more gruesome stories being told at the country weekend necessitate some sort of relief—preferably, comic relief. And just in the nick of time! For, as stated above, Walter Craig is about to flee the scene in a panic. His premonitions about the country weekend have repeatedly come to pass, and his most intense premonition—that something "unspeakably evil" will occur to him there—terrifies him. The host, Eliot Foley (note the name!), comes to the evening's rescue and saves the party. Armed with a bottle of Schnapps for Van Straaten, he provides a story of his own that defuses the collective tension—at least temporarily.

In this story, the narrator is the host himself. He is only tangentially related to the narrated action. It is about two good friends—golf buddies. In their attitudes, interests, and general behavior, they are virtually identical. Both are bachelors and both love golf. Their names, Parratt and Potter, are almost transpositions of each other. They even come to love the same woman. Each is the *alter ego* of the other. And, of course, their common love object cannot choose between them. So they play golf for her. The winner in golf wins the lady in marriage. *But the winner cheats.* The loser, in his despair, commits suicide by drowning, walking into a deep lake near the golf course—his golf cap floating where his head once was.

But his ghost comes back to haunt his rival by disrupting his golf game. Indeed, the host himself is witness to the strange, ghostly pranks played by the defeated dead man upon his victorious, cheating, living rival. Finally, the ghost accomplishes analogous revenge in the realm of sexuality. For, through a mix-up in magical, supernatural gestures, the two near-equivalent rivals switch places: the victor in golf is defeated in sex and becomes dead; the loser is now alive again and about to enter the honeymoon bedroom to claim the sexual prize. (Here also, beside the anticipating bride in the honeymoon bed, there is "Just room for one inside, sir!")

As in the previous story, this one is about difficulties encountered in getting married, about jealousy, and about murder and death. But here

the grim and grisly undercurrents are denied by a light vein of English, mildly risqué, "drawing room" humor related to the priority of golf over love and sex; the concern with a ghost also being a "gentleman" and discrete in his secret observations of the living; and a "tunnel" of uplifted golf clubs, instead of swords, at the wedding. The murderous aggression between the two rivals is expressed in calm (even bored) exchanges of "I wish you were dead." Their latent misogyny is expressed by their languid, disparaging comments about their shared love object. The viciousness of mortal combat is transformed into lying about one's score on the eighteenth hole. Haunting becomes a technique that draws on meaningless gestures learned through orientation courses in the after-life, and its greatest danger is an inconvenient presence during intimate activities—which is probably the true psychological meaning of *haunting* anyway.

Even the fatal blow of the golf duel is passive: the cheating victor "kills" the defeated rival by the latter's suicide. Masochism substitutes for murder. The suicide by drowning is devoid of the terrifying agonies of gasping and choking; only the gentle and innocuous bubbles tell the tale. Even the symbolic castration (up to this point in the film, it is partial decapitation by throat slitting) has been minimized, or trivialized, to the floating golf cap separated from the drowning head. Thus, this episode may be seen not simply as comic relief in this truly innovative horror film, but more critically as a satirical debunking of the classic horror genre of the ghost story.

However, for all its sardonic deviation from the other stories in the film, this one is still faithful in its essential thematic structure. For the premarital orientation of the two men is essentially misogynously homosexual—sublimated in golf through their joint play with their sticks, holes, and balls. The guilty victor's penitent willingness to give up the woman, *but not golf!*, indicates where his, and the other's, heart really is. And as Freud (1922) pointed out, shared heterosexual attraction to the same woman is an expression of homosexual attachment between men—defensively disguised as heterosexuality.

But besides being homosexual in nature, their relationship is also narcissistic. Through their near identity, each loves himself in the other. And the story's ending, in which the two men become equivalent to each

other even in the honeymoon bed, emphasizes the fact that each is an *alter ego* of the other in every essential way—and, most pointedly, in sex.

It should be clear that there is neither serious psychopathology nor any real supernatural phenomenon being described here. The answer in *this* story to the question "Is it psychopathological or supernatural?" turns out to be "Neither!" And this is probably the real joke that the host plays on his increasingly grim and serious guests. And Eliot Foley is successful: his joke mocks Walter Craig's panic and induces him to stay.

*The Psychoanalyst's Story*

Most of the narrative of the psychoanalyst's story is told several levels removed—at least partially. The main narrator is Dr. Van Straaten himself. Although he participates centrally in the events of the story, they take place essentially outside his control or immediate involvement. He is a consultant on a London police case in which a ventriloquist, Maxwell Frere, renowned in his theatrical field, attempted the murder of another ventriloquist, Sylvester Kee. So in this story, two men—professional *alter egos* of each other—are involved in a murderous issue. But, as will be seen, the more elemental and basic murderous *alter ego* relationship is between the homicidal Maxwell Frere and his dummy, Hugo Fitch.

In any case, most of Van Straaten's story, itself a flashback from the country weekend, consists of a further flashback of the police deposition made by the victim. Van Straaten reads the document, but it is presented in the film as a twice-nested story told by Sylvester Kee.

The central point of the story is the dummy Hugo Fitch. He is not only Maxwell Frere's "partner" in their nightclub act; he also expresses all the masculine aggression, the misogynous scathing and hateful wit, the perky and impudent arrogance that the enervated, hysterical, and limp Frere cannot manifestly display in his own right. Hugo Fitch is not only Frere's *alter ego;* he is also his phallic prosthesis. Furthermore, Hugo appears to express Frere's hatred of himself, for Hugo depreciates and humiliates Frere, dominates him, and even threatens to betray him. This provides an uncanny perspective on this ventriloquist and his dummy, which disposes to seeing them as relatively detached and dissociated from each other.

Van Straaten's story revolves around the question of whether the dummy Hugo Fitch is (psychoanalytically) a phallic *symbol*, and a symptomatic incarnation of Maxwell Frere's complex masochism and very severe identity dissociation. Or is Hugo Fitch (supernaturally) the real, *living* person Maxwell Frere believes him to be? In the story, the indications that Hugo is an autonomous person come in two places: Frere's dressing room in a Paris nightclub called Chez Beulah, and Sylvester Kee's hotel room in London. In the former, Kee has a conversation with the unseen dummy Hugo that appears to take place without Frere's knowledge, or even his presence. In London, Hugo turns up at the foot of Kee's hotel bed, without Kee or (seemingly) Frere having put him there. In this second encounter, Frere—in a fit of jealous rage—shoots and almost kills Kee.

The seeming ability of the dummy Hugo Fitch to behave as an autonomous "person" is the hypothetical supernatural dimension of this story. That is the point of its being told at the country weekend.

Though the psychoanalyst Van Straaten does not go into an extensive psychodynamic elaboration (after all, he is addressing a lay audience), he nevertheless has put together a very coherent psychoanalytic description of a bizarre, though understandable, psychiatric illness that he terms *dual identity*. Its formulation is based upon the premise that the dummy Hugo Fitch, for all his seemingly miraculous feats, is in fact Frere's disguised vehicle of masculine self-expression and undisguised masochistic self-hatred . . . and *only* that.

Maxwell Frere develops a paranoid delusion that Hugo Fitch is an independent living person and that Sylvester Kee and Hugo want to be theatrical partners—thus not only leaving out Frere, but actually robbing him of his whole identity, professionally and personally. This almost-visible homosexual, paranoid jealousy is already evident when Kee visits Frere in his dressing room in Paris. There the dummy depreciates Frere and frankly proposes that he and Kee should become partners. Frere's jealousy reaches homicidal intensity when he confronts Kee in the latter's hotel room, accusing him of physically stealing Hugo Fitch and, quite literally, *taking him to bed*. However, the reason for Frere's paranoid jealousy arose earlier, *just before* Kee visited his nightclub dressing room.

The immediately previous encounter between the two men took place during the nightclub act of Frere and Hugo at Chez Beulah. There Kee played a professional trick on Frere by appropriating the dummy Hugo's voice, having him sing "Cock-a-Doodle-Do"—that is, making Hugo act like a cock, beyond the control of Frere. This mild, relatively innocent prank resulted in two disastrous psychological transformations in the tenuously stable Frere. First, Hugo (Frere's unconscious *alter ego*) immediately showed contempt for Frere and very positive interest in Kee, suggesting that they become theatrical partners. Second, Frere's *unconscious* homosexual attraction to Kee expressed itself through a *conscious* paranoid delusion that Kee wanted to take Hugo from him, to appropriate Frere's phallic extension. For Frere, the conflict could only be resolved through the death of his "enemy," Kee. He shoots Kee, nearly fatally.

Frere's murderous attack on Kee brought Van Straaten into the case as a psychiatric consultant. However, Van Straaten did not accurately assess the degree to which Frere was homosexually stimulated by Kee's playing with Hugo's voice, or how guilty Frere unconsciously felt about attempting to murder him. Accordingly, when the doctor brought the dummy Hugo Fitch to Frere's jail cell to gain some insight into Frere, the prisoner performed an act of self-punitive auto-castration: he destroyed Hugo, the vehicle of all his masculine narcissism—first by smothering his face with a pillow, and then by an act equivalent to partial decapitation. He pulverized, through stamping, half of Hugo's head. (As noted, both strangling-choking-smothering and also symbolic castration were murderous elements in the second, third, and fourth nested stories of *Dead of Night*.)

Later, Van Straaten brings the recuperating Kee to Frere's padded cell in order to shock Frere out of the catatonic stupor into which he has fallen after Hugo's destruction. And Frere does come out of his catatonia when he recognizes Kee. Now, devoid of all masculine narcissism, he frankly expresses his homosexual longings for Sylvester Kee and croaks out lovingly in Hugo Fitch's voice: "Hello, Sylvester, I've been waiting for you." *Maxwell Frere has become Hugo Fitch*—the only acceptable component of his prepsychotic personality. Within Frere's mind, the previous dual

identity has become the single, dominant identity. There was, indeed, "Just room for one inside, sir!"

As already indicated, the questions of how the dummy Hugo managed to talk to Kee without Frere knowing about it in Paris, and how Hugo later got to the foot of Kee's bed in London, remain unanswered. Van Straaten stated with his usual pedantry that Frere unconsciously did it all himself. Is this true? Or did something supernatural occur?

The five stories recounted in *Dead of Night* were told specifically to demonstrate the existence of the supernatural in everyday life, and also to indicate the explanatory impotence of science, particularly psychoanalysis. In this respect, they were essentially inconclusive, though the sequence of stories became progressively more persuasive, as well as more horrible.

## THE FILM'S UNCONSCIOUS FANTASY STRUCTURE

As has doubtless already been surmised from the preceding discussion, the film's five inner stories are not a random collection of tales. They are related to each other in content, form, and sequence. As the stories proceed, the supposedly supernatural events begin as relatively benign, even protective, and become progressively more malignant and destructive. And the protagonist of each story becomes more and more unable to control or avert dangerous involvement in the horror. Further, the psychopathological states presented become progressively more severe. This is particularly true regarding the growing confusion between self and object, as indicated by the growing clarity and centrality of the phenomenon of the *alter ego*.

More specifically, the psychopathological conditions evince an increasingly destructive, combative male homosexual orientation—starting with a benign, blatantly heterosexual, oedipal drama and ending with a psychological suicide through the destruction of a narcissistic homosexual object. As may be seen, the sequence of stories shows a progressively more distinct and more intense theme of two males (in Sally's story, her masculine aspect and the little boy), more or less equivalents

of each other, who are nevertheless pitted against one other in a sadomasochistic—and profoundly narcissistic—homosexual struggle over who becomes whom. The destructive but also consummatory act comes increasingly to involve suffocation or strangulation, and also symbolic castration through partial decapitation.

There is another theme in the sequence of five stories that is quite prominent at their beginnings and becomes progressively less and less prominent over the course of the sequence. That theme is the *dangerous enclosure,* or *claustrum*—the universal symbol of the maternal womb. The sequence begins with the *vehicle of death:* a racing car/hearse/bus as the lethal claustrum. It becomes the hidden bedroom of Francis Kent's murder in Sally's story. And then Francis Hetherington's bedroom in Peter Courtland's mirror. And then the honeymoon bedroom, where life and death are humorously exchanged. And finally the jail cell and padded cell of Maxwell Frere, containing his self-destroyed mental life.

The film *combines* the first theme of sadomasochistic homosexuality and narcissistic combat with the second theme of the dangerous encounter in the claustrum. Thus, a more complex—but also a more precise—unconscious fantasy structure for all five stories emerges: *the mortal encounter between two male, near-equivalent antagonists in the mother's womb, where one kills or castrates the other through some form of sexual violence in order to take his place and/or to become him.*[5] This complete fantasy is inherent in each of the five nested stories, *but it is never fully or manifestly expressed.* For, as one theme becomes progressively more pronounced, the other

[5] This fantasy is typical. Arlow (1960, 1972) designated it as especially characteristic of only children and twins. He demonstrated the prevalence of the unconscious fantasy of the mother's womb as the dangerous place where the paternal phallus, sibling rivals, or hideous monsters may attack, castrate, or kill the subject who abides there—or the subject may do comparable things to them. Mythological, literary, and cinemagraphic instances of this fantasy abound: Theseus and the minotaur in the labyrinth; Odysseus and his shipmates in the cave of the Cyclops; Jacob and Esau contending in their mother's womb; Edgar Allan Poe's "The Pit and the Pendulum," "The Cask of Amontillado," and "The Fall of the House of Usher"; the dangerous gold mine cut into the mountain in *The Treasure of the Sierra Madre;* and the Indiana Jones movies, with all their treacherous caves and tombs. These are just a few instances of this view of the lethally dangerous maternal claustrum and the murderous aggression that occurs there.

theme becomes less so. The dual and reversed sequential format consistently provides a degree of defensive disguise for this horrific fantasy, and thus *makes the audience receptive to adopting it as their own* (Alexander 1925; Freud 1900, pp. 333-334). The film therefore persistently stimulates the acquiescing audience subliminally along narcissistic, sadistic, masochistic, and perverse modalities. How that stimulation is handled by the audience is pivotal for the emotional effects of the film.

Most important, the five nested stories not only subtly and subliminally stimulate the audience along sadomasochistic, narcissistic, and perverse modalities; they also pari passu color along the same lines the framing drama taking place in the country weekend. For there the two protagonists (Walter Craig and Dr. Van Straaten) are locked in an intellectual—and then very personal—fatal battle. In the claustrum of the country house, Craig's murder of Van Straaten takes place. For there could only be "Just room for one inside, sir." While the audience may experience a cognitive dissonance in Craig's sudden, murderous change of personality, that dissonance is not so jarring. This is because, in their sequence, the *five nested stories tell the same essential story as that of the country weekend.*

But also, while the film's manifest nesting structure relegates the inner stories to a different ontological realm of reality than the framing country weekend drama (they are *only* narrated stories, about other people, other places, and other times), the unconscious thematic consonance between these two tiers forces the audience to project onto the country weekend the horrific underlying fantasy repeated fivefold by the nested stories. This gives Walter Craig's fearful premonitions an unconscious validity in the minds of the audience, and so his mounting expectant anxiety is also experienced empathically by the audience. However, that anxiety is nevertheless contained by the two-tier narrative structure. The audience can still defensively test the well-defined reality between the frame of the telling of stories and the nested stories told.

This is the psychologically *tense, but emotionally defended and controlled,* condition of the audience's anxiety wrought by the film just before its radical discontinuity.

## THE FILM'S RADICAL DISCONTINUITY AND HORROR

Upon the murder of the psychoanalyst Dr. Van Straaten, the distinction between the telling of stories and the stories told collapses. The guilt-ridden Craig tries to hide somewhere in the claustrum of the country house. But what he finds there are the several worlds of the nested stories and their characters—*recognized as such by Craig*. The previous part of the film had Craig not actually *see* the nested stories (which the audience *did see* through the flashback device). Now the nested stories *are* Craig's reality, and the reality of the country weekend has dissolved.

Furthermore, all the latent perverse malignancy of the inner stories is now manifest in that *Craig is persecuted by them*. Sally's children's Christmas party seeks him while he hides, trying to escape detection. Sally finds him, shouts to expose him, and he "hits her savagely," as he predicted. She then appears dead. Peter Courtland's mirror bedroom will not accept him, instead reflecting the dead Dr. Van Straaten on the bed. Hugo Fitch and Sylvester Kee, now cozy theatrical partners at the crowded nightclub Chez Beulah, sneer at him, expose him to all as a murderer, and suggest he "see a doctor; or maybe he *has* seen a doctor." Finally, the upper-class audience at Chez Beulah becomes a snarling, sadistic mob, and carries the struggling Walter Craig to Maxwell Frere's jail cell. The leering hearse driver/bus conductor ushers him in. Jeering maliciously, the latter does *not* say, as he did in the racing driver's story: "Just room for one inside, sir." Instead, he says: "Just room for one *more* inside, sir!" There is already someone else in that jail cell claustrum, waiting for Craig.

Walter Craig had just previously been the *active, murderous* protagonist embodying the film's core fantasy. Now he is the *passive, helpless* victim in the core fantasy. And this leads to Craig himself being locked into a murderously dangerous claustrum: *a jail cell shared with Hugo Fitch*—formerly a ventriloquist's dummy but now a completely autonomous, independent "person." Hugo Fitch is at once an attacking phallus, a murderous child, an adult automaton without human inhibition or compassion. He is the *alter ego* of Craig himself, who had become a de-

humanized, robotlike murderer. Blatantly acting out the fateful fantasy central to the whole film, Hugo Fitch reaches out to give Walter Craig the homosexual embrace of death by strangulation. He sarcastically asks Craig, as he had earlier asked Maxwell Frere, who desperately pleaded not to be abandoned and ruined: "*Wouldn't I*?"

The very content and form of this second part of the film is a psychosis. The defensive reality-testing distinction—between the inner nested stories (located in the past) and the outer framing country weekend drama (located in the present)—has collapsed. The inner stories and the country weekend have become one. With the murder of the psychoanalyst—the scientific defender of sanity, reason, and reality—Craig also murders *in himself* all restraint, all reason, all reality, all morality, all humanity. The ordinary rules of logic, the laws of physics, the order of temporality and causality, the distinction between fantasy and reality, and the inhibition of aggression by compassion—now all these no longer apply. Heralded by the murder of the psychoanalyst, the inescapable result is a breakdown of the basic dimensions of mental differentiation and integration, both in the film itself and in Craig himself—the film's protagonist.

Walter Craig, consumed with guilt and the sole occupant of the world he has conquered for the supernatural, must now face directly the supernatural horror of the stories themselves. They are the substitutes for the real world of objects he has "destroyed." The punishment he both needs and fears regresses into the perverse aggression inherent in the stories. And that murderous aggression, having no other object in his solipsistic world—just room for one inside—now turns upon Craig himself.

This is what the audience itself must experience. The audience is forced to empathize with Walter Craig in a psychosis-like horror. They have been prepared to tolerate the horror's anxiety *without breaking off that empathy* by the two-tiered structure of the first part of the film. That is, the film first stimulates the audience to unconsciously, subliminally participate in a horrific perverse unconscious fantasy, with all the defensive safeguards inherent in its nesting/nested narrative structure. It then suddenly undercuts those defensive safeguards by collapsing the

two tiers. The result is the audience's *undefended* experience of the protagonist's psychosis-like horror.[6]

## THE RESTITUTION OF CONTINUITY . . . AND HORROR

But at the moment of the audience's most intense experience of horror, when Hugo Fitch reaches out to strangle Walter Craig, the whole premise of the film is suddenly turned on its head—*again.* The actuality of the country weekend drama that was contrasted to a dream turns out to be a dream in actuality. Craig wakes up in his bedroom strangling himself. It suddenly becomes clear that *the whole previous part of the film was Craig's recurrent nightmare.*[7]

And all the problems of reality in the film are now instantaneously resolved for the audience. *Regarding Craig, the protagonist,* his strangling himself while dreaming that Hugo Fitch is doing it indicates that the characters of the country weekend, including the characters of the nested stories, are all products of his dreaming imagination. *Regarding the reversal of dream and actuality in the film,* the film now utilizes the denying defense most consistently used in the country weekend: "It was *only* a dream!" *Regarding the argument between the advocate of the supernatural*

[6] At the time of the film's creation, the predominant psychoanalytic theory of the psychoses was based almost exclusively on the libido theory (an initial "silent" decathexis of objects followed by a "noisy" restitution phase, where object substitutes—word representations, as in told narratives—are cathected [Freud 1911]). This film adheres strictly to this psychoanalytic theory. The subsequent advances in the psychoanalytic theory of the psychoses wrought by ego psychology (e.g., Arlow and Brenner 1964; Beres 1956) lay in the distant future, as did the still-later contributions of object relations theory. For all the quaintly archaic nature of the film's *theory* of the psychoses, it is by no means clear that further psychoanalytic progress in the psychoses vitiates in any way the film's *phenomenological* rendition of a psychosis.

Incidentally, *Dead of Night* was not the only major British film of the 1940s that presented a psychosis based on the then-current psychoanalytic theory. The 1948 film *The Red Shoes* contains the nested *Ballet of the Red Shoes.* This modern ballet portrays the subjective experience of the diphasic psychotic process. The film emphatically indicates that the ballet makes a profound psychological comment on the film's ballerina protagonist, who ultimately commits suicide in a state of severe mental decompensation.

[7] The denying, retrospective relegation of something distressing *as a dream* ("It was *only* a dream!") is also seen in dreams (Berman 1985; Mahon 2002). And of course it occurs in many other works of art, especially movies (e.g., Fritz Lang's melodramatic film noire *The Woman in the Window,* and the science fiction film *Invaders From Mars*).

*and that of science*, all this is resolved in a flash—Van Straaten is correct: it *is* just the distorted product of Craig's mind. And Craig is correct, too: the country weekend, now perceived as a recurrent nightmare, *is* familiar simply because he has previously dreamt it innumerable times.

*But, at this point in the film, the country weekend drama immediately begins to take shape "for real."* Eliot Foley calls and arranges the country weekend with Walter Craig, who has already forgotten his dream. And, for the audience, that nightmare—retrospectively framed in the past—predicts *a fortiori* what will now happen in the framing, real, wide-awake world of Walter Craig. For the closing shots of the film repeat those that open it: Craig arrives by car at the uncannily familiar country house. This is the final triumph of the supernatural in Craig's life, and in the film.

The hyperstimulated audience has been deprived of the film's structured defenses inherent in its multiply nested/nesting structure ("It is only a told story!" "It is only a dreamt nightmare!"). But the audience was not given a chance to abreact the mobilized anxiety. It must now anticipate passively the terrifying course of events it knows to be inevitable. The real world, clearly under supernatural domination, has become the lethal claustrum. There is no escape. And for the tense audience, there is no climax either—no final catharsis for the perverse horror generated about the supernatural. That horror is kept in suspense, static . . . and permanent.

As the film ends, the audience experiences expectant claustrophobic anxiety and despair about the certain murder and madness that await the unsuspecting doomed protagonist. And, if anyone appreciates in this film a recurring cycle of "real" worlds, each psychotically collapsing into the next, it is *a series of nightmarish horrors repeated infinitely, over and over again.*

## CONCLUSION

The whole film, including its ending, reproduced in the war-weary English public the same kind of passive expectation of horror that they had just repeatedly endured, virtually daily and nightly, for six years by threats of invasion, the *Luftwaffe's* blanket bombing, robot bombs, and rockets. Clinically, such repetition of cumulative trauma through art, just as through dreams, is not so surprising. But here this repetition demonstrates how consummate artists react through their creativity to the

social, political, and psychological stresses of their time and place. In this case, they appear to have responded to the fact that Great Britain had become, over the war period, a grimly determined national organism stubbornly dedicated to its survival and victory, *while holding its anxieties in abeyance*. The British truly did "keep a stiff upper lip"! Unlike the Nazis, the histrionic venting of collective emotions was alien to their temperament and their needs.

*Dead of Night* allowed the psychological processing of passively expectant anxiety through apprehending a work of art. It is immaterial whether the filmmakers had "therapeutic" motives in the film's creation. With victory and the sudden lifting of horrifying intimidation, the British film industry performed its proper social and aesthetic functions in this extremely well-crafted film. *Dead of Night* reflected and expressed the dark underside of what Winston Churchill glowingly termed "their finest hour."

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*544 East 86th Street, 1SW*
*New York, NY 10028*

*e-mail: LBalterMD@aol.com*

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# PSYCHOANALYTIC TECHNIQUE AND THE CREATION OF ANALYTIC PATIENTS: AN ADDENDUM

BY ARNOLD ROTHSTEIN

**Keywords:** Analytic technique, analyzability, analytic practice, analytic training, analytic research, resistance, enactment, countertransference, diagnosis.

The purpose of this addendum to my book, *Psychoanalytic Technique and the Creation of Analytic Patients* (Rothstein 1995b), is to respond to criticisms that have been raised since its publication and to clarify premises that have been misunderstood.

For the past quarter century, I have been interested in why so many well-trained psychoanalysts have such difficulty developing successful and satisfying psychoanalytic practices. This interest has resulted in a number of presentations and publications (see also Rothstein 1986, 1990, 1992, 1994, 1995a). These publications derived from and emphasized clinical data rather than theoretical formulations.

However, in the process of discussing my findings (Rothstein 2000, 2003), I became aware that there has been a failure in the traditional pedagogy employed for the past eighty years regarding the selection of suitable patients for analysis. Authoritative training analysts have propagated the illusion that prospective analysands could be *evaluated* in a vis-à-vis consultation, and that suitable "good cases" could be selected. This myth has been conveyed in courses on "selection" and "analyzability." These courses persist despite research demonstrating that it is not possible to accurately prognosticate outcome at the beginning of an analysis. Relatedly, many analytic candidates begin analyses with patients who

Arnold Rothstein is a member of the faculties of the New York Psychoanalytic Institute and the Psychoanalytic Institute affiliated with New York University School of Medicine.

have been "chosen" and "approved" by others; this process deemphasizes the importance of the match as a factor in outcome.

Such a model proposes that the analyst, as authority, greet a prospective patient with an *evaluative* attitude. The analyst is trained to ask the question "Is the patient analyzable?" In an effort to answer that question, the analyst assesses the patient's personality and makes a diagnosis. If the patient is considered neurotic—or, in Glover's (1955) term, "transference accessible" (pp. 185-187)—analysis is the recommended treatment. This evaluative model proposes that analysts can "make an *objective* and *unbiased* evaluation" (Lagerwof and Segrell 2003, p. 126, italics added) of a prospective analysand who is "suitable . . . for candidates . . . . By 'suitable case' is meant a patient who is believed to be able to cooperate . . . with a good enough analyst in training and to complete the analysis" (p. 126). Like Glover, Lagerwof and Segrell seek compliant patients.

Results of recent studies reported from the Columbia University Center for Psychoanalytic Training and Research support my view that the evaluative model has failed, and that patients are more likely to have successful analytic experiences if they are collaboratively developed rather than evaluated and assigned.

Caligor et al. (2009) described evaluations conducted by candidates supervised by training analysts. Their methodology attempted to make their evaluations as objective as possible. Prospective analysands participated in structured interviews and questionnaires, as well as specific tests intended to quantitatively measure depression and anxiety. In employing these tests, as well as evaluations of ego functions, symptoms, and diagnoses, Caligor et al. found no differences between patients accepted for psychoanalysis and those who were rejected. Reflecting on their findings, they suggested that "the criteria used to recommend analysis may simply reflect the perpetuation of unfounded myths about who would and who would not benefit from analytic treatment" (p. 690).

Hamilton, Wininger, and Roose (2009) reported that 40% of patients evaluated as analyzable dropped out of analysis with candidates within the first year of treatment. Cases were more likely to fail (50%) if they were assigned to an analysis rather than converted (29%) from candidates' psychotherapy practices. These findings support the idea that success is more likely if cases are collaboratively developed.

In responding to criticisms of my work, I inadvertently stumbled upon a revolutionary (with a small *r*) way of assessing this problematic situation. I discovered in my *attitude* a new "concrete puzzle solution" (Kuhn 1962, p. 175) for doing a consultation, which I have designated a *trusting model*. This model, which emphasizes analytic attitude and subjectivity, and which privileges countertransference, has seven points:

1. Analysis is the optimal therapy for most patients who seek an analyst's help.
2. Therefore, a trial of analysis should be recommended.
3. The trial should begin in any way the patient is able to begin. The ultimate goal is to help the patient experience the optimal parameters associated with an analytic experience: use of the couch at a frequency of four or five times per week.
4. The patient's reluctances should be thought of as enactment resistances.
5. Consideration should be given to the possibility that the urge to diagnose a patient may reflect a countertransference enactment.
6. The patient should be considered analyzable until he or she proves to be unanalyzable in a trial of analysis with a particular analyst at a particular time in the lives of both patient and analyst.
7. Analytic impasses and/or failures should be thought of as failures in the collaboration, rather than reflective of the limits of the patient's analyzability.

Because so many analysts struggle in their efforts to develop analytic practices, there has been a good deal of interest in this *trusting model*. In discussing the model with graduate analysts and candidates, I have been impressed with the not-infrequent experience of being misunderstood and/or misquoted. Five such criticisms will be discussed and clarified: First, the idea of analysts' "creating" patients. Second, some colleagues have understood me to be recommending analysis to *all* patients I see in consultation. Third, the distinction between recommending analysis and recommending a *trial* of analysis must be clarified. Fourth, the concept

of *enactment resistance* needs elaboration. Fifth, the idea that analysts' diagnostic activity *may* reflect countertransference must be clarified.

In *Beyond the Pleasure Principle* (1920), Freud reminded us that "people are seldom impartial where . . . the . . . problems of science . . . are concerned. Each of us is governed in such cases by deep internal prejudices into whose hands our speculations unwittingly play" (p. 59). Freud's comment emphasizes the impossibility of objectivity in scientific discussions. We all maintain a subjective fealty to the tenets of our preferred paradigm. The "evaluative" model has been a fundamental component of the "normal science" (Kuhn 1962, p. 5) of psychoanalysis; it has roots in the medical tradition of physicians making a specific diagnosis and, relatedly, recommending a specific treatment. Colleagues consider new and different ways of thinking and working only when a premise of normal science has failed. Such is the case with the concept of "analyzability" and the derivative practice of "selection" of "suitable" cases.

First, some colleagues have been critical of my discussion of "creating" analytic patients and of a model that emphasizes trust and optimism. I agree that it is more accurate to speak of "collaboratively developing," rather than creating, an analysand. The analytic pair collaboratively explores whether they can work together at this time in their lives. The question under consideration is not whether the patient is analyzable, but whether this specific pair can be collaborative.

Second, although the trusting model reflects my view that the optimal treatment for *most* patients is a *trial* of analysis, it is not unusual for colleagues to erroneously infer that I recommend analysis to *all* patients. Some critics suggest that "Rothstein thinks all patients are analyzable," despite the fact that, in my book (1995b), I described six patients to whom I did *not* recommend a trial of analysis. This was either because the patient was afflicted with serious psychiatric illnesses, because I experienced him or her as "too disturbed and disturbing for me" (p. 63), or because the patient presented with an immediate crisis.

Patients who fall in this second group—"too disturbed and disturbing for me"—might be capable of collaborating with another analyst who does not experience them as too disturbing. The *psychoanalytic diagnosis* "too disturbed and disturbing for me" conveys the ubiquitous

influence of unconscious conflict and derivative conscious subjectivity on any judgment that is rendered; it emphasizes the limits that my subjectivity imposes on the scope of patients with whom I can successfully collaborate.

Finally, there is a third group of patients for whom I do not consider a trial of analysis to be the optimal treatment; these individuals present with a problem in their current life situation that they experience as an emergency. A brief therapy seems the correct recommendation in such cases. After the containment or extinguishing of such a patient's personal "forest fire," the potential benefit of more extensive treatment could be explored and evaluated.

Third, the difference between recommending a trial of analysis and recommending analysis is frequently obfuscated and/or confused. Freud (1913) was clear about the distinction between these two recommendations:

> I have made it my habit, when I know little about a patient, only to take him on at first provisionally, for a period of one to two weeks . . . . No other kind of preliminary examination but this procedure is at our disposal; the most lengthy discussions and questioning in ordinary consultations would offer no substitute. This preliminary experience, however, is itself the *beginning of a psychoanalysis* and must conform to its rules. [p. 124, italics added]

By contrast, recommending analysis—rather than a trial of analysis—derives from the evaluative model and a belief in the analyst's capacity to render an objective judgment. However, my recommendation of a trial of analysis derives from my belief that, without a trial, the analyst cannot know with whom he or she can successfully collaborate. For this reason, I often say to a patient, "We can give it a try, and we will know in three to six months if it is for you."

Fourth, I would like to clarify the concept of *enactment resistances* within the context of the *trusting model*. It is not uncommon to hear a colleague say, "Rothstein considers a person resistant if he or she does not accept his recommendation of analysis." One skeptical colleague asked, "What is it, exactly, that the patient is resisting? He seems to be resisting

the authority of the analyst. It sounds like disobedience." Such skepticism is understandable when one considers that the term *resistance* has traditionally referred to unconscious defenses experienced by a patient who is already in analysis. It is beyond the scope of this paper to discuss the panoply of modifications of standard technique that have been described by colleagues (such as Stone [1954] and Stein [1973]) in order to facilitate work with enactment-prone patients. However, I emphasize that the term *enactment resistance,* and the associated technique with which to work with reluctant prospective analysands, specifically pertains to beginning-phase process with such patients.

It is a common experience that prospective analysands respond to the recommendation of a trial of analysis by objecting to one or another aspect of the anticipated analytic situation: they desire lower fees or different hours or less frequent hours, and they may object to the supine position. I inform such a patient that I am willing to begin a trial of analysis without using the couch and at the frequency he or she suggests, with the understanding that we will attempt to understand why the patient is unable to accept the recommended manner of working. In such situations, I frequently refer to the recommended parameters as the minimal requirements for optimal treatment, and I often suggest that the patient seems afraid to allow him- or herself to have an analysis or to be in analysis.

In a sense, my approach frames the patient's reluctance as a self-defeating, masochistic enactment and, *in collaboration with the patient,* it focuses an aspect of the early work on understanding this expression of the neophyte analysand's character. It is a not-infrequent finding that this symptomatic expression may indicate more pervasive masochistic conflicts. If the prospective analysand accepts the "contract" explicitly stating that an aspect of the "modified analytic situation" will be an inquiry into the subject's reluctance, then, and only then, are the prospective analysand's objections conceptualized as enactment resistances.

A colleague noted that "indeed, a patient's reluctance might be an expression of a masochistic conflict, but by the same token, might not the readiness to accept the analyst's recommendations also be an expression of a masochistic conflict?" This colleague's point is absolutely correct. The compliant patient, traditionally considered a "good" patient,

may in fact be masochistic, the compliance being an expression of an unobjectionable positive transference (Stein 1981). Analysts such as Glover (1955) have traditionally been quite happy to accept such compliance.

I emphasize that the term *enactment resistance* was created to facilitate analytic work with enactment-prone, reluctant neophyte analysands. It is also important to emphasize that, in order for the analyst to consider a trial of analysis to be the optimal treatment for most patients seen in consultation—and to conceptualize resistance to accept the recommendation of a trial as an enactment resistance—he or she must be convinced of the therapeutic efficacy of psychoanalysis.

If a patient adamantly expresses disinterest in my recommendation of a trial of analysis but wishes to work with me once a week, I will explore the wish to work in that manner. The patient who requests once-weekly meetings might state that he or she likes me and/or has heard nice things about my work. In response, I might say, "It is the [analytic] method rather than the messenger that is important." If the patient's refusal of my recommendation persists, I might suggest that he or she find an analyst who regards this wish as optimal for the patient. Such comments continue to communicate the analyst's inevitably subjective, optimistic belief in the therapeutic efficacy of the psychoanalytic method.

Fifth, some colleagues seem not only to misunderstand my suggestion that the analyst's urge to diagnose *may* reflect countertransference; they also seem to find it offensive. One colleague strongly objected to my emphasis on the possible relationship between the analyst's activity of diagnosing and countertransference difficulty by asserting that "it is my professional responsibility to make a diagnosis. It is malpractice not to make a diagnosis." However, in the fifth point of my trusting model, I state: "Consideration should be given to the possibility that the urge to diagnose a patient *may* reflect a countertransference enactment." I emphasize the qualifier *may,* which derives from an analytic attitude that privileges countertransference.

It is obvious, of course, that some patients (such as those characterized by the Axis 1 diagnoses of *DSM-IV*) would be better served by a form of treatment other than psychoanalysis (American Psychiatric Association 1994). However, for the vast majority of patients, the decision about whether to recommend analysis is more a matter of the analyst's

taste than of sound, scientific decision making. The analyst cannot help being *evaluative*. I have emphasized (Rothstein 1995b) that it is useful for the analyst to consider such urges as possible expressions of countertransference. From this perspective, it is best that the analyst concentrate his or her efforts on understanding the patient's reaction to the recommendation of a trial of analysis as the optimal treatment for that patient.

Analysts wear two hats: one is that of a psychoanalyst, and the second is that of a psychiatrist, psychologist, or other mental health clinician. In wearing the second cap, one will inevitably diagnose patients, particularly those with serious psychiatric conditions. In wearing the cap of psychoanalyst, however, the analyst will find that the collaborative pair profits if the analyst considers that his or her urge to diagnose the patient as "borderline," "narcissistic," "infantile," or "sociopathic," for example, may reflect a countertransference reaction. Such patients might be better served if they were diagnosed as "too disturbed and disturbing for me."

Finally, my experience of teaching a course on "Developing an Analytic Practice" to second-year candidates at the psychoanalytic institute affiliated with the New York University School of Medicine has impressed me with the employment of the evaluative model in the service of other countertransference manifestations. As a generalization, candidates seem afraid of psychoanalysis. They seem to mystify it, and to consider it something that is potentially dangerous. Not only may they resort to diagnosing in order to diminish countertransference anxiety, but they may also employ clinical descriptions of hypothesized ego deficits, such as in anxiety or depression tolerance or capacity for guilt, in order to reduce the unpleasure experienced with disturbing and/or enactment-prone patients. It is important to remind them that ego functions and the psychiatric diagnoses they relate to are no more than manifest contents. These candidates are seeking safe cases, rather than cases with whom they can work to optimally develop as psychoanalysts.

We know that successful analytic practices are not developed by pursuing safe, cooperative, compliant collaborators. Glover is reputed to have stated, "If you want to sleep well, choose your patients carefully." I comment, "If you want to have a successful analytic practice, welcome

disturbing patients. Privilege self-analytic inquiry into your experience of them as disturbing."

In conclusion, I emphasize that I am writing about practice in an effort to communicate my experience to colleagues who are not satisfied with their analytic practices, and to candidates who are having difficulty developing a sufficient number of analysands to succeed in progressing through their analytic training. I suggest that they try on the trusting model for size, and in so doing, modify and adapt it to fit their personalities.

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*275 Central Park West*
*New York, NY 10025*

*e-mail: Aroth275@aol.com*

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# PSYCHOANALYSIS AND THE TREATMENT OF PSYCHOSIS: A BOOK REVIEW ESSAY

BY MARTIN A. SILVERMAN

TREATING THE "UNTREATABLE": HEALING IN THE REALMS OF MADNESS. By Ira Steinman. London: Karnac, 2009. 207 pp.

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THE PSYCHOTIC WAVELENGTH: A PSYCHOANALYTIC PERSPECTIVE FOR PSYCHIATRY. By Richard Lucas. London/New York: Routledge, 2009. 335 pp.

**Keywords:** Psychosis, hospitalization, schizophrenia, psychotherapy, medication, psychoanalytic training, Klein, Bion, borderline pathology, hallucinations, paranoia.

When I was a first-year resident in psychiatry at University of Rochester Medical Center, I spent a four-month rotation at the Rochester State Hospital to learn about chronic, severe mental illness. One of my responsibilities was to interview 250 of the long-term patients housed there and write a "six-month progress note" on each of them. (I use the term *housed* because, although everyone seemed kind and caring, resources were scarce and the patients received little or no definitive treatment.)

One of the patients I interviewed was a regressed, disheveled, schizophrenic man in his late thirties who wore a wild stare and displayed palpable physical tension. I was informed that he had not spoken an intelligible sentence in a very long time. I introduced myself, asked how he

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Martin A. Silverman is a Training and Supervising Analyst and Supervising Child Analyst at the psychoanalytic institute affiliated with New York University College of Medicine, and a Training and Supervising Analyst at the Center for Psychoanalysis and Psychotherapy of New Jersey.

was doing, and asked if I might be able to help him in some way. He spewed out an emotional torrent of disorganized, disconnected verbiage that was utterly incomprehensible. I tried hard to discern some kind of thread in the profusion of words he was spraying in my direction, but was unable to make out anything at all. After a while, I said: "I'm sorry, Mr. Adams. I've tried to understand what you're telling me, but I just don't know what you're saying."

What happened next startled the psychiatric nurse who was accompanying me—to such an extent that she stumbled backward and knocked over a cart laden with instruments and medication containers, which fell to the floor with a loud clatter. Mr. Adams had spoken his first intelligible sentence in seven years! "You're the first honest psychiatrist I've ever met," he said to me. "What do you mean?" I asked. "The others *say* they understand me," he replied, in an increasingly agitated tone of voice, "but they—" and here he erupted into a flurry of word salad. He flew into a sputtering rage and had to be led off by a big, burly aide who had been standing nearby.

Before he departed, I said, in all innocence and naiveté, calmly but firmly: "Look how angry you are! Maybe that's part of your problem. Maybe you get *so* angry that it scares you—and then you speak in a way that makes sure that no one can understand you and everyone stays away from you." He only growled and muttered as the aide led him away.

About ten days later, as I was standing in the hall talking to some nursing students whom I was expected to teach, I felt a tap on my shoulder. It was Mr. Adams. "Hi, doc," he said, "how are you?" We chatted for a while, during which he told me that he had thought about what I had said to him about his fear of his anger, and had concluded that I was right. He asked if we could talk about it.

From that point on, Mr. Adams and I spoke for a while almost every day. He told me about experiences he had had with people in the past that still bothered him, and we came to understand the self-protective function served by some of his psychotic symptoms. Although he was by no means "cured," the hypercritical voices that had been tormenting him for years eased up in their relentless attacks upon him, and his condition significantly improved.

A few days before my rotation was to come to an end, Mr. Adams walked by me and snarled, "I heard you're leaving; I don't care!" "Yes you do," I said, "You do care." His physiognomy softened, and he said, "You're right. I do. Thanks for your help. I'll miss you." I did go back and visit him a number of times.

There have been other psychotic patients—during my stint at the state hospital, when I was at Strong Memorial Hospital, and throughout my clinical experience since then—with whom I have been able to work psychodynamically. The vast majority of them have been able to make good use of this work and have made significant gains in their struggles with illness. I am fortunate to have had a first-rate psychiatric residency at a time when psychoanalytic understanding was valued in most psychiatric training programs. It has been sad for me, as it has been for many of my colleagues, to observe the shift that has taken place in psychiatric training away from a psychodynamic orientation and toward a predominantly pharmacological and behavioral one.

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It was delightful, therefore, to come upon Ira Steinman's wise, wonderful, lively, and engaging book, *Treating the "Untreatable": Healing in the Realms of Madness*. Steinman has dedicated himself to working psychodynamically with severely ill, schizophrenic, bipolar, and multiple-personality patients. His description of his work is clear, hard-headed, convincing, and inspirational. *Treating the "Untreatable"* is filled with rich clinical detail that is both fascinating and a distinct pleasure to read.

Steinman begins by observing that humane institutions that employ judiciously administered medications together with group and individual psychotherapy are not only few in number at present, but are rapidly disappearing. Even in the best of them, furthermore, the treating personnel do not generally delve deeply into the meaning of psychotic delusions and hallucinations. For many years, he has worked intensively on an outpatient basis with psychotic patients, a large number of whom previously spent years in one or more of those institutions without achieving a major change in their condition. His approach has revolved around the expectation that helping these patients understand the origin and func-

tions of their psychotic symptoms is the most effective way of helping them become able to relinquish them.

> Not only is the symbolic meaning to the patient of the content of delusions and hallucinations explored, but a rigorous attempt is made to try to figure out how, why, and when psychotic thinking began, and under what emotional and life circumstances. [p. 20]

The "defensive retreat from psychological conflict, painful reality, and powerful affects" is made clear to the patients, so that they can come "to accept and work through the chaotic feelings of neediness, fear, fury, guilt, and despair which often preceded the development of delusions and hallucinations" (p. 29).

Steinman emphasizes the value not only of helping the patient understand his or her need for these psychotic mechanisms—especially "to diminish loneliness and assuage terror" (p. 29)—but also of reaching back with the patient to when and where these mechanisms began to be employed. He makes the cogent observation, furthermore, that even when there are neurophysiological deficits and disturbances that predispose one to the development of psychosis, the symptoms that develop always have genetic, historical significance and centrally important dynamic meaning.

> Crucially important is the knowledge—to be gleaned through repeated interactions—that even psychotic patients transfer the past to the present and repeat past developmental stages and interactions in their relationships, delusions, and schizophrenic productions. If anything, the psychotic patient's transference reactions are more dramatic and extreme . . . [and they] . . . can be dealt with by the usual therapeutic technique of exploring and dynamically understanding these intense phenomena. [pp. 30-31]

What is brought to the surface in the course of exploring the origin and meaning of psychotic manifestations can be terrifying to the patient, and can lead to chaotic outbursts and suicidal impulses. A therapist who carries out this kind of treatment has to stand by the patient very closely during difficult times, although this can prove extremely demanding on

both participants in the treatment process. Steinman appreciates the value of antipsychotic medications, but he tries to wean the patient off them as quickly (or at times as slowly) as possible. He is also prepared to rehospitalize patients at times of crisis, although he attempts to keep the hospital stays as short as possible.

Most of the pages of this book are filled with clinical examples that dramatically illustrate the author's therapeutic approach (one possible cavil is that the book is quite short on general and theoretical explication). Daphne, for example, a 50-year-old woman diagnosed as schizoaffective, was unable for years to hold a job because of erratic, eruptive behavior, which alienated even her children from her. She had been hospitalized thirty-five times and had made a number of serious suicide attempts before Steinman began to work with her. She often sat mutely, staring into space, during their early sessions.

Daphne was very surprised when Steinman asked her to please tell him what she was staring at, as no psychiatrist had ever asked her that before. They explored at length the meaning and origins of her intermittent, delusional communication with an imaginary companion who had been part of her life since early childhood. "Mary" was a "good" friend who had accompanied her when she dissociated away from her depressive, at times abusive mother and from the alcoholic father who repeatedly molested her from the time she turned four years of age. At other times, Mary was a "bad" friend who encouraged her in childhood to try to do away with the baby sister who stole the meager attention she received from her mother, and who periodically pushed her to try to kill herself.

The treatment was prolonged and stormy. Suicidal inclinations emerged, which necessitated four brief hospitalizations. Despite this, Daphne made such good use of her intensive, dynamic psychotherapy that she "returned to work, had ten good years with her husband before his death, and was reconciled with her children" (p. 59). She remained "essentially delusion-free" (p. 60) during the twenty-five years that led up to the publication of this book. Her previous psychiatrist-psychoanalyst was "chagrined" that he had not pursued the kind of vigorous treatment Steinman described; he regretted having maintained the erroneous be-

lief that "one had to treat severely disturbed patients with kid gloves, not with intensive psychodynamic psychotherapy" (p. 60).

Some of the vignettes in the book are tantalizingly brief, leaving the reader yearning to know more about the patients described. Also, Steinman's interventions tend to sound perfectly timed, crisp, and dramatically on target. I should have liked to read about his struggles to grasp what was going on, about the interventions that did *not* hit the target, and about the slow, difficult, groping efforts to make emotional contact with the extremely mistrustful and wary patient population on whom he reports—which I know from experience had to play a huge part in his work with them.

I should also have liked to hear about the role of empathy, understanding, compassion, and human caring in contributing to good results. The patients the author describes were hungry for safe human contact. What he does tell of his clinical work very much points to the important role played by his coming across to his patients as decent, caring, and above all respectful—not only of them as human beings, but also as capable individuals whom he believed in. Many of these patients had had prior experiences with mental health professionals who seemed to view them as helpless, defective, and hopeless.

I found myself somewhat startled by Steinman's accounts of several severely regressed, very poorly functioning, long-time schizophrenics who apparently gave up their psychotic symptoms in just six to eight months of treatment, and who maintained their gains for years thereafter. I cannot help but wonder whether some of them may have hidden their psychotic symptoms rather than truly given them up. On the other hand, I have treated some extremely paranoid individuals who were able to get over their paranoid delusions after twelve to eighteen months of treatment and remained free of them for years afterward. None of these patients appeared to be schizophrenic, however.

This brings me to another important dimension of working with very seriously disturbed patients. Steinman correctly observes that the therapist's goals may not necessarily coincide with those of the patient. A reduction of symptoms may be as wonderful a result for some people as total removal of them is for others.

> Occasionally, a markedly delusional patient comes along who is both so intelligent and so intractably paranoid that the best that can be hoped for in the course of a short-term psychotherapy is a type of therapeutic impasse, where the patient saves face and insists on the correctness of paranoid beliefs, while clinical improvement occurs. Such a stalemate is unsatisfactory for the therapist, but may be of crucial help to the patient in terms of work, relationships, and involvement in life. [p. 74]

I am reminded of another experience I had at Rochester State Hospital. The superintendent of the hospital was a warm, humane, wonderful man who truly cared about the patients. When I arrived, he gave me a list of seven patients in whom he hoped I would take particular interest. He felt that they had potential for much more clinical improvement than they had been showing, and he hoped that something might click with one or more of them that might enable me to be of real help to them. Unfortunately, none of them showed any indication of an interest in working with me while I was there. To my great surprise, however, one of them approached the superintendent after I had left, saying that he thought I might be able to help him. Arrangements were made for Mr. Brown, as I shall call him, to enroll in the outpatient clinic at Strong Memorial Hospital (my next rotation site) and to begin twice-weekly psychotherapy with me. He paid the minimum fee of one dollar per session and walked the two miles between the two hospitals each time he came, even during Rochester's harsh winters, in order to save the bus fare.

The treatment went very well for six or seven months, during which Mr. Brown—a man in his early thirties who had been hospitalized for about ten years with a diagnosis of chronic, undifferentiated schizophrenia—worked with me at trying to understand the origin and meaning of his extreme anxiety, social isolation, and subtly paranoid symptoms. He became less and less withdrawn and isolated, and more and more interested in intellectual pursuits, than had been possible for him for many years. He began to make home visits for the first time in a long while, and started to look up some old friends from the past.

Then everything seemed to come to a halt. Mr. Brown became increasingly hesitant and even silent during his sessions. We tried together

to figure out what had happened, but seemed to get nowhere. Finally, something dawned on me. The next time we met, I told him I had an idea: "When you asked to come into treatment with me, [the superintendent] was excited and hopeful, and I was flattered. You thought I might be able to help you. I also got excited—I was going to cure you of your schizophrenia. But I never asked you what *you* wanted. I think that might be the problem."

"I'm glad you mentioned that," said Mr. Brown. "That *is* the problem. You want me to get out of the state hospital. But I'm never going to leave the hospital; I'm going to spend the rest of my life there. What I want is for you to help me become less anxious. I'm anxious all the time—all I do is pace all day. I started making a rug in O.T. six months ago, but I've only been able to finish two inches of it. Please help me so I can feel better and be able to do more . . . but I'm never going to leave the hospital."

A subsequent visit to me by the patient's parents made it clear that they did not want him to be discharged either, and they had no intention of letting anyone make them change their minds about this.

Mr. Brown and I adjusted our sights, and progress resumed in the treatment. I scaled back my therapeutic zeal, and he, to his credit, allowed me to encourage him to raise his own goals to a meaningful extent. By the time his treatment ended, about a year later, he had finished his rug and two others, was taking a greatly reduced amount of medication, was elected president of the patient council, and had become the regular left fielder of the hospital softball team (which competed in a league whose teams were not all hospital based). He also convinced his parents to agree to regular, biweekly weekend visits back home with them, and got them to assist him in looking for some kind of part-time work.

A large number of the patients Steinman describes in *Treating the "Untreatable"* eventually revealed to him that they had been sexually, physically, and/or emotionally abused as children. When he helped them recognize that there was an understandable genetic and dynamic link between these experiences and the content of their delusions and hallucinations, they could see that these disconcerting symptoms actually made sense, rather than being bizarre, foreign, or incomprehensible.

Steinman's willingness to side with them in feeling anger at their abusers enabled them, furthermore, to regain ownership of the human emotions from which they had been desperately fleeing for many years. He was then often able to help his patients recognize that the psychotic mechanisms they had been using did not truly contain or reduce the terrors that bedeviled them, and that much more effective ways with which to deal with them were available. He also helped them understand that the delusions and hallucinations themselves contributed significantly to the loneliness and isolation from which they suffered, even though the delusions and hallucinations gave the illusion of connecting these lonely patients with other people.

I found myself, as I read the clinical vignettes recorded in this book, wondering to what extent the success of the treatments derived from gains that the patients—some of whom had been ill for a very long time—had obtained from various earlier treatment experiences that had enabled them to summon the courage and the will to end their withdrawn isolation and definitively tackle their problems. I also wondered to what extent it was Steinman's enthusiasm, courage, and determination that inspired them to succeed. My inevitable conclusion, of course, is that no one factor suffices on its own, and that a combination of things must have helped his patients. At times, furthermore, enlisting the assistance of an equally courageous, caring, and determined family member also played an important part in facilitating progress in treatment.

Once again, I find myself thinking back to Rochester State Hospital, to a young male patient in his early twenties who was mute and catatonic. Charles could not speak to me, but—being an artist by vocation—he demonstrated his desire for help first by showing me paintings he had already done, and then by producing more paintings to show me. I hazarded guesses from the content of the paintings about the emotions swirling within him, behind the impassive mask he wore. Gradually, Charles began to speak and we could have more conventional therapy sessions.

One day, he was moodily silent and then angrily blurted: "You're the only person who sees my real self! Everyone else only sees what I show them. You're stealing my soul!" From that point on, he objected to having sessions with me, but I refused to give up on his treatment. I even

traveled back to the state hospital to see him for sessions after I rotated to another hospital.

In an attempt to get away from me, Charles misbehaved in order to get himself transferred to units for more and more seriously disturbed patients. He finally ended up in what was known in the hospital as "The Snake Pit," where patients paced naked, masturbating, frothing, and growling in rage, guarded by the biggest, burliest aides in the institution. An aide would lock up the two of us in an interviewing room when I came for his therapy session, in order to keep me safe from the other wild and dangerous patients.

At this point, Charles gave up his flight from treatment and resumed working collaboratively with me. He rapidly improved and became well enough to leave the hospital within another six months. He expressed deep gratitude for my belief in him and for my persistent refusal to give up on his treatment. Seeing these attributes in me, he said, had enabled him to appreciate his own self and to fight against his illness. Interestingly, I met Charles again by chance a year after the treatment ended, at an art show, where he was exhibiting some of his work. Two of the paintings I saw there, each with a "sold" tag on it, were ones he had done as part of our work together.

I include references to my experiences as a psychiatry resident in this essay because of my deep appreciation that those who trained me, at a general hospital and at a state hospital, viewed psychotic patients as human beings who were often just as capable as nonpsychotic ones of participating in intensive, dynamically oriented psychotherapy that could lead to a successful outcome. Training based on this viewpoint enabled me to go on to successfully treat a good number of such patients over the course of my career as a psychiatrist and psychoanalyst.

At times, Steinman was able to apprise his patients that the very paranoia that expressed their anxious distancing from their families and from people in general simultaneously kept them connected to others. George, for example, had been ill for a quarter of a century, and had spent ten years in a leading psychiatric hospital, where the consensus opinion was that he would have to reside there for the rest of his life. Steinman enabled him to recognize that his paranoid conviction that his father had enlisted the aid of the Mafia to observe and control his

every move served surreptitiously to provide him with the illusion that his father had not abandoned him, but was actually maintaining constant, vigilant contact with him.

> Even though George was convinced he perceived the world as it was, I [indicated to him that] . . . our task was to help him understand how he got to see things as he did. I told him that I didn't expect him automatically to give up his beliefs, since they must mean something to him. Wasn't it curious, I went on, that he was so lonely and cut off from his family and friends, yet believed that "the Family" and his father followed his every move? Could the extent of his paranoid beliefs be a reflection of his loneliness? Could the paranoia be his way of trying to maintain contact with his family or other people? [p. 123]

George was dubious at first, but then agreed to explore the possibility that Steinman was correct. Not surprisingly, they discovered that behind George's fear of his father was rage toward him—a rage that terrified George. When the two of them explored George's powerful delusions—first, that a television personality was in continuous personal contact with him; then that a famous movie star was in love with him; and then that a female psychiatrist who had once treated him was not only in love with him, but was even prepared to leave her husband to marry him—George finally realized how empty these beliefs were. This led to his giving up his delusional solution to preoedipal and oedipal conflicts in favor of healthier, more reality-bound solutions—although his first reaction to the debunking of the delusional connection he felt with the television personality was to fill the emptiness within himself with alcohol and drugs, necessitating a hospitalization for detoxification. (This episode graphically illustrates Steinman's willingness to take risks, as well as the consequences that can follow when a treatment misfires.)

In the course of their trip toward a healthier level of functioning for George, Steinman accompanied him on an exploratory peregrination through the world of "Georgeland," in which George was the favored child of a fatherly "Unconscious God" who even at times loved him, unlike his ever-critical and unappreciative actual father. He came to recognize that the Christ-like suffering to which he had subjected himself was not really appreciated by his father.

> George was doing whatever he could to hold on to the experience of love he felt when held by "God the Father." If not his father's most loved child, he was his god's favorite . . . . Slowly, he began to see that the "Unconscious God" devoted to George was a compensation for his perceived position of being less favored in his family . . . . More and more clearly, George began to see that he had been following his own promptings and wishes for a close relationship in his own family, and that he had not been following the dictates of an "Unconscious God." [pp. 134-135]

George became able to progressively abandon the delusional alternative world to which he had retreated in order to escape the pain he experienced in the external world of reality. George continued in outpatient therapy with Steinman during the fifteen years that led up to the writing of this book. During that time, he established a good relationship with his father and stepmother and lived almost exclusively in the real world, retreating only briefly to his delusional one at times when he was under great stress. He was not "cured," but he was greatly improved. How many of our neurotic patients do better than that?

It is important to note that the author does not arrogate to dynamic psychotherapy the sole, or even always the central, role in the treatment of psychosis. He recognizes that antipsychotic medication is necessary most of the time, and that social support, work with patients' families, and hospitalization are necessary for many psychotic patients. What he laments is the tendency to underestimate the capacity of a large number of psychotic patients to make use of intensive, exploratory psychotherapy to understand and gain control over the terrible illnesses from which they have been suffering.

> It is one thing to diagnose and medicate and treat with supportive psychotherapy and social technique. But if this is not enough, and it certainly was not enough in George's case, one must unwind the threads that entwine the patient's delusions. The skein, the warp and weft of encircling and debilitating intrapsychic yarn must be unraveled . . . . Why was this method, in conjunction with the judicious use of antipsychotics, not employed in [his] many years in treatment settings? I believe that it has to do with our field having become convinced that anti-

> psychotic medication is all we can do for severely psychotic patients: at best, we can medicate, reality test, and help with social adjustments. Furthermore, young psychiatrists have no experience treating such patients with psychodynamic techniques, and older colleagues (who for the most part have not tried it) doubt that it can be done. [p. 143]

Steinman can be critiqued for only scantily addressing the literature on psychodynamic treatment of psychotic patients and for the lack of a rich theoretical section in his book. Nevertheless, his effort to demonstrate the effectiveness of psychodynamic psychotherapy for psychotic patients by providing multiple, convincing clinical examples is quite successful, and we can be very grateful to him for it.

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Fortunately, *The Psychotic Wavelength: A Psychoanalytic Perspective for Psychiatry,* also appeared in 2009. Written by the British psychiatrist and psychoanalyst Richard Lucas, who has himself devoted a lifetime to working with psychotic patients, this book contains the extensive literature review and theoretical perspective that is lacking in Steinman's book, so that the two volumes complement each other admirably. Lucas, too, is determined to facilitate understanding of the effectiveness of treating severely disturbed people with psychodynamic psychotherapy.

In *The Psychotic Wavelength*, the author stresses the wide variation among psychotic patients in the ability to successfully participate in intensive psychotherapy—a variation that is, of course, just as wide among neurotic patients. Lucas's experience confirms for him the correctness of Bion's (1967) observation that there is a more or less powerful, nonpsychotic dimension within psychotic individuals to which a therapist can speak, and which can be engaged in the struggle to overcome the dominance of the psychotic dimension within the individual's psychological organization. He strongly disagrees with those who believe that psychotics are unable to think logically and are incapable of working with dynamic principles to wrestle with their emotional problems, and he presents multiple clinical vignettes to demonstrate the cogency of his contention.

Lucas, like Steinman, contends, furthermore, that much more can be accomplished in the treatment of psychotic patients than what he perceives as the very limited or even spurious results obtainable from cognitive-behavioral therapy. He seriously questions the assertion that people can be induced to give up entrenched, intensely self-protective delusions in ten formulaically programmed sessions. When that seems to occur, he maintains, the delusions have merely gone underground. He quotes Britton (2009), who, in a volume coedited by Lucas, "distinguishes between beliefs that have merely been surmounted and those that have been worked through and relinquished" (p. 41).

Lucas also points out that CBT outcomes can often be understood via the observation that "many psychoses resolve through a flight into health, by identification with an idealized parental figure" (pp. 42-43). This mechanism dovetails with something else about psychosis to which the author gives emphasis in this book, namely, that "the commonest symptoms of schizophrenia are not auditory hallucinations or paranoid delusions, encountered in some 60% of cases, but denial and rationalization, found in over 95% of cases" (p. 30). Intensive therapy is required to obtain meaningful, lasting results.

Lucas provides a condensed summary of the theoretical underpinning of intensive psychotherapy of psychotic patients as it tends to be viewed in Great Britain. He describes Klein's (1975a, 1975b) concept of lifelong oscillation between paranoid-schizoid projection of "phantasized" envious, destructive, spoliating attacks upon the maternal sources of all good things, so that they are perceived as persecutory (organizing the structure of paranoid delusions), on the one hand, and depressive, guilty, self-accusatory attacks upon the self in punishment for those destructive inclinations (generating the suicidal inclinations of schizophrenics), on the other hand.

Klein as well as Segal, Lucas indicates, stressed the importance of manic defenses that produce grandiose "feelings of triumph, control, and contempt . . . to protect the individual from experiencing severe underlying anxiety of psychic pain, whether predominantly persecutory or depressive in nature" (p. 67). The concept of manic reparation can help explain instances of sudden, apparent recovery from a schizophrenic or major depressive decompensation. Segal (e.g., 1981) also distinguished

between true, metaphorical symbolism and concrete "symbolic equation" of internal reality with actual external reality.

Rosenfeld (1965) observed that psychotic patients experience transference reactions, although they tend to be concrete in nature, and that these transference expressions can respond to analytic interpretation. He emphasized, however, that the paranoid-schizoid splitting and projection that occurs in psychotics is greatly confused, so that the patient has much difficulty distinguishing between self and other and between good and bad. Steiner (1993) emphasized the significance in psychosis of a desperate retreat from intense, overwhelming anxiety and pain to an idealized, delusional world that protects against the threat of disintegration and annihilation (Lucas, p. 79). Enormous therapeutic effort is required, therefore, to convince the patient of the necessity of leaving that world.

Lucas puts great stock in the importance of Bion's (1967) emphasis upon distinguishing between the psychotic and the nonpsychotic self and upon strengthening the latter so that it can deal more effectively with the psychotic self. Lucas cites Bion's view that:

> The psychotic part cannot think (lacks the capacity for symbolic thought); it can only fragment and expel. If the expelled parts come back, individuals experience this as an assault by actual objects. The more they aggressively fragment the particles coming back at them, the more they experience them as increasingly hostile. [Lucas, p. 91]

It is necessary to promote emotional strengthening and integration, and to advance to higher-level, symbolic thought, in order to empower the psychotic patient to apprehend and deal with destructive forces emanating from the psychotic part of his or her psychological structure. Bion (1967) believed that everyone begins in early life with a psychotic part that aggressively attacks and attempts to destroy all disturbing elements, both internal and external, with initial inability to distinguish between what is internal and what is external. A nonpsychotic, reality-oriented part develops, beginning very early, that grows larger and larger over time, with increasing divergence between the two, until the gulf between the two parts becomes so great that it is unbridgeable. (Unbridgeable

except, perhaps—it seems to me—in certain controlled ways in exceptionally talented, creative, artistic individuals.)

In those who will eventually become psychotic, the nonpsychotic part does not develop sufficiently enough to dominate, control, and adumbrate the psychotic part—but there is always, to a greater or lesser extent, *some* nonpsychotic structure, and it is this which the therapist must address (Lucas, pp. 91-93). Bion also made reference to the nonpsychotic part of a patient being concerned with neurotic conflict while "the psychotic personality was concerned with the problem of repair of the ego" (Lucas, p. 161).

Lucas briefly summarizes Bion's theoretical explanation of hallucinations, derived from his clinical experience, by picturing an infant who expects the arrival of a nurturing breast but encounters a "no-breast" or absent breast. The author posits an infant who is unable to tolerate this experience and therefore evacuates the painful image of "bad breast" in the form of a hallucination of it—in contrast to the emotionally stronger baby who develops increasing tolerance for frustration, associated with the development of thought; i.e., this baby comforts him- or herself by thinking of a (good) breast. The mother plays a crucial role. A mother who accepts split-off, bad contents and detoxifies them via her reverie, according to Bion, facilitates the child's increasingly capability of reaccepting and reinternalizing the detoxified elements. Without this process of maternal containment of hostile projections, the infant experiences *nameless dread*. The implications for therapeutic technique are clear.

Lucas also applauds the clinically derived conclusions about schizophrenia made by Freeman, Cameron, and McGhie (1959). At the core of this illness, according to these three co-authors, is dissolution of the personality, with regression to early, primitive modes of psychological functioning, dominated by primary rather than secondary processes, to deal with stress and overload. Lucas agrees with Freeman, Cameron, and McGhie that biological factors play a major role in schizophrenia, necessitating the administration of antipsychotic medication. Although psychotherapy is necessary to mitigate and control psychotic mechanisms, it is unrealistic to subscribe to the concept of a neurotic–psychotic continuum that might support the idea that a "cure" can be obtained from psychotherapy.

Lucas draws in particular upon the work of Henri Rey at the Maudsley Hospital to distinguish, albeit in a somewhat oversimplified manner, between borderline and schizophrenic patients, with respect to what they look for from therapy. The former, he indicates, search for a helpful container for their extremely needy and destructive inclinations, and if they find it in a therapist, they worry about losing it again. The latter, in contrast, fearfully reject the container in the external world in favor of retreating into an internal delusional world of their own making. (The catatonic young artist I worked with at Rochester State Hospital dramatically epitomized this.)

Rey believed that

> The only safe position for [borderline] patients is the border between the depressive and paranoid-schizoid positions. If the demand for perfection experienced in the depressive position becomes too much, the pain is split off and projected, and the patient reverts to a paranoid-schizoid mode . . . [and] . . . the border is the only safe position where both depressive pain and persecution from the paranoid-schizoid position can be avoided. [Lucas, p. 132]

Lucas embraces Steiner's emphasis on the need to employ analyst-centered interpretations ("You experience me as . . ." or "You are afraid that I . . ."), rather than patient-centered ones, with borderline patients. This view stems from Steiner's observation that these patients "are more concerned with what is going on in the analyst's mind rather than in their own" (Lucas, p. 133). It might be said, it seems to me, that this applies as well to other classes of patients who are narcissistically extremely sensitive and vulnerable.

Lucas distinguishes clinically between what he terms *borderline states* and *a major psychotic disorder,* with respect to the kind of transferences that can develop and to the patient's ability to participate in a psychodynamic treatment process. With patients in borderline states, there are intense transferences, the ability to work psychotherapeutically (albeit with hypersensitivity and a tendency to experience narcissistic injury from the analyst's interventions), a sizable nonpsychotic self, and only brief, intermittent psychotic episodes. By contrast, in patients with what Lucas calls

*major psychotic disorder,* there is no transference, because splitting and projection are so intense that all that is bad is ejected, and the capacity to feel the ambivalence necessary for entering into relationships is lacking; the nonpsychotic self is miniscule; and there is constant psychosis (although it can be disguised and hidden), due to the patient being on a constant *psychotic wavelength* covered over by denial and rationalization, rather than having frank delusions and hallucinations. With the latter group of patients, the therapist must depend heavily on working with family members, on environmental manipulation, and on assistance with socialization, as well as on the major use of powerful medication.

There is probably something of a continuum between these two groups of more or less accessible psychotic patients, however. Steinman, for example, describes very difficult but ultimately quite successful work with a number of patients who would appear to fit easily into Lucas's more seriously disturbed group. Some of the patients who did well in psychodynamic outpatient therapy with him had been delusional and hallucinatory for many years, and/or had had lengthy hospitalizations before he began to work with them. Giving up too quickly, or too hastily labeling patients "untreatable," can be a very unfortunate error.

Lucas, too, describes a case in which he often felt like giving up during a lengthy treatment that eventually turned out to have a happy ending. He provides a relatively detailed account of his heroic attempt to analyze a severely manic-depressive woman who had to be repeatedly hospitalized for florid manic episodes—in which she was flagrantly psychotic—that alternated with deep depressions. He persisted doggedly, although he was frequently on the verge of despair, until she finally made a significant and lasting clinical improvement (after the death of her mother, whom she hated).

Unfortunately, Lucas provides relatively little detail about his own interventions during his work with this patient; he prefers to speak mainly about his conception, in Kleinian terms, of what seemed to him to be taking place within the patient, which included an ambivalent, hostile "identification with an all-powerful mother figure" (p. 192), "clinging to pathological object relations" (p. 198), and "manic defense and manic reparation . . . in order to defend against underlying persecutory and

depressive feelings . . . characterized by triumph, control, and contempt" (p. 199).

In connection with his work with this patient, Lucas cites Rey's belief that:

> In depression, the maternal breast, as part-object, represented the destroyed mother, and through identification, the subject felt depressed. In contrast, in manic states, the identification was with the penis as the object of reparation, with a magical ability to re-create the mother's attacked babies and breasts, that is, through phantasy of making her pregnant and refilling her empty breasts with milk (Rey 1994). [Lucas, p. 194]

Lucas emphasizes further that:

> The depressive phase is dominated by dependence on a tyrannical object, which demands total obedience and suppression of individuality . . . . Hidden resentment builds up gradually and silently . . . . These feelings of resentment gradually tighten the spring until eventually it unwinds explosively in the manic phase. [pp. 201-202]

The division of patients into groups labeled *borderline states* and *major psychotic disorder* somewhat troubles me, however. It can be heuristically useful to distinguish between the characteristics of those who are more accessible to psychotherapeutic intervention versus those who are less so, but there is a danger here. It seems to me that therapists can too easily fall prey to a tautological tendency to apply the rubric *borderline* to patients with whom their therapeutic efforts prove to be relatively successful, and apply a term like *major psychotic disorder* to those who do not respond well to treatment. This is similar to the tendency among some analysts to label patients who do not do well in analysis as *borderline* rather than *neurotic,* in order to explain inadequate results. In actuality, there is a wide range of variation among neurotic as well as psychotic patients in the ability to participate in an intensive treatment endeavor, and an individual analyst or therapist is not likely to be able to do well with every patient who lands on his or her doorstep.

It is also clear that Bion's heuristic division between the psychotic self and the nonpsychotic self is not be taken literally. *Everyone* is developmentally uneven, full of contradictions, different from day to day and from circumstance to circumstance, and unique in the details of the balance between rational and irrational. I am reminded in this regard of Bishop Berkeley's rejoinder, in response to John Locke's assertion that "beasts abstract not," that—as Carl Sagan quotes him in *The Dragons of Eden* (1977)—"if the fact that beasts abstract not be made the distinguishing property of that sort of animal, I fear a great many of those that pass for men must be reckoned into their number" (p. 113).

Greenspan (1997) wrote an interesting book on the topic of building ego structure in developmentally stunted, emotionally and intellectually primitive, but nonpsychotic individuals in order to enable them to participate in psychotherapy—just as Fonagy and his co-workers (2002) emphasized the necessity of assisting borderline and developmentally stunted but nonpsychotic patients in developing a capacity for mentalization before they can be expected to make use of traditional modes of psychodynamic psychotherapy.

Lucas's tendency to focus almost entirely on his conceptualization of what is going on within his patient psychologically, without providing as much detail of his own participation in the therapeutic work as I would have liked to have seen or of the interchange between them, can convey the impression that he is applying theoretical concepts to what is emanating from the patient rather than extrapolating understanding from it, although I am aware that this might be an artifact of shorthand expression. Examples include such statements as:

> When she was severely depressed, Mrs. L would also report a sensation that she had swallowed two tablets of stone that lay heavily on her stomach, i.e., the unresponsive stone breasts of her mother. The image also evoked [an image of] the Ten Commandments, not to be disobeyed. [p. 213]

Another such example involves a man in a withdrawn, psychotic state who suddenly threw bleach into the face of a woman who was waiting to pick up her child from school.

> He said at the time that his aim had been to scar her. His action could be understood in terms of the wish of the psychotic part of his personality to avoid any reflection on his current mental state. Mr. R envied the child, who seemingly had no problems, as he was totally looked after by his mother. The psychotic part of his personality wished to ensure that any current self-criticisms were projected and disowned into the mother, so that he could remain in an omnipotent state of mind. [p. 257]

Lucas provides a longish account of supervision of a therapist working with an extremely depressed, frequently suicidal woman, in which the central point seems to be that the therapist needed help recognizing that her patient required something specific: that is, assistance in realizing that her (the patient's) guilt about seeking care and attention by being ill was only the surface manifestation of her problem. The patient's self-deprecation actually stemmed from the attacks of a brutal superego that had developed out of an internalization of intensely hypercritical parental figures who could never be pleased, and who had convinced her that she was incorrigibly bad and sinful.

In psychotic depression, Lucas emphasizes, the patient is

> . . . totally identified with an idealized ego-destructive superego, which remains tyrannically in control . . . . There is a pull to remain in identification with the absolute in order to avoid all the confusing mixed feelings towards the ideal that result from starting to experience separateness. [p. 278]

Lucas, following Rosenfeld (1987), stresses the need to speak both to the (sadistic) psychotic and the (timidly tortured) nonpsychotic parts of the patient's personality, in the interest of "furthering the move in the sessions from a monologue to a dialogue . . . thereby moving them away from a total domination by a relationship with an ego-destructive superego" (Lucas, p. 277). This is quite consistent with Steinman's approach to such patients.

In the last section of the book, Lucas addresses a number of practical issues concerning the treatment of psychotic patients, including those that arise during hospitalization. These include risk assessment, the management of violent outbursts and (especially) of suicidal incli-

nations, working with family members, and the need for education of mental health professionals and auxiliary personnel about psychosis and about the challenges presented by psychotic patients.

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These two books by Ira Steinman and Richard Lucas dovetail and complement one another in very useful ways. They convey the joint message that psychotic people are not necessarily untreatable, so long as psychotherapists understand what is taking place within them, are able to tune in to what Lucas terms the *psychotic wavelength* within them, and are able to speak to and establish a constructive alliance with the nonpsychotic dimension of the personality. If these therapeutic aims can be successfully carried out, it is possible to engage many patients with a psychotic condition in such a way that they can collaborate effectively in psychodynamic psychotherapy, which in turn can lead to extremely welcome clinical results.

These two books inspire and inform. They deserve a place in all mental health training programs.

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*551 Ridgewood Road*
*Maplewood, NJ 07040*

*e-mail: msilverman551@earthlink.net*

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# BOOK REVIEWS

## BOOK REVIEW EDITOR'S NOTE

The termination of psychoanalytic treatment has long been an important focus of attention. The topic of termination is integrally connected with core issues involving the goals, achievements, and limitations of analytic therapy. We believe that the following group of three reviews of recent books on this topic will be of interest to *Psychoanalytic Quarterly* readers.

ENDINGS AND BEGINNINGS: ON TERMINATING PSYCHOTHERAPY AND PSYCHOANALYSIS. By Herbert J. Schlesinger. Hillsdale, NJ: Analytic Press, 2005. 238 pp.

The complexity of Herbert J. Schlesinger's compact book on the termination of psychotherapy and psychoanalysis mirrors the complexity of his subject, the ending phase of treatment. While I am not the fastest reader (let alone reviewer), I puzzled over the length of time it took me to read this book. The answer, I believe, lies in the text: virtually every sentence is meaningful; there is no filler. Not only are the ideas carefully delineated, but Schlesinger also takes the reader on excursions into adjacent territories that form the important tributaries leading to the end of a treatment experience. These excursions are not side trips meant as diversions or a respite from the main subject; they inform and enrich the author's ideas on termination.

For example, in setting the context for this book, Schlesinger includes the word *beginnings* in its title. Indeed, his chapter entitled "Beginning from the Vantage Point of Ending" is a masterful summary of how one begins a psychoanalytic process. His cumulative clinical wisdom is evident here as well as elsewhere, and the content is distilled in a

manner that both the experienced clinician and the relative newcomer to analysis and therapy will find helpful.

I use the term *relative newcomer* because this book may not be the best choice for those just starting out in the field. The author's deep knowledge of psychoanalysis and his clinical experience provide us with material that makes considerable demands on us to pay close attention. Each chapter is a stand-alone document that both contains a wealth of theoretical ideas and is supported by multiple clinical examples.

One of the central pillars of Schlesinger's approach and upon which his ideas of technique and termination rest is that a careful psychoanalytic assessment in the beginning of a treatment will foreshadow not only how the termination might eventually unfold, but whether or not an ending phase is likely to be traversed at all. Moreover, he frames the entire treatment process as a helical model (p. 48) with a series of endings and beginnings, until some final end point is reached. These ideas appear to depart from the familiar model taught to generations of psychoanalytic students that there is a beginning phase, a middle phase, and an end phase to analytic treatment. I am unsure whether Schlesinger himself considers his ideas about the treatment process to be postmodern, but I think of the book as part of that genre, inasmuch as the author notes that a therapy may stop at numerous points along the way, and that patient and therapist are best served by not feeling bound to accomplish all the tasks that may have been identified either early on or later in the process.

Some readers may feel that here Schlesinger conflates psychotherapy with psychoanalysis; that is, in a full analysis, one would not be as inclined to stop at various points along the way, but would continue until the main goals of the analysis were accomplished. Schlesinger addresses the premise of a formal ending phase in a full analysis. In my view, however, he also seems to acknowledge that many treatments, both psychotherapies and psychoanalyses, arrive at an ending when only some objectives have been met. I find this view true to the clinical world that most of us work in today.

In considering the means of assessing "task accomplishment" in analysis, Schlesinger addresses formal methodologies, but also does not overlook the more global assessment tool of the analyst's clinical intu-

ition. More than once, he reviews the importance of bearing in mind that a therapist's or analyst's own conflicts or personality dynamics may impede the ending of a treatment. In my view, his observations about the hazards of long-term therapies or analyses that become interminable cannot be emphasized enough. Most of us who have done this work for more than a decade—and most clinicians in the field of psychoanalysis have been practicing for multiple decades—have experienced clinical situations in which we question whether or not the treatment is getting at what we think is necessary to bring about mutative change, or indeed whether it is going anywhere at all.

Schlesinger addresses the problems of impasse or stalemate in depth and with sensitivity to both therapist and patient, recognizing that both have made essential contributions to the "dead-in-the-water" place at which the analytic couple finds itself. Unaddressed dependent sexual transferences have likely brought a number of otherwise successful treatments either to an impasse or to an unhappy ending, the author notes. Another common issue leading to impasse is the patient's deep attachment to the therapist; that is, the work of a treatment may be more or less accomplished, but it continues because the patient cannot bear to leave and sever contact with the therapist.

This latter phenomenon calls attention to one of the greatest challenges of our work: we engage with someone in a process that, most often, requires a deep attachment in order to be most effective, yet we also know that, from the beginning, an ending is part of the contract. In what other relationship do we anticipate an end to things once they have improved? This is one paradoxical aspect, among others, in an analytic relationship.

Schlesinger locates himself solidly in what I would call a contemporary, conflict psychology model, obviously well informed by the rich tradition of ego psychology. He asserts at one point that, with a highly vulnerable patient, one does not need a special psychology of the self in order to understand or treat him or her. Yet there are many in our psychoanalytic tent, including myself, who have found other psychoanalytic points of view not only useful, but also essential, to the treatment of so-called vulnerable patients. While the author consistently acknowledges the importance of the therapeutic relationship—in which attachment

components form a key element—he does not take into account the substantial body of work in which relational and attachment aspects lie at the core of the treatment.[1]

In other words, much of Schlesinger's point of view tends to deemphasize the co-constructed nature of the therapeutic enterprise. The question of the core elements of an analytic treatment will not be settled any time soon, but I would have preferred him to acknowledge that treatments in which relational or attachment components are central, and in which interpretations may occupy a somewhat secondary role, can be advantageous not only for the highly vulnerable patients he discusses. If I read him correctly, he feels that relational elements are crucial to providing a context in which the analytic work proceeds. This view, certainly a well-accepted one, stands in contrast, however, to other analytic points of view in which the relationship aspects are *an integral part* of the analytic process, not merely a facilitating element.

I will conclude by focusing on the importance of Schlesinger's chapter on the life course of the analyst. He calls attention to the situation of analysts who no longer derive pleasure from their work, and who may be unable to face termination with a particular patient. As analysts, we, too, have to deal with the loss of an important "object"—in the person of the patient. The author's observations on the bidirectional nature of treatment endings are well worth reading and assimilating.

Patients who stay with their treatment for a full measure of work leave an indelible mark on us. The work of an ending phase, I think, is nearly as much one of mourning for us as analysts or therapists as it is so for the patient who has successfully traversed a difficult path.

**CHARLES BURCH (ANN ARBOR, MI)**

[1] See, for example, the following: (1) Beebe, B. & Lachmann, F. (2003). The relational turn in psychoanalysis: a dyadic systems view from infant research. *Contemp. Psychoanal.,* 39:379-409; (2) Fonagy, P. & Target, M. (2002). Fonagy and Target's model of mentalization. In *Psychoanalytic Theories: Perspectives from Developmental Psychopathology.* London: Whurr, pp. 270-282; and (3) Stern, D., Sander, L. W., Nahum, J. P., Harrison, A. M., Lyons-Ruth, K., Bruschweiler-Stern, N. & Tronick, E. Z. (1998). Non-interpretive mechanisms in psychoanalytic therapy: the "something more" than interpretation. *Int. J. Psychoanal.,* 79:903-921.

GOOD GOODBYES. By Jack Novick and Kerry Kelly Novick. Lanham, MD: Jason Aronson/Rowman and Littlefield, 2006. 147 pp.

*Good Goodbyes* is an interesting and provocative book about the process of termination of psychoanalytic treatments. Among the authors' major points is that a good termination is essential to the success of a psychoanalytic treatment. They add that the significance of termination has been underestimated in the past, and that excellent analytic work can be undermined—sometimes with tragic results—if issues pertaining to termination are not addressed effectively (pp. 2-3). As a corollary point, they also emphasize that a coherent understanding of the overall psychoanalytic process is essential for a good termination, and that the subject of termination needs to be kept in mind and worked on throughout the treatment, from start to finish.

A great strength of this book is the authors' clearly articulated concept of what they regard as the essence of analytic treatment. They demonstrate in unusual detail, and with an unusually clear explication, how their overall concept is manifested at each stage of the treatment and how issues related to termination are worked on throughout the treatment.

On the other hand, I have some concerns about the book. One such concern is that, at times, Novick and Novick make what seem to be simple, declarative statements that obscure important levels of complexity. A particularly salient example occurs at the outset, when the authors indicate that their statements in this book apply equally to both psychoanalysis and psychotherapy (pp. 1-2)—although I agree with their comments about the usefulness of a psychoanalytic perspective for the practice of psychotherapy. I also find apt the analogy of psychoanalysis to a slow-motion camera that a baseball player in a hitting slump can use to pinpoint the problem and correct it. However, the following statements give me pause:

- We don't use different theoretical ideas *or have different goals for patients whatever the frequency of treatment.* [p. 1, italics added]

- *We know* that these ideas can be applied to patients of all ages, *in all intensities and modalities of treatment.* [p. 2, italics added]

While there is much in common among the spectrum of psychoanalytically informed psychotherapies, one thing that differentiates them is intensity and depth, particularly in the transference relationship. It is inevitable that this difference would make itself felt in regard to termination. That the core concepts might be the same and can *be applied* to all patients, is one thing; however, that does not necessarily mean that they can *be usefully applied in the same way* to all patients, or that the outcomes of all kinds of psychoanalytically informed therapies can be the same. It would behoove Novick and Novick either to give examples of the differences, or to demonstrate how those differences ultimately fade in significance. To simply assert that there are no differences worthy of note is not sufficient.

*Good Goodbyes* is divided into eight chapters, each of which corresponds to a particular phase of psychoanalytic treatment, plus an initial "Overview" and a concluding section, "Final Thoughts." Each phase of the treatment is defined by a specific set of tasks and is correlated with the overall treatment in general and with the issue of termination in particular. Each chapter is divided into a series of sections, each section elaborating on a specific question or set of questions, which pertain not only to explication of that particular phase, but also to how the specific tasks of that phase relate to termination.

Illustrative clinical examples are included in just about every section. This way of organizing the material is extremely user-friendly, as it greatly helps the reader in following the authors' thinking throughout the book. This organization is also helpful for those who want to locate specific issues for further consideration.

In the "Overview" chapter, Novick and Novick explore the history of psychoanalytic ideas about termination and present their rationale for devoting an entire book to the subject. They also use this chapter to state their fundamental assumptions. Most basic to their work is their concept of *two systems of self-regulation.* They define the goal of analysis as the movement away from what they call a *closed system,* in which the patient's

talents, skills, and emotional and intellectual capacities are co-opted in the service of maintaining omnipotent beliefs and sadomasochistic interactions, for the purpose of controlling the other. This movement *away from* a closed system is also *toward* an "open system," which is "tuned to inner and outer reality, has access to the full range of feelings, and is characterized by competence, love, and creativity" (p. 7). Relationships in this open system are "loving, mutual, and reciprocal."

Novick and Novick follow the evolution of these two systems of functioning through the various phases of treatment. They describe the specific changes that the analyst helps the patient achieve in regard to these two systems of functioning at each phase of the analysis. They also describe how the analyst facilitates change in general throughout analysis, and how he or she ultimately makes a good termination possible.

One question in this context has to do with the degree to which the authors' ideas about termination apply only to analyses conducted in accord with the theoretical conceptualization they advocate. On the one hand, I applaud the authors for making the effort to explicate their central concepts and demonstrate how those concepts pertain to the subject of termination. On the other hand, I think it would have been useful for them to address the fact that their concept of the two regulatory systems, and the analytic goal of moving from a closed system to an open system, is one among a number of different ways of conceptualizing how analytic treatments work.

Novick and Novick's ideas about termination are so tightly woven together with their concept of analytic process that each seems to inevitably imply the other in a simple and direct manner. Once one acknowledges that the authors' way of working is just one among many, the question of whether their thinking about termination can apply elsewhere becomes unavoidable. My own impression is that the authors' treatment of the subject of termination will be of value to analysts of a variety of theoretical persuasions. However, I think the book would have been more useful if Novick and Novick had addressed this area of complexity.

At times, the description of two systems of self regulation has a concrete quality, as though two distinct, separate regulatory systems are being described. In general, the authors' discussion of their clinical cases indicates that they see their patients functioning along a continuum,

on which there are varying degrees of closed-system versus open-system functioning.

The authors discuss this issue more directly in the section on "Phases of Treatment":

> In practice, there are not such clear lines of demarcation between phases; they are not stops along a railroad line . . . . However, particular themes and tasks are highlighted as treatment progresses . . . . This *heuristic device* allows us to sharpen our focus on termination phenomena as they appear at different times. [p. 13, italics added]

This is an important point. However, on the very same page, the authors state that their "developmentally based theory of the therapeutic alliance gives clinicians a *road map* for working with defensive omnipotent resistances" (italics added; see also pp. 51-52). While being provided with a road map is most welcome as we try to navigate the always perplexing and challenging terrain of analytic treatments, the authors here risk creating the impression that they are actually using their concepts more concretely than they intend to.

On balance, I think that the authors' discussion about the various details of the analytic process can be used to good effect without our necessarily thinking of the analysis as being made up of specific, concrete phases. The questions the authors raise, and the clinical material they present to illustrate how they deal with those questions, pertain to matters that all analysts would do well to ask themselves at some time during the course of the analytic work, whether or not they think of these questions as pertaining to specific phases per se.

Another feature that stands out is the book's emphasis on the "therapeutic alliance." Each task during each phase of the analysis is typically defined as a "task in the therapeutic alliance." This emphasis is related to the authors' concept of the two regulatory systems, closed-system and open-system, which in turn emphasizes the quality of the relationship between therapist and patient. The emphasis here is on the relationship itself (i.e., a closed, sadomasochistic one in which there is a struggle for dominance and control, versus an open-system relationship characterized by love and mutuality). In fact, Novick and Novick's approach

blends relational issues with principles of ego psychology and conflict theory (defense mechanisms, ego strengths, sublimation, neutralization, etc.) in an interesting way.

The authors build on their concept of two regulatory systems to define the goal of analysis as "restoration to the path of progressive development" (p. 12). Ultimately, this concept is elaborated as "restoring the patient to the path of progressive, open-system development, so that there is a real choice of how to proceed with life" (p. 13). One question here is whether the authors may be singling out sadomasochistic fantasies and "omnipotent beliefs" at the risk of possibly underestimating the significance of other relevant psychic phenomena, given the vast array of conflicts that can contribute to a resistance to forward movement in the course of analytic treatments (cf. p. 19).

The chapter on the "Evaluation Phase" gives a particularly clear exposition of how Novick and Novick think of, and use, their concept of termination from the very beginning of an analysis. For example, the questions that introduce the sections of this chapter include:

> What can you see at evaluation that is relevant to termination?
>
> Why is sadomasochism relevant to termination?
>
> What alternatives is the therapist looking for? How does this help set treatment goals?
>
> When will treatment end?
>
> What is gained from talking about termination at the very beginning?

These examples illustrate the authors' accomplishment in breaking down their subject into manageable nuggets. In so doing, they articulate their ideas explicitly, to a degree not often found in psychoanalytic texts. They also highlight issues that help the analyst to think through his or her ideas, and to address issues with the patient in ways that help orient the patient to the mystifying and intimidating blank screen that often represents how analysis may seem—especially as the patient is considering whether to begin treatment or is just about to do so. At the same time, that blank-screen quality is also what creates the condition

for maximal freedom of expression. There is an inevitable tension between these two ways in which the ambiguity of analytic treatment can be experienced.

The following chapters are organized around specific phases of analysis: "Beginning," "Middle," and "Termination," of course, but also a chapter on "Pre-Termination" and one on "Post-Termination." Novick and Novick clarify why they think it is important to include the concept of a pre-termination phase. They define this phase as that portion of the analysis that occurs after the bulk of the analytic work has been achieved during the middle phase, but a termination date has not yet been set. The idea of termination is now a realistic possibility, and issues and conflicts relating to the decision to terminate can be explored. As one of the authors said to a child patient, Eddie:

> The way treatment ends is by taking some time to do the work of saying goodbye. There is a lot of work to do in that time, so it is important before starting to make sure that everyone is ready. [p. 76]

The determination of readiness for termination is one of the essential features of the pre-termination phase, according to the authors.

Characteristically, Novick and Novick specifically define their criteria to assess readiness for termination, including evidence of internal change, as well as indications of corresponding changes outside the analysis (see especially pp. 72-73). They also make clear a crucial distinction between readiness for termination, on the one hand—which includes a sense of momentum toward more consistently open-system functioning—and, on the other hand, achievement of the goals of analysis, which requires the work of the termination phase to be completed.

One of the values of conceptualizing a pre-termination phase is the opportunity during this phase to explore the "various ways of ending [and conflicted issues related to termination] . . . without the reality and pressure of an actual final date [looming]" (p. 95). In this chapter, there is an interesting discussion of the goals of analytic work and of the authors' concept of autonomy, which includes the capacity to take pleasure in one's successful functioning, both within and outside the analysis (pp. 77-89). Novick and Novick include a sensitive discussion of transference-

countertransference reactions to termination in this chapter, as well as in the chapters on termination and post-termination.

The discussion of the issue of "tapering" or "weaning," while interesting, illustrates one of the limits of the authors' style, referred to above. They indicate their belief that these methods are not adequate ways to terminate an analytic treatment. However, they do not really consider any of the arguments typically made in favor of such practices; instead, they believe that the decision to terminate in this way is attributable to countertransference reactions to the difficulty of fully engaging emotions associated with termination. But since the treatments being considered in this book include psychotherapy as well as psychoanalysis, there are times when "tapering" or "weaning" might be appropriate, given the variety of patients' needs, clinical conditions, and modes of treatment that the authors say they include in their formulations.

While the book emphasizes the movement to open-system functioning, characterized by mutuality, Novick and Novick seem to advocate reverting to a hierarchical relationship at one point in the termination phase, after the final date has been set. The authors several times refer to patients' attempts to force the analyst to change the termination date. Stated this way, it sounds as though the analyst has become the sole guardian of that date, with the consequent potential for the kind of sadomasochistic struggle that patient and analyst have been working to overcome.

The case of Mr. G illustrates what appears to be an extreme version of this therapeutic challenge. The authors say that after

> . . . failing to get me to change the date, . . . Mr. G begins to tease and humiliate his younger son quite brutally. I asked him why, when he had all the skills to direct his analysis and his life, he was trying to force me to intervene actively, for instance, by calling Children's Protective Services? Mr. G . . . said, "I was having a temper tantrum . . . . I love my son and yet I was willing to destroy him to hang on to this craziness." [p. 113]

The authors state that, from that point onward, Mr. G began to mourn the real loss of the analysis and the analyst. Thus, the matter

appears to have been resolved analytically, but with perhaps more of a sadomasochistic flavor than what the authors strive for.

Another such example occurs in the chapter on pre-termination, in regard to Ms. D, a patient who says:

> "If I just persist long enough, finally you will take care of me and be my mother. I'll make you tell me what to do and I will never have to leave you." I told Ms. D [here the authors' narrative continues] that I was angry at her for pushing me around in this way . . . . I pointed out that Ms. D could make her own choices, which would be respected . . . . But I would not distort or collude in destroying what we had learned together of her strengths. [p. 90]

The patient's sadomasochistic effort to control the analyst is well documented. But in the analyst's pushing back, is there an element of the use of transference authority that may not fully adhere to the open-system goal of mutuality?

An issue discussed in the chapter on termination that I find confusing is the idea that the patient "sets aside" closed-system functioning in favor of open-system functioning (see especially pp. 109-118). This view is used to explain the fact that patients can return to periods of closed-system functioning even after open-system functioning has been achieved to a large degree. On the one hand, it is a commonly accepted observation that patients *do* return to earlier modes of functioning during periods of stress—such as in anticipation of termination—no matter how thoroughly conflicts have been analyzed. The term usually applied here is *regression*. This concept is based on the notion of unconscious defense mechanisms being mobilized during stressful periods. My question here is whether the term *setting aside* is simply a new expression for the same concept, or whether it implies something conceptually different. For example, is the episodic return to what has been *set aside* considered something other than an unconscious defense mechanism—perhaps a more consciously determined process?

The issue of *setting aside* is also discussed in relation to the matter of mourning during the termination phase, as follows.

> With a dual-track, two-system mode, we can posit that a belief is never mourned or gone but *set aside* . . . . Setting aside organizing convictions [such as omnipotent fantasies] may be painful, but the pain may be likened to the withdrawal from an addictive substance [rather than to mourning]. [p. 117, italics added]

Novick and Novick add that "the crucial issue is sadness, which is present only when there is love, when there is a genuine loss" (p. 117), associated only with open-system functioning and not closed-system functioning. "What is truly mourned by both patient and analyst at a good goodbye is the unique working and loving relationship that enhanced each person and will now persist only internally as they separate" (p. 118). I find this statement unclear; it again seems to raise questions about the degree to which the two systems of functioning are being considered as concrete realities, rather than as abstractions along a continuum.

The authors make a brief reference in their "Overview" chapter to features in the termination of analyses of candidates in psychoanalytic training that are specific to those cases—especially the fact that, in almost all such analyses, there will be a post-analytic collegial relationship (p. 5). The authors regard the potential effects of this on candidates—both personally and professionally—as a cause for concern, especially in relation to how the analyst works with the patient/candidate around termination. The discussion of this matter is brief, and, other than another brief reference in the chapter on pre-termination, it is not taken up later in the book. Perhaps Novick and Novick regard the detailed treatment of this matter as beyond the scope of the present work; in any case, the subject deserves more thorough exploration than is provided here.

The authors establish the idea of a post-termination phase to address issues that need to be engaged by both the patient and analyst following completion of the termination phase. I agree with the importance that the authors give to the period following cessation of analytic sessions. Their elaboration provides useful perspectives on transference and countertransference issues, as well as on the potential for further analytic growth for both analyst and patient during this period. Novick and Novick convey a flexible attitude in relation to the possibility of patients returning for help—an attitude that seems useful in and of itself. Their flexibility also provides a nice balance to the firmness bordering

on rigidity, referred to earlier, that seems to characterize sections pertaining to the setting and maintenance of the termination date in the chapter on termination.

Although the clinical vignettes in *Good Goodbyes* tend to be brief, they are well chosen, and in general they provide useful illustrations of the concepts the authors are trying to convey. After all, there is nothing like clinical material to bring theoretical concepts to life and make them meaningful. However, I am unsure why the vignettes are written as though the book has a single author, with no distinction of which author actually did the clinical work described. Perhaps this represents an attempt to protect patient confidentiality by pooling the two authors' clinical material. But I think that, regardless of the reason, it would be useful for the authors to clarify their thinking in this regard.

In addition, I think it is important for psychoanalytic authors to state how they are protecting the confidentiality of the patients whose cases they cite. Although I make the point in relation to this book, it is applicable to psychoanalytic texts in general. Despite some thoughtful writings on the subject, we have not as a profession established urgently needed standards in this matter.

In chapter 8, "Final Thoughts," the authors state: "Our aim is not to give final answers, but to engage readers in a dialogue around ending in a growth-enhancing rather than traumatizing way" (p. 137). I offer my comments here in that same spirit of continuing the dialogue. Although I appreciate Novick and Novick's clearly documented exposition of how they work on termination clinically, they seem to write as though one needs to use their specific concepts and methods in regard to analysis in general in order to end the treatment with a "good goodbye." I think that the complexity of the termination process would be more fully illuminated if consideration were given to the variability of termination issues that arise in differing types of psychoanalytically oriented treatments.

Nevertheless, I find *Good Goodbyes* both interesting and useful. The authors raise issues that will be valuable to analysts of varying theoretical points of view and of varying degrees of experience. The authors' explicit style and efforts to provide a termination "road map" will undoubtedly be welcomed by beginners. At the same time, the various issues

presented in regard to how the authors think about and work with termination make this book an excellent read for even the most seasoned analysts.

**BARRY J. LANDAU (WASHINGTON, DC)**

ENDINGS: ON TERMINATION IN PSYCHOANALYSIS. By Fausta Ferraro and Alessandro Garella. Translated by Dorothy L. Zinn. Amsterdam, The Netherlands/New York: Rodopi, 2009. 203 pp.

Psychoanalytic work is arduous and demanding. We do it because we recognize its therapeutic power, and because it is very satisfying to help people free themselves from intolerable symptoms and create the full and happy life toward which we feel everyone is entitled to strive. It can be very frustrating, therefore, when analytic effort does not reach all the goals toward which we and the analysand have been working, or when it is broken off prematurely rather than arriving at a smooth, triumphant, planned termination process.

The authors of this book have long been interested in understanding what is entailed in successful completion of analytic work and in puzzling out what at times interferes with our achieving that end. It has troubled them that, far too often, their work and that of other psychoanalysts approaches a successful conclusion, but then does not seem to reach it, either because of a stalemating of the process or as the result of an abrupt interruption of the work. In this volume, they examine what appears to be involved in those instances of frustrated analytic effort.

In the first two-thirds of the book, Ferraro and Garella devote themselves to constructing a historical review of the concept of psychoanalytic termination, and of the psychoanalytic process of which it is a part. The result is concise, yet impressively inclusive and richly informative. They begin by reaching back to Freud's ideas about termination as expressed in various of his works.[1] They also discuss Ferenczi's ideas about how to decide when an analysis can be brought to an end, and in particular his idea that "a complete analysis entails an infinite period of time" (Fer-

[1] See, for example: (1) Freud, S. (1914). From the history of an infantile neurosis (the "Wolf-Man"). *S. E.,* 17; and (2) Freud, S. (1937). Analysis terminable and interminable. *S. E.,* 23.

raro and Garella, p. 5)—because of which analysands need to be actively weaned away from it. The authors describe early debates among Ferenczi, Jones, Strachey, Balint, Anna Freud, Glover, and Reich about what needs to be accomplished in an analysis in order for it to be considered complete.

Ferraro and Garella explore differences between the views of Freud and of Ferenczi, such as Freud's emphasis on the importance of fantasy in generating neurosis, versus Ferenczi's position that "privileges the actual traumatic event" and seeks to guide the patient to "immersion in the traumatic past" (p. 23). They note, too, that "Ferenczi introduced the bi-personal model in which the discovery of the truth depends on the behavior of the analyst, who is therefore a full participant" in the work (p. 23). They cite Balint's epitomizing the dialectic between Freud and Ferenczi in terms of whether a natural, healthy developmental process is freed up by analysis, or whether analytic "cure" is "manufactured" by it, and therefore is highly variable in its course and outcome.

The authors cite Schmideberg's and Fenichel's observations about the tendency of some analysts to overidealize what analysis can do, in contrast with Freud's more modest claims. Fenichel critiqued Freud for underappreciating the importance of exploring and repairing ego disturbances, which he viewed as no less important than drive-related, neurotic conflicts. He also advocated appreciating the experiential and social factors that contribute to emotional problems, in addition to the biological ones stressed by Freud.

In the chapter titled "After Freud: The Theme of Termination in the Mid-1900s," Ferraro and Garella describe Glover's close examination of the criteria for termination. Glover focused on the transference neurosis and its resolution, leading "toward a modification in the order of identifications, with the analyst serving as an auxiliary superego" (p. 31). He was skeptical about the idea that countertransference reactions might cloud the analyst's judgment about readiness for termination, and he, too, subscribed to the view that there are limits to what psychoanalysis can accomplish. He recalled, for example, Sachs's "provocative statement that the most complete analysis is little more than a scratch on the surface of a continent" (p. 31).

During a 1949 English symposium on analytic termination, Rickman, Hoffer, and Bridger addressed changes in the analysand that they felt had to be observed, including, as Hoffer put it, "identification in the ego with the analyst's functions" (p. 33). Bridger recommended investigating the way in which the analysand has experienced brief interruptions in the analytic work, and how he or she has dealt with the ending of a relationship outside the analysis.

Klein, during the same symposium, expressed her belief that "the crucial point is precisely the reduction of maniacal defenses which impede introspection, and the reduction of splitting processes, insisting on the analysis of the negative transference as the *sine qua non* condition for an effective termination" (p. 34). This was in keeping with her attribution of decisive importance to attainment of the depressive position. Balint's contribution appears to Ferraro and Garella to have represented, in part, an attempt to bridge the conceptual gap between Anna Freud and Melanie Klein, when he added the criterion of refinding the "primary object love" that facilitates a "new beginning" (p. 36).

Ferraro and Garella attend briefly to discussions of termination at an American panel and a French symposium that took place at about the same time as the English one. Edith Buxbaum addressed the issue of therapeutic versus analytic results, and she reaffirmed Freud's view that analysis should create the best possible condition for ego functioning. She also discussed the technical challenges involving the transference and the issue of timing that she considered to be crucial to the termination phase, in which core issues tend to be revivified and worked through.

Annie Reich compared Freud's and Ferenczi's ideas. She emphasized the analysis of important character traits, the tenaciousness of the libido, and what she saw as Ferenczi's overestimation of the likelihood of achieving dissolution of the transference. She noted that the analysand's bond to the analyst is infantile in nature at first, but develops and evolves beyond that in the course of an analysis, so that it is necessary to maintain a friendly relationship with the analyst that is much more than the original infantile one. She advised paying close attention to the positive or negative nature of new relationships into which the analysand enters as the one with the analyst is coming to a close.

At the French symposium, Bouvet, Nacht, Held, and Shentoub explored the role of intuition and countertransference during termination and the technical modifications that might be required to break up interminable analyses, such as actively directing the analysand toward seeking gratifications in the real world and weaning the patient away from dependence on the analyst.

The last section of Ferraro and Garella's historical review includes attention to Meltzer's emphasis on examining the evolution of the transference and on weaning away from "introjective infantile dependency on the mother's breast" and the attainment of a capacity for independent "introspection, thought, and responsibility" (p. 44). This section also focuses on the French emphasis upon differences between the analysand's and the analyst's goals (Gendrot); "quality of insight rather than the quantity of analyzed material" (Diatkine, p. 45); "the search for a natural termination respectful of the patient's freedom" (Lebovici, p. 46); ego modification resulting from establishing and resolving a transference neurosis (de M'Uzan); "transference of transference," rather than dissolution of it (Laplanche, p. 50); ascension of secondary over primary process (David); and the extent to which constellations viewed as biological can be altered (Bemassy, Barande, Chasseguet-Smirgel, and Kestemberg). The French analysts also stressed the importance of loss and mourning during termination and the role in it of *Nachträglichkeit* (*après-coup*), Ferraro and Garella note.

The authors comment on American Psychoanalytic Association panels on termination in 1962, 1968, and 1974. The issues addressed included the relationship between analysand and analyst after the analysis, the abandonment dynamic and the mourning process during the final phase, the distinction between treatment goals and life goals, the myth of perfectibility, and the matter of "transference cure" or pseudocure. They look at an issue of *Psychoanalytic Inquiry* on this topic that appeared in the 1980s—in particular, at Rangell's concept of a postanalytic phase; Dewald's observation that termination is a final frustration that can unleash intense negative feelings, even as it represents a welcome emancipation; and Jack Novick's similar comments about these adolescent-like features. Ferraro and Garella also cite the ideas of Bion, Pontalis, Quinodoz, Flournoy, and others about termination pressing the

analysand to face and deal with troubling and conflicted psychological elements that he or she would otherwise prefer to avoid.

En route to examining the concept of a "termination process," Ferraro and Garella devote a chapter to what appears to be involved in the "psychoanalytic process" that leads up to it. They explore the notions of working alliance (Greenson), therapeutic alliance (Zetzel), regression in the service of the ego (Ernst Kris), therapeutic regression (Etchegoyen), developmental progression (Greenacre), the psychoanalytic situation (Rangell), psychoanalytic biography (Lipton), character analysis (Stein), the Ulm model of process (Thomä and Kächele), one-person versus two-person psychology, resolution of intrapsychic conflict versus/together with structural change, and the role of the transference and of transference neurosis.

The authors also describe French skepticism about the concept of a psychoanalytic process, because of their belief that it connotes a view that perceives "elements of . . . transference, regression, remembering, and working through, etc.," as clearer, more specific, linear, and dialectical than they can actually be within "the complex unpredictability of analytical movements," and because of their belief that analysis cannot actually proceed in a prescribed fashion leading to "a definite end" (p. 80). Ferraro and Garella emphasize that an analyst's theoretical orientation exerts a powerful impact upon his or her concept of psychoanalytic process:

> The expectations of theory contain a predictive element regarding who, what, when, and how the therapy can or cannot interest and modify; this element interacts with personal, individual elements, attributing them with—or receiving from them—all sorts of confirmations. [p. 84]

After they have completed their extensive and impressive review of the literature, the authors turn to their own special interest: the topic of time in relation to the process event of termination, both in its own right and "as a prefiguration of post-analysis outcomes, an indication of the particular qualities of the relationship with the analyst" (p. 104). They draw upon the ideas of Arnold van Gennep on the rites of passage that society imposes on its members as they undergo transition from one

identity to another over time: so-called liminal rites.[2] They extrapolate from this a concept of analytic termination as a crystallization of the personal history that is constructed in the course of an analysis—not unlike the denouement and final chapter of a novel, which pull together and give cogency to the episodes leading up to them, as Ricoeur has pointed out.[3]

Ferraro and Garella's concept of "liminality," in which they assert that initiating termination is doubly traumatic for the analysand, leans heavily upon application of the concept of *Nachträglichkeit:*

> The beginning of the termination phase . . . bears a doubly traumatic quality, in the sense . . . of re-presentation or precipitation of pre-existing traumatic nuclei, as well as in the sense of the formation of a new traumatic nucleus presented by the very prospect of termination. [p. 141]

At this point, Ferraro and Garella appear to this reader to present a tautological argument as they propound the view that interruption of analysis before the kind of ending that the analyst would have preferred is only a variation of something that *always* occurs:

> Our essential idea is that analysis cannot but remain incomplete, and that the individuation of the termination event seems to confirm this through its unfulfilled and prohibited elements . . . . If all analyses are incomplete, then those we consider more or less properly terminated and those instead marked by interruption or interminability all share a basic feature, and are therefore closer than we tend to think. Their difference is to be found in something other than the distance with respect to a model of termination that is both ideal and hypothetical. [p. 160]

There is certainly a degree of truth to the observation that no analysis can be "complete," and that psychoanalysis cannot produce perfection in anyone.[4] In this regard, Ogden (1997) depicts analytic success as

[2] Van Gennep, A. (1909). *The Rites of Passage,* trans. M. B. Vizedom & G. I. Caffee. London: Routledge, 1960.

[3] Ricoeur, P. (1983). *Time and Narrative, Vol. 1*. Chicago, IL: Univ. of Chicago Press.

[4] See Silverman, M. A. (1985). Countertransference and the myth of the perfectly analyzed analyst. *Psychoanal. Q.*, 54:175-199.

consisting of "the planned ending of a *fruitful* analysis, . . . [as] differentiated from the illusory conception of a 'completed' analysis that has been brought to a successful termination after the transference conflicts and distortions have been successfully resolved" (p. 10, italics added).[5]

Ferraro and Garella go well beyond this, however. They state that:

> We might say that the only analyses which actually exist are interrupted ones. This would provocatively confer the status of truth to the widely shared recognition, which remains clandestine and informal in that it is confided only in private, that truly terminated analyses are scanty. [p. 161]

The authors indicate, on the other hand, that they are not really so sure about this. They devote a good deal of effort to trying to pinpoint the factors that lead to interruption of analysis. In so doing, they imply that there actually *is* an important difference between an analysis that appears to have been satisfactorily finished and one that has been interrupted or has been deemed interminable. They indicate that patients who have had overwhelmingly traumatic or intensely unhappy early lives often cannot bring themselves to suffer the intense pain they would feel if they were to reexperience their dreaded past during the *Nachträglichkeit* experience that is an integral part of analytic termination. These patients have to break off the analysis before that can occur.

Ferraro and Garella devote many pages to examining the role of *Nachträglichkeit* during the termination process—i.e., of the analysand's reexperience of wrenching negative feelings from his or her traumatic past that unavoidably occurs when the analyst, in an exquisitely palpable way, abandons and discharges the analysand from treatment during the termination process.

Although Ferraro and Garella refer generically to "trauma" in this regard, the (albeit too brief) clinical examples they adduce of patients who prematurely broke off analysis all involve the violent loss of a parent early in life. Such a loss may cause the patient to find the prospect of losing the analyst so intolerable that the patient must avoid the pain of

[5] Ogden, T. H. (1997). *Reverie and Interpretation: Sensing Something Human*. Northvale, NJ/London: Jason Aronson.

abandonment by leaving the analyst before the analyst leaves him or her. The authors state that:

> Interruption of analysis seems to replicate traumatic separation (as in our example, the loss of a parent in the early years of life) functioning in this way as a primitive and active mode of mastery, and at the same time expressing a certain degree of signal anxiety aimed at heading off the repetition of an identical loss and separation. [p. 171]

Perhaps the connection with extreme early traumatization *in general* resides in the fact that, when a child is brutally traumatized, a major component of that experience—even if it is not the parents who have been the perpetrators—is that children inevitably feel brutalized by the parental failure to protect them, and therefore they feel abandoned by the parents.

However, even with patients who have been severely abused in childhood, and who are therefore terrified of the unendurable, phantasmagoric intensity of what termination stirs in them, there are technical guidelines that can be followed to allow an analysis to proceed—albeit slowly—toward a true termination process. Ladan,[6] for example, described the way in which even analysands who have been so severely abused in childhood that they have spent their lives distancing themselves not only from terrible memories, but also from the vulnerability that comes with having needs, feelings, and human desires, can be helped analytically to eventually face and deal with the effects of childhood abuse. Ladan described the need for a great deal of patience, sensitive attunement to the analysand's self-protective imperatives, very careful attention to the analysand's needs and sensibilities, the utmost tact and forbearance, vigilant attention to the analyst's own frailties and countertransference tendencies, and assiduous avoidance of distortion of clinical judgment from excessive allegiance to one or another theoretical framework. The clinical examples Ladan provided movingly and convincingly demonstrate how effective such an approach can be.

[6] Ladan, A. (2005). *Walking Heads: On the Secret Fantasy of Being an Exception,* trans. M. de Jager. New York: Other Press.

Even with sensitive, unhurried, skillful analytic technique, however, there are some patients who will not be able or willing to undergo the rigors of a planned termination process. I think, for example, of a man I analyzed who gained enormously from the treatment, for which he expressed deep gratitude, but he was so terrified that his life would be ended by his familial cardiomyopathy (because of which he eventually required a heart transplant) that he could not possibly consider participating in a planned "termination." He had to bring the treatment to a close before it could come to an end.

I am also reminded of a woman patient of mine who was raised by a mother who cared for many other children but did not have time for her daughter, and by a father who was so afraid of closeness with anyone that he wore clothing two sizes too large so that he would not have to get close even to himself. In the past, this patient had had a 10-year analysis in which, as she put it, she "did not find her identity; she became an entity." An unfortunate occurrence permanently injured her in a way that was extremely distressful to her; she became depressed and was referred to me for assistance by her former analyst. Her most intense concern was that she would be unable to be a good parent to her children.

This woman had been unsuccessful in her attempt to move to a location far from her parents, and at the time she and I began to work together, she felt forced to live only a few blocks away from them. She responded extremely well to analytic treatment, and proved to be a devoted, excellent parent to her children. When she attempted to plan termination of her treatment with me, however, she became so anxious that she simply could not go through with it.

After a long struggle with this, we agreed upon gradually extending the interval between her sessions until it reached a week, two weeks, a month, three months, six months, and finally a year. After a number of years, the patient became able to merely drop me a line once or twice a year, and to come in to see me for a visit once in a while. For many years, I have not seen her, but we have spoken briefly on the telephone on occasion, and I receive a call from her pharmacist several times a year to renew her prescription for a small dose of a tricyclic antidepressant. I consider both of these analyses to have been quite successful.

Ferraro and Garella express themselves as troubled by "intermittent analyses," which they appear to consider a form of nonterminated analysis. Here I find myself unable to agree with them. That some people leave analysis only to return for additional analysis later on, and others go back for "re-analysis" after an interval of time, does not necessarily connote failure of the analytic process. Every analysand is unique; every analysis is unique; and every termination is unique. To expect every analysis to close in a prescribed, formulaic manner is to subject analysands to something that turns the analytic couch into a Procrustean bed.

A three-and-a-half-year-old boy, for example, was brought to me because of intense, angry, destructive behavior that began when his mother died following a brief period of rapid deterioration caused by a suddenly appearing, particularly aggressive form of cancer. He threw himself into the analysis, and his behavior improved dramatically. After a number of months, however, he announced to me that the analysis was too painful—he could not take it any more—and he had to stop the treatment. He assured me that he would be back. He not only kept his word, but he returned many times over the next sixteen years to work on what he called "chapters of [his] book." This, too, I consider a highly successful analysis—and, even more important, so did he.

What we as psychoanalysts might desire for and from our analysands is not always necessarily what they need or want. It is unrealistic, furthermore, to require more from them than that of which they are capable. We need to be modest in our expectations of patients—although not modest in what we offer them.

Despite my reservations about some of Ferraro and Garella's conclusions about interrupted and intermittent analyses, I am grateful to them for having provided this extremely informative and heuristically stimulating book about analytic termination. I recommend it warmly to all analysts, and, in particular, to those who are teaching analytic candidates. It not only contains an unparalleled summary of the core issues involved in debates about termination as they have unfolded over the years; it also explores questions about the termination process that are very relevant to current practice. It is a book well worth reading.

**MARTIN A. SILVERMAN (MAPLEWOOD, NJ)**

DOUBT, CONVICTION, AND THE ANALYTIC PROCESS. By Michael Feldman. London: Routledge, 2009. 288 pp.

As a first-year psychoanalytic candidate, I was introduced to Melanie Klein via a surprising and impressive pedagogical moment. We were discussing child development, and the instructor asked the innocuous-enough question: "Who can define projective identification?" Just as I was raising my hand, he cautioned, "If you can, you fail the course." My instructor's point of view, universally embraced, represented an evident bias against Klein's propositions.

The antagonism has softened a good deal since I was a candidate in the early nineties, owing to the work of Roy Schafer and others, and a greater general familiarity in the United States with Kleinian concepts and practice. Despite this tacitly greater openness, however, stereotypes are still to be found, particularly about the way in which Kleinian analysts work with their patients.

Clinical work is what Michael Feldman depicts with astonishing richness and clarity in the essays contained in *Doubt, Conviction, and the Analytic Process*. Just as Freud asserted that instinct represents a demand on the mind for work, Feldman shows how each patient, through the complex mechanisms of projective identification and splitting, exerts a demand on the analyst's mind for work—and that the analyst's experience of this demand, and his or her capacity to think about it usefully and constructively, constitutes the work of analysis.

While profoundly attuned to the patients he describes, Feldman moves our attention from the patient to the patient/analyst pair, taking the encounter between patient and analyst as the focus of his efforts. He demonstrates that the analyst's responses are generated under the influence of the patient's state of mind, the nature of his or her anxiety, the quality of his or her object relationships, and the pressures s/he brings to bear on the analyst in the session. Feldman thereby shifts the analytic inquiry from the mind of the patient to the interplay between two persons, in what is sometimes referred to as the here and now of the analytic session. The analyst's state of mind is relevant insofar as it reflects the patient's means of acting on the analyst, which is happening all the time, in every hour.

Still, this view should not be mistaken for an intersubjective or relational approach to psychoanalysis. The approach described by Feldman is one that upholds analytic neutrality while at the same time appreciating that the analyst is drawn in by the patient's efforts to manage his or her own state of mind, as well as to deal with the anxieties brought on by an awareness of the analyst's separateness.

As his starting point, Feldman takes Klein's notion that the presence of the object is foundational for the formation of the ego. He conceptualizes the patient's relation to the analyst as a reprisal of the phantasies linked to early object relationships. The patient's history, as Freud taught us, is recorded in the patient's relation to his or her objects. The way in which the patient orients him- or herself to the analyst tells the analyst a great deal about the patient's internal object relations, which in turn tell about the patient's phantasies, conflicts, and mechanisms of defense. But rather than taking the patient's word about his or her objects or personal history, Feldman concentrates on what happens in the sessions—not only what the patient says, but what s/he does.

Inevitably, therefore, subtle, ubiquitous enactments of complex internalized object relations make up psychoanalytic work. Feldman, citing Tuckett, says: "Enactment makes it possible to know in representable and communicable ways about deep unconscious identifications and primitive levels of functioning which could otherwise only be guessed at or discussed at the intellectual level" (p. 35). Feldman discusses enactment in relation to a range of topics—the role of the analyst in projective identification, the Oedipus complex, and manifestations of the death instinct.

For example, in the first chapter, titled "The Oedipus Complex," Feldman demonstrates how the analyst may be drawn into the reenactment of a dilemma that originally was the patient's as a child, but in which the parent had inescapably become involved. Oedipal fantasies "are often derived from a very early period of the patient's experience and are not represented in his mind in words, but in feelings or action or impulses toward action" (p. 2). Here as elsewhere, Feldman illustrates the importance of paying close attention to the dynamics of the session, and in particular to the "countertransference experience (including the subtle pressure on the analyst to act in particular ways)." But this

is not a conventional countertransference; it is one that derives from an acute sensitivity to various subtle communications from the patient—communications that are themselves derived from what the author referred to earlier as the "nature of the oedipal couple as it exists in the patient's mind, partly derived from his perceptions and partly distorted by projection."[1] This will influence both the nature of the transference and the countertransferential pull toward reenacting with the patient aspects of his or her oedipal conflict.

While several chapters of *Doubt, Conviction, and the Analytic Process* allow us to see Feldman's take on a foundational Kleinian concept (e.g., projective identification, splitting, the Oedipus complex, the death instinct, envy), there are also a number of chapters (on grievance, compliance, conviction, and doubt) that exemplify the author's rare capacity for detailed clinical/theoretical understanding. Many chapters begin with Freud, allowing the reader to see the ways in which Klein is both grounded in Freud and extends Freudian theory. Other pervasive influences on Feldman's thinking have been Bion, Rosenfeld, Joseph, and the contemporary Kleinians. The author not so much describes these influences as shows himself in active discursive relation with them.

Several chapters help clarify a number of vexing clinical concepts. Those on "Splitting and Projective Identification" and "Projective Identification and the Analyst's Involvement" clarify often elusive and difficult concepts, while also offering clear access to Feldman's way of orienting himself to clinical material. Feldman notes that, for Klein, splitting constitutes one of the earliest defensive operations of the immature ego. It arises in response to intense early anxieties afflicting the nascent ego. In Klein's view, the early ego is capable of *phantasy,* and this phantasy often concerns its objects.

Feldman notes that the pleasurable experiences of infancy are felt to be good. In phantasy, their source is a "good" object. Correspondingly, the source of painful experiences is linked in phantasy with a "bad" object. The primary objective of splitting is "to segregate the objects associated with good experience from those associated with bad in order

[1] Feldman, M. (1989). The Oedipus complex: manifestations in the inner world and the therapeutic situation. In *The Oedipus Complex Today: Clinical Implications,* ed. R. Britton, M. Feldman & E. O'Shaughnessy. London: Karnac, p. 106.

to protect and preserve the good objects on which the survival of the self depended" (p. 22). This elemental segregation is enhanced via the projection of the "bad" from inside to out. The psychic equivalent of this projection/expulsion of dangerous substances from the body is a mode of relating to one's objects that is often seen in the clinical setting. As Feldman states, "These functions can be used aggressively, to control, or to engage the other in a positive fashion" (p. 23).

Klein introduced the concept of projective identification in 1946, leading to an integration of her ideas on splitting, projection, and an early form of identification—each a mode of defense against primitive anxieties. Feldman emphasizes that projective identification relies on an unconscious omnipotent phantasy that, by definition, does not require the participation of the object. Along lines theorized by Bion with his model of containment, Feldman illustrates how patients attempt to use the analyst as a kind of repository for the "projection of unbearable mental contents by inducing feelings or thoughts in the analyst, or by drawing the object into forms of enactment that serve in complex ways to protect the patient from pain" (p. 23). Feldman indicates that, in dealing with projective identification, the analyst must be prepared to study his or her own countertransference reactions—not merely as an indicator of the analyst's psychopathology, but as an instance of registering what the patient is attempting to convey.

Grounded as he is in Rosenfeld and Bion, Feldman distinguishes various types of projective identification used by the patient in analysis. In one instance, the patient might rely on the analyst to contain what has been projected and to transform nonverbal communication into a verbal interpretation that the patient can use. However, it is also possible that the interpretation of a projective identification, however tempting it is for the analyst to make, will be experienced by the patient as persecutory—in which case the patient's unconscious desire is "not for understanding, but for the repetitive living out of certain object relationships that the patient does not want to think about or understand" (p. 25).

The paradox here is that, although the object comes to be partly identified with an aspect of the self, the link between the subject and that which has been projected is denied. Therefore, the object is perceived as having nothing to do with the self, so that the object is seen to

"contain these qualities, motives, or functions, in its own right" (p. 31). In depicting this, Feldman takes us into the world of patients whose desire is not so much to be understood, but who, for a variety of reasons, aim to defeat the analyst in his or her efforts to understand. Feldman develops this insight throughout the book.

The patient enlists the analyst's involvement via projective identification as a means of reducing the distance between the patient's archaic object relationship and the current relationship with the analyst. The patient exerts pressure on the analyst to conform to unconscious expectations that are embedded in phantasies regarding early objects. Feldman states:

> The impingement upon the analyst's thinking, feelings, and actions is not an incidental side-effect of the patient's projections, nor necessarily a manifestation of the analyst's own conflicts and anxieties, but seems to be an essential component of the effective use of projective identification by the patient. [p. 36]

Although the analyst might be inclined to take for granted or nudge away a sense of sleepiness, irritation, confusion, or even pleasure, Feldman helps us see that these states of mind in the analyst can be linked to the patient's communication of his or her object world. For Feldman, this means that how the analyst orients him- or herself to the patient's material and mode of communicating must be central to the analyst's listening.

This concern with orientation begins with each and every hour. Feldman pays exquisite attention to how the patient enters the room, how s/he begins to speak, and the story that is told. The telling of a story is a theme that Feldman takes up in several chapters. In one chapter, the author describes a patient's use of the phrase "I was thinking . . ." as a way to begin the session. Feldman links this "I was thinking" to the reassuring quality captured by the familiar "once upon a time" of fairy tales. Feldman observes that "I was thinking" defends against "intense, often quite primitive emotions evoked by the immediate contact with the analyst, into whom powerful archaic phantasies are projected" (p. 160). The intense feeling triggered by entering the room is dissipated through the phrase "I was thinking," since it references the space outside

the room, or a prior moment; the phrase takes both patient and analyst away from the immediacy of the analytic encounter. Immediacy is crucial to the analyst's optimal functioning, however. Lulled by "I was thinking," the analyst is liable to miss the moment at hand and the defensive turn this storytelling phrase represents.

Feldman further develops ideas about anxiety, reassurance, and the encounter between patient and analyst in his beautiful chapter entitled "The Dynamics of Reassurance." Starting with a clinical example, he explores his patient's use of a story to engage the analyst in a predictable reaction of judgment and criticism. The author takes up the curiously comforting and repetitive function of the patient's use of the story, which allows the patient to avoid having to explore his own role in the scene he describes. In this ordinary material, Feldman finds meaningful communications about the way the patient might influence his own way of thinking and responding. The impact this has on the analyst and the analyst's ensuing response can then become a way for the patient to defend against more severe anxieties.

Different versions of the patient's objects are presented in the stories that patients tell, and these object representations serve different functions for patients at different moments in the analysis. Among the many versions of an object that is perhaps most threatening is one in which the analyst is capable of thinking for him- or herself, has a separate mind, and is capable of enjoying independent thoughts and responses. (This formulation hearkens back to Feldman's ideas about the Oedipus complex as well; he repeatedly shows that the analyst/parental figure's capacity for creative thought—either alone or in a couple—is experienced by the patient as exclusionary.)

Different versions of the object entail a splitting off of the object's dangerous dimension, and this involves—as both Klein and Freud believed—a corresponding splitting of the ego as well. Feldman recalls a clinical moment between Klein and her 10-year-old patient Richard that occurred during war time. Richard was saddened when he thought that the envelope that held his paintings might have been destroyed, and he asked Klein whether it had; she responded reassuringly, saying it was salvaged. In the next moment, Richard spotted a curly-haired girl outside, walking on the street, and said that she looked like a monster in his

book. Klein's notes tell us she was aware in answering Richard's question that she had given him a direct reassurance. Her doing so had to do with her countertransferential concern for her patient, whose father was very ill and who was worried about the prospect of ending his analysis.

Feldman demonstrates the impact on the patient of this direct form of reassurance. When "Mrs. Klein" told her patient that the paintings were saved, Richard at first told her she was "patriotic"—indicating that she was, in Feldman's words, "a very good object" (p. 61). Next, however, Richard pointed to the curly-haired girl whom he thought resembled a monster. Thus, the good, patriotic Mrs. Klein and the monstrous Mrs. Klein were split. Klein tells us that: "We find that mistakes of this kind are unconsciously resented and criticized, and this is true in spite of patients' longing to be loved and reassured" (Klein quoted by Feldman, p. 62).

What Feldman believes would actually have reassured Richard would have been the presence of an analyst who "was able to bear the patient's and her own anxiety and pain without trying to give an apparent reassurance" (p. 62). Instead, what ensued was that

> Richard felt confronted with not only a version of his analyst as good and kind, but also the doubtful or "monstrous" version of her as someone who could damage or destroy what was precious to him and was unable to face this with him . . . . The situation was quickly dealt with by projection of the "monstrous" analyst on[to] the girl passing outside. [p. 62]

Feldman then indicates that the analyst, in responding to various pressures from the patient, may be disinclined to tolerate a version of the analyst that is projected by the patient. The analyst tends to enact, the author believes, in response to the discomfort or anxiety induced in him or her by the patient's particular phantasy. Responding in a way that diminishes the anxiety and discomfort may provide reassurance not only to the patient, but to the analyst as well. An unfortunate fit between the patient's and the analyst's unconscious defenses and needs can militate against real analytic progress.

But when analysts are able to tolerate states of uncertainty and doubt (as the book's title suggests), they are in a better position to be able

to recognize and think about the nature of the relationship with the patient, and in this sense offer something that is actually reassuring. A diminished need for splitting results when the patient senses that the analyst is capable of tolerating and responding to the patient's needs and projections. In other words, what is comforting to the patient is the analyst's capacity to think and to understand, even in the face of the patient's pressures for both parties to do otherwise.

In "The Illumination of History," Feldman shows how the history unfolds between analyst and patient in the hours and is present in the transference-countertransference relationship. This time adding Viderman, Laplanche, and Kris to his acknowledged influences, Feldman argues that a significant shift takes place in analysis when what was once a treatment giving primacy to direct genetic reconstruction becomes one whose primary work is "the strengthening of the ego—leading to further integration, which in turn may give the patient greater access to and a fuller understanding of his history" (p. 78).

For Feldman (here following Joseph), what is crucial for psychic change is the analysis of direct, immediate transactions between analyst and patient in the present. Though links with the past can be enriching for both patient and analyst, providing as they do a sense of greater meaning and continuity for both parties, the patient's "understanding" or "insight" can be used defensively to protect against the analyst's involvement. What we think of as historical objects are in fact internal objects, the author notes, and these can be most fully understood in the present through the ways in which they are experienced and lived out. As Feldman expressed it in another recent work:

> It is in the detailed exploration and interpretation of the way the patient's anxieties, needs, and defences express themselves in the moment-to-moment interactions that some modification of internal forces maintaining pathological structures and relationships can take place. The analyst's understanding, and his capacity to make links, can modify the force and the nature of the patient's use of projective identification. [p. 616][2]

[2] Feldman, M. (2007). The illumination of history. *Int. J. Psychoanal.*, 88:609-625.

The analysis of this minute-by-minute interaction in the present is, in Feldman's view, what allows for psychic change.

The central terms of the book's title—*doubt* and *conviction*—signify states of mind familiar to both analyst and patient in the midst of an analysis. In the chapter entitled "Filled with Doubt," Feldman describes the kind of doubt one feels in response to questions about one's objects. The chapter begins with the tale of Hansel and Gretel, who, abandoned by their parents, come upon an old woman who speaks kindly to them and offers them nourishment. After this initial encounter with her apparent goodness, they come to find that she is in fact a witch who is going to eat them. Their initial impression of an object (the witch as a good, generous figure) turns out to be flatly wrong. The author uses this reference as a backdrop to describe two types of experiences. In the first, one knows the object is posturing as good when s/he is really bad. In the other, the object is irreducibly ambiguous, and the child or patient cannot tell what sort s/he is dealing with.

Feldman explores these dynamics as they emerge in patients who have profound doubts about the nature of their objects. He states that, to a greater or lesser degree, such patients manage to provoke doubt in the analyst's mind. This then renders the patient free of doubt, but instead possessed of a kind of manic confidence, while the analyst is left with considerable doubts about his or her own understanding and sense of the value of what the analyst can offer the patient, as well as about the nature of the analyst's own motives (p. 217).

Via the clinical account of a young woman patient with an eating disorder, Feldman describes one use of doubt: his patient made everything she described vague and ambiguous as a defense against difference. This defense against difference protects against envy of the analyst's separate capacities. Feldman distinguishes between "ordinary" doubt—the doubt that we are all familiar with—and a more incapacitating (more defensive) state of being "filled with doubt"—doubt as a means of blurring difference.

The other side of doubt is *conviction*. Feldman explores conviction through a return to Bion's notion of a *selected fact*. As Feldman interprets it, this term refers to a process of arriving at an interpretation via intu-

ition, more than from deduction or theorization. Feldman states, "What emerges [from the selected fact] has the quality of a correct interpretation, accompanied by a sense of conviction in the analyst" (p. 237).

It is this feeling of conviction that Feldman examines in this chapter. He suggests that analysts strive for a balance between a state of openness to new meanings and new ways of understanding (even some doubt), on the one hand, and a state of being overinvested in one's own ideas and formulations, on the other. Citing Steiner and Britton (1994)—who point out that, "once uttered, the interpretation loses some of its conviction, and thus the experience of doubt, guilt, and other feelings associated with the depressive position are an inevitable part of the experience" (p. 238)—Feldman emphasizes that it is useful to recognize when interpretations are "overvalued" (i.e., have too much of a sense of conviction) because this investment can interfere with the evolution of the analytic process.

Certainty is different from conviction. Feldman cautions against certainty. He describes it as a state of mind in which the analyst already knows how to view the patient and is thus free from the disquieting experience of doubt. Doubt is an inevitable, if uncomfortable, part of the analytic endeavor for both patient and analyst. Citing Heraclitus, who noted that "no man ever steps in the same river twice, for it's not the same river and he's not the same man" (p. 233), Feldman vividly depicts the strain of the unknown that is part of every analytic hour, and the pressures brought to bear on the analyst either to collapse into doubt or to avoid it through too much analytic certainty and conviction. The problem of remaining open to the unknown, both in oneself and in one's patients, constitutes an aspect of psychoanalytic work that Feldman courageously confronts.

*Doubt, Conviction, and the Analytic Process* conveys a unique understanding of the problems that arise for all of us in our psychoanalytic work. It is a book of enormous breadth, strength, and value. About this I have no doubt. I also do not doubt that accounts of work such as Feldman describes go a long way toward dispelling the long-standing bias against Kleinian theory and technique and the many erroneous assumptions that surround them. Because of his such carefully detailed work, we have at our disposal the means to think carefully and openly about the

Kleinian tradition and the work of the contemporary Kleinians. Feldman expands the vocabulary we might use to speak about patients and our own experience with them. This is a lasting contribution.

**LYNNE ZEAVIN (NEW YORK)**

SPONTANEITY: A PSYCHOANALYTIC INQUIRY. By Gemma Corradi Fiumara. London/New York: Routledge, 2009. 149 pp.

Gemma Corradi Fiumara is an Italian training analyst and a retired professor of philosophy at the Third University of Rome. Her previous books have offered psychoanalysts profound reflections about essential theoretical aspects of psychoanalysis: *The Symbolic Function, The Other Side of Language, The Metaphoric Process,* and *The Mind's Affective Life.* Her new book, *Spontaneity: A Psychoanalytic Inquiry,* builds on the accumulated insights of her previous contributions.

Psychoanalysts have focused on *technical* issues of spontaneity in their practice: ritual, restraint, improvisation, self-disclosure in relation to spontaneity. Self-disclosure frequently arises not from technical considerations, but from a momentary impulse on the part of the analyst to convey something to the analysand during a session. The focus is on the *analyst's* mode of functioning.

Corradi Fiumara returns to the etymological origin of the term, the Latin expression *sua sponte,* which means "of one's free will, of one's own accord" (p. 5). This spontaneity can only arise from the core of human experience and poses critical questions of agency, particularly subjective agency, in all our psychic activities. The focus in this conception of spontaneity is on assisting the *analysand* to increase the capacity to be the agent of his psychic functioning. Yet the author recognizes how elusive spontaneity is as a concept.

> For, in fact, we cannot ask the question "What is spontaneity?" It only exists as a worthy concern if we are interested in the quest and question of spontaneous actions. And although it cannot be approached as a topic of empirical research, once our attention, or insight, has captured its psychic intensity, it will ultimately enhance the quality of clinical observation. [p. 1]

Thus, the author is not interested in the narrow issue of the *analyst*'s technical spontaneity, but in the foundational spontaneity that is the source of psychic life in all of us—that *sua sponte* of the will to be and to act.

Corradi Fiumara confronts us with her relentless inquiry about the active participation of the subject in responding to the pleasures, demands, and injuries that life brings to all humans. Her questions cannot be dismissed: they go to the essence of our work as interpreters of the analysand's experience of life and of his own self. These questions are profoundly original and originally profound.

Psychoanalytic literature on self-formation and pathogenesis focuses on external *causes,* while neglecting "inner sources of early mental growth" (p. 2). In this outlook, the quality of early caretaking and object relations *determines* mental development. This view ignores the potential of early subjective agency in the formation of personal experience and of the self. Corradi Fiumara opts for a more balanced approach: "We try to integrate this unduly deterministic scenario through exploration of spontaneity, agency, intentionality—that 'easily bruised creativity'—which we do not regard as an exclusive adult function" (p. 3).

The author alerts us to the risks of reducing motives to causes, and illustrates this with Freud's tendency to use the phrase *nothing but,* as when he says, "parental love, which is so moving and at bottom so childish, is nothing but the parent's narcissism born again"[1] (Freud quoted in Corradi Fiumara, p. 6). As analysts, we need motives because "if behaviour and pathology were so heavily determined, it would not even make sense to speak of strategizing therapies, options, efforts, or aspirations" (p. 7). Our theorizing cannot ignore determinism, but also cannot be limited to it. We must make room for an understanding of human experience as simultaneously both free and determined. This conclusion seems implicit in what the author calls psychoanalysis's *paradoxical perspective:* "The inchoate self is regarded as something at the mercy of external caretakers, while at the same time it should aspire to the subjectivity and agentiveness of parental figures" (p. 10).

Corradi Fiumara's book explores the implications of attending to the individual's agency and the emergent spontaneity of this agency in

[1] Freud, S. (1914). On narcissism. *S. E.,* 14, p. 91.

the process of internalization, in the psychic function of paradox, and in the dynamic need for forgiveness, responsibility, and empathy. She ends her book with a creative idea: we have a need for *self-decreation* in order to remain alive as a self.

The author uses the term *internalization* "to refer to the essential *activity* of assimilating and metabolizing experiences for the sake of self-formation and psychic survival" (p. 11, italics added). Internalization is not an easy task and requires laborious processes on the part of the agent of internalization. It also implies "recognition of the active propensity of the early ego" (p. 11), as implied by Klein's understanding of early objects and the manner in which they are dealt with by the infant—how they are attacked and transformed into persecutory internal objects. Corradi Fiumara observes that "whereas some analysts claim that frustrating outer figures are avoided as not being sufficiently good, or even bad, Klein emphasizes the way in which the infant may actually manage to *make* them bad" (p. 11, italics in original).

Freud, too, must have assumed the active participation of the individual when he concluded that it is not actual events that are internalized, but the personal experience of them. It is regrettable that we neglect this active component of internalization; as Corradi Fiumara notes, "without the idea of some creativity in the process of internalization, we would be left with an abstract, pro forma exchange of positions" (p. 12). Without understanding fantasy as a "real psychological activity" (p. 12) of the affective life, we might again reduce internalization to a mechanical process. What counts is not only the experience that confronts the child, but also the manner in which the child actively responds to it, and how the child uses it for self-formation. Shouldn't we consider that the child, following an obscure but real quest for identity, might use some judgment in his selection of internalizations in the service of self-formation?

Corradi Fiumara considers two modes of internalization: "one that seems a natural mechanism, and one that consists of an elaborate process" (p. 14). When the object is taken in passively as a natural internalization, it cannot remain neutral: it either enhances or inhibits the personality. To the experiencing subject, they *are* what they *feel like*. The active elaboration of internalization re-creates the object in a certain

manner that does not require blind identification. This distinction points to the difference between psychic health and pathology. In health, we master well enough our internal objects and processes; in illness, we feel mastered by them.

From this distinction, Corradi Fiumara extracts some critical dynamic dimensions of projection and its connection to our hatred. We hate the submissive action we carry out ourselves, and then we project the hatred. She concludes: "True liberation would require that we realize that the enslaving principle is the inner submissive act" (p. 15). The continuous risk of psychic life is to submit to internal objects as though we have no part in keeping them alive or in surrendering to them. The next problem is our hostility toward the very objects that we keep psychically alive and our capacity to project them onto others. Corradi Fiumara gives no technical recommendations here, but her insight is precious: we torture ourselves with great suffering on account of our failure to own that we sustain our internal objects and our submission to them, because we fail to reach our potential for agency and spontaneity—*sua sponte*—in relation to them.

Paradox is essential for analytic work. Freud understood that transference love is real and unreal at the same time. He did not say that this was a paradox. Yet such a love and the real unreality of the entire analytic enterprise make analysis possible: "This paradoxical setting is what allows the work of analysis to take place" (p. 28), according to Corradi Fiumara. The elaboration of mentalization may call for the creation of "endurable, paradoxical inner structures that can coexist in our mind" (p. 25). "The process may ultimately propose a reverse itinerary: from conflict to paradox, from reactions to actions" (p. 25), and a replacement of "nothing but" and "either/or" with "both/and"—the domain of paradox. Yet the active process of accepting paradox may be deeply painful; we must recognize that there is a limit to paradox when severe trauma makes it impossible to tolerate and leads the subject to "the default mechanism of fragmentation" (p. 26).

Winnicott's seminal work indicated that paradox is essential, in particular at the beginning of life, in order to develop subjective agency and spontaneity. Corradi Fiumara's "basic hypothesis is that while conflict induces psychic reactions (rather than actions), tolerated paradox is

the condition for proper actions" (p. 29). The challenge to psychic and psychoanalytic work consists in using the mind's integrating capabilities in the service of the bridging process: "conflicts and hiatuses can be surmounted not so much because the self becomes ideally unified, but because being divided comes to be tolerated" (p. 31). Paradox enforces the need to negotiate and elaborate, but it does not guarantee unity. In the author's view, the active task of the subject is to find a way of living with paradox whenever possible. Certainty and absolute self unity are ideals that must give way to the capacity to live with one's own paradoxes.

In Corradi Fiumara's view, psychoanalysis assumes the existence of subjective agency, but does not theorize about it. To confirm this point, I reviewed the best-known dictionaries of psychoanalysis in English and French, as well as the index of Freud's *Standard Edition*, and found no entry for *agent*—only for *structural agencies*. Yet Freud wrote: "The ego has to be developed. The auto-erotic instincts, however, are there from the very first; so there must be something added to auto-erotism—*a new psychical action*—in order to bring about narcissism" (italics added[2]). He did not elaborate on the agent of that action.

Corradi Fiumara's use of *agency*, I believe, refers to the agency in the individual who is capable of such transformative psychic effect. For her, "personal action is the metabolic act of a principle of integration, whereas impersonal behavior is ultimately a sequence of reactions" (p. 34). Without this concept, psychoanalytic theory is not coherent with itself.

Passivity as a psychic attitude leads to the search for another who is capable of acting on behalf of the inactive subject, who disclaims his own activities. The end result is the avoidance of spontaneity, freedom, and ownership of one's own experiences. A psychoanalytic approach committed to the enhancement of initiative on the analysand's part can be compared to midwifery, the process of "helping the healthier part of the self to spring to life, to become real and living, notwithstanding reluctances and difficulties" (p. 42). Psychoanalysis may thus be seen as "a profession *and* a way of being alive" (p. 47, italics in original) for the practicing analyst. Such a conception creates tension in relation to the

[2] Freud, S. (1914). On narcissism: an introduction. *S. E.,* 14, p. 77.

need to ground analysis in theoretical principles that do not include the function of subjective action. In Corradi Fiumara's view, finding one's personal idiom and making life "a continuing act of self-discovery and self-creation" is what it makes life worth living. This is the active life of a living self.

Chapter 5 of *Spontaneity: A Psychoanalytic Inquiry* presents a masterful examination of the dynamics of *entitlement,* the exact "contrary of spontaneity" (p. 54). Entitlement is the "view of oneself [as] having been forced into a hopeless psychic state *together* with the demand for total healing" (p. 56), and the use of this conception "to *causally explain* the inexorable destruction of any personal agency" (p. 57, italics in original).

Kohut's view of psychopathology locates all causality in empathic parental failure, without allowing the existence of inner resources in the child; his therapeutic approach calls for compensatory empathic attunement. Yet many narcissistic analysands are intent on defeating the help offered to them and on becoming the tyrant of those who try to aid them. The way out of this conundrum can be very difficult because narcissistic problems are insidious. Perhaps the key, among other issues, is the patient's fear of losing control, "the dread that he may lose control of everything" (p. 64). The narcissist cannot allow separateness. Yet, in Corradi Fiumara's understanding, "the patient might allow himself to be 'conquered'—that is, [to] lose the battles he provokes—in order to win his soul" (p. 64). I read this to mean that the patient can accept some otherness, some knowledge that he is not totally in charge, and that he accepts that the analyst is there to assist him to actively live with himself and his past injuries.

In the chapter about actions and reactions, Corradi Fiumara asserts: "The kind of question about which most of us are in constant trouble is our understanding of the nature of our actions and reactions and of the reactions/actions of those around us" (p. 70). Reactions can be considered in causal terms. Actions, on the other hand, call for an agent intent on the achievement of goals, of desires. The human being who acts to achieve goals and fulfill desires calls upon cognition and affects simultaneously, to the point that Corradi Fiumara proposes that "affects are cognitive and cognition is affectual" (p. 71). The transformation that

the therapeutic process can bring about is achieved through our effort to become active "managers of our deep energies" (p. 73) and of our pain: "common causes of suffering [can be transformed] into motives for psychic growth; one can then use frustrating experiences to develop ego strength and capacities for paradox" (p. 73).

As already noted, Corradi Fiumara does not discuss technique. My reading leads me to believe that, if her ideas are implemented, we must take a second look at our technical approach in order to allow the patient the psychic freedom that his psychic activity calls for. Our technique may also need to incorporate a different way of communicating with and interpreting to the patient.

Forgiveness involves relationships between individuals. To forgive is a creative act that responds to suffering or insult, beyond reacting: "Forgiveness enables revolt, by enhancing a transfer of affects and drives into a more articulate signification" (p. 79).

> In fact, if one can be so personally agentive as to arrive at the level of forgiveness, then one can also be sufficiently active to freely make a promise. The genius of forgiveness is expressed in a double action of unbinding: the pardoning individual disengages himself from the enduring results of offense, and by pardoning the other he disengages the offender from his own action. [p. 80]

In Corradi Fiumara's understanding, "the absence of forgiveness translates into continued hatred of inner and outer objects" (p. 81). The hatred consumes its owner and deprives him of the possibility of freedom and spontaneity. Analysis contributes to the transformation of this hatred through the mediation of the transference: "The analysand projects his inner oppressors onto the analyst, and at the same time actively absorbs an experience of acceptance that enables him to 'forgive' his internalized oppressive objects" (p. 80). I read this to mean that psychoanalysis is built on the analyst's capacity to accept and "forgive" the persistent insults and accusations of the analysand. That forgiveness, as I understand it, opens the analysand's mental space for self-observation, inhibition of reactions, and psychic actions that reevaluate his inner world and the transferential relationship.

Developmentally, Corradi Fiumara attends to the implication of forgiveness for the oedipal passage. An atmosphere of forgiveness is a condition for successful emergence from the oedipal situation. Its absence leads to a fear of harm and a sense of being scared of what might happen. "The thesis here is that it is not the fear of castration that is the ultimate propeller of the oedipal passage, but rather the possible experience of forgiveness" (p. 82). This is truly an original idea and one worth exploring. Culturally, the absence of forgiveness creates an atmosphere of the perpetuation of hatred, subjection, and shame.

"Responsibility is essential for personhood and . . . is the critical element for healing and creativity" (p. 85), the author notes. The key responsibility to be assumed is that which leads to *freedom-to,* not only *freedom-from.* Freedom arises from having acquired insight about the fact that the analysand is the agent who initiates his own actions and is capable of assuming psychic responsibility for them. Corradi Fiumara illustrates this point by comparing the Oedipus myth with that of Orestes. The two myths contrast with each other in the area of what concerns responsibility. "In fact, in neither the Oedipus myth nor in its psychological Freudian rendition is there a mention of the critical value of owning up, admission, acknowledgement" (p. 90), according to the author. Orestes has killed his adulterous and murderous mother, and when brought to justice assumes responsibility for his crime. Apollo defends him and says that "he must be acquitted because he has assumed responsibility for the crime he has committed" (p. 90). Thus, the *Oresteia* opens broader panoramas beyond oedipal secrecy; it involves admission of a crime in the open forum of a community that has the right to judge human crimes, even internal family crimes. Therefore, "the act of assuming responsibility, of recognizing subjective agency, and the community attitude of forgiveness appear [to be] the key to maturation and development" (pp. 90-91).

Corradi Fiumara's chapter on empathy and sympathy deals masterfully with the distinction between the two. Sympathy is cost free: it comes to us from our very nature. Empathy, by contrast, requires psychic work on the part of the person who is intent in knowing the other as another. The first labor is to make contact with oneself, in order to be able to reach the inner sources of empathy for the other. Empathy also calls for

"cognitive, inferential, and synthetic capacities; it is in fact relatively neutral and nonjudgemental" (p. 102). It accepts otherness and difference and makes every effort to understand the other, even at levels where the other does not understand himself. Empathy is a conscious, spontaneous activity that opens the empathizer to transformative contact with the strangeness of the other. Such an effort to understand the other in his otherness makes empathy "the ultimate expression of communication between creatures" (p. 106). Metaphor serves empathy: "We could think of human metaphoricity as the capacity to make connections and thus empathize with something that was previously regarded as alien or nonexistent" (p. 110), Corradi Fiumara observes.

The final chapter of *Spontaneity: A Psychoanalytic Inquiry* explores the processes of self-formation and self-decreation. The author states:

> We could say that we are constantly intent on the task of self-formation and self-preservation, whereas the cultivation of spontaneity often seems to require self-decreation. Without this attitude of unconditional consent to otherness and time, all forms of "heroism" or psychic marvels are still subject to the mechanisms of repetition and narcissistic falsification. [p. 113]

This task is particularly difficult because we need to reshape or discard "something that has been quite useful for psychic survival" (p. 113). It is a process that we can actively, spontaneously enforce on ourselves in the service of maintaining our aliveness, and "for the sake of a more intense inner life" (p. 115). Finally, to live as fully as possible, we must accept our finitude: "The labour of spontaneity does not tread well-worn psychic paths; it develops, instead, through an inner attitude springing from the knowing acceptance of our interlocking experiences of death and birth" (p. 118).

We need to accept our frailty and the disruption brought about by crises that affect "our 'wonderful' established selves" (p. 120). These crises confront us with our limited power and contribute to acceptance of our vulnerability, in counterpoint to our inclination for "illusory power" (p. 120).

I highly recommend this book to all practicing analysts. It offers neither prescriptions nor proscriptions; instead, it provides a consistent and

much-needed analytic reflection about our active participation in all aspects of our own psychic life in health and pathology. It softly calls for a new manner of looking at our patients and our theories in regard to causality and determinism, in contrast to the ever-present psychic potential for creative and spontaneous psychic action.

This book is beautifully written in a style endowed with a subtle but persistent Socratic irony. It is a pleasure to read.

**ANA-MARÍA RIZZUTO (CAMBRIDGE, MA)**

THE ANALYTIC FIELD: A CLINICAL CONCEPT. Edited by Antonino Ferro and Roberto Basile. London: Karnac Books, 2009. 223 pp.

Psychoanalytic concepts of an analytic field have been written about and used clinically for half a century. Yet until recently, outside the Spanish- and Italian-speaking psychoanalytic communities, analytic field concepts have been relatively little known and understood. Fortunately, in the last decade, more of the previous and contemporary work on the subject has been translated into other languages. In particular, *The Analytic Field: A Clinical Concept* brings to English-speaking analysts a rich collection of papers on the subject.

The concept of the analytic *field* as it is understood and used in this collection of essays is not to be confused with the *fields* of relational psychoanalysis. While the two field concepts overlap on some points, each leads to and is embedded in specific ways of working clinically that are distinct from each other as well as from other psychoanalytic perspectives. The concept of the analytic field was introduced by Madeleine and Willy Baranger, in print first in a paper published in 1960–1961 in Spanish, and not translated into English, for example, until 2008.[1] The Barangers' work was influenced by the Gestalt theory of Kurt Lewin, Maurice Merleau-Ponty, and Enrique Pichon-Rivière; it was steeped in Racker's work on countertransference and based on Kleinian and espe-

[1] Baranger, M. & Baranger, W. (2008). The analytic situation as a dynamic field. *Int. J. Psychoanal.,* 89:795-826.

cially Bionian thought. Out of these strands, the Barangers developed a vibrant structure with which to describe and guide clinical work.[2]

For *The Analytic Field: A Clinical Concept,* Ferro and Basile have edited a collection of contemporary essays, each of which pushes the frontiers of the possibilities of working with this concept. Contributions represent the work of analysts in Argentina, Belgium, Brazil, Italy, Spain, and the United States. The contributors to the collection are the two editors (the introduction and chapter 1, on basic concepts of fields and on the characters and presences that populate them), Claudio Laks Eizirik (chapter 2 on therapeutic action), Claudio Neri (chapter 3 on an expanded concept of field), Luis Kancyper (chapter 4 on using fields for intergenerational work, including that with adolescents), Laura Ambrosiano and Eugenio Gaburri (chapter 5 on the temporal and transpersonal aspects of fields), Carlos Sopena (chapter 6 on the understanding of the unconscious in field work), Rudi Vermote (chapter 7 on the basic layer), Thomas Ogden (chapter 8 on the analytic third), and James Grotstein (chapter 9 on the role of fields in psychoanalytic process as drama).

Even though each is written by a different author, the essays taken together form a cohesive discussion that includes much rich, illustrative clinical material. In these times of not only psychoanalytic pluralism but also of discord within and between different perspectives, it is of interest in itself that this book conveys an overall sense of agreement, communication, and collaboration about the theoretical and clinical approach. Therefore, rather than describing each paper in turn individually, I will discuss the main themes of the book as a whole.

The central concept of the psychoanalytic structure initiated by the Barangers is the analytic field. This concept is used to describe the analytic situation as a whole. The field encompasses all aspects of the analytic situation, including the spatial, temporal, and functional. Employing this conception of an analytic field broadens the understanding of the analytic relationship and analytic process to explicitly include all these

[2] For discussions about the influences on and genesis of the field model, see: (1) De Leon de Bernardi, B. (2000). The countertransference: a Latin American view. *Int. J. Psychoanal.,* 81:331-351; and (2) Lewkowicz, S. & Flechner, S. (2005). *Truth, Reality, and the Psychoanalyst: Latin American Contributions to Psychoanalysis.* London: Int. Psychoanal. Assn.

dimensions.[3] In this way, every aspect of the analytic process—including, for example, the positioning of furniture in the consulting room—is explicitly acknowledged as having multiple meanings for the participants, and thereby as contributing meaning to the analytic process.

Thus, the structure of the field includes spatial elements, such as the consulting room and its arrangements; temporal elements, including the frequency of, spacing of, and disruptions in sessions; and functional, dynamic elements. While there are asymmetries in the field between the participants, the analyst is not considered to have the authority or control over or in the process as this is posited in some other psychoanalytic models. In this model, the analyst is not in any way self-contained, nor is he or she an observing interpreter, but instead is an active contributor to the production of the basic fantasy of the field. Thus, the analyst is also an immediate part of the object of psychoanalytic study within the psychoanalytic process.

The individuals participating in the analytic process are considered derivative of the field, as are their unconscious processes. The field itself is posited to contain an unconscious dynamic, which is more than and different from the sum of the unconscious dynamics of each participant. In this model, the unconscious of the field and the concomitant fantasies, called *basic fantasies,* are the immediate objects of interest in the analytic process. The contents of the discourse, including the analysand's associations, are understood to indicate aspects of the field. The analytic object of interest is neither the analysand nor the two-person interaction taking place, but the field itself. Projective identification and projective counteridentification are salient processes in the field; these also arise out of the field. Similarly, transference and countertransference are viewed as arising out of the basic fantasy of the field.[4]

Impasses and stagnation within analytic processes are described in terms of this structure and are called *bastions.* These are understood as blockages in the field, about which there is unconscious collusion by

[3] See Ferro, A. (2005). Commentary. In *Truth, Reality, and the Psychoanalyst: Latin American Contributions,* ed. S. Lewkowicz & S. Flechner. London: Int. Psychoanal. Assn., pp. 87-96.

[4] See Baranger, M. (1993). The mind of the analyst: from listening to interpretation. *Int. J. Psychoanal.,* 74:15-24.

both parties to remain blind. The analyst's sense of the presence of such an obstacle in the field gives rise to what the Barangers call *taking a second look* at the field as a whole. Thus, the central concepts of this approach, overall, are: *analytic field, basic fantasy, bastion,* and *second look.*

The quality of the analytic field is described as oneiric and as a dream membrane. The field is conceived as atemporal in important ways, and as embodying a virtual reality. The fantasies of the field arise within it and are not simply imports from either participant. Similarly, the characters and presences who inhabit the field are the results of and take shape in the fantasies of the field, and are thus neither solely from the past nor solely from the present of either analysand or analyst. The field and its fantasies are novel creations that could not have arisen or been constructed in any other circumstance. This means that, of necessity, there will be different fields associated with different analytic couples, and consequently different analytic processes. Every analysand would have a different therapeutic experience with a different analyst.

The intrapsychic is considered to be derivative of the intersubjective. That is, the individual participants are understood as emerging from the field, rather than as components of it. Through observation and understanding of the basic fantasy, the intrapsychic functioning of the analysand can be revealed; the intrapsychic is viewed as a precipitate of the basic fantasy of the field. Working within this model clinically entails actively pursuing the psychoanalytic conception that the analysand's communications always convey multiple meanings, and the salient meanings are those pertaining to the field and its basic fantasy.

Abundant clinical examples in *The Analytic Field: A Clinical Concept* vividly portray, within sessions, the analyst's process of pursuing this way of listening, understanding, and interacting with the analysand. It should be noted that this way of working, in which both participants are considered to be highly interactive, does not entail disclosure from the analyst.

Given the posited nature of the field as unique and new, repetition as such is not considered to occur within it. That is, if the basic fantasy, created by the analytic couple, is atemporal and novel, then what occurs in and arises out of the field cannot be understood in this model as simply a repetition of the analysand's unconscious dynamics. Therapeutic change occurs by means of the working through of what is pre-

sented in the field. The atemporal basic fantasy, then, gives rise to the potential for a recontextualization of the analysand's intrasubjective understanding of experience.

The notion of the unconscious that has developed in this model is a departure from the classical psychoanalytic understanding of this concept, as well as from the unconscious as viewed in other analytic schools of thought. The central unconscious is that of the field, and thus is not tied to an individual person. The unconscious processes of the two individuals involved in the analytic process derive from the unconscious of the field. From this conception of the unconscious in the field model, the potential for genuine creativity and novelty follows.

By contrast, in other models, accounting for creativity and novelty is problematic, and is taken more on faith rather than following directly from principles or concepts. That is, if the main action in analytic process is seen as, for example, individual and transferential, together with the understanding of these, then there is no clear route to genuinely new meaning. Rather, individuals are modeled as undergoing experiences on the basis of transference and fantasy, both of which ultimately derive from previous experience and meaning.

If, however, an unconscious process is part of the field that creates and is created by the unconscious processes of the analytic couple, then the potential for the creation of new meanings—for the analysand, in particular—directly follows. When creativity and novelty are present, the potential for therapeutic change emerges as a consequence. When the conception of the unconscious employed in this model is utilized, longstanding problems for other psychoanalytic perspectives, those of conceptually explaining creativity and change, are dissolved.

Another interesting and vital subject alluded to at several points, but not taken up directly in the book, is the relationship of the field model to other psychoanalytic perspectives. The similarities and differences amongst various perspectives, including the field model, is an important area for further discussion. Areas where there are similarities—in particular, where the field model uses different terms to describe accepted concepts in other perspectives—would be of interest for all parties, in order for analysts to learn and appreciate another way of looking at familiar ideas and practices. Identifying fundamental differences among

approaches is also clearly of interest in facilitating the ability to evaluate the relative strengths of each perspective.

This book is stimulating—and, this reviewer would say, essential—reading for every psychoanalyst. In it a specific way of working clinically, as well as a specific theoretical understanding, is portrayed in clear and engaging prose. It is not only the well-chosen and highly illustrative clinical examples that give the reader a firm grasp of the subject matter, but also the open and clear manner in which the theoretical discussions are presented. Whatever one's own psychoanalytic perspective, engaging with the concepts articulated in *The Analytic Field: A Clinical Concept* is a worthwhile endeavor.

**MONTANA KATZ (NEW YORK)**

FREUDS' WAR. By Helen Fry. Stroud, Gloucestershire, UK: The History Press, 2009. 223 pp.

Helen Fry, a research fellow in the Department of Hebrew and Jewish Studies at University College, London, has written a moving volume of Freudiana that captures the war exploits of one line and two members of the Freud family. Using hitherto unpublished material, she describes the heroic World War I experiences of Jean Martin Freud (Freud's oldest son, known as Martin) and the equally heroic experiences of Martin's son Anton Walter (known as Walter) in World War II. Along the way, she offers an intimate picture of the Freud family at war and in peace time, their escape from the Nazis, and a detailed genealogy, as well as many previously unpublished pictures. Thus, for fans of Freud, this book is a revealing and delightful treat.

In a 1988 unpublished manuscript, "An Austrian Grandfather," Walter Freud wrote fondly of his grandparents, and alluded to the later collapse of his own parents' marriage:

> The first star of that court was without doubt grandmother. Not only was she the first, but she was also the catalyst who made the whole court function . . . . . Detractors of Grandfather, unable to attack him on scientific grounds, have imputed sexual malpractices such as cessation of intercourse and a switch of affection from his wife to his sister-in-law. These stories were either

> malicious inventions or repeated by those who did not have the privilege of knowing my grandparents. According to my personal experience, and my own parents have unfortunately given me plenty of opportunity to recognize an unhappy marriage, my paternal grandparents were a particularly devoted couple . . . . Grandfather's whole demeanor toward his wife showed his affection. [pp. 20-21]

Martin's marriage to Esti Drucker, who was described as "too pretty" for the Freud family, ended sadly and with hostility. Walter stayed in Europe with his father after the escape from the Germans, and his younger sister Miriam Sophie (called Sophie) came to the United States with Esti, her mother, after their own narrow escapes. Sophie Freud wrote movingly about her experiences in two books, one of which includes an autobiography of Esti Freud.[1]

Fry draws heavily on the above-mentioned works and on a biography of Sigmund by Martin,[2] as well as on a published autobiographical novel of Martin's about his World War 1 experiences.[3] The latter vividly describes the horrors of war and Martin's narrow escapes. Needless to say, each book tells a different story, with some painting a less idealized picture of the Freud family than the above quotation of Walter's.

Fry records some interesting views of the Freud family during the inter-war years, when Martin left the business world to become manager of the Verlag psychoanalytic publishing house. A chapter on the final years in Vienna again raises the question of why Freud waited so long to leave when many earlier opportunities were presented, particularly by Marie Bonaparte.

Martin Freud fought valiantly with the Austrian field artillery as an officer on both the Russian and Italian fronts. He was wounded and decorated. Following a major defeat of the Austrian forces at the hands of the Italian army in October 1918, the war was soon to end, and Martin

[1] See (1) Freud, S. (2007). *Living in the Shadow of the Freud Family*. Westport, CT: Praeger (which includes an autobiography of Esti Freud); and (2) Freud, S. (1988). *My Three Mothers and Other Passions*. New York: New York Univ. Press.

[2] Freud, J. M. (1958). *Sigmund Freud: Man and Father*. New York: Vanguard Press.

[3] Freud, J. M. (1939). *Parole d'Honneur*. London: Victor Gollancz.

became a prisoner of war until 1919. He described the retreat of the Austrian forces in his novel as follows.

> It was a desolate sight. The two howitzers were standing alone on the embankment, their barrels pointing upward, each of them in a pool of blood, as though they were living creatures. It wasn't the blood of howitzers, but that of my best men. [M. Freud quoted by Fry, p. 48]

As an "enemy alien" in England, Martin again served in the military, this time in the Pioneer Corp of the British forces.

Walter Freud's World War II experiences sound like a war movie: his heroism and adventures were extraordinary. After serving in the Pioneer Corp, he was posted as a British officer to a special training school to prepare for his eventual drop behind enemy lines, close to the end of the war. After training, he was parachuted back to Austria with instructions to secure an airfield. Although the drop occurred in the wrong place, by sheer bravado and cunning, Walter was able to succeed and captured the airfield. Following the end of the war, he remained in the army, and with his knowledge of German he was assigned to interview war criminals.

Fry's excellent use of archives from the Freud Museum and the Imperial War Museum, and her careful selection from both published and unpublished writings of Martin and Walter Freud—in addition to her enthusiasm for her subject—make *Freuds' War* a valuable contribution to the history of the Freud family, as well as a good read.

**JOSEPH REPPEN (NEW YORK)**

BETTELHEIM: LIVING AND DYING. By David James Fisher. Amsterdam/New York: Rodopi, 2008. 181 pp.

Twenty years have passed since the death of Bruno Bettelheim—who committed suicide at the age of eighty-six in Silver Spring, Maryland—and, contrary to what one might imagine, there have been only three previous major biographies of this controversial figure in American psy-

choanalysis.[1] David James Fisher—a scholar and staunch defender of Bettelheim who was also his friend—pens his collection of essays with words to this effect. Himself a psychoanalyst, Fisher has previously published a biography of Romain Rolland[2] and another psychoanalytic text.[3]

*Bettelheim: Living and Dying* is organized into five sections and twelve chapters. It begins with biographical information and an assessment of Bettelheim's overall impact on culture, education, and psychotherapy. Born in Vienna in 1903, Bettelheim published seventeen books over the course of his lifetime, as well as a large number of scientific and popular articles, prefaces, and book reviews. He had an encyclopedic knowledge of psychology and demonstrated an impressive ability to write cogently about a broad spectrum of topics. He is perhaps best known for an international bestseller on child rearing.[4]

Bettelheim came into contact with psychoanalysis in Vienna during the 1920s and '30s. He was in analysis for eleven months with Richard Sterba, but this analysis (a personal one, not a training analysis) was interrupted by the rise of Nazism. Bettelheim made an interesting comment on his analysis with respect to the analytic training of the time: "During the therapeutic analysis, one was not supposed to read psychoanalytic writings. One might have read them before. In the didactic analysis, one was encouraged to read" (Bettelheim quoted by Fisher, p. 139).

Like many other analysts trained in Vienna at that time, Bettelheim shared with Sterba a high opinion of Wilhelm Reich. According to Fisher, "for Bettelheim, Reich's *Character Analysis* (1933) represented the birth of modern psychoanalytic theory and practice" (p. 157). Fish-

[1] The three previous biographies are: (1) Sutton, N. (1996). *A Life and a Legacy.* New York: Basic Books; (2) Pollak, R. (1997). *The Creation of Dr. B: A Biography of* Bruno *Bettelheim.* New York: Simon & Schuster; and (3) Raines, T. (2002). *Rising to the Light: A Portrait of Bruno Bettelheim.* New York: Alfred A. Knopf.

[2] Fisher, D. J. (2004). *Romain Rolland and the Politics of Intellectual Engagement.* New Brunswick, NJ: Transaction Publishers.

[3] Fisher, D. J. (1991). *Cultural Theory and Psychoanalytic Tradition.* New Brunswick, NJ: Transaction Publishers.

[4] Bettelheim, B. (1987). *A Good Enough Parent: A Book on Child Rearing.* New York: Alfred A. Knopf.

er's book also includes comments by Bettelheim on the impact of Anna Freud's work on the Vienna psychoanalytic community of the early and mid-1930s.

In 1938, Bettelheim was one of the last students to acquire a doctorate in philosophy at Vienna University, just before the Anschluss. Later that year, Bettelheim was interned in Nazi concentration camps, first at Dachau and then at Buchenwald. He wrote of his experiences in the camps in a book and an article.[5] In May 1939, he left Europe for the United States.

Bettelheim did not follow a traditional course of psychoanalytic training, a fact that—together with certain aspects of his character—made him unpopular with many colleagues. In a 1988 interview published at the end of Fisher's book—entitled "A Final Conversation with Bruno Bettelheim"—he speaks with candor about a number of controversial topics, such as the problem of so-called lay-analysis and his own non-institutional training in psychoanalysis. Of the latter, Fisher writes that Bettelheim's "credentials as a psychoanalyst were largely self-created. He became an analyst through a process of self-authorization" (p. 4).

Fisher quotes Bettelheim's opinion about the heart of psychoanalysis: "I feel that psychoanalysis is an art and not a science. I am critical of the efforts to make it an objective science when it is an art" (p. 142). For his stated skepticism about many aspects of Freud's theories, Bettelheim was considered a kind of renegade by some members of the psychoanalytic establishment. He tended to be very critical of theoretical and abstract considerations, and perhaps—not being a trained doctor or psychoanalyst himself—he felt a certain inner satisfaction in expressing criticism of the theories proposed within mainstream psychoanalysis. In the 1950s, Bettelheim and Erich Fromm[6] were lone voices in loudly criti-

[5] See (1) Bettelheim, B. (1960). *The Informed Heart: Autonomy in a Mass Age.* Glencoe, IL: Free Press; and (2) Bettelheim, B. (1943). Individual and mass behavior in extreme situations. *J. Abnormal & Social Psychology,* 38:417-452. It has been noted that General Dwight Eisenhower distributed copies of this paper to American military officers working in occupied Germany; see Zaretsky, E. (2004). *Secrets of the Soul: A Social and Cultural History of Psychoanalysis.* New York: Alfred A. Knopf.

[6] Fromm, E. (1959). *Sigmund Freud's Mission: An Analysis of His Personality and Influence.* New York: Harper & Row.

cizing Ernest Jones's official biography of Freud.[7] Bettelheim's writings reached a large audience of intellectuals and scholars, and some of them helped perpetuate controversy.[8] He was known as a good storyteller who brought forward Freud's ideas even when he did not agree with them, and his books sold very successfully.

As director of the University of Chicago's Sonia Shenkman Orthogenic School from 1944 to 1973, Bettelheim acquired a great reputation, but also received significant criticism for what he described as his "successes" in the care of autistic children. There were even accusations that he mistreated these children.[9]

Non-academic in his style as well as in his life choices, Bettelheim preferred addressing the public at large rather than small circles of specialists, which led him to be charged with "trivialization," and even to be suspected of plagiarism.[10] Furthermore, there seems to have been a rising crescendo at the end of Bettelheim's life, as his writing style and way of behaving in public were often considered intolerant, abrasive, argumentative, and self-referential. This led some to conclude that more substantive criticisms of his writing and clinical work were essentially invented as a result of personal animosities. Fisher ends the book with accounts of attacks launched by some of his former patients and students immediately after his death, as well as reflections on his suicide.

Although indisputably supportive of him, Fisher gives a realistic representation of Bruno Bettelheim as a human being, full of contradictions and frailties—a man who found in psychoanalysis not just a profession, but his true purpose in life. As Jon Mills writes in his foreword to *Bettelheim: Living and Dying:*

> Fisher treats his subject matter with sensitivity yet brutal honesty, examining Bettelheim's paradoxical contradictions in profes-

[7] Roazen, P. (1992). The rise and the fall of Bruno Bettelheim. *Psychohistory Rev.,* 20:221-249.

[8] In particular, see: Bettelheim, B. (1982). *Freud and Man's Soul.* New York: Alfred A. Knopf.

[9] Darnton, N. (1990). "Beno Brutalheim." *Newsweek,* 10:59-60.

[10] Dundes, A. (1991). Bruno Bettelheim's uses of enchantment and abuses of scholarship. *J. Amer. Folklore Society,* 104:74-83.

> sional and personal demeanor . . . . What emerges is a holistic appraisal of a troubled genius who was at once an intellectual celebrity, maverick clinician, and traumatized depressive who had a divided self. [p. i]

It is of significance that Bettelheim's suicide—an act that, as Fisher notes, ended "the torment, the loneliness and sense of futility about his present and future" (p. 149)—occurred exactly fifty years after the Nazis' entrance into Austria on the night of March 13, 1940.

**ANDREA CASTIELLO D'ANTONIO (ROME, ITALY)**