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EDITOR'S NOTE

While this issue of *The Psychoanalytic Quarterly* marks the end of my tenure as Editor, it is also an opportunity to welcome Jay Greenberg as our new Editor-Elect. In January 2011, at the start of the *Quarterly's* 80th year, Jay will assume editorship of the oldest free-standing psychoanalytic journal in North America. Well known to most readers for his accomplishments as a psychoanalyst and writer, Jay also comes to us with considerable editorial experience, having served as the North American Editor for the *International Journal of Psychoanalysis* and as Editor-in-Chief of *Contemporary Psychoanalysis*. It is our good fortune that he will guide the *Quarterly* through the next phase of our history.

I am grateful to everyone who has worked with me these past nine years to make the *Quarterly* as strong as it is. With escalating costs and Internet competition, these are not easy times for independent journals unsupported by the financial backing of large organizations. Despite these challenges, since the beginning of 2002 we have managed to increase the size of the journal by more than 50%; introduced several new and popular features; significantly increased the number of international papers; published several special issues, including a popular supplement on therapeutic action organized by Sander Abend; published a book by Charles Brenner, *Psychoanalysis or Mind and Meaning;* and, with the help of Carol Abend, Gina Atkinson, and Tami Margolis, established a way for active individual subscribers to access recent and current issues through our own website. Much of the current strength of our financial base is due to Gina Atkinson's dedicated work as our Managing Editor. We are all in her debt.

I am also very grateful to the members of our Editorial Board and Editorial Readers. When authors tell me why they submit their work to the *Quarterly*, they speak of the attention their papers receive from reviewers, the detailed letters they receive, and the care we offer them in working with their manuscripts. This starts with the care our reviewers take in reading manuscripts and ends with the care with which Gina

copyedits, lays out, typesets, and puts to bed the final copy. As a result, we sometimes hear that the *Quarterly* is the journal our readers most look forward to receiving. For all these reasons this has been a job I have loved over these years and will greatly miss.

As I turn the journal over to Jay Greenberg, I am thankful to the entire *Quarterly* family for their contributions and wish Jay every success as our new Editor.

HENRY F. SMITH

Volume LXXIX, Number 4

THE BODY EMERGING FROM THE "NEVERLAND" OF NOTHINGNESS

BY RICCARDO LOMBARDI

The author considers sensory perceptions arising from the body to be the first expressions of self-consciousness and mental existence in patients who are overwhelmed by a dimensionless abyss of nothingness. This perspective can help the analyst in catalyzing the patient's integration with his deepest levels of mental functioning. Clinical material from the four-session-per-week analysis of a psychotic patient is discussed. To this analysand, finding the body meant finding "the land that never was," a "land" that could begin to exist in analysis thanks to a relational working through within the analytic couple.

Keywords: Body–mind relationship, psychosis, working through, ego, id, alpha function, Bion, annihilating anxieties, analytic relationship, somatic sensations.

The psychoanalytic revolution introduced by Freud is in some ways related to Darwin's epistemological revolution that had unequivocally placed man in the context of the animal kingdom. Unveiling the undeniable connection that the human being has to the biological force of his animal instincts, Freud places the operations of the human mind in relation to an irrefutable link with the body. That fundamental assumption of psychoanalysis seems to have passed into the background as a consequence of the growing relevance that research has attributed to the object relationship and intersubjectivity. Although there is no doubt

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that the intersubjective emphasis has definitely enriched clinical and theoretical psychoanalysis, at the same time it must be recognized that psychoanalytic research still lacks a full integration with the importance that the body holds, especially in relation to the deepest areas of mental functioning.

THE BODY AS A COMPASS FOR PSYCHOANALYTIC WORKING THROUGH

In this paper, then, I would like to take as my starting point two brief quotations from Freud, in order to locate them in the most current vein of psychoanalytic reflection and research (Anzieu 1985; Aron and Anderson 2003; Ferrari 2004; Lieberman 2000; Lombardi 2002, 2009a; McDougall 1989) that finds a pivotal element of elaboration in the relationship between body and mind. In doing this I will utilize clinical material stemming from the analysis of a psychotic patient, accompanying my presentation of the material with comments and reflections stimulated by the clinical evidence.

With the passing of years and the accumulation of clinical experience, I have become ever more surprised by the strength of Freud's intuitions in his first clinically important work, of which I will quote a brief but very significant passage, from which I derive inspiration for the title of this section. Freud writes:

> Her painful legs began to "join in the conversation" during our analyses . . . . *I came in time to use such pains as a compass to guide me*; if she stopped talking but admitted that she still had a pain, I knew that she had not told me everything, and insisted on her continuing her story till the pain had been talked away. [1893, p. 148, italics added]

And twenty years later, tackling his maximal effort at systematization of his clinical discoveries, Freud (1915a) wrote:

> It is only the analysis of one of the affections which we call *narcissistic psychoneuroses* that promises to furnish us with conceptions through which *the enigmatic Ucs. will be* brought more within our reach and, as it were, *made tangible*. [p. 196, italics added]

> *Some reference to bodily organs or innervations* is often given prominence in the content of these remarks. [p. 197, italics added]
>
> I would call attention once more to the fact that *the whole train of thought is dominated by* the element which has for its content *a bodily innervation* (or, rather, the sensation of it). [p. 198, italics added]

In these passages, it seems to me that, in a single, clear conceptual network, Freud holds together the *body,* the *unconscious,* and *the psychotic levels of mental functioning,* and that he considers *bodily sensations to be a privileged "compass" with which to establish a pragmatic relationship with the unconscious in the context of clinical working through.* To me the choice of this compass seems consistent with his assumption that psychic life finds its origin in the world of drives (*Triebe*). The models for elaboration of affects and thought are located in the body due to the "demand for work" (*Arbeitsanforderung*): "as the psychical representative of the stimuli originating from within the organism and reaching the mind, as a measure of the demand made upon the mind for work in consequence of its connection with the body" (1915b, p. 122).

From an analytic point of view, the deepest psychic levels coincide with a close proximity to the confused and boiling cauldron of the id. In the psychoanalytic lexicon, the adjective *psychotic,* then, in addition to a psychiatric diagnosis, has come to indicate an internal disposition in which the relationship between the ego and the id is privileged over that between the ego and external reality (Bion 1957; Freud 1924). This fact seems to emphasize that the utility of clinical experience with psychosis pertains not only to the specificity of this dimension, but also has general interest for the treatment of all our patients, from the moment that we consider that *the psychotic levels are involved in every psychoanalytic treatment that may include among its objectives an improvement of the relationship between the subject and his emotional and instinctual world*—or, rather, more integrated communication between the ego and the id.

The body is the point of origin of the ego (Freud 1923a), as well as the subject's first vital "object" of reference (Ferrari 2004), and so it seems indispensable to activate an elaboration of this area. In treating difficult patients, we must often confront explosive disorganization and

uncontainable acting out, as well as a strongly "de-emotionalized" orientation, resulting in the patient's having the "texture," almost, of a zombie deprived of life, of a mechanical automaton or a puppet made of ice, who often remains estranged from symbolic requests made to him by the analyst, with the consequent risk of an arrest of analytic elaboration. In his experience, Bion had to confront the same difficulties when he posed himself the problem of modifying the Freudian perspective centered around the working through of the repressed unconscious—in which symbolic interpretation, principally of the oedipal level and the analysis of defenses, is central—in order to introduce his own model of the *alpha function,* in which the principal task of analytic work becomes that of producing thinkable elements, on both conscious and unconscious levels.

In this way, for Bion, the *most urgent* clinical necessity is not that of revealing the unconscious to the conscious, but of utilizing and producing the unconscious in order to permit the conscious mind to function. Alluding to the dramatic dehumanization and de-emotionalization that the analyst finds himself confronting in his clinical work, Bion noted that "the attempt to evade the experience of contact with live objects by destroying alpha-function leaves the personality unable to have a relationship with any aspect of itself that does not resemble an automaton" (1962b, p. 13).

A CONTEMPORARY PERSPECTIVE

In my clinical experience, the importance of the body and the body–mind relationship is particularly clear in relation to the treatment of so-called difficult cases; this has been a "found" element, rather than one that I specifically looked for on the basis of a theoretical expectation (Lombardi 2005). These experiences have triggered my more attentive consideration of the implications of body–mind dissociation and the specific modalities of clinical approach with which to catalyze a change in these conditions that are particularly vulnerable to situations of impasse (Lombardi 2003a, 2004, 2008a).

According to my experience, the "attempt to evade contact with live objects" to which Bion alludes is not to be understood only as a

reference to the object relationship—or rather, to the sphere that, for example, has been explored in the post-Kleinian tradition by various authors, such as Joseph (1988), who described so-called difficult-to-reach patients in the context of the transference relationship—but also as a reference to the *subject's relationship with his own body*, that is, with the simultaneously biological and psychological object that has characterized him since birth, and with the diversified sensorial and emotional world that derives from it. In this perspective, the analyst must be considered not so much as an object to be interiorized as the first organizational core of the ego, but as an external facilitator who carries out his role through *reverie* (Bion 1962b).

With respect to Freud's discoveries, my conception of the body as a compass for working through is characterized, then, in a different way. In Freud's conception, the body is the repository of repressed content waiting to become conscious: the bodily symptom has a focal meaning, with *specific contents of anxiety, conflict, and defenses*. My conception of the body, by contrast, reflects clinical experience with patients of the nonneurotic sector, who—even when they seem to be well integrated with reality—suffer from defects of representation, profound splitting, and an incapacity to freely associate, as well as being continually confronted with annihilation anxieties.

In such a context, the *sensori-perceptive experience of the body corresponds to the beginning of an early mental autonomous functioning and to the capacity to exist as a separate subject*. Thus, the body does not express an unconscious repression to be interpreted in symbolic terms, but is a central, driving factor of liberation from the whirlpool of an unrepressed unconscious, from a "dark and formless infinite" (Milton cited by Bion 1970). These patients' primary anxiety does not correlate with the pressure of the drives, but with the annihilation anxiety that derives from the shattering or absence of spatiotemporal parameters (Bion 1970; Bria and Lombardi 2008; Lombardi 2009c; Matte Blanco 1975).

In my conception, the analyst has a prominent leading role, much greater than in the Freudian conception, from the moment that the birth of self-awareness is set in motion in the context of a deep intersubjective exchange. The analyst welcomes *transference as the total situation,* in the sense introduced by the clinical work of Klein and Bion—at the

same time, however, paying attention not to rush transference interpretation—*as he utilizes the relationship to de-saturate the patient's internal experience through reverie* (Bion 1962b)*, and facilitates the analysand's transference onto his own body* (Lombardi 2005).

A psychoanalytic focus on the internal experience helps the subject emerge from an undifferentiated internal turmoil, as he develops the capacity for representation of this sensorial turmoil and the ability to differentiate his own feelings internally. This working through is accomplished jointly with the exploration of the internal layout and unconscious theories that influence and regulate the patient's body–mind relationship (Bion 1962b; Lombardi 2003a, 2003b).

In this sense, we can understand *an approach toward the relationship with the body as the precondition for the activation of the analysand's alpha function,* and, as a consequence, for promoting his orientation to mental growth, to the world of object relationships and to change. It seems to me that a perspective that places the body and sensorial working through in the foreground highlights the most well-known and widely shared aspects of Bion's approach—that is, those centered on thinking and intersubjectivity—reaffirming in a new key the link between body and mind, which has characterized psychoanalysis since its origins.

I think that this emphasis on the body may permit us to avoid the stumbling block of transforming Bion's hypotheses on thinking into a system of self-referencing abstractions. Some contemporary Bionian authors, in fact, seem to conceive of the mind only on an abstract plane, a relational and narrative one, risking loss of contact with the primarily conflictual, wild, and irreducible nature of an unconscious of a bodily origin, and with the mysterious psychosensorial experience of being ourselves.

My reference to the body thus does not aim to return to the past through obeisance to a reverent orthodoxy, but is rather an attempt to place value on the fundamental and generative role of the body with respect to a mental dimension constantly in evolution and potentially infinite: an area that can perhaps help us in orienting psychoanalysis toward the future.

The clinical material drawn from the psychoanalysis of a psychotic patient that I will consider in this paper appears to me significant in

demonstrating the *importance of bodily experiences* in the context of the psychoanalytic session as first expressions of self-consciousness, and *for the activation of* "learning from experience" (Bion 1962b).

THE FIRST PSYCHOANALYTIC SESSION

With these brief reflections in mind, I will present some highlights of the clinical case of Simone, a tall and athletic young man who began analysis at four times per week at the age of twenty-one, in the context of his second acutely psychotic episode. The first episode had appeared five years earlier and had been treated only at the pharmacological level. He now presented as delusional, with hallucinations and paranoid symptomatology, and with violent anxieties of annihilation related to feeling he was being watched. While he was in this acute, full-blown phase, the analysis was set in motion at its full rhythm, following a technical approach that I have explored in particular on other occasions (Lombardi 2003b).

Treatment during this period was supported by my collaboration with another psychiatrist who, besides seeing to the medications and maintaining a connection with the patient's family, took care of the hospital management during the more dangerous phases[1]; moreover, the patient's mother initiated a parallel personal analysis with a third colleague. A few months after the beginning of analytic treatment, the risk of suicide appeared very high, and a hospitalization was organized according to a modality that permitted the patient to continue to attend sessions with me. A very dangerous development occurred at the moment in which his murderous impulses—sometimes of self-murder, i.e., suicide—had infiltrated the transference, and the analysand had declared homicidal ideation toward me as well.

In this case, the relationship with the body appeared central in initiating an analytic process of change and the activation of a capacity for self-containment. I will not describe the initial period of analysis, which I have addressed elsewhere (Lombardi 2007a), and instead will present some vignettes from sessions that took place during the second and third years of analysis.

[1] The collaborating psychiatrist-psychoanalyst was Dr. Giuseppe Martini, whom I thank for his invaluable contributions.

I will begin with a Thursday session, the last of the week, from the second year of analysis. At this point, it has not been long since the acute phase of psychosis has receded clinically. Simone enters with his head held high, displaying a challenging air. He sits rigidly on the couch. He begins to speak: "I feel cold. I don't know what's happening to me. I'm becoming a piece of ice." I notice with alarm his extreme coldness, which manifests itself in a mechanical aspect to his gestures and way of speaking, and I begin to fear an arrest in the process of working through, and a downward slide toward regression of an autistic type. I reply to him: "You're making yourself into a piece of ice out of a fear that your hate may become a dangerous explosion that will again overwhelm both you and me." At this point, Simone wheels his head around toward me, and says to me with a carefully pronounced and articulated voice, "Why don't you look at me?"

I notice a wave of hate and a strong sense of challenge emanating from him and, at the same time, I am aware of the importance of not refusing this challenge, which appeared to represent an important occasion for an encounter between the two of us. I raise my head—which, until that moment, had been bent in concentration, as I tried to find an internal space in which to think—and face toward him in order to look directly into his eyes, and I say to him: "Certainly, I look at you. And I am here with you even though I am not always looking at you." Simone looks fixedly at me, as though to scrutinize me, and says: "It's strange that I'm not afraid to look at you . . . . It isn't like other times when I've felt your eyes were dangerous."

At this point, I begin to understand the intersubjective meaning that Simone attributes to the gaze: in looking into my eyes, he is in reality looking, first of all, into his own eyes, which speak to him of himself, of his body, and of the hateful emotions that live within it. I realize with a shiver of emotion that I am witnessing an important development, and so I say to him: "Now you are looking at me, and you see in my eyes your hatred, and you feel that it is not the uncontrollable hatred that you fear, because now you see it. And in seeing it, you can withstand it and think about it." At this point, I see that the lines of Simone's face have softened, and in his left eye a tear is forming, which remains there, halted, like a tiny sac deposited in his eyelashes. Gazing fixedly in front

of himself, he says: "I feel heat, something hot that moves within me . . . . I feel pain inside. I don't understand what it is, but I feel pain that grabs me inside . . . . Maybe it's sadness." And I say: "When you accept your hate, the ice melts inside of you. You find the warmth of your acceptance and can refresh yourself with your tears."

At this point, Simone appears to have adopted a more relaxed posture, almost as though he has become a different person with respect to the rigidity of a mechanical automaton that was displayed at the beginning of the session. He moves very slowly, and transitions from crouching on the far corner of the couch to lying down upon it, relaxed. It seems to me that time has become less dense, to the point that every instant seems an eternity to me.

After a period of silence, he says to me: "What are these dead things . . . ? Dead things that I feel inside." I notice a profound anguish, and I have the impression that Simone's discovery of feeling himself sensorially alive has opened him up to the devastating perception of his internal state of death, resulting from the paralysis of an internal being made up of emotions and thoughts. At the same time, I notice with anxiety that his thinking may be starting to lean in the direction of concreteness (dead things), and I fear that a downward slide toward concrete thinking could paralyze him. Thus I try to locate, inside myself, *a formulation that might give symbolic connotations to the emotional working through* that I feel is being activated inside him, and so I say: "You recognize the pain of death, of experiences that come to an end, but this is a way of being alive and of allowing live emotions to run their course inside of you."

At the same time that I say this to him, I realize the end of the session is drawing near, and we are thus confronting "death" together; in fact, the session has been an experience of life that we must now prepare to relinquish. After a long silence, Simone begins to move about on the couch in slow, sideways movements, though he remains lying down. Then he says to me softly, with an almost suffocated voice: "Few people could understand what I am suffering."

I feel a rush of compassion in realizing that Simone is acknowledging an experience shared together with me—in "at-one-ment," Bion (1965) would have said—in which his relationship with himself accompanies a relationship with an otherness located on the same emotional

wavelength. At the outer reaches of my mental space, Wolfgang Goethe's lines echo in my mind, those he gave to the delicate character of Mignon and to which Franz Schubert gave incomparable musical substance: "*Nur wer die Sehnsucht kennt, weiss was ich leide*" ("Only he who knows longing, can guess at my suffering").

Keeping my own tone of voice subdued as well, I said to Simone: "To feel that you are understood in the relationship with me makes your pain tolerable, because you know that you are no longer the only one to feel it." He remained silent, as though in assent; and after a moment, I stood up to signal the end of our meeting.

In this session, Simone transforms himself—through the mediation of analytic reverie (Bion 1962b)—from an icy automaton oriented toward "evading the experience of contact with live objects," into a human person characterized by sensations and feelings. "I feel heat, something warm is moving inside me": through this sensorial experience, not unlike Elisabeth von R's painful legs as described by Freud, an elaborative carrier has been set in motion, capable of advancing the analytic working through and the growth of the nonpsychotic part of the personality (Bion 1957). At the same time, through the sensorial register, the enigmatic unconscious is rendered "tangible," so to speak, caught in its first-born dimension: "dead things . . . dead things that I feel inside." And the unconscious experience becomes our shared legacy in the intersubjective space.

After this session, I felt inside myself the almost inexplicable unblocking of an oppressive sense of paralysis, which for some time had been associated with my feeling exhausted, as though from an enormous physical effort. I felt that I regained my internal energies, which had been momentarily "used up" inside me, as though from an unknown illness that deprived me of every strength. These experiences validate the *massive bodily and unconscious participation* that is required of us by the analytic processes that proceed along the most obscure levels of psychic depth, in which *the sharing of sensorial states deprived of a corresponding representation* sets the stage for developments that cannot be realized in the absence of this ample sensorial, internal territory, mutually shared by the analytic couple.

COMMENTARY

Tustin (1981) emphasized the minimal capacity to regulate sensorial experience that is connected to hypersensitive states in psychotic children, and the parallel tendency to activate rigid and impenetrable, protective armor in confronting waves of sensual experience that come to be feared as potentially catastrophic. The sensorial world—at these levels of functioning—is characterized by an "all-or-nothing" modality, for which the subject is either deprived of sensations or is overwhelmed by them. Tustin writes: "Thus, bodily sensations have been transformed into *psychological* experience through reciprocal and rhythmical activity between mother and infant. The stage is set for percept and concept formation. But this is a mysterious process" (p. 101, italics in original).

In analysis, such processing involves contact with levels that precede those of projection and introjection, which imply some sense of bodily separateness, in order to leave a place for states characterized by what Tustin defines as a "overflowing-at-oneness": "mysterious" and unconscious states experienced in the analytic relationship. Through the "hardness" of the transformation into a piece of ice at the beginning of the session, and the "softness" of an internal warmth, Simone's experience comes close to internal levels that—from Tustin's perspective—can be likened to autistic levels of the personality, in which the integration and differentiation between opposing sensorial orbits (like hard and soft, cold and hot, etc.) play a central, driving role.

For Ferrari (2004), too, the experience of internal contact with sensations, and the collapse of an overarching and chaotic sensoriality caused by a decline in internal containment (Bion 1962b), implies—in the processing that characterizes the analytic relationship—an approach toward a "*vertical relationship" between body and mind,* which is understood to pre-date the phenomena of projection and introjection, which had been conceived by Klein (1952), in contrast, as the earliest levels. With respect to the levels of functioning that Tustin related to autistic problems, we could say that Ferrari tends to consider them, instead, to be in some way structural, that is, as typical elements of the human being as a Darwinian, "ethological" subject. In other words, for this author, *the con-*

flict and the dialogue between body and mind characterize the deepest levels of mental functioning and determine the constitutively "catastrophic" nature of thinking acts, in the sense that had already been pointed out by Bion (1970). With respect to the undifferentiated sensorial flood that characterizes the primordial sense of self according to Tustin, Ferrari's emphasis on the *role of sensorial perception,* furthermore, appears particularly significant as the starting point of mental functioning. Sensorial perception, in fact, breaks the "all-or-nothing" system and parcels out (we could say "asymmetricizes," in Matte Blanco's sense) the undifferentiated sensorial world into discrete and recognizable phenomena.

In the same way as Tustin and Ferrari, Matte Blanco (1988) highlights the inadequacy of a point of view that limits itself to projective-introjective dynamics and to the description of transference-countertransference dynamics, in order to emphasize the "*symmetricizing" impact that derives from an approach to the deep unconscious.* In fact, that level is characterized by an augmentation of the proportions of symmetry with respect to the asymmetrical and differentiating resources of thinking. Approaching *the experience of indivisibility* as an expression of deep aspects of human nature, for Matte Blanco, implies abandoning the external-internal antithesis—in which analyst and analysand are differentiated persons—and instead coming closer to non-tridimensional aspects of being, where the confused logic of the dream is dominant and where an individual may trespass on the other in a disquieting way.

The symmetrical experience of transference, or *symmetrical transference* (Lombardi 2009c), implies a conception of transference that is not a duplicate of past parental relationships, but is an essentially generative process in which new experiences are put into play, characterized by an openness to the future rather than a reorganization of the past. From this point of view, a different way of looking at the role of transference interpretations also emerges—which, when used at these levels, can imply a dangerous iatrogenic role of anti-developmental *impingement,* to use an expression dear to Winnicott. Instead, what counts is the use of the experience of the analytic relationship as an instrument to give substance and visibility to the subject's internal experience—in the sense of that intrasubjective transference (*Ubertragung*) emphasized by Freud (1899) in relation to dream formation—as happens, for example, in the

session with Simone, when I correlate his *looking into my eyes* with *seeing his own hate.*

The analytic relationship, more than a setting of "transference"—in the classical sense of a new edition of past parental relationships, which has been attributed to it in the Freudian tradition—is thus a place where an *intersubjective relationship* unfolds, one of sharing new experiences, which, when it moves into the really "deep levels" of the unconscious, assumes the connotations of indivisibility and lack of distinction that stem from the dominance of the "principle of symmetry" (Matte Blanco 1975).

Likewise, I should like to observe that Freud's point of view regarding the body–mind relationship never moved away from a perspective that took continuity for granted, leaving undeveloped the problems connected to the clinical phenomenology of body–mind dissociation. Consistent with his personality that led him to "have no use for other people's ideas when they are presented to [him] at an inopportune moment" (1923b, p. 287), the founding father of psychoanalysis remained deaf to the revolutionary implications of Tausk's (1919) writings on the "influencing machine," in which for the first time some clinical cases of dissociation of the body were described in a specific way. We can perhaps fully appreciate the relevance of these descriptions only today, thanks to the current epistemological models of authors like Bion, Tustin, Ferrari, and Matte Blanco, who updated and reformulated the Freudian point of view in the light of urgent situations arising in contemporary psychoanalytic practice.

In this sense, a communication such as "I feel heat, something hot that moves within me . . ." is an important indicator of an early internal dialogue between the analysand's body and mind, which contrasts with the body–mind dissociation and the paranoid split of his hatred. And as a whole, the entire session—which I have discussed in some detail up to this point, in order to consider its implications—was shown to be important in preparing the way for a more ample involvement of sensorial experiences in Simone's analysis—an experience that rooted the analysand in his body, no less than in his unconscious, confronting him with the need to tolerate the unknown that he was encountering inside himself, and permitting him to accept an early form of awareness of being a separate person.

I would also like to emphasize that, as we simultaneously move closer to anxieties tied to the sensorial and bodily experience of the self, *the analysand achieves an important relational experience.* In opening himself to eye contact with me, Simone asks me to confront his paranoid expectation of being destroyed by an external gaze. In fact, in the past, he had felt me to be "the devil," and so he absolutely could not look at me without fear of being destroyed. The new experience of the mutual gaze that Simone achieves in this session transmits important inter-human contact, and this relational experience of acceptance and human communication is sensorially perceived inside him as an internal warmth.

In my verbal intervention, however, I decide not to emphasize the relational component in order to focus on the patient's new capacity to *use his eyes to look at and to see* his internal feelings, rather than to control and destroy. This clinical passage is an example of what I mean by working through that approaches and modifies the patient's unconscious theories influencing and regulating the body–mind relationship.

In fact, this analytic development permits the *modification of an important internal theory inherent in the visual function,* through which *the eye* is no longer considered in the light of *primitive sensorial functions* linked to the pleasure principle (possession, control, etc.), but begins to align with the *perceptive* functions linked to the reality principle and thought. This evolution—from concrete affects subjected to motor discharge, toward an abstract representational function—permits Simone to *begin to contain his paranoid violence of hate through his own mind* (Bion 1962; Freud 1911).

To put it another way, in refusing to center my intervention on myself as a transference object, I do not wish to negate the importance of this "moment of meeting"—as Stern would say—but I am trying to protect the development of the delicate and complex arrangement of *internal experience* that the patient is beginning to actualize: in fact, he begins to utilize his bodily resources (his eyes) in a perceptive way, constructing new and decisive links between body and mind, between affect and representation (Freud 1915a).

From this point on, Simone can proceed to the point of perceiving his internal state of devitalization ("dead things that I feel inside"). The painful discovery of death leads him to discover, furthermore, how it

may be possible to share these burning internal experiences with another human being. With these movements, the analytic couple reaches experiences of at-one-ment that gradually open up to a depressive organization and a recognition of otherness (Klein 1936).

FURTHER CLINICAL DEVELOPMENTS

In light of the clinical material I have just described, a session appeared significant in which Simone began by saying: "I feel something in my stomach, like an emptiness, like when you ride a roller coaster." In telling me this, the analysand was communicating to me that his incipient tolerance of sensations was furthering the ego's early resources of containment, offering in parallel an early representability and containability of his feeling of falling into an annihilating void on the occasion of breaks in the analysis. (This subject had already been addressed in sessions and contexts that I will not describe more specifically here.)

The void was no longer what it had been in earlier phases of the analysis, however—a black hole into which the patient fell, feeling himself to be annihilated, in the sense discussed by Bion (1967) when he evoked the "dark and formless infinite" described by Milton, or by Winnicott (1973), when he referred to the so-called *primary agonies*. Instead, the void had a new element, in that *"falling forever" immediately followed a phase of internal support*—as happens on a roller coaster, in fact—from the part of his sense of self that derived from contact with his bodily experience.

In this way, the internal experience of registering the sensorial data permitted a *comparison with absence on the relational level*, which was mediated by the *constant trustworthiness of a sensorial internal presence*. In this way, *the contact with absence*, as a condition for the structuring of a capacity to think abstractly (Bion 1962a), *met an important antecedent* in the intrasubjective relationship that the subject came to establish with *the organizing layout of his own bodily sensations*.

To return to the same session, after a little while, Simone added that a friend of his had told him: "There are those who succeeded in surviving the concentration camps." At this point he had thought: "Maybe I, too, can succeed in overcoming my fears." This is an affirmation that

opens a perspective on the *resources of faith* that the registration of bodily sensations can activate in relation to the catastrophic impact of the more primitive, unthinkable anxieties and nameless terrors. At the same time, the experience of the body can appear in some way—at these archaic levels—indistinguishable from the horror of a concentration camp, inasmuch as it forces one to confront the discovery of the *limits* of space and time, and, almost in contradiction, the anxiety of the unknown and of the *infinite* unconscious that lives inside us.

SECOND PSYCHOANALYTIC SESSION

Let us turn to a session in a subsequent period, a Monday—that is, the first session of the week—in which Simone presented with a big smile. He took off his jacket and put it on the chair. He then immediately got up from the couch to pick up his jacket and put it on again. I asked myself whether he wasn't trying to modulate a relational distance between the two of us, utilizing the jacket almost as a way to define the border between our two identities that risked being mixed up.

Simone then began to tell me about being happy to have spoken with a friend about the problems of young people. "We understood each other," he added. It seemed evident to me that this was a reference to our analytic exchange and to the fact that facing his problems together might set in motion an experience of his feeling understood. My choice, however, was not to interpret these relational movements, waiting to see which directions he took in his elaboration.

At a certain point, Simone suddenly asked me, "Have you seen *Neverland*?" In this way he introduced a reference to Marc Foster's 2004 film, *Finding Neverland,* winner of seven Academy Awards, which at that time had just appeared in local theaters. The film tells about the famous Scottish playwright James M. Barrie and the story behind the creation of *Peter Pan,* his most famous work. Four children, mourning their father in Victorian England, meet a writer, who, while visiting the family, begins to write the famous play mostly to speak to the emotional needs of the youngest child, the one suffering the most from grief for his father. Later on the children lose their mother as well.

I remained struck by his reference to the movie, which had impressed me very much for its depth, and I answered affirmatively, asking him what had interested him. Simone answered: "The fantasy. It is something that can be used." Having in mind the constructive value that fantasy has in the film in portraying dramatic situations, I said to him that fantasy could be helpful to him when he was dealing with self-expression in relation to painful situations. At this point, he answered, "I can't stand taking showers. I don't know what to think about. Maybe I should put some music on, then I would think of that."

From the subject of fantasy, the analysand was moving on to consider a very concrete element like showers, and I thought that his reference to showers might indicate an occasion of *meeting with the body*, as well as with sensations and emotions, according to a *non-"oceanic" modality,* as distinct from the overwhelming and infinite dimension that he found himself living in when sensations and emotions had felt inundating (for more on the relationship between the body and the infinite, see Lombardi 2009b, 2009c).

At the same time, I caught in the background a reference to our relationship as well, now more defined in the spatiotemporal realm in which the analytic session, which put him in emotional contact, was "a shower": a vital shower, but which at the same time was felt to be—concurrently with the blossoming of a binomial of life-death opposites (Lombardi 2007b)—potentially deadly. For my part—perhaps not by chance—I noted that the tragically famous showers in concentration camps came to my mind, recalling Simone's previous reference to "those who succeeded in surviving the concentration camps."

The emphasis that he introduced on "not being able to stand it" seemed to hearken back to an "attack on linking" with the body, with that link being a potential source of emotions. Considering this, and also having in mind his initial association to *Neverland,* I said to him: "Evidently you hate your body, which is the land that is and where you really live. If you recognize this body of yours, then it can cease being *the land that is not—Neverland.*" And at this point, Simone referred to his experience over the weekend: "I didn't do well on my trip to England. I couldn't look people in the eye. I left a pub where there was music, and I started to cry. Desperation came over me. Maybe it wasn't worth it."

His contact with an area of depressive feelings (the music and the tears) seemed to me the sign of a very positive development, and I tried to show him its value, underlining his capacity to master this emotional experience, which was—I said— "certainly worth it." Conversely, Simone risked underrating the value of the experience of feeling bad, of crying and desperation that pulled him along toward the depressive position. Inside myself I thought that, in some way, Simone—in communicating this episode to me—was also living it: he was, in other words, using the session to have contact with his emotions (through the emotional experience that was shared between us as well), detoxifying his expectation of being left annihilated by emotional contact. In this way, Simone demonstrated a beginning capacity to *interweave ways of being with feeling and thinking,* tolerating the impact of an integrated mental functioning.

At this point, in an unexpected way, Simone asked me: "Can you become a pedophile because you don't recognize your own sexuality? I saw a little girl of six, maybe eight, and I felt strange." I thought that the analysand was fantasizing a pedophilic component in the relationship of the adult with the children described in the film *Finding Neverland,* and this seemed to permit access to a representation of his personal pedophilic instincts. The reference to pedophilia brought up the risk of a destructive act of expulsion of his desire for contact with the emotional world onto the body of a child. It was an expression of his omnipotent denial of his real body and his adult sexuality, as well as of his deadly hate of the real passing of time. The risk of pedophilic acting out had been one of my concerns in the analytic management of this difficult case, especially when the analysand's discriminating capacities had appeared particularly weakened by psychotic devastation.

I tried, then, to read his reference to pedophilia in relation to a disavowal of his relationship with his own body, characterized by real limits, and so I said to him: "If you deny having an adult body and deny that time has passed, as though you lived in a perpetual Neverland, then you end up with a '*body that isn't.*' At this point, you can discharge sex and hate through pedophilia."

Simone, however, corrected me: "It *is* Neverland. It isn't 'the land that isn't.' It is 'the land that never was.'" In saying this, Simone seemed to me to be alluding to his tragic lack of integration with the body as a

fact that had been inexorably missing from *all* his personal development, and to the revolutionary and innovative meaning of the new experience that was being realized in the analysis (cf. Williams 2007).

At that point, searching for a communicative bridge with what was circulating inside him at that moment, I answered: "In this sense, you are right that you need to construct the relationship with your own body, a body that for you never was. Because, if you are there with your body and your emotions, it is also certain that you are there as a person." And Simone said: "I was thinking that when there's a good film playing, you see it."

Appreciating the recognition that the patient was offering me for my emotional participation in his personal experience, I said: "Well, in a certain sense, here in the session, we are watching a movie together that permits feeling and thinking. And so you discover how useful it is to be able to look at experiences that you feel inside your body—just as at the cinema, where it is not enough only *to feel,* but it is also useful *to watch,* to be able *to talk* together here in analysis, and to be able *to think*."

COMMENTARY

In the context of this session, it emerged that the analysand, starting from his experience of being understood by me, was progressively giving space to his experience of his own body, endowed with a sensorial and emotional, live flow. *The working through of his hate for the connection with his body* ("I can't stand taking showers") *made possible a defense of the bodily framework of Simone's emotional working through*—in the sense of what I have reaffirmed of Freud's view in regard to the "demand for work" that connects the mind to the body—facilitating the constitution of a *thinking connection* with his own body. The body was for Simone a land "that never was," and the business of analysis was to approach and discover it, with all its sensorial music and emotional scenery.

In this phase of the analysis, the experience of a body inhabited by vital and tolerable sensations became ever more frequent in Simone's experience, as we have seen in the experience of internal warmth and in the tolerance of his stomach sensations. This achievement diminished the pressure to use an evacuative projective identification—for example,

through the investment of his external body into the figure of a child, wanting to then destroy it and to re-animate it at the same time through pedophilic acting out. Simone's body was becoming a real "land," a truly possible place, where he was discovering the ability to live without fear of being destroyed by his catastrophic annihilation anxieties.

In this session, encountering his own real body seems to Simone to be an indissoluble experience of the appropriation of his own real story and of the cumulative trauma of his childhood history. The unthinkable, buried childhood pain inside the patient at a sensorial level—*memories in feelings,* according to Klein's brilliant intuition—can be approached thanks to the mediation of my analytic reverie, just as the child's grief for the loss of his parents in the film could be tolerated thanks to Barrie's mediation. The fact that the playwright invents a character whom we could define as *psychotic* (Peter Pan) shows us the protective function that psychosis has with respect to childhood catastrophe, and, at the same time, how important it is that the analyst keeps clearly in mind that psychosis has an important creative function of survival, without repudiating the destructive components of this.

At the same time, an *awareness of the intersubjective relationship* has to be growing in Simone. In his separation from analysis during the trip to England, he regresses to the point of feeling himself incapable of looking other people in the eyes, and he must immediately leave a pub. In this way, the analysand experiences the difference between moments of mutuality constructed in analysis, and other moments—like the weekend—in which he is separated from the analyst, and in which his paranoid anxieties reemerge. The analytic relationship contributes, with its alternation of presence and absence, to the creation of a *living experience of temporality;* and thanks, too, to these experiences, it becomes possible for Simone to liberate himself from the negation of real time that characterizes his "land that never was."

In this session, I find the working through around Marc Foster's *Finding Neverland*—a film of great emotional and aesthetic quality—very moving. Simone's associations induced him to think of the role of fantasy as an expression that permits the translation of internal, ineffable sensorial states, which otherwise lack equivalent representations. Furthermore, when the expression of internal emotional states risks paral-

ysis—as in the case of the young protagonist of the film, paralyzed in the grief he cannot elaborate—there is someone who succeeds in translating his internal emotional states for him, as the writer Barrie does.

The psychotic patient's receptivity to works of art can be very acute, and this gift may enrich the analytic experience in a profound way. The empathic capacity to appreciate a film dominated by the spirit of grief and loss, one that focuses on the creative implications that can be derived from grief, is striking in a patient dominated by paranoid symptoms. This fact strikes me less intensely when I remember that this patient, on his own, demonstrated significant creative tendencies in drawing, music, and cinematographic short subjects.

Equally moving is the sequence in which the patient speaks of his trip to England, when he left a pub with loud music, in order to find a personal way to express, through crying, his own "unheard melodies," to use Keats's words (cf. Lombardi 2008b).

After he had reappropriated his emotions, Simone could approach the topic of pedophilia, with its dangerous and destructive implications that derived from the denial of his actual, adult sexual body and from the missing elaboration of his grief for the end of his childhood. Keeping up an active verbal elaboration of this topic every time the occasion arose made it possible to avoid pedophilic acting out, which was addressed on several occasions in the course of this analysis.

THIRD PSYCHOANALYTIC SESSION

At this point, let us move to a later session in which the violent conflictuality pertaining to recognition of the body reappears. I will describe this session by emphasizing the sequence of analytic dialogue. As soon as he lies down on the couch, Simone begins:

PATIENT: When I got home, I looked at myself in the mirror and I felt as though I were in prison.

ANALYST: [*I am very positively struck by the patient's capacity to look at himself in the mirror: it is a way of establishing a relationship with himself and a possible avenue toward symbolic self-reflection. But I am equally struck by the violence*

of his claustrophobic reaction, through which the body, in the same moment that it is recognized, is immediately felt as a prison to be evaded. I also notice a claustrophobic feeling in the physical form of a limitation of my own breathing. I set about exploring whether the analysand already has some hypothesis about his experience that he brings to the session.] What would this come from, in your opinion?

PATIENT: The hatred, the hatred that I recognize.

ANALYST: [*I notice a sense of relief of my respiratory oppression, as though his verbal allusion to hatred permitted me to begin "dreaming" (Bion 1990) the sensorial precursors of hatred that were already circulating in the session.*] You keep your hatred imprisoned and so also yourself.

PATIENT: [*He begins to move more freely on the couch.*] When I work at the bar and I'm behind the counter, I don't want to do anything. Maybe it's hatred that makes me fall into boredom. [*His voice changes and he becomes more energetic.*] You are a shit!

ANALYST: [*My initial physical discomfort is at this point replaced by a clear perception of the hateful emotions that are circulating. I observe within myself that cohabiting with hatred may be less oppressive than feeling oneself oppressed by unrepresentable obscure elements.*] You recognize the hatred toward me. If you are prepared to recognize your hatred, you can also think about it, instead of discharging it into boredom.

PATIENT: I have so much hatred that I make my body disappear. [*pause*] My cock is bugging me. It's peeling. A while back the urologist gave me a cream that cured me, but then I didn't put it on any more. Now it's peeling again; I always forget to put on the cream.

ANALYST: [*Simone returns to his hatred of his body, alluding to concrete and symbolic damages caused by his denial of it. I try*

to alert him to the destructive implications of his denial, which leads him not to take care of himself.] In not worrying about your body, you then damage it in acting out hatred against yourself.

PATIENT: [*after a silence*] I'm not paying attention. I should pay more attention. Today I had wet hands and I pulled out a plug. I noticed an electrical discharge. [*pause*] I feel like I'd like to die: when I'm bored, I feel that I want to be dead.

ANALYST: [*I note that Simone's level of awareness and explication with respect to his internal violence is improving. The patient recognizes his attitude of not thinking, of being inattentive, with all the risk of leaving space to unwittingly act out against himself—with suicide—all the hatred that he doesn't think about.*] In not paying attention to your body, you believe you can make homicidal hatred toward yourself disappear. But instead it is really canceling out your body, so that you can continue to be a victim of your hatred, to the point of being capable of killing yourself in reality through an act of carelessness.

PATIENT: [*with a more relaxed and reflective voice*] On the way home, I stopped at Piazza Venezia with my Egyptian friend. There was a homeless man outside a bar, and a barista came out to give him a cappuccino and a croissant. The man thanked some people who were there.

ANALYST: [*After a moment in which the hatred seemed to me to be hypersaturated and almost paralyzing, I notice that the tension is diminishing. Simone's communications seem more oriented in a reparative direction, and not exempt from a shade of gratitude for the "analytic cappuccino" that I am serving up to him with my analytic propositions. I leave aside these relational implications in regard to me, however, and I decide*

to intervene by continuing to focus on the relationship that the patient entertains with himself, appreciating the development of feelings of self-acceptance that are taking the place of the initial claustrophobia at dwelling inside himself and in his own body.] When you are prepared to recognize your tendency not to live, as happens to a homeless person, you can accept yourself and take care of yourself.

PATIENT: I didn't feel superior to the homeless man outside the bar. Other times I have felt superior.

ANALYST: [*I notice in him a certain sincerity, and a clear reduction in the destructive narcissism and the omnipotent push to dissociate from the self. The figure of the homeless man helps me put into focus the abandonment anxieties of precariousness and solitude that the patient gives evidence of when he sets about living inside his body and recognizing it, and so I make the following remarks.*] You don't feel superior to your body, to the fragility of a needy body, as you do when you cancel it out or wish yourself dead. Now you can make use of the sense of coming close to it as your real self.

PATIENT: I remember when I was at university and I went crazy. I was walking along and I saw people who looked at me with very bright eyes. They hated me. It makes me angry to remember this.

ANALYST: [*I feel that his hatred here does not have expulsive connotations, but rather that he is in constructive contact with himself. I find a very positive, elaborated element in his memory of his acute phase, toward which the patient finds a certain reconciliation, approaching his paranoid hatred that was not processed or digested at the time. Simultaneously, I find that he is speaking to me of the horror that he feels when he recognizes madness in his previous experience: a body lacerated by explosive emotions devoid of containment. A condi-*

tion that the patient seems to feel is worse than that of a homeless person, abandoned and without hope.] Now you are ready to recognize your madness and your precarious state when you do not succeed in thinking, but if you tolerate your hatred, you can take care of yourself, you can think in order not to go crazy. The situation today can be different from what happened to you in the past.

PATIENT: Yesterday my father left me 100 euros on the table. They were for me. I thought that I didn't want them. I want to know how to count on what I earn myself. I hate my parents.

ANALYST: [*It seems to me that Simone's discovery of being capable of thinking about his self-hatred, and of containing it, activates in him a sense of pride that encourages him to take a certain distance from his parents, whom he feels are hyperprotective and infantilizing. At the same time, I notice that the subject of separation begins to assume currency in the transference, as we approach the end of the session.*] When you agree to separate yourself, like today in separating from me, then you hate me. And this hatred of yours is a price you are prepared to pay in order to recognize yourself as differentiated from your parents, and also from me.

PATIENT: I feel proud that this summer I was alone in a foreign city.

ANALYST: [*It seems to me that Simone is looking at his capacity to be alone with a realistic perspective. His attitude is barely tinged with a manic tendency, which I decide not to interpret in order not to disturb his positive orientation toward assuming differentiation.*] Also here, in some way, you can be proud of yourself for placing yourself here, facing me, as though you are a foreign country that has its own identity and its own differentiation with respect

to the different country that I am—a differentiation that you can take away with you as well, when we separate for interruptions in the analysis.

COMMENTARY

The material in this session demonstrates an analysand capable of discovering his body in the mirror in an autonomous way, as a development of a previous stage in which the function of the mirror had been performed especially through analytic reverie and through self-reflection in the person of the analyst, as we saw in the material from the preceding session on the reflection of the self in the analyst's eyes, in order to see and perceive his own hatred. In the moment in which Simone recognizes *his own body,* this *comes to be seen as a prison from which to escape,* because it confronts him with the limits of reality, and, again, with his own hatred of reality.

The activity of the personality's psychotic area (Bion 1957) generates intense claustrophobic anxieties and pushes for denial of the body. Conversely, recognition of the body furthers the working through toward a sense of reality (Freud 1911) and the assumption of personal responsibility, creating the conditions for tolerance of deep anxieties of helplessness.

When, for example, the analysand takes care of his body by using the ointment to protect his genitals, this genital protection seems to assume a *concrete value,* referring back to the protection of his body and of his real sexuality, and at the same time to a *symbolic value* of mental "potency." The penis seems correlated with the function of a *skin-thought* endowed with containment functions (Bick 1968): the penis is then felt to be "peeling," just as Simone feels his own mind is also "peeling" in the absence of a protective membrane provided by the function of thought.

In these dynamics, it becomes important to emphasize the active relationship that exists between the working through of hatred and the capacity to integrate oneself on the level of the body–mind relationship: "I have such hatred that I make my body disappear." This demonstrates to us, in other words, that the body–mind integration accomplished over the course of the analytic evolution of such cases is not only the result

of a facilitation induced by the analytic relationship, but is also a psychic act that is subjected to the subject's discretion and choices. This is an element that cannot be overlooked, and that explains the impossibility of furthering the analytic working through in those cases of psychosis that find specific secondary gains in the maintenance of an illness state.

The hatred brought to the relationship with the analyst ("You are a shit") demonstrates phenomena ascribable to the negative transference: movements that have the determining function—mediated by analytic reverie—of lowering the pressure of hatred that the patient feels toward himself. The transference movement in this case is especially characterized by the *use of the analyst to de-saturate the vertical body–mind relationship,* when it is exposed to the risk of a paralyzing overload, rather than a movement connected to specific relational dynamics. The analyst again fulfills the active function of a mirror and a mental shield for the analysand; lending himself to the containment of these emotional dynamics, he contributes to lightening the impact of the concreteness of emotional pressure—which would risk again petrifying the analysand into an ice crystal—and facilitates, instead, the working through, helping the analysand to master and to "think" his homicidal hatred against himself.

When emotions assume particular intensity, the containing resources of thought are exposed to the risk of being placed in check, so to speak. This is demonstrated to us by the myth of Perseus, in which the *direct vision* of hate, personified by Medusa, becomes a source of annihilation. The analyst contributes to the realization of this *indirect vision* through his reverie, which lightens the concreteness of an "unbearable heaviness of living"—as Italo Calvino (1988) would say.

The emotions described by Simone as boredom and a desire for death call to mind Freud's (1920) statements about the death instinct as an underhanded force, not easily recognizable—elements that are gradually worked through in the analytic exchange. To actively evoke the *body in the analytic session permits its placement in reality* (Freud 1911) *and brings it within the radius of the mental functioning of attention (*"I should pay more attention. Today I had wet hands . . ."). This body–mind integration becomes an important instrument of containment with respect to the more underhanded and dangerous manifestations of the destructive instinct. Destructiveness appears in this way to be more connected

to a defect of thinking—or rather, to the difficulty that the patient has in mentalizing—than to a primitive death drive.

At the same time, we see how the connection with the body catalyzes a connection with the deep unconscious (homicidal self-hatred), coming close to more fragile and undefended aspects of the personality (the homeless man) and a recognition of the role of external objects (the barista who serves cappuccino and a croissant to the homeless man). For the patient, the fully conscious assumption of his experience of madness ("I remember when . . . I was crazy") facilitates a process of integration between the psychotic area and the nonpsychotic one.

Later on, when I assign value to Simone's capacity to take a certain distance from external objects who help him (his father who offers him money, and his analyst in the session)—after which he recognized the importance of this—I attempt to mobilize an elaboration of taking real care of himself ("I was proud that I was alone"). This clinical orientation of mine springs from the urgency of accomplishing an internal integration of the analysand's ego—even at the price of risking a slight maniac coloring—rather than emphasizing his dependence on external objects, which would risk promoting regression in a patient already inclined toward paralysis. With these choices, I try to support the analysand's perception of "belonging to himself" with which he had begun the session, or rather the recognition of his existence as a separate bodily identity.

CONCLUSION

Even though our contemporary sensibility leads us to emphasize the subjective and intersubjective dynamics of the analytic relationship more strongly than we have in the past—as a result of which our approach is generally more concentrated on the patient and on the analytic relationship than on theory (cf. Renik 2006)—it is nevertheless very important to utilize our experience in recognizing that the body can be used as a compass for psychoanalytic elaboration. These vignettes are an example of how the absence of memory and desire in the psychoanalytic session (Bion 1970) can meet up with reflections, after the session, on the role of the body in the analytic process.

In the course of this clinical presentation, we have witnessed the patient gradually drawing closer to the mental experience of his own body, in parallel with a lessening of paranoid symptomatology and of other threatening disturbances. Emerging from a "Neverland" of non-existence, Simone could open himself to a vast range of sensori-emotional experiences: his body, from being cold and mechanical, has been transformed by warmth and liveliness. Changeable new sensations have become tolerable, to the point of his being able to withstand his hatred of limitations and the claustrophobic anxieties connected to living inside his own body. All these experiences have led the analysand toward the gradual definition of a *real subjectivity,* characterized by *real, bodily space–time and by an internal body–mind dialogue,* allowing the emergence, in parallel, of a *growing awareness of intersubjectivity.*

From this material, it emerges that the conditions that make possible the analysand's mental growth do not derive only from a good communicative and empathic capacity in the intersubjective context of the analysis; instead, the activation of a *relationship between the patient and his own body is likewise determinative,* combined with *elaboration of the conflictual and claustrophobic implications* connected to living, feeling, and thinking within the borders of his own real body.

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THE KORE COMPLEX: ON A WOMAN'S INHERITANCE OF HER MOTHER'S FAILED OEDIPUS COMPLEX

BY CORDELIA SCHMIDT-HELLERAU

The Greek myth of Kore/Persephone captures a particular psychopathology of women who are torn between a deadened and often asexual husband (Hades) and an ongoing close relationship with a caretaking mother (Demeter). Psychoanalytic work often reveals that these women live in the shadow of their mothers' failed oedipal complex. Their identificatory preoccupation with maternal object preservation disrupted or distorted their oedipal development, and ever since continues to serve as a defense against sexual strivings. Thus, these women are trapped in a Kore complex: as maiden caretakers, they remain attached to and torn between a "grain mother" and a grandfather transference object.

Keywords: Greek mythology, Kore/Persephone, life and death drives, female development, oedipal phase, object preservation and self-preservation, transgenerational transmission, object choice, sexuality, anxiety, libido and lethe, mental structures.

TWO BRIEF CLINICAL OUTLINES

Cindy

Cindy, a single nurse who is thirty-seven years old, has been in a four-times-per-week analysis with me for two years. She came to treatment

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because she desperately wanted to get married, but never seems to get past the first weeks of a new love relationship. She feels like a failure, she says, for not being able to have someone who loves her in the way she wants to be loved. However, she continually finds fault with her various lovers—in particular with how they treat her, how they communicate with her, and in what they demand sexually from her. Her biological clock is running out, she tells me, and she blames me for not being more successful in my analytic work with her. Her biological clock is a reality, I understand, and I do find myself sometimes wishing she would find a good mate—even though I notice that this wish is part of a complicated countertransference.

Cindy subscribes to an Internet dating service and tells me at length about the different candidates she chooses from their list, as well as about those who choose her. Here is how her encounters with these men usually go:

First, Cindy is interested. The profile of a man whom she gets in contact with—let us call him John—sounds promising. John is divorced and has an adult daughter; he is interested in jazz, literature, gardening, and hiking—things Cindy enjoys a lot. Also, he is a gourmet, which is a particular area of Cindy's expertise. The two meet, and Cindy comes into her next session raving about John. They really hit it off right away. He is so smitten with her that he said he would terminate his dating service subscription the next day. The conversation went very well, and he seems to have good manners, something Cindy cares about.

"John is too good to be true," Cindy says to me. "Where are the flaws?" She will soon find them—so soon that there is not even time for us to watch the early signs of mismatch sneak in. As if out of the blue, the just-blossoming romance is abruptly crushed under a sudden load of ice. What happened?

Having turned delight into indignation, Cindy now finds John's sexual behavior odd, to say the least. She complains that he urged her to allow him into her bedroom, which she was not ready for, but finally agreed to anyway. Then his performance seemed to prove that he was impotent. On top of all that, it turns out that he is a smoker! The whole love story unravels in a few hours (or days, or a couple of weeks at best, depending on the individual man involved).

Then part two of the drama unfolds. Cindy now accuses me of having pushed her to pursue this relationship despite the fact that she had uttered some early doubts. Did I do that, I silently wonder? She would never have gone so far as to go to bed with John, she claims, had I not indicated that she could do so. Why would I think that she did not deserve someone better than this elderly, conservative man, divorced for murky reasons, who still has a strange relationship with his ex-wife, has neglected his daughter for years, is currently unemployed, lives on his dwindling assets without health insurance, and has looming kidney failure?

Well, this now sounds horrible to me, too. Cindy is furious with me. Why do I think her unworthy of someone better? Even worse, she claims that, time and again, I have let her rush headlong into these disastrous sexual encounters. She stops short of saying that I delivered her to these rotten, dependent, sickly, passive, demeaning, and depressing guys; but she does say that she feels I would be happy if she settled down with any one of them. Then I would feel I had reached my goal. I silently wonder, *is* this my goal—to see Cindy settled with *any* man?

Jane

Then there is Jane, who is very different from Cindy. Five years ago, she came to analysis depressed and rather desperate because she had discovered that her husband, Frank, had a secret collection of pornographic videos that he would watch at night. She tells me of the many problems they have had almost from the beginning of their six years of marriage: difficulties in talking with each other, a lack of sexual intimacy, and an inability to forget the many hurts that each felt had been inflicted by the other.

At age twenty-eight, engaged in a teaching position that she seems to do very well in, Jane is always tired. She speaks to me dutifully in analysis, but with little interest in what she is saying—or in what I might say to her. Jane always talks about how much work she has to do, how much she has already done, and how hard it is for her to accomplish all this. And when she comes home from work, Frank sits in front of the television, and she has to first shovel the snow, then bring in the groceries,

go through the mail, cook dinner, and finally clean up the kitchen, all by herself.

Does she address this with Frank, I wonder? Frank does not seem to hear her, she replies, because he does not react to what she is saying—that is, to what she needs, which is some help. He says that he has his own stress and that he needs to rest. And Jane continues to restlessly perform all the work.

Soon something very similar seems to be established in her analysis. She "works" all by herself, I feel—or rather, she launches into some sort of analytic routine that starts to bore me not long into her sessions. I wonder aloud about that with her, too. She reacts as though I had not heard what she was saying and continues in the same vein.

One of Jane's complaints is that she is all alone in her marriage, but she feels helpless to change this, and—as it turns out—she also feels alone in her analysis; she thinks this is how it has to be, and that something will change over time to make her analysis better. But she actually has no idea how I could possibly help her. And regarding the redundancy with which she fills her sessions, and her resistance to considering that there might be something to notice or to think about, I sometimes *do* feel helpless, as if overwhelmed by this ongoing repetitiveness that seems to cancel out any possibility that something I say could make a difference.

Discussion

Now, there is something very similar in the histories of these two seemingly very different patients that eventually began to intrigue me. As remarkably little as they told me about their childhoods, both Cindy and Jane seemed to have grown up in an atmosphere that I would characterize as *oppressive* in a particular way.

Jane's parents had a hard time making ends meet. Her mother was a cook in a government-run drop-in facility for homeless people, and worked eight hours a day for very little money. Her father, a freelance salesman, was on the road most days of the week, and was wiped out when he came home on Saturday afternoons. Jane and her younger brother were latch-key children. After school, Jane prepared the meals

for her brother and helped him with his homework. She also did most of the cleaning in their apartment so that her mother could rest when she came home. There was little praise for all the hard work she did.

Cindy's family, on the other hand, was financially comfortable. Yet she, too, had a somber childhood. She was the only child of a mother who worked part-time in a museum, restoring ancient pottery, while her considerably older father, once a successful lawyer, became a diabetic invalid when she was just nine years old. He eventually lost his sight as well as one foot, and from then on rarely left the parental bedroom; instead, he spent most of his time listening to a radio through headphones.

Cindy's widowed maternal grandfather, a wealthy former real estate broker, maintained an apartment nearby, but could most often be found in Cindy's home, ensconced in a corner of the kitchen from which he ordered her mother around. Cindy says that she hated to see how submissively her mother behaved toward him, in an exhausting and fruitless struggle to please him.

SELF- AND OBJECT PRESERVATION

In discussing the repetition compulsion, Freud (1920) mentions the case of a woman who "married three successive husbands each of whom fell ill soon afterwards and had to be nursed by her on their death-beds" (p. 22). In contrast to other well-known cases, in which love relationships or other relationships repeatedly fail according to a certain pattern that can be analyzed as related to the early infantile neurosis of the patient, cases like this one, where the subject apparently suffers from "a passive experience" (p. 22) beyond her influence, seemed to Freud to confirm a *compulsion to repeat,* a dark force behind his pleasure principle.

However, was the woman who was widowed three times merely the victim of some uncanny fate? She was the one who chose her spousal objects, after all. So we might wonder: did she unconsciously pick *sickly* objects? And if so, what might have driven her to do so? Did she perhaps feel the need, the urge, to take care of others and to ultimately nurse them to death?

Freud—who fiercely held on to, but never elaborated on, his concept of a self-preservative drive—did not consider that the urge to pre-

serve others could be as primal as the self-preservative urge or the sexual one. Thus, it did not occur to him that this woman's object choice could have been an expression—an unconscious striving—of her *preservative drives*. And this will be the particular focus of my discussion here, in relation to a particular kind of failed oedipal conflict.

As I have shown elsewhere in my revision of drive theory (Schmidt-Hellerau 1997, 2001, 2005b, 2006b), we can reintegrate Freud's neglected concept of the preservative drives as part of the death drives, if we take into account that it is the structuring intervention of the nurturing object that tames, limits, and modulates the power, reach, and intensity of the death drives—and brings self- and object preservation into being. To conceptualize the preservative drives as a necessary, healthy part of the death drives is to recognize the fact that, in the end, self-preservation is about walling up the dangers of death; it is a matter of survival. *We are all driven to survive.*

Freud successfully worked with the primal antagonism of sexual and preservative drives until 1920, when he introduced the new notions of life and death drives. In trying to integrate his first drive theory into his second one, he joined sexuality with life and briefly tried to combine preservation with death—which seemed self-contradictory to him, as it seems counterintuitive to all of us. Thus, he made preservation, together with sexuality, part of his life drive—now declaring both as libidinal—and declared the death drive an aggressive/destructive drive.

However, this reorganization canceled the antagonism between sexual and preservative drives, thus obscuring the dialectic movements between different energetic investments in conflict. For instance, with regard to oedipal rivalry and castration anxiety, it is the *need to preserve* and hold onto the paternal object (object-preservation) that counters the patricidal fantasies of the oedipal boy; and it is the *need to preserve* his own penis from castration (self-preservation) that counterbalances his erotic desire and leads him to renounce the forbidden maternal object.

Mindful of this basic antagonism and of the initially unstructured, unlimited power of the primal drives, I showed in a previous communication (Schmidt-Hellerau 2006b) that, while it makes sense to conceptualize sexuality as the structured part of the life drive (Eros), it is important to understand the preservative drives as the structured part

of the death drive. Hence in my conception, aggression is not a primal drive and representative of the death drive, as Freud suggested, but is the unbound, unlimited, intensified expression of either the preservative or the sexual drives (Schmidt-Hellerau 2002, 2005b).

An additional point regarding the relation between drives and structures: representations are built up and elaborated following experiences with various objects; they are the structures of our mind. However, the complex *representation of father,* for example, can be activated predominantly by preservative or by sexual strivings, leading to two very different (momentary) experiences or needs/desires of father, in the former case as a protective, nurturing object, and in the latter case as an exciting erotic object. It is the energetic investment with libido (the energy of sexual drive) or lethe (the energy of the preservative drive) that determines the function and meaning of the activation of the representation of the object father in a particular moment.

The need for self- and object preservation is so basic and powerful that it can temporarily or permanently cancel out the major portion of an individual's sexual strivings. In this case, a *powerful preoccupation with survival* ensues, with severe consequences for the individual's fantasy life and state of mind. Whereas sexual strivings elicit *desire,* and aim at joy, pleasure, romance, success, happiness, and related representations—thus structuring an imaginary world that colors our experience and guides our daily life—preservative strivings are expressed in the *need* for maintenance, repair, and safety; they go with sadness, sorrow, aches, and pains, and they stir up anxieties about starvation, suffocation, and dying, leading to rescue and escape fantasies. See Figure 1 on the following page, in which the preservative and death drives, with their energy, lethe, and related feelings and fantasy formations, are depicted.

THE OEDIPAL PHASE IN WOMEN

In two previous papers (Schmidt-Hellerau 2005a, 2008), I have shown how the preoccupation with self- and object preservation impacts an individual's Oedipus complex. Here I want to explore the effects of the parent's preoccupation with self- and object preservation on the daughter's oedipal phase.

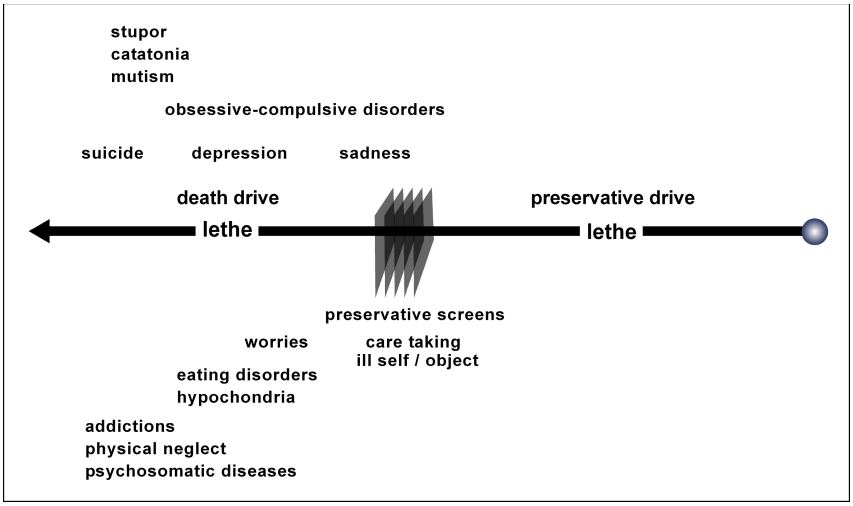

FIGURE 1

The importance of the aforementioned opposition between the preservative and death drives on the one side, and the sexual and life drives on the other, has become apparent to me in my clinical work with certain young women who are married or in stable relationships, but who do not have a sexual life. Instead, they have been mostly and often exclusively devoted to taking care of children, husband's or boyfriend's more mundane needs, and the needs of other family members, as well as household duties and/or the tasks of their professional lives. These women tend to be dutiful, on the obsessional side, rather depressed, easily worried, and frequently consult doctors for physical concerns. Also, amazingly enough, they do not miss having a sexual relationship, nor do they complain about a lack of fun and amusement.

Some of these women have declared to me: "After my children were born, I didn't feel like sleeping with my husband any more; I just didn't care about it." Others have said: "With menopause, or with my depression, my libido is gone—actually, I don't need it. Maybe I never did." Or: "Men always want sex—it makes me furious!"

Instead, they have established themselves, or so it seems to me, in a land far away from amor's lust and passion. They have been preoccupied

with self- and object-preservative activities. And when the patient and I, often after years of analysis, unearth traces of an oedipal conflict, it unfolds in a strangely dull way. It seemed as though, in their minds, there was no *sufficiently attractive father* who could spark excitement, longing, and dreaming. Yes—there had been rivalry and fury, yet it was in the area of caretaking; for example, one patient said: "Whenever I set the table, my mother came and finished it up so that she could say she had done it." Or: "I remember once in winter, when my father wanted to go out, I hurried to bring him his woolen scarf, as my mother used to do, saying, 'Daddy, you should keep warm when you go outside'—and he brushed me off, saying, 'I know what to wear!' and left. It hurt me so much!" Or: "My mother and I, we always have this fight about how to load the dishwasher. I've done it for many years and it always works fine. But when she visits, she takes out what I have just put in and starts to rearrange things, saying it works better her way—it drives me nuts!"

Notice how different these struggles sound from clearly erotically charged complaints, such as: "Mother did all the exciting things with Daddy, like staying up late, dancing rumba, going for fun trips on weekends, dressing up for the opera with her long dresses and high-heeled shoes, and on top of it all, they slept together in one bed and would chat and laugh together in the bathroom."

KORE BETWEEN DEMETER AND HADES

As so often, Greek mythology provides us with a story that can help capture a major problem in failed female oedipal development as I have outlined it here. It is the story of *Kore*—and Kore is not an individual name, it simply means *girl* or *maiden* (which is interesting in itself: if she has no name of her own, is she really just a narcissistic extension of her mother?). Kore's mother is *Demeter*, the barley mother or goddess of grain. Demeter has important powers in the preservative sphere: mythology has it that she can condemn a person to eternal hunger, for example, or free someone from stomach pains forever. She presides over fields and harvests and can threaten the world with starvation and death.

Demeter has no husband, which is also interesting. It is Demeter's brother Zeus who fathered Kore. And Hades, who will wed Kore, is an-

other brother of Demeter and Zeus. Thus, there is no other, *new object* outside the family circle in this story, as is essential for a mature love relationship. (Incest is such a pervasive feature in Greek mythology that I will not discuss it here.)

One day, Kore is out with friends collecting flowers, and just as she starts to pick a narcissus, her uncle Hades, god of the dead, emerges. He abducts and rapes her, and makes her his wife and the queen of the underworld. From then on, Kore is called Persephone. Demeter, desperately searching for Kore for nine days, is furious when she eventually learns that Zeus cowardly gave in to Hades's desire for Kore. Thus, we learn that Kore's father does not *protect* his daughter—or, as I would express it, he shows a lack of object preservation that increases Kore's dependency on her mother for her protection, and thus severely impairs a healthily balanced structuring of Kore's own self-preservative drives. In her pain, Demeter withdraws into year-long mourning, thus causing a famine that threatens everyone with starvation.

Finally, Zeus negotiates a compromise with Hades that allows Persephone to return to her mother. However, since Hades has fed her the seeds of a pomegranate, she has to return to Hades in the underworld for four months each year. Thus, Persephone is trapped between her mother, the goddess of nutrition, and her husband, the god of the dead. Eros is not in the picture, and in at least some versions of this myth, Persephone has no children, which makes sense: how could the king of death father a child? Persephone, who by marriage became the queen of the underworld, is destined to wander endlessly between the living and the dead (which is in some way the realm of the transference). She must shuttle back and forth between her deadened husband and her nurturing mother.

In recent years, the Persephone/Demeter myth has been used to emphasize aspects of female development and oedipal conflict that were not captured in Freud's classical analogy drawing on Sophocles. Fairfield (1994) presents a thorough analysis of a whole cluster of myths related to Persephone, Demeter, and Hades in order to illustrate unconscious anxieties of both male and female preoedipal children who struggle with separation-individuation conflicts—causing anxieties of which separa-

tion (from mother Demeter) is experienced as equal to death (being drawn into the underworld).

Better known is the extensive work of Kulish and Holtzman (1998) on the female oedipal complex. They argue that the Persephone/Demeter myth captures the oedipal dilemma of a little girl who finds herself in a conflict of loyalty between father and mother, struggles with the fear of losing her virginity, and defends against a sense of agency over her sexuality before eventually coming to a peaceful resolution of her adult sexuality.

Closer to my own understanding is Krausz's (1994) view of the Demeter/Persephone myth. Emphasizing the transgenerational transmission of *pathological mothering,* Krausz shows that it is Demeter's refusal to separate from her daughter, her pathological mourning, that prevents Persephone from safely expressing her desire to her husband, or from wishing for a husband worthy of her feminine desire. It is this transgenerational, unconscious legacy that keeps Persephone trapped between a mother dedicated to excessive mothering and a husband who is merely a shadow of death. Krausz goes on to explore the fantasy of invisibility in women.

My interest centers around the psychic drives. Staying close to the narrative of the myth, I explore Persephone's entrapment between Demeter and Hades, and I focus on self- and object-preservative issues in relation to the threat of death—which, when unresolved, severely inhibits, taints, or even prevents female sexual development to a degree that requires our psychoanalytic attention.

FURTHER OEDIPAL CHALLENGES

As I have previously emphasized (Schmidt-Hellerau 2005a), the oedipal phase is a challenge to the child's mind that extends beyond the well-known, classical issues of positive and negative erotic desires, murderous rivalry, castration anxiety, narcissistic defeat, and acceptance of the law of the father and the generational difference. All of these important and more prominent features are infused by Eros, the libidinal instigator of this crucial developmental phase.

But in the shadow of these dramatic processes, another challenge must be met simultaneously: the child has to differentiate between preservative and sexual aims and functions (e.g., in recognizing that the genitals are the organs of excretion as well as procreation), between needs and desires, care and love, protective and erotic objects and interactions. If there is a serious "confusion of tongues" (Ferenczi 1949) in which the child's tenderness and attachment to her parents and her need to be taken care of is interpreted as a seductive gesture that requires a sexual response from the parent, or if the child's oedipal seductive behavior, rather than being understood and contained by her parents, is misconstrued as a heightened worry and need for caretaking, this process of differentiation will be impeded and will ultimately fail. The result is the child's permanent sense of threat, as well as a severe inhibition of sexual pleasure.

However, if the work of differentiation (which is basically a working through of conflicts between preservative needs and sexual desires) has taken place, then the two types of strivings do not need to be anxiously kept apart, but can instead be integrated on a new level (where it is possible for a single object to be an object of care as well as an object of desire), leading to a well-structured, balanced mental life in which both preservative and sexual strivings can be pursued and fulfilled.

In order for these processes to take place in a good enough way, the child's parental objects must be both good enough caretakers and good enough lovers. They need to communicate that care is about safety and the preservation of health and well-being; it is calming and comforting. Erotic desire, on the other hand, is about joy, pleasure, and making babies; it is exciting and enlivening.

As I have suggested elsewhere (Schmidt-Hellerau 2006c), structure building is the consequence of a dynamic process between subject and object (if this were not so, psychoanalysis would not work). It differs depending on the libidinal and lethic components that infuse the dynamic process between subject and object, demand and response, action and reaction. The mind's structures represent not only one's own drives, with their related objects and all the memories, fantasies, and feelings associated with them, but also one's *object's* needs and desires—the "enigmatic messages," as Laplanche (1997) would call them, that are continuously

perceived, even if subliminally and unconsciously. Both these sets of psychic elements together weave the dynamic tapestry of mental structures.

One of the key points in the resolution of the Oedipus complex is that a child experiences her parents as being in love with each other, when she observes them exchanging a tender hug, a kiss, a stroke, when they have a good time with each other. As jealous as an oedipal child may become, in the end it is the safe nature of her parents' happiness that proves to her that her jealous and rivalrous fantasies, her angry outbursts and secret murderous wishes, could not do any real harm to her parents' relationship. This assures her of the stability of her own romantic future. I have heard more patients in my office complain about and mourn the *absence* of their parents' loving gestures and romantic vibes (which can also represent denial, of course) than I have heard of the classical oedipal jealousy that Freud focused on. (Were marriages at the beginning of the twentieth century happier than in recent years?)

If we listen to our patients who talk about a lack of erotic affection between their parents, and also between their parents and themselves, we will frequently discover an accompanying overemphasis on what I would call *preservative* measures: order and routine, a search for harmony at all costs—often embedded in strictness or hyper-cleanliness, for example, at times combined with anxiousness. We may uncover a smoldering disease or distrust in the family, a persistent financial crisis, a sudden professional defeat, or the like. Subtle or more open signs of disaster have clouded the family atmosphere; causes for worry are everywhere, and self- and object preservation are the highest priority. How will such a situation influence a child's development during the oedipal phase?

TYPES OF OBJECT CHOICES

Freud (1914, p. 90) describes the individual's object choices, characterizing the *narcissistic type* as a man who loves:

(a) what he himself is (i.e., himself),
(b) what he himself was,
(c) what he himself would like to be, and/or
(d) someone who was once part of himself.

Freud's counterexample of a non-narcissistic or "real" object choice is the *anaclitic* or *attachment* type, according to which a man seeks:

(a) the woman who feeds him, or
(b) the man who protects him.

Clearly, the two latter types function as the lethic or preservative object. Even though Freud intended to show how the "real" object choice develops out of the nurturing one, it is intriguing that he stayed with the preservative choices (at the time, an expression of his self-preservative drive, it would seem), and despite his predilection for sexuality, missed spelling out a *third type* of object choice, which I think is important to include here for the sake of differentiation: the *erotic type*, of which examples would be:

(a) the sensual, exciting, physically attractive man or woman, or
(b) the funny, intellectual, artistic, high-spirited woman or man. (The latter type indicates a focus on the more sublimated forms of sexual strivings.)

To *distinguish between the attachment and the erotic type of object choices* seems important when we work with patients who split the preservative object from the sexual object—for example, the man who wants a caretaking wife at home but seeks sexual love elsewhere; in effect, this expresses the classic Madonna/whore dichotomy. "Where they love they do not desire, and where they desire they cannot love. They seek objects which they do not need to love, in order to keep their sensuality away from the objects they love" (Freud 1912, p. 183). Here we see that differentiation between preservative and sexual strivings and functions has not been safely accomplished, and thus needs to be—most often forcefully and obsessionally—maintained and enacted. Integration cannot take place when fusion looms.

From a drive perspective, we can wonder what object choices might result as a consequence of different parent–child constellations in the female oedipal phase. First, let us consider the *ideal or mature type of constellation:* A good enough parental couple that is *loving* and *caring* toward each other and toward the child can help her resolve her Oedipus com-

plex, which would then lead to a *mature object choice,* in which the woman will choose:

(a) a man whom she loves (the sexual element) and whom she wants to take care of (the preservative one), and
(b) a man who loves her (sexual) and wants to take care of her (preservative).

In the above, (a) presents active strivings, and (b) passive ones. The same is true for a man's mature heterosexual object choice (with a woman as the object, of course).

However, the child's experience of an imbalance between love and care within the parental couple—whatever the cause of this (e.g., one parent's or both parents' physical or mental health problems, or the child's unresolved infantile conflicts involving frightening fantasies and related distortions of sexual and/or preservative functions)—will gravely impact the child's development. Such an experience can result in a distortion of oedipal conflict, leading in turn to various consequences; for instance, a woman might choose her husband based on the model (or anti-model) of either parent.

Thus, in the *imbalanced (neurotic) object choice,* a woman may choose her transferential father-husband as either:

(a) predominantly an erotic lover (the "sex-machine"),
(b) predominantly her caretaker (the "sugar-daddy"),
(c) an object of mutual caretaking (in which both partners will be preoccupied with taking care of each other), or
(d) predominantly an object to take care of (as was the case in Freud's example of a woman who nursed three husbands to their deaths).

These types of object choices express important differences: In the first two cases of the imbalanced type, (a) and (b), there is either a lack of differentiation between what is care and what is sex—with the consequence that every action is aimed primarily at satisfying just one of the two drives—or (a) and (b) are used in a counterphobic way, so that the choice of a "sex machine" can defend against feelings of shame around wishes to be dependent and cared for, and the choice of the "sugar-

daddy" can turn out to be a defense against an infantile hypersexuality, expressed as a compromise in the attitude of a "sex-vamp" (who sucks blood money from her provider) while maintaining a childlike dependency.

The second, third, and fourth imbalanced types (b, c, and d) express the predominance of self- and object-preservative strivings (primary or defensive ones): either the wish to be taken care of by an omnipotent provider (the permanent breast), or, in the case of a caretaker couple, the common worry that is jointly defended against by being careful, neat, concerned, and so on. This couple might get into a sort of caretaking rivalry that threatens their safety and survival, which might then be responded to by a heightened need to preserve the couple, defending against competition and hence increasing the anxiety level in an endless vicious circle (Schmidt-Hellerau 2006a).

In the fourth imbalanced type, a woman chooses a man whom she can take care of, whether because he is sickly (as in Freud's example) and will need to be nursed, or because he demands caretaking (e.g., men who prefer to marry the stereotypical housewife), or because he is totally absorbed by his career (the "absent-minded professor" type) and leaves all caretaking responsibilities to his wife. Whatever the complaints of our women patients about their husbands or partners, we are mindful that the patients have chosen to be with them, and hence these men are fulfilling some unconscious wish or need of the patients (even if this becomes ego-dystonic to them).

We can fairly say that a woman who makes a predominantly preservative object choice (imbalanced types b, c, and d) at the expense of her sexuality (in the broadest sense of this notion) suffers from a heightened feeling of insecurity. Her own as well as her object's survival unconsciously feels to her as if it is always in jeopardy; thus, she must first ensure that she establishes herself close to the larder, so to speak (type b). She might also behave defensively against her own needs by projecting them onto her objects, and calming herself down by taking care of them (types c and d).

If a girl's father was experienced, portrayed, or fantasized as weak, if he was in fact sick, invalid, or actually died from a disease or addiction, or if he was or seemed to be an object in need of being cared for, this

might become the focus of a woman's way of relating to a man—not in the sense of a simple replication of her childhood situation, but in terms of the subtext of all her object communications, namely: "There is a threat that father is going to die." The little girl, instead of developing sexual fantasies toward her father, will then feel *driven to rescue, protect, and preserve him,* because she is in a constant state of anxiety about losing him. (Of course, an overemphasis on preservative urges can also be a defense against the girl's forbidden sexual longings, or a compromise formation that allows her to be close to the desired object without having to feel guilty, competitive, or bad.) In these situations, oedipal development is thwarted by object-preservative needs. The girl's father, instead of being a model for her erotic strivings, comes to be represented as an object to care for; the lack of resolution of this attachment and the resultant conflicts will later stir up *an urge to preserve the man.*

This exaggerated urge to preserve should not be confused with a strong superego. On the contrary, it is my impression that in these cases, the superego is often only rudimentarily structured. Having missed out on a clear shift from predominantly preservative needs in early infancy to predominantly sexual strivings in the oedipal phase, these women have not had much to renounce and repress, one might say. Consequently, there does not seem to be a clearly designated, separate mental unit within the patient's psychic apparatus that can exert the potentially mitigating influence of a superego, which would create a conflict with urges from the id, to be resolved by the ego. Rather, there is an overriding, essentially unconscious threat to survival that expresses itself in fundamentally anxious, overprotective fantasies and activities, and makes these women prioritize always being "nice" and "good."

Furthermore, it is because of the lack of a solid superego structure that occasional breakthroughs of anger (aggression toward the object that thwarts preservative needs, as well as aggression toward the self) cannot sufficiently be contained and internally worked through—with the consequence of an even greater need to repair, heal, and protect. And where we do find a set of superego ideas at work, they tend to be rigid, limited, and predominantly preservative—while the libidinal (narcissistic) investment in the ego ideal that could promote progress and renewal, and that could spur development, can do little to counterbalance the anxiousness of the woman's conscience.

These cases follow the classical transference model in that they relate the patient's choice of husband or boyfriend to an unfulfilled childhood wish in relation to the father. This wish by no means needs to be, or to genuinely include, a sexual wish, but can in fact be a predominantly preservative one. The fact that these relationships might initially embrace sexuality—sometimes just until a woman's wish for children (who will need to be cared for) is sufficiently fulfilled—does not prove that sexuality is a major motive. The unconscious wish to be preserved by the object can still be the decisive one, if sexuality is understood to be the price for staying safely in a relationship.

I suggest that *women who choose and create their marital relationships in a way that excludes or marginalizes sexuality, who instead focus predominantly on self- and object preservation* (in order to fight off the idea of looming death), suffer from what I would call the *Kore complex.*[1] Like Kore, they must remain trapped between a nurturing "grain mother" and a deadened spouse who is to be rescued from dying or to be nursed to his death. Actually, they remain girls in a deeper sense, and have yet to discover and represent their sexuality—an implicit goal of their analyses—in order to become mature women.

Looking at genealogy allows us to trace the situation even further back. Careful analysis more often than not reveals that the patient's deadened husband is her mother's own transferential oedipal father, cast onto and picked up by the little girl in order to perpetuate her mother's failed Oedipus complex. Failed in the very sense that I outlined before: be it for reasons of conflict, deep anxieties, or a predominance of their preservative drives' strivings, the mothers of these patients had chosen to relate to their fathers at the oedipal stage not as potential sexual objects, but as objects of caretaking. Thus, they avoided their sexuality and remained attached to their fathers in an object-preservative stance. Later, these women married considerably older, sick, or alcoholic men for whom they functioned as caretakers—remaining depressed themselves (and often abused), while yearning for a better life. Since these mothers could not or could only barely represent their own sexuality, they often

[1] Fairfield's (1994) notion of the Kore complex has a different meaning (see earlier description).

lacked the necessary desire and determination to leave these malignant relationships. Instead, they continued to aim at providing better and better care, and to draw their daughters into this vortex of misery and exhaustion as their allies.

The daughters of these mothers—our patients—present themselves to us as overshadowed by their mothers' failed Oedipus complex. Identified with a caretaker mother and confronted in their early oedipal love with a sick and/or weak father, they have aborted their own oedipal development and are trapped in a Kore complex. As maiden caretakers, they are bound by the need to help their grain mothers with the burden of caretaking and to heal their mothers' paternal transference objects. Yet the inherited dead father is too heavy to be carried, too sick to let go of, and too sad to be an enjoyable object. Such an impossible task pulls these women into a vicious cycle of guilt and/or rage, which defensively increases their preoccupation with caretaking, nurturing, and repair.

"SO MANY MEN WHO STRUGGLE"

Jane recently told me that, when she was eighteen years old, she and her brother accompanied their father on a trip to Paris. For most of the trip, they were on their own and arranged their own sightseeing. One day, however, their father took them to the red light district, Pigalle, and it was revealed that he had been going there every day. She started to wonder what he had actually been doing during all the years when he was on the road for his work.

"He never was at home much," Jane says to me, "and he became an alcoholic, like my grandfather. Why couldn't he have a job in town—why couldn't he be happy with my mother? But when he got her roses on Valentine's Day, my mother would complain that he had spent too much for flowers, and anyway they would die in a few days. There were so many problems, and we were always short of money."

I say: "There were so many problems to worry about, and the lust sneaked out to a secret and unexpected place."

Jane then tells me that she had lunch with her brother Barry the previous day. "He reminded me of this trip to Paris," she says, "and then he told me that his girlfriend has broken up with him. He always has

problems in his relationships, and he also loses his jobs—or at least he never stays at one place for long. And he has this allergy—he itches all the time, it drives him nuts. If he would deal with these problems on a deeper level, they would go away. [She cries.] I have the fantasy of being a therapist. I would talk with him and I could help him, because I wouldn't charge him. He can't afford therapy. He would get better. [She sobs.] I think there are so many men like Barry! I found help here, and I will get better. But there are still so many men out there who struggle—and Frank [her husband] is one of them, too."

What makes these constellations so inescapable? Sorrow, concern, and care always trump lust, pleasure, and fun. If there is something to worry about, going for the fun things seems careless and inconsiderate. Jane deeply cared for her brother, and it pained her to see how lost he was in his life. She felt she could not let go of him until she had saved him. Just as Jane had always felt driven to protect her brother, she had wished to save her father from becoming an alcoholic like her grandfather. Moreover, she felt the need to help her mother with the burden of making ends meet, a burden that thwarted the pleasure of roses and killed the potential for happiness.

And that was how Jane continued on in her marriage to Frank. In a lethic atmosphere full of misery, sorrow, and oppression, libido—the very energy that could turn things around for the better—is often split off; it "sneaks out" and finds a perverse release (as in Frank's use of pornography).

Something I learned over time from Cindy was that her mother had worshipped her own father, Cindy's grandfather. She had submitted to him so completely that she did not hesitate to dutifully sacrifice everything—her marriage, her daughter's well-being, and even her own life—to this complaining old man. Mother limited her professional career in order to stay home and take care of her father; she catered to her father's food predilections (his favorite was pasta) at the expense of her diabetic husband's health. And she would send her daughter Cindy to sit on his lap and cheer him up. Cindy had hated to sit on his hard knees, uncomfortable with his unrelatedness and disgusted by the two warts on his chin and the slightly rotten scent that exuded from his worn-

out sweaters. But she felt she had no right to protest—"Be quiet!" her mother would say, "Grandpa had a bad day. He is old and sick."

And Cindy would tiptoe away—disappointed, sad, furious, and guilty for being enraged. Yet she continued to do her household jobs, to fold the laundry and clean everybody's shoes. Thus, Cindy found herself in a dilemma: she wanted a man and wanted a child, but she could not go out to play and find a fun man; instead, she felt guilty about abandoning *me*, her analyst, and was angry at my wanting her to "come in every day." And when she met a man and felt for a moment smitten by him, the uncanny fear crept in that she would lose her freedom and end up as a provider for a needy old grandfather. On top of all this, it felt as if it were not *her* choice, but her mother's (her analyst's).

So we seem to have ended up with quite a classical constellation in which sexuality is repressed and filled with conflict. However, this is not because it is shameful or forbidden; it is because of an *overbearing sense of misery* that continuously stirs up the need for self- and object preservation.

What I would like to emphasize here is that self- and object preservation are not part of a life drive (Eros)—in line with sexuality, an expression of libidinal strivings. On the contrary, they are its *antagonist*. If exaggerated (as is the case when one is overprotective), they oppose and sometimes completely suffocate lust and pleasure. Analyzing the overwhelming urge to help, and working through the pain and defeat of not being able to preserve, protect, and rescue, means to alleviate survivor guilt (in the most general sense of the term). It eventually frees the patient's libido and enables her to balance love and care in more fulfilling relationships.

CONCLUDING REMARKS

It goes without saying that typologies are rough abstractions put forward in order to highlight a particular aspect or phenomenon. Real life, psychic pathology, and neurotic conflict are always more complex than a bare scheme. Furthermore, we recognize that differences in constitution allow one person to flourish despite miserable circumstances, while another becomes discouraged and gives up all hope, and still another

endeavors to fix all the problems in the world. And there are always more objects around a little girl as she grows up than her primal family offers; hence she might find pleasure and a good, suitable man for her awakening sexual strivings outside her own home, and she might then transfer what she experiences with others to her sickly father, thus investing him with all he needs to be the frog-turned-into-a-prince whom she can build her fantasies around.

And finally, too much misery can also lead to a compensatory erotic fantasy life that might at first glance look rather normal and oedipal (even though it is most often split off)—until the heavy weight that is attached to it finally reveals its defensive function, and sometimes even an overwhelming preservative undercurrent in need of being analyzed. Yet despite the fact that these and other possibilities necessarily complicate the simple picture sketched in this paper, an awareness of this dynamic and of the differentiation between sexual and preservative strivings seems to me to be crucial in our psychoanalytic work with patients.

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THE TRAUMATIC ROOTS OF CONTAINMENT: THE EVOLUTION OF BION'S METAPSYCHOLOGY

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W. R. Bion wrote repeatedly about his World War I experiences as a tank officer, thus engaging in historicizing a traumatic emotional experience. A close reading of the many layers in these writings suggests that the war experiences influenced the metapsychology he created. The author argues that haunting questions regarding the ability of the mind to survive trauma led Bion to elaborate on the process of containing emotional experience, and hence to address the lack of an intricate theory of thinking in psychoanalytic metapsychology and to offer a vision of a mind struggling to survive, culminating in the growth of a postmodern consciousness.

Keywords: Bion, war trauma, war memories, metapsychology, containment, autobiography, learning from experience, Post-Traumatic Stress Disorder, death, shell-shock, fear, group dynamics.

Bion's theoretical contribution can be conceived as a creative way of dealing with the arbitrariness of surviving the Great War, both physically and mentally. The concept of *containment* of these traumatic roots is the unique vision of a mind struggling to survive the devastating impact of internal and external reality by means of *learning from experience* (Bion 1962).

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In general, most of the discussion of Bion's concept of containment focuses on its clinical usefulness, and is concerned with nuanced intricacies of mental exchanges projected and introjected within human interaction. The delicate and complex images of a mother providing her baby with α-function that are sketched by this discourse stand in sharp contrast to the vast and desolate landscape of burning tanks and shallow trenches strewn with dead bodies of men and mules, conjured up by the observations in Bion's memoirs of his experiences in the First World War. I argue that these diverse images are related to each other—the traumatic memories can be conceived as dreadful answers lying at the root of certain metapsychological questions, which in turn led him to conceptualize containment.

Although some authors have commented on the influence that Bion's war experiences had on his contribution (Bléandonu 1994; Boris 1986; López-Corvo 2003; Meltzer 1981; Sandler 2003; Symington and Symington 1996; Wisdom 1987), these comments have not gone far beyond an intuitive delineation of a significant thread—linking these war experiences with certain clinical and conceptual aspects of Bion's work. Brown (2005, 2007), in an innovative discussion of the clinical and conceptual end of this thread, does explore the connection between Bion's war experiences and his theory of thinking. Brown offers a reading of the theory of thinking that accentuates the mind's reaction to traumatic experience and highlights the usefulness of this theory to clinical work with traumatized patients, an inference implicit in Bion's writings.

In this paper, I explore the other end of this thread, reading Bion's writings about his war experiences while highlighting hinted reflections and subtle echoes in order to demonstrate that his metapsychology in general, and the concept of containment (Bion 1970) in particular, are the fruits of these traumatic roots. I will use a close reading of the many layers in Bion's writings regarding his war experiences to trace his metapsychological questions. I will suggest that particularly those questions regarding the ability of the mind to survive trauma led him to elaborate on the complex process of *containing* emotional experience. This process in turn inspired him to address the lack of an intricate theory of thinking in psychoanalytic metapsychology.

"A QUESTIONING ATTITUDE" BETWEEN REVISITING AND REVISING WAR EXPERIENCES

Bion served as a tank officer in France from June 26, 1917, to January 10, 1919. Three of his published works are autobiographical, all published posthumously (1982, 1985, 1997), and, together with significant parts of other works (1991, 1992), they deal with Bion's war experiences. These three works are:

- *War Memoirs, 1917–1919* (1997), which in turn contains three texts: the "Diary" Bion wrote for his parents soon after demobilization, when he went to Oxford (pp. 5-196); "Commentary," dated 1972, written after Bion read the typescript of the Diary (pp. 199-211); and "Amiens," written following a visit to France with his wife in August 1958, and abandoned in mid-sentence in 1960 (pp. 215-308).
- *The Long Week-End, 1897–1919: Part of a Life* (1982), in which 187 of a total of 287 pages are dedicated to war experiences (pp. 100-287).
- *All My Sins Remembered* (1985), significant sections of which deal with Bion's experiences in World War II; these are explicitly linked to his experiences in World War I.

Such an immense autobiographical effort can be seen as "a ceaseless struggle" to bear witness (Felman and Laub 1992, p. 75). Bion attempted to decipher the meaning of these experiences through writing about them time and again from different vertices, using various literary styles—including the hybrid genre he created in the monumental *A Memoir of the Future* (1991).

The constant presence of these memories throughout Bion's life has been described by his wife, Francesca Bion (W. R. Bion 1997), who wrote in parentheses, containing her testimony: "(It was clear that that war continued to occupy a prominent position in his mind when, during the first occasion we dined together, he spoke movingly of it as if compelled to communicate haunting memories)" (p. 2); and also by his daughter,

Parthenope Bion Talamo (W. R. Bion 1997), who noted that her father continued to buy books on war "right up till his death, as though the subject was never far from his mind, perhaps constituting . . . a great unsolved puzzle" (p. 312). Parthenope Bion Talamo argues that in *A Memoir of the Future* (1991), Bion used some episodes "carried over almost unchewed and apparently undigested . . . as though no further working-through were possible" (W. R. Bion 1997, p. 310), to demonstrate the constant presence of regressive states of mind. Beyond this rhetorical function, I regard Bion's various forms of repeated reflection as aimed at historicization of a traumatic past (Brown 2007).

Regarding Bion's question in Christmas 1917, "Had everyone gone mad?" (1997, p. 69), Parthenope Bion Talamo comments: "He gives it no immediate answer, but reading *War Memoirs* makes me wonder whether he did not perhaps spend a good portion of the rest of his life exploring the avenues of enquiry that it opened up" (1997, p. 309). As I argued elsewhere (Szykierski 2008), Bion's war experiences lie at the foundation of his adherence to what he termed more than forty years later "a questioning attitude" (1961, p. 162), accounting for his ability to develop a radically innovative approach to work with groups.

Bion's recurrent emphasis on "a questioning attitude" is also expressed in the title of the published collection of his works, *Seven Servants* (1977). Here Bion borrows Rudyard Kipling's metaphor of the six servants—*What, Why, When, How, Where, Who* (Kipling 1900, p. 85)—and adds another: the opinion "each individual has to arrive at for himself: his opinion and only *his*" (introduction to Bion 1977, italics in original).

As part of her exhibition entitled "Attacks on Linking" at Tel-Aviv Museum of Art, the Israeli artist Michal Heiman (2008) presented a video of a lecture incorporating other video works that refer to Bion's term *attacks on linking* (Bion 1959, 1967a). Suffused with uncanny premonition and saturated with anxiety, Heiman's video works decontextualize Bion's terminology from its theoretical universe and filter it through visual images expressing the artist's subjective experience of anguish, the anguish of witnessing human contact attacked—failing, falling, bleeding, or vanishing without a trace within spaces without witness. Questions stamped under the visual images undermine our habitual ways of seeing, and accentuate the anguish caught up in the images.

Contrary to terms like *attacks on linking*, in which there is a certain affinity between the connotations aroused and the clinical phenomena referred to, the word *containment* is defined in various contexts—some mundane, referring to the containing of inanimate or animate objects in a semiclosed space; but most of these definitions accentuate first and foremost the containment of dangers: from the political influence of a hostile nation, to radioactive fallout, to epidemics.[1] Hence, there is a significant gap between the commonplace function of the word and the penumbra of associations attached to the psychoanalytic usage of Bion's concept of containment (1970). Bion was aware of the military implication of the word, and chose it to convey a sense of "one force containing another" (p. 112); thus, a disciplined control of violence is at the root of a concept fundamental to the metapsychology Bion constructed.

However, in current psychoanalytic discourse, the concept of containment is usually discussed in the context of dyadic relations—either mother–baby or analyst–analysand—while disregarding its traumatic roots; thus it tends to be misconceived as a complex process crossing the conscious/unconscious, verbal/nonverbal, cognitive/emotional divisions. In a seminal paper, Ogden (2004) addressed a similar confusion between *containing* and *holding*. Such is the case, for example, when Langs (1981, p. 446) discusses Bion's concept of containment, Winnicott's concept of holding, and Chan's concept of the maternal shield; Langs narrows significantly the meaning of the concept of containment, as he sees all these as metaphors for protective, non-interpretative aspects of the analyst's relationship with the analysand.

Heiman's work, in its sensitive following of her own subjective associations, throws light on a certain tension in Bion's conceptualization, motivated by his similar sensitivity to the restrictive effect of a penumbra of associations, which might compromise an open-minded exploration of clinical material. Along the lines of this consideration, a subtle tension can be detected in Bion's work between the creation of evocative

[1] For example, we read of "a policy aimed at controlling the spread of communism around the world, developed in the administration of President Harry S. Truman. The formation of the North Atlantic Treaty Organization (NATO) in 1949 was an important step in the development of containment" (Hirsch and Kett 2002, p. 283).

terms such as *attacks on linking* and *containment,* both saturated with a threatening sense of danger, and the offer of "empty" concepts yet to be saturated by psychoanalytic inquiry (Bion 1962, p. 3). This tension culminates in the formulation of Bion's Grid (1962), where ß-elements are to be transformed by α-function into α-elements, and statements are contained by careful classification into precise categories.

The evolution of Bion's language did not stop at that. Bléandonu's (1994) formulation of an epistemological period in Bion's work, which includes the four works collected in *Seven Servants* (1977), blurs salient differences in structure and style yet to be explored between the first three books, on the one hand—*Learning from Experience* (1962), *Elements of Psychoanalysis* (1963), *Transformations* (1965)—and *Attention and Interpretation* (1970), on the other. For my purpose here, it is sufficient to note the difference, which for me signifies a move away from the deconstruction of the mind in an effort to create an "empty" scientific conceptual system, and toward an integration of individual and group, thought and emotion, leading to a decade of autobiographical writing and the creation of *A Memoir of the Future* (1991).

Bion's theoretical evolution is bound by two attempts on his part to write about his war experiences.[2] At one end is "Amiens," which was his first attempt to revisit the subject in writing, following a visit to France in 1958 with his wife—an attempt later relinquished in favor of "other, more pressing commitments" (1997, p. 214): the writing of the aforementioned four books during the 1960s. At the other end are "Commentary," the autobiographical writings, and *A Memoir of the Future*—all written during the 1970s.

Before discussing this evolution in the light of Bion's "ceaseless struggle" (Felman and Laub 1992, p. 75) to bear witness, it is necessary to evaluate the function fulfilled by the "Diary" (1992) that Bion wrote for his parents after his demobilization.

[2] Bion's attempt to revisit his war experiences in "Amiens" happened on the boundary between the publications of his papers on psychosis in the 1950s (later collected and republished with his reviewing commentary in *Second Thoughts* [1967a]) and his theoretical publications of the 1960s.

"ALL WAS *NOT* WELL" IN NO-MAN'S LAND, BETWEEN INSIGNIFICANCE AND IRRELEVANCE

An awareness of psychological casualties in modern warfare, as well as the severe, long-term consequences they suffer, is the result of constant tension between an urgent need to address these clinical phenomena and a pressing wish to deny their political meaning and disavow their social significance.

The changing psychiatric terminology regarding psychological casualties of modern warfare reflects the constant tension between clinical needs and political interests. Bilu and Witztum (2000) describe the changing nosology in detail. During the American Civil War, it was designated *nostalgia* or *soldier's heart,* pointing to the idea that the breakdown was caused by homesickness. In World War I, the term *shell-shock* indicated that the etiological factor was neurological damage due to excessive exposure to shelling and bombing. After the Great War, the growing influence of psychoanalysis on psychiatry shifted the emphasis to unconscious conflicts as vulnerability-increasing factors, expressed in the term *war neurosis.* In 1943, during World War II, the term was modified into *combat exhaustion* or *combat fatigue,* conveying the notion that the psychological breakdown is reactive and transient rather than a manifestation of premorbid personality defect. In the same vein, the term *combat stress reaction* (CSR), prevalent in current psychiatric discourse, underscores the exposure to stress in combat as a critical factor. The long-term sequelae of CSR were termed in 1980 *post-traumatic stress disorder* (PTSD), as a result of effective lobbying by war veterans and mental health professionals in the aftermath of the Vietnam War to cast the crippling effects of CSR into a medical diagnosis (Bilu and Witztum 2000, pp. 15-16).

Thus, the emergence of war-related PTSD as a psychiatric syndrome—indicating a common disturbance, chronic and severe, manifested in a wide range of symptoms and significant malfunctioning—followed from longitudinal studies concluding that approximately 50% of CSR casualties suffered from PTSD. Even more disconcerting were data

indicating that, of a control group of soldiers who ostensibly survived the war without any psychic damage, 10 to 20% suffered from some form of PTSD a few years later (Bilu and Witztum 2000, p. 22; Solomon 1993). Hence, "certified" patients suffering from PTSD can be understood as located at the exposed end of an enclosed continuum, a space without witness containing numerous "uncertified" veterans dealing with hidden—and at times unacknowledged—psychic damage, to varying degrees.

Although Bion evidently did not suffer from CSR, there were consequences to his exposure to the horrors of the Great War. Francesca Bion (W. R. Bion 1997) states that:

> He was catapulted, like millions of others, from schoolboy to combatant soldier in a few months. The horror of that war inflicted on such young men did not contribute to their maturity; it destroyed their youth and made them "old" before their time. Bion's remarkable physical survival against heavy odds concealed the emotional injury which left scars for many years to come. [p. 2]

In 1972, after reading the typescript of his "Diary" written in 1919, Bion wrote the "Commentary" in the form of a dialogue between MYSELF (that is, Bion at the time of writing the Commentary) and BION (Bion at the time of writing the Diary). There, BION says that, while in Oxford, he was not able to work or to enjoy games (1997, p. 209), and MYSELF states that he "did not stand up to the rigours of war very well." BION replies:

> Of course we did not know that, though I was always afraid I would not. I think even the diary shows that as it goes on, though at Oxford I was still too ashamed to admit it, and very glad of the opportunity that Oxford gave me to be seduced into a more self-satisfied state of mind. But I never quite got rid of the sense that all was *not* well. [1997, p. 201, italics in original]

After which MYSELF concludes: "That ultimately drove me into psychoanalysis" (1997, p. 201).

So, what does the Diary show us as it goes on? The Diary is first and foremost a text Bion wrote to his parents. Francesca Bion (W. R. Bion 1997) says that

> He would have been unable to express his very recent painful experiences, especially to his parents. But it is evident that he had them in mind throughout: detailed descriptions of tanks and equipment, explanations of battle strategy, photographs and diagrams were included for their benefit—and "bloody" became "b–y" in deference to their disapproval of swearing. [p. 2]

These detailed factual descriptions of external reality, as well as meticulous visual representations (Heiman 2008, p. 147), are the most salient feature of Bion's effort to reach out to his parents, the witnesses to his testimony. Additionally, explicit references invoke the readers throughout the text, mostly through the use of the pronoun *you* (and the imperatives *note* or *imagine*). These references function as a repeated appeal for understanding as they insert the readers directly into the situation, inviting them to experience Bion's experience.[3]

Bion's intent to communicate his emotional experience to his parents is stated in the opening paragraph of the Diary, in the first-person plural: "to give you our feelings at the time," etc. (1997, p. 5). It seems that Bion's difficulty in "express[ing] his very recent painful experiences, especially to his parents" (p. 2) led him to weave his experience into the common experience he inferred from observed group behavior. For example, he wrote: "We felt very miserable, as we had no idea what was going to happen, and really felt quite useless if the enemy did attack" (p. 59).

Still, the use of first-person plural pronouns does not blur the emotional experience Bion depicts, as in the following sentences:

> All our nerves were in an awful state, and we tried not to think of what was coming. The waiting was awful and seemed to be almost a physical pain—a sort of frightfully "heavy" feeling about one's limbs and body generally. [1997, p. 29]

Such hybrid statements exemplify Bion's ability to integrate observed group behavior with internal emotional experience composed

[3] These references appear in two forms: thirty-five (70%) occur in the context of describing external reality—both in the text and in captions for drawings, maps, diagrams or pictures; and fifteen (30%) occur in the context of explaining Bion's internal reality.

of physical sensations and psychic impressions, in order to recount the complex event of anxious waiting saturated with psychic terror that is experienced as physical pain.

Moreover, Bion detects the detrimental effect anxiety has on thinking, further explored as the hybrid statements make way to increasing differentiation of Bion's internal experience from the group's expressed emotions, as formulated in the following statement written in regard to walking upright under a barrage: "I must have been very nearly mad to do it. But I never *thought* more clearly in my life" (1997, p. 106, italics in original). Bion notices that while terror arising from contact with a dreadful external reality inhibits thinking, severing this contact brings about a semblance of clear thought unimpeded by the facts. In contrast to the inhibition of thinking when he is within the group, when he is alone, trying to return to his men, thinking seems to be facilitated.

Thus, Bion becomes aware of the complex relation between unthinking group behavior and the thinking individual, shaping the constant conflict between individual and group; as noted by Eisold (2005, p. 366), Bion came to conceive himself "in his own terms" as "a group animal at war, both with the group and with those aspects of his personality that constitute his 'groupishness'" (Bion 1961, p. 168).

Although the Diary, as Francesca Bion (W. R. Bion 1997) says, "has none of the nightmare quality he so vividly depicted in *The Long Week-End* [1982]" (p. 2), it is difficult to read, even more so than other autobiographical writings about the war. Contrary to these, the Diary is not divided into short chapters, focused and integrated, but is an ongoing, dense report conveying the sense of an endless war, referred to in *The Long Week-End* by quoting "catch phrases such as 'the first seven years are the worst'" (1982, p. 268). While the Diary is more about describing external reality than contemplating internal experience, much of Bion's state of mind is conveyed through his observations, accounting for the sense impressions that he had to historicize into a coherent sequence of events. Thus, the reader sees the battlefield through Bion's eyes: "All the enemy trenches were outlined in low-bursting shrapnel. It looked like clouds of white with golden rain in the bursts. It was very beautiful—and very deadly" (1997, p. 47).

The devastating impact war has on the land unfolds as Bion draws near the line:

> There were no trees with a leaf to be seen . . . . Old houses were simply mounds of bricks. Here and there guns were firing. The stench was terrible in places, and every now and then you came across dead horses and mules . . . . Everywhere the desolation was complete. You would see small parties of men hurrying over duckboard paths—no one loitered but tried to get out of the danger area as fast as possible. [1997, p. 22]

In this landscape, human behavior expresses the sense of imminent danger (see also 1997, p. 132).

In order to write the Diary, Bion had to overcome various obstacles, some due to losses—external and internal—hindering his testimony. The first sentence discloses that this text is not the diary Bion wrote during the war, but a reconstruction of that diary, which he has lost: "In writing this, I cannot be absolutely accurate in some things, as I have lost my diary" (1997, p. 5). Not only the original diary was lost; other losses are mentioned, too. The loss of men is noted frequently (1997, pp. 89, 136, 138, 149, 186); on a few occasions, Bion states he himself was "hopelessly" or "thoroughly" lost (1997, pp. 28, 30, 91). But another loss that is gradually revealed in the Diary is the accumulating mental damage, the loss of mental faculties—either a temporary loss, as in "I had lost all sense of time now" (p. 95), or a persistent state of mind, as in:

> There was one thing that was becoming very clear—I had lost my nerve. Everything I did was difficult; in action I had to force myself to do my mere job. I became more or less paralysed at the thought of action, and my brain would *not* work. [p. 156, italics in original]

Bion describes a progressive deterioration in his functioning (1997, p. 120), and as he struggles to make sense of the crushing impact the war has on him, he is using the framework available to him then—a descriptive classification prevalent at the time:

> I seemed unable to shake off a kind of sluggishness and terror that threatened to crush all life out of me. I had reached the

> stage that many had reached before me—the B.E.F. [British Expeditionary Force] man who was "not as good as he had been." [1997, p. 156]

The sense of mental injury clarifies Bion's preoccupation with his inability to give an accurate report of external reality, although it is not material to communicating his internal experience. He says: "My dates of events out of the line cannot be accurate. Actions are, however, accurate as they are very clearly stamped on one's memory!" (p. 5).

But even his confidence in accuracy, at least in regard to actions, is undermined as the Diary unfolds. It seems Bion intuitively sensed that the ability to remember an accurate sequence of events is crucial to historicizing traumatic emotional experiences. Bion's preoccupation with accuracy also informs another preoccupation with the relation between uncertainty and knowledge: "Although now one sees how unfounded some of our fears were, yet at the time we could not tell, and it was just the uncertainty that made things difficult to judge and unpleasant to think about" (p. 5). Bion seeks accurate knowledge of external reality in order to remedy the detrimental effect of the anxiety flowing from uncertainty, since the space stretching between uncertainty and knowledge, between the "general scheme" and the particular action, is dominated by "terrific confusion" (p. 5).

Hence, I assume that the original diary that was lost served as an anchor meant to preserve Bion's contact with reality—external and internal—despite the "terrific confusion" from without and the physical wear compounded by psychic tearing from within. The function of the reconstructed Diary that was written after the war was to pin down the facts in a coherent sequence as accurately as possible, and thus to historicize emotional experiences by transforming traumatic, "undigested" facts into memories (Brown 2007). In writing the Diary, Bion essentially engendered a therapeutic process of transforming trauma into memory, emotional experience into verbal thought, as it is understood by Felman and Laub (1992):

> The survivors did not need to survive so that they could tell their story; they also needed to tell their story in order to survive. There is, in each survivor, an imperative need to *tell* and thus to

> come to *know* one's story, unimpeded by ghosts from the past against which one has to protect oneself. One has to know one's buried truth in order to be able to live one's life. [p. 76, italics in original]

However, the task of historicizing traumatic experiences was not accomplished effortlessly. Psychic erosion and physical exhaustion caused fragmentation of memory, as expressed in Bion's comment on going into action on August 8, 1918, sick with influenza:

> I am really at a loss to describe the rest of the action. I only remember incidents and can't remember how I got from one place to another. I think that the best thing I can do is simply to give you a series of incidents in the order in which they came (as far as I know). [1997, p. 147]

In *The Long Week-End* (1982), Bion concludes: "Though we did not realize it, we were men who had grown from insignificance to irrelevance in the passage of a few short years" (p. 286). In the no-man's land stretching between the insignificance of being mobilized as one of millions thrown out to be killed in trench warfare, and the irrelevance of being demobilized and thrown back into a society that ignored them and forgot them as quickly as possible, Bion returned home to discover that veterans just fade away: "I think to some extent we were depressed by the lack of welcome. No one took any notice of us, no one seemed to know we had been fighting and were glad to be back" (1997, p. 194).

Under these circumstances, Bion had to attend to repairing the internal damage he suffered. In the Commentary (1997), MYSELF notes that events left out from the historicization process in the writing of the Diary—"events that in retrospect seem utterly horrible, [like the] sickly, sweet stench of corpses" in a farmhouse, "when you were asleep on the stone floor"—continued to gnaw him from within:

> That was what was so awful. You were not even frightened. By the time you got to Oxford, you had "forgotten" it. *I* don't remember it, but my gut does. I was and am still scared. What about? I don't know—just scared. No, not even "just" scared. Scared. [1997, pp. 209-210, italics in original]

Although writing the Diary enabled Bion to counteract the avoidant tendency to ignore and forget, the therapeutic effect was incomplete, leaving haunting residues, so he continued to feel that "all was *not* well" (p. 201).

"A THOUSAND SLEEPLESS NIGHTS": WITNESSING SHREDDED BODIES AND SHATTERED MINDS

Beyond the function of historicizing experiences and transforming them into memories, Bion's testimony can be conceived as explicit answers to implicit questions, some of these remaining open to further exploration as Bion became a psychoanalyst. A close reading of the Diary and other autobiographical writings allows one to trace the haunting questions that form the roots of the evolution of a unique metapsychology.

The Great War was a full-scale display of modern warfare's destructiveness on an unprecedented scale. Out of 70,000,000 soldiers mobilized, 15,000,000 were killed, 7,000,000 were permanently disabled, and 15,000,000 seriously injured. About 8,000,000 surrendered and were held in POW camps, with a much higher survival rate than their peers on the front. In addition to various contagious diseases claiming many lives, an influenza epidemic started in Western Europe in the last months of the war and spread rapidly, killing millions in Europe and 50,000,000 around the world. The war to end all wars exposed the vulnerability of body and mind, and is discussed here as it is represented in Bion's war memoirs.

Death was omnipresent, imminent (Bion 1997, pp. 36, 38; 1982, pp. 135, 176), and on occasion occurred without any warning, as reported by Bion in reference to a fighting comrade: "He said everything was going splendidly. A moment later a sniper got him through the head, and he died a bit later" (1997, p. 51; see also 1991, p. 454). On occasion, death was so sudden and swift that it was incomprehensible (1982, p. 283). Thus, upon receiving orders to attack at 10:30 a.m. without a smoke screen, Bion realized that these "were not orders," but "sentences of death"; the tank officers "tried the previous evening to insist to the divisional command that zero would have to be at dawn. When the mind

will not receive the obvious there is nothing to be done" (1982, pp. 253-254). As a result, all tanks and crews were destroyed.

A serious injury might result in permanent mutilation and was no less terrifying than death, maybe more so (1997, pp. 147, 211, 240). Bion understood that "sooner or later my parents would be bound to have the telegram announcing my death; the war had only to go on long enough. Already I had exhausted my quota of chances of survival" (1997, p. 247).

While the number of casualties was generally high (roughly 1:10), the rate of casualties among the tank battalions was extremely high: "The proportion of killed to living remained one in three" (1982, p. 253). Bion realized that only promotion afforded greater chances of survival, but even these were slim:

> Some tank commanders escaped being killed long enough to be promoted to command sections. As section commanders their expectation of life was greater; they might accordingly survive to reach to the command or second in command of companies. For non-commissioned ranks it was virtually impossible to reach safety by promotion . . . . Slight wounds were so rare that the avenues of escape were restricted to chronic invalidism or forms of elaborate foot-dragging. After August 8 there were no senior officers with actual experience of tanks in action, and no junior officers who could reasonably suppose they had a chance of survival to higher rank. [1982, p. 268]

Uncertainty and arbitrariness saturated day-to-day survival, leading to fluctuations between fear and hope, and taking its toll in permanent anxiety (1997, pp. 241-242). Fear was difficult to evade while "being pushed into the unknown—into the terror all the inhabitants had been fleeing" (p. 79); nevertheless, Bion notes, "It is curious how one hoped for the best when one had the chance" (p. 108). Lack of control over one's fate accentuated the importance of luck (pp. 36, 38, 84, 132) and enhanced the spread of superstition (p. 135). Bion tried to maintain a rational view by turning to statistics:

> Only two out of every three who took part in the tank war survived to tell the tale within twenty-four hours of the start of the

> action. This was not a matter, then, for any optimism; it was not even a matter of fighting; it seemed to be simply a question of statistics and the laws of chance. [1997, p. 240; see also Bion 1985, pp. 181-182]

Hence, the unavoidable conclusion was that these laws indicated his inevitable death (1985, p. 43). Still, the mind resisted inescapable reality:

> "Oh my, I don't want to die, I want to go home," we used to sing. *That* was true; we hoped that the ugly reality would not penetrate the joke armour-plate. The armour-plate of a tank was penetrable; we were bewitched, bemused, "probability"-dazzled cowards. "Probably" we would not be killed. [1991, p. 396, italics in original]

Bion's fear was continuously stimulated by sense impressions of the dead, scattered about in grotesque postures and in various stages of decomposition (1982, pp. 138, 251). The arbitrary certainty of death and mutilation induced helplessness, which Bion resisted paradoxically by resigning himself to death. In the Diary, Bion struggles against the anticipated misunderstanding of his parents, explaining how it was that wishing for death enabled him to survive emotionally:

> But the fact remains that life had now reached such a pitch that horrible mutilations or death could not conceivably be worse. I found myself looking forward to getting killed, as then, at least, one would be rid of this intolerable misery. These thoughts were uppermost with me then and excluded all others—and I think many were in the same state. After all, if you get a man and hunt him like an animal, in time he will become one. I am at a loss now to tell you of our life. Such worlds separate the ordinary human's point of view from mine at that time, that anything I can write will either be incomprehensible or will give a quite wrong impression. Briefly, I felt like this: I didn't care tuppence whether we held the "line" or not. Germany's victory or defeat was nothing. Nevertheless, I would do my job by my men as well as I could, as there was nothing else to do. I wasn't interested in religion or world politics or any rot like that. I was merely an

> insignificant scrap of humanity that was being intolerably persecuted by unknown powers, and I was going to score off those powers by dying. After all, a mouse must feel that it is one up on the playful cat when it dies without making any sport for its captor. With this new idea before me, I felt better. I didn't feel afraid anymore, and I walked about doing my job feeling as if I had scored off Providence. [1997, pp. 94-95]

A mouse's compliance with dying as its only means of defiance against a playful cat constitutes a paradoxical metaphor of Bion's emotional experience.[4] In *The Long Week-End* (1982), the mouse turned into a rat—maybe because the mouse was a euphemism for a rat, or maybe even as an ironic tribute to actual rats encountered: "There was one old chap, bald, bloated, corpse-fed, who sat on my chest one night—it made me laugh because his whiskers tickled my face" (p. 265). This metaphor is referred to several times, and "the cornered rat being clubbed to death all over again" accentuates the incomprehensible, persecuted-animal existence of one tortured indefinitely by anonymous powers that be (1982, p. 227; see also pp. 198, 209, 262; 1991, pp. 76, 77). Animal-like existence threatened to take over one's behavior:

> From under this crawled Osprey. Pale, watery-eyed, unshaven, he was "like things you find under a stone," but he *was* a thing under a stone! . . . Osprey agreed readily enough not to take shelter in that way again; so readily in fact that I was sure he was afraid of what that rat-like life had done to him. [1982, p. 210, italics in original]

The regression to animal existence damaged cognitive function: "Our questions had little to do with a thirst for information; it was a mindless activity, the individual becoming merged into a primitive brute, an army" (1982, p. 123). Bion points to the source of mindlessness in the unpredictability of events: "Could a shell fall short or over? It could—so I gave up thinking about it, thus taking shelter instinctively in mindless-

[4] Curiously, the Greek bucolic poet Bion of Smyrna, who lived in about 100 B.C., was said to have commented on cruelty to animals: "It was the saying of Bion that, though boys throw stones at frogs in sport, yet the frogs do not die in sport but in earnest" (Plutarch [c. 100 A.D.], p. 170).

ness" (p. 130). Once questions become meaningless, what Bion later referred to as "a questioning attitude" (1961, p. 162) ceases to exist.

In *The Long Week-End* (1982), Bion describes Broome's repeated attempts to tell how he tripped into a shell hole filled with a "human soup" of body parts, blood, and mud, while his peers repeatedly refuse to listen to him—a refusal echoed in the omission of the incident from the Diary written to his parents (1997, pp. 139-140). Contrary to such omissions, Bion wrote different versions of some events, the most salient of which is the fatal injury of his runner Sweeting that "had his thoracic wall blown out, exposing his heart" (1991, p. 256), while both were taking cover in a shell hole (1997, pp. 126-128, 254-255, 290; 1982, pp. 247-250, 264; 1991, p. 290).[5] Both omissions and repetitions are extreme opposite strategies for dealing with traumatic memories.

In retrospect, Bion noticed he was "surprised that these casualties had so little impact on us at the time . . . . We did not discuss the casualties; they had gone and that was that" (1982, p. 166). Silence enveloped the dead (p. 255), but not only loss was encapsulated by silence—all emotional experience was barred from conversation, as in the refusal to listen to Broome's tale. When Bion tries to tell another officer, Carter, how he feels before action, Carter reacts angrily: "Why the hell do you keep on talking about it then?"—adding that "I'm scared out of my wits. I'm not daft—you'd have to be daft or a nit-wit not to be scared. But why talk?" Bion sums up the brief conversation: "I was angry and felt no better for feeling he was right" (p. 233).

Elsewhere Bion elaborates on the mindless loneliness instigated by silencing emotional experience:

> The behaviour, facial expression, and poverty of conversation could give an impression of depression and even fear at the prospect of battle. Fear there certainly was; fear of fear was, I think, common to all—officers and men. The inability to admit it to anyone, as there was no one to admit it to without being guilty of spreading alarm and despondency, produced a curious

[5] Souter (2009) argues that Bion's repeated explorations of this event crystallize the impact of Bion's war experiences on his insight into the nature of the mind and "the horrors of psychic abandonment," as well as "the absolute necessity of the presence of another mind for psychic survival" (p. 795).

> sense of being entirely alone in company with a crowd of mindless robots—machines devoid of humanity. The loneliness was intense; I can still feel my skin drawn over the bones of my face as if it were the mask of a cadaver. [1997, p. 204]

The encapsulation of emotional experience probably enabled many men to withstand the strain of fighting at the cost of gradual mental deterioration and increasing mental vulnerability; it was crucial to keep the encapsulation intact, since its rupture was conceived as equivalent to mental breakdown. Bion describes one occasion when the silence, disguised as a matter-of-fact exchange, cracked when he was informed of the death of his second in command in the Battle of Amiens:

> Cook was back and drew me aside. "We found a bullet through his heart." I stared at him; he looked serious. I nearly said "Liar!"—what I meant was "Don't be a melodramatic ass!" what I said was "Oh." Then I burst into tears, wiped them off my face. "Sorry," I said, "I'm tired." Cook looked at me curiously. I hoped he wasn't going to suggest I had "shell-shock." [1982, p. 256]

Encapsulation was founded on clinging to the facts, leaving one with dreadful answers devoid of the muted questions about the meaning of it all—shredded bodies and shattered minds. For Bion, the *containment* of war experiences—a concept yet to be created by him—began with the rupture of encapsulation when writing the Diary, which was only the beginning of an ongoing process, one that culminated in writing the autobiographical works. While the harsh reality of physical vulnerability was barely understandable, mental vulnerability was incomprehensible and left a trail of haunting questions, which may have contributed to Bion's creation of his theory of thinking as the foundation for a metapsychology in which the concept of containment is a central organizing principle.

Bion was repeatedly exposed to a wide variety of manifestations of mental vulnerability (1997, pp. 36, 38, 48, 50, 51; 1982, pp. 137, 156, 169-170, 176-177, 186, 209-210), ranging from the officer Quainton's baffling hospitalization after driving a car into a ditch while on leave in England (1997, pp. 237, 299); to Gunner Allen's "dumb insolence" (1982, p. 236); to Gunner Harrison, who had "gone nuts" and started

shooting at German prisoners of war (1997, p. 290). Thus Bion concludes:

> So; the officer had died of wounds—or was it shell-shock? Shell-shock was obviously complicated—from Quainton who, according to Clifford, was working his ticket, to the officer who did not bother about his wounds but thought that everyone from the Boche to his nurse was trying to murder him; all apparently had shell-shock. [1982, p. 193]

A confusing state of affairs, dealt with in pragmatic terms in relation to the army's task, fighting. As an officer, Bion had to recognize that when one was on the verge of shell-shock, "his nerves were too far gone for him to be any real use" (1997, p. 113; see also p. 62). Shell-shock presented a problem since it led to withdrawing the soldier from active duty and then invaliding him from service. Hence, the military addressed the problem of mental breakdown as malingering resulting from cowardice, i.e., as a means to the end of getting away from the battlefield (1997, pp. 228, 237). In *The Long Week-End* (1982), Bion reflects on this conception: "Nowadays I would not make such a simple diagnosis, but as it was I was impelled to prove my courage—the lack of it being, as I thought, my main defect. This erroneous idea was and still is, generally held" (p. 200).

Bion himself struggled with a sense of cowardice; he was acutely aware of his fear and attempted to hide it: "I knew only too well that if I relaxed my grim, determined jaw, my teeth would chatter" (1997, p. 205; see also pp. 224-225). It seems that reflective awareness regarding emotional experience protected Bion from a rupture of encapsulation, which would be tantamount to mental breakdown, but it also taxed him with agonizing self-consciousness:

> I was aware that *I* was not competent, particularly as I was so scared and that did not seem to fit in with being a soldier. I could not even be sure of what I was frightened. Death? No. Being terribly mutilated? Perhaps. I knew a bit more about the possibilities later. Going mad? No. Whatever I thought of, it didn't seem to be right. [1997, p. 202, italics in original]

Even receiving the Distinguished Service Order (DSO) did not appease Bion's excruciating sense of cowardice:

> But . . . I had not reckoned with cowardice. I still felt just as ridiculous . . . . I felt I might with equal relevance have been recommended for a Court Martial. It depended on the direction which one took when one ran away. [1982, p. 278]

In the Commentary (1997), MYSELF remarks: "Incidentally, I think the VC could have toppled *you* into a 'breakdown.' You were lucky not to get it"[6] (p. 204, italics in original)—thus positioning cowardice and valor in a complex relation to mental breakdown. Commendation was supposed to mollify his sense of cowardice, but it did not. Instead, it enhanced two dangers—breakdown and death, both stemming from a desperate attempt to deserve it: "I suppose awards for valour do stimulate the impulse to be valorous. I think professional soldiers may be able to survive them unharmed better than people with fewer years of discipline" (1997, p. 205; see also 1982, p. 193, and 1991, pp. 149, 451).

Bion realized the importance of discipline, the value of adhering to the task at hand so as to maintain contact with reality, an understanding that would serve him well in years to come—as a psychiatrist in World War II, suggesting that disciplined activity can be a prophylactic and a cure (Bion 1940; Bion 1961, pp. 12-15; Szykierski 2008). This was also true later, when he became a psychoanalyst advocating a discipline of no memory, no desire, no understanding, in order to enable containment (Bion 1967b).

Discipline was necessary not only to withstand the strain of fighting, but also because of Bion's sense of duty regarding his role as an officer to his men. The latter was expressed in the Diary in two opposite directions: on the one hand, the only occasion he mentions that he was "very proud" of himself is when he managed to bring hot tea and boiling stew to his men (1997, p. 84); and on the other hand, he initiated what Parthenope Bion Talamo designated "a rough sort of 'behaviourist' group

[6] Initially, Bion was recommended for the Victoria Cross (VC), Britain's highest award for conspicuous valor, but received the DSO.

therapy" (1997, pp. 310-311) "by pretending . . . to enjoy action and to discourage in mess and elsewhere all talk of 'wind up,'" so as to enhance morale and create "a better fighting spirit" (pp. 89-90).

In retrospect, Bion comments regarding the behavior of some of the other officers: "They did not seem able to feel with their men and yet retain their awareness that although they were men like their men, they were paid to be gods, very minor gods perhaps, but gods" (1982, p. 236). Thus, the practices of his role as an officer left Bion sensitive to the politics of shell-shock, an obscure phenomenon encumbered with doubts:

> I was still suffering from the DSO that had been inflicted, with my collusion, on me: the Senior Psychiatrist was suffering from having to appoint officers to the Shell-shock (as it was called) Hospital. None of us knew what shell-shock was or even if it existed outside the imagination of soldiers like me and Sergeant O'Toole who had to cope with the "dumb insolence" of the little board-school slum-dweller, Allen, who had been considered to be just the stuff that heroes are made of, coming from a land fit to be loved by slum-dwellers who would want to die for it. [1985, p. 56]

Bion's skepticism about authority and leadership was consequent to a harsh disillusionment; as BION says in the Commentary (1997): "We could see for ourselves what our immediate seniors were" (p. 205). His attitude was transformed into a more complex position, even if a no less critical one, when he realized—as MYSELF asks—"Don't you think your immediate seniors had fears that likewise had to be masked? They too had seniors in rank and time." Young BION tenaciously holds his ground: "They died; we were killed" (p. 205). But later on, he comments: "At Oxford, when I wrote the account, we were not so critical . . . because it was less awful to think all was well than to believe our bigger enemy was what you later called—," and MYSELF fills in, "the Establishment" (pp. 205-206). MYSELF adds, "But I do not blame the Establishment. It is us I blame—all of us. Victory seems to be regarded by us as desirable because it leads to an opportunity to sink into slumber again" (p. 207).

For Bion, sinking into slumber as a refuge was undermined by the residues of war. Already in the Diary, Bion tried to explore the blurring of the boundary between dream and reality: "It was almost impossible to distinguish dream from reality . . . . The German machine-guns would chime in with your dream with uncanny effect, so that when you awoke you wondered whether you were dreaming" (1997, p. 94). The reality of war sneaked into one's dreams, but waking up did not guarantee peace of mind:

> For some time we had been unable to sleep except in full equipment . . . . The first time I did it I woke with an awful taste of blood in my mouth, and you can imagine the effect on a very sleepy man who had been dreaming action. [1997, p. 104]

While in the Diary Bion relates to the slide from realistic nightmare to nightmarish reality, in *The Long Week-End* (1982), he elaborates the evolution of a dream:

> The ground was hard, but I was tired. So I slept and I had a terrible dream. I awoke just as I was about to go into battle; it was unnerving to find that I was. The dream was grey, shapeless; horror and dread gripped me. I could not cry out, just as now, many years later, I can find no words. Then I had no words to find; I was awake to the relatively benign terrors of real war. Yet for a moment I wished it was only a dream. In the dream I must have wished it was only a war. [p. 237]

Bion traces the grey shapeless horror in the background of a recurrent nightmare he had at Oxford:

> The grey scene later formed an amalgam with the scene at the Steenbeck and became the backcloth of a dream I had at Oxford—"when the war was over." Night after night I found myself on my belly clinging by my toes and fingers to a glistening slope at the bottom of which was a raging torrent—the dirty trickle of the Steenbeck. Towards this I slithered. If I tried to arrest my progress by sticking my toes or fingers it accelerated the descent; if I desisted, it again accelerated my descent. I did not make a

> sound. I just woke up bathed in sweat. [1982, p. 211; see also 1997, pp. 207-208][7]

It was difficult to acknowledge the damage done to him by the war, and yet it was impossible to deny it:

> Nevertheless, I did not see; I did not see that peacetime was no time for me. I was twenty-four; no good for war, no good for peace, and too old to change. It was truly terrifying. Sometimes it burst out in sleep. Terrified. What about? Nothing, nothing. Oh well, yes. I had a dream. I dug my nails into the steep and slippery walls of mud that fell sheer into the waters of a raging, foaming Steenbeck. Ridiculous! That dirty little trickle? If blood is thicker than water, what price the thickness of dreams? Suppose broad daylight was not thick enough to keep out the terror. Suppose I was so terrified that I ran away when it was really a battle. I woke up. Was I going crazy? Perhaps I *was* crazy. [1985, p. 16, italics in original]

Bion was awarded the Legion of Honour decoration for the action on August 8, 1918, and although "the citation had a curiously plausible resemblance to the 'facts,' yet I could not believe that the battle I had experienced and the one cited were the same" (1982, p. 273). Bion continued to reflect on the impact that particular action had on him: "I cannot imagine what was wrong, but I never recovered from the survival of the Battle of Amiens" (1997, p. 209). He concluded that "they have a way of making people look so life-like, but really we are dead. I? Oh yes, I died—on August 8, 1918" (1982, p. 265).[8] He says: "My feeling of guilt about my last battle in the war grew steadily for many years after" (1982, p. 276; see also 1991, pp. 450, 506).

These experiences furnished Bion's private hell with sleeping and waking nightmares (1982, p. 191). Haunted by his ghosts, Bion says: "I

[7] One of the war's major conflicts, the Battle of Passchendaele, took place near the River Steenbeck between July and November 1917 (see also footnote 10).

[8] The Battle of Amiens began on August 8, 1918, and was the opening phase of the Allied Hundred Days Offensive that led to the end of World War I. It was one of the first major battles involving armored warfare and marked the end of trench warfare on the Western Front. This quotation is one of several instances when Bion said that he had died on August 8.

see them still in the watch fires of a thousand sleepless nights, for the soul goes marching on" (p. 128). He conceived himself as a witness to disaster—"nothing less than murder of the spirit of incomparable men. For me the disaster was to have survived and to undergo the mortification of being watched leaving the battle by men condemned to stay" (p. 212).

Bion had to deal with survivors' guilt not only in regard to the dead and the mutilated, but also to those who did not survive mentally, like Quainton. When Bion met him years later, he found that

> He was changed from a cheerful, frank fellow whom I had envied for his easy capacity for deep friendliness, into a timid, cautious and scared apology for a man . . . . Of course, I did not know that the Quainton I knew was only surviving as a physical representation of himself. [1997, p. 202]

While Bion's physical survival could be understood by him as an arbitrary result, his mental survival remained intriguing (1982, p. 105), and eventually he concluded: "No, I had not got shell-shock. What nonsense they were ready to talk! But, love had died. Love for anyone and anything" (1991, p. 150). Bion stayed sane, and made his way to the psychoanalytic study of the mind.

Bion's above-mentioned attempt in "Amiens" (published in 1997, though written in 1958) to revisit his war experiences was aborted in order to write what can be regarded as the three books that together form the core of his metapsychology (1962, 1963, 1965). Bion abandoned the writing of "Amiens" in mid-sentence: "He felt that people who cracked up were merely those who did not allow the rest of the world to . . ." (1997, p. 308); it reads as though Bion were about to formulate the great unknown of mental catastrophe, but could not find the words, and went on an intellectual journey to find the elements and factors determining the transformations that determine whether a mind will *learn from experience* or "crack up."

A clue to Bion's view on the matter appears in his description of a particular soldier's fate, where he says that an ability to endure alone the horrible truth about the reality of war is crucial to mental survival.

> No, poor chap, he went sane long before the war was over; he couldn't bear the truth and being in a minority of one at the same time. It was pitiful—lying there in the ditch blubbing. He took to drink; even that couldn't save him from reality. [1991, p. 423; see also p. 515]

CONTAINMENT OF A "CRACKED-UP," POSTMODERN CONSCIOUSNESS

Bléandonu (1994) argues that the war experiences are at the root of Bion's explorations of extreme unbearable emotions, and suggests that, in light of these experiences, Bion's "enigmatic concepts . . . acquire extraordinary reality and depth" (p. 31). As a psychiatrist in World War II and for a few years after its end in the Tavistock Clinic, Bion concentrated his work on the tensions between the individual and the group, and on the value of "a questioning attitude" for the empowerment of individuals caught in a web of group tensions (Szykierski 2008). He turned to a psychoanalytic study of the psychotic mind, thus laying the foundations for a theory of thinking by exploring its most severe disorders (Bion 1967a). The evolution of Bion's metapsychology in these contexts accentuates the influence of questions regarding his mental survival on the exploration of internal and external dangers to the functioning of the containing mind.

Wisdom (1987) considers Bion's war experiences to be of "inestimable importance" to his ability to "stay functional under stress" (p. 543). However, the impact of Bion's military service in World War I was far more fundamental and comprehensive. According to artist Michal Heiman (2008), "Bion, in his diary and in his entire theoretical work, both early and late—acts in the space of combative thought, the space of shell-shock, like one under attack" (p. 147).

In a similar vein, Meltzer analyzes Bion's response to questions presented to him in seminars, when "under pressure of the group," and suggests a military model describing Bion's mind at work:

> When confronted with a direct question, Bion's tactics seemed military indeed. He seemed to start off in a direction quite con-

> trary to that of the question, as if in retreat from the aggressive intent, then made a wide sweep ending by taking the enemy, not even on its flank, but from the rear. During this excursion he would make little sallies at the question, trying one vertex after another, until one of them found a rather soft spot in the armour of the language in which the question had been phrased. [1981, p. 11]

An example that supports Meltzer's analysis regarding the impact of the war experiences on Bion's clinical thinking appears in one of Bion's discussions of his work with psychotic patients, written on May 16, 1959, wherein he states that the analyst's

> . . . position is not unlike that of the soldier in war who is aware of his own troubles but not of his enemy's. It must therefore be borne in mind that the fundamental importance of our work demands that kind of fortitude and high morale which places the welfare of the analytic group and its work before the welfare of the individual analyst, and sometimes before the welfare even of a particular patient. [Bion 1992, p. 24]

So it seems that Bion's war experiences engendered a deep-seated strategy, applied to the study of mental phenomena, which he used in creating a theory of thinking only after making "a wide sweep" through the study of groups and the analysis of psychosis—thus not approaching his subject on the flank of PTSD, but from the rear of other regressive states of mind. Armed with a new understanding of the mind, Bion returned to his war experiences, "trying one vertex after another," so as to find "a soft spot in the armour" of opaque memories. As previously noted in this paper, Bion's metapsychology is viewed from the vertex of his war experiences—quite the opposite of reflecting on these war experiences from the vertex of metapsychology, as he himself did in his autobiographical works (1982, 1985, 1991).

"So—why write an autobiography?" asks Bion, and he answers, "Because it is interesting to me to review the life I have led in the universe in which I have lived" (1985, p. 22). In the Commentary (1997), BION says: "I forgot it as fast as I could" (p. 207), but half a century later, Bion reviews his testimony despite internal resistance and external silence

(1982, pp. 124-125). These are the recurring obstacles to testimonies concerning horrors, as evident not only in the time gap before Bion's return to his World War I testimony during the 1970s (a gap of about a half century), but also in the gap between Felman and Laub's (1992) work regarding testimony and its subject—the Holocaust, and in the difficulties encountered in the group relations conferences entitled "Germans and Israelis—the Past in the Present" during the 1990s (Erlich, Erlich-Ginor, and Beland 2009).

Bion wrote a coherent and integrated chronological narrative about his life, while also writing down his fragmented and conflicted self in *A Memoir of the Future* (1991). A salient feature of his autobiographical works is the juxtaposition of various states of mind encompassing all objects contained in the simultaneous time and multidimensional space of internal reality, thus allowing for learning from experience by connecting diverse phenomena across time and space.[9] Although learning from experience is ruthless at times, Bion regards it as the only feasible method of mental survival (1982, p. 202).

From the vertex of war experiences, it seems that Bion's metapsychology evolved so as to resolve haunting questions regarding what determines one's mental growth or another's psychic death. Therefore, this metapsychology concentrates on the functioning of the mind when confronted with emotional experience, always oscillating between evading contact with reality and learning from experience. It is not surprising, then, that Bion found Freud's tragic vision of knowledge appealing, as suggested by Hamilton (1982, pp. 238-255). According to this tragic vision, the pursuit of knowledge originates from the absence of the object, and hence necessarily involves frustration and pain, and is motivated by

[9] *A Memoir of the Future* (1991) is constructed by means of a conversational juxtaposition of different experiences. Such connections appear in the Diary (1997, pp. 17, 103, 122). They are also prevalent in *The Long Week-End* (1982), moving forward and backward in time and space between childhood memories and war experiences (pp. 16, 20, 22, 29, 115, 202), as well as between distant and diverse experiences during the war (pp. 103-104, 113, 119, 120-121, 156, 160, 267, 272). In this latter work, Bion points to forgotten meanings lost in time (pp. 124-125, 127, 142), reflects on the impact that some haunting residues of war had on his life (pp. 143, 191, 256), and reviews his war experiences (pp. 264, 276, 279).

survival. Bion's comprehensive exploration of knowledge evolved from his war experiences and addressed the lack of an elaborate theory of thinking in psychoanalytic conceptualization.

In all his autobiographical works from the Diary onward, Bion is always concerned with knowledge—its inadequate sources in rumors (1982, p. 183; 1997, pp. 53, 130), its influence on one's state of mind (1997, pp. 37, 132, 137), its importance for one's survival (1982, pp. 126, 131; 1997, pp. 59, 72, 135), and the dangers (1982, pp. 40, 275) as well as the relief (1982, pp. 156, 163) inherent in ignorance.

Bion learned from experience that knowledge can be used defensively: "It is such a relief to know *exactly* where everyone is. When you have no idea whatever where you are yourself, it is, as I discovered, an admirable substitute" (1982, p. 208, italics in original). Although Bion regarded learning from experience as crucial for survival (1982, p. 201; 1997, pp. 89, 135), he was attentive to the defensive maneuvers undermining it by congealing knowledge in social institutions and political establishments:

> But how, in war, does one decide what is daft? The answer is that one does not, if one can help it, decide these things in war. They are decided in peace, formulated in training manuals, enforced by orders. Such is the perversity of the human animal that these prudent dispositions intended to protect against irresponsibility and uniformed improvisation are then erected into rigid barriers as a defence against thought . . . . When we learn, like the child walking, to act automatically without expenditure of thought we also learn how to avoid pain by economizing thought. [1982, p. 204]

Thus, in retrospect, Bion becomes aware of the absence of a critical attitude in the military system, as well as among his peers and within himself:

> Looking back now it amazes me that I do not remember any occasion when it occurred to me or any of my friends to debate the military wisdom of our procedures. It is the more surprising that a critical attitude was common enough but never took a constructive form. It did not occur to me, or any tank

> commander of whom I heard, to report that Ypres was unsuitable for tank warfare. The tank commanders who might have provided the initiative and knowledge were either killed in action or too stunned, stupefied, to contribute anything. [1982, pp. 268-269][10]

Even when a critical attitude took a constructive form, as in the above-mentioned event when the tank officers warned against an attack at 10:30 a.m. without a smoke screen, their advice was ignored and all the tanks destroyed (1982, pp. 253-254); only then was the event mentioned by Marshal Foch: "A short note advised that in future all general officers should take the advice offered by officers in command of technical units" (1997, p. 135). Learning from experience was achieved only after the fact, after the experience had taken its death toll.

Hence, when exploring the intricacies of knowledge, Bion remains alert to the dangers awaiting one while confronted with the choice between containing emotional experience so as to maintain contact with reality, and various defensive maneuvers intended to evade contact with reality and avoid learning from experience.

In *A Memoir of the Future* (1991), Bion introduces the metapsychology of the multilayered and multivoiced, fragmented self, informed by Freud's conflicted self and Klein's self-containing phantasized objects. As Parthenope Bion Talamo argues:

> This vision of the mind as a palimpsest with a continual potentiality for almost instantaneous regression can be seen to tie up to the theory of beta-elements, a continuous flow of unprocessed pre-mental sensory data, which then have to be subjected to alpha-function in order to be used for thinking at all. [W. R. Bion 1997, p. 310]

[10] The third battle of Ypres, or the Battle of Passchendaele (see footnote 7), was Bion's first battle during the war (see 1982, pp. 121-141; 1997, pp. 22-38), and has become known for attrition warfare fought in thick mud, since it took place on reclaimed marshland, swampy even without rain. The summer of 1917 was unusually cold and wet, and in addition, the preliminary heavy artillery bombardment of the Allied forces destroyed the surface of the land and the drainage system, exacerbating the problem. As a result, tanks bogged down in mud, and soldiers often drowned in it.

An overwhelming surplus of experience is Bion's point of origin (Boris 1986, p. 160) when conceptualizing "the mind that is a too heavy load for the sensuous beast to carry" (Bion 1991, p. 38)—a mind that is constantly assaulted by sense impressions, forever oscillating between containing emotional experience and evading contact with reality. Note that while discussing the various functions of containment, Bion explicitly states that he is using "the word with its military implication of one force containing another" (1970, p. 112); thus military containment serves as a model for mental containment, a concept that gradually becomes essential to Bion's account of the ceaseless struggle of the human mind to survive reality. In the context of the mind's struggle to deal with the threat of overwhelming sense impressions and to contain experience, Bion's evocative term *nameless dread* (1962, p. 96) marks a common denominator of PTSD and psychosis, signifying both cause and effect of a serious impairment in contact with reality.

J. Symington and N. Symington (1996) conclude that Bion tried throughout his life to assimilate his appalling war experiences, and thus much of his theoretical work can be viewed as an effort to work through these traumatic experiences. As Brown (2007) argues, "From this perspective, therefore, Bion's theories of thinking and its disturbance devolve from both his personal experiences with trauma as well as his work with the psychotic portion of the mind" (p. 1571). Bion regarded analytic work in general and with psychosis in particular as analogous to war in its requirement for mental containment of dangerous states of mind (1991, pp. 516-517), when even physical containment fails from time to time:

> Psychiatrists try to restrain "illogical" systems physically within mental institutions. As often as not the guardians—doctors, nurses and others—fall to the assault of the systems they are supposed to "contain," like an army which, "containing" a besieged force, falls to an attack by the besieged. They call the psychiatric casualties "breakdowns." [1991, p. 266]

On occasion, Bion explicitly used the military implication of the term *containment* in order to create a *thick description* (Geertz 1973) of

nuanced subtleties of mental phenomena, as exemplified in his discussion of a stammerer:

> The man was trying to contain his experience in a form of words; he was trying to contain himself, as one sometimes says to someone about to lose control of himself; he was trying to "contain" his emotions within a form of words, as one might speak of a general attempting to "contain" enemy forces within a given zone. The words that should have represented the meaning the man wanted to express were fragmented by the emotional forces to which he wished to give only verbal expression. The verbal formulation could not "contain" his emotions, which broke through and dispersed it as enemy forces might break through the forces that strove to contain them. The stammerer, in his attempt to avoid the contingency I have described, resorted to modes of expression so boring that they failed to express the meaning he wished to convey; he was thus no nearer to his goal. His verbal formulation could be described as like to the military forces that are worn by the attrition to which they are subjected by the contained forces. The meaning he was striving to express was denuded of meaning. [Bion 1970, p. 94]

Hence, the concept of containment as elaborated in *Attention and Interpretation* (1970) evolved into an organizing principle in Bion's metapsychology, as the different relations between container and contained can be applied in the study of all the arenas of function (or dysfunction) of the mind, while allowing for movement between distinct levels of functioning, including the political function of an individual or the dynamics of a social group. In this sense, *containment* is an elastic concept, describing both nuanced intricacies and gross maneuvers, since it is conceptualized as a complex process, determined by various relations between container and contained, and determining mental functions as well as social interactions and political phenomena.

Bion's metapsychology was configured by a modern war that was a ruthless capitalistic struggle for survival (Eisold 2005), barely disguised by a veil of patriotism, and thus was the point of origin for postmodern consciousness that became embedded in Bion's vision of a mind struggling against fragmentation to contain emotional experience.

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NEEDINESS AND NARCISSISTIC DEFENSIVE ACTION

BY STANLEY J. COEN

Action-prone patients are difficult for most analysts to treat. The author describes patients who act in treatment by pressuring themselves and the analyst to get rid of what is wrong, to change the imperative, life-and-death qualities of need into something else. Viewing neediness in treatment as narcissistic defensive action helps the analyst address the patient's pressured flight away from focusing on the need of the analyst and toward action aimed at riddance. Ghent's (1992, 1993) views on neediness are discussed and seen to be complemented by a view of action as protection against narcissistic vulnerability. Analysts' intolerance, vulnerabilities, and needs with such patients are considered.

Keywords: Action, narcissistic defense, neediness, need, needy, intolerance, vulnerability, countertransference.

> By the gravity of the means I require to thrust you from me, measure the tenderness I feel for you. Judge to what degree I love you from the barricades I erect in my life and work . . . so that your breath—I am corruptible to an extreme—may not rot me. My tenderness is of fragile stuff.
>
> —Genet (1948, p. 207)

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ARE ACTION-PRONE PATIENTS DIFFICULT FOR ANALYSTS TO TREAT?

Most contemporary psychoanalysts do not believe that we need to differentiate patients who are prone to go into action from those who are able to think and talk about what troubles them. These colleagues believe that all patients need to protect themselves by various defensive maneuvers that then become the subject of analysis. However, a small group of analysts suggests that patients who readily use action to avoid intrapsychic conflict are difficult for most analysts to treat (e.g., Goldberg 2002; Kohut 1977; Rothstein 1984, 1998, 2002). Rothstein (1984) disagreed with Kohut (1977) that narcissistic patients' use of action implies more severe pathology.

There is a vast psychoanalytic literature on acting out—even some on the *acting-out character* (e.g., see Kanzer 1957)—as well as on enactment, but not much about why many analysts have difficulty with action-prone patients, other than that these patients' behavior in treatment is resistant. Obsessional psychoanalysts uncomfortable with aggressive action (Rothstein 1984, 1998, 2002), who are out of touch with their wishes for forbidden gratification, do better not to analyze acting-out patients (Bird 1957). Some analysts themselves act out when narcissistically regressed, acting-out patients project and evacuate intolerable dependency and depressive feelings into them (Grinberg 1968). In order to analyze action-prone patients, analysts have to become caught up in identification with their behavioral mode (Goldberg 2002), which they need to tolerate.

Some authors have expressed the optimistic attitude that action within analysis may be invaluable and even necessary (e.g., Boesky 1982; A. Freud 1968; Katz 1998; Roughton 1993), especially to gain access to what has not already been processed in words. Understanding and action in analysis proceed in tandem (Smith 2006). *Acting out* has referred to poorly regulated, impulsive behavior, especially in borderlines; the term has also been used in relation to neurotic analysands whose treatment behavior and attitudes threaten to derail their analysis. Here the analyst appeals to the healthy part of the patient's ego to show the patient

how he is preventing an effective analysis (Erard 1983; Renik 1999). Defensive repetitive enactment, central to perversion (Khan 1969), also occurs in dependency, sexualization, and sadomasochism—preserving stasis and blocking change (Coen 1992).

None of my patients would be considered "acting-out characters"; hence I had no reason to expect that they would make repetitive use of defensive action. They seemed to avoid facing conflict and even to run away from it. Only when I had to search more deeply to understand how their self-protective behaviors worked was I able to grasp how much they relied on action to relieve painful conflict.

The action with which I am particularly concerned here is a kind of pressured action in the relationship with the analyst, who is to make what is wrong in the patient disappear. This refers especially to the patient's dependent need of the analyst, which evokes the patient's helplessness, vulnerability, sadness, and rage, all of which must be gotten rid of through some action.

My central points overlap somewhat with those of others who have written of the action of perversion, delinquency, and addiction (Goldberg 2002; Kohut 1977; Rothstein 2002). This paper will focus on these smaller forms of action in treatment. Two of the ten patients I considered for this paper might be thought of as perverse, and one could be considered addictive. All of them, although very needy of human contact, were avoidant, fearful, and ready to flee from need.

I have previously considered dependent patients (Coen 1992) and remote patients (Coen 2003, 2005), but not those who use action to eliminate the dependent need that they fear but unconsciously seek. Such a patient presses the analyst to help solve concrete problems to remedy what is wrong, externally and internally, while rejecting attachment to the analyst. This pressure pulls in the analyst intensely. In a more negative version of this situation, the patient angrily insists on the analyst's uselessness and failures, while the analyst is to feel—for both of them—the intense connection between them.

This paper contends that the interpretation of such defensive action can be helpful when ordinary interpretation of defensive narcissism—including schizoid, omnipotent protection against human need—is ineffective. With action-prone patients, it is helpful to interpret defensive

narcissism in the patient's own terms, that is, as an action defense, to affirm the patient's invulnerability and importance so that the patient does not have to feel helpless, needy, vulnerable, sad, and angry.

Following are three ordinary clinical vignettes to show what such pressured action in treatment looks like.

CLINICAL EXAMPLES

Professor R

Professor R was in crisis because of workplace criticisms of his leadership of his department. It was said that he was insensitive, arrogant, unempathic, and insufficiently concerned about the needs of his colleagues. Yet his vision for his department was so intelligent and valuable, he believed, that his colleagues should simply accede without troubling him with their own needs. Sad and anxious, he also felt pressured to immediately find an alternative position where he would be valued. He asked me to help him write a script that he could use to tell others what had happened in a way that would get rid of his difficulties.

I hoped that Professor R and I could address what had repeatedly gone wrong in his career to help motivate him to address why his colleagues had, once again, become so angry at him. I had to keep telling him that he continually wanted to go into action so as not to have to face the pain of the difficulties he caused himself by his urgent demand to get his needs met at the expense of others. For him to restrain himself meant to accept that he could not have everything he wanted, that the world could say "no" to him, and that he had to say "no" to himself. We had been here many times before in his treatment. Despite repeated crises in his academic career and his intimate relationships, he could not or would not rein himself in.

I hoped that Professor R's anxiety about losing his position and his ability to partially acknowledge the ill effects of his demandingness would better motivate him to manage himself than had heretofore been the case. He put both of us under pressure to find a solution that did not require him to change his impossible expectation that others should always put his needs first. He wished that I would help him rid himself

of his conscience so that he could feel free to do as he pleased without guilt—which, by contrast, he certainly felt very intensely.

He fought frequently with others about getting what he wanted. Early in the treatment with me, he kept asking to change his session times. His parents had not helped him accept limitations and disappointments. He was surprised when I pointed out that he was pressuring me to try to get something better from me. He tended to arrive at the last minute for his sessions, claiming that he had heard analysts did not like their patients to hang out in the waiting room.

When we could slow down Professor R's pressure to act so as to get whatever he wanted, we could see his fear that others—now especially me—would ignore and reject him and his needs. Then he would feel sad and lonely and become sleepy in the session; his bad feelings would evaporate. At times, he would say it now seemed as though he had been neglected as a child by both parents because of their own intense, unfulfilled needs. Although he thought of himself as an angry man, it was hard for him to connect his anger with his parents. Nor could he make much emotional connection with the pain of his childhood between sessions. His pressure for action in order to affirm the illusion that he could have whatever he wanted now appeared more clearly as a narcissistic defense against painful affects, especially his feeling of helplessness as a neglected child—needy, sad, lonely, and angry. These were feelings he now experienced and struggled against in his relationship with me.

This proved to be a more effective way to interpret Professor R's thick-skinned narcissism (Rosenfeld 1987), and eventually led him to want to change his expectations of and attitudes toward others. As his pressure to act in sessions decreased, he was able to become curious about his smaller actions, such as becoming sleepy and closing his eyes. Now he could connect what he could not bear to see or feel with his feeling of being neglected by me in the treatment—just as he had felt neglected by both parents as a child.

Mr. B

In his treatment, Mr. B often went into action when he felt vulnerable, needy, or painfully disappointed. When it happened that one of

his family members experienced a serious problem, he was driven to solve the problem in his sessions. He insisted on the obviousness of what was wrong and how to fix it. The situation called for action on his part, which could have prevented this problem from occurring in the first place. Action would thus make him feel strong, powerful, and important rather than helpless and vulnerable. But his preoccupation with doing something to remedy the situation kept him far away from his feelings, needs, and conflicts.

I told Mr. B that he had once again gone into action, insistent that he had the answer, in order to keep himself from feeling anxious, sad, and helpless. Briefly, what followed was a dramatic change in his behavior. Now he felt sad, disappointed, angry, and anxious that he had to endure what had gone wrong for his family member, surprised that such events could happen to him. I needed to repeatedly interpret Mr. B's pressure to go into action so as to affirm his power and importance, by which he avoided recognizing that he, like all the rest of us, could be so disappointed. Sometimes we could see his sadness, while at other times it seemed to be gone until I could again show him what he was doing to get rid of it.

Earlier in this treatment, I at times felt helpless and disappointed that Mr. B was perpetually running away from his conflicts. At such times, I might feel like giving up on him as someone who was just not amenable to analytic work. But once I could grasp and talk with him about his persistent pressure to go into action to affirm his invulnerability—an imperative narcissistic defense—I could better help him tolerate feeling like an ordinary human, which at this point meant to feel helpless and needy.

Ms. A

Ms. A, a young woman new to treatment, returned from the summer separation wholly focused on plans to move immediately to a distant city where she had family. During the separation from me, she had realized that being on her own in New York City was too much for her to handle. Her erythrophobia (fear of blushing) when she was with others was unbearable; she was panicky that it would last forever, making her a virtual

hermit. The erythrophobia eased during her first session back, after we talked about her terror of exposing how much she craved connection with other people; she could even emphasize that it was progress for her to want connection with and help from her family. She wanted to finalize the details of her move.

I suggested to Ms. A that, before she act, we take at least a few sessions to explore what she had been feeling. She remained emotionally closed off, as she had been in July before our separation—"cringing" when she briefly allowed herself to join me in thinking about her experience, terrified that she would end up wanting to remain in New York City just to be with me. She could feel how much she wanted to join her family, how much she dreaded being on her own. But she continued to feel terrified of bringing her neediness into the consulting room with me. Unable to concentrate on her homework when alone at home, afraid to invest herself and really try, she withdrew from school.

It was not at all unreasonable for this very young woman to want to live near her family. Our treatment had helped her better tolerate her intense longings for caring from her parents and their substitutes. I interpreted her focus on action as an attempt to remove herself from her very painful feelings of longing and neglect. Of course, committed action made it easier for her to talk more openly about feelings and need. But even after her move was finalized, I had to persist in interpreting her pulls to action before she could open up her intense hurt.

Eventually, we could talk about Ms. A's fear that I would judge her critically for having given up school, and about her tremendous fear of others' criticism and rejection, which led her to close down, pull away, and turn on herself. What was new was her allowing herself not only to talk with me about her extreme expectations of others, but also to fill in much more about her mother's inability to listen to her feelings—in effect, mother's pressure to push away both her own and the patient's feelings. Hence Ms. A felt she was on her own to manage her feelings. Father was no longer present, stepfather could be harshly critical, and her only sibling was highly competitive and derogatory.

Now we had access to what the summer separation had stirred up: Ms. A's pent-up, as-yet-unacknowledged feelings of emotional neglect. Now she could talk about how hurt, sad, and lonely she had felt as a child

with her emotionally rejecting mother and her absent father. Earlier we had not had contact with the searing pain of her feeling neglected, both as a child and now during the summer separation from her analyst. Her pressure for action abated. During the remaining sessions before her move, she was once again able to talk with me about how much she wanted to be cared for and how uncared for she had felt. Now it was possible to help her see her cravings as legitimate, despite her shame and self-hatred—which protected her from her needs, disappointment, sadness, and anger. Her needs were now available within the treatment. I would emphasize that what was most important here was Ms. A's shift from an action stance to an emotionally available one.

ACTION DEFENSE

In these examples, each patient's behavior caused problems in the treatment when each sought to magically eradicate what was wrong, to reassure him- or herself that need, sadness, and disappointment did not have to be tolerated. The impossible pressure for a solution that would eliminate all difficulty became a burden for both patient and analyst. As each patient began to hate attachment to the analyst and went into action to eradicate his or her vulnerability and affirm omnipotence, each refused to be a patient.

Here the pressure for magical action as a narcissistic defense covers and hides the hungry need that it seeks to disavow. All three patients had to interrupt their powerful usage of action defenses. For such patients' treatment to succeed, Kohut (1977), Goldberg (2002), Rothstein (1984, 1998, 2002), and I believe that the analyst has to be prepared to focus consistently on the patient's flight into action, away from conflicted feelings and needs. Otherwise, the patient will persistently pull for the analyst to join in and make what is wrong go away, rather than ultimately addressing the patient's painful, conflicted feelings. The fixed defense of action-prone patients persists unrelentingly as though the patient's very life were dependent upon it.

I use the term *action defense* in contrast to *acting out* or *enactment* in order to convey the patient's pressure to use action during treatment as a defense, so that analysts can approach this behavior empathically, non-

judgmentally. Otherwise, there is a risk that analysts may respond in a critical, rejecting way to the pressures put on them by such patients. Earlier critical attitudes toward acting out still taint recent, more optimistic ones. Unfortunately, considering these patients as acting-out characters may help to rationalize the analyst's critical attitude toward them. When the patient's pressured need of the analyst collides with the analyst's need of the patient, the analyst must be able to see this.

In this paper, I am interested in which analysts have difficulty with patients who tend to go into action in treatment, and why they may have such difficulty. Earlier, I had assumed that the concept of *action defense,* in addition to the term *acting out,* was readily accepted and used by psychoanalysts. I was surprised to find very few references to it in the psychoanalytic literature; it appears primarily in relation to borderline patients. Such patients make active attempts to involve others defensively so as to avoid the awareness of need and anger (Holtzman and Perry 1986; Perry and Cooper 1986); accident-prone patients use action as counterphobic behavior against passive and regressive wishes (Litman and Tabachnik 1967). These are the meanings that I had expected to find more broadly applied to all patients.[1]

WHY INVOKE NEEDINESS?

In order to highlight the considerable discomfort entailed for both patient and analyst, I will refer to this urgent pressure for action as *neediness.* This term takes into account the critical attitudes in patient and analyst about how the patient is expressing and defending herself against her need of the analyst. When patient and analyst struggle about whose need should take priority, each may regard the other as too needy, as fouling up the treatment with neediness.

Neediness refers to imperative, life-and-death qualities of need, which the bearer cannot tolerate in its presently expressed form—hence the urgent pressure to change it into something else. More acceptable need, no matter how intense, is not considered *neediness.* Neediness protects

[1] A different use of the term *action defense* refers to action in analysis that expresses underlying conflict without the associated thoughts being emotionally available (Busch 1995, 2001; Zeligs 1957).

against clear, direct expression of need. When the patient's longings have life-and-death proportions, they *must* be satisfied, so that their frustration necessarily generates murderous rage. For example, if a patient imagines that he has to have everything or he will have nothing, partial fulfillment is unbearable; he will be under continuous pressure to try to gain everything. He cannot hold still, cannot remain patient or content. Thus, action as narcissistic defense aims to affirm one's invulnerability, omnipotence, and greatness, as opposed to helpless need, mistrust of others, sadness, loneliness, hurt, and rage. In order to be effective, such action must be endlessly repeated.

Ordinarily, patients tolerate feeling needy without an urgent drive to go into action. When patients can tolerate needing the analyst's help and caring, they do not need to force themselves or the analyst to alter this situation. But with some patients, the triad of *need, needy, neediness* floods the treatment, embroiling analysts in their own struggles with and against need. Under such pressure, analysts can easily become caught up in transference-countertransference binds. Naturally, analysts vary in their degrees and types of need and vulnerability.

Neediness in patients has been described by many analysts, but it has been elaborated only by Ghent (1992, 1993; see also Phillips 2001 on Ghent). The perspective that some patients have had to learn to avoid clear, direct expression of need—which is then expressed in distorted, disguised, and provocative forms—has helped analysts work more effectively with challenging patients. These patients' expressions of need, both in treatment and outside of it, may repel rather than attract the other.

For example, Ghent's writings (1992, 1993) emphasized that the analyst must be empathic with the patient's hidden needs, which may be difficult to grasp. When patients stir up trouble with their analysts, vulnerable analysts, in their countertransference anxiety, hurt, and resentment, may lose perspective on this way of relating—resulting in interactions that we recognize as a form of sadomasochism. Ghent (1992, 1993) considered neediness a defense against genuine need that has been aggravated by rage and vengefulness, so that it actually aims to provoke further deprivation and rejection. From this perspective, neediness does not express genuine need, but rather reflects a kind of perverted,

distorted, camouflaged need. Thus, neediness protects against genuine need and reflects the history of the patient's struggle with parents and other caretakers against and about her need of them.

Ghent (1992) regarded neediness as a *defensive malignant need* against *benign need,* although he insisted that neediness does not simply cover over need. The analyst's task is to preserve an empathic appreciation of the patient's genuine need and wish without getting caught up in the latter's angry and provocative struggles. Sullivan's (1953) concept of *malevolent transformation* is somewhat similar; he noted that parents' harsh rejection of children's tender need can foster mischievous behavior. Children may be willing to be whatever they have to be in order to elicit parental responsiveness (see also Berliner 1947, 1958; Loewenstein 1957; Menaker 1953).

Only some of my patients considered for this paper showed Ghent's type of rage-filled, vindictive neediness; it did not apply to most of them. It was more evident in some, but not all, of my patients with negative neediness. Instead of rage-filled, vindictive neediness, my patients used action as a narcissistic defense against need, vulnerability, and helplessness. Their neediness protected against need, but not, as Ghent described, by provocatively engaging the analyst; rather, they put both of us under pressure to affirm through action the patient's invulnerability and intense importance. The urgent, imperative quality of repetitive action to make needs disappear stands out as a central feature of these analyses.

Patients who use persistent, repetitive action to rid themselves of painful feelings and needs cannot be willing analysands. Better that the analyst anticipates this, rather than becoming frustrated and disappointed that this is necessarily a very difficult treatment. Patients whose human need leads them to feel terror, hatred, and shame cannot tolerate needing the analyst. Experience of need, no matter how legitimate, triggers dread, terrifyingly and shamefully exaggerated, of the loss of autonomy and separateness. So the patient now feels despicably needy, vulnerable, unprotected. Such patients have to appear respectably self-sufficient—as they tend to do—and not dependently needy. Their treatment will carry the burden of shame and vulnerability—for them and potentially for their analysts, if similarly susceptible. The analytic situation, ordinarily designed to open up and foster the patient's experience

of need, must lead these patients instead toward defensive, pressured action.

When a patient's intense needs seem available in treatment, we tend to feel pleased that the patient has allowed himself to be open and vulnerable. In these circumstances, we tend not to think of the patient as needy or to judge him as being in a position of neediness, despite what may be intense longings. If the patient can be empathic and tolerant of the present intensity of his need, and is aware that it is excessive and impossible to fulfill—leading to the wish to better manage it—the neediness is not excessively restrictive. But that is very different from the sense of neediness I am focusing on here.

NEGATIVE NEEDINESS

Most neediness appears in a positive form in which the patient presses the analyst to do something transformative. Neediness can also appear in a negative form in which the manifest aim seems to be avoidance of all need. Such patients obscure their dependency by camouflaging it behind negative, provocative, angry engagement of others. This is more similar to Ghent's (1992, 1993) patients, although he did not emphasize eradication of all need, which seems to be the predominant aim here. While these patients insist that they want nothing from the analyst (whom they see as unable to help), out of awareness, they keep trying to stir up the treatment. Patient and analyst become caught up in intense struggle as the former rejects, criticizes, and disapproves of the latter, who seems to keep delivering the wrong stuff, not what the patient wants.

Negative neediness is prickly, irritating, aimed at getting underneath the other's skin so as to involve her. The intensity of the patient's need to fight with the analyst expresses the intensity of attachment to the analyst. This motivation remains outside the patient's conscious awareness. Unlike the latency-age boy who, in pulling a girl's pigtails or teasing her, reveals his attraction to her, here the positive erotic component is invisible. What is visible is the analyst's disturbance, which shows the patient that he has affected the analyst. The patient has the illusion of power and control over the analyst and over his own need; otherwise, intense need and mistrust of the other make the patient feel anxiously vulner-

able and ashamed. The analyst is to be drawn into this attachment by guilt, dissatisfaction, resentment, and mutual longing for caring.

INTOLERANT PATIENTS WITH INTOLERANT ANALYSTS

In supervision and clinical discussion groups, I have repeatedly found it helpful to focus on colleagues' vulnerability, of which they are sometimes unaware, to being drawn into patients' disturbances. Of course, I first had to learn this about myself. In what follows, the reader can assume that I am drawing upon those of my own struggles that are not merely idiosyncratic, on what I know from the inside. I encourage the reader to identify with me as both a successful analyst and a struggling one.

For example, I am supervising a colleague who responds too rapidly, too intensely to the flood of disturbance with which her patient overwhelms the consulting room. As she reads process notes, I try to show her how much noise her patient makes, how much her patient keeps trying to grab her attention, as if otherwise her patient could not imagine that she would be listened to and helped. This analyst does not yet recognize her own vulnerability. It can be so easy for the analyst to rationalize the entire difficulty as belonging to the patient, who is indeed being difficult.

I tell my colleague a bit about my own temptation to be drawn into such disturbance—and my struggle against it—and invite her to imagine how and why she becomes drawn in, too. I encourage her to join me in imagining wishes to be hurt, criticized, subjugated by her patient, or to actively hurt, criticize, and subjugate her. I encourage her to join me in feeling pressured to make her patient behave more reasonably so as to feel a caring connection to her. It can be painful for analyzed analysts to have to accept persistent wishes for connection to a critical, abusive object, now located within the patient. At such times we can become defeated by our patients' attacks—stuck, unable to recover our analytic position.

A colleague (see Barry 2008) admirably described his difficulty treating a patient who would fight with him about what was wrong with the treatment and with him as her analyst. She needed to keep poking

at him to find vulnerability in him. What a difference it made when he was able to grasp his own temptation to struggle excitedly with her so as to connect sadomasochistically! He realized that his discomfort with separateness from her and with bearing the full force of her rage helped propel him to that point. Then he could see that they were both struggling with somewhat similar issues. Once he could tolerate this tendency in himself, he became less susceptible to the patient's provocations. He became comfortable with using his self-knowledge to help her with her conflicts.

The more similar are patient and analyst in their defensive requirements, the more trouble will they have in being together. The analyst's empathy is disrupted by intolerance of the patient and of the self. To the degree that the analyst wishes to get rid of what is wrong in herself via action, the analyst will also have difficulty tolerating similar wishes in the patient, and will be unable to help the patient understand his or her pressure toward action. In addition to the promise of getting rid of problems, there is the attraction of exciting action with the other—transgressive, forbidden, incestuous, hurtful. The analyst may be unable and unwilling to analyze her patient's desires in the transference—perpetuating them for gratification, avoiding them out of fear.

For example, my patient Dr. E—a gay man who was lonely, and very hungry for emotional and physical contact—felt driven to search for sexual masseuses and younger gay men who would touch him. In his analysis, I could feel pleased that I was able to resonate with and enjoy his wishes for action and longings for physical contact with me without feeling threatened. He had had previous experiences of sexual boundary crossing with therapists. He had not told his last therapist about his sexual attraction and longings for him. When Dr. E reported this in our second consultation, he added that I was not his type. I responded with a smile and said that, in that case, we would be safer being together. I was deliberately indicating that I was not afraid of his longings and would welcome them. It felt good to be able to invite this frightened, guarded man toward emotional intimacy with me in the treatment. It was clear to both of us that he could not stand to be alone.

After several episodes with younger men in which they felt traumatized that he had, in effect, raped them, we could begin to talk about Dr.

E's angry pressure to go after and take what he wanted. We talked about his need to sexualize his hungry longings, to focus on excitement so as to take himself away from his need for caring and from his angry, sad, lonely feelings.

I told Dr. E that he indiscriminately went into action with other men in order to provide himself with what felt like an essential connection, and that allowing himself a more intense connection with me might alleviate his pressure for action. His wishes for physical contact with me became intense and frightening to him as he explored and tested whether boundaries between us were secure, such as by sitting very close to me on the couch. He insisted that his financial situation would allow him to come to treatment only once a week. We worked on his anxious vulnerability when he allowed himself to feel closely attached to me, as evidenced by his bringing his intense longings for caring in the transference.

It took patient, persistent interpretation—over a very long time—of Dr. E's terror of turning to me in his profound hunger for human contact before he finally felt able to add another session per week. He felt that others had to be forced to respond to him, and that their responses would be negative. But now he was taking a chance in allowing himself to become more vulnerable in feeling attached to me. Aware that he was liking himself better, he thanked me for helping him—and then began to sob at length. I think it was essential that I was able to identify with, tolerate, and analyze Dr. E's wishes to go into action so as to manage his intense longings for emotional and physical contact with parental figures.

Earlier in my career, when I was less comfortable with my own longings for exciting contact with both women and men, or with my defenses against such longings, I could not be as effective with patients. That is the good side of this story.

But the bad side is that I could still feel excessively anxious and angry when Dr. E—despairing, depressed, and lonely—complained that he could no longer bear to be alone. He felt too bad to go to the gym to work out with his trainer after his session. He did not want to go to work the following day. After one session, following on the heels of a painfully lonely Thanksgiving, he walked home along the river and looked into

the eyes of strangers; it seemed that no one responded to him. When he was late for the next session, I worried about his regressive and suicidal risks.

Another reason for my anger with Dr. E at the time of this session was that he had fired his psychopharmacologist and was getting medication from his internist. I felt like pressuring him to see the psychopharmacologist whom I had recommended, since I needed someone with whom to share my worry about him. I felt like struggling with him. I came to understand how angry I was at him for worrying me about his well-being. I wanted to make him stop doing that and again become my good patient with whom I could feel like a successful analyst.

Fortunately, Dr. E arrived only a little more than five minutes late for his next session, feeling better. As I listened to him, I saw that I had not let myself resonate with how much he wanted to worry me, to vengefully get back at me for leaving him at Thanksgiving and during the forthcoming Christmas break. I was the doctor who had been fired, reversing his feeling of being fired by me.

This all seems obvious in retrospect as it had been before Thanksgiving, when we had talked about such feelings. But in the first session back, I had had difficulty letting Dr. E be desperately despairing; I needed him to feel better. Later I was able to grasp that the holiday separation had stirred my anxiety about losing him, just as it had stirred his anxiety about losing me. And it had intensified my need to feel successful with him. Once I caught that need in myself, I was able to back off, give him space to express his bad feelings, and wait for him. I could again be empathic with his fear and rage about my unavailability and his wanting to draw me in to worry about him. My need of him was no longer in my way.

EXCESSIVELY NEEDY ANALYSTS

What I have been describing is, of course, ordinary countertransference, except that I am focusing it from the perspective of the analyst's excessive need of the patient. I do so with the hope of making it easier for all of us to consider our need of our patients, extending what I have previously written about analysts' narcissistic neediness (Coen 2007).

My impression from clinical consultations is that many analysts do not have comfortable access to what they need from their patients. Some contend (Hirsch 2007; Wilson 2003) that, much of the time, our narcissistic needs influence what we want from our analysands. Much of our character remains outside of our subjectivity, not subject to our own conscious awareness (Kite 2008), so that we cannot possibly manage it objectively.

Harris (2008) and Harris and Sinsheimer (2007) have recently encouraged us to speak openly about our vulnerability in relation to our work with patients so as to normalize our anxiety and distress. We will then become able to talk to each other about our distress and to get help—from ourselves as well as from others. Slochower (2006) skillfully shows us examples—including her own—of collisions between what patient and analyst seek from each other. I think that more central focus on analysts' needs of patients helps us work more effectively.

Therefore, my aim here is to try to make it more expectable that we be prepared to search for our excessive need of our patients. In this way we can catch these needs more easily and with more equanimity. We will be able to return the focus to the patient's analysis, away from our own needs, especially by trying to grasp their defensive functions within the treatment.

What makes us vulnerable to patients' pressured action? I expect that all of us will have some trouble with patients who do not want to contend with what is wrong, with whom we cannot feel effective. I do not believe that this is only a countertransferential problem affecting a small group of insufficiently analyzed analysts. I am referring to the analyses of patients who do not seek to use the skills we have so carefully honed. But the more we need from our work with patients, the more vulnerable we are to the frustration of such satisfactions, and we are more likely to be drawn in by the other's disturbance. When our need to feel connected is intense, negative or positive affects in the other beckon us to come closer. This causes us to have difficulty maintaining analytic equilibrium rather than becoming embroiled in overly intense feelings. The patient's love and hate matter too much.

Our difficulty is greatest when we are needy for human contact, but because of feelings of vulnerability and shame, we must also repudiate

that need in ourselves and in the other. So long as the patient feels an urgent need to get rid of what is wrong, the analyst's pressure to change the patient's way of being will aggravate the analytic situation, leading the patient to feel even more angry and critical of the analyst.

Warning signs that the analyst needs too much from the needy patient include: a fixed preoccupation with the patient, so that the analyst thinks about him too much, being unable to shift easily and flexibly toward and away from the patient; too much excitement, dread, and rage on the analyst's part in the presence of this patient; the analyst's excessive concern with wanting the patient to change; and the analyst's excessive vulnerability to being drawn in by the patient's provocations, causing her to be dislodged from the analytic position.

How do we allow ourselves more tolerance for what we cannot stand in our patient and in ourselves? Our love for psychoanalysis (Caper 1997) and for ourselves as psychoanalysts, our ethical stance in relation to the patient (Scarfone 2010)—including pride in our ability to tolerate what we otherwise could not stand—can help us tolerate our vulnerabilities, protections, and needs *for the sake of the patient's analysis.* Adopting such tolerance may require considerable struggle against our defensive wishes not to do so. Once we are able to acknowledge that we have become unreasonably caught up with a patient, we are well on the way to being able to extricate ourselves. But first the analyst must catch himself in overinvolvement with the patient and admit that the patient has become too important.

In the example of my colleague's treatment of a rageful patient who fought with him, mentioned earlier (Barry 2008), the analyst was able to acknowledge to himself that he had become too drawn in by his patient, and then to grasp how this had happened. Once he could catch his own motivations to become entangled with her, he could free himself and then analyze her needs of him, which were as yet insufficiently acknowledged.

In my treatment of Dr. E, I could connect my anxiety about his suicidality with my anxiety and anger about possibly losing him, leading to my need to pull him in more closely into a good relationship with me. I could use my anxiety and anger toward him to again become empathic with his anxiety and anger about losing me, and his wanting me to worry

about him. It helped both my colleague (see Barry 2008) and me to take pride in our ability to acknowledge our excessive need of the patient; it also helped me to be able to write about my patient.

Doing analysis can be an action defense for the analyst, a defense against having to tolerate the pain of her own vulnerability and neediness. For example, we can try to deny a patient's persistent limitations and difficulties by trying to change them, but we will be repeatedly surprised, disappointed, and resentful when the problems keep reappearing. We may need to protect ourselves from threatening feelings of anxiety, sadness, and rage about the patient's limitations and difficulties, which we may unconsciously equate with the dangers of being with a difficult parent.

The unconscious magical wish may be that *somehow* everything will come out right. But when we can tolerate the limitations of a difficult parent without feeling pressured to fix or change that parent, we will be able to help the difficult patient with his pressure to magically fix what he feels is wrong in himself and in his own parent. Sometimes, the analyst may engage with the patient in an exciting, sadomasochistic struggle about what is wrong, aimed at avoiding and transforming what each cannot tolerate in the other. Intolerance and need intersect as we pressure difficult patients not to be themselves, but instead to act more lovingly so that we will not have to feel anxious and guilty about hating them.

Once outside the pressure to change the patient, the analyst can work to catch similarities between himself and the patient. How does the intense need for each other felt by both analyst and patient protect them from something intolerable in and between them? What is the patient doing that stirs up the analyst's need and intolerance? How does what the analyst craves from the patient and yet cannot stand relate to what the patient, too, both craves and cannot stand? We must examine our own needy, intolerant feelings in the effort to reach what the patient is running away from.

The analyst is fine when she regains her focus on her own excessive need of a good connection with the patient, away from his withdrawal, rejection, hatred, unwillingness to change, persistent unreasonableness—that is, the patient remaining himself. As analysts, once we can

take a psychoanalytic perspective on ourselves, then we can do the same with our patients.

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INHERENT CONTRADICTIONS IN THE EGO IDEAL

BY ERROL B. DENDY

The author puts forth a concept of the ego ideal as the fantasied self that the child believes will bring it gratification and happiness. He then shows how the ego ideal's content evolves through the various stages of psychosexual development in accordance with its mission. A picture emerges of an ego ideal in inherent conflict because it is shaped by contradictory wishes, as well as contradictory fantasies of how to make those wishes come true. A section on romantic love points to a second contradiction within the ego ideal, beyond its contradictory content: a contradiction of aim.

Keywords: Ego ideal, wish, narcissism, conflict, compromise formation, latency, adolescence, romantic love, superego, shame, guilt, identity.

– I –

Although he never encountered the term *ego ideal,* William James (1892) offered an illuminating observation—if a superficial one, from a psychoanalytic perspective—related to this concept. He noted that he would, if possible, be at once a millionaire, a lady-killer, a warrior, and a bon vivant, as well as a philosopher, a tone poet, and a saint; but (regrettably) these admired identities would begin to "trip each other up." He referred to this predicament as the "Rivalry and Conflict of the Different Selves" (p. 53).

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In this reflection, James pointed to an inherent feature of the ego ideal that psychoanalytic thinkers have generally overlooked or, through contrived terminology, simply brushed aside: that is, the ego ideal's inconsistent and even self-contradictory nature. I believe that the contradictions in the ego ideal are inherent, run far deeper than James could have imagined, and extend not only to its ideational content but to its very aims.

For Freud (1914), who coined the term, the ego ideal had a dual origin. On the one hand: "What he [man] projects before him as his ideal is the substitute for the lost narcissism of his childhood in which he was his own ideal" (p. 94). On the other: "What prompted" the individual to form an ego ideal was "the critical influence of his parents, . . . to whom were added, as time went on, those who trained and taught him and the innumerable and indefinable host of all the other people in his environment—his fellow-men and public opinion" (p. 96). To make sense of this dual origin—these aims of both recapturing the lost narcissism of childhood, and winning the approval and love of the important figures in one's world—requires a more fundamental concept of how the ego ideal begins.

Schafer (1967) had an interesting thought in this regard. He noted that, when viewing things in a certain way, one could say that

> *Every wish creates an ideal* . . . . Perhaps it is more precise to say that the ideal inheres in the wish, or in the fantasy or expectation that expresses the wish. The ideal includes an ideal self and an ideal object, or alternatively, a self and object in an ideal wish-fulfilling relationship. [pp. 161-162, italics in original]

If, however, we are to view the ego ideal as a *distinct* entity—a body of connected, if potentially conflicted, images and conceptions to which the ego aspires—we would have to say that these images and conceptions have been extracted from various experiences of wishing and put together to form an agency, one we call the ego ideal. As Lampl de Groot (1961) said, the ego ideal would be "an agency of wish fulfillment" (p. 96). It would arise as the beloved imaginary self that the child, or infant, believes will make its wishes, whatever they may be, come true. It would arise from the failure of the actual self to fulfill those wishes and the

consequent devaluation of and loss of love for that self. Its narcissistic function of restoring lost self-love would follow from its primary function of wish fulfillment.

Once we recognize that the primary function of the ego ideal is wish fulfillment, we can begin to make sense of the bewildering array of aspirations it comes to house. The clash of ego ideals will inevitably reflect the clash of the wishes that engender them. It will also reflect the conflicting fantasies that emerge as to how one can best gratify those wishes.

Consider the situation of the infant or small child. Those who meet its needs and fulfill its wishes and whose love it comes to seek—the adults of its world, and especially its parents—make known to it, sometimes clearly and sometimes only subtly, what pleases them and what will evoke the responses from them that will please it. Therefore, the child or infant will make of these instructions, tacit or explicit, ego ideals. It learns, for instance, that smiling and acting lovingly pleases its parents and evokes loving and gratifying responses from them. It learns that being angry and feeling or showing hate generally do not. It should come as no surprise, then, that lovingness becomes idealized and hate condemned as bad. The crime of the ancient mariner was not to love *every* living thing.

Hate, we may also infer, becomes bad not only because it evokes painful responses from those on whom the infant or child depends, but also because its fulfillment, as envisioned in fantasy, would mean their destruction and loss. We all grow in childhood to believe that, through love and through the control or elimination of hate, we can make the world love us and grant us the fulfillment of our wishes.

As time goes on, we learn of more specific requirements, which then in turn become part of our ego ideal. This list of do's and don'ts extends to all the psychosexual spheres and all the corners of our lives. If we do things the right way, we are good; the wrong way, we are bad. Likewise, our body and its productions are viewed in this dual fashion. Shit can feel like something great, presented at the right time; at the wrong time, we and it are just "a piece of shit." The acceptance of parental values and instructions requires a certain amount of both sacrifice and suffering, and so sacrifice and suffering must themselves to some extent become idealized.

In fact, to some extent, the child must idealize suffering because it concludes its parents *want* it to suffer, a conclusion reinforced when parents are gratuitously cruel or inordinately frustrating. Curious that an ego ideal formed to achieve gratification and pleasure should almost from the start come to incorporate the concept of pain. In a healthy family, the child gets the message that suffering is to be limited. Indeed, parents get vicarious pleasure from their children's successes, and sensing this, the child knows that thwarting them through failure and suffering violates the fundamental precept of the ego ideal to give the parents what they want, and therefore constitutes another form of being bad. Masochistic self-defeat thus embodies virtuousness and wickedness at the same time.

Parents want their children to achieve triumphs and gratifications in the proper ways, and herein lies a dilemma for the child. It recognizes, if only through fantasies, that direct paths exist to gratification, paths that do not involve pleasing the parents, but lead instead to breaking their rules. In preoedipal and oedipal fantasies of power—of omnipotence, in fact—the child must imagine itself at times able to simply take what it wants. What it wants depends, of course, on its stage of psychosexual development. At the core of its desire will at first be the mother's breast, then her body in a more general way, and then for the girl the father and his penis. Being good offers only a very indirect path to these objects. Being bad and having the power to be bad offers a much clearer path. And so power and being bad must in this regard become idealized. And the child's idealized models for omnipotently possessing its most desired objects must be the very parents who hypocritically bar the way to them.

At first, the child will see mother as possessing what it wants most: her own body, the body she controls and can do whatever she wishes with. For this alone, she will be envied and made an ego ideal. But when the child becomes oedipal and configures the world in a triangular fashion, the picture will change. Father will then be seen as possessing mother's body and having power over it, and for this, *he* will now be envied and made the child's main ego ideal. After all, if the ego ideal is the fantasied self that will save the day, rescue the child from despair, and usher in the fulfillment of its deepest needs, then it is this sexualized father, ultimately the father of the primal scene, who must become for the boy, and for some period of time the girl as well, the central ego ideal.

Now, the question arises of whether in these considerations a partial explanation exists for the exaggerated idealization of the penis by both boys and girls and the phenomenon of penis envy. Freud (1926) summarizes (and regards as correct) the following line of thinking of Ferenczi's:

> The high degree of narcissistic value which the penis possesses can appeal to the fact that the organ is a guarantee to its owner that he can be once more united to his mother—i.e., to a substitute for her—in the act of copulation. Being deprived of it amounts to a renewed separation from her, and this in its turn means being helplessly exposed to an unpleasurable tension due to instinctual need, as was the case at birth. [p. 139]

Exactly as stated, Ferenczi's idea cannot be correct (or the mental processes it describes must clearly be superimposed on other factors) because the narcissistic overvaluation of the penis in boys and the envious admiration of it in girls, dating back in both to before the age of two or three, well precedes the child's knowledge of the mechanism of copulation. (At least, this certainly appears to be the case.)

On the other hand, a modified version of this explanation might fit better with the facts. Specifically with regard to girls, Lax (1994) asserts:

> Penis envy, devaluation, dejection, and loss of maternal love are specific psychic experiences of little girls, culminating when the "negative oedipal" constellation comes to an end. They are evoked when the erotic longing and fantasies which the little girl has directed toward her mother are confronted by the reality of mother's unattainability as an erotic object. This state of psychic conflagration is experienced by the girl during the conflictual rapprochement subphase, which adds intensity to the mother/daughter loving and hostile interactions. The merging tendencies of the girl, which were reinforced by the sense of "sameness with mother" and by having had mother as her erotic object, are now curtailed when the girl painfully discovers she "doesn't have what it takes" to gratify mother. [p. 291]

In this view, penis envy persists as a residue of a "negative oedipal" phase, prior to the efflorescence of the Oedipus complex proper, when the girl still takes mother as her primary erotic object. In this phase and

to whatever extent this phase continues to hold sway over her, the girl, like the boy, would identify the penis, and in particular father's penis, as the path of reunion with mother and instinctual gratification. Moreover, she would idealize it, based on this magical power, as the boy does, and indeed make it part of her ego ideal. Reich's (1953) observation that "the ego ideal of particularly narcissistic persons with deep fixation and insufficient faculty of desexualization *is to be the paternal phallus*" (p. 30, italics in original) would have wider application than Reich herself envisioned. It would refer to a phenomenon universal in boys and girls and in childhood's residue in the unconscious—one that is merely more visible in those with narcissistic pathology.

To what extent these considerations account for the child's overestimation of the penis, I cannot say. Surely, other factors come into play, such as the penis being more visible than its female counterpart (and to the child's concrete way of thinking, what is visibly bigger will be better) and its being better suited to the exhibition of urinary power (Horney 1924). Moreover, there may well exist in general—though there is some disagreement about this (Parens 1979)—"an early genital phase starting some time between the fifteenth and twenty-fourth month," which "runs concomitantly with the infant's increasing ability to differentiate self from object," "occurs in both boys and girls," and "appears to be without any oedipal resonance" (Roiphe and Galenson 1981, pp. 35-36).

In addition, Roiphe and Galenson note that

> At this juncture, the specific anxieties of the two contiguous phases, object loss and castration, are indissoluble. We believe that the later castration anxiety of the phallic phase is genetically linked to that of the early genital phase, and, by virtue of this, has a direct developmental connection to the anxiety of object loss. [pp. 33-34]

From my perspective, this could mean that in the second year of life, even prior to oedipal concerns, the penis would become idealized for its connection to, and perhaps even its imagined power over, mother—that is, its presence or absence becomes associated with the presence or absence of mother. This connection would be bolstered by the presence of genital sensations during contact with or fantasies about mother.

Only later, in both boy and girl, would the connection of the penis to father—or, more specifically, to his fantasied sexual role with regard to mother—enter into the equation.

Then, throughout a negative oedipal phase, it would remain the focus of the girl's ego ideal, until for reasons biologically or psychologically determined, she switches to the oedipal phase proper. At this point, mother and her special physical equipment would begin to move again to the center of the girl's ego ideal. This secondary idealization of mother, as a sexual ego ideal, would follow the primary idealization of her for owning and controlling her own body—and, it should be noted, for being able to have babies: in effect, for the power to create, control, and own the world.

The secondary idealization of mother, and specifically the idealization of the instruments of female sexual power—with their implication in particular of power over father and his penis—occurs in boys as well as girls, and gives the breasts, the female genital, and other distinctive features of femaleness added layers of meaning. In addition, in the fluidity of the unconscious, with its tendency to conflate opposites, idealized male and female sexual powers and equipment will to some extent become equated. So, too, will masculine and feminine sexual (in the sense of genital) ego ideals become equated with pregenital ego ideals of the oral or anal phase based on mother, the wish to please her, or the urge (the need) to rebel against her. And, finally, each bisexual or cross-sexual fantasy that develops in the boy or girl can be expected to engender a corresponding wish-fulfilling ego ideal.

Just as ego ideals of sexual power must clash with ego ideals of sexual virtue, so, too, must ego ideals that promise fulfillment of one's rageful and vengeful wishes clash with those that embody the protection of others and the elimination or containment of hate. And because (as Freud discovered) what we find in the unconscious is to a great extent infantile mental life, we must expect to find there primitive ego ideals of vengeance, domination, rapaciousness, and violence, alongside extreme and primitive ego ideals of sacrifice, self-negation, self-injury, and suffering.

With regard to the former, I am reminded of Nietzsche's comment that evil is "the atavism of an old ideal" (1886, p. 85), except we know

that in the unconscious, the "old" ideal will live on. Too often, we see the reflection of this idealized infantile evil in "heroes" who rule nations. There have always been the "great men"—the Caesars, the Napoleons, the Hitlers, and their followers, inflated by a sense of union with their all-powerful, conquering heroes. The greatness they share is at once projective and phallic and devouring and prephallic. It is a greatness that feeds on the flesh of the vanquished.

Thus, it is not just greed, lust, and anger that lead humans to conquer and ravish and destroy: it is also a kind of vanity, the yearning for self-esteem, the longing to join with a primitive, grandiose, and beloved ego ideal that evolves early in childhood.

– II –

Thus far I have focused on events prior to latency. Latency brings, for the most part, an emphasis on ego ideals of sacrifice and self-restraint, for the essential spirit of latency lies in the fearful retreat from competition with the parent of the same sex. The need and wish to escape the consequences of this competition, such as castration or exile, are the dominant need and wish of the latency-aged child. The retreat thus required enshrines in the ego ideal a proliferation of rules to limit and protect the self. These rules augment, are built upon, the child's earliest conceptions of sacrificial goodness, and they further develop existing trends toward masochism and self-denial.

Of course, such ideals of obedience and self-restriction hold sway only imperfectly. Oftentimes, especially when adults are not present, the latency-aged child reverts to play and behavior more in keeping with the sexual, aggressive, and grandiose ego ideals that took shape in its oedipal past. During that period, the ego ideal responded to what was *then* the child's most urgent need (and wish), that is, to address its sense of smallness, frustration, and overwhelming desire. The clash between the dominant ego ideals of the oedipal period and those of latency reflects, in the realm of the ego ideal, the clash between desire and fear.

The ego ideals of latency bring up the topic of the superego and its relationship to the ego ideal. To begin with a question about the superego—focusing in particular on the boy's development as Freud en-

visioned it—how can the boy's superego arise, as Freud claims, from an identification with his father when he must unconsciously see (and idealize) his father as personifying the violation of all that the superego requires? The answer to this question must reside in the boy's capacity to institute a split in the ego, in his sense of self, such that part of the ego identifies itself with father and his interests, serving as a kind of watchdog—or, as Freud put it, a "garrison" (1926, p. 99) for him—while the rest of the ego, the predominant self of body, action and thought, remains subjected to it.

We might call such a partial identification the *internalization* of father or the *introjection* of him, somewhat along the lines of the comments of Sandler (1990), who distinguishes the latter term from identification proper. In fact, Sandler goes further and makes the point that introjection may occur with or without any identification—that is, one may internalize an object, make it "an internal companion, a sort of backseat driver" (p. 865), with or without any alteration of self-image.

I think it is probably most accurate to see the superego as containing within itself two idealized images: an idealized but terrifying father whom the self cannot approach too closely, can identify with only partially and unconsciously; and an idealized, obedient son whose submission ensures the father's love and protection. Despite the partial identification that may be involved in internalizing or introjecting the father, it is clear that for the son (and to the extent she relates to the father as a competitor, the daughter, too), the integrity of the superego depends on maintaining a state of tension between the father's unconscious imago and the self, just as it does on maintaining a state of tension between that imago and the outside world. If identified too strongly with father, the self would begin to presume his special prerogatives, and the identification would reveal itself as inherently corrupting. If too strong an identification exists between his internalized imago and an external authority, the superego would lose its autonomy. That is, it and individual morality would dissolve into obedience to and enthrallment by the external authority. Witness, for instance, the morally corrupting potential of the charismatic leader.

For Freud, particularly in *The Ego and the Id* (1923), the ego ideal seems at times to morph seamlessly into the superego, a point of view

clearly not sustainable. At other times, he characterizes the ego ideal as one aspect of the superego: "We have allotted it [the superego] the functions of self-observation, of conscience and of the ideal" (Freud 1933, p. 66). Most psychoanalytic writers, as will be discussed in the next section, confine themselves to this concept of the ego ideal—which is understandable since, after all, Freud originated the terms *superego* and *ego ideal*. Nonetheless, this view of the ego ideal seems incomplete if one also considers Freud's initial concept of the ego ideal as the substitute for the lost narcissism of childhood, particularly when one looks at the timing of the ego ideal's origins.

Reich (1953) considers the superego and the ego ideal to be two distinct, though related, concepts (as do I). She writes:

> The superego represents a taking over of the parental do's and don'ts. In spite of childish misunderstandings, the formation of the superego is based upon acceptance of reality; in fact, it represents the most powerful attempt to adjust to reality. The ego ideal, on the other hand, is based upon the desire to cling in some form or another to a denial of the ego's as well as of the parent's limitations and to regain infantile omnipotence with the idealized parent. [p. 29]

Modifying Reich's comments somewhat, I would add that even the ego ideals encompassed by the superego, the idealized do's and don'ts commanded by the internalized parent, originate in fantasies of omnipotence—in this case, fantasies that through goodness and sacrifice one can completely control one's world (i.e., can control the omnipotent parent).[1] By pointing to its recommended ideals of self-denial and restraint, the internalized parent says, essentially, "Thou shalt not imitate me." The superego offers to the self one kind of pride, or narcissism or self-enhancement, while denying it another. Failure to obey the superego's commands and to adhere to the ego ideals that embody them brings on feelings of worthlessness and guilt. Shame, in contrast to guilt, follows from failure to achieve any ego ideal, moral or immoral, whether or not it stands for obedience to an internalized authority's command.

[1] For a clinical elaboration of this point, see Almond 1997.

Let me mention several more points with regard to the superego and/or ego ideal before moving on to the subject of the ego ideal in adolescence. First, to expand a previous thought, maintaining love for, or libidinal cathexis of, the parental imago in a state of suspension between the self and the outside world is necessary in order for the imago to function as a superego, an autonomous agent of morality. Likewise, for an ego ideal of any sort to exist in the mind as an autonomous agent, it must be loved, and the love for it must be suspended somewhere between the object that served as its model and the self, lest the ego ideal dissolve into erotic fixation or self-glorifying narcissism.

Second, it should not be forgotten that, when I speak of a parental imago as the basis of an ego ideal or the superego, I am speaking of a complex, fantasy-distorted (and projection-distorted) image and concept of the parent, which will retain variable degrees of faithfulness to reality.

Third, although Freud's model of the superego focuses on the dilemma of the oedipal and latency-aged boy, all that has been said here with regard to the superego should apply equally to the girl in her relationship to the unconscious imago of the mother—that is, mother in her role as sexual competitor, a powerful and frightening one whose internalized representative jealously guards *her* special prerogatives.

Fourth, we should note that the internalizing of a prohibiting parental authority, i.e., the forming of a superego or conscience, clearly begins before the resolution, or even the advent, of the Oedipus complex. The effort to resolve preoedipal struggles with the parents—along with the threats these struggles entail—by internalizing parental prohibitions goes back into early childhood, as many since Freud have observed. However, when the voice of internalized authority comes to include the interests of a sexually competitive and possessive parent, one who is determined to protect his or her rights against the child, the superego takes on a special intensity and character that it had not had before, and Freud was particularly alert to this transformation.

Fifth, what we consider moral inhibition should not necessarily be equated with the presence of a superego or moral ego ideals, for humans are also, almost from the start, inhibited from doing bad simply by their love for others and their empathic capacities.

It should also be noted that, for the sake of simplicity, the model I am constructing of the ego ideal's development, particularly in relation to the superego, has not addressed the inherent bisexuality of human beings. But I think the reader can envision without much difficulty how this feature of human psychology will complicate the picture, with the same-sex parent being the object, and the opposite-sex one the envied and feared model for identification. Complicating things even further will be those sexual yearnings that arise from the wish to unite with one's model and the ego ideals they can engender. I think the reader can also envision—despite my focus on the psychosexual aspects of the ego ideal's development—how ego ideals will develop based on parental power or the wish to please the parents without regard to sexual differences.

To continue with my model of the ego ideal's progress through the psychosexual stages, let me turn now to adolescence. In adolescence, the natural progression (now to be enacted in the *real* world, not the make-believe one of the oedipal child) is toward the reunion of the self with the idealized unconscious imagoes of the parents—predominantly, in general, the same-sex parent. The expectations of the outside world, the growing pressures of instinctual need from within, and the visible changes in one's own developing body all urge this on and, in fact, seem to demand it. In fear and nostalgia, the adolescent may, however, resist this natural progression and exaggerate latency ego ideals of sacrifice and self-denial as part of that resistance. Extreme religiosity sometimes expresses this counterreaction and its impact on the ego ideal.

Consider, for instance, such idealized injunctions as "If thy hand or thy foot offend thee, cut them off . . . . And if thy eye offend thee, pluck it out"; or "If thou wilt be perfect, go and sell that thou hast, and give it to the poor" (Matthew, Ch. 18). Ultimately, such ego ideals of religiosity embody a retreat to childhood and self-castration: "Except as ye be converted and become as little children, ye shall not enter into the kingdom of heaven. Whosoever shall humble himself as this little child, the same is the greatest in the kingdom of heaven" (Matthew, Ch. 18); and "There are some eunuchs which are so born from their mother's womb: and there are some eunuchs, which are made eunuchs of men: and there be eunuchs, which made themselves eunuchs for the kingdom of heaven's sake" (Matthew, Ch. 19). In typically extravagant and almost desperate

fashion, adolescents may cling to ego ideals of religious or other forms of devotion that express and serve the wish to return to childhood's safety, to the time when parental protection was assured.

Despite the inevitable reactions of fear and nostalgia, however, the essential spirit of adolescence lies not in retreat, as it does in latency, but in the opposite direction, rebellion, in the imperative to challenge the unconscious imago of the envied parent. To guide itself along the path it desires—to assist itself in its new project of adult wish fulfillment—the adolescent invokes and builds upon unconscious ego ideals of rebellion already in place from its preoedipal and oedipal past. It forms ego ideals of sexuality and aggression that, while rooted in its past, are revised to take into account the current realities of itself and its surrounding world—the world of an altered self and tempting new objects. In keeping with its new ego ideals, the adolescent sees everything differently. The sexual innocence that it proudly insisted upon in latency now becomes an embarrassment; virginity becomes a source of shame.

Inasmuch as the adolescent is focused on reality, no longer fantasy (at least, to alter reality is now its overt aim), it must attempt to achieve a consistent, coherent, and convincing identity—one that can resolve all the contradictions within it and win the belief of the outside world. To do this, the adolescent must fashion an overarching ego ideal that incorporates the principles of balance, moderation, and realism, and must attempt to sustain a new identity in the image of that ideal. This new imagined and idealized preconscious identity constitutes an enormous compromise formation, for its roots go back to the earliest and most primitive unconscious ego ideals, with all the contradictory forces of wish and defense they express. This new idealized adult self, while imbuing a feeling of coherence and maturity, must also convey at least hints of both devil and angel.

A preconscious fixture, this idealized identity—or at least pride in it—serves as the final gate to consciousness. Thoughts or feelings incompatible with this identity, which would bring shame and loss of pride with regard to "who I think I am," generally do not make it into consciousness. The road to consciousness for a thought or feeling can be obstructed, we may assume, by many forces: fear of real or imagined dangers, opposing impulses, the voice of the superego, or anticipated psychic

pain of various other sorts. But for its relative closeness to the surface, I think we can consider simple pride in oneself—one's valued preconscious sense of self—as the last hurdle. Laplanche and Pontalis (1973) observe that in *Studies in Hysteria* (Freud and Breuer 1895), when Freud depicted the hysteric's wish as opposed and rendered unconscious, in his words by the "dominant mass of ideas" constituting the "ego," "such an unconscious wish is easily identified in that it is incompatible with the self-image which the patient wants to keep up" (Laplanche and Pontalis 1973, p. 133).

With regard to one's overall sense of self-judgment or self-worth, a curious principle comes into play to which I would now like to draw attention. One might call this principle "the-rich-get-richer-and-the-poor-get-poorer" principle. Or one might think of it as the "adding-insult-to-injury" principle. This means that, inasmuch as the ego ideal grows out of the child's needs and wishes—out of the belief that by altering oneself one can control the world—the ego's perception of how close to or far from its ego ideal it is will depend on how well its needs and wishes have been met. If one endures pain, is neglected or unloved, or is otherwise mistreated or afflicted, it must be because one is bad or stupid or weak or small; it must be because one has failed to meet one's ego ideal. The whole point of the ego ideal is, after all, to remove pain and transport one to a state of happiness and fulfillment.

This principle of measuring oneself by how well one's needs and wishes have been met, embedded in the ego ideal from the start, stands in utter opposition to the requirement to suffer that has been added to the ego ideal, to varying degrees, as the child develops. It imposes yet another layer of misery on the already suffering, while it makes for the empty self-satisfaction of the fortunate. Over and over as clinicians, we see how the sick and the suffering (whether physically or emotionally) blame themselves, regardless of how unfair their self-blame may be.[2] The biblical story of Job is uplifting in its effort to move humankind beyond

[2] A six-year-old boy with leukemia, being tortured by medical procedures, cried out, "I'm bad, I'm bad!" (an account given to me by his mother). Likewise a Little League team that loses feels it "sucks," but one lucky bounce the other way, and the team would feel it was "great." The latter example illustrates that this "rich-get-richer-and-poor-get-poorer" principle applies to all ego ideals, not just those that are moral.

this primitive principle of self-judgment, beyond the primitive unconscious logic of the ego ideal. Yet that merciless logic, inherent in the ego ideal's very purpose, can never be more than partially mitigated.[3]

– III –

Up to this point, I have tried to outline the evolution of the ego ideal—in particular, the evolution of its content—in response to the changing needs and wishes, the shifting tides of desire and fear, that dominate the child in various stages of development. I hope the picture that has emerged, though sketchy, is coherent and remains true to the most reliable and consistent of psychoanalytic observations. That picture is of an ego ideal fundamentally and inherently conflicted.

The concept of the ego ideal that I have put forward is not generally shared in the psychoanalytic literature, for previous authors have tended to exclude from the ego ideal either that which does not support its role in the service of the superego (and thus they have followed Freud's primary usage), or that which seems unworthy to them of the term *ideal* or inconsistent with their concept of the ego ideal's major action. The result is a contrived terminology that complicates theory and does not assist understanding. And this applies even to the finest of psychoanalytic thinkers.

Take, for example, Schafer (1967). He recognizes that

> Too often, where we are prone to think of "weakness" of ideals, as in the case of delinquency, we overlook the powerful development of socially disruptive and disapproved ideals: one may aspire to be a superior con man or brute too. [p. 165]

However, preserving Freud's original concept of the ego ideal, Schafer separates what he calls the "ideal self" from the ego ideal, and assigns to it the "disruptive" and "disapproved" (and thus, we may assume, more prone to be unconscious) elements. The ego ideal itself remains synonymous with the "humanistically conceived 'good,' 'desirable,' and 'moral'" (p. 132).

[3] It is, of course, true that, working in the other direction, ego ideals can creatively incorporate and exploit suffering to generate feelings of achievement and satisfaction.

Jacobson (1964) separates from the ego ideal the "wished-for" or "wishful" self-image:

> Gifted acting-out patients with such a narcissistic personality structure, if familiar with psychoanalytic terminology, will frequently try to account for their agonizing experiences of anxiety, shame, and inferiority by pointing to their "high ego ideal." This is often misleading. In studying these conflicts, we find that they do not actually refer to the ego ideal or, for that matter, to any true "ideal"; but, on the contrary, they relate to aggrandized, wishful self images. These patients will express primitive narcissistic desires, such as becoming the greatest and most potent lover, the most handsome and creative person in the world, the greatest connoisseur of art, acquiring great wealth, being exquisitely dressed, reaching the top of society, and so on. These are the cases in which grandiose sexual and aggressive (pre-genital-phallic), narcissistic-exhibitionistic strivings have either survived unchecked since childhood or become revived and so much intensified in adolescence that they have succeeded in entering and asserting themselves enduringly in the superego and goals of the ego under the guise of an ideal. [pp. 203-204]

Following Jacobson's terminology, Milrod (1982) asserts:

> More difficult than the distinction between the wished-for self image and the self representation is the distinction between the wished-for self image and the ego ideal. The psychoanalytic literature is filled with examples of their confusion. One reason for this is that both are concerned with values, and both play an important role in the regulation of self-esteem. Common English usage adds to the confusion, since an admired idol who might contribute to a child's wished-for self image is often called an ideal. But this need not be an ego ideal. The ego ideal is a part of, or, as Hartmann and Loewenstein (1962) described it, "one of the functions of the superego" (p. 60). It is formed when the superego is formed, with the resolution of the Oedipus complex. The wished-for self image therefore develops earlier than the ego ideal and is in fact one of its important precursors. The differences between the wished-for self image and the ego ideal are essentially those differences that distinguish the superego from its precursors. First, the values built into the wished-for

> self image follow the phase development of the drives and include gratification, strength and power, possessions, and phallic attributes. Values built into the ego ideal are limited to moral and ethical values. In fact, one could define the ego ideal as a more or less stable substructure in the superego, made up of the moral and ethical values meaningful to that individual. [pp. 98-99]

In spite of the transforming nature of the Oedipus complex and its resolution, including the creation of an oedipal superego, it seems to me that the problem lies not in the "common English usage" of the term *ideal,* but in a terminology that ignores the insight embedded in that usage. Moreover, a terminology that separates ego ideal "precursors" from the ego ideal proper, denying them the designation of ideals, seems to me akin to a terminology that would separate adult sexuality from its infantile precursors and deny the latter the designation of sexual.

In contrast, Chasseguet-Smirgel (1985) sees the ego ideal as an agent of instinctual maturation and fulfillment, and thus is reluctant to include within it what she refers to as "Edith Jacobsen's model little girl" (p. 185): "the ideal of an unaggressive, clean, neat, and physically attractive little girl who is determined to renounce sexual activities" (Jacobson quoted by Chasseguet-Smirgel, p. 169).

> Although it seems as if these aspirations towards being perfect (imposed on the subject) can be likened in all respects to those grandiose models that some set themselves, I wonder whether one should consider them as belonging truly to the order of the ego ideal, at least as I understand it following the 1914 paper [Freud's "On Narcissism: An Introduction"]. [Chasseguet-Smirgel 1985, p. 185]

Note that, whereas the previously discussed authors see themselves as consistent with Freud's notion of the relationship between ego ideal and superego, Chasseguet-Smirgel considers herself faithful to his concept of the ego ideal in its narcissistic implications. She presumably would likewise question as an ego ideal the "humble" "little child" one must emulate to enter and become "the greatest in the kingdom of heaven" (Matthew, Ch. 18).

What seems generally missing in the psychoanalytic literature is a unifying concept of the ego ideal—a concept that can embrace all our diverse and contradictory aspirations, all the goals for ourselves that create the dynamic of pride and self-love versus shame and self-loathing, which I believe must constitute the emotional hallmark of what we call an ego ideal. Kaplan and Whitman (1965) do speak of "negative" ego ideals, particularly ideals of failure, but they see only negative affects; no positive ones attend their realization. Thus, they ignore the unconscious pride and self-satisfaction that comes (paradoxically) from achieving such ideals, and they distinguish them fundamentally from the rest of the ego ideal.

An exception more consonant with my concept is Deutsch's (1964) observation that

> In some individuals the ego ideal is more abstract, directed inward. In others it has to be externalized and gratified by action. At one end we find the ascetic saint, on the other an individual whose ego ideal is under the rule of the pleasure principle, and even achieved by directly sexual means. [p. 512]

In contrast, however, I consider this sort of contradiction to be universal within the ego ideal of every person.

It should be noted that Reich distinguishes between the ego ideal and the superego, but she believes that, after adolescence, the ego ideal is normally absorbed into the superego. Murray (1964) and Hendrick (1964) also distinguish the superego from the ego ideal; they separate the mature ego ideal from its pregenital or preadolescent precursors, though they recognize that under the weight of certain traumas, the individual may revert back to these precursors (for Murray, particularly "pregenital narcissism," and for Hendrick, "prepuberty ego ideals"). Chasseguet-Smirgel (1985) states that "the ego ideal can live in friendship with the superego" when it has acquired "maturative quality" and "effected a certain number of instinctual integrations" (pp. 187-188).

From my point of view, these authors, along with others, err to the extent that they ignore the universal persistence in the ego ideal of what is earliest and most primitive alongside what is most mature and developed. In other words, they err to the extent they ignore the fundamental

conflicts and contradictions in the ego ideal, the set of ideals created for the self, that neither the "resolution" of the Oedipus complex nor the successful, mature completion of adolescence can be expected to more than partially remove.

One aspect of human experience might be considered to pose a special challenge to my model of the ego ideal as the consistent outgrowth of evolving need and wish: the birth of a younger sibling. What of the child who envies its younger sibling and wishes to take its place? To be the infant, the crying, whining, useless little thing, is now (largely unconsciously) its wished-for self-image. Is this an ego ideal? To some extent, yes, one might acknowledge; that is, to some extent, the envious older child will idealize the appealing cuteness, neediness, demandingness, and even helplessness of its successful younger rival. But to a greater extent, doesn't this envy serve to undermine what Chasseguet-Smirgel refers to as the whole "project" of the ego ideal? Doesn't the whole effort to become something other than what one naturally is, to purify or enlarge the failed self, come into question, such that all self-directed effort seems pointless? In its regression, the older child would have, according to this thinking, evolved a wished-for self-image—to be the baby—that is not an ego ideal.

In answer, I would say that it is one thing for the older child to collapse into apathy, simply to give up; but if it maintains a longing to displace the baby, then this longing will generate an ego ideal, even if it is an ego ideal of having the power to be loved for being useless and doing nothing. One might wonder, in fact, to what extent the residue of such an ego ideal, arising out of this or some other source, could distort the lives of some adults. With regard to the effect on the ego ideal specifically of the birth of a younger sibling, we should note that, of course, many countervailing forces will come into play: the inflaming of oedipal rivalry, the parents' renewed insistence of how proud they are of what a big boy or girl the older child has become, the wish to be oneself the parent of the baby, and so forth.

The "project" of the ego ideal requires, I believe, attaching powerful affect to the idealized idea (of whatever sort), in order to give it an intrinsic pull of its own. That affect preeminently is love. Only if that additional charge of affect—that hypercathexis of love, if you will—is added

to the idea will it function independently of the fantasy from which it springs, will it become an ego ideal.

Inasmuch as the primary affect that gives the ego ideal its independent power is love, the child, as Freud noted, can win back its lost self-love by merging with its ego ideal, in fantasy if not in reality. Yet, as the child surrenders to the reality principle, its ego ideal must become increasingly out of reach and a source of pain. The self-love it promises is contingent and requires constant effort and self-renewal. No surprise that the child should move from a system of inherent narcissism to contingent narcissism only grudgingly, that a diluting or corrupting tendency should, in fact, persist throughout life to make an ideal of what one already is, to at least force a compromise on the part of the ego ideal with the self.

A somewhat related observation that Ritvo and Solnit (1960) credit to Hartmann is that "the ego ideal can be considered to arise from three main sources: the idealization of the parents; the idealization of the child by the parents; and the idealization of the self by the child" (p. 299). The parents themselves, to a certain extent, assist the child in maintaining the delusive sense of idealness and omnipotence that reality must inevitably wear away.

Finally, I think it important to note that the narcissistic function of the ego ideal can work in perfect opposition to its primary function: attainment of the necessary object and the merger with that object in a union that implies complete satisfaction. This constitutes, I think, the greatest paradox, or intrinsic contradiction, within the ego ideal. In the next section, I will use the psychology of romantic love, together with insights from Chasseguet-Smirgel and Loewald, to explore this paradox further.

– IV –

One area of human experience where the ego ideal can clearly be seen to play a major role is that of romantic love, and authors from Freud (1921) to Reik (1941), Chasseguet-Smirgel (1985), and Person (1988) have made this observation. Let us look at the relationship between the ego ideal and romantic love to see more deeply into the ego ideal's inherent nature and contradictions.

In his *Symposium*, Plato tells us allegorically that Love is the child of Poverty and Plenty. Reik (1941) puts this concept in psychoanalytic terms. He believes that we fall in love, succumb to the spell of romantic love, when we find another who fulfills our "secret ego ideal" (p. 43). Romantic love thus grows out of unconscious envy.[4]

Freud (1921) portrays the connection between romantic love's object and the ego ideal in a similar but not identical way. He observes that, when taken to the extreme, in romantic love

> . . . the object has, so to speak, consumed the ego. Traits of humility, of the limitation of narcissism and of self-injury occur in every case of being in love . . . . Contemporaneously with this "devotion" of the ego to the object, which is no longer to be distinguished from a sublimated devotion to an abstract ideal, the functions allotted to the ego ideal cease to operate. The criticism exercised by that agency is silent, everything that the object does and asks for is right and blameless. Conscience has no application to anything that is done for the sake of the object; in the blindness of love remorselessness is carried to the pitch of crime. The whole situation can be completely summarized in a formula: *the object has been put in the place of the ego ideal.* [p. 113, italics in original]

Both Reik's and Freud's theoretical depictions of romantic love accord with the exaggerated idealization of the object that characterizes romantic love. Freud mentions (1921) George Bernard Shaw's "malicious aphorism to the effect that being in love means greatly exaggerating the difference between one woman and another" (p. 140).

How does the idealization of the object serve the aims of romantic love, and how does romantic love illustrate the contradictory functions of the ego ideal?

If, as Reik says, the one we fall in love with fulfills our secret (or unconscious) ego ideal—or, as Freud (1921) notes, "It is obvious, in many

[4] Reik also makes a more general claim. "*Love*," he says, "*is in its essential nature an emotional reaction-formation to envy, possessiveness, and hostility.* This characterization covers all kinds of love, infatuation, and passion, tenderness for one's wife, friendship and love of one's neighbor. All these are founded on the overcoming of envy and the will to dominate, of hostility and jealousy" (p. 66, italics in original).

forms of love-choice, that the object serves as a substitute for some unattained ego ideal of our own. We love it on account of the perfections which we have striven to reach for our own ego, and which we should now like to procure in this roundabout way as a means of satisfying our narcissism" (pp. 112-113)—then the importance of idealizing the desired object (and specifically of equating it with our ego ideal) becomes self-evident. Our imagined union with it can elevate us to the status of the ideal only if it has achieved that status. In romantic love between the sexes, it would seem likely that each lover would fulfill the other's oppositely sexed ego ideal, that is, the man the women's unconscious masculine ego ideal, and the woman the man's feminine one.

However, more than this lies behind the romantic lover's idealizing his or her object. For one thing, there is some truth in Reik's assertion that what propels love—or, at least, its most intense adult form, the voracious and obsessive passions of romantic love, of the state of being "in love"—is the reversal of, the reaction formation against, envy and rage toward the invidiously endowed, all-consuming object (an object envied both for its fantasied narcissism and its magnetism). The romantic lover takes unconscious pride in the power of his or her love, and unconsciously in his or her conquest over all that is selfish and hostile within. As part of this conquest of hate by love, romantic love's initially envied object must be idealized, and the urge to destroy and devalue it thereby renounced. This renunciation brings with it both the narcissistic gain of perceived virtue and the expectation of invaluable love in return.

In addition, romantic love's object must be idealized to promote transference. Only if the object is glorious and incomparable can it replace the original object, which was glorious and incomparable. And, in turn, transference promotes idealization—of the object simply as object and as ego ideal. And, finally, like its original parental models, the object of romantic love will be idealized above all else, simply for its expected power to gratify, utterly and completely, all one's needs.

The nature of the transference and idealization in romantic love is both oedipal and preoedipal. Romances in fiction and in real life conjure up stirring oedipal scenes of struggle and triumph in which protagonists must overcome rivals, senseless obstacles thrown in their way by

society or fortune (which function as rivals), or the resistance of the beloved object itself. A sense of anticipated victory, of winning the idealized king or queen and becoming the corresponding king or queen oneself, permeates triumphant love stories and makes romantic love a vehicle for self-enhancement, for the narcissistic pride of achieving a sexual, and specifically oedipal, ego ideal, and also for achieving a preoedipal sense of power over the object.

And yet—and here is romantic love's contradiction—the end point toward which romantic love seems ultimately directed entails the very opposite of self-enhancement, and, in fact, through merger with a glorified, all-encompassing preoedipal object, seems to involve the very dissolution of the self. Person (1988) refers to moments of "exaltation . . . made possible by the lovers' periodic achievement of 'merger,' with its sense of release from the burdens of self, the immersion in something larger than self" (p. 129). She points out that such moments need not involve overt sexuality; they may involve "no more physical an exchange than a gaze, the touching of fingertips, one lover's arm around the other's shoulder." She muses, "Perhaps these moments evoke something of that oceanic sense of oneness that floods mother and infant in their early days together" (p. 127).

One might insist that the dissolution of the boundaries of the self serves only the purpose of self-enhancement, through merger with the ideal along the lines observed by Reik and Freud, but it seems to me that the very state of dissolution, the oceanic state of blissful release of the self to its object, is actually the ultimate goal that the romantic lover seeks. This state of dissolution or abandonment of the self is sought and sometimes achieved not only in aim-inhibited ways, but also in passionate sexual release. Romantic novels typically depict such release as the culmination of romantic love. And it is utterly appropriate that once the glorified, all-gratifying object is obtained, the project of the ego ideal, and the very self that because of that project has become so painful and onerous, should be joyfully abandoned.

In its conflicting aims—that is, the enhancement of the self versus the dissolution of the self—romantic love reflects the conflict inherent in the ego ideal. Chasseguet-Smirgel (1985) writes:

> Where the inclination of the male child to avoid having to confront rivals, castration and painful oedipal defeat (present to some extent in everyone) has not been supported and encouraged, his ego is led to look for, to discover and to admire that which makes the father his mother's chosen object. Hence, he forms the wish to be like him at some time in the future. In Freud's terms, he "projects" (this) before him: the father will become the boy's ego ideal. Man's *biological immaturity* is the foundation-stone of the concept with which we are concerned here. It owes its origin to the child's early helplessness (*Hilflosigkeit*) and to the way in which this brings the state of primary fusion to a violent end. It is impossible to recover this fusion with the mother immediately through incest (and he who has not been castrated—who, in other words, has not lost his omnipotence—is incestuous) because of physiological immaturity (genital deficiency). This prompts the development of the ego ideal, the "project" of identification with the genital father containing, within the implied incest fantasy, the hope of a return to this state of primary fusion. I would remind the reader here of Ferenczi's theory of genitality as described in his admirable *Thalassa* (1924) in which he establishes that the wish to return to the mother's womb is the most fundamental human desire. [pp. 26-27]

A bit later, Chasseguet-Smirgel adds: "The pinnacle of human development thus contains within itself the promise of a return to the mother's womb, or in other words, to the most primitive phase of development" (p. 27).

Of the girl, she writes:

> It is nonetheless the case that for the girl, motherhood is a solution that allows her to reconcile, in a sense, her erotic wishes which are directed towards her father with her wish to recapture the primitive state of fusion with her mother. The mother can re-experience with her child, admittedly on a much more evolved level, the sense of fusion which as a child she experienced with her own mother. It can be seen that, for obvious reasons, the girl is led to situate her wish in the future. And hence she is led to constitute for herself an ego-ideal that will include the project of becoming a mother—as mother, but also as the

> father's wife, who has been given a child by him. Along with Ruth Mack Brunswick (p. 194), in the article she wrote jointly with Freud, I consider that the wish for a baby is something that appears very early, prior to penis envy (I am not concerned here with the little boy's wish to have a baby). But whereas she considers its sole origin to be the desire to take over the principal possession of the omnipotent mother, I believe this desire also includes that of reconstituting the primary mother–infant unity. [p. 35]

I would note that in romantic love, too, through identification with her lover (= father = penis = baby = preoedipal mother), the grown-up girl can achieve this unity.

Chasseguet-Smirgel's central insight, as I would extrapolate from it, means that the whole project of the ego ideal—ego ideals that are phallic, masculine, feminine, that emphasize virtue, renunciation, rebellion, aggression, or whatever, together with the music of narcissism and self-congratulation that accompanies them—is aimed ultimately at its own destruction. Romantic love, as the attempted solution in an adult sexual relationship to the problem of the ego ideal, reflects this paradox.

In romantic love, both the wish to enhance the self by attaining the ego ideal and to dissolve the self and the ego ideal in an idealizing love point the lover in the same direction: toward the grandiose pursuit of the grandiose object. Hence, the conflict between these wishes is not apparent. But these wishes remain in inherent opposition, and they represent, in the realm of the ego ideal, the two opposing sides of a fundamental human conflict: to join with mother or to escape from her.

Loewald (1951) has something to contribute to the discussion here. He observes:

> Against the threatening possibility of remaining in or sinking back into the structureless unity from which the ego emerged, stands the powerful paternal force. With this force, an early identification is attempted, an identification which precedes and prepares the Oedipus complex. It would seem that Freud has in mind this positive, non-hostile aspect of the father figure (preceding the later passive identification due to the castration threat) when he speaks of an identification which "plays a role in the early history of the Oedipus complex. The little boy mani-

> fests a special interest for his father, he wants to become and be like him . . . . *This behavior has nothing to do with a passive or feminine attitude towards the father (or towards the male in general), it is, on the contrary, exquisitely masculine.* It is not in opposition to the Oedipus complex, but helps to prepare it." And further: the boy then "shows two psychologically different attachments, towards the mother a clearly sexual object cathexis, towards the father one of identification with an ideal" [Freud 1921]. [pp. 15-16, italics in original]

Here Loewald invokes Freud, noting the preoedipal idealization of father, the making of him into an ego ideal as a means to escape mother and the danger of annihilation that she, and gratification through her, poses. It follows, in fact, that all ego ideals can serve as narcissistic protection against the vagaries and dangers of the outside world, including, at times, the very objects for which the ego ideals have been created.

Finally, a word on the meaning of *narcissism* is called for here. The "structureless unity" against which the paternal ego ideal protects the child is referred to by Loewald as a narcissistic state, the "primary narcissistic position" (1951, p. 15). In this usage, Loewald resembles Chasseguet-Smirgel and Freud himself. Yet this narcissism is not the narcissism of which I have spoken and which one most commonly encounters in the psychoanalytic literature, including Freud, and in general parlance. It requires no self and in fact would dissolve the self. What is narcissism when there is no sense of self? Does the structureless primordial psychic state deserve to be called one of narcissism? I think strong arguments could be made on both sides of this question; however, to do so would go well beyond the bounds of the present paper.[5]

[5] One might also ask what it means to speak of the "dissolution" of the self or, let us focus on here, of the ego ideal into an idealizing love. This dissolution, like Freud's formulation that "the object has been put in the place of the ego ideal" (1921, p. 113), represents a regression in two related senses. First, the libido, or love (the term I prefer), or psychic energy, or cathexis, invested in the complex, multilayered psychic entity called the ego ideal—that is, the force that gives the ego ideal its independent power in the mind—returns once again to the object (in an updated and of course perceived-to-be-improved version) that served as the model or the impetus for its creation. And second, in the sense used in chapter 7 of *The Interpretation of Dreams* (Freud 1900), cathectic excitation flows back "regressively" in the direction of sensation, primarily visual perception.

– V –

This paper attempts to delineate two types of contradictions within the ego ideal: contradictions of content and of function. Pictured as arising out of the evolving needs and wishes of the developing child—specifically, as the fantasied self the child believes will enable it to fulfill its wishes—the ego ideal is seen to embrace inevitable contradictions within its content. This is because the child's needs and wishes are contradictory, and because its fantasies about how to best realize a given wish may also be contradictory.

Beyond that, however, the ego ideal is seen as more than merely an extension of the child's wish-fulfilling fantasies. It is seen as an entity that, by virtue of the love invested in it, assumes a life and a function—a narcissistic function—of its own. Its narcissistic function, the reward of self-love promised by the ego ideal, reinforces the drive to achieve its original goal: generally, possession of the object for whose love it was created. And yet, the ego ideal's narcissistic function can oppose its initial aim, inasmuch as gaining and merging with the loved, needed, and wished-for object implies a threat to narcissism and the very sense of self.

> Then wear the gold hat, if that will move her;
> If you can bounce high, bounce for her too,
> Till she cry "Lover, gold-hatted, high-bouncing lover,
> I must have you!"
>
> —Fitzgerald [1925, p. 1][6]

What if wearing the gold hat and bouncing high assumes such narcissistic importance that the object becomes almost forgotten? That would represent an extreme example of the narcissistic importance of an ego ideal eclipsing its initial purpose.

It is generally recognized that the ego ideal functions as a set of standards that when met provide narcissistic enhancement, that is, as a

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As the romantic lover's distant past is re-created, a complex world of tormented thought is replaced by a joyous perception.

[6] This epigraph to *The Great Gatsby* is attributed to Thomas Parke D'Invilliers, a pen name of Fitzgerald himself (http://en.wikipedia.org/wiki/Thomas_Parke_D'Invilliers).

tool of narcissistic regulation. Murray (1964) sees the "sound" or "mature" ego ideal as replacing an earlier, pregenital narcissism, which if not supplanted leads to pathological results (from neurotic to criminal). His discussion draws heavily on Freud's formulation:

> The development of the ego consists in a departure from primary narcissism and gives rise to a vigorous attempt to recover that state. This departure is brought about by means of the displacement of libido onto an ego ideal imposed from without; and satisfaction is brought about from fulfilling this ideal. [Freud 1914, p. 100]

Murray also sees the ego ideal as "born as an effort to restore the lost Shangri-La of the relations with the all-giving primary mother" (1964, p. 478) (a state that he, like Freud, considers narcissistic). His concept of the ego ideal as originating in the wish to reunite with the primary mother is much like mine (and Chasseguet-Smirgel's [1985]). He does not, however, think in terms of the primitive or perverse potentials of the ego ideal. As I see it, the ego ideal, even in its most primitive manifestations, including the most primitive sexual and aggressive ones, will serve the purpose of narcissistic regulation. It will, moreover, while aimed ultimately at regaining the "primary mother," serve paradoxically as narcissistic protection against her, against the threat that reuniting with her would present—the threat, as Loewald put it, of "remaining in or sinking back into the structureless unity from which the ego emerged" (1951, p. 15).

To assume its role in narcissistic regulation, at the primitive or mature level, the ego ideal must exist as an independent entity, must be loved (as noted) of its own accord. Thus, it will steal love from existing sources, the beloved objects for whom it is created, as well as the beloved self it is meant to save. It depletes the self, which is despised anyway for its failures, while (as noted) it rescues it with a new kind of narcissism, whose completion is always just a fantasy or a magical feat away. It also protects the self (as from the "primary mother")—or at least promises to protect it—from its own aggression, from being destroyed by inwardly directed blame and hatred.

Unfortunately, once the ego ideal exists, by virtue of the ego ideal's initial purpose, the ego must judge itself, in reality, as failing to mea-

sure up to that ideal to whatever extent it finds it still has not achieved the satisfactions it desires. And so self-hatred—inwardly directed aggression—persists. The transformative aim of this aggression is revealed in a poem (whose erotic as well as religious nature is made clear by the end) by John Donne, who calls on God's aggression to help remake him. The poem begins:

> Batter my heart three personed God, for you
> As yet but knock, breathe, shine, and seek to mend.
> That I may rise and stand, o'er throw me and bend
> Your force to break, blow, burn, and make me new . . . .
> —Donne [1609–1610, pp. 104-105]

Donne's call for God's aggression to make him new sheds light, by the way, on the boy's and girl's masochistic erotic yearnings for father. But here the ideal in whose image the new self is to be created is not so much one of virtue (as Donne requests) as it is one based on the sexual father himself.

The relationship between the *ego ideal* as envisioned in this paper and the *ego* differs from that depicted by Freud. In Freud's schema, the ego (as a psychological system) mediates between the id, the superego, and the external world. Freud's terminology equates the ego ideal with the superego or an essential aspect of it. But if we adopt a terminology (as I have attempted to do here) that fits better with the full range of ideals, conscious and unconscious, created for the self (or ego, in Freud's other meaning of the term), the relationship between the ego (as a psychological system) and the ego ideal takes on a different look.[7]

[7] I allow myself to use the term *ego* in both senses in which Freud uses it, as self and as psychic agency. Although some may object to this, the term is used widely in both senses—and I think there may be some wisdom in this terminological ambiguity. That is in part because the sense of self, or *I* or *ego,* in one meaning is allied closely to the set of functions and (self-evidently) identifications subsumed by the term *ego* in the second, systemic meaning (that is, as a psychic agency)—particularly insofar as these functions and identifications contribute to what we call *personality* or *character* (i.e., how we deal with our drives, prohibitions, and fears; the elements of these drives and prohibitions that we consciously or unconsciously take ownership of; and the characteristic patterns of behavior and thought to which all this leads). I do not myself find it a problem to speak of the self (the self-image or self-concept) in terms of its relationship with the superego or id, though I realize many do find this mixing of frames of reference to be a problem.

The ego ideal is then seen as the centerpiece of the ego: it is the fantasied self, central to the ego's efforts, that shares with the ego as a whole the dual and potentially contradictory aims of protecting the self and of achieving, through the agency of the real world, instinctual gratification. While playing a key role in the workings of the superego and the ego's efforts to deal with it, the ego ideal as here envisioned also plays critical roles in the ego's efforts to deal with the id (the exigencies of instinctual need) and the demands of the surrounding world.

With regard to the superego, the ego ideal serves primarily as the pose that will appease the internalized parent, the position of the self that will ensure protection from attack by the parent within as well as without. It is a pose of relinquishment and humility, embodied perhaps most exquisitely in religious canons, and serving to assuage the sharpest fears of castration or abandonment. With regard to the urgings of instinct—or drive or id, if you will—the ego ideal glorifies not exactly the instinct itself, but the capacity through one means or another, through physical power or charm or virtue or whatever, to achieve the instinct's gratification. It must do so by virtue of the ego ideal's very raison d'être.

With regard to the external world, with an eye to its dangers as well its enticements, the ego ideal must also, of course, incorporate the very opposite of instinct, the renunciation of libidinal and aggressive urges, just as it does at the behest of the outside world's internalized voice of prohibition, the superego. On the other hand, when the child perceives the world as demanding surrender to the id, rather than ineffectual and childish inhibition, the ego ideal must accommodate this perception. Complicating things even further is the fact that ego ideals of innocence, purity, and goodness that are meant primarily to appease the superego and outside world also aim to win their love, seduce them, and extract various gratifications from them. Furthermore, over time, as the child's perceptions of the outside world mature, so does its superego, and the ego ideals meant to address the demands of the outside world and the superego will undergo corresponding adjustments.

This brings up the ego ideal's role in maturation and identity. Not only is the ego ideal in its content an ideal of sexual and moral maturation, but its development is essential to the process of psychological maturation. Although preconscious ego ideals embodying the principle

of compromise formation spring up throughout childhood, it is the task of the latter part of adolescence to attempt to create an overarching ego ideal, perceived as realistically within reach, that can serve as the ultimate compromise formation, tying together all the disparate and contradictory unconscious ego ideals of childhood, and that can form the basis of a mature, pride-enhancing adult identity.

One might imagine that, when William James said that if he could he would be everything from a millionaire to a lady-killer to a warrior, a bon vivant, a philosopher, a tone poet, and a saint, and lamented the incompatibility of these aspirations, he nonetheless in some fashion, with or without realizing it, pictured himself as an amalgam of all of them. But we have seen that the mature adult sense of identity must embrace contradictions not just in the preconscious, of the sort James envisioned, but far more radical and unconscious as well. For instance, the preconscious ego ideal of a "good" wife could unconsciously represent both virtuous submission to mother, father, and husband, and, at the same time, vaginal power over and conquest of all of them. And vaginal power could unconsciously equate to phallic power. Likewise, ego ideals of stoicism incorporated into an adolescent or adult preconscious ego ideal and identity could simultaneously represent in the unconscious the adherence to latency and preoedipal ideals of self-control, self-denial, and even self-castration, on one hand, and oedipal and preoedipal ideals of power, ferocity, and even sadistic sexuality—with the self as the victim—on the other.

The fluidity of unconscious processes makes the unconscious equation of contradictory elements possible. It permits the creation of preconscious ego ideals that in their most mature expression can help to control both the disorderly world without and the disorderly world within.

And finally, inasmuch as the preconscious ego ideal and sense of idealized identity serve as the final gate to consciousness, allowing only those thoughts and feelings that are compatible to enter, the ego ideal becomes the ultimate organ of self-deception. By impelling us to strive to be something more than we really are, the preconscious ego ideal and idealized sense of identity help to organize our lives, give them meaning, and make them successful, but they also serve to avert our gaze from

what lies beneath the surface. They serve to help us deny, among other things, the primitive, frightening, and unceasing contradictions within the very psychic organ of which they form but the surface, the ego ideal.

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PEOPLE ARE NOT CABBAGES: REFLECTIONS ON PATIENT AND ANALYST CHANGE

BY ANNIE SWEETNAM

The author describes how her own internal change was a vital part of transformation between herself and two patients. She draws on Loewald's work as she discusses how change in her own internal relationship with her father was part of a lifelong emotional reorganization of oedipal relations. She describes a process of mutual change whereby her and her patients' unconscious growth each stimulated the other. She suggests that the analyst's own emotional growth is a vital, not an incidental, part of psychoanalysis, as it brings new life to the work for patients as well as analysts themselves.

Keywords: Analysts' change, analysts' dreams, Loewald, alcoholism, fathers, dreaming, spontaneity, transference, mothers, lifelong development, oedipal complex, internalization, fantasy.

> The depression I'm talking about usually occurs out of the blue. For no apparent reasons, patients become slowly more and more depressed. First they feel depressed and lacking "go" in the morning; this may wear off during the day, but gradually it may come to envelop their whole lives. As a patient once said to me, "It's like having a blanket thrown over your head."
> — Excerpt from a talk given by my father, a family physician

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PROLOGUE

"Dr. Sweetnam, I nearly killed myself," Paul stammered, his eyes staring at my mottled carpet. "I drank too much, I was out of control, I couldn't handle my bike, I could have crashed. It's crazy."

Paul and I had recently started a twice-weekly psychoanalytic psychotherapy, and I was panicked. I didn't know if I could help him—what if he drank himself to death?

"I'm going away for two weeks; we need to think about what's going to best help you while I'm gone." I found some words that muffled the fear of the moment, the fear of him poisoning himself with drink, the fear of feeling responsible for a life that was not my own. I was reminded of more of my father's words:

> I often feel as a family doctor that patients and I may play a game where neither really admits to the other the inevitability that death is around the corner.

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In the spring of my second year at university, I got a call from Dad in the middle of the term telling me that mum was seriously ill with meningitis.

The morning after I had come home, there was a knock on the door. Two policemen stood there.

"There's been a bit of an accident, Miss," the one with the unmistakable look of a policeman said.

What? Who? I felt myself tighten, the blood draining from my face.

Now the younger one with the squeaky shoes stepped forward. "It's your father, Miss—he's all right, but he's in the hospital. Can we come in?"

I closed the front door after them and walked into the living room. I sat down as they stood side by side, and the older one delivered the news. "Your father passed out at the wheel. He plowed into a car showroom. Nobody knows why he passed out; they're checking him out at the hospital, but he's okay; don't worry."

The words did nothing to calm me. Being told not to worry always increases my fear that there's something to worry about.

"Lucky it's a holiday, Miss," the younger one chimed in, "else there would have been cars on the road. Nobody else touched, nobody hurt—lucky your dad isn't worse off."

The policemen took me to the hospital where I'd just visited Mum. I brought Dad home; he was pale, pale and shaky. "I could have killed someone," Dad said to me, leaning on the dresser, his face white, eyes empty.

"Dad . . . you didn't, you didn't." I sat on the bed, pleading, scared, drawing a blank, unable to find the words that might help.

"I know, I know, but I could have really killed someone," he said staring out of the window. "I really could have."

A DREAM: DANCING WITH MY FATHER

On returning to my practice after my vacation, the night before I am to see my patient Paul, I dream that I am dancing with my father, dancing and talking closely. In the dream, a waiter in the room glides by, offering us coffee from a silver pot on a silver tray. I wake up feeling dreamily happy. Later in the day, Paul drifts in and out of my mind. I become anxious—will he come back? Has he been drinking his way through my absence? Can I help or must I let him go?

Paul returns. He did not drink while I was gone; he followed our plan. I am surprised and relieved, but confused and wary of my own desire to help. Paul tells me he is very depressed. My father's words come to mind:

> What should be done for patients with depression? First of all, the advice given by near relatives or well-meaning friends is usually not the best. They tend to say, "Pull yourself together, God is in his heaven, the sun is shining, the birds are singing—go out to a party, throw off those feelings." For a patient thinking that he should do this tries, and finds unfortunately that he cannot respond to the mood of those surrounding him and comes home very much the worse.

Dad being Dad, he went back to work after the car accident; it was a while before friends and family would admit he had a drinking problem. He never drank when he drove; the day he passed out in the car was the

morning after drinking the night before. He tried a treatment program, but his drinking continued as a painful illness worsened. His depression took hold. He carried on his practice with his patients who meant so much to him, and him to them.

"In reality, it was a population in despair, . . . believing in the miraculous, the drunken, as it may be . . . . They believed in him: Rivers, drunk or sober. It is a plaintive, failing story" (Williams 1932, p. 40).

Five years later, I saw Dad for the last time.

Memories, fantasies, and internal senses of our parents alter their shape over the years. In this paper, I am exploring how memories and changes in my sense of my father altered and were altered by my work with two patients, Paul and Clara. I reflect on instances with both patients when the creation of internal familial relations, conscious and unconscious, was generated differently for me and for each patient. I will discuss how I came to see that a vital part of the clinical work was for me to recognize and use these mutual evocations of unconscious material.

When I returned from this vacation from my practice, a few days after seeing Paul again, I sat with my colleagues. Mexican lights were strung around a cozy living room as we sipped wine and ate freshly picked raspberries. "What is it you are really worried about if you don't see this patient?" Sherrie asked me.

Without a thought, I said, "He'll kill himself." My colleagues were kindly curious: why would I worry about that? "It's your dad, isn't it?" Sherrie, who knew me, asked. I was shocked and upset. Paul was my dad—my dad was Paul. It was so obvious—why hadn't I seen it myself? As I talked with my colleagues, I was shocked to realize how this patient had so quickly brought my long dead father back to life. I was disconcerted and embarrassed to realize how clearly my clinical work was still so affected by my relationship with him. These were not the memories or reveries that lazily and mysteriously drift in and out of consciousness, the ones I had come to honor and use in my clinical work; this felt like a throwback to a more unmediated, anxious response. I had wanted to believe that I was past that.

Other feelings about my father gradually crept into my mind. Feelings of great loss for my father, as well as my own helplessness and anger, had been a part of my own internal work for many years. I was surprised

at their resurgence; I was clearly making unconscious associations between the love and loss of my father and the potential love and loss of my patient.

CLARA: A SPONTANEOUS MOMENT

My clinical experience with Clara is different. She finds her work disappointing and aggravating, her days full of pettiness and bureaucratic nonsense. As I listen to her, a feeling of dread spreads through my body—a feeling of being dragged across the floor by my feet. I don't want to go where I am being pulled, but all I can focus on is the familiar sensation of being drawn into a tangled mess. I remember conversations about these kinds of experiences—wishes that mother and daughter would feel the same thing, wishes that we would share this misery together, alternating with wishes that there would be a tug, a fight that would pull one away from the other. I feel myself sinking into a mind-numbing helplessness.

And then I find myself saying to Clara:

> Many years ago, my father gave a talk in which he said, "Thank goodness people aren't cabbages, we have moods, ups and downs . . . . These variations in mood of this nature are the common lot of man, . . . character traits that make us all unique and different."

"Maybe you're not depressed so much as you are struggling with facing the ups and downs of life," I add.

"Your father said that?"

Yes, he did. Another kind of dread spreads over me: I have revealed too much; I feel anxiously vulnerable. "Why is it that words often make use of us, we see them approach menacingly, like an irresistible abyss, yet are unable to ward them off and end up saying precisely what we did not wish to say?" (Saramago 1992, p. 182).

"I said something I don't usually say," I offer.

"I know—I'm surprised. Why did you?"

"You know, I'm not sure."

"You wanted to separate us." Clara's voice is hesitant.

"Hmm . . . separate us?" I wonder aloud.

"Yes, separate us," Clara repeats.

"You and your mother," I say.

"Me and you . . . . Me and everything disgusting in me . . ."

"Your disgusting mother in you."

Clara says, "I feel like it is my mother in me, I have no control . . . . I often think you must have had a mother like mine because you seem to understand the experience so well."

"Maybe you've been worried I've understood it *too* well," I reply. "That I've been in it so much with you that I couldn't help you find a safe path away from her."

"I don't want to think about that—I don't want to be disappointed in you, to think that you can't help me and I can't help myself," Clara replies.

To think that I could collapse into your misery . . . to think that I needed help from my father, the kind of help that your own father couldn't give you.

REDISCOVERING MY FATHER

> Mothers should aim at taking in about three pints of fluid a day. Three cups of tea make a pint, so this should give you an idea of how much to take.

This was my father's advice to pregnant women ("ladies in waiting," as he liked to call them) and new mothers. A few years ago, I came across the manuscripts of some talks in which my father gave medical advice on our local radio station. They were brief, about five to ten minutes each, and covered a variety of topics, from the health effects of working in the local pottery factories to heart attacks, from how to make friends with your stomach to warts, from prenatal care to the pros and cons of tea drinking.

I was surprised to rediscover these talks, some in the form of indecipherable series of lines and slopes that constituted my father's handwriting, others typed on that old translucent typing paper. I started to read them first with astonishment and then with increasing curiosity. I felt that I was finding my father again for the first time, finding something of my father that I had known but not really known until now. I had a growing sense of connection between my work with Paul and Clara

and the reenlivened internal experience of my father as a lively writer who, before his drinking, had relished the joys of life.

LIFELONG DEVELOPMENT

> Life, then, I feel, is made to be lived, and this applies to old age as much as to young age. There is a good deal of truth in saying to old people, "Live dangerously—well, anyway, if you don't live dangerously, don't sit in a corner and wilt away."

Emotional growth carries on throughout life. Analysis does not resolve all internal difficulties but, when successful, provides the internal structure for continuing psychological learning and growth. As we grow older, we do not "wilt away" but continue grappling with the psychic dangers that are an inevitable part of emotional growth.

A number of psychoanalytic authors (Erikson 1963; Hildebrand 1988; Loewald 1979; Milner 1987) have discussed the lifelong nature of psychic growth and creativity; "mature creativity in later life may well transmute and express earlier infantile and adolescent themes in a more ego-syntonic and satisfactory way than earlier theorists have suggested" (Hildebrand, p. 356). As clinicians, we face the added challenge of growing through our work and learning how to use our own growth in the service of our patients (Bezoari and Ferro 1992; Ogden 1994; Parsons 2000; Searles 1975; Symington 2007).

As I sat discussing the work with Paul with my colleagues, it became clear (at first painfully so) that I was mistaken to think that certain feelings I had about my father were or should be over, or to think that these feelings were the same as feelings from the past. I came face to face with my fantasy, like Laius's, that Oedipus was dead and gone.

Freud, too, had a fantasy: that in normal circumstances the Oedipus complex passes, is dissolved, destroyed, or demolished (Loewald 1979). Loewald—and later Ogden (2006)—recognized the unrealistic nature of this fantasy and suggested instead that, far from being destroyed, the Oedipus complex waxes and wanes throughout life, enriching life and love as it does so. He described this process as a periodic resurgence of old, merged relations that create unity, and as we experience them anew, we have the opportunity to integrate them in different ways with fresh, adult

forms of love (for Loewald, adult love is based on increasing equality). We create richer and more complex forms of love as we move—not in a linear way toward ever-greater adult forms, but back and forth among these different types of oedipal relationships.

For Loewald, because Oedipus relations are indeed so complex, comprised as they are of the continuous reintegration of several different forms of relationships, there is never resolution. "To master all these currents permanently and without the aid of degrees and waves of repression appears to be beyond human capacity" (1979, p. 760). The reason we revisit the Oedipus complex in this ongoing way, notes Loewald, is that we continue throughout life to seek new forms of emotional emancipation from our parents, to find ever-new aliveness. The struggle for new forms of aliveness necessitates continuously killing off our parents, but in so doing giving them new forms of life within us. This re-creation of the internal parents comes to constitute the internal atonement structure of the Oedipus complex.

In re-creating Loewald's re-creation of Freud's thinking, Ogden (2009) brings to life Loewald's twin notions of parricide and the reinvention of parents as a metamorphosis. He compares the metamorphosis of caterpillar to butterfly to the metamorphosis of the internal parents. Ogden cites Karp and Berrill's (1981) description of the metamorphosis of a caterpillar that changes into a completely distinct insect, a butterfly, while the DNA of the two entirely distinct insects remains the same. Such is the painful yet life-affirming process of the internal metamorphosis of our parents, he suggests. We struggle to push away from them and give them a different form of life, and yet they always remain our parents; the DNA never changes.

Through this analogy, Ogden brings home the powerful nature of emotional change that is just as real and profound as that found in the natural world. As one of Banville's (1997) characters puts it:

> Metamorphosis is a painful process. I imagine the exquisite agony of the caterpillar turning itself into a butterfly, pushing out eye-stalks, pounding its fat-cells into iridescent wing dust, at last cracking the mother-of-pearl sheath and staggering upright on sticky, hairs-breadth legs, drunken, gasping, dazed by the light. [pp. 59-60]

In the process of my work with Paul and Clara, Loewald's (1979) ideas took on an intimate meaning that gave oedipal theory new life for me. Although I had mourned my father's death many years previously, at the time I am writing about here, I had entered another disorganizing period in which the death of my father and my love for him, my merged and adult identifications, dipped and rose in new emotional configurations. As I came to understand it, my patients and I were encountering and reencountering oedipal relations in our distinct but overlapping, conscious and unconscious ways, at distinct periods in our own lives. We were engaged in a process of mutual emotional growth.

PAUL: REVISITING MY DREAM

At the time of the treatment I am describing, I had not known Paul very long, but from the beginning he evoked very strong responses in me. Initially, when I brought Paul to my consultation group, I was preoccupied with worry—and, less consciously, with anger toward this alcoholic man. It was my dreams that helped remind me that he was, like everyone, a complex human being and not just an alcoholic, suicidal patient.

One of my colleagues suggested that the dream in which I was dancing with my father, mentioned earlier, might represent my manic denial of loss. It did not feel like that to me. It can be hard to distinguish between a celebratory, joyous experience and a manic defensiveness, and there may always be some elements of each in both. Loewald (1988) talks of the celebratory part of sublimation: "This 'manic' element of sublimation is not a denial, or not only that, but an affirmation of unity as well" (p. 22).

Feelings of joy, pleasure, and beauty are natural companions to feelings of loss and mourning (Silverman 2000; Sweetnam 2007). My feelings and associations to this dream did not feel like "the return of the repressed" or a "manic defense" against loss or dependency. The dream was light, intimate, and beautiful. It felt like the creation of an enchanted relationship with my father that had existed unconsciously in my fantasies, only to have gone underground, waiting to be reevoked. The regeneration of this romantically blissful relationship seemed something to enjoy and integrate.

In my associations and later thoughts about the dream, Paul came to mind. Mulling it over, it seemed to me that I had dreamt into existence a kind of romantic (oedipal) love with my father, and also with Paul. It was through a deeper acceptance of my father's death and of Paul's potential death that I became more conscious of my deeper romantic feelings for both of them. Romantic love in adult life creates a new basis from which we can better tolerate revisiting deep feelings of unity with another. As Loewald says, as we revisit melancholic and romantic identifications, they are reintegrated in new ways. This is perhaps why I dreamt this dream early in the treatment with Paul, as a basis from which to experience the more melancholic and illicit forms of love that I recount below. As the work progressed, I realized that the physical and emotional absence of Paul's mother's left him with many obstacles to blissful love and unity. It was too soon to offer Paul my thoughts about his longings for love; for now the longings needed to rest in my mind.

WAKING-SLEEPING REVERIE: I AM HE

Paul and I gradually settled into an unsettling relationship with each other. I learned that he came from a very chaotic family background. His father traveled for work and, during periodic abrupt separations between his parents, his father would take his brother and him on the road, leaving Paul's alcoholic mother behind. When Paul pleaded to stay with his mother, she would utter drunken rebukes, such as "Oh, grow up!" He talked of himself as a "waiting child," spending many hours waiting with his brother while his father attended business meetings, and all the while he desperately waited to return to his mother. In many ways, he and his brother were left to bring themselves up. One day about a year into the treatment, Paul recalled a memory of waiting so long in his father's car that he became extremely hungry and left the car with his brother in search of a fast food restaurant. When they returned to the car, their father screamed at them for leaving the car without him.

A few days after Paul recounted this episode, as I was drifting into sleep, I imagined that I was Paul, lying in a hospital bed; feeling sleepy, I experienced a very intense sense of oneness with him. The fact that this was a strong, nonconflictual feeling, such that I felt entirely normal

being him, suggested to me that I was establishing a connection of oneness with Paul in an attempt to ward off the finality of death. It was not the lighter, blissful kind of togetherness of the first dream, but a more melancholic identification with someone severely ill.

I was young when my father died and had not had the capacity at the time to truly mourn him. For a while after his death, I had the occasional intrusive thought, "Maybe I will become depressed, 'just like dad.'" In the dream described above, I felt I was re-creating not just closeness with Paul, but a deeper togetherness that I had longed for with my father.

I tried to let the tangle of my emotions unravel so that I could think about how the dream might be relevant in my work with Paul. A few sessions later, I spoke to him about how his longing for food while waiting for his father might perhaps have also been a deep longing to be closer to his absent mother. He said he remembered missing his mother, but not longing for her. At this point in the treatment, it was clear that Paul could not yet allow himself to know the intensity of his longing for his mother or for me. But, my dreaming our deep fantasy of oneness helped me become aware of the unconscious longings for mutual closeness that were hidden by his drinking. For now, I needed to hold onto these feelings in my mind, rather than banish them as Paul's mother had done; it was for me to dream the dream that Paul could not yet dream.

ANOTHER DREAM: ILLICIT LOVE

Several months later, Paul and I were exploring his fears of being abandoned by me if he allowed me to help him. I have another dream: I am with my patient, who is a much bigger man than Paul or my father; he is "bigger than life." I am surprised at how much "better" he seems, articulate and "together." I am out with him—on a date? I am enjoying being with him but have a powerful sense of doing something illicit. When I awake, I feel like a spurned lover.

This time Paul appeared to be "bigger than life." My mind was a little hazy when I thought about the dream, but it occurred to me that perhaps I longed to make him "bigger than death." In this dream, I was again dating someone, but this time with the clear sense that I should not be. It reminded me of the small but relevant sense of shame I had

had about my love for my father. For Paul, love for his mother felt illicit in many complicated ways; she was forbidden to him in a literal way and in psychic ways. To love her in a more separate and whole way would have meant breaking the sacred bond (Loewald 1979) of his torturous emotional tie with her. I wondered with Paul about his feeling that not only was help forbidden, but also love itself was forbidden; he should "grow up" and not need me or anyone else. Paul fervently denied this, and again, for now, it was I who held in mind the illicit nature of his loving and needing.

This process of shifting feelings between my father and Paul occurred primarily through dreams (at least in terms of what I became aware of). Our dreams are the means through which we create our own self-understanding. As analysts, they also help us to continue evolving our own analytic identity and our understanding of our patients, as well as helping to deepen the work with our patients (Parsons 2000).

> If a man could pass through Paradise in a dream, and have a flower presented to him as a pledge that his soul had really been there, and if he found that flower in his hand when he awoke—Aye! and what then? [Coleridge 1894, p. 282]

Both my early responses to Paul and my dreams helped me not only to "find the patient within oneself" (Bollas 1987, p. 202), but also to simultaneously find myself within the patient. The power of the unconscious communication between us generated new dreams and meanings of my internal relationship with my father and with Paul. My dreams helped me think about the nature of love and longing that Paul had for his mother in particular—his hope of feeling closely united with her and his dread of being abandoned and vilified. I came to see his alcoholism as part of a melancholic identification with her, substituting for his need to be close. As I let my dreams unfold in my conscious mind, I could then silently bring the dreaming "flower," the experience of love in its blissful, melancholic, and illicit forms, into my relationship with Paul.

These dreams and reverie related to specific moments in my treatment with Paul, but they did not represent any clear developmental trajectory. Rather, I think they were part of the lifelong transformation (Bion 1984; Rey 1994) that occurs as we dip in and out of identifications

and desires. My internal relationships with both Paul and my father became more whole as their drinking released its hold in my mind. I was able to relate to both of them as complex human beings. Awareness of the multilayered meanings of Paul's alcoholism and depression, while still central in our work, ceased to dominate my feelings and thoughts about him. I felt less anxious and freer to experience both love for him and potential loss of him as a patient and as a person. I moved into a greater ease and relaxation with him as I recognized the limits of what Paul and I might be able to achieve together. I was able to help us focus on his conflicted desire to live a fuller life, as much as on his potential death.

In one of the sessions during this period, Paul said, "I am glad I don't feel the pressure from you that I feel from my boyfriend to quit drinking right away." Paul started to make associations between his unsympathetic, verbally abusive boyfriend and his father. Previously, he had spoken of his father in idealized terms; he did not consciously feel that his father's abuse had any real affect on him. He now became more conscious of his internal struggle to hang onto the sense of his father as his only reliable, caring parental figure. Close to this time, Paul expressed interest in lying on the couch for the first time.

The refinding of my father as writer and the initial encounter with Paul stimulated a period of ongoing transformation of my relationship with my father. As I danced another dance and feared another death, I revisited blissful and illicit love, melancholia, and mourning. The work with Paul gave me the opportunity to dream a new integration of my deep desires for oneness, for romantic and illicit love, as each form of love stimulated a deeper experience of the others. I was able to refind with greater pleasure—one not so clouded by loss—the closeness and playfulness in my early relationship with a lively, playful father and a dedicated physician who helped many.

CLARA: A FATHER'S HELPING HAND

At the time I will describe, Clara had been in psychoanalysis multiple times a week for many years. Enough work had been done between us to make it possible for both of us to take a risk and to make use of my

relationship with my father in a way that neither of us could have done earlier in the treatment.

From a too-young age, Clara had developed a tremendous emotional and mental resilience as a way of psychically removing herself from her parents' chaos and emotional abandonment. She had developed many capacities to take care of herself (Winnicott 1949), but was highly ambivalent about this resilience. She was terrified that if she needed anyone, she would drive them away, as she feared she had done with both her parents. But Clara's resilience came to her aid in our work, as over the years she courageously faced profound losses, disappointments, emotional collapses, hurt, and anger in relation to her parents and to me.

Her mother was a pitiable person too submerged in her own inner chaos to show much more than unpredictable, harsh, and transitory care. Her father was more able to emerge from himself and offer a kind but inconsistent attentiveness to his daughter. Clara's many concerns about whether I could help her ebbed and flowed between hope that I would be able to protect her from her mother, and despair at the thought that we would both feel helpless in the face of mother's clinging arms. Some short while before the conversation described earlier in this article, Clara had wondered whether she might be better off with a male therapist who would "have what it takes" to help her separate from her intrusive mother.

In the year or so prior to the session with Clara described above, I had been rereading the medical talks my father gave. As mentioned, it was not new knowledge that my father had given these talks, but it was a new emotional truth for me. Reading his writing, I felt I came to know him differently; my internal sense of him was shaken up as I created a new identification with him as a writer. Sometimes when I write—as I am doing now—I re-remember him chortling to himself as he sat at his desk, scribbling away. I mourn again and I write again with more joy and less anxiety.

Transforming my internal relationship with my father was affected by and affected my work with Clara. At the time of the dialogue quoted above, Clara had been reexperiencing a feeling of drowning in a merged identification with her mother. But now I felt stuck in this kind of

"mother morass" with her; I felt anxious—unconsciously at the time—about how I could possible free myself.

During the conversation between Clara and me recounted earlier, I became confused; it was unclear whom either of us was referring to—was it the two of us, or her and her mother? Her mother, the patient herself, and I seemed briefly jumbled together. Earlier in the treatment, Clara's need for my close attentiveness to her experiences with her mother had been paramount. She had periodically felt completely collapsed into her mother, and craved for me to painlessly lift her away from the torments of feeling so helplessly subsumed. She had long been consumed by the fantasy that she could not "break the rules" that demanded she must take care of her ungrateful mother. She was afraid of catastrophically hurting her mother if she inched herself away from her, and of then being tortured by her own guilt.

It is not hard to imagine that my bringing my father so directly into the treatment in response to our conversation was an intrusive shock on both sides of the couch. The reverberations were palpable between us. The unexpectedness of my words left Clara wondering why I had said something so out of character. Was this the beginning of a slippery slope toward an unpredictable, motherlike craziness? Was I a leopard that could change its spots? On the other hand, was I pulling myself away from the mother inside her and toward my own father, who was less disgusting and more interesting to me? For my part, I was anxious about the wisdom of my intervention and whether it had been unconsciously motivated by my own powerlessness.

As I sat with my feelings, I became more keenly aware of the difference between that enormous tidal pull I had felt in the past and how I felt now. I realized that I had been struggling with my own wish that *she* would free *me* from the need to be the freedom fighter, that she would save me from my own difficulty in asserting myself more directly. Now we both needed me to free myself from the internal relational confusion created between Clara, her mother, and me. Neither of Clara's parents had been able to provide a transitional relationship in her move to a more differentiated relationship with her mother; her fantasies were of a wrenching, destructive separation. Clara needed me to place myself at a

clear emotional distance between her and her mother and between her and me.

I realized in retrospect that I was unconsciously using my revitalized internal relationship with my father to help me find this position in between Clara, her mother, and me. I needed to find the father within me whom we could both use as a transitional relationship in this process of separation from her mother. Others have discussed the use of an internal other in this way as a *third*. Smith (2000) gave an account of how thinking about his father helped him remain steady in his analytic role with a patient (although he did not reveal anything about this to the patient). Loewald (1979) and Ogden (1989) have talked about the child's need for a transitional, incestuous oedipal relationship as she gradually separates from early "motherly" functions. Benjamin (1988) discussed the girl's need for an identificatory love with father before a more complex oedipal relationship can be experienced.

As Clara expressed her anger and fear about what my sudden comment meant, memories from her past were stirred up. She remembered her father's death (which had occurred several years prior) and her mother sitting at his bedside, screaming at him. Clara felt a resurgence of profound grief as her father literally left her alone with her mother's craziness. She recalled times when her mother relentlessly berated her for something she had not done, and although her father sometimes stood up for her in a protective way, he would often say with resignation, "Don't upset your mother." She mourned in a new way the loss of both an extremely incapable mother and an inadequate, abandoning father. As she was able to let go of a primary identification with her mother as intrusive and disgusting, feelings of sadness emerged for her mother and her compromised life.

In the transference, Clara expressed her anger and disappointment with me for not protecting her from her mother or helping her separate sooner and less painfully. That moment when I acted out of character, like a leopard that could unpredictably change its spots and become aggressively crazy, now took on new shape as my spontaneous comment was seen to communicate my desire to help her rather than attack her. She became able to reinternalize me as a helpful (rather than crazy) presence—as the father who was able to help her stand up to her internal

mother, rather than the father who would collapse in the face of his wife's tenacious hold.

Over the months that followed, Clara's fantasy that she and I had similar mothers receded; she no longer needed this kind of merged identification. Instead of feeling that "you must have had a mother like mine," she experienced me as someone who had the kind of father whom she had not had, a shift in her identification with me that involved many conflictual feelings. Gradually, Clara "metamorphosed" her internal relationship with her own father into someone who was not just abandoning, but was also in actuality a dedicated and accomplished teacher. Her love for him became more emotionally apparent to herself and to me. We now talked about how we both had fathers who were intellectually curious, who gave talks (as I had previously known about her father), and of whom we were proud.

The way I spoke to Clara, suddenly and revealingly, was new and different in our relationship. On previous occasions when I found myself in similar situations with her, I had responded differently. For instance, I sometimes interpreted from my feeling of being pulled into something with her, or I wondered if she might feel a similar pull from her mother and from me, accompanied by a similar helplessness to resist. By this point in the treatment, it was up to me to provide something clearly and starkly separate that would help her psychically pull away from her mother in a less gradual way than had been the case so far. We both needed this "burst of aliveness" from me, a bold unequivocal stepping in (Alvarez 1992) to help break a rigidified entanglement.

Clara's internal mother had such a tenacious hold on her that the enmeshment needed to be pulled, not teased, apart. As Alvarez discusses, sometimes patients need us to offer our liveliness to help draw them out of such entanglements or withdrawals. Our own lively subjectivity at such times can be a transition to the more gradual integration of aliveness—in Clara's case, alive separateness. The shock of my comment was thus a productive shock (Symington 1983), necessary for change to occur as something unconscious suddenly becomes accessible; as Phillips (2006) puts it, "being caught off guard is an opening" (p. 219).

Spontaneous communication, coming as it does suddenly and without pre-thought, is rawer and closer to unconscious experience than

our preformed thoughts. Spontaneity offers an opening for the elaboration of unformed thoughts into new, mutually created symbolic forms. Particularly when the transference-countertransference relationship has become rigidified, spontaneous communication can be a useful way to open up fresh, surprising thinking. Clara was able to use this opening; she became able to play (Winnicott 1971, p. 51) more spontaneously and with refreshing ease with what I said, something that would not have been easy for her earlier in our work.

For my part, I had to create this opening by changing myself. I spoke spontaneously without knowing why I was saying what I did or what the consequences would be. Spontaneous moments are by definition risky, exposing our own vulnerability (Aron 2006). We do not always feel ourselves to be bursting with a fresh, liberating feeling or thought; we are less likely to feel the reassurance that comes (sometimes erroneously) from having formed our thoughts before we speak them. When there is not enough psychic grounding on which to build links among different internal relationships, these sudden changes and the shocks that accompany them may be the only way, in life and in treatment, to create new connections.

Later on in Clara's treatment, there was another such shock. This time, *I* experienced the surprise when Clara told me that she had dreamt of her "sweet and kind" grandmother. This news arrived out of the blue, paralleling the shock that occurred when I had mentioned my father. In this instance, I was shocked out of a rigidified sense of Clara's past, in which I had joined with her in feeling that she had had no loving or kind relatives who might have tempered her parents' shortcomings. Although the relationship with her grandmother had not been enough to counterbalance the chaos of her immediate family, I was shocked into a re-creation of my sense of Clara; she had in fact received some kernels, some drifting feelings of love, from her grandmother and her father. She was now able to uncover and enliven these memories with new meaning; she could begin to create a sense of herself as loved and loving.

Some time later, Clara told me about having been on a date that she was not enjoying but found it hard to cut short. She told me that she had tried to think of me as she got stuck in feeling bad about herself for having agreed to meet a man who turned out to be a dud. She continued

castigating herself for castigating herself, and then she told me a dream fragment in which an older woman was helping her with something.

As we responded to her dream, I told Clara I thought that, although she attacked herself for her inability to escape from the "dud" and was upset that she could not find me in her own mind, she had in fact refound her grandmother, a kind internal presence who was helping her to refind her own kind self. A direct transference interpretation did not seem as important at this point as allowing the experiences with her grandmother to evolve.

A few days after that, Clara mentioned, as if in passing, that her father had said to her, "You have such a nice personality, you're friendly and open." It was not a surprise to me to hear her father's words; the surprise was that Clara now clearly felt her father's love in a new way, and spoke to me from the depth of that feeling.

As we continued the treatment, my patient was surprised by other things I said, but was more curious than threatened; she experienced more internal flexibility. This new identification with her father and me helped her tolerate her own anger and guilt and feel less conflicted about her separation from her mother. Sometimes the steps we take in our outer lives toward emotional growth appear minor when compared to the inner emotional transformation they represent. Clara had previously made significant steps toward creating emotional space between herself and her mother, but now the steps were bolder and more decisive. Most important, she began to shed the enormous burden of guilt she had been carrying for so many years.

Clara drew on her own aliveness to draw necessarily sharp, firm lines between her own and her mother's life, which were of great emotional import. For instance, she stopped responding to her mother's insistent, vitriolic letters and phone calls; she cut down the number of visits to her mother and made them briefer. All this she did with a sense of freedom and sadness, as she felt more able to "break the rules"—as I had done in a small but important way.

Being able to experience me in the transference as a more helpful father who was willing to step in helped Clara be receptive to loving and caring relationships with men. About a year or so later, she fell in love. She did so while trusting that she could open herself to the caring of a

kind, reliable man, and that she could tolerate periods of emotional disorganization and reorganization. As it became clearer that this was likely to be the man whom she would spend the rest of her life with, I found myself feeling a profound mixture of joy and pride, as well as a twinge of sadness.

The occasion that I have talked about here helped both Clara and me find our fathers in new ways and move to a greater sense of freedom within ourselves. The transformation of my internal father, which had begun with my rereading his writings, now helped me respond to Clara in a freer, more spontaneous way. As I told her some words my father had spoken, I used my newfound sense of him as writer to bring her and me away from an entangled relationship with her mother. Unconsciously, Clara formed a new identification with "my father within me" and revitalized her internal relationship with her own father as a loving and accomplished man. Responding more freely to Clara's unconscious communication of her need for an assertive presence helped me continue the process of transforming my relationship with my internal father. Drawing on my revitalized identification with him as a companion and as someone who had chosen to communicate with his patients in an unusual way for a family physician, I now communicated in an unusual way with my patient. Clara expressed her wish to know that the work was changing me, that I was growing and thriving (Searles 1975) through my work with her. On this occasion, the mutual need to change and be changed by the other helped us both thrive together.

"The parents who are restituted (re-established) are parents who had not previously existed (or, perhaps more accurately) had existed only as potential" (Loewald 1979, p. 760). In these two treatments, to greater and lesser extents, there was a process of mutual restitution of identifications with our internal parents. I came to see my own "functional neurosis" as part of continued growth with my patients. The nature of the transformation of my internal father was specific to psychic time and place. The internal back and forth in this confluence of conscious and unconscious identifications and needs kept stirring things up in necessary ways in these treatments and in my life.

The mutual evocations between me and my patients were neither as linear nor as clear as this writing may make them appear to be. It is dif-

ficult to tease out the strands of these transformations in both my own and my patient's lives; when we work with unconscious processes, linear connections are always hard to see. Both these treatments stretched over time and were unconsciously linked with each other in my own mind; Paul, Clara, and I all affected each other in subtle, unconscious, and often barely discernible ways.

KEEPING OURSELVES AND OUR WORK ALIVE

As we age, we become more able to let go of self-interest in what we do and to embrace a more "libidinal investment in that which is being generated" (Erikson 1963, p. 267). As analysts, with time and experience, we have increasing opportunity to enjoy psychoanalysis for its own sake. Anxieties about performance and success loosen their hold while paradoxically opening psychic space in which familiar anxieties can be integrated afresh. With my patients, perhaps I was confronting my need for an increase in generativity, for a revitalization of my relationship to the psychoanalytic process itself (Parsons 2006) that prevents the work and ourselves from stagnating. With both Clara and Paul, the unconscious communications between us helped me revisit my thinking about the work, making me more receptive to offering responses to my patients that were unusual for me. On both occasions, I felt less pressure to tread a well-worn path of interventions, to follow what may be considered psychoanalytic norms. The responses I discussed were out of my usual analytic character, but were grounded in my analytic background and training, in my experience with these two patients, and in my own life—especially at this point, as I confronted my own vulnerabilities about aging.

With Paul, I initially struggled with what I considered to be only two options: either to not work with him until he was clean and sober, or to treat him under strict rules of sobriety. Instead of opting for either of these choices, I embarked with him on a collaborative approach of figuring out what would best help us tackle his substance abuse and his more underlying emotional difficulties. This involved moving back and forth between focusing on concrete, everyday issues and on uncon-

scious realms. Working in this way addressed Paul's conflicted desires to know himself, as well as his unconscious need to find and create me as a mother who was interested in him and who also stepped in when he was putting his life in danger.

Paul and I recognized that if the psychotherapy did not seem to be helping him, we might need to readjust things. I was not doing anything that had not been done by therapists far more experienced than I with this integrative approach (see, for instance, Weegmann and Cohen [2002], for an interesting psychoanalytic collection addressing substance treatment), but it was new for me to think about this approach with my patient.

With Clara, I intervened in a way that was unusual for me: I brought something of my own personal life into treatment. I spoke spontaneously and directly about my father. It was part of my changing relationship—unconscious in that moment—to both my patient and to the psychoanalytic process itself. It felt risky to me to bring my own subjectivity so directly into our relationship. But it is how we use ourselves in our treatments and our willingness to take risks founded on experience and thoughtfulness that help us maintain a generative relationship to the psychoanalytic process, as we bring the fruits of our curiosity and vitality into our psychoanalytic practices. With Paul and Clara and in my personal relationships, I was reorganizing my internal world and my relationship to the work in ways that I could not have done earlier in my life.

THE END IS THE BEGINNING

> Finally, having a baby needs good strong muscles; so all mothers should try to walk at least three miles a day; and I would like to see all expectant mothers walking each day from these studios in Cheapside, Hanley, through Hanley Park, to Stoke Town Hall and back again. What a splendid sight it would make.

These days there are a multitude of theories that help explain the transformative nature of psychoanalytic treatment. Each perspective offers its own view of the psychoanalytic process, and some readers will undoubtedly feel that they would have worked from a different perspective than I did, and/or that other ways of working could have been equally

or more useful. Readers will see the gaps in my work, in my discussion about the treatment, and my own dreams. But, as in previous papers (Sweetnam 2001, 2006), I have attempted to describe clinical experiences in ways that encourage the reader to draw his or her own theoretical conclusions, starting from the ground up. I have wanted to give a flavor of how it is that our own emotional growth as analysts is not a byproduct of the work with patients, but vital to it.

At the same time, I have described how my own relationship to Loewald's theory took on new, more intimate meanings for me in these treatments. If we are to build up our psychoanalytic muscles as we age, we need to continue to make clinical use of the opportunities for mutual change that occur in our work. As we do so, we reenliven psychoanalysis for ourselves and for each individual patient.

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THE PREDISPOSITION TO ANXIETY

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The considerations which I present have to do chiefly with the predisposition to anxiety and its relation to increased narcissism, especially in severe neuroses. I present these considerations largely in the form of questions rather than conclusions. The stages by which I arrived at these questions I give here in order to present the background of this paper: (1) the analysis of particularly severe neuroses in adults, (2) the searching for supportive or related data in the medical, psychiatric and psychoanalytic clinical experience of myself and others, (3) a supplementary review of some experimental work and observations, (4) a review of Freud's later publications concerning anxiety, especially The Problem of Anxiety, (5) and finally, a return to my own case material which I reviewed in the light of my questioning. For the sake of consolidating this presentation, however, I shall now take this circle of search in a little different order. I shall reserve the presentation of the case material for a subsequent paper in which I hope to discuss also some special considerations of treatment. I have chosen this order because I believe that the clinical material in itself is inevitably so detailed as to be possibly confusing unless the reader is already aware of the underlying thesis. In my work, however, the clinical material came first and the thesis was the result of my observations. In this paper I shall first discuss Freud's later statements concerning anxiety; I shall then present factual observations

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and the results of experiments of some significance in the problem of basic anxiety.

I

In The Problem of Anxiety,[1] Freud says:

> Anxiety is the reaction to danger . . . . But the dangers in question are those common to all mankind; they are the same for everybody; so that what we need and do not have at our disposal is some factor which shall enable us to understand the basis of selection of those individuals who are able to subject the affect of anxiety, despite its singularity, to normal psychic control, or which on the other hand determines those who must prove unequal to this task. (p. 121)

Then after commenting briefly on the inadequacy of Adler's organ inferiority explanation, Freud turns to a critique of Rank's birth trauma theories. What Freud says here is of importance in regard to his own evaluation of the role of the birth trauma and is in no sense an endorsement of Rank's somewhat mystical therapeutic aggrandizement of it.

> The process of birth constitutes the first danger situation, the economic upheaval which birth entails becomes the prototype of the anxiety reaction; we have already followed out the line of development which connects this first danger, this first anxiety-occasioning situation with all subsequent ones; and in so doing we saw that they all retain something in common in that they all signify a separation from the mother, first only in a biological aspect, then in the sense of a direct object loss, and later of an object loss mediated in indirect ways. (p. 122)

Then, in objecting to Rank's emphasis on the severity of the birth trauma as a determinant—the main determinant—in producing varying degrees of intensity of the anxiety reaction in different individuals, Freud says:

> The emphasis on the varying severity of the birth trauma leaves no room for the legitimate etiological claim of constitutional

[1] Freud: *The Problem of Anxiety.* Trans. by H. A. Bunker. New York: The Psychoanalytic Quarterly Press and Norton and Co., 1936.

> factors. This severity is an organic factor, certainly, one which compared with constitution is a chance factor, and is itself dependent upon many influences which are to be termed accidental, such as for example timely obstetrical assistance . . . . If one were to allow for the importance of a constitutional factor, such as via the modification that it would depend much more upon how extensively the individual reacts to the variable severity of the birth trauma, one would deprive the theory of meaning and have reduced the new factor . . . to a subordinate role. That which determines whether or not neurosis is the outcome lies, then, in some other area, and once again in an unknown one . . . . For no trustworthy investigation has ever been carried out to determine whether difficult and protracted birth is correlated in indisputable fashion with the development of neurosis—indeed, whether children whose birth has been of this character manifest even the nervousness of earliest infancy for a longer period or more intensely than others. If the assertion is made that precipitate births . . . may possibly have for the child the significance of a severe trauma, then *a fortiori* it would certainly be necessary that births resulting in asphyxia should produce beyond any doubt the consequences alleged . . . I think it cannot yet be decided how large a contribution to the solution of the problem [of the fundamental basis of neurosis] it [i.e., difficult birth] actually makes. (pp. 124–126)

From his chapter on Analysis of Anxiety in the same book I quote the following:

> But what is a "danger"? In the act of birth there is an objective danger to the preservation of life . . . . But psychologically it has no meaning at all. The danger attending birth has still no psychic content . . . . The foetus can be aware of nothing beyond a gross disturbance in the economy of its narcissistic libido. Large amounts of excitation press upon it, giving rise to novel sensations of unpleasure; numerous organs enforce increased cathexis in their behalf, as it were a prelude to the object-cathexis soon to be initiated; what is there in all this that can be regarded as bearing the stamp of a "danger situation"? . . . . It is not credible that the child has preserved any other than tactile and general sensations from the act of birth [in contrast to

> Rank's assumption of visual impressions] . . . . Intrauterine life and early infancy form a continuum to a far greater extent than the striking caesura of the act of birth would lead us to believe. (pp. 96, 97, 102)

Here I realize we are symbolically and figuratively in deep water, but at the risk of finding myself in a sink or swim situation, I shall raise some questions now and repeatedly throughout the rest of the material of this paper. It certainly seems clear that the birth trauma occupies no such exalted place in etiology or therapy as was once assigned to it by Rank; it seems indeed to have fallen quite into disrepute as an etiological factor in the neuroses. Yet we raise the question whether variations in the birth trauma are so insignificant in their effect on later anxiety—when birth is indeed the prototype of human anxiety—as we have been assuming. Is the birth trauma so opposed to the importance of constitutional factors as is implied in Freud's critique of Rank's position, as really "to leave no room for the legitimate etiological claim of constitutional factors,"[2] or may not the anxiety-increasing factors of a disturbed birth process combine with or reinforce the constitutional factors in the fashion of multiple determination of symptoms with which we are quite familiar? If

[2] I believe that elsewhere Freud himself has stated his attitude a little differently, and clearly does not in general consider the constitutional and the accidental as leaving no room for each other. He deals with this in a forthright fashion in his footnote to the first paragraph of his article on the Dynamics of Transference (1912).

> We will here provide against misconceptions and reproaches to the effect that we have denied the importance of the inborn (constitutional) factor because we have emphasized the importance of infantile impressions. Such an accusation arises out of the narrowness with which mankind looks for causes inasmuch as one single causal factor satisfies him, in spite of the many commonly underlying the face of reality. Psychoanalysis has said much about the "accidental" component in etiology and little about the constitutional, but only because it could throw new light upon the former, whereas of the latter it knows no more so far than is already known. We deprecate the assumption of an essential opposition between the two series of etiological factors; we presume rather a perpetual interchange of both in producing the results observed . . . . The relative etiological effectiveness of each is only to be measured individually and in single instances. In a series comprising varying degrees of both factors extreme cases will certainly also be found . . . . Further, we may venture to regard the constitution itself as a residue from the effects of accidental influences upon the endless procession of our forefathers.

Coll. Papers, II, p. 312.

the accumulated birth trauma of the past is so important as to leave an anxiety pattern in the inherited equipment of the race, is it then to be expected that the individual birth experience will have been nullified by this inherited stamp? If so, when does an anxiety reaction begin to appear—after birth, at birth, or is it potentially present in intrauterine life, to be released only after birth?

We are used to thinking of anxiety as having psychological content, but is there a pre-anxiety response which has very little psychological content? There are anxiety-like behavior patterns in lower animals, even in those that are not viviparous. The human anxiety pattern varies greatly in its symptomatic form. Most commonly it contains cardiorespiratory symptoms which seem indeed to be the nucleus of the birth experience. But are there events besides birth itself, perhaps in the way of untoward events in intrauterine life or in the first few weeks following birth, which might constitute danger situations and be reacted to with something akin to anxiety in fetal life or in the first few weeks of postnatal life?

The fetus moves about, kicks, turns around, reacts to some external stimuli by increased motion. It swallows, and traces of its own hair are found in the meconium. It excretes urine and sometimes passes stool. It has been repeatedly shown that the fetal heartbeat increases in rate if a vibrating tuning fork is placed on the mother's abdomen. Similar increases in fetal heart rate have been recorded after sharp loud noises have occurred near the mother. This finding is reported by a number of investigators. Two of them (Sontag and Wallace) found marked increase in fetal movement in response to noise of a doorbell buzzer; this was especially strong and consistent when the buzzer was placed over the fetal head. Responsiveness to sound began at the thirty-first week of intrauterine life and increased as the fetus neared term.[3] The fetus

[3] Peiper, A.: *Sense Perception of the Prematurely Born.* Jahrb. f. Kinderh. 1924, pp. 104-195; 1925, pp. 29, 236.

Catel, W.: *Neurologic Investigations in Premature Children.* Monatsch. f. Kinderh. 1928, pp. 38-303.

Ray, W: S.: *Preliminary Report on a Study of Foetal Conditioning.* Child Development, III, 1932, p. 175.

Sontag, L. W. and Wallace, R. F.: *The Response of the Human Foetus to Sound Stimuli.* Child Development, VI, 1935, pp. 253-258.

Forbes, H. S. and Forbes, H. B.: *Fetal Sense Reactions: Hearing.* J. of Comp. Psychol., 1927, VII, pp. 353-355.

may suffer hiccoughs, even as early as the fifth month; and respiratory-like movements are noted in the last month. Sometimes the fetus sucks its own fingers and cases have been recorded in which the infant was born with a swollen thumb;[4] and it is by no means rare for newborn babies to put their hands directly to their mouths. One questions what has been the role of sucking in these cases. Has a fortuitous meeting of hand and mouth served any function and been prolonged because of this? It would seem that the fetus is relatively helpless; and that while we cannot speak of any perception of danger, we still are faced with the quandary of what is the reaction to untoward conditions of intrauterine life, such as might in postnatal life produce pain and discomfort and be reacted to by crying. I raise the question whether the fetus which even cries *in utero* if air has been accidentally admitted to the uterine cavity, reacts to "discomfort" with an acceleration of the life movements at its disposal—sucking, swallowing, heartbeat, kicking. What is the relation of such accelerated behavior to anxiety? This is not the more or less organized anxiety pattern which we are used to thinking of as the anxiety reaction, to be sure; but do not these responses indicate an earlier form of anxiety-like response of separate or loosely constellated reflexes? I realize here that I run the risk of encroaching on the domain of neurology and reflex reactions, and on the field of biology which describes anxiety-like (frantic) behavior in lower animals and even insects. So I must retreat again to an attitude of inquiry.[5]

[4] Ahlfeld, Friedrich: Verh. d. deutsch. Gesellsch. f. Gynäk, II, 1888, p. 203. Also see footnote 20 (Gesell and Ilg) of this article.

[5] In the chapter on Analysis of Anxiety (*The Problem of Anxiety*, pp. 105-107) Freud postulates a kind of anxiety signal which is different from the anxiety reaction itself, but sees the first as derived from the second, the latter being operative in the development of the actual neuroses, the former of the psychoneuroses. "But when it is a matter of an 'anxiety of the id,' one does not have so much to contradict this as to emend an infelicitous expression. Anxiety is an affective state which can of course be experienced only by the ego. The id cannot be afraid, as the ego can; it is not an organization, and cannot estimate situations of danger. On the contrary, it is of extremely frequent occurrence that processes are initiated or executed in the id which give the ego occasion to develop anxiety; as a matter of fact, the repressions which are probably the earliest are motivated . . . by such fear on the part of the ego of this or that process in the id. We have good grounds here for once again distinguishing the two cases: that in which something happens in the id which activates one of the danger situations to which the ego is sensitive, causing the latter to give the anxiety signal for inhibition; and that in which there develops in the id

II

When we examine (vicariously) the behavior of the newly born infant (according to Watson's studies made in 1918–1919),[6] we find three types of emotional reaction, described by Watson as "fear," "rage" and "love." The behavior which Watson describes as a "fear" response is "a sudden catching of the breath, clutching randomly with the hands, sudden closing of the eyelids, puckering of the lips, then crying." These responses are present at birth. Watson found no original "fear" of the dark, and postulated correctly that later fear of the dark in older infants was due rather to the absence of familiar associated stimuli. The conditions which he found capable of producing a "fear" response were: (1) sudden removal of all means of support, i.e., dropping the child (or this same condition in a lesser degree—namely the pulling or jerking of the blanket or the sudden sharp pushing of the infant itself when the child is falling asleep or just awakening, and (2) loud sounds made near the child. Thus we see here a response (with the addition only of the cry) similar to the one which presumptively is called forth *in utero,* and provoked by the reversal of the most favorable mechanical features of intrauterine life, namely, the full support of the fetus, and the presence of a shock-absorbing fluid pad. The reaction to noise both in intrauterine life and immediately after birth raises the interesting problem as to whether this is real hearing or whether it is a tactile reaction to vibration. In favor of its being a reaction to actual hearing are the facts that embryological research has shown that the ear is functionally complete in anatomical structure and nerve supply long before birth,[7] and that many clinical

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a situation analogous to the birth trauma, which automatically brings about a reaction of anxiety. The two cases are brought into closer approximation to each other if it is emphasized that the second corresponds to the initial and original situation of danger, whereas the first corresponds to one of the anxiety-occasioning situations subsequently derived from it. Or, to relate the matter to actually existing disorders: the second case is that which is operative in the etiology of the 'actual' neuroses, the first is characteristic of the psychoneuroses." What I am suggesting sounds as though it were comparable to this distinction, but it is really quite at variance with it.

[6] Watson, John B.: *Psychology from the Standpoint of a Behaviorist.* New York: J. B. Lippincott, 1919.

[7] Streeter, G.: *On the Development of the Membranous Labyrinth and the Acoustic and Facial Nerves in the Human Embryo.* Am. J. Anat., VI, pp. 139-166.

observations of prematurely born infants indicate that they are almost uniformly hypersensitive to sound; also that fetal reactions are greatest when the sound stimulus is applied over the fetal head. Of this reaction to sound I shall have more to say later in the paper. It seems possible in fact that the intrauterine situation in which the fetus is surrounded by water may furnish conditions in which sound is actually magnified: that is, the amniotic fluid may absorb mechanical shock but amplify sound.

The behavior which Watson characterizes as "rage" is indicated in the newborn infant by "stiffening and fairly well-coordinated slashing or striking movements of the hands and arms. The feet and legs are drawn up and down; the breath is held until the child's face is flushed. These reactions continue until the irritating situation is relieved, and sometimes beyond. Almost any child from birth can be thrown into rage if its movements are hampered; its arms held tightly to its side, or sometimes even by holding the head between cotton pads." Here I would emphasize that this behavior appears as an aggressive reactive response to situations which are at least faintly reminiscent of the recent birth experience, in which the child was perforce helpless and the victim.[8]

Watson designates as "love" the response characterized by cessation of crying followed by smiling or gurgling, but does not differentiate between a positive pleasure gained and relative pleasure from relief of fear or discomfort. This pleasure response he sees produced as the result of stroking, tickling, gentle rocking, patting and turning upon the stomach across the nurse's knee. I do not know that it is necessary to

[8] Watson's division of the behavior into "Fear" and "Rage" has been questioned by other writers. I am concerned here, however, with the actual observations, rather than with his theoretical designations. While there is a considerable literature also on the related phenomena of the Morro reflex and the startle pattern in infants and adults, I do not wish now to become involved unnecessarily in these questions. From going over a number of reports in the literature it seems that reactions of newborns to loud sound and to loss of support are generally observed while the active reaction to confinement of motion is less constant. (Some writers describe the slashing rage-like movements only in some babies, while other babies show a quieting of activity.) This suggests to me that such behavior of the newly born babies varies, perhaps according to the pressure and firmness with which the infant is held, intense pressure producing the active "rage-like" reaction; lighter holding pressure falling in the same category as patting, stroking, supporting stimuli, provokes the quieting response which Watson designated "love."

comment further upon this here. These behavior reactions of newborns described by Watson would appear then as centrifugal and centripetal responses possibly correlated with disturbances of intrauterine life in the case of "fear," and with prolonged or difficult birth processes in the case of "rage." This is too schematic, however, and I shall presently be in danger of overemphasizing a contrast beyond its value. Certainly in most instances they would combine and reinforce each other. In brief then, I would raise the question of a pre-anxiety intrauterine response to (threatening) stimuli, consisting of reflex oral, muscular, cardiac and possibly prerespiratory reactions. This precedes the anxiety pattern established by the birth trauma, and probably augments it. It is inconceivable to me that there should be much psychic content to this, and it may indeed be the stuff of which blind, free floating, unanalyzable anxiety is constituted—sometimes adding just that overload to the accumulation of postnatal anxiety which produces the *severe* neurotic.

There is one other phenomenon sometimes associated with birth to which I would now call attention: the frequent appearance in male babies of an erection immediately after birth. (In a subsequent paper I shall have something to say regarding the corresponding reaction in the female.) Although this phenomenon has been frequently observed clinically, I am under the impression that systematic studies of its occurrence are lacking. It has mostly been observed and then passed by. There is a possibility, however, that its occurrence immediately following birth is not merely coincidental but is the result of stimulation by the trauma of birth itself. In a verbal communication from one of the obstetricians on the New York Hospital staff, I learned that erections in male babies are not the rule but are by no means rare. The erection is usually present immediately after birth. As this man described it, "I turn the baby over, and there it is. I have to be careful not to clamp the penis in with the cord." It had never occurred to him to consider the cause of these very early erections and he had no idea whether they were in any degree correlated with birth traumata or prolonged births. Again I ask, is there any correlation of such birth erections with anomalies or disturbances of the birth process resulting in more than the ordinary—and presumably benign—sequelae of tension?

That extreme emotional excitation may be accompanied by an orgasm even in adults has also been noted[9] and is in line with Freud's early conception of the overflow of dammed up libido. Cannon, approaching the same phenomenon from a physiological angle, says in discussing this, "Certain frustrations which bring about strong emotional upheavals characteristically energize at least some parts of the parasympathetic division . . . . Great emotion, such as is accompanied by nervous discharge via the sympathetic division, may also be accompanied by discharges via the sacral fibres . . . . The orderliness of the central arrangements is upset and it is possible that under these conditions the opposed innervations discharge simultaneously rather than reciprocally."[10] Later he states that "any high degree of excitement in the central nervous system—whether felt as anger, terror, pain, anxiety, joy, grief or deep disgust—is likely to break over the threshold of the sympathetic division, and disturb the functions of all organs which that division innervates."

Mrs. Margaret Blanton, in some observations on the behavior of the human infant during the first thirty days of life, published as far back as 1917,[11] noted that erections occur immediately after birth, and mentioned specifically erections in four different babies whom she studied. Although this study meticulously and objectively recorded the infant behavior, even measuring the angle of the erection, it is unfortunately of little value for our purpose as no systematic record of the behavior in relation to the infant's biography to date is given; nor was the total number of infants observed specifically mentioned, leaving us thus in the dark as to the frequency of the observation. Mrs. Blanton made some other interesting and rather striking observations, however, which may possibly fit in with and certainly do not contradict the line of my questioning. She noted sneezing as occurring even before the birth cry. Strong rubbing

[9] Freud: *Three Contributions to the Theory of Sex*. Fourth Edition. Nervous and Mental Disease Publishing Co., 1930. p. 62.

Köhler, in his observations on chimpanzees, noted that any very strong emotion "reacted on the genitals." (*The Mentality of Apes*. New York: Harcourt, Brace and Co., 2nd Ed., 1927. p. 302.)

[10] Cannon, W.: *Bodily Changes in Pain, Hunger, Fear and Rage*, 2nd Ed., Appleton, 1929.

[11] Blanton, M.: *The Behavior of the Human Infant During the First Thirty Days of Life*. Psychological Rev., XXIV, 1917. p. 456.

(in contradistinction to patting or stroking—the rubbing, for instance, of the first real cleansing of the body) is accompanied, she says, by the most intense screaming and rage-like reaction that the infant showed at any time during this first month of life. The screaming is most intense of all when there is vigorous rubbing of the scalp and of the back. I would point out here that these are obviously the areas of body surface which have been most exposed to trauma during the birth process. She also remarks that the kinesthetic sense is probably the earliest developed of all the senses, appearing, as may reasonably be supposed, before kicking does in the fourth or fifth month. (What is the basis of this conclusion?) She quotes Miss Millicent Shinn (Notebook No. 2) as referring to the quieting influence of monotonous jarring as compared with smooth motion. Mrs. Blanton observed that walking with a baby quiets it even on the first day, and that in her experience, babies almost never cried when being carried through the hospital corridor. This too seems to support Ferenczi's and Freud's suggestion of the practical continuum of fetal and postnatal life; for the fetus has, in fact, been accustomed to being carried for nine months subject to the rhythmical motion of the mother's walking.

In regard to finger sucking, Mrs. Blanton enumerates a number of instances occurring almost immediately at birth, the hand to mouth movement being so well established as to leave little doubt that it had already been established earlier. Here again we regret the lack of a systematic recording of the observations for each child. She indicates, however, that the finger sucking was sometimes especially strong in otherwise weak or disturbed infants. "One baby (a blue baby) two hours old, put fingers directly into the mouth. Another, a Cesarean delivery, very feeble, was seen sucking two fingers so vigorously, it required a decided effort to remove them. She [the infant] put them back at once without trouble . . . . Another, a malformed baby [type of malformation not specified], at ten days and in a dying condition, put finger in his mouth after four trials, and the sucking reflex was moderately good." This is circumstantial evidence, to be sure, but it is especially interesting that these are the instances specifically noted.

I have recently come upon some further observations from a psychological laboratory which are somewhat supportive, though not conclu-

sive, of the suggestions I have indicated. This is the experimental work of Dr. Henry M. Halverson of Yale.[12] Dr. Halverson studied reactions of ten male infants, varying in age from one to forty-three weeks, who were subjected to various nursing situations. Here again the observations are mitigated for our purpose by the psychological interest in the experiment rather than the infant. Even so, Dr. Halverson's results are extremely interesting to us. He observed erections of the penis occurring quite frequently during some nursing situations; actually sixty times in two hundred and twelve different situations of eight different types.[13] It is first to be noted that the erections took place characteristically (with the exception of the first situation) in situations in which there was some frustration in the nursing—delay, difficult nipple, removal of breast or nipple. There were three situations in which there was an especially high frequency of erections in proportion to the frequency of the situation: (1) in sucking at a difficult nipple, where erections occurred twenty-four times in twenty-nine such situations; (2) on removal of the breast (prematurely), where erections occurred ten times in fifteen such situations; and (3) during sucking at an empty (air) nipple, where erections occurred thirteen times in thirty-nine such situations. On the other hand an erection occurred on removing the difficult nipple only once out of twenty-nine such situations. (Chart 1.) Halverson does not make clear whether this single instance was in an infant who had had no erection during the nursing on the difficult nipple but had developed one on its removal, or whether one of the twenty-four infants was doubly stimulated by frustration: first by the difficulty of the nipple, and then by the removal of even this modicum of sucking comfort. Halverson also remarks that erections never occurred during sucking at the breast or at an easy nipple. The appearance of tumescence, according to Halverson, "occurred decidedly most often associated with vigorous body movement, and fluctuating gripping pressure with the infant quiet or quieting." In

[12] Halverson, H. M.: *Infant Sucking and Tensional Behavior.* J. of Genetic Psychol., 1938, LIII, pp. 365–430.

[13] The eight type situations were: (1) when the infant was being carried by the nurse, (2) two-minute delay in feeding, (3) breast removed, (4) easy nipple removed, (5) sucking at difficult nipple, (6) difficult nipple removed, (7) sucking at empty nipple, and (8) empty nipple removed.

other words, the tumescence was associated with a general reaction to the frustration and did not appear as an isolated phenomenon.

FREQUENCY AND NUMBER OF ERECTIONS	Frequency of Situation	No. of Erections
1. Infant carried or held by nurse	29	3
2. Two minute delay in feeding—gripping pressure only	29	5
3. Breast removed	15	10
4. Easy nipple removed	3	1
5. Sucking at difficult nipple	29	24
6. Difficult nipple removed	29	1
7. Sucking at empty nipple	39	13
8. Empty nipple removed	39	3
TOTAL	212	60

(from Halverson)

CHART 1

The author also correlated the situations of the appearance of tumescence with those of detumescence. (Chart 2.) This brings out some striking findings: viz., that in ten instances where erections occurred in sucking at a difficult nipple, they disappeared when an easy nipple was given; and in nine cases where erections occurred when the breast was withheld, they disappeared when the breast was restored. These findings seem outstanding, as they indicate the importance of frustration excitement in the situation of tumescence. Halverson again summarized the behavior as follows: "Tumescence is accompanied by restlessness, frequent fretting or crying, marked alterations in muscular tension and vigorous body movements, most of which have no connection with sucking activity. Detumescence is accompanied by general quiescence, during which the muscles may be relaxed or *in a state of sustained tension*" (p. 412). (The italics are mine, as I would emphasize here that this might appear then as a residual tension, or paradoxically, comparative relaxation.) The author believes that erections are probably quite common from birth, but are not observed because of the presence of clothing and the general taboo against noticing this phenomenon.

FEEDING CONDITIONS UNDER WHICH ERECTIONS OCCURRED	FEEDING CONDITIONS UNDER WHICH ERECTIONS DISAPPEARED										
	Sucking at easy nipple	Breast restored	Weak sucking and mouthing	Resting and mouthing	Sucking air	Resting	Sucking at own bottle	Nipple removed	Sucking at difficult nipple	Weak sucking	Infant removed
Sucking at difficult nipple	10	. .	2	4	2	2	1	1	2	. .	. .
Sucking air	1	. .	3	1	1	2	1	. .	1	1	1
Withholding breast	1	9	. .	. .	. .	. .	. .	. .	. .	. .	. .
Delayed feeding—gripping pressure only	1	. .	. .	. .	1	. .	3	. .	. .	. .	. .
Delayed feeding—held by nurse	. .	. .	. .	. .	. .	1	1	. .	. .	. .	. .
Sucking air—nipple removed	1	. .	. .	1	1	. .	. .	. .	. .	. .	. .
Easy nipple removed	1	. .	. .	. .	. .	. .	. .	. .	. .	. .	. .
Difficult nipple withheld	. .	. .	. .	. .	. .	. .	. .	. .	1	. .	. .

(from Halverson)

CHART 2

While these results of Dr. Halverson's experiments are harmonious with the assumption of anxiety even to the point of accumulation and a general overflow, any evidence of the association of any such susceptibility to discharge of anxiety or the possible correlation of it with the disturbances of the prenatal, natal, or very early postnatal experiences is lacking, as the experimenter made no effort to view his material from this angle. Here, however, is a useful field for observation if the cooperative interest of the obstetrician and the pediatrician can be obtained; and while we still lack direct observations (which Freud so earnestly wanted) as to the effects of difficult birth, this nevertheless seems possible, and even a step nearer of attainment.

There are two other groups of observations in fields adjacent to psychoanalysis that contain facts of some relevance to the problems I have been discussing: (1) pathologicoanatomic evidences of the degree of trauma resulting from birth or conditions associated with birth; (2) clinical observations on very young, prematurely born children.

Concerning, first, the pathologicoanatomic evidences of trauma occurring at birth, there are many facts available. The mass of evidence

is that *cerebral injury resulting from birth is very much more common than one might suppose.* There is an excellent review of this subject in a monograph by Ford published in 1926,[14] from which I shall select some findings pertinent to our problems. While the study indicated that birth trauma did *not* play the etiological role in the spastic paraplegias and hydrocephalus that had been assigned to it,[15] the secondary implications of the study are important. The pathologicoanatomic study was made of course on the dead victims of the birth struggle; but the author notes, "There is some evidence that intracranial hemorrhage occurs in babies who survive and may even show no clinical signs of (gross) birth injury . . . Old blood pigment is found in the meninges of babies up to the ninth month even where there is no (clinical) evidence of injury at birth." Routine lumbar punctures done within a few days after birth show modified blood in the cerebrospinal fluid in a surprising number of instances without clinical indications of trauma.[16] Please do not think that I am implying that anxiety comes from blood in the meninges. I emphasize these facts simply because such a finding is a positive indication of one kind of trauma associated with birth and is in some measure an index of the degree of trauma occurring.

The same study also gives evidence that injury to the cerebrum, even to the extent of petechial hemorrhages in the white matter, results not so much from the trauma of the birth process as from asphyxia and strangulation which may occur with birth and may also occur in some degree through circulatory disturbances if the cord is caught around the fetal neck *in utero.*

Other pathologicoanatomic findings of note are evidences of disturbances of intrauterine life which leave gross effects on the fetus, without any clinically observable disturbances in the maternal health. Some fetal disturbances formerly thought to be due to defects in the germ plasm or to accidents at birth are evidently caused rather by local fetal illness.

[14] Ford, F. R.: *Cerebral Birth Injuries and Their Results.* Medicine, *V,* 1926, pp. 121-191.

[15] It is of incidental interest that this was the conclusion of Freud also, in a monograph published by him in 1897 on *Cerebral Birth Injuries.*

[16] Ford quotes a report of blood in 14% of the cerebrospinal fluids obtained by routine lumbar puncture following birth in 423 colored babies. Only 6% of these babies had shown any clinical evidence of cerebral lesion, and less than 3% died.

We are quite used to the idea that the fetus may suffer from systemic maternal disease; but it is pointed out (by Ford and Dandy) that in hydrocephalus, in which mechanical birth trauma was previously thought to play an important part, examination reveals adhesions and structural changes of meningitis resembling closely those found in meningococcus meningitis in adults, and that such occur without being associated with any history of maternal illness. There is further evidence of a very high incidence of intracerebral hemorrhage in prematurely born babies where the effect is not so much due to the pressure of labor as to the state of unpreparedness for extramural life of the tissues of the infant at the time of birth. Much greater sensitivity of the skin and fragility of the cutaneous and retinal vessels have been demonstrated in prematurely born babies than are found in the infants born at term.

It is well known that infants born without any cerebral hemispheres[17] may, nonetheless, carry out all the normal early activities, including sucking and crying. Evidently then, these may exist at first entirely at a reflex level. Severe cerebral injury, however, seems to add signs of cortical irritation: localized twitchings and convulsions.

These findings seem to me important as indicating the frequency, the intensity and the far-reaching effects of birth trauma and of the variations in the birth process. They suggest the possible intensification of the organization of the anxiety pattern at birth at a reflex level and in the absence of psychic content. How this psychic content may later develop, partly out of dawning self-awareness during the first months of extrauterine life, and partly elaborated through and coalescing with the infantile birth theories of the young child with contributions from the stories he hears regarding his own birth—this I hope to consider a little more definitely in a subsequent paper dealing with the clinical pictures in some cases of severe anxiety hysteria.

Surveying the clinical observations on young prematurely born children, we find interesting facts. There are two particularly important

[17] Two such infants were born at the Johns Hopkins Hospital during the ten years I was associated with that hospital; numerous other instances have been reported elsewhere.

studies of behavior, one by Shirley[18] at the Child Development Center in the Harvard School of Public Health, the other by Mohr and Bartelme[19] in Chicago. Neither of these gives us the very early day by day observations we desire, but they at least present some controlled observations. Shirley's report is the more valuable to us because it includes observations on sixty-five infants made periodically from three months to five years, while the other studies include fewer very young children. Shirley states that young prematurely born children (those up to the age of two and one-half years) were much more keenly aware of sounds and very early seemed more interested in their meaning than full term babies of the same age. They were distracted by footfalls, voices, and incidental noises. Older prematures (those in the two-and-one-half to five-year-old group) often manifested the "hark" response, stopping in their play and whispering in a startled voice, "What's that?" at the hiss of a radiator, the chirp of a cricket, or the dropping of a paper. Premature babies were more fascinated by a yellow pencil used in the test than were full term infants. Yellow objects were definitely preferred to red ones, and this preference for yellow seemed in many instances to persist through the early years. Premature babies seemed also to be more keenly aware of ephemeral visual phenomena like shadows, smoke plumes, dancing motes in a sunbeam, or reflections thrown by a mirror. The observer thought, however, that this visual-sensory sensitivity was less marked and less easily checked than the other characteristics she noted. Although premature babies seemed to respond as well as "normal" babies in comprehension of speech and in making attempts to imitate words, they had more difficulty in achieving correct pronunciation, persisted longer in baby talk, and showed substitutions of letter sounds. (Mohr and Bartelme reported a higher percentage of stammerers in older prematures.) In general, prematures showed difficulty in manual and motor control. They had difficulty in pointing, showed tremors readily, spilled and scat-

[18] Shirley, Mary: *A Behavior Syndrome Characterizing Prematurely Born Children.* Child Development, X. No. 2, 1939.

[19] Hess, Mohr, and Bartelme: *The Physical and Mental Growth of Prematurely Born Children.* University of Chicago Press, 1934.

tered objects, and frequently went "all to pieces" after making especially sustained efforts at manual manipulation. They were delayed in walking and tended to be clumsy. In activity, they went to extremes, tending to be soggy and inert or to be overactive and distractible, and had short spans of attention. In the older group (two and one-half to five years of age) these children might continue to work or play "at a high level of interest and concentration until they collapsed in rage from fatigue and frustration." The author also notes that premature children stood out above others in the desire to create artistically (especially through drawing and painting), although they were conspicuously less able, because of their poor motor coordination, to produce very effective results. The emotional responses of the prematures were noted generally to be volatile, with marked petulance, irritability, shyness, and a tendency to explode in a panic or a tantrum. There was a greater incidence of enuresis and day dribbling in the prematures than in others. The author submits no findings about thumb sucking, but Mohr and Bartelme reported that more than 20% of their group showed thumb sucking which persisted beyond twenty-eight months of age. In an attempt to make a quantitative study of these characteristics, Shirley made observations of premature infants comparing them with an equal number of observations of infants born at term. Here are three tables adapted from her report:

CHARACTERISTICS SHOWN IN TEST SITUATIONS

Age group (6–24 months)	50 Prematures	50 Controls
Interest in yellow pencil	16	0
Distraction by sounds	36	6
Throwing toys around	30	6
Banging and slapping toys	20	10
Trembling and shuddering	18	10
Hesitate to touch toys	10	12
Comprehend but refuse to perform	18	8
Seek adult help	22	6

(from Shirley)

Chart 3

CHARACTERISTICS SHOWN IN TEST SITUATIONS

Age group (2½–5 years)	22 Prematures	22 Controls
Very distractible	45	13
Distracted by sounds	18	4
Short attention span	13	9
Trembling	9	4
Throwing toys around	13	9

(from Shirley)

CHART 4

CHARACTERISTICS MANIFESTED DURING PLAY PERIOD

Age group (2½–5 years only)	30 Prematures	30 Controls
Remarks about unusual sounds	67	37
Speech difficulties	60	23
Crying in play room	80	57
Rapid change from toy to toy	43	23
Jittery—nervous	83	27
Bowel movement during play	40	30
Five or more urinations	27	12

(from Shirley)

CHART 5

Although these findings by Shirley, some but not all of which have been confirmed by other observers, deal predominantly with children already old enough to be surrounded by complicated life situations possibly outweighing the single factor of prematurity, the picture gives the impression of markedly increased infantile anxiety. How much this is due to the discrepancy between the earlier time development of sensory sensitivity and the later motor coordination, and how much it may be due to the traumatic factor, is not clear.

To summarize, (1) there is evidence of the possible existence of a pre-anxiety reaction occurring in fetal life, consisting objectively of a set

of reflex reactions; (2) there seems to be an increase in the intensity of such responsiveness occasioned by the presence of untoward conditions of the prenatal, natal, or immediately postnatal period, such an increase presumably leaving a kind of deepening of the organic stamp in the pattern of response; (3) it seems evident that this pre-anxiety response is, in the fetal period, devoid of psychic content and probably is to be regarded as pure reflex whereas the birth experience, especially where there is severe trauma, would seem to organize the scattered responses of the fetal period with the addition of the birth cry and what it entails, into the anxiety reaction of which birth itself has been considered the prototype; (4) although the prenatal period is, as Ferenczi pointed out and Freud emphasized, practically a continuum with the postnatal life, the caesura of birth has not only the organizing effect of a single momentous event, but it also marks the threshold at which "danger" (first probably in the sense of lack of familiarity) begins to be vaguely apprehended and it is therefore the first dawn of psychic content.

There are other problems which suggest themselves along these lines. There is first the question of whether an increased overload of pre-anxiety, something felt presumably as simple organic tension, is capable of producing a diffuse overflowing reaction including at one and the same time oral, sphincter, and genital stimulation at a reflex level. Further, is it possible that chance touching of the mouth by the hand may produce a premature oralization on the basis of the very earliest autoerotic response tending to promote relaxation of tension? Again, is similar specialized sensitization possible in the case of other zones, anal and genital? We ask, in other words, whether repeated accumulated simple organic tension of the fetus, diffusely discharged, might not deepen reflex response reactions in a way which would anticipate and tend to increase the various later polymorphous perverse stages; or whether some libidinal phase, probably most frequently the oral, might not be accentuated by being anticipated in fetal life, and a preliminary channelization for discharge established.[20]

[20] Gesell and Ilg (*Feeding Behavior of Infants.* New York: J. B. Lippincott, 1937) quote Minkowski as eliciting an oral reflex associated with movement of the leg when lips were stroked in a fetus at the beginning of the second lunar month of intrauterine life. Opening and closing of the mouth appeared as a discrete local reflex at about the eighteenth

III

I am quite aware that these borrowed observations are by no means conclusive, and that it may justly be said that I am conjecturing. Having committed myself thus far, however, I shall go further and ask, "What might be the effect of such early increase in the anxiety potential, provided this does occur, on infantile narcissism?"

Now narcissism is difficult to describe or define. It is, one might say, the great enigma of life, playing some part at one and the same time or in alternating phases in the drag of inertia and in the drive to the utmost ambition, and contributing its share to the regulating function of the conscience. Freud speaks of the "narcissistic libido" of the fetus, in the passage already quoted, and suggests that its gross economy is disturbed by birth. We can hardly think of the fetal narcissistic libido being more than a degree of sensitivity and susceptibility to stimulus, bringing about the response which I have characterized as the reflex antecedent of the later anxiety response. Freud speaks elsewhere of narcissism as the "libidinal complement to the egoism of the instinct of self-preservation, a measure of which may justifiably be attributed to every living creature."[21] This is an extremely significant statement, for it implies that narcissism is coincident with life throughout and that narcissistic libido is in fact to be found wherever there is a spark of life. We can readily see then, that there is a peculiar complexity to the conception of narcissism in the fetus which occupies a unique position between individuation and functioning as part of a whole larger than itself. Practically, however, we would think that in the fetus the narcissism is reduced to its simplest terms, being almost or entirely devoid of psychic content. I can only think that the disturbance of the gross economy of fetal narcissistic libido which occurs at birth is just this: some transition from the

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fetal week. They conclude that "it is safe to say that many of the elementary neural and muscular components of sucking and deglutition are prepared as early as the third or four month . . . . Even the hand to mouth reaction is anticipated in utero" (p. 15). Gesell notes (p. 123) "that more boys than girls are thumb suckers; and also that thumb suckers are good sleepers, but otherwise are inclined to be more rather than less active and given to sudden fatigue."

[21] Freud: *On Narcissism.* Coll. Papers, IV, p. 31.

almost complete dependence of intrauterine life to the very beginnings of individuation, at least to the quasi-dependence outside the mother's body instead of the complete dependence inside. That this transition is accomplished with a marked increase of tactile, kinesthetic, and light stimulation seems evident.

There are some attributes, derivatives or forms of postnatal narcissism with which we are familiar under whatever names: (1) the sense of omnipotence with its derivatives; (2) the overvaluation of the power of the wish and (3) the belief in the magic power of words; (4) the mirroring tendency, derived partly from primary narcissism and partly from an imperfectly developing sense of reality, the two in fact being hardly distinguishable. It seems to me quite evident that an increased early infantile anxiety can be expected to be associated with a complementary increase in the infantile narcissism (cf. Freud's statement quoted above); that in fact excess narcissism develops as part of the organism's overcoming of the excess anxiety before it can function even slightly as an independent unit in the environment. We might figuratively refer to the simplest primary narcissism in its relation to anxiety as surface tension which may be great or little according to the organism's needs. It is evident that in the birth experience the cry of the newly born infant is the main addition to the prenatal activity, and while it seems largely determined by reflex responses, it is quickly assimilated into behavior both as a primitive emotional expression and a call for attention. That this latter function continues to be utilized in a way to materialize or substantiate omnipotence need hardly be remarked. The cry, in one sense, is the simplest forerunner of speech, though originally appearing as a simple discharge of nervous excitation.

In this paper, I am not concerned with the vicissitudes of speech development other than to point out that the belief in the magic power of words is probably in line of descent from the utilization of the cry of rage at birth.

The "mirroring" part of narcissism I believe has its simplest beginning in the incomplete psychic differentiation of the infant from its surroundings, which now include the mother—in the change in fetal narcissistic libido economy entailed in beginning individuation, in the pinching off of the amoebic pseudopod, to use a homely biologic meta-

phor. I am inclined to believe that this involves dim psychic content from the time of birth, content which is closely related to and dependent on vision, and which develops almost as early if not coincidentally with the cry as a means of communication. Mrs. Blanton noted that a large percentage of babies fixate on light at birth; other authors have noted that even within the first few weeks babies seem to have some recognition of a familiar face and cry when confronted with an unfamiliar one. I am inclined to believe that probably quite early this tendency to cry, i.e., to show an anxiety response to the unfamiliar, becomes augmented by another factor, something which I would characterize as a kind of visual and kinesthetic introjection of those around the infant. The child reacts with a puckered, worried or tense expression when people around are cross or gloomy. This may come about through an association of mild discomfort (the restricting, frustrating sensations of being held or handled by a tense and jerky nurse or mother) with the gloomy expression which it sees; nevertheless the infant soon seems to make the connection directly, an anxious nurse being reflected in an anxious baby without the intermediate kinesthetic link. This is an observation of which sensitive nurses are quite aware. This is a kind of centripetal empathy; perhaps introjection still remains the best word. At any rate I believe that babies vary greatly in this obligatory capacity to reflect those around them, and that it is the tense, potentially anxious infant that is the most sensitive reflector. This may, indeed, have something to do with the peculiar clairvoyant quality sometimes encountered in severe neurotics, and may be even more closely related to the marked facility of identification in severe hysterics who so readily assume the symptoms of those around them.

The infant's developing adaptation to the outer world soon proceeds, however, beyond this introjective stage to a more definite sensing of the environment as separate from itself, involving in this, however, oscillations between introjection and projection. In Freud's article "Negation,"[22] he described the preliminary ignoring of reality as a transition stage in its acceptance, and stated that acceptance itself implies a second stage of verification—the perception that the unpleasant experi-

[22] Imago, XI, 1925.

ence is *really* true. Freud says in this paper, "The first and most immediate aim of testing the reality of things is not to find in reality an object corresponding to the thing represented, but to *find it again,* to be convinced that it is still there." This is certainly familiar enough in the experience of adult life when one sees some particularly shocking sight: there is an initial anxious tendency to block it out, and only by actually reviewing it or recalling it visually is it finally assimilated as a fact. This is, indeed, the familiar abreaction. All this is discussed in Ferenczi's paper On the Acceptance of Unpleasant Ideas,[23] as well as in his earlier one (1913) On Stages in the Development of a Sense of Reality, in which he endeavored to show also that the fixation point of the psychoses occurs at this stage. Now this touches what I have thought about the severe neuroses: that where infantile predisposition to anxiety is great due to an overload of potential in the prenatal, natal, or immediate postnatal experience or the combination of this with constitutional factors, new anxiety occurring at this period might pull down the whole load as it were, and by its peculiar paralyzing effect on the organism, impair the sound synthesis of these two stages of reality. Such patients often have, in fact, an extraordinarily clear and vivid visual representation of reality, but one which is insecure and easily dislodged. This disturbed or fragile sense of reality is observed clinically in connection with the too easy identification of such patients with those around them. They are hunting eternally for satisfactory and secure models through which they may save themselves by a narcissistic identification.[24] On the surface it appears later as a scattered, superficial pseudo competitiveness.

While I have laid considerable emphasis in this paper on the possible exigencies of intrauterine life and the trip through the birth canal, I believe that severe traumata occurring during the first weeks of postnatal life would have a comparable effect. I would again emphasize that I see these factors as producing a *predisposition to anxiety* which combined with constitutional predilections might be an important determinant in

[23] Ferenczi, Sándor: *Further Contributions to the Theory and Technique of Psychoanalysis.* London: Institute of Psycho-Analysis and Hogarth Press, 1926, p. 367.

[24] Do Wittels' "Phantoms" have their inception here? Cf. Wittels, F.: Unconscious Phantoms in Neurotics. This *Quarterly,* VIII, 2, 1939. *Psychology and Treatment of Depersonalization.* Psa. Review, XXVII, 1, 1940.

producing the severity of any neurosis; for such anxiety is a burden, ever ready to combine with new accesses of anxiety later on in childhood and throughout life.

I know that in presenting this paper, I run some risk of being misunderstood. It is possible that the same human tendency to which Freud refers (in the footnote at the beginning of the article on the Dynamics of Transference that I have already quoted), the tendency to narrow the conception of causes to a single cause, or to single out only one adversary to be attacked, may cause some to conclude that I am just dusting off and reviving the birth trauma theory with slight modifications and an intrauterine embellishment, and that I am thereby avoiding dealing with the events of the first few years of life. This is not my intention. If I did so, I should be reducing treatment to a very fatalistic management basis—little better and no deeper than therapy by adroit management of the current situation of the patient which, to be sure, is so often necessary in psychiatric practice. I hope that by bringing this possible misconception to the fore in advance, I may at least partially forestall it. In a later paper I shall present some clinical material with a statement of what I have found useful in treatment of these especially severe neuroses. I shall indicate the ways in which I believe this excess narcissism and anxiety may be managed during the course of analysis—the ways which must be used, in fact, in order that a "regular" analysis dealing primarily with the disturbances of libidinal development may proceed. Certainly the excess of narcissism in these cases is the presenting and terrifying problem to the analyst. But I am inclined to think that the narcissism can be educated sufficiently, if it is carefully done, to permit the patient to stand the pain of the analysis, provided that due heed is given at the same time to the blind anxiety which is the cornerstone of this insecure character structure. Much can be salvaged for such patients, many of whom are talented, intuitive people.

SUMMARY

Freud considers that anxiety is the reaction to danger, and that birth is the prototype of the anxiety reaction. He sees this, however, as operating through the assimilation into the constitution (genetically) of the

endless procession of the births of our forefathers. He doubts the importance of the individual birth experience in influencing the quantum of the anxiety response, largely because the birth experience is without *psychological* meaning; at the same time, nevertheless, he emphasizes the continuity of the intrauterine and the postnatal life.

From the various experimental and clinical observations cited, the question arises whether we may not look at this in a different way. The anxiety response which is genetically determined probably manifests itself first in an irritable responsiveness of the organism at a reflex level; this is apparent in intrauterine life in a set of separate or loosely constellated reflexes which may become organized at birth into the anxiety reaction. How much this total reaction is potentially present but not elicited before birth, and how much birth itself may, even in the individual life, play a reinforcing or an organizing role, is not clearly determinable at present. Certainly, however, "danger" does not begin with birth but may be present earlier and provoke a fetal response which is inevitably limited in its manifestations and exists at an organic rather than a psychological level. Variations in the birth process may similarly increase the (organic) anxiety response and heighten the anxiety potential, causing a more severe reaction to later (psychological) dangers in life. Painful or uncomfortable situations of the earliest postnatal weeks, before the psychological content or the means of defense have been greatly elaborated, would similarly tend to increase the organic components of the anxiety reaction.

Observations on the special reactions of the fetus in intrauterine life and at birth give rise to new questions as to the effect of these on the later libido development. Further, where there is an increase in the early anxiety there is an increase in the narcissism. This situation favors an inadequate development of the sense of reality and furnishes additional predisposition to the development of especially severe neuroses or borderline states.

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THE PREDISPOSITION TO ANXIETY
Part II

BY PHYLLIS GREENACRE

Practical Considerations of Treatment

In a previous paper, The Predisposition to Anxiety,[1] I advanced the tentative hypothesis that severe suffering and frustration occurring in the antenatal and early postnatal months, especially in the period preceding speech development, leave a heightened organic stamp on the make-up of the child. This is so assimilated into his organization as to be almost if not entirely indistinguishable from the inherited constitutional factors which themselves can never be entirely isolated and must rather be assumed from the difficult maze of observations of the genetic background of the given individual. I believe this organic stamp of suffering to consist of a genuine physiological sensitivity, a kind of increased indelibility of reaction to experience which heightens the anxiety potential and gives greater resonance to the anxieties of later life. The increase in early tension results in, or is concomitant with, first an increase in narcissism, and later an insecure and easily slipping sense of reality. I referred especially to the increase in the sense of omnipotence which may occur in a compensatory way to overcome or balance the preanxiety tension state of the organism, and to the increased mirroring tendency arising partly from the primary narcissism and partly from the imper-

[1] This *Quarterly,* X, No. 1, 1941.

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fectly developing sense of reality. This increased mirroring tendency is the antecedent of the tendency towards overfacile identification of neurotic individuals, and in psychotics towards easy projection. I spoke also of the derivatives of omnipotence: the overvaluation of the power of the wish and belief in the magic of words. With all of these narcissistic weaknesses, the sense of reality is often very poor and even when it seems quite good, it may be facile rather than strong and break down readily under the fresh impact of anxiety producing situations of later life. Further, owing to the pressure of early tension and anxiety, the ego development is exceedingly faulty; libidinal attachments are urgent but shallow and the ego drives not well directed toward satisfactory goals. The patient is not well individuated and often gives the impression of being in too great a state of flux, with many interests, many attachments, with the libido quickly and urgently invested and withdrawn.

The main general considerations of the treatment of the severe neurotic or borderline states depend upon the characteristics of development described in my first paper. In order to organize my material, I shall discuss these problems of treatment from four main aspects: first, the handling of the overload of anxiety to produce an optimum state for the progress of the analysis; second, the education of the narcissism to better ego proportions; third, the analysis of the "essential" neurosis; and fourth, the management of the residue of blind, unanalyzable anxiety which is present throughout the analysis and which continues to operate in the life of the patient after analysis. I use the term "essential" neurosis here to differentiate those neurotic elements arising after the development of speech from the predisposing constitutional ones present before this landmark.

I would for the time being divide the overload of anxiety of the severe neurotic into three subdivisions: first, *the basic,*[2] *blind or amorphous*

[2] I shall use the term "basic anxiety" throughout the rest of this paper. In the first paper I used the term "'preanxiety" to designate the condition of heightened irritability arising before the dawn of speech and contributing to the later conditions which I am describing in this present paper. I feel justified in using the convenient term "basic anxiety" as I am now dealing with the adult version of this earlier preanxiety—namely, the form in which it appears as anxiety, or at least amalgamated with anxiety from other sources. The question of the relationship of basic anxiety to the affect of anxiety is one which may well be considered, but cannot be dealt with in this paper.

anxiety which is always present in some degree and may in moderation furnish some of the drive of life, but which may be so heightened and combined with the anxiety of fresh dangers as to constitute a serious menace; second the *anxiety arising in response to these fresh experiences of danger and frustration;* and third, the *secondary anxiety* arising out of the inadequacy of the neurotic defense and the additional dangers, real or illusory, following the production of the symptoms themselves.[3] What we term secondary anxiety is familiar enough in the form in which it appears in the malignant compulsion neurosis, in which the compulsions or obsessions appearing as defenses against the repressed erotic drives become themselves erotized and require a fresh line of defense to be erected in the form of new obsessional symptoms, until the patient is so involved in the complexity of his fortifications that the rest of life is virtually crowded out. At this stage a secondary atrophy of disuse (habit deterioration; functional dementia) finally occurs, and the end result may be not unlike the schizophrenic process. Although such a malignant development may occur in hysteria also, it is less frequent, less regular in its development and more dependent on the presence of a markedly increased predisposition to anxiety. This is to be expected on the theoretical grounds that the compulsion neurosis arises from trauma and fixation at an earlier level (and therefore closer to the factors producing basic anxiety) than is the case in the hysterical neurosis.

To illustrate the unhappy cooperation of the predisposition to anxiety with the anxiety of later life and finally with secondary anxiety, I shall describe a type of situation which I believe to be nuclear in the development of many severe neuroses.

If the traumata, distress or frustrations of the earliest months are particularly severe, the stimuli do not remain focussed but overflow through the body and act upon various organs. We see direct evidence of this in the oral, excretory and genital responses at birth and under stress in earliest infancy. These responses may be activated simultaneously rather

[3] A simple form of this is evident in the crying fit. "It causes disagreeable visceral sensations, perhaps also pains, and it can end in exhaustion. Even if it does not last that long it can be traumatic for the infant. During the screaming fit the infant is not responsive to any attempts to quiet it." Benedek, Therese: *Adaptation to Reality in Early Infancy.* This *Quarterly,* VII, 1938, pp. 200–215.

than in a relatively orderly progression. I shall illustrate the further succession of events by isolating now, for the purposes of description, the genital stimulation and response which arises so precociously as part of a widespread pain-helplessness situation. (I have dealt with some clinical and experimental evidence in my earlier paper.) The response to this situational stimulus is automatic and spontaneous. It subsequently gains an additional pleasure value when the infant discovers the further advantage accruing from body movements which also stimulate the genitals. The genital response next takes on a primitive masturbatory character, more obvious in girl babies than in boys. Although in the latter the appearance of an erection is the visible index of stimulation, the appearance of the most primitive type of masturbation by thigh pressure may be the first evidence of genital stimulation in the girl. The occurrence of repeated and almost continuous stimulation of this sort may produce so prolonged a tonic state as to simulate Little's Disease, and to be capable of interruption only when mechanical obstacles or barriers stop the masturbatory activity.[4] At any rate, where a polymorphous discharge of tension has been carried on in the organism at a very early date, we may conceive of its leaving a heightened irritability for channels of discharge in later life, intensifying first the reaction to traumata of later infancy and early childhood which form the understructure of the essential neurosis, and then, at later periods in life heightening the anxiety of frustration and danger and aiding in turning the flow of activity backward along the old channels rather than continuously forward. If the anxiety is severe at these later periods in life (and it is likely to be severe because of the established predisposition) the overflow response of the earliest days or weeks of life may be repeated, and anxious erotic stimulation again occur. This is the setting of the frantic compulsive masturbation which so often precedes a psychosis. At these later periods in life, however, such masturbatory response is no longer the simple physiological response of the days after birth, but has accumulated the special wrappings of sado-masochistic fantasies (partly or wholly unconscious), guilt

[4] I first became aware of the reappearance in a changed form of this initial genital stimulation in anxious states of later life through a series of clinical observations made during my preanalytic work. I have put these together later in the paper in the section dealing with clinical case reports.

reactions, etc., which have invested its development in the intermediate stages. Thus the vicious whirl is set in motion.[5] The poorly developed sense of reality begins to go to pieces, bringing a threat of collapse to the ego; panic and sometimes dissociation ensue. This secondary anxiety may be further increased by inept and poorly directed treatment of the patient, and follows regularly in types of treatment which consistently undermine the patient's confidence in himself and limit his spontaneous activity, as in poorly advised and arranged hospitalization.

While I have singled out for description the course of the early genital response from physiological tension stimulus and response to masturbation, and have indicated its vicissitudes in later development, it is clear that a somewhat similar course may occur in the case of the nongenital areas (oral, anal, cutaneous) and that the selection of the one or of the other for first place is largely determined by the special traumata of later infancy (the roots of the essential neurosis).

Patients suffering from severe neuroses quite often come to analysis in a very acute state of anxiety or even panic. Subsequent panic states, however, seldom surpass those which brought the patients into treatment or those which were precipitated at the outset of treatment. If the experienced therapist watches the anxiety of his patient carefully and tempers the treatment accordingly, such panics will occur in the course of treatment only if some new danger appears. Even then the panic can generally be avoided. Obviously a patient who is frenzied or in a panic is in no state to be analyzed. He is much too near to a state of psychic paralysis to lend himself to the analytic process. The first aim of treatment must then be to penetrate the panic and relieve some of the anxiety. In this the composed, firm, assured attitude of the analyst is of the greatest importance.[6] As is to be expected in such highly narcissistic patients, the tendency to exhibitionism is great and is unconsciously used by the patient, in reaction to the intense underlying fear, to excite the sympathy

[5] Rado described the ego aspects of such a struggle in a vicious circle in Developments in the Psychoanalytic Conception and Treatment of the Neuroses. This *Quarterly*, VIII, 1939, p. 27.

[6] This need of the psychotic patient to be met with calm receptivity is emphasized by Dr. Dexter Bullard in his account of the organization of psychoanalytic procedure in the hospital. *J. Nerv. & Ment. Dis.*, XCI, No. 6, 1940.

and counteranxiety of the analyst in a desperate effort to retain neurotic control of the situation. Such patients simulate the behavior of psychotic patients and the inexperienced analyst may indeed be alarmed by them. It is extremely important in these early stages to have the understanding cooperation of the people who are close to the patient during most of the other twenty-three hours of the day, whether this be in a hospital or at home; much of the gain of the therapeutic hour may be lost by hostile, solicitous, or too active friends or relatives. Naturally this means that the analyst has to be in contact, directly or indirectly, with some key person in the patient's milieu, and this may create problems later in the analysis. In my experience, this initial situation has been handled most readily when some other analyst has been in contact with the family of the patient as friend, relative, or professional interpreter.

A word about the role of reassurance: most patients seem to react badly to direct reassurance. A quiet attitude of knowing one's business usually suffices; on occasion one may remind the patient very simply that we are the doctor and he the patient. Such patients have often been treated previously with too much reassurance. They beg for and distrust it because they have in the past been overly placated, comforted and lulled with promises that could only come to naught. The same thing is true of advice. Although emergencies occur with appalling frequency at this stage, the analyst is in a better position if he does not permit himself to be drawn into the role of adviser. The patient is quick to seize upon any weakness, inconsistency, or falseness in the analyst's attitude, and if inadequate advice or superficial reassurance is given, it undermines rather than strengthens the patient's confidence. Calmness in the analyst induces calmness in the patient, and it is not generally necessary to be more "active" with these patients at this stage than later, although it is very easy to be drawn into active participation. Because of the patient's insecure hold on reality, the analyst must maintain an attitude of clear, hard, unperturbed realism, and must refrain from giving verbal assurance.[7] Patients respond well to a simple clear statement defining rather

[7] Years ago Dr. Brill emphasized the necessity for the therapist to reiterate, consistently and firmly, a realistic negation of the schizophrenic's distortions. This was done patiently and without argument. But Brill was dealing with a group of patients who were more frankly psychotic than those I am reporting, and his therapy, although based on an-

than sympathizing with their disturbed state. It gives them relief and a feeling of security to know that the analyst sees through their surface situation and sees it as bad as it is, though not in the exaggerated terms in which they have presented it. A negative therapeutic attitude is encouraged if the analyst is too gently sympathetic, shows solicitude or anxiety. Obviously this increases the secondary gain of the neurosis and draws it further into the analytic situation.

Some patients will force an emergency or a crisis with a demand for a decision or for advice; and to ignore this is to push the patient to an even higher pitch of frenzy and perhaps to some disastrously convincing exhibitionistic act. Where I think this may occur, I indicate a course of action to the patient, usually with a succinct restatement of the possibilities which he has already indicated to me. It is possible to put a little more emphasis in one direction or another while being very careful to leave the impression of autonomy with the patient (e.g., "You may find you wish this, or that; but the decision will naturally be your own"). In this way the appearance of stubbornness or evasiveness on the part of the analyst is avoided, the patient gains in self-reliance, and the first step in the education of his narcissism is begun.

There is one other tendency which appears throughout in such severely ill patients and which must be "managed" as well as analyzed. This is the habit which Stern[8] once graphically and tersely characterized as "scab-picking." I had myself already made use of the analogy of "pulse feeling." This can be so severe as almost to crowd out other mental activities, and it must then be dealt with before the initial stage can be passed and the deeper work of analysis begun. It is usually adequate to call the patient's attention to this process insistently and to interrupt it

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alytic insight and judgment, could not be considered psychoanalytic. (Brill, A. A.: Schizophrenia and Psychotherapy. *Am. J. of Psychiat.*, IX, 1929, p. 519.)

Dr. Zilboorg, reporting the treatment of a paranoid schizophrenic patient, also emphasized the preliminary state of reality testing before the analysis itself. His patient had been in a definite psychosis, and the subsequent recapitulation of the psychosis in an acting-out in the analytic situation was at once more dramatic, and more massive than is the situation in the severely neurotic patients of my own study. (Zilboorg, Gregory: Affective Reintegration in Schizophrenia. *Arch. Neurol. & Psychiat.,* XXIV, 1930, p. 234.)

[8] Stern, Adolph: Borderline Group of Neuroses. This *Quarterly*, VII, 1938, p. 467. Dr. Stern's article touches on my own observations in many respects, and mentions also the "deep organic insecurity or anxiety," with which my study is largely concerned.

repeatedly. This tendency is so clearly a kind of masochistic autoerotic gratification, analogous to compulsive masturbation and to some forms of brooding, that it must be repeatedly interrupted in order to turn the energy elsewhere even temporarily. The "scab-picking" is itself partly a derivative of the active but poor cooperation of the strong superego and the weak ego; it frequently utilizes a highly developed scoptophilia turned back on itself. Late in the analysis, when the narcissism has been sufficiently educated to result in a strengthening of the ego, what remains of this self-watching tendency may be converted into a genuine capacity for self-criticism, indispensable for the management of the residual basic anxiety.

In general, then, the work of this part of the analysis is to increase the immediate reality hold of the patient, first through the attitude of the analyst, then through the relentless defining or clarifying of the immediate conscious attitudes and problems of the patient, and finally through the interruption of special self-perpetuating autoerotic tension states. While this must be done at the beginning of the analytic work, it is rarely accomplished adequately in the first stages of the treatment and usually has to be repeated in many different ways through the course of the treatment.

This stage of treatment differs from the beginning of any analysis only in its greater importance, not only early but often throughout almost the entire course of the analysis. Because of the patient's insecure sense of reality, the larger topographical outlines of the reality problems and the reflection of the unconscious factors on reality situations have sometimes to be gone over and over with almost monotonous repetitiousness. In this way there is an infiltration of this sort of insight into the microscopy of analytic work and there ensues a helpful organization of the latter in a manner which places it at the disposal of the patient. One must guard against making the analysis simply a tour of minute morphological inspection.

Analyses of these severe neurotic states are inevitably long. The sooner the patients and their relatives accept this and settle down to the analytic work, the better. The patient himself is usually under con-

siderable urgency and scab-picks at the time element as well as at other aspects of the total situation, keeping himself in a state of pleasurable disappointment, attempting to extract promises and time-tables from the analyst. To such patients and their relatives I emphasize that analytic work involves genuine growth which cannot always be budgeted or scheduled.

Throughout the analysis there exists the need for a strengthening of the patient's ego through the education of his narcissism. As a part of this, a reduction of the tendency to easy and widespread identification should be accomplished.[9] This occurs partly spontaneously through the liberation accomplished by the analysis of the essential neurosis, but it has to be reinforced through a training in its actual recognition as a general tendency, and a self-critique must be established in regard to the tendency. By these means some of the otherwise dissipated energy may be reclaimed and brought back into the service of the ego. Many of these patients have a remarkable poverty of interests, i.e., very few external goals of ego achievement; or if they have any, they have too many and flit from one "interest" to another, developing nothing satisfactorily. In the first instance, the analyst has to help the patient to find some satisfactory goal, and in the second, to select or organize those which he has already found. This cannot be done by prescription, suggestion, or even by direct encouragement, for the patient reacting assertively to any positive direction (and rightly so since such direction would only increase the dependence with which he struggles), then lays the responsibility on the analyst and blames him for uncertainty or failure. Patients often demand such advice and would almost trap the analyst into giving it only to disregard or disprove it, and so prove their neurotic negative "strength." It is possible sometimes to accomplish the desired result by an adroit underlining of the patient's own inclinations, again emphasizing the patient's autonomy. "You will find interests ready for you as you are ready to invest in them. It is unnecessary to force yourself (in one direction

[9] Schilder describes this florid tendency to multiple identification in the schizophrenic in his chapter on Identification in Schizophrenia in his Introduction to Psychoanalytic Psychiatry. New York: *Nervous & Mental Disease* Monograph Series, No. 50, 1928.

or the other), but only to take steps as you yourself feel at all ready for them. Even then you may be disappointed." It is like helping a child with the first steps of walking.[10]

The analysis of the essential neurosis of such a patient is not fundamentally different from the analysis of any neurosis. The first stages of the analysis may have to be prolonged in order to strengthen the patient to bear the distress of the later analytic work. This has often been spoken of as the period of preparing a patient for analysis. In my experience, this work can hardly be confined to a preparatory time but has to be continuously reinforced throughout the analysis by constantly working through the material with reference to the current situation and the infantile roots of the behavior and symptom patterns, never omitting the larger outlines of behavior tendencies as a framework for the dissection of the finer details.

In the analysis of these severe neuroses, the risks involved in giving too early interpretations for which the patient is not ready are greater than ordinary. The temptation to do this may be great as the patients so often present rather florid material and have themselves some inkling of the symbolization involved, in this respect resembling the frankly schizophrenic individual. Patients meet premature interpretation by a marked increase in their defensive walling off or they seize upon the interpretations to construct an intellectualized formula which serves their narcissistic demand for magic and with which they may satisfy themselves temporarily and dazzle their intimates sufficiently to give the semblance of a cure. They improve temporarily because they have been given a magic initiation. This can be avoided by giving interpretations with special caution and always working back from the current situation to the deeper roots, never allowing the analysis to become strangulated at one level or

[10] I combat the tendency to a negative therapeutic reaction here by being slightly negative myself: never praising, rarely permitting myself any enthusiasm, but definitely recognizing ability or achievement when it is shown, and always indicating to the patient that he may achieve further. I believe this attitude is more in keeping with the need of the patient for reality above all else; at the same time it diminishes overstimulation with subsequent disappointment, and avoids the pitfall of having the patient do things to please me. Others may find it possible to establish activity first on the basis of pleasing the analyst, and subsequently analyze this oversubmissiveness after the patient's activity has gained a certain momentum of its own. I presume these differences of procedure must depend in some measure on differences in the temperaments of the analysts.

the other. Great analytic agility is sometimes required in order on the one hand not to allow the ever-ready deluge of anxiety to overwhelm the patient, and on the other hand not to permit the patient to rest on the relative comfort of somewhat reduced anxiety. To keep him at his analytic work, he should have enough anxiety to spur his effort, but not so much as to block it.

It is equally important, however, not to *overlook* the essential neurosis. The symptoms are often embedded in wider tendencies of behavior, and the improvement from the concurrent education of the patient may be so striking that it may be easy to be fooled into dealing inadequately with the neurosis itself.

There are some peculiarities of the transference relationship to be considered. The transference at the beginning of the analysis is generally urgent but shallow, and characterized often by an ambivalent identification with the analyst. These patients ask everything and trust nothing.[11] Later in the analysis it may develop into an intense obligatory erotic transference. Throughout it is a relationship of exquisite sensitivity.

These patients have in the very nature of their organic sensitivity to experience a remarkable faculty of observation, but not so good an ability to make use of it. The constant mirroring of life and the diffuse competitiveness resulting from this is evident throughout, especially in the dream material. The patients seem to hear and see everything about the analyst, his situation, his family, etc. They take in and register a mass of details without being aware of them. These reappear only slightly disguised in dreams which are full and remarkably elaborated. At the same time the patients are less able than are those suffering from milder neuroses to use the transference readily as a genuine medium of working out the reflected intricate patterns of their behavior, and only seem to achieve this in the ordinary way towards the end of the analysis. While the mirroring tendency produces the semblance of the transference in most of the patient's dreams, the continued detailed analysis of its appearance tends either to confuse or merely to fascinate the patient. Consequently in the transference relationship too, one has to work early especially on the general larger patterns. Only after the patient's tendency

[11] Cf. Fromm-Reichmann, Frieda: Transference Problems in Schizophrenics. This *Quarterly*, VIII, 1939, p. 412.

towards identification has been somewhat reduced is it possible to do much detailed transference work with him.[12]

Because of the remarkable capacity for observation on the part of the patient, any changes at all in the analyst's arrangements are reproduced in the patient's dreams and attitudes. Sometimes these may by good chance bring out some special pocket of material from the patient. More often, however, they serve as artifacts and unnecessary complications in the analytic picture. For this group of patients it makes for a real economy of work to keep the immediate environment of the analytic work as constant as possible.

Later in the analysis the development of an erotic attachment to the analyst can readily cause the accumulation of transference anxiety. This is particularly intense in the patients under discussion, as there may be in them a considerable deepening of emotional experience and libidinal expansion occurring in the course of the analysis and not for the most part after it is over. In this sense the transference represents more than a "transference,"[13] since there is an addition of new elements not previously experienced by the patient. Such a transference presents one of the greatest values and some of the severest problems of the analysis, as the dissolution of the transference demands the realignment of the deepest attachment the patient has yet felt. How much erotic tension piles up in the transference and how readily it is deflected onto and used in the reality of the patient's life clearly depends first on the specific life situation of the patient when he enters the analysis, and second, on how the analyst handles this emotional current. In these severe neurotics constant drainage of this is necessary, erotic tension never being allowed to accumulate and stagnate. One should deal with it by always indicating directly or by implication the other love goals to which the current must

[12] In years past, in my psychiatric experience, I have seen patients quite often thrown into brief psychotic episodes by too assiduous and early work with the transference. I believe this still happens though not to the same degree, since the emphasis on continuous detailed interpretation is less. These episodes were not followed by any prolonged psychotic states. We used to refer to them as "psychoanalytic deliria."

[13] This was exemplified in an even more intense form in the affect hunger described by Dr. David Levy in Primary Affect Hunger. *Am. J. Psychiat.,* XCIV, No. 3, 1937.

return. The erotic tension thus escapes becoming fixed in a transference bondage or coming to an explosive rupturing.

The patient must become acquainted during the course of the analysis with the necessity of managing his own basic anxiety, which is not completely analyzable and will always remain at least potentially with him. Neglect of this part of the treatment may cause the subsequent breakdown of much of the accomplishment of an otherwise effective piece of analytic work. The patient must acquire a considerable degree of self-critique and self-tolerance. In the course of the analysis, I gradually acquaint the patient with the fact that analysis will not be a complete revelation or a magic rebirth such as he demands; that he will in fact always have problems of tension and balance to deal with. This tempering of his expectations may be started very early in the treatment, with the same firm realistic attitude which is generally effective in combating his panic. If this is coupled with a clear statement of the fact that there are definite gains to be legitimately expected, it stimulates the patient to work rather than discourages him. Then as the work proceeds, he is gradually made familiar in a very simple way with the theory of basic anxiety. This is not given him as a packaged theory, but is interpreted to him as he refers to the material which, according to my mind, justifies such a theory. These patients always give some accounts of what they have heard regarding their own births, possible antenatal influences, and earliest postnatal experiences. These come to the surface often directly, sometimes combined with birth theories and fantasies of later childhood which again are revived in connection with current contacts with birth experiences. As patients speak of their own birth injuries, their earliest illnesses, accidents, the attitudes of their mothers towards and during pregnancy, I reconstruct for them the possible effects of such experiences on a young child, and indicate the inevitable contribution to the general tension and amorphous anxiety of the later adult. In this connection, it is interesting that one can in the course of such interpretation pretty well reconstruct what has been the specific experience of the given patient. He does not recover clear memories or confirmatory evidence which he can convert into words, but he reacts with wincing, increase of tension, or the appearance of confirmatory somatic symptoms when the old sen-

sitive areas are touched, even when this has to do with events of the very earliest weeks and months of life.[14] It might be expected that this sort of interpretation would furnish the stuff for a negative therapeutic reaction and that the patient might fall back on the attitude, "I was born that way; so what?" This has not been my experience. Perhaps it is counteracted by the special attention already paid to the education of the narcissism. These patients must learn to know and appreciate themselves as genuinely sensitive individuals, and come to utilize their sensitivity if possible. In this way may be built up a valuable self-critique which is then at the disposal of the patient rather than turned against him. Finally at the end of such an analysis there has generally occurred a reorganization of the individual. The level of the tension may still be somewhat elevated. But if the essential neurosis has been adequately dealt with, the organization is sounder, the behavior more spontaneous, and the balance less easily tipped. Such treatment is, perhaps more than an analysis, an education; in procedure it necessarily lies somewhere between the classical psychoanalytic technique and the methods used with children.

Clinical Studies

In presenting the clinical material in connection with this paper and the previous one, I give only one case history with any degree of fullness but shall first present briefly from a clinical experience extending throughout a number of years, the observations which formed the beginning of my queries about the effect of birth and other early traumata on the production of a tendency to anxiety.

A. One of my patients, a competent and serious unmarried lady in her late thirties, suffered from hysterical symptoms. On the periphery of these was one which did not yield to analysis. This consisted in certain irregular jerky movements with her feet. She complained that when she was driving her car, the free foot tapped rhythmically on the floor of the car. This was not a tic, nor yet a genuine compulsion, but an inconstant and seminvoluntary act which she found herself repeating like a bad

[14] One sees here very clearly the significance of Freud's statement that the symptoms take part in the discussion. In this part of the analytic work, symptoms are the patient's main discussion.

habit. She also noticed that when in company she was tense and felt people were looking at her, she was unable at times to keep from wriggling the toes sometimes of one foot and sometimes of the other. This embarrassed her, although it seemed to her that she did it only under scrutiny and to relieve embarrassment. It was obviously an autoerotic discharge in a state of mild anxiety, but like other neurotic symptoms, it turned back on its purpose and increased the state it seemed intended to relieve. The same patient gave a history of having rubbed her toes on the sheet in order to put herself to sleep in her childhood, a habit which was maintained until she was six or seven and which recurred subsequently especially during illness until puberty.

In the analysis of this patient's dreams, there were a number of associations which indicated the familiar foot-penis symbolism. This patient suffered from an unrecognized extreme envy of her brothers, among whom she was the only girl. I shall not attempt to go into the whole story of the neurosis, but I was puzzled by the route of selection of the foot in this particular case. I thought at first it was a simple displacement downwards, occurring with partial or complete renunciation of infantile masturbation. It was evident that the foot and leg were equated with the penis (and also breast) not only in accordance with the familiar symbolism but also directly by association with her mother who had suffered a milk leg earlier, and then later became lame from other causes when the patient was at puberty. One could readily see that the foot tapping was a combination of the illusory penis masturbation and an anxious exhibitionistic calling attention to her castrated plight. But the patient's original foot rubbing to put herself to sleep was said to have occurred from "earliest infancy." Her mother had told her that she had been a quiet baby and had slept well, except for the foot rubbing and some thumb sucking. It seems clear that the foot erotism had preceded the problem of castration anxiety and penis envy and had certainly antedated the mother's lameness and knowledge of the milk leg story.

B. In seeking the possible derivation of this patient's symptoms I recalled another patient who some years ago had told me that at the height of an orgasm she would have peculiar tingling sensations in the toes of both feet. There were certain similarities in the developmental

histories of the two patients. Neither remembered childhood masturbation but had come upon masturbation in adult years when it occurred "spontaneously" as part of a diffusely felt sexual arousal with sensations emanating from the genital areas and spreading throughout the body. In the patient under discussion this had occurred in the setting of a quasi intellectual erotic stimulation (reading and looking), and seemed to her a short-circuited response. In both patients the masturbatory habit was a recurrence of the most primitive thigh-pressure type. In neither case was there any clitoris masturbation. In the second patient, the masturbation was accompanied by fantasies of intercourse which, in the patient's imagination, consisted simply of holding the penis within her vagina, i.e., clearly a possession of the penis in this way. It seems probable that the masturbation which had been initiated so late was only a recrudescence of what had occurred and had been renounced very early in life.

This type of genital sensation without awareness of any preliminary stirring or fantasying but consisting rather of sensations suffusing suddenly upwards from the genital region and extending throughout the body, reminds one of the distribution of dissociated and disclaimed erotic sensations described by schizophrenic patients as due to electrical or hypnotic influences.

There is one other fragment of a case history, which I recall from my early clinical experience, of a young woman who was at first considered to be a very severe case of hysteria. This young woman had an autoerotic orgastic tic with a sucking muscular movement culminating in a snapping noise sufficiently loud to startle bystanders. I have recently been able to learn the bare details of the later history.

C. This young woman first came to the hospital at twenty-three because of especially violent quarrels with her father in which she threatened to kill him and also threatened suicide. The family was one in which talent and instability intermingled and fused. The father was a brilliantly able man, who sank later into a cranky senile state. I saw this patient first twenty-one years ago. She was the third among five children. One had died of meningitis, and one had had a manic attack precipitated by the torpedoing of his transport during the first World War. In the years since, a younger sibling too developed a psychosis, so that four

of the five children developed severe psychic disturbances. Genetically determined constitution may be considered to have had a possible influence here; however, the early individual history is also of note. The patient was a seven-month baby, cyanosed and weighing four pounds at birth. Because of a neglected ophthalmia neonatorum, her vision was permanently impaired and a constant lateral nystagmus developed. There were many fainting attacks in childhood. She was never able to study adequately, both because of the reduced vision and because of inability to concentrate. She had a particularly severe temper with sudden exceedingly violent outbreaks occasioning chagrin and a religio-moral struggle for control. She became a religious fanatic and wished to be a Deaconess. Masturbation occurred throughout the entire childhood, and she could recall no period in which it was even temporarily in abeyance. The childhood history was so full of sexual traumata, explorations and experiments with other children and with a variety of animals, as to give the impression that this frustrated child was in a state of continual autoerotic overflow in which her impulsive discharges set up new excitations until she was involved in a frenzy of polymorphous perverse excitement with almost no relief. In this patient, too, masturbation by thigh pressure was the earliest and still predominant form of masturbation, although to it had been added a great variety of autoerotic practices.

In the hospital she was at first extremely scattered, distractible and restless; she then developed the tic, which was clearly an effort at relief. "If it does not occur my eyes get misty and roll up into my head, and my brain gets confused." She described it as "a contraction and expansion of one of my organs." It occurred, however, without her volition and became a thoroughly automatized tic. She complained also of pain and a feeling of paralysis in both legs and sensations in them "like mercury in a thermometer." Withal she moved about freely.[15]

Obviously this case presents a mesh of complications. But I quote it here because of certain similarities in symptom constellations with other cases. Having recently obtained an abstract of the history of the younger sister of this patient who suffered a psychosis some seventeen years later,

[15] I wish to thank Dr. Adolf Meyer for permission to use these and other clinical observations from the period of my work at the Phipps Clinic.

I have learned that all of the children in the family were born by extremely difficult labors. It thus appears that this part of the family situation, dependent on the pelvis of the mother, and an accident as far as the children were concerned, may have combined with and reinforced the later results of the pathetic neglect which the patient suffered as a child.

In thinking over the possible relations of this pressure masturbation to the toe, foot and leg symptoms in these cases, I believe that I may have come upon a somatic rather than a purely symbolic link in the possibility that in severe pressure masturbation of this type, where the body is held in a state of prolonged, frenzied, autoerotic tension and the legs crossed in scissor fashion, there may actually be referred sensations of tingling in the legs and feet. This seemed to me the more probable when I recalled having seen several times in my student days on a pediatric ward, cases of very young female infants in exactly such states of unrelieved tension, with the body in a condition of rigid tonicity and legs crossed scissorswise. I recall that one of these little patients was at first thought to be suffering from Little's Disease because of the history of birth trauma and the superficial resemblance of the posture to spastic paraplegia. Separation of the infant's legs with soft cotton pads was followed by the cessation of this masturbatory tension and a relative degree of general relaxation. The recollection of these instances of very early masturbation in girl babies then related itself to the observations of erections following delivery of boy babies, and the line of query which I have developed in my first paper began to take form.[16]

Any one who has attempted to give a fairly full account of the analysis of a single case, knows how difficult this is. The mosaic of the analysis is inevitably complicated and delicate and while a few relatively simple patterns stand out boldly in almost all cases, what pattern unit stands out most sharply depends on the angle from which the whole is viewed. Thus, what looks like a diamond to one person may look like a cross to another. It is often important to establish *some* pattern unit, at any rate, and go along from there. In dealing with the following case history, I

[16] *Cf.* Lorand, Sandor: Contribution to the Problem of Vaginal Orgasm. *Int. J. Psa.*, XX, 1939, p. 438.

have found it impossible to present all my data and have consequently organized it for purposes of presentation along the lines already indicated. It was the tendency of this material to organize itself along these very lines, however, which stimulated my attempts to bring together my observations and to formulate ideas about treatment of this group of severe neuroses.

D. This patient came to me at the age of twenty-eight, a trim young woman of small stature, probably not more than five feet or five feet one inch tall. Her figure inclined to boyishness, especially in the straight slimness of the hips, but this was by no means conspicuous. The upper part of the torso was feminine and the breasts well developed, but with inverted nipples. There was a slight excess of hair on the forearms and a little heaviness of the hair of the upper lip. She walked in an overly energetic tense fashion, with her head thrust forward, her arms swinging freely. Her speech resembled her gait in being hurried, urgent, inaccurate, and often ahead of itself. She was accompanied by a nurse companion, as she was afraid to go any place alone.

At the time I first saw the patient I had already been given the general facts of the formal history, and all arrangements had been made in advance for her treatment. Another analyst was in touch with the family and had done the not inconsiderable job of explanation and interpretation of treatment to them. The patient came with the anticipation of being analyzed, but she accepted analysis as a last and probably futile resort and was not kindly disposed to it.

The presenting symptoms were those of a severe anxiety hysteria, with phobias, a tendency to doubt and some compulsive activity. She was afraid to be alone, afraid of high places, and especially of windows above a ground level. In attacks of panic she was afraid of losing consciousness. At other times she described herself as dazed and without positive feelings, "as though I were looking inward instead of outward," and again, as though she "just stared out." Sometimes she felt as though she were not herself, and her face felt stiff. She felt like an infant and was afraid of drowning in her tub. Again, she felt very tiny, like "just a tiny atom lost in space." Sometimes she insisted she was feebleminded. Going to high places, having to eat alone, going to the hairdresser, or being in any

situation in which she sat directly facing another person, were all situations in which she was likely to have anxious feelings mounting almost to panic. At this particular time she could not bear to look in a mirror, which was as bad as having any one else look at her. She was tense almost to the point of frenzy, but there nevertheless appeared an element of play acting in her manner.

She had really been sick most of her life, and while one could recognize stages of change in her symptoms, there had been only a few relatively short periods when she had seemed reasonably well and active. She had never finished school or held any position. (Tests, however, had indicated her to be well above average intelligence.) She was married and had a daughter of four, and kept up an intermittently active participation in the social affairs of her friends. She had been more or less in contact with psychiatrists and psychoanalysts since the age of seventeen. At that time her parents consulted an analyst who advised that they take her to Vienna to Freud. A neurologist thought a Eurpoean pleasure trip would be better. Later she was successively in the hands of a psychiatrist, a child guidance specialist, and what appears to have been an "analyst" without training. She spent two years with this man and became quite familiar with the general symbols and some of the concepts of analysis. Next an analyst advised against analysis and the patient then entered a psychiatric hospital. There she remained for about seven months, showing marked improvement at first and then getting rapidly worse, with the appearance of more marked frenzy and desperation than at any time previously. She was now so bad that it seemed impossible for her to live outside of a hospital and in order to start the analysis it was arranged that she remain hospitalized but commute daily accompanied by a companion. All arrangements were made with the help of another analyst who was a friend of the family and proved an invaluable aid during the first months of the treatment, acting as an interpreter and shock absorber in the situation.

I shall not attempt to describe the minutia of the therapy. It proceeded essentially along the lines I have already described. At first the patient behaved in a crazily frenzied fashion reminiscent of the "antics" of patients in a psychiatric hospital. She would refuse to lie on the couch though she knew from her previous experiences that this was expected.

Sometimes she paced about threatening to throw herself on the floor, or walked up and down wringing her hands. She went through the motions of choking herself and threatened to jump in front of a train on the way to the office or to jump from a window. She would sometimes ask me how I dared to let her go around outside of the hospital. She attempted to entice me into some commitment about the outcome of the analysis, the length of time, my expectations, etc., and she tried a number of bullying methods. She told dreams and quickly gave crude symbolic interpretations, sometimes saying, "I suppose *you* would think that means thus and so." She now repeated in order to discard them the many symbols learned in her previous "analytic" experience. She was mildly obsessed with a great variety of sexual thoughts—a kind of pansexualization of thought content which may have been partly induced by the previous rather blunt therapeutic efforts. It was usually futile for me to say more than a sentence or two, as she would turn her head away and say "I am not listening to you. I don't hear anything you say;" or "I can't hear you, because I can't concentrate." A little later she was able to hear more of what I said, but often attempted to convert the session into an argument, amply demonstrating the basis for her having been affectionately dubbed "a last word artist" by her parents when she was a child. When she asked me if I were a good enough analyst to treat her, she was surprised when I simply said "Yes." (This served to check temporarily the potential sado-masochistic argument with which the patient was used to drowning out all therapeutic contacts. Somewhat later I was able to help her first to see that she blocked her own progress in this way, and later to begin to analyze these tendencies in herself.) She was an inveterate scab-picker, sometimes drawing her husband and her mother into the process by scaring them with her behavior and inducing them to call me up, then demanding verbatim accounts of what our talk had been.

During the first two or three months there was a gradual simmering down. Her failure to arouse counteranxiety in me was probably the most effectively "reassuring" factor. Gradually I began the most elementary explanations. Ignoring the symbols which she displayed so generously, I began with simple suggestions that her feeling like a little atom was a kind of picture of her feeling lost in the world, that she didn't really feel grown up and able to take care of herself, and that being unable to be

alone was like being a child again. Even this was too much for her at first, and when she once grasped the idea that she was reacting to a feeling of insecurity in many ways, she was relieved that at last she had understood something. This is just an indication of the extreme simplicity with which we began. The gradual deepening of her understanding, the emphasis on her appreciating herself as an individual, her increasing ability to assimilate more and more interpretation and the extreme caution with which progress could be made, can be imagined from the content of the patient's history. These first weeks were essentially a stripping off of the secondary adornments of pseudo-psychotic behavior which she had picked up in a psychiatric hospital, together with much of their complement of secondary anxiety. She began to feel that she had rights and independent functioning. The use of the simplest sort of explanations permitted her to abandon the analytic vocabulary which she had previously acquired and which served only as a meaningless burden to her, having already lost even the quality of being magic words.

This girl was the first child and second pregnancy of a young mother. An earlier tubal pregnancy resulted in operative interference and a stillborn fetus. The maternal grandmother died suddenly ten minutes after the patient's birth. The mother then went to her father's home to live and to take her mother's place with the grandfather. The family remained there until a second child was born twenty-seven months later. (This story was part of the family saga and the patient could not remember when she first heard it.) The patient was delivered by cesarean section because of the mother's contracted pelvis. She was a fretful baby in spite of the fact that she sucked her fingers from earliest infancy, presumably beginning the first week of life. At a very early age she began sucking her blanket. She recalls that later she sucked the blanket and then smelled it before falling asleep. In summer she had to have a piece of flannel to suck and smell. Intermittent finger sucking occurred until the patient was fourteen or fifteen. It then was gradually replaced by smoking which is still a deeply fixed habit and is largely an oral pleasure; she inhales little and is as well satisfied with an unlit cigarette in her mouth. Another childhood habit was rubbing her foot on the blanket in order to put herself to sleep. In adolescence she twisted her hair with her fingers continually. She was nursed until she was a year old

and was then weaned on principle rather than exigency. She wet the bed throughout her entire childhood up to the age of seventeen, when there was a further extension of neurotic symptoms. She was constipated intermittently in childhood and was given enemas frequently. One of her early recollections was of being held struggling and fighting on the bathroom floor while the mother inserted the enema nozzle. She masturbated throughout childhood. This was a rather ineffective clitoris masturbation described by the patient as "touching myself but not working at it." The details of the beginning of her speech are not known to the patient, but she recalls having had a mild speech defect, something of a lisp, which gradually disappeared at eight or nine. Later in life she complained a good deal about getting mixed up in her speech: under any excitement she used words which had the approximate sound of those she wanted—a mild degree of malapropism under stress. There were no serious illnesses except mastoiditis in the patient's infancy. She had had occasional spurts of fever, however, often accompanied by brief delirium, and on one occasion a series of convulsions.

When she was twenty-seven months old, a younger sister was born. The mother was permitted to go into labor, which proceeded unsuccessfully for some time; then forceps were applied and the child was severely injured. From the first it was feared that the baby would not develop normally, and by the time the baby was two or three years old it was evident that she was both deaf and an imbecile. At the time of the birth the mother had gone to another city for delivery, taking the older child with her. On the train returning home, my patient, then twenty-seven months old, developed acute mastoiditis necessitating a mastoidectomy. She remained in the hospital nine weeks and later had to have very frequent dressings. She fought so against these that an anesthetic was given, and she is supposed to have had chloroform almost daily for some time. (This is the mother's account. The patient herself has always thought it would be impossible to have been anesthetized as often as the mother reports to have been the fact.) The patient's earliest conscious recollection is of being held by her nurse, looking out of a window in the hospital and watching some negroes on a nearby roof. The mother devoted herself to caring for the patient but was under great stress in her position as successor to her own mother and in concern over the next pregnancy.

(A certain oedipal ambidexterity was patently needed.) After the sister's birth, first the patient and then both the children were in charge of a *Fräulein* who was very strict and methodical and punished them severely for spilling anything. The two children were brought up together until the sister was about six, when the latter was sent away to a special school.

The patient's neurosis developed in successive stages and with increasing intensity (1) at seventeen, when she first went away from home, (2) during her engagement and (3) after the birth of her child. It just happened that the birth of this child came in a period when there were many deaths in the family, so that again birth and death were juxtaposed even as they had been at the time of her own birth when her grandmother died ten minutes after she was born. At the time the patient entered analysis, she stated that her sexual response was good, i.e., that she usually had an orgasm in intercourse. It developed, however, that she was averse to intercourse and had an inadequate orgasm overly readily.

In considering the etiological factors in this young woman's illness, I shall confine myself to the simplest statements in regard to the two groups: the very early, *predisposing* ones, and those producing the *essential* neurosis. In regard to their effects, it is not possible to make a clear cut distinction between those predisposing causes resulting from the genetically determined constitution and those arising predominantly from the very early distresses which I have conceived of as leaving an organic (constitutionally assimilated) imprint in their wake. I believe that these two groups of factors are inevitably together and sometimes fused.

In this case, we have a history of competence and some brilliance on both sides of the family, but with an incidence of neurosis which seems very high. In addition the mother was tense and apprehensive during her pregnancy with the patient, as her previous pregnancy had ended in a defeat and suffering for her. She was, incidentally, a rather undaunted sporting type of woman, with considerable bravado as a cover for her disturbance. Although there were no particular data regarding the patient's nutritional state at birth, my surmise from the contents of her symptoms and dreams would be that she had not been a markedly undernourished baby. She was born by cesarean section. It is interesting here that the patient does not describe any sensation of a band or localized "brain stiffness" or head pressure feelings which are so commonly described

by schizophrenic patients and by some neurotics, but rather feelings of light-headedness in her panic states, as though her head would "fly to pieces," and a feeling of stiffness in the face. The last was definitely a reproduction of the chloroform mask and disappeared readily on analysis. That she was an uneasy infant from the very first was attested by the crying, excessive sucking, twitching and rubbing which began in the very first weeks, and the convulsions and easy deliria within the first two years. The mother's constant watchfulness and tension almost certainly was reflected in her face[17] and in her handling of the young baby. The mother prided herself on taking care of the little one alone, in spite of her own emotional burdens and practical responsibilities at the time. The mother described the first few years of her childrens' lives as "a hell of worries" to her. It does not seem to me too far-fetched to consider that the patient's truly extraordinary sensitivity to facial expression, strikingly apparent in the first few months of her analysis, had its roots in this early period, although it may have been augmented in infancy by the birth of the somewhat mutilated sister and by her own abundant experience with anesthesia. Subsequently it was sustained by a severe father who exerted much control through frowns and scowls.

Similarly the direct effects of the caesarian birth became amalgamated later with the images called up by the verbal accounts of it which she heard, and gave substantiating form to some of her later birth theories. We see further in this girl's birth a situation which favored a sense of abnormality and, with the death of the grandmother following so closely, gave rise to questions of her own identity, expanded her omnipotence even to the point of killing, and intensified her guilt feelings, etc.

For the *essential* neurosis two events were especially important: the birth of the younger sister, a mutilated half dead baby, when the patient was twenty-seven months old, and a rape by a grown man occurring when the patient was five years old. The patient's own mastoid infection and operation, following so closely on the sister's birth, had psychologi-

[17] Therese Benedek quotes C. Bühler as observing that the infant recognizes the face of the mother or nurse at an earlier age than it recognizes the bottle. She draws the very pertinent conclusion that the confidence inspired by this recognition is a stage of object relationship preceding positive object love. This regularly occurs by the third month. Adaptation to Reality in Early Infancy. This *Quarterly*, VII, 1938, p. 203.

cally the importance of birth to her, and the repeated experience with anesthesia merged with her death and rebirth fantasies. It is interesting too, that there was a recurrence of the mastoid following the mother's miscarriage when the patient was about seven. The time of the birth of the sister was remembered quite readily by the patient, but its emotional significance was completely annulled in consciousness and had to be unfolded to her in analysis against the customarily stern defenses of the obsessional neurotic. For the rape, however, occurring as it did at the beginning of the latency period, she had a deep hysterical amnesia.

SUMMARY

In presenting this clinical paper I have had to condense and simplify the material very greatly and have attempted only to sketch it in such a way as to indicate the fundamental outlines of the work. In the last case cited, the work began with the problem of management of the anxiety laden behavior and the establishment of a better grasp of immediate reality. The education away from narcissism extended throughout the entire analysis, permitting the patient an increasingly useful self-critique. The interpretation was gradually deepened until the essential neurosis could be reached. I believe that these general principles are applicable wherever there have been many severe and early traumata, whether or not there is any possibility of antenatal and natal contributing factors in the underlying anxiety.

This is a group of patients who are coming to analysts with increasing frequency, asking and needing help. It is clear that the consideration of these cases takes us back to the need for more observation with infants, work which appears to me the source of the richest material for psychoanalysis.

Before closing, I want to give due appreciation to the work already published by others dealing with many aspects of these problems. I think of the publications of Brill, Zilboorg, Sullivan, Schilder and others of about a decade or more ago; more recently there have appeared the publications of Hill, of Tidd at the Menninger Clinic, of Fromm-Reichmann and Bullard at Rockville; and in our own Society the papers of Stern, Franz Cohn, Lorand, and Thompson. By and large these have

dealt, however, with conditions as encountered in the franker psychotic states, or with relatively circumscribed problems of interpretation or of method. I hope that my own paper may serve to bring these observations and considerations together in a general form, and especially to demonstrate them in the severe neuroses or borderline states which so often occupy a sort of no man's land between the hospital and the analyst's office.

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GREENACRE'S "THE PREDISPOSITION TO ANXIETY," PARTS I AND II: A REVIEW

BY FRANCIS BAUDRY

Keywords: Phyllis Greenacre, anxiety, history of analysis, Winnicott, Freud, infancy, early trauma, transference, countertransference, seriously disturbed patients, Klein, development.

INTRODUCTION

Phyllis Greenacre's two-part article "The Predisposition to Anxiety" (1941a, 1941b) constitutes one of those classics occasionally read during early training and then unjustly forgotten until a special occasion resurrects them from undeserved oblivion. In rereading Parts I and II in 2010, it is hard to imagine that they were written seventy years ago in 1940. In a tribute to Greenacre presented at a scientific meeting of the New York Psychoanalytic Society honoring her eightieth birthday, Arlow (1975) wrote that, in his opinion, these papers—along with her article, "On the Biological Economy of Birth" (1945a)—"stand alongside of *The Ego and the Mechanisms of Defence* by Anna Freud and *Ego Psychology and the Problem of Adaptation* by Heinz Hartmann as landmarks in the development of modern psychoanalytic thought" (p. 4).

I will try in this review to evaluate Arlow's high praise. I will first put Greenacre's papers in the context of psychoanalysis as it was during the period shortly after the outbreak of World War II.

PSYCHOANALYSIS IN THE 1940s

In 1941, Freud had been dead less than two years. Although he had elaborated his structural theory, the seminal collaboration among Hart-

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mann, Kris, and Loewenstein, which led to the fundamental papers on ego psychology (e.g., 1946), still lay in the future. Anna Freud had published her work on the mechanisms of defense in 1937, but interest in the earliest phases of life and the preoedipal period was still in its infancy, and few had done relevant work. The immigration of refugee analysts who came to American and British shores fleeing the horrors of the war was already underway. The influx of analysts of a classical persuasion was starting to destabilize the British psychoanalytic establishment, whose most charismatic figure was Klein, who outdistanced Ernest Jones. Her work was extremely controversial and was thoroughly disliked by a number of child analysts in the United States, including Berta Bornstein. Greenacre and Winnicott mutually influenced each other (Thompson 2008); the latter was in the process of elaborating his observations of young children based on his clinical work as a pediatrician.

Freud's views on trauma still dominated the field. He clearly differentiated between psychoneurosis based on conflict and *actual neurosis,* in which anxiety had no psychic content (see, for example, Freud 1917, p. 386). The concept of birth trauma, initially proposed by Freud, was given a bad name following Ferenczi and Rank's (1924) work that gave it too concrete a form, going so far as to suggest that analysis should last nine months—the period of human gestation. Fenichel, who was part of the initial group of second-generation analysts, would not publish his classic text on psychoanalysis until 1946.

From a technical point of view, abstinence was still the gold standard, and the potential for long silences was considered part of good analytic technique. Although attention was paid to the transference, countertransference continued to be seen largely as an obstacle to the work. Racker did not begin publishing his seminal contributions to the field until 1957.

Attention to borderline pathology was likewise nascent. There were early differences of opinion about the category of patients so defined. Were they a wastebasket group of patients whose diagnoses fell between neurosis and psychosis and who were defined by what they were not, or did they form a distinct entity with clearly distinguishable dynamics and conflicts?

GREENACRE'S PSYCHIATRIC AND PSYCHOANALYTIC TRAINING

Born in 1894, Greenacre trained as a psychiatric resident at the Phipps Clinic at Johns Hopkins Hospital in Maryland, where she worked with Adolf Meyer. This clinic was at the time one of the few places in the United States where one could receive excellent training in psychiatry. Meyer emphasized the importance of detailed case histories and careful observation, as well as the link between biology and psychiatry. His clinic was famous for its treatment of sicker patients. A number of future analysts, including Bertram Lewin, Clara Thompson, Lawrence Kubie, and Ruth Loveland, were trained at the Phipps Clinic; yet Meyer, who was quite ambivalent toward psychoanalysis, bemoaned the fact that some of his best students became analysts (Thompson 2010).

Greenacre graduated from the New York Psychoanalytic Institute in 1937 and was appointed as a training analyst in 1942. She presented "The Predisposition to Anxiety" (1941a) at a scientific meeting at the New York Institute on November 12, 1940; it is hard to believe that it was written only three years after her analytic graduation. At the time, a number of analysts criticized it as not "sufficiently analytic." Nonetheless, the author's calm sense of being well in charge and knowing what she was doing stand out as the hallmarks of a very experienced clinician; this fact alone suggests that her previous psychiatric experience must have influenced her stance. Greenacre herself noted several times that her twelve years at the Phipps Clinic had exposed her to the psychopathology of sicker patients. She brought this to her analytic training and work.

GREENACRE'S OVERALL APPROACH

It is a pleasure to reread Greenacre's papers as her prose, in contrast to that of many writers, is clear, precise, and full of imagery. Although she deals with abstract principles, she allows the reader to see the clinical material from which she derives her ideas. In fact, she indicates that her theoretical ideas were all derived from her clinical experience, not the other way around. I find that the most salient qualities that emerge

on this reading of "The Predisposition to Anxiety" are the author's empathic understanding of the psychology of the sicker patient, her interest and belief in the value of reconstruction, and her subtle understanding and management of the therapeutic relationship in this difficult group of patients. Greenacre is willing to engage in reconstruction of events from very early in life, even suggesting the influence of events *in utero*, thus approaching issues in the early preoedipal period that were off-limits for many classically trained analysts because they could not readily be represented in words.

The two parts of "The Predisposition to Anxiety" belong to a series of communications concerned with trauma and reconstruction, including, e.g., Greenacre 1945a. From early in her career, Greenacre focused on the role of trauma in the life of the baby. This enabled her to successfully blend the physiological substrate of anxiety before the birth of the ego (a sort of pre-anxiety)—which she labels *basic anxiety*—with the essential anxiety that arises during the early stages of neurosis formation. In this way, she affirms the very real continuity between the earliest physiological reactions of the organism and its shift in function during processes of maturation. She anticipates the concept of the *psychophysiologic self*, elaborated years later by Jacobson (1964). In contrast to those analysts who think of development as a series of discontinuous processes, Greenacre clearly sees development as one continuous process.

GREENACRE'S THEORETICAL UNDERPINNINGS

A glance at the list of references for "The Predisposition to Anxiety—Part II" (1941b) reveals a startling fact: of the seven references cited, none is by Freud. Instead, we find Bullard, Cohn, Lorand, Thompson, Tidd, and two articles by Sullivan. In the body of the work, she also mentions Hill, Zilboorg, and Schilder as having contributed to her thinking.

Yet her analytic approach was clearly rooted in Freud's theoretical ideas, particularly on libidinal development, memory, the role of aggression, and trauma. Her clinical work also seems rooted in his principles of technique, though it departs from them at least in regard to the early stages of treatment. Throughout the text, references to a number of pa-

pers by Freud may be found, including his paper on negation (1925), cited in the first part of her paper (1941a, pp. 1071-1072[1]); Greenacre also cites Ferenczi (1926) in this first part.

SUMMARY OF PART II OF "THE PREDISPOSITION TO ANXIETY"

Part II (1941b) begins with a section called "Practical Considerations of Treatment." Greenacre starts by summarizing the key aspects of the first part of her paper, published approximately nine months earlier:

> In a previous paper, . . . I advanced the tentative hypothesis that severe suffering and frustration occurring in the antenatal and early postnatal months, especially in the period preceding speech development, leave a heightened organic stamp on the make-up of the child . . . . I believe this organic stamp of suffering to consist of a genuine physiological sensitivity, a kind of increased indelibility of reaction to experience which heightens the anxiety potential and gives greater resonance to the anxieties of later life. [p. 1075]

Greenacre introduces the term *basic anxiety* to describe a particular affective consequence of early trauma. She differentiates this from essential anxiety—that is, anxiety in the postverbal period associated with neurosis formation. She adds a third type of anxiety, *secondary anxiety,* resulting from inadequacy of the neurotic defenses and from additional dangers, real or illusory, following the production of symptoms. She cites crying fits in young infants as an example of the latter.

Whereas I can appreciate Greenacre's attempt to describe different types of anxiety originating in response to well-defined situations, I fear that these three categories might well be difficult to differentiate in clinical practice. For example, how is one to know when basic anxiety is present? Is it to be found in the very early, diffuse, presumably contentless anxiety and panic with which these patients present? Or is it also to be identified by the persistence of anxiety manifestations after the essen-

[1] *Editor's Note:* In this article, page numbers from Greenacre 1941a and 1941b refer to the numbering in the republication in this issue, not to the original *Quarterly* publication of that year.

tial neurosis has been more or less successfully dealt with clinically? I will return to this point when discussing one of the cases presented.

Greenacre introduces a useful link between intrauterine disturbances and very early traumatic states in which we see all the biological, physiological manifestations of anxiety (cardiovascular and respiratory) in the absence of a mental apparatus to register it. How soon does she think the primitive mental apparatus develops? Relying on infant observation, she identifies very early affective responses such as fear, rage, and love (the cessation of crying followed by smiling and gurgling). Greenacre's approach could be contrasted with the work of Klein, with whom she was at least partially familiar as she quotes from Klein a number of times in her paper. Greenacre clearly disagrees with Klein about the presence soon after birth of internal object relations and a structured mental apparatus.

In the group of patients she is concerned with, Greenacre accurately describes the consequences resulting from repeated early trauma, including early development of narcissism; omnipotence; magical thinking; an increase in the tendency to mirror, leading to overly facile identification; excessive use of projection; and inadequate development of the sense of reality. Ego development is faulty, and libidinal attachments are shallow. Ego drives are not well directed toward satisfactory goals, and they furnish additional predisposition to the particularly severe neurosis Greenacre is concerned with. In her findings, she anticipates Deutsch's (1942) description of the *as-if personality.*[2]

Greenacre believes that if early traumata are particularly severe, the stimuli "overflow through the body and act upon various organs" (1941b, p. 1077)—by which she is referring to oral, excretory, or genital overflowings. This interest in overflow phenomena would lead to a number of very interesting papers connecting physiological expression with psychological elements (e.g., Greenacre 1945b, 1945c). Here Greenacre does not yet have the necessary theoretical apparatus to include the nature of representation of these phenomena; her descriptions are very

[2] Deutsch's paper was recently republished by *The Psychoanalytic Quarterly* with an accompanying discussion by Bass (2007), which proceeds along the same lines as my argument.

much grounded in economic issues. In this she anticipates the work of the French psychosomatic group and the ideas of Winnicott.

CLINICAL MANAGEMENT: GENERAL OVERVIEW

Greenacre's general approach is a mixture of dynamic understanding, educational interventions, and, most important, the provision of a stable frame, a reliable container, which anticipates the work of Bion and Winnicott. Although Greenacre terms her treatment *analysis,* she deems it necessary to introduce a number of parameters to manage the chaotic nature of the patient's behavior and affects, particularly early in the treatment. She is aware that a substantial part of her task is educative in nature.

"The composed, firm, assured attitude of the analyst is of the greatest importance" (1941b, p. 1079). In this way Greenacre very much maintains an analytic attitude, eschewing more supportive measures and anticipating the negative effect of reassurance, as described so accurately by Feldman (1993). She is aware of the exhibitionistic tendencies of these patients and their desire to "excite the sympathy and counteranxiety of the analyst in a desperate effort to regain neurotic control of the situation" (Greenacre 1941b, pp. 1079-1080).

Along the same lines, Greenacre also refrains from giving direct advice. When faced with urgent demands for advice, she does not yield but conveys the patient's options that he himself has already stated, and at most might suggest a course of action, while being very careful to preserve the patient's sense of autonomy. She is astutely aware that "a negative therapeutic attitude is encouraged if the analyst is too gently sympathetic, shows solicitude or anxiety. Obviously this increases the secondary gain of the neurosis and draws it further into the analytic situation" (p. 1081). In this she clearheadedly indicates that the analyst is a therapist, not a friend. However, with particularly difficult patients, Greenacre is aware of the need to have the understanding and cooperation of those close to the patient during the other twenty-three hours of the day. This may include the intervention of another analyst who keeps in contact

with the family, thus allowing Greenacre to maintain a more strictly therapeutic function.

In this way, Greenacre applies analytic ideas but combines them with external management of the total situation. She warns of the tendency of such patients to "scab-pick" (p. 1081), a sort of masochistic autoerotic manifestation, which she actively interrupts and discourages. She combines a number of educational interventions and sets limits with the aim of increasing the patient's immediate reality hold—in other words, a sort of preparatory strengthening of the patient's ego prior to the analysis of so-called essential anxiety. She is aware that such measures may not be limited to the early stages of the treatment, but may have to be repeated throughout. She emphasizes that such treatments are long, and that growth cannot be budgeted and occurs slowly.

The Management of Basic Anxiety

Greenacre's novel contribution centers on the management of basic anxiety as a necessary prelude to true analytic work. Since in her view basic anxiety is not connected with unconscious fantasies, but is instead the result of early trauma, she does not base her management on dynamic interpretations. Rather, she makes use of a keen understanding of the mostly maladaptive consequences of basic anxiety and discusses how it can be kept in check, so that eventually the essential neurosis can be tackled according to prevailing standards.

Greenacre is very impressive in her capacity to maintain a calm, unperturbed demeanor, especially in the face of the patient's provocations. Her remaining in the present with the patient means that intellectualizations are avoided. Yet Greenacre is also willing to make certain constructions about some of the consequences of early traumas, though more as educational interventions than as true interpretations. She does not expect recovery of actual memories, but looks for confirmatory responses in the somatic sphere, including wincing, tension, or somatic symptoms. Here, she anticipates the work of some of the researchers on early preoedipal stages and the nature of primitive representations.

THE NATURE OF THE TRANSFERENCE

In a more theoretical section (1941b), Greenacre points out that the patients on whom she is focusing are less able than more neurotic patients to use the transference as a genuine medium of work, even though she mentions that an idealizing transference is often present. In describing the nature of the bond with the therapist, Greenacre alerts us to the possibility of an intense erotic attachment to the analyst, causing much transference anxiety. She feels that "the transference represents more than a 'transference,' since there is an addition of new elements not previously experienced by the patient" (p. 1086). Here she anticipates the work of Loewald (1960), with his emphasis on the role of the analyst as a new object. Aware that the patient may bring grandiose expectations, she counsels about the need to manage the patient's narcissism and the probability that a fair amount of basic anxiety will continue after the end of treatment.

Greenacre's concerns at this early stage remain very much centered on the patient's immediate reality and the need to strengthen the ego as a prelude to more intense analytic inquiry. She is keenly aware of the danger that premature intellectualized interpretations may encourage a view of the analyst as magical and omnipotent. Yet at one point, when the patient asks if she feels competent to treat him, her only response is a dry "yes." This reply was meant to "check temporarily the potential sado-masochistic argument with which the patient was used to drowning out all therapeutic contacts" (1941b, p. 1095).

CLINICAL MATERIAL: CASE D

I will now turn to the most extended case presentation in the two articles (1941b) in order to illustrate the strengths and weaknesses of Greenacre's approach. She does not describe her work on the essential neurosis, assuming that most analysts would handle this according to well-known principles. As she informs us, her case presentation is both condensed and simplified. She presents the material mostly to illustrate the theoretical points developed in Part I, dealing with the preliminary

management of basic anxiety. As a consequence, many aspects of the history are left out. For example, the patient's father and the quality of her relationship with him are never mentioned. Similarly, the patient's problems with sexual life are brought up only in passing.

Greenacre's acute capacity for clinical observation is most impressive. Her initial description of her 28-year-old female patient reveals her acuity and her skills as a novelist, as well as those of a therapist who begins to make connections and hypotheses from the very first contact with the patient, whom she describes as follows:

> . . . a trim young woman of small stature, probably not more than five feet or five feet one inch tall. Her figure inclined to boyishness, especially in the straight slimness of the hips, but this was by no means conspicuous. The upper part of the torso was feminine and the breasts well developed, but with inverted nipples. There was a slight excess of hair on the forearms and a little heaviness of the hair of the upper lip. She walked in an overly energetic tense fashion, with her head thrust forward, her arms swinging freely. Her speech resembled her gait in being hurried, urgent, inaccurate, and often ahead of itself. She was accompanied by a nurse companion, as she was afraid to go any place alone. [p. 1093]

With these few lines, Greenacre captures the patient's bodily characteristics, posture, gait, speech, and her bisexuality and its interrelations, and she calls attention to the relation between body and speech. She is particularly sensitive to overflow phenomena and traumatic issues occurring around the time of speech development. Suffering at present from a multiplicity of anxieties, phobias, and panic attacks, the patient has been hospitalized for the past seven months and at first behaved in a crazy fashion with Greenacre, pacing back and forth, refusing to lie down on the couch, and being provocative by threatening to throw herself on the floor. She also cannot listen to more than a sentence at once, claiming, "I can't hear you, because I can't concentrate" (p. 1095).

Greenacre must be admired for her willingness to consider embarking on analysis with such a sick patient. It is noteworthy that she stands firm in telling the patient she is expected to lie down on the couch, considering the extreme nature of her behavior. I suspect that

Greenacre was not taken in by these more histrionic aspects, given the fact that the patient had been in a hospital environment for the previous seven months.

The past history is most impressive, revealing multiple traumas from the earliest stages of life. Immediately after the patient's birth by cesarean section, her maternal grandmother died, causing her mother to become depressed. As a child, the patient had difficulty falling asleep, rubbing herself and needing a transitional object (a blanket). She was weaned abruptly at age one, and she required frequent enemas for constipation.

When the patient was twenty-seven months old, her mother gave birth to another daughter, who turned out to be "deaf and an imbecile" (p. 1097). At that point, the patient developed severe mastoiditis and had to be hospitalized for nine weeks, and, according to the mother, required frequent anesthesia to allow the doctors to change her dressings. Later, when the patient was six, the sister had to be sent away to a special school.

Toward the end of the report, we also hear in passing that the patient was raped by an older man at age five, but that this event was covered over by hysterical amnesia. She had been in more or less continual treatment since the age of seventeen, having had a period of pseudoanalysis consisting of intellectualized explanations of her symptomatology. It is stated that the patient never finished school or held any position of employment. It is quite remarkable that in spite of the above, the patient was able to get married; she had a child of four upon starting her treatment with Greenacre.

Greenacre's calm interventions and explanations were obviously key in enabling this very disturbed patient to be managed according to Greenacre's views about the handling of basic anxiety. Greenacre saw the patient's psychotic, anxious symptoms not as an indication of her core makeup, but rather as a facile identification with other psychotic patients with whom she had been in contact during her recent hospitalization. One must admire the aptness of Greenacre's simple explanation that the patient was "feeling like a little atom . . . [which represented] a kind of picture of her feeling lost in the world, that she didn't really feel grown up and able to take care of herself, and that being unable to

be alone was like being a child again" (pp. 1095-1096). This straightforward way of connecting with the patient's felt experience is a hallmark of Greenacre's extreme sensitivity to what was required to reach traumatized patients. She also discarded the many symbolic equations used in the patient's prior (so-called) analysis as mostly intellectualized attempts through magic to control the uncontrollable.

Case Commentary

In rereading this case some seventy years after it was written, what can we add to Greenacre's account of her impressive management? First, from a diagnostic point of view, we should recall that some Kleinian authors have pointed out that both psychotic aspects and nonpsychotic aspects can coexist in the same patient, a point well made in a paper by Bion (1957). It is likely that in light of the multiple traumatic events in her early life, the severe symptomatology, and a gross functional impairment, the patient had considerable psychotic components in her personality, and that her bizarre behavior at the beginning of her treatment with Greenacre was more than a facile imitation of the behavior of other disturbed patients in the hospital.

In 1941, there was simply no range of medications available to deal with such severe anxiety and panic, whether anxiolytic or antidepressant (SSRIs and the like). Would Greenacre have resorted to management of these symptoms with medications such as these, as an adjunct to her approach? I suspect that she might have cautiously relied on occasional medication usage.

FURTHER CONSIDERATIONS

Two particular issues remain to be addressed: (1) the connection between trauma and conflict, and (2) the contribution of newer theories to the management of this type of patient.

The Connection Between Trauma and Conflict

While it is possible to follow Greenacre in her conclusion that there had been massive traumas very early in this patient's life, there are some puzzling omissions. For example, it is not clear to this reader why so

little was said about her rape at age five by an older man, which must have been exceedingly traumatic in its own right, and must also have stimulated sexual fantasies *après-coup* or even at the time. Other factors might be connected with it: the repeated enemas, for example, or the bed-wetting till age seventeen.

Other aspects of the patient's situation are mentioned in passing, leaving out possible connections. For example, it is stated that the patient insisted she was feebleminded. It seems plausible that this feeling represented a complex identification with the defective sister; whether it stemmed from guilt or jealousy is not clear.

In fact, there were many complex elements of a traumatic nature embroiled in conflict almost from the very start of the patient's life. These include (A) the fact that her birth had been preceded by a stillborn fetus, (B) the death of her maternal grandmother a few days after her birth, (C) a sudden interruption of breast-feeding at age one, (D) the hiring of a strict and punitive nurse, (E) the birth of a deformed sister at twenty-seven months, (F) institutionalization of this retarded, deaf sister when the patient was six, and (G) the patient's mastoiditis following the sister's removal and a nine-week hospitalization with frequent application of anesthesia.

Greenacre is careful in not dating the onset of the essential neurosis, while acknowledging the defective sister's birth and the childhood rape as significant factors. Although Greenacre mentions that the essential neurosis developed with increasing intensity, she highlights age seventeen, when the patient left home. Yet in reading the case report, I gain the impression that the patient's neurosis was more or less continually present from earliest infancy, with multiple symptoms throughout life (finger-sucking until age fifteen and bed-wetting until age seventeen being the more obvious examples). In fact, the childhood neurosis seems to have blended seamlessly with the adult disturbance.

Greenacre's belief that basic anxiety has to be managed and is not really connected with unconscious fantasies may screen out the important reliving of earlier scenes—in this situation, experiences such as enemas, a mastoiditis operation, a forcible rape, etc. Perhaps the patient could not tolerate hearing more than a sentence or two because there was such profound mistrust of the therapist (the rapist!) in light of such

childhood mismanagement and abandonment—whether by the mother when her own mother died right after the patient's birth, or when the mother was hindered by the birth of a second, defective daughter only twenty-seven months after the patient's birth.

Was some of the patient's symptomatology an identification with the defective sister, who must have taken up so much of the mother's time and emotional energy? What was the impact of the sister being sent away when the patient was six years old? Triumph over the elimination of a rival, guilt, and anxiety that she, too, might suffer the same fate are all highly probable.

Advances in the Theory and Management of Severe Neurosis

The concept of *basic anxiety* implies a quasi-traumatic etiology early in life. Often, these traumatic experiences do not achieve representation and cannot be managed by the usual verbal interpretation of meaning. More recent psychoanalytic thinking in France, as expressed by Green (1993) and by Botella and Botella (2005), suggests that, in many patients who have been traumatized in a way similar to Greenacre's case, one finds no trace of the trauma. There is instead an excess of excitation that cannot be processed or transformed. The analyst has to allow him- or herself to regress, permitting primitive material to emerge consonant with the patient's experience. When this is done successfully, the patient may acquire through construction a new piece of his or her history. Of course, whatever deficits occur secondarily become embroiled in conflict.

One unfortunate consequence of Greenacre's theory is that it precludes thinking about the early material in terms of conflict and transference. In fairness to her, it must be added that Greenacre takes the position that "only after the patient's tendency towards identification has been somewhat reduced is it possible to do much detailed transference work with him" (1941b, pp. 1085-1086). In a footnote, Greenacre adds that, in years past, she has "seen patients quite often thrown into brief psychotic episodes by too assiduous and early work with the transference" (p. 1086).

There have been some major advances in the understanding of such patients by the Kleinians, Winnicott, and Kohut, on both clinical and

theoretical fronts. Theories not available to Greenacre include those on the development of object relations, internal objects, the nature of self, and object representations and defects in the capacity to use the object (Winnicott 1969). Klein's concept of projective identification was not yet properly disseminated, and the relevance of countertransference as a clue to what might be happening in the patient intrapsychically was not yet recognized or developed.

Greenacre's patient seems to function at the paranoid-schizoid level of development, using projective identification and splitting, and having part-object relations with either idealized objects or degraded objects. Her anxiety level is very much related to fears of intrusion by a paranoid object or abandonment by an idealized, unattainable object. The profound disturbance in the patient's sense of self and her symptoms of depersonalization are typical of this group. The patient's inability at the beginning to listen to more than a sentence is a good example of this fear of intrusion, which could at appropriate times be interpreted.

In developing her theory and technique, Klein would pay close attention to transference-countertransference issues, with countertransference seen as providing an opportunity to garner additional clues about the patient's inner state. The interpretation of transference might be a requirement for integration to take place, even in the early stages of treatment. Seeing some of the early bizarre behavior as a reliving of early object relations scenarios would offer another window of understanding.

In addition, some of the patient's extreme affective states and impaired sense of self could be viewed from a Kohutian approach. There were in all likelihood major deficits in empathy for this young girl, leading to both a sense of deficit in relation to caretakers and to complex defects (Pine 1994), requiring careful management of the frame and repeated awareness of unavoidable empathic failures and their disorganizing effects. It is here that Greenacre's sensitivity was so helpful in managing multiple environmental failures.

The work of Winnicott might suggest additional approaches to helping this patient establish a safe transitional area in order to assist with structure formation, and helping her learn how to play with her thoughts. Also at the forefront is the erection of a false self to secretly preserve what was truly her most authentic identity. Winnicott (1969)

would pay particular attention to the treatment setting as well, and to the gradual evolution of the patient's stance from what he termed *relating* to him (a primitive sort of fixed transference) to using him as a real object (following the patient's destruction of the analyst in fantasy and the analyst's survival). It sounds as though Greenacre's calm, unperturbed manner, when she failed to respond to the patient's provocation but remained rather neutral, did indeed fulfill this important function.

CONCLUSIONS

Within the framework available to her, it is quite remarkable that Greenacre did not succumb to this patient's massive affective outbursts. Greenacre's theory, whether broadly generalizable or not, enabled her to successfully treat this difficult and troubled patient with both containing and interpretive measures. Without this extraordinary endeavor, it is highly probable that the patient would have spent a large part of her life between hospitalization and ineffectual or even harmful outpatient treatment (e.g., the pseudoanalysis she underwent before seeing Greenacre).

Because Greenacre does not give us the detailed course of later phases of this treatment, the reader is left with a view of the patient's pathology that is perhaps more extreme than warranted. Surely, since the patient was able to marry and have a child, she must have had some appealing adaptive capacities. It is a pity, however, that we are told nothing about the state of her little girl. I can well imagine that, at age four, the child might have been a good candidate for Greenacre's sensitive care and management.

At the end of her paper, Greenacre observes that the increasing frequency with which these patients are coming for treatment "takes us back to the need for more observation with infants, work which appears to me the source of the richest material for psychoanalysis" (1941b, p. 1100). This is in line with Winnicott et al., who saw that work with more disturbed patients offered an avenue into infant psychodynamics.

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A LONDON COMMENTARY ON PHYLLIS GREENACRE'S "THE PREDISPOSITION TO ANXIETY" (1941)

BY DAVID TAYLOR

Keywords: Phyllis Greenacre, anxiety, history of analysis, analytic theory, analytic research, early caregiving, psyche-soma, Freud, Klein, trauma, neuropsychology.

INTRODUCTION

It is inevitable that the ideas of substantial men or women of a previous time will be subjected to critical verdict. Sometimes these verdicts assume that the writers should have been more aware of subsequent discoveries or facts that we now take for granted. Yet it can be unwise to reply that hindsight is a wonderful thing. These kinds of rejoinders inevitably sound defensive or clichéd, and the irony barely registers. Omniscient opinions, full of the confidence that comes with a lack of historical imagination, will nearly always strike a stronger note.

Yet this is not the only possibility when we have the opportunity to revisit some important classic. We may equally be surprised by the depth of the questioning, by the modernity of the possibilities raised, by the fact that whatever the advances may have been we continue to lack exact answers to many of the questions raised. We may be led to conclude that there has not been as much progress as we had thought, or that in some way the quality of modern inquiry has been overestimated. The risk here is that this may cause us to idolize the work or the writer, placing either beyond the reach and usefulness of critical examination.

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In fact, aside from the awkwardness of these intergenerational transference factors, considerable breadth and depth of learning are required if we are to avoid the twin perils of denigration and hagiography when looking at the work of an earlier period. Only with both knowledge and generosity are we able to benefit from one of scholarship's more rewarding tasks: the duty that we periodically go into little-visited parts of the library and restore to contemporary scientific discourse some of the goods that have been in storage.

Here, in relation to my discussion of Phyllis Greenacre's two-part paper (1941a, 1941b), I am keenly aware of the superficiality of my knowledge both of the era and of the particular psychoanalytic context in which her work was undertaken. A proper commentary upon the line of argument in the first part of her paper requires an up-to-date knowledge of empirical research into the psychological and behavioral capacities of the fetus and the premature baby (Mellor et al. 2005; Wood et al. 2000), their vulnerability and reaction to suboptimal or adverse environments (Marlow et al. 2005), and other consequences for later development of early environmental adversities—including, sometimes, the physical trauma that can accompany a protracted or complicated labor.

The amount of work in these subject domains, already surprisingly large in Greenacre's time, has grown exponentially. No working psychoanalytic clinician can now become sufficiently expert to interpret what is a complex array of often contradictory findings whose scientific significance is open to dispute. This is to say nothing of the fact that, by virtue of their relevance to abortion, such findings have additionally been imbued with the significance forced upon them by fundamentalist, evangelical hypermoralism. The only solution is to make the study of these subjects into a life's work—and then what would have become of psychoanalytic clinical expertise? However, as I hope will become evident in the course of this essay, these are the kinds of problems that it is sometimes more important to grapple with than to avoid.

In order to get a view of the challenge Greenacre faced in setting out what was then a new and previously unformulated point of view, I begin from what Greenacre said was actually her point of departure: her experiences in the analysis of severe neuroses in adults. Having consid-

ered the nature of these original observations and how she went on to account for them, I then discuss the clinical technique that Greenacre felt they required—and go on to say how I would see this type of phenomena today, coming as I do from a very different psychoanalytic tradition and from different times.

In the final section, I return briefly to some of the major theoretical and empirical issues raised in the first part of Greenacre's paper (1941a). These relate to matters of general psychoanalytic theory and observation concerning the nature and possible transformations of anxiety. These are also matters where psychoanalysis and other disciplines overlap, and so their different theories serve either to lend support or to raise questions, and their findings to confirm or disconfirm. As well, they have the potential to inform the directions of further inquiry.

OBSERVATIONS AND INTUITIONS

In the opening paragraph of her first paper (1941a), Greenacre tells the reader about the chronology of the factors she examined in arriving at her conclusions:

> (1) the analysis of particularly severe neuroses in adults, (2) the searching for supportive or related data in the medical, psychiatric and psychoanalytic clinical experience of myself and others, (3) a supplementary review of some experimental work and observations, (4) a review of Freud's later publications concerning anxiety, especially The Problem of Anxiety, (5) and finally, a return to my own case material which I reviewed in the light of my questioning. [p. 1049][1]

But she decides that, in her paper, these steps will be taken in reverse, because "the clinical material in itself is inevitably so detailed as to be possibly confusing." The purpose is to make the "reader aware of the underlying thesis" (p. 1049).

I will return to what I think might be the significance of this later, but for the moment I want to emphasize the fact that Greenacre's clin-

[1] *Editor's Note:* In this article, page numbers from Greenacre 1941a and 1941b refer to the numbering in the republications in this issue, not to the original *Quarterly* publications of that year.

ical observations and intuitions came first. We note that, while clinical intuition was actually the writer's starting place, in the paper it has become her destination. Although she explicitly tells us otherwise, we are also led by a line of argument to think that this destination is a place to which the logic of the writer's various research endeavors has itself inevitably led.

In the second part paper (1941b), Greenacre mentions in footnote 4 (p. 1078) that, long before her psychoanalytic training, her attention had first been drawn to the occurrence of various forms of masturbatory self-stimulation in the hospitalized and regressed adult patients whom she encountered while working as a psychiatrist. Her thinking seems to have included a realization that very high levels of anxiety are manifest in some mentally ill patients, especially when in states of crisis or decompensation, and that in some way these are connected with the patient's resort to these compulsive autoerotic or self-soothing behaviors. Greenacre also sensed a quality of infantile need or desperation in the regressed states manifested by these patients.

Later, Greenacre recollects how certain further experiences with patients in analysis reminded her of "very young female infants" whom she saw in her student days on a pediatric ward. They were in "states of unrelieved tension, with the body in a condition of rigid tonicity and legs crossed scissors-wise" (p. 1092). She notes the similarity between these states of physical contortion and stereotypical behavior, on the one hand, and some of the features of cerebral palsy and spastic diplegia, on the other. In some way, this resemblance reinforced her impression that there exists an organic and somatic level to these mental states. At the same time, she indicates that these conditions partially responded to physical interventions (cotton pads carefully placed between the children's painfully adducted knees), which had a humane and tender quality.

Presumably, the condition of these girls was due to the effects of institutionalization and emotional or maternal deprivation, to which attention was drawn by Spitz (1945), Spitz and Cobliner (1965), Bowlby (1969), Robertson (1958), Ainsworth (1962), and many others. As a direct consequence of extensive subsequent research, much more is now known and understood about the vulnerability of babies, as well as the

serious consequences of such deprivation for their long-term emotional and interpersonal development.

When Greenacre first provides material from an analytic patient, we again see how her attention focuses upon the infantile period. We find her rightly concluding that classical explanations based upon oedipal conflict and problems posed by the differentiation between the sexes cannot provide a satisfactory account of the kinds of difficulties she saw in some of her patients:

> A competent . . . lady in her late thirties [showed] . . . hysterical symptoms. *On the periphery of these was one which did not yield to analysis.* This consisted in certain irregular jerky movements with her feet . . . not a tic, nor yet a genuine compulsion, but an inconstant and semivoluntary act which she found herself repeating like a bad habit. *She also noticed that when in company she was tense and felt people were looking at her* . . . . [She] gave a history of having rubbed her toes on the sheet in order to put herself to sleep in her childhood . . . . I thought at first it was a simple displacement downwards, occurring with partial or complete renunciation of infantile masturbation. It was evident that the foot and leg were equated with the penis (and also breast) not only in accordance with the familiar symbolism . . . . But the patient's original foot rubbing to put herself to sleep was said to have occurred from "earliest infancy." Her mother had told her that she had been a quiet baby and had slept well, except for the foot rubbing and some thumb sucking. It seems clear that the foot erotism had preceded the problem of castration anxiety and penis envy. [1941b, pp. 1088-1089, italics added]

On the basis of this and other, similar observations, Greenacre's next step—the framing of a first, very provisional idea about the nature and origin of these difficulties—appears to have been much influenced by two suppositions that she treats as facts. The first of these can be seen in her comment, "On the periphery of these was one which did not yield to analysis." This is the germ of what later becomes one of Greenacre's main theses: namely, that there exists a category of emotional reactions or of emotional reactivity that in some crucial sense lies "on the periphery," in a manner beyond the reach of the processes of analytic understanding. In place of analysis (as Greenacre conceives it to be),

she advocates a kind of analytic steady stance, albeit a clinically highly educated and soundly sensible one. The patient may identify with this stance, and in a number of senses, both this stance and the analyst herself may be said to "educate" the patient. But her contention is that whatever it was that was felt to lie on the periphery of this patient's difficulties is of such a kind that it cannot be modified in a more fundamental way. Or perhaps—Greenacre sometimes seems to be implying—one should not even think of visiting these areas of the patient's functioning.

In her search for the origins of these difficulties, Greenacre is much taken by the contentless quality of the sensations associated with this broken thread of infantile masturbation that runs through the lives of some of her adult patients. Interestingly, these are all women. In addition to the contentlessness that she seems to regard as irreducible, she also particularly notes the anatomical distribution of the bodily sensations, and implies, I think, that their diffuseness is linked with the lack of a precise body schema localization, then widely assumed to be characteristic of the immaturity of the infant's nervous system.

To consolidate the weight of these observations, Greenacre continues:

> I recalled another patient who some years ago had told me that at the height of an orgasm she would have *peculiar tingling sensations in the toes of both feet.* There were certain similarities in the developmental histories of the two patients. Neither remembered childhood masturbation but had come upon masturbation in adult years when it occurred "spontaneously" as part of *a diffusely felt sexual arousal with sensations emanating from the genital areas and spreading throughout the body* . . . . In both patients the masturbatory habit was a recurrence of the *most primitive thigh-pressure type* . . . . In the second patient, the masturbation was accompanied by fantasies of intercourse which, in the patient's imagination, consisted simply of holding the penis within her vagina, i.e., clearly a possession of the penis in this way . . . . *This type of genital sensation without awareness of any preliminary stirring or fantasying but consisting rather of sensations suffusing suddenly upwards from the genital region and extending throughout the body,* reminds one of the distribution of dissociated and disclaimed

> erotic sensations described by schizophrenic patients as due to electrical or hypnotic influences. [pp. 1089-1090, italics added]

It seems to me that here Greenacre puts forward a way of looking in a propositional yet also tendentious way. The clinical observations are supposed to support a view that the preverbal child is to all intents and purposes the same as a child without mentation (in the sense of the baby's mind being without ascertainable content, and in particular without fantasies—no matter how ill-formed—concerned with self or objects). Conversely, this supposition that, in the infant and child, *preverbal* is synonymous with *pre-mental* subsequently determines the significance that can be placed upon putatively preverbal levels in adult material: i.e., these adults must be "without accessible content," and therefore they are beyond analytic reach.

Of course, Greenacre's allegiance to Freud's early theoretical models of the hydraulic nature, phasic sequence, and timing of autoerotic, narcissistic, and object cathexes is a big factor in the logical contortions and entanglements of all this. But Freud reserved for himself—and why not?—the right to say many often-contradictory things. However, for Greenacre as for many others, these ideas translated into a constraining orthodoxy that distorted the potential of her original thinking. It was one of the bits of received wisdom, which along with her own disposition, prevented her from following through on the possible implications for the baby's mental capacities of the *evidence* of the behavioral competencies of the fetus, the newborn, and the infant-in-arms, which she had so carefully assembled in the first part of her paper.

This may be the reason for the noticeable neglect of interpersonal or subjective content in Greenacre's approach to her clinical material and to primitive states of the psyche-soma. For instance, she shows no awareness of the possible significance—both for the patient's extra-analytic life, and for the transference relationship with her analyst—of the fantasies behind the statement in which Greenacre reports, "She also noticed that when in company she was tense and felt people were looking at her" (p. 1089). This is presented merely as if it were a natural consequence of the patient's other, supposedly more fundamental problems,

and no thought is given to the possibility that this phenomenon might provide a way into object-relational data of a more primary kind.

With her next example, Greenacre continues to build her picture of a constellation of difficulties bearing the stamp of physical, organic damage. This is incurred during antenatal life, in the course of physically traumatic births, or by equally profound effects operating in the course of infancy.

> This young woman first came to the hospital at twenty-three because of . . . quarrels with her father in which she threatened to kill him and also threatened suicide . . . . She was the third among five children. One had died of meningitis, and one had had a manic attack . . . . A younger sibling too developed a psychosis, so that four of the five children developed severe psychic disturbances . . . . The patient was a seven-month baby, cyanosed and weighing four pounds at birth . . . . Her vision was permanently impaired and a constant lateral nystagmus developed . . . . She was never able to study adequately, both because of the reduced vision and because of inability to concentrate. She had a particularly severe temper with sudden exceedingly violent outbreaks occasioning chagrin and a religio-moral struggle for control . . . . This frustrated child was in a state of continual autoerotic overflow in which her impulsive discharges set up new excitations until she was involved in a frenzy of polymorphous perverse excitement with almost no relief. In this patient, too, masturbation by thigh pressure was the earliest and still predominant form of masturbation . . . . In the hospital she was at first extremely scattered, distractible and restless; she then developed the tic . . . . I have learned that all of the children in the family were born by extremely difficult labors . . . . This part of the family situation, dependent on the pelvis of the mother, and an accident as far as the children were concerned, may have combined with and reinforced the later results of the pathetic neglect which the patient suffered as a child. [pp. 1090-1092]

Greenacre is keenly aware of the multifactorial etiology of this patient's difficulties. Her patient's visual problems, nystagmus, tics, problems with affect control—all of which Greenacre as a doctor is careful to mention—strongly suggest a minimal kind of cerebral damage, quite

possibly as a result of anoxia. But she is referring to this case expressly because of these similarities in symptom constellation with other, less severe cases in which the etiology is more psychological than physical. This particular case is one of the bridges supporting her hypothesis that there is "a somatic rather than a purely symbolic link" in the relationship between this kind of masturbation (primitive toe, foot, and leg sensations experienced by these patients) and many other features of the clinical picture that she has described. Greenacre is positing the permanent installation of these psychobehavioral predispositions in the course of an individual's early neurodevelopmental history. She intends something more than mere psychological registration or repetition, no matter how deep or permanent we may conceive these to be.

This is what Greenacre means when, at the beginning of the second part of her paper, she writes of the "conclusion" to the first part:

> I advanced the tentative hypothesis that severe suffering and frustration occurring in the antenatal and early postnatal months, especially in the period preceding speech development, leave a heightened organic stamp on the make-up of the child. This is so assimilated into his [sic] organization as to be almost if not entirely indistinguishable from the inherited constitutional factors. [1941b, p. 1075]

With this conclusion, it seems to me that Greenacre's original intuitions and observations have served her well. Our modern understanding of the profound nature of the interdependence between the development of mind and brain in the fetus and infant, and its early emotional and physical environment (mainly mediated by the intrauterine environment and by early maternal caregiving), has revealed that early experience and early development are radically and mutually constitutive. Subsequent research confirms that, at least in some individuals, early adversity of a wide variety of kinds increases the likelihood of anxiety and other common mental disorders. While an enormous amount of detail remains to be worked out, it is already increasingly clear that mind and body often cannot be meaningfully distinguished. In the words of one eminent philosopher of mind, "The mind looks to be irremediably infected with the body" (O'Shaughnessy 1980, p. 507).

However, having acknowledged the clinical and theoretical significance of Greenacre's thesis, I suggest that her account of more complex organizations of the psyche—including the wide variety of phenomena that have been placed under the rubric of *narcissism*—is less convincing, and in fact is not sufficient. Many of these doubts carry over to the soundness of the quite major implications that she believes her theory to have for clinical technique.

She continues:

> The increase in early tension results in, or is concomitant with, first an increase in narcissism, and later an insecure and easily slipping sense of reality. I referred . . . to the increase in the sense of omnipotence which may occur in a compensatory way to overcome or balance the preanxiety tension state of the organism, and to the increased mirroring tendency arising partly from the primary narcissism and partly from the imperfectly developing sense of reality. This increased mirroring tendency is the antecedent of . . . overfacile identification of neurotic individuals, and in psychotics towards easy projection. I spoke also of the derivatives of omnipotence: the overvaluation of the power of the wish and belief in the magic of words. With all of these narcissistic weaknesses, the sense of reality is often very poor and even when it seems quite good, it may be facile rather than strong and break down readily . . . . Further, owing to the pressure of early tension and anxiety, the ego development is exceedingly faulty; libidinal attachments are urgent but shallow and the ego drives not well directed toward satisfactory goals. The patient is not well individuated and often gives the impression of being in too great a state of flux, with many interests, many attachments, with the libido quickly and urgently invested and withdrawn. [pp. 1075-1076]

Greenacre goes on to recommend the approach that she felt was necessary as a consequence of the psychic inaccessibility of these features. Her recommendations are placed under four headings: handling of the overload of anxiety to produce an optimum state for the progress of the analysis; the education of narcissism to better ego proportions; the analysis of the "essential" neurosis; and the management of the residue

of "blind, unanalyzable anxiety" that will continue in the life of the patient.

Here Greenacre makes a great deal of sound, good clinical sense. Her remarks about the inadvisability of too much reassurance, of getting drawn in to telling the patient what to do, and the general advisability of distinguishing between pseudopsychosis and real psychosis, between hyperbole and the underlying reality of feeling, and generally of maintaining an attitude of reasonable steadiness—these all hold good today. She has some interesting things to say about mental breakdown and deterioration and about the erotization of ego functions, and she makes important observations about the conditions under which the development of a fetish is likely.

While it seems to me that aspects of the clinical picture with which Greenacre is concerned will be readily recognizable to most experienced clinicians, as an account of a pathogenetic sequence, it does not pass muster. The lack of precision and the compression of terms, as Greenacre employs them, mean that there is too much question-begging, and that too much must be taken as read. We all understand, however, that Greenacre was writing at the same time as the major controversy taking place in the United Kingdom between Klein and Anna Freud over matters very closely connected with Greenacre's preoccupations: the capacities of the infant and the importance of the preoedipal period (using the original classical dating).

Given my own analytic education, I believe that closer attention to the details of the clinical encounter between patient and analyst in situations of this kind will always reveal a much greater degree of internal and external object relatedness, with more far-reaching implications than Greenacre could possibly have envisaged. For instance, the analyst's ability to maintain a position of calm and confident steadiness of the sort Greenacre recommends—indeed, the fact of taking it up in the first place—may itself be the outcome of factors in the patient influencing the preconscious and unconscious of the analyst. This may be much less a product of the analyst's reasoning than we like to think. Obviously, I am not talking of simple manipulativeness, but of the way in which the pattern of the patient's internalized object relations, and the nature of

his or her internal anxiety situations, elicits responses in the analyst of a kind lawfully connected with the patient's internal world.

By looking at some extracts from Greenacre's final and most extended clinical example, I will offer a few illustrative examples of what I have in mind:

> This patient came to me at the age of twenty-eight . . . afraid to be alone, afraid of high places . . . . In attacks of panic she was afraid of losing consciousness. At other times she described herself as dazed and without positive feelings, "as though I were looking inward instead of outward," and again, as though she "just stared out." Sometimes she felt as though she were not herself, and her face felt stiff. She felt like an infant and was afraid of drowning in her tub. Again, she felt very tiny, like "just a tiny atom lost in space." Sometimes she insisted she was feeble-minded . . . . She was married and had a daughter of four . . . . She was now so bad that it seemed impossible for her to live outside of a hospital. [1941b, pp. 1093-1094]

Greenacre adopts a calm and decidedly non-alarmist attitude to the patient's "crazily frenzied fashion reminiscent of the 'antics' of patients in a psychiatric hospital" (p. 1094) . . . and her threats to jump in front of a train or from a window. The aim was to help reduce the excessively high levels of basic anxiety Greenacre found in this kind of patient. As this began to happen, the patient sometimes inquired how Greenacre could dare to let her go around outside the hospital. In fact, Greenacre's attitude was very helpful to the patient. I strongly suspect that Greenacre was also listening "with a third ear" for the patient's more subtle or implicit communications, but did not, as least as far as her explicit theory went, transform this into interpretation.

Sometimes she minimizes what I consider to be crucial elements in the success of any piece of analytic work. For instance, she writes:

> Gradually I began the most elementary explanations. Ignoring the symbols which she displayed so generously, I began with simple suggestions that her feeling like a little atom was a kind of picture of her feeling lost in the world, that she didn't really feel grown up and able to take care of herself, and that being unable to be alone was like being a child again. [pp. 1095-1096]

Greenacre diminishes the importance of this kind of approach by saying that this is "*just* an indication of the extreme simplicity with which we began" (p. 1096, italics added).

In the London of the period in which Greenacre was writing, this kind of material would have been understood much more in terms of early object relations, transference, and unconscious phantasy—at least by the majority who were influenced by Klein. In London today, Greenacre would also be seen as doing something more sophisticated than what is conveyed by her own description of "handling the overload of [basic] anxiety"; it might instead be viewed as a benign kind of *acting in* by the analyst. Greenacre would be seen to be following the model of what Bion (1962) thought constituted the mother's provision of psychological care for her baby, although only up to a point. Greenacre's capacity for emotional openness and balance is what, interestingly, Bion viewed as a mother's capacity for maternal reverie. His hypothesis was that this plays a fundamental part in developing the infant's capacity for symbolic thought and reasoning; it is one of the most important and ambitious parts of his theory.

Bion developed these ideas substantially on the basis of some of Klein's work (see, for example, Klein 1932, 1940, 1952). Here Klein gives an account not only of the infant's mental life, but also of the mother's function in enabling the infant to repeatedly recover from states of disintegration by virtue of restoring its organization around a good object—originally, the mother and her breast. Accordingly, the way of working that has grown up on the basis of these and other connected ideas involves the analyst exemplifying containment through his or her openness and mental balance, *but also* through an ability to transform emotional components into verbal communications, which contain the meaning of what is going on. In other words, *as well as* containing anxiety and managing the situation, they convey and communicate meanings that are vital to the patient's achieving integration.

I will try to give an example of what this might look like. When Greenacre gives her account of the several factors thought to predispose to the excess of "basic" anxiety that she found in her patient, she mentions that her mother—"incidentally, a rather undaunted sporting type of woman, with considerable bravado as a cover for her disturbance"

(1941b, p. 1098)—was in fact apprehensive during her pregnancy. The mother described the first few years of her children's lives as "a hell of worries" to her. Greenacre goes on, "It does not seem to me too far-fetched to consider that the patient's truly extraordinary sensitivity to facial expression, strikingly apparent in the first few months of her analysis, had its roots in this early period" (p. 1099).

Nor does it to me either. But let us try to take this further. First, there is nothing intrinsic to this material that in any way places it beyond the reach of symbolic thought and understanding. It is embodied, but then so are all our thoughts and behaviors unless there is something seriously wrong with us. But Greenacre herself says that the patient has shown this sensitivity toward her own facial expressions in the early period of the analysis. Would it really have been too far-fetched, too wild, or so disturbance-inducing for the analyst to have attended to the significance of this relationship *with the mother* that is being played out in transference?

I do not intend that the analyst should make an interpretation in which the patient's sensitivity to the analyst's facial expression is attributed to the fact that, when she was a baby, she was worried about her mother. However, I would draw to such a patient's attention her worry about what she fears is written on my face. After all, this sensitivity is a potentially valuable part of the patient's ego, presumably called into play precociously to deal with anxiety stirred up by her mother's sense of strain and loss. Interpretations of this kind, if delivered in the right manner, can lessen, modify, transform, and provide insight about anxiety, and represent an analytic way of integrating different parts of this patient's experience.

Of course, the material does not necessarily come in an easily accessible form of direct communication. Often, the patient's symptoms contain, in a highly compressed form, some of the patient's internal object relations and the anxiety situations connected with them. Thus, when Greenacre adds that her patient was born by cesarean section (another of the factors supposedly behind her disposition to anxiety), she goes on:

> It is interesting here that the patient does not describe any sensation of a band or localized "brain stiffness" or head pressure feelings which are so commonly described by schizophrenic pa-

> tients and by some neurotics, but rather feelings of light-headedness in her panic states, *as though her head would "fly to pieces,"* and a feeling of stiffness in the face. [pp. 1098-1099, italics added]

I speculate that Greenacre's patient might have feared that *her analyst* would "fly to pieces." And that, again, this is important not only as a description of her state of mind or of the anxieties that might have been less "on the surface," but also because it begins to piece together some kind of story about how she currently feels about the objects in her infantile self, and more conjecturally how she might have felt as a baby about her mother. There were serious and difficult events in her infancy and childhood in which she might have felt that neither she nor her mother was coping easily. Is it stretching credulity to think that the patient might have been sizing up her analyst, and even secretly seeking more of the reassuring stability from her analyst that she had already seen as a potential in her?

What does the patient's earliest conscious recollection, at the age of twenty-seven months, actually *say*? She has just developed mastoiditis immediately following her *very* damaged baby sister's birth (not *somewhat* damaged, as Greenacre at one point describes her). The patient is being held by her *nurse,* not her mother. She is looking out of a hospital window and "watching some negroes on a nearby roof" (p. 1097). Space constraints prevent my examining in detail here the possible effect of early-loss experiences in increasing the anxiety felt by this kind of patient about the potentially damaging effects of her own aggressive and destructive feelings. However, to my ear, this patient's early memory has an air of melancholy about it. I would hazard that early anxieties about harming her objects played a considerable part in her make-up and in the generation of her high levels of anxiety.

Toward the end of her paper, Greenacre also mentions that her patient had been raped, in addition to her earlier remarks about the patient's penchant for sadomasochistic argument. These facts point toward the patient's fantasies being of a more destructive kind. However, one might conjecture that her reputation as a "last word artist" (p. 1095) had more to do with avoiding anxieties in connection with letting her objects go than with a wish for triumph.

CONCLUDING REMARKS

I hope I have made it clear that my purpose in introducing these considerations has not been to suggest that I could have analyzed Greenacre's case better than she did herself. I would have grave doubts as to the realism of such an intention. That Greenacre so carefully details these kinds of emotional materials surely indicates her basic sensitivity to them. Perhaps, given where she was coming from and what she had available to her, it would be expecting too much if I were to say that she did not always join up what she probably sensed, and that aspects of the clinical technique she recommended serve to close off analytic inquiry rather than to open it up.

However, I would not want these more critical comments to detract from my appreciation of the substantiality of Greenacre's two papers. Some indication of their substance is evidenced by the fact that I have not been able to discuss here a great many of her considerations, particularly those in her first paper. Her discussions of Freud's view of birth as the prototype of anxiety, and of Freud's differences with Rank, are searching; through them, she manages the difficult task of establishing a position of her own that differs from Freud's. She achieves this partly by logical means, but also by an appeal to empirical evidence gained through direct observation.

In my view, it is important that psychoanalysis relate its views to those of other disciplines, although doing so is clearly fraught with conceptual and categorical issues. Greenacre's paper, as a significant and early example of this linking process, provides food for thought about how to do this and how not to do it. Isaacs (1933a, 1933b, 1948) performed much the same task in relation to Klein's ideas about infants and young children.

It is also instructive to consider again some of the modes of explanation that have characterized psychoanalytic theorizing, especially in its first period. I have in mind the way that Freud repeatedly employed the conceptual methods of natural history in his approach to human psychology. Charbert (2009) detailed how often Freud carried over some of the principles of his prepsychoanalytic embryological and developmental research endeavors to his psychoanalytic explanations. As far as

we know, as explanations, most of them are false; it is easy to dismiss them as anachronistic or to be embarrassed by their Lamarckian elements. However, I believe that such quick dissociation deprives us of the opportunity to consider an interesting mode of explanation, which if applied in a different, more subtle way, might be found to have some correlate in how the elements of human nature develop and are transmitted.

Something of the same line of reasoning applies to Freud's thinking about the libido, narcissism, and the death instinct (which, incidentally, Greenacre completely ignores). We no longer think that the existence of the capacity to feel anxiety and fear requires a registration in the memory of the race of this or that prehistoric event. As Greenacre implies, anxiety reactions and their forerunners are part of the genetic equipment of most animals, for without them they would not survive. We know more about the mechanics of evolution and genetics than could possibly have been foreseen by either Freud or Greenacre. Notwithstanding this, evolutionary psychology—which is currently the triumphant successor to their outmoded forms of thought—will at some point in the future be revealed to have had its own excesses.

Neurodevelopmental studies cannot by themselves furnish an account of the purposefulness of anxiety reactions, of their teleology. Psychoanalysis is one of the few disciplines in a position to provide this. And we may yet find that some of the ideas entertained by Freud and his successors about the transformations of the libido, and of the death instinct, and about their relation to anxiety, will be found to be closer to the biological systems underpinning them than is dreamt of in modern psychology.

Toward the beginning of this reconsideration, I drew attention to the way that, in writing her paper, Greenacre reversed the actual order of her thought. Her clinical intuitions were in fact what had come first. The fact that such an independent thinker felt the need to put theory and direct observation first in writing her paper speaks to the extraordinary difficulty of beginning with a clinical observation or intuition outside the consensual framework provided by accepted facts and opinions. This is one of the main challenges facing the clinical researcher as he or she tries to put nascent ideas into a form that the world in general will find comprehensible.

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BOOK REVIEWS

BOOK REVIEW EDITOR'S INTRODUCTION

Madeleine and Willy Baranger on the Analytic Field

We are offering our readers a pair of commentaries on a book that is of particular importance. The work of Madeleine and Willy Baranger addresses a theme that has been receiving increasing attention within psychoanalytic theory and practice in recent years. It involves the evolution within psychoanalytic thinking about the extent to which psychoanalysis is a one-person psychology, a two-person psychology, or a complex combination of the two.

Does the analyst remain apart from what is taking place within and being expressed by the analysand, as a "neutral" observer who comments upon and interprets what he or she perceives to be emanating from the analysand? To what extent is the analyst a participant-observer who agrees to be assigned roles by the analysand in a drama that unfolds within the psychoanalytic situation—and in fact to allow him- or herself to be drawn into co-creating that dramatization?

If the latter situation prevails to a significant extent, just what is it that is created by the two participants in the dramatization? Is it a transference-countertransference collaboration that stages important matters from within the analysand's inner world, so that analyst and analysand can directly experience and observe what has been troubling the analysand from his or her past, en route to altering the effect that the past has been having upon the analysand's present and is threatening to have on his or her future?

If this is so, how does the analyst refrain from intruding into the unfolding drama with his or her own human problems and issues in a way that the patient's care could be compromised by contamination and

obfuscation imposed by the analyst? How does the analyst, in this kind of interaction, keep track of what is coming from the analysand and what is coming from the analyst? How does the analyst manage to play the dual roles of participant in something being created by the two members of the psychoanalytic dyad, and of treating clinician whose responsibility is to provide assistance to the analysand? How does the analyst accompany the analysand, that is, in what is after all a treatment process in which the analysand has chosen to wrestle with his or her problems in order to become free from internal entanglements that create emotional distress and interfere with the pursuit of happiness and fulfillment in life?

A further very important but thorny question involves what is created by the analysand and the analyst on the analytic stage. More and more attention is being paid to the extent to which what is created is not merely a re-creation of the analysand's past, but something entirely new that, although inevitably influenced by what each participant brings to the interaction from his or her past, goes beyond the impact of the past so as to reach toward the future. There is increasing interest in psychoanalysis in the concept of a third participant, situated between and created by the two participants in the psychoanalytic process, which must be recognized, explored, and come to terms with in the interest of obtaining resolution of the problems brought to the interaction by the suffering patient.

To what extent do analysand and analyst need to examine, understand, and transform what the two of them have created—as a means not only to gain access to what has been troubling the analysand, but also to create a way to overcome it, to move beyond it, and to replace it with something new and better via an act of joint creativity?

Madeleine and Willy Baranger have been addressing this question for decades, in a series of papers that focus upon the analytic field and upon what is created within it by analysand and analyst—what is created, that is, that can provide tools for conquering the past and creating a future that can be used to free the analysand to pursue the kind of life for which he or she has been yearning.

As our commentators note, the Barangers' work has been much better known in Europe and in South America than it has in North America. The publication of *The Work of Confluence: Listening and Inter-*

preting in the Psychoanalytic Field, which contains their collected papers, can help to redress this imbalance. In the review and the review essay that follow, Montana Katz and Richard B. Zimmer, respectively, examine the Barangers' ideas about this very important topic. We expect that our readers will find their thoughts about the book both informative and thought-provoking.

MARTIN A. SILVERMAN

THE WORK OF CONFLUENCE: LISTENING AND INTERPRETING IN THE PSYCHOANALYTIC FIELD. By Madeleine and Willy Baranger. Edited by Leticia Glocer Fiorini. London: Karnac, 2009. 254 pp.

The innovative and truly path-breaking work of Madeleine and Willy Baranger is scantily known and poorly understood amongst North American psychoanalysts, while in Europe and South America their unique psychoanalytic perspective is highly valued. Over half a century ago, they described a new psychoanalytic model involving a particular kind of space they called the *analytic field.*[1] In *The Work of Confluence: Listening and Interpreting in the Psychoanalytic Field,* important clinical and theoretical applications of this model are explored.

This is an unusual, challenging, and deeply rewarding book. The writing itself is highly original, elegant, clear, and thoroughly engrossing. This collection is essential reading for anyone interested in the fundamental tenets of psychoanalysis and their clinical application.

The Work of Confluence consists of a collection of ten previously published essays as well as a foreword by Claudio Laks Eizirik and final comments by the editor, Leticia Glocer Fiorini. The ten essays include papers co-authored by Madeleine and Willy Baranger, by the two of them with Jorge Mario Mom, and by each of the Barangers individually. They were first published between 1961 and 1987, and six of them have not previously been translated into English. While all of the papers were written some time ago, the concepts and insights offered are still fresh and innovative today; it is unfortunate for English-speaking analysts that they were not translated into English earlier.

In addition to the concept of the analytic field, the Barangers introduced related clinical concepts. For example, impasses and stagnation in the analytic process are called *bastions.* These are understood as blockages that require the analyst to review the field; this process of review is referred to as a *second look.* These concepts and others have led to a new psychoanalytic paradigm that can be employed as the basis from which to explore and understand the fundamental concepts of psychoanalysis. The book's essays allow the reader to embark on just such an explora-

[1] See Katz, M. (2010). [Review of] *The Analytic Field: A Clinical Concept,* ed. A. Ferro & R. Basile. *Psychoanal. Q.,* 69:864-869.

tion; readers who have been content to use familiar concepts without scrutiny will be alerted to gaps in the foundation on which their clinical work rests, and simultaneously they will be provided with needed "cement." For example, the book includes discussions of the basic concepts of *analytic material* and *analytic insight*.

In the Barangers' model, the analytic field is bipersonal, asymmetrical, and includes all aspects of the analytic situation. The field has an unconscious dynamic that is different from the unconscious processes of either participant in the field. There are also fantasies of the field, including what is called the *basic fantasy*, which is the object of study within an analytic process. Given that the field contains a unique unconscious, it follows that something genuinely new to the analysand can emerge in the field.

The Barangers' model brings light to gray areas where there has been cause for clinical and theoretical confusion. For example, some of the debates related to models of one- and two-person psychologies revolve around the locus of therapeutic action; therapeutic process has been conceived as centered in the mind of the analysand, the analyst, or both. The first two of these ideas have been studied throughout the history of psychoanalysis, and it is arguable that neither has held up as a unitary solution. But if therapeutic process is centered in the minds of *both* analysand and analyst, then the way in which these two separate minds are bridged so that interaction is meaningful must be understood. In other words, a psychoanalytic model must account for what has to take place between the two participants in order for meaning to be made and change to occur.

Looming questions in psychoanalytic history, which have continued into the present, are whether or to what degree mental functioning is intrapsychic or idiosyncratic. A related question is whether or to what degree mental functioning occurs by means of generalized transferential processes. Further issues arise concerning the location of the analyst: should he or she be considered partially or fully inside the process, outside of it, or both? The latter, in this case, has been a common position, but also, arguably, one that has not held up over time. Thus, if the analyst is inside the process, how effective analysis can take place requires

explanation. These questions find unique answers in the light of the Barangers' model.

According to the Barangers, the locus of therapeutic action is the field. Once the participants enter into the analytic relationship, a unique field is born. The title of this book, *The Work of Confluence,* seems not entirely suited to capturing the nature of the field, however; an analytic field is intended as more than the meeting or flowing together of the unconscious processes of the participants. It is instead akin to a chemical reaction in which something new is created, something with a different structure, from the same ingredients. The field is a third space, an organic, independent one in which fantasies as unconscious metaphorical processes unfold.

The field envelops the participants for the period of time spanning the analytic process, and it also exists between them. Neither analyst nor analysand has control over the evolution taking place in the field, nor can either fully survey the field. Both participants are wholly in the field and each is struggling in an idiosyncratic fashion within the process. Their positions are asymmetrical: the analysand free-associates out loud, while the analyst's associations are not spoken. Furthermore, the analyst has specialized training that affords a perspective and ability to work with both sets of associations in and on the field, differently from the analysand.

Each chapter of *The Work of Confluence* exhibits a way of using the model, applied to specific subject matters. A common strand in the essays is an exploration of different aspects and components of the analytic process and how it can effect change. This includes a look at what happens—and also what might occur—when analyst and analysand talk over time within the structure of the analytic setting. Part of what is described is how the participants, each with a unique unconscious process and unique fantasies, become immersed in, create, and are created by the analytic field. Words uttered by each may contribute to the dynamic of the field, which they may lead to change and the possibility of new experience, differently so for each participant.

Chapter 1, "Insight in the Analytic Situation," provides a detailed articulation of the concept of psychoanalytic insight. It is noted that analyst and analysand evolve a common language as they work together; this

language is used to speak about and understand the analysand's communications—the metaphors with which he or she thinks and speaks, including those of underlying unconscious fantasies. Discussion and the common language are forged by both participants and thus incorporate ingredients from the analyst's understanding and fantasies.

The common language expresses derivatives of the unconscious of the field. The participants' understanding of each other by means of this common language is complex, utilizing the channels of understanding the other that are necessarily different in each participant. In order for meaning to be made or discovered in the field, bipersonal understanding must take place; that is, the understanding must run in both directions at the same time.

The concept of analytic material—what the analyst works with in formulating interpretations—is the subject of chapter 2, "The Notion of Material and the Prospective Temporal Aspect of Interpretation." Analytic material consists of the analyst's understanding of communications from the analysand, together with the way in which this understanding leads to an interpretation. Analytic material necessarily involves bipersonal understanding. The analysand's communications that do not lead to interpretation do not constitute material of the analytic process.

Within the unconscious process of the field, patterns of repetition emerge that engage both participants and from which both need to be extricated. These patterns in the field are not straightforward repetitions by the analysand; rather, they are repetitions of the field itself that may reveal aspects of the analysand's experience. Such aspects are not only based in the analysand's past experience, but are fused with it. Repetition forecloses the possibility of the present and therefore of the future.

It is the task of the analyst, through interpretation, to unravel the meanings of this pattern. In *The Work of Confluence*, this is dramatically described as the rescuing of both participants from a cycle of repetition in the field. Thus, the analyst is both involved in the fantasy of the field, and at the same time can use analytic technique to survey the field and interpret the meanings of its dynamic.

This surveying of the field by the analyst may lead to the discovery of a *point of urgency* in the field, the place at which a fixation is located. This in turn may lead the analyst to arrive at analytic insight and the formula-

tion of an interpretation. The core of chapter 3, "Spiral Process and the Dynamic Field," is a discussion of the role of interpretation in breaking the cycle of repetition. Interpretation restores the possibility of temporality for the analysand. What emerges is the prospect of an unfolding of the future, in place of the fusion of present and past. When a point of urgency is discovered in the present and interpreted, the discourse delves into the history of the analysand, and this history thereby becomes structured. In this way a greater understanding emerges, allowing the analysand and the field to move forward into the future, having dislodged something from a frozen state.

Over sessions, this process continues, affording greater depth of understanding of the history of the analysand and of the field. Incrementally, this allows for greater freedom of movement in the present and therefore into the future. Interpretation aimed at structuring the past and opening up the future also gives meaning to temporal dimensions, leading to a characterization of the analytic process as the location of both regressive and progressive, bipersonal movements in the field.

A discussion of impasses and blockages within analytic processes more generally is found in chapter 4, "Process and Non-Process in Analytic Work." This chapter contains a discussion about the process of the analyst taking a *second look,* forms of *bastions,* and indications of the movement or lack thereof within a psychoanalytic process. Movement within the process is ultimately characterized by affect mobility and the convergence of variations in the narrative. Along the way, indications of movement are noted, such as new access to childhood memories, alternating moments of blockage and affective mobilization, surges of feeling, and the transformation of transference and affects. Lack of movement consists in an immobilized, unrecognized structure in the field; both analyst and analysand participate in the existence of such a bastion. Such structures are described as either *parasitic* or *symbiotic.*

Insight is the elaboration of the field by means of the analyst's interpretation, together with the analysand's understanding of this. Insight is specific to a moment in the analytic process and occurs relative to the particulars of the field. Moreover, insight involves bipersonal understanding. An interpretation that does not reach the analysand does not lead to psychoanalytic insight; that is, an interpretation meaningful to

the analyst alone will not contribute toward opening repetitive patterns to change and the possibility of a genuine future tense for the analysand. The analyst formulating and expressing an interpretation, and the analysand understanding and taking in the interpretation, are different aspects of one and the same process. Something new necessarily emerges in this process—for both participants.

Chapter 5, "The Mind of the Analyst: From Listening to Interpretation," continues to elaborate the process of arriving at analytic insight. This chapter offers a fascinating exploration of the mental functioning of the analyst within an analytic process—in particular, what happens in between the analyst's listening to the analysand's communications, and the point at which the analyst arrives at an interpretation. It is here that the search for the present *point of urgency* in the field takes place. This search entails the analyst's attention to the analysand's communications, to the unconscious structure of the field, and to meanings that are emerging but not yet fully evident. When the analyst perceives how the current fantasy of the field and the dialogue between the participants fit together, the point of urgency has coalesced in his or her mind; this perception is then ready to be formulated in an interpretation.

Many other subjects are explored in these essays, all of which are illuminating and valuable. There are discussions about personal history versus genetics, mourning, the relationship between trauma and the death instinct, the crucial roles of fantasy and *nachträglichkeit* in trauma, and the distinction between trauma and "pure" trauma, among other topics. All these discussions contribute to a view of the clinical application of the model of the analytic field. And each of the subjects addressed is in itself of great significance to psychoanalysis.

Whether or not one fully agrees with or adopts this model clinically, it would be impossible not to be absorbed by the discussions in *The Work of Confluence*. Because of the breadth of the subject matter covered, and because the book is composed of a collection of individual papers, there is some repetition of basic theory; however, this reviewer did not find this distracting, and in fact at times found it helpful to read different formulations and consider different aspects of the theoretical arguments.

The Barangers and their colleagues offer psychoanalysis not only a clinical model of great interest, but also one of analytic thought and ex-

position. They have taken the analytic process with which all analysts are familiar and provided an alternative framework for it, incorporating a new vocabulary to explore what happens in that process. They offer not only a new language, but also a new way of looking at analytic work—one that clarifies the relevant issues as it untangles very old, entrenched knots. At a minimum, the Barangers have devised a heuristic picture that captures clinical process.

The contents of this book, even though originally written decades ago, point the way to the future of psychoanalysis, in my opinion. In that future, the concept of a psychoanalytic field will become increasingly familiar to practicing psychoanalysts in all corners of the world. Grappling with the model that the Barangers created and its applications may well prove to be an essential next step for the evolution of psychoanalysis.

MONTANA KATZ (NEW YORK)

A VIEW FROM THE FIELD: CLINICAL PROCESS AND *THE WORK OF CONFLUENCE*

BY RICHARD B. ZIMMER

Keywords: Field theory, analytic theory, bipersonal field, basic unconscious fantasy, bastion, "second look," temporality, *nachträglichkeit,* spiral process, one- and two-person psychologies, intercultural issues, sociopolitical impact.

The publication of *The Work of Confluence: Listening and Interpreting in the Psychoanalytic Field,* by Madeleine and Willy Baranger, edited by Leticia Glocer Fiorini (Karnac, 2009), marks an important moment in the development of clinical theory in psychoanalysis. It makes the bulk of the pioneering work of the Barangers (as well as that of Jorge Mario Mom, who coauthored two of the papers in the book) readily accessible to the English-speaking psychoanalytic community for the first time, in fluent English translation and collected into a single volume. (Many of the Barangers' lesser works remain unavailable in English. Another major work, published originally in Spanish in 1961–1962, first appeared in English translation only recently [Baranger and Baranger 2008], and is not included in this volume.)

Taken together, the papers in this book constitute a reenvisioning of the nature of the psychoanalytic process, the therapeutic action of psychoanalysis, psychoanalytic technique, and the structure and workings of the unconscious. Ferro (2010) calls the concept of the analytic situation as a bipersonal field an "earthquake" in terms of its power to shake up and reconfigure our thinking about the psychoanalytic process. The Barangers draw on the work of Pichon-Riviere, Klein, Bion, Racker, Merleau-Ponty, and the Gestalt psychology of Kurt Lewin. The breadth and depth of their understanding of Freud's work, and their capacity to articulate nuances of the analytic process in a way that resonates with the clinical experience of all practicing psychoanalysts, draw the reader

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into a process of reexamination of many of his or her basic theoretical assumptions and technical approaches.

The absence of any detailed clinical material is a frustrating aspect of this book; for the reader who is not already a convert to the Barangers' model, it can be all too easy to be swept along by the cogency of their abstract ideas about the nature of clinical process and to avoid thinking through what it would look like and feel like to put these ideas into practice in the actual clinical situation, and what difficulties might be encountered. That said, and despite their somewhat revolutionary quality, these ideas nonetheless invite dialectical engagement.

THE MAJOR CONCEPTS OF BARANGER AND BARANGER

The Bipersonal Field and the Basic Unconscious Fantasy

For Baranger and Baranger, it is the *dynamic bipersonal field*, rather than the individual psyche of the analysand, that is the central focus of psychoanalytic inquiry. The field is an outgrowth of a *mutual* regressive process between patient and analyst that characterizes the psychoanalytic situation and gives rise to a *basic unconscious fantasy* of the couple. This fantasy is different from, and not simply the sum of, the individual fantasies of each of the participants; rather, it is the freshly created, shared, co-constructed fantasy of the patient/analyst couple that manifests in the unfolding process between them. This shared basic unconscious fantasy is the source from which spring the individual transference and countertransference fantasies of the two participants.

Interpretation, then, is both about and within the field; it is simultaneously a playing out of the basic unconscious fantasy, and meant to disclose unconscious content. The primary focus of attention is on the present moment of the analysis; although the past is relevant, it is the experience of the present moment as part of the unfolding story of the bipersonal field, rather than "facts from the past," that the analytic couple seeks to elucidate. In interpreting, the analyst aims not so much to shed light on the patient's functioning outside the analysis and its links to the past, as revealed in the transference, but rather to rescue both himself

and the patient from micropsychoses that develop within the field; patient and analyst are "in the same boat."

The analyst in this model is not a neutral observer of phenomena who must occasionally right his own lapses of neutrality; rather, his subjectivity is constantly engaged and is always a part of the phenomena being observed. For Baranger and Baranger, analytic listening is diametrically opposed to the model of the neutral observer in the natural sciences.

The Bastion and the "Second Look"

When the field is functioning properly, there is a process of its natural evolution in which there is an ongoing redistribution of parts of patient's and analyst's inner experiences as they come together within the field; this process is set in motion by the establishment of the analytic frame and the contract of the fundamental rule. But inevitably, obstacles to this natural evolution arise and the process becomes stalled. These are the result of pathological crystallizations within the field—contingent structures that are created between patient and analyst, which silently undermine the process established by the structure of the analytic frame. These contingent structures become established when one member of the analytic pair splits off some area of his or her mental life (and thus the parts of the field that would include this split-off area), and the splitting-off process meets with the unconscious compliance of the other member of the pair.

The Barangers call these pathological structures *bastions*. The bastion presents a particular clinical challenge: not only is it a structure that is unconscious and ego-syntonic for both members of the pair, but it also involves elements of the field that provide a sense of positive attachment between patient and analyst being mobilized against the process that is the purpose of the establishment of the field. Often these elements may involve, for example, shared unconscious fantasies about the nature of the patient's "illness" and the means by which "cure" is going to occur.

For Baranger and Baranger, the identification, elucidation, interpretation, and dissolution of these bastions are central events in the analytic process; but working effectively with the bastions involves the recogni-

tion of the analyst's dual role in the analytic field. On the one hand, the analyst is the establisher and enforcer of the frame, and in this role functions as the patient's "present interlocutor," listening to and helping the patient understand "non-field" material; on the other, he or she (henceforward "he") is a willing, perhaps even driven, participant in the establishment of bastions that undermine the analytic process. Bringing these bastions into the analytic process requires the analyst to step back and take a *second look* at the *non-process* aspects of the situation in which he participates and, by interpretation, brings them into the process.

Temporality

While maintaining respect for the importance of the past in the origin of psychic symptoms, the Barangers question—and ultimately discard—the archeological model of psychoanalysis as put forward by Freud (1930). Further, they point out that Freud's concept of the *timelessness of the unconscious* is a shibboleth that has been widely misunderstood and misused. Indeed, this concept—first described in 1911—actually refers to an attribute of primary process thinking, which Freud believed (at that time, before the advent of the structural theory) to characterize all contents of the unconscious.

For the Barangers, the unconscious has a temporal organization, and every mental content that presents itself in analysis has a past, present, and future dimension. Psychopathology involves confinement in the past—and the more confined the individual is in the past, the more the future disappears. A technical approach that is organized around the archeological model—focused on the idea of the lifting of repression and the "uncovering" of a veridically true past—splits off both the future dimension and the implicit demand for change in an interpretation; such a shared vision of the analytic process becomes a form of bastion.

It is, for Baranger and Baranger, Freud's concept of *nachträglichkeit*—that early events derive meaning retrospectively from later events and from a different temporal perspective—that should guide our understanding of the actual data of psychoanalysis (that is, the events within the field, in the present). Further, it is through the operation of *nachträglichkeit* that interpretation in fact derives its power to enable psychic change. Psychoanalytic insight works not so much by uncovering memo-

ries that explain the present, but by a process of historicization, wherein a retrospective narrative of the patient's past is constructed that enables a redistribution of psychic contents among the temporal realms of past, present, and future. The past is neither discovered nor erased, but it is more clearly differentiated from the present and the future.

Spiral Process

The Barangers borrow and expand upon Pichon-Riviere's concept of *spiral process* to reimagine the unfolding course of the psychoanalytic process and its mechanism of action. As the analyst listens to his patient's associations, he pays special attention to the immediate events within the analytic field, as well as the field's basic unconscious fantasy. He looks for a *point of urgency*—a moment in which the manifest dialogue of the session and the basic unconscious fantasy converge—and makes an interpretation, implicitly or explicitly bringing together past, present, and future dimensions of the psychic event being interpreted.

As patient and analyst engage in further dialogue about the event and the interpretation, both elements of the past and the vision of the future are understood in a new way in the light of the present moment's fresh understanding, and there is a resulting shift in the shared basic unconscious fantasy of the analytic couple moving forward. It is a process in which the unfolding story of the present sheds light on the past and the future, rather than one in which the unfolding story of the past as manifest in the transference sheds light on the present.

A CLINICAL VIGNETTE AND A "SECOND LOOK"

A "second look" at a fragment of my own clinical work through the lens of Baranger and Baranger's model helps me understand its clinical usefulness, and raises questions in my mind about its relationship to other models of the psychoanalytic process.

Case Vignette

Ms. D, a gifted professional woman in her early thirties, had initially come with concerns about her inability both to find direction in her

work and to become seriously involved in any lasting romantic relationship. Now, after a number of years of productive treatment, she had fallen in love and was engaged to be married.

From the beginning of our work together, I had found her a motivated, talented, and gratifying patient. She was curious about the meaning of her feelings, had a good feel for the workings of the unconscious, and reported dreams and worked with her associations to them; her inner world seemed to grow richer through our work together, and she used insights gained in her treatment to make changes in her life.

As her marriage approached, Ms. D found herself relinquishing control of most of the concrete details of her wedding to her mother, from whom she had gained autonomy and emotional distance only with great struggle. At the same time, her sessions became increasingly filled with details of flowers, invitations, and seating arrangements. I felt slightly bored and longed for the more emotionally complex, nuanced quality of our earlier work together; at the same time, I found myself feeling intensely and uncharacteristically opinionated about some of the wedding details, and often had to restrain myself from intruding on Ms. D's discourse with my opinions.

I was reminded of Ms. D's mother, whom I had gradually come to see as omniscient, imperious, and having a capacity for recklessness and cruelty in the service of doing things in what she felt was "the right way," despite Ms. D's initial benign depictions of her. I felt inhabited by Ms. D's mother, and I wanted to begin to demonstrate to Ms. D how her tone, actions, and ways of using the treatment were re-creating the relationship with her mother that she had come to find so noxious. I said to her that as her wedding approached, it seemed she wanted me to assure her that she was doing everything in just "the right way"; that perhaps it would even be reassuring to have me overrule her if I felt she was doing something wrong, and that it seemed very much like her earlier relation with her mother, which she seemed to be falling back into.

Ms. D responded: "When you say I want to be overruled, it makes me think of when I broke off with L" (a man with whom she had seriously pursued an earlier relationship, which had had disturbing sadomasochistic overtones). "I remember thinking afterwards that I was surprised

you hadn't advised me to break off with him. Would you have just let me go ahead and marry him if I decided to?"

I felt somewhat surprised at this revelation. I remembered that, during the time she had been involved with L, I had been quite concerned by the relationship and pointed out to her quite actively—I wondered often if it bordered on an abandonment of neutrality—aspects of L's behavior, and the feelings and actions engendered in Ms. D by that behavior, that gave me cause for concern. And when she had finally broken off the relationship (although somewhat in a fit of pique), I had believed it was at least partly out of an understanding she had gained from that work.

I said to her that I had believed I was working hard to call her attention to the problematic aspects of her relationship with L, but at the same time had had to respect her autonomy and could not come out and tell her how to lead her life. Ms. D laughed softly. "Yes, I suppose you were. And now I realize that, as it was going on, I wasn't even telling you the worst of what was happening between me and L."

The tone of our work together shifted after this session. Ms. D seemed sobered by the idea that she bore responsibility for her own actions and decisions. With this, there came an increased sense of mistrust of me and the motives for my interventions, and a greater awareness of moments when my own personal interests might not coincide with hers. She remained able to work with her feelings productively, and much valuable work ensued in the context of this shift in our relationship. But there was an idyllic feeling between us about our work together that was lost for good.

A Second Look in This Analysis

Ms. D's unexpected response to my interpretation made me think that a bastion had crystallized in our work together, and I went back and reconsidered what complicity, beyond being a container for Ms. D's projections, I might have had in the impasse we had reached. Ms. D was a patient who made me feel very good about my work. She provided a great deal of material that lent itself to processing with my favored theoretical models. She had benefited substantively from the treatment and

readily acknowledged this. I felt that my thoughts and ideas were powerful, and that I knew everything I needed to know in order to help her. Further, Ms. D was bright, beautiful, hardworking, lively, and engaging. I felt great confidence that she would find love, and that I would help her overcome her neurotic obstacles to doing so.

My feeling of boredom as she planned her wedding should have been the tip-off that a bastion was crystallizing and that "non-process" was taking over our work. Perhaps I waited until the bastion was a bit overripe, and projective aspects of our interaction had intensified to such a degree that I felt uncomfortably disidentified with the feelings of omnipotence that were stirred in me by my work with Ms. D. Drawing on this countertransference, I had suggested to Ms. D that she wanted me to reassure her she was "doing things the right way," and perhaps even overrule her—a comment on the here and now of our interaction—and speculated she was re-creating with me her earlier relationship with her mother, implicitly inviting Ms. D to return in her associations to her past and her relationship with her mother.

Ms. D responded by bringing our dialogue back—not to the antecedents of the current situation in her earlier relationship, but to the history of our relationship together, which would be more in accord with the Barangers' technical approach. She brought us back to a difficult moment in our relationship that we had conspired in papering over. Ms. D had realized that I could not be relied upon to protect her from her own wishes and actions. And I had realized that there was danger in Ms. D's autonomy—that she could easily choose to be in an abusive and demeaning relationship, that she had her mother's capacity for recklessness and cruelty at times, and that I could not necessarily stop her from being destructive without abandoning technical principles that were important to my sense of professional identity.

Ms. D "rescued" us from having to look together at these unpleasant realizations by taking it on herself to break off with L, and we conspired to look away from our disillusionment with one another, replacing it with an illusory, shared narrative of talented analyst and talented patient working congenially together toward an inevitable happy ending. This enabled us to do some valuable work together, but also led to a gradual impoverishment of the treatment, as all material that threatened to touch

on the split-off aspects of the field had to drop out of our discourse—at least until the "happy ending" appeared to be presenting itself.

A Third Look

My "second look" convinced me that close attention to the analytic field, an increased sensitivity to the development of impasse, and the analysis of the bastion through close attention to the history of the field as it evolved could open up important areas of exploration, and could also provide more rapid access to a certain sphere of intrapsychic life than the "archeological" approach. I could see how technically keeping close to the evolution of the field lent itself to the revision of the narrative of the patient's personal past occurring through *nachträglichkeit*. This revision felt more intellectually satisfying than those that would be made through reconstruction of hypothetical past events or relationships, and this kind of insight lent itself more readily to a simultaneous revision of the vision of the future than did "reconstructive" insights, which implicitly emphasize the degree to which the patient remains a prisoner of the past.

After this session, Ms. D retrospectively became much more aware of the degree to which her submission to her mother was motivated by her wish to be protected from error and to ensure a "right" outcome for herself in all things; she understood that, going forward, thinking for herself would involve tolerating the anxiety that she might make mistakes she would later regret, as well as accepting greater responsibility for her decisions and actions.

Still, I was unwilling to discard as irrelevant my observation that Ms. D was re-creating the past in her relationship with me through projective mechanisms. I still believed it to be true, and believed that ultimately it would be useful to Ms. D to see what she was doing and how she was doing it. I felt that, had I been more sensitive to the developing impasse and made an interpretation drawn from consideration of the field earlier on, the projective re-creation might not have crystallized to the degree it did, and whatever benefit that would derive from its examination would have been lost. I wondered if, just as important material could be neglected through ignoring data from the analytic field, it might be that

other important material might be neglected by strict adherence to the technical approach the Barangers seemed to be prescribing.

ONE-PERSON PSYCHOLOGY, TWO-PERSON PSYCHOLOGY, AND FIELD THEORY

The current generation of psychoanalysts has seen the rise of a two-person model of psychoanalytic investigation that has gradually come to supplement, and in some ways to supplant, the one-person model. One-person psychologists adhere to a vision of the analyst as neutral scientific observer whose subjective experience of and with the patient is relevant primarily as an impediment to his capacity to objectively observe the workings of the patient's inner life.

Two-person psychologists acknowledge the subjectivity of the analyst as inevitable, and view the mutual impact of patient's and analyst's projections on each other as a fruitful, perhaps even the central, focus of psychoanalytic investigation. Field theory takes this progression one step further by focusing not on the mutual impact of two individuals on each other, but on the spontaneously created, inextricably shared, and co-constructed unconscious fantasy of the couple that patient and analyst elaborate as they interact.

Each of these models limns out its own observational realm of data that it privileges as the central data from which psychoanalytic inferences may be drawn, and each prescribes its own method of processing this data. It might then be said simply that each model is of value in understanding a particular realm of psychic experience and is less useful in understanding others, except that there is an implicit hierarchical organization among these three realms of data, which moves from a position of sharply defined interpsychic boundaries in the one-person model to one in which greater fluidity or even dissolution of boundaries prevails.

While it might be said that this hierarchy traces a reverse developmental line in terms of the establishment of psychic boundaries between self and object, from the point of view of our capacity as analysts to observe and process clinical data, each of these models builds on the foundation of the previous, more well-bounded (and, in terms of the development of psychoanalytic theory, historically earlier) model, and the

analyst needs the understandings that the hierarchically more boundaried models offer in order to comfortably and productively observe and process the data from the less boundaried models. While it is possible for an analyst working in the two-person psychology model to ignore data gleaned from observation of the field, and it is possible for an analyst working in the one-person model to ignore data both from the field and from evoked countertransferences, the reverse is probably less true, and an analyst working in either of the latter two models is, to one extent or another, always moving back and forth between observational realms of his primary model and those of hierarchically "lower" ones.

Even to the degree that it is possible, it seems to me that it is not particularly desirable to attempt to discipline oneself to an exclusive attention to the evolution of the field. Exclusive attention to any one realm of observation can be used in the service of avoiding important data from other realms. The Barangers themselves point out that there is no single "therapeutic action of psychoanalysis," but rather a multiplicity of actions, and, similarly, in an analysis that is conducted with attention to all three observational realms, the establishment of the analytic frame sets into motion a number of processes that proceed simultaneously, and that, optimally, move forward synergistically. Privileging any of these processes as "the" analytic process can give the analytic pair a comforting sense of having a trajectory and a road map, but I think it imposes a false linearity on the whole process—one that is, in the end, not an accurate vision of the way analysis works, and not in the service of maximizing the therapeutic potential of that process (or, more accurately, the group of interconnected processes).

Still, the "spiral process" that derives from the examination of the evolution of the analytic field is one that I think clinical analysts can ill afford to ignore. The data of field theory, with its focus on unconscious mental contents shared by two individuals, may bring under analytic scrutiny psychic contents that might otherwise escape attention, that are intensely anxiety-provoking for both patient and analyst, and are defended against for both by the establishment between them of an illusory feeling of one-ness, which on its surface appears to be anxiety-free. Because they are usually organized around the vision of the shared task that, in reality, patient and analyst come together to carry out, the

mini-*folies à deux* that constitute the bastions are unlikely to come under scrutiny unless there is an active search for them.

Further, because field interpretations focus on psychic contents that are not only shared between patient and analyst, but also—for each member of the pair—condense elements of present reality, impressions from the past, and received projections from the other member, they have an undeniably here-and-now quality, serving both to draw together and to consolidate insights derived from other modes of observation. And, as the Barangers assert, field interpretations also serve to mobilize revision of the understanding of both past and future.

FIELD THEORY, THE CULTURE-BOUNDNESS OF PSYCHOANALYTIC THEORIES, AND THE CHALLENGES OF INTERCULTURAL PSYCHOANALYTIC DIALOGUE[1]

The Barangers' vision of the psychoanalytic process casts fresh light on the matter of the culture-bound quality of psychoanalytic theories. The centrality of interacting subjectivities to the Barangers' model underlines that psychoanalysis is a science whose subject is the individual rather than the universal, as paradoxical as such a concept might be; that each analysis is unique in both content *and* form, with the evolving form being part of the studied content; and that form and content are determined by the subjectivities of the two participants, which are, in turn powerfully influenced by the cultural milieu from which each springs—and, of particular note, of that sector of the cultural milieu that the two individuals share. Further, culture not only has a powerful influence on the content of the unconscious fantasies that the two participants bring to the analysis and then on those they elaborate between them, but also influences the way in which unconscious experience is organized.

"Regionally" prevailing psychoanalytic theories (e.g., American ego psychology, British object relations theory, Francophone Lacanianism) are likely to be drawn from clinical material that is to some extent cul-

[1] I am grateful to Drs. Antoine Corel and Haydée Faimberg for personal communications about psychoanalysis in Argentina and the facilitation of international psychoanalytic dialogue, which have stimulated my thinking on these topics.

ture-specific. Though these theories may describe universal human phenomena, these phenomena are inevitably shaped by indigenous influences; and these influences affect the degree to which these phenomena manifest themselves, as well as the manner and situations in which they do so. For example, American ego psychology took hold in the United States under the influence of a generation of analysts who had emigrated from Europe and encountered American culture with its particular qualities of optimism, materialism, and pragmatism. Thus, a theory of mind emphasizing adaptation and the centrality of a forward developmental thrust might well have had special appeal and utility to these analysts, who were encountering the specific concerns of their American patients and struggling themselves with the adaptive demands of the immigrant experience.

The French language, with layers of ambiguity introduced by its particularly homophonous quality as a spoken language (and the related skew toward context as a means of fixing the meaning of the spoken word), may have provided fertile ground for observation of the ways in which language operates to structure and organize unconscious experience. And certainly, Freud's original formulations on the psychology of women, and the centrality of the repression of sexual wishes in his theory, have long come under criticism as specific to the culture of upper-class Vienna in the late nineteenth and early twentieth centuries.

It is important, I think, to see the culture-boundness of psychoanalytic theories drawn from clinical data as not only inevitable, but also as not simply being an "artifact" that invalidates or detracts from the clinical usefulness of those theories. Rather, I would see each cultural milieu as bringing forth and highlighting its own particular way of organizing mental experience, and thus shedding light on another aspect of the wide variety of potential modes of mental organization. The analyst who is able to "import" pieces of psychoanalytic theories spawned in different cultural milieus may thus have his attention called to aspects of mental functioning that are present, and potentially important, but more obscured by his, and his patients,' immersion in their own cultures.

The Barangers immigrated to Argentina as professors of philosophy and classical literature in 1946, and became caught up in the burgeoning psychoanalytic movement there. It was the same year that Juan Perón,

who had seized power in a military coup in 1943, was elected president of Argentina. Perón was overthrown and exiled in 1955. Decades of alternation between elected civilian governments and dictatorships established by military takeover of the government ensued. Perón returned from exile in 1973 and was reelected president; his death in 1974 set the stage for yet another coup in 1976, which established a particularly brutal military dictatorship, lasting until the restoration of civilian government through the democratic election of Raul Alfonsin in 1983. In July 1989, when President Alfonsin was succeeded by a constitutionally elected successor, it was the first time in sixty years that such a transition had occurred.

The papers in *The Work of Confluence* span the time period between 1958 and 1994. Interestingly, the earliest published paper in the collection is entitled "The Ego and the Function of Ideology" (1958), and suggests to me the impact of political repression and turmoil on the inner lives and thinking of both patients and analysts during this era.

Though of course it is a conjecture that would be difficult—if not impossible—to prove, it seems to me that the importance of *nachträglichkeit*, both as an organizer of the unconscious and as an engine of therapeutic action in psychoanalysis—as well as the concept of unconscious dimensions of temporality—may have had particular resonance with the clinical experience of analysts practicing in this kind of political milieu. In an atmosphere in which repeated political upheavals cause rapid shifts and discontinuities in social, economic, and political reality, it may be that *nachträglichkeit* becomes a particularly well-exercised mental muscle, and that sharper lines of demarcation between unconscious realms of past, present, and future come more to the fore than in other cultural environments where mental forces that tend in the direction of condensation of these realms obscure their distinction.

In order to benefit maximally from the intercultural exchange of psychoanalytic ideas, it is necessary to resist the natural inclination to translate new ideas into the idiom of our own theoretical systems in order to consider and evaluate them. I think we need to first focus on the universal language of description of clinical phenomena (though even our descriptions are colored to some extent by our theoretical models), and then try to listen to new theoretical models on their own

terms and in their own idiom, testing these models against the clinical situations that have been evoked for us, rather than against our own "competing" theoretical models.

We should also consider the cultural conditions in which these ideas have been generated, keeping in mind that our own theories are also culture-bound in ways we may be less aware of. The psychoanalytic reader who is able to approach the work of the Barangers in this way will find his technical armamentarium much expanded, and his understanding of the clinical situation greatly enriched.

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PARTNERS IN THOUGHT: WORKING WITH UNFORMULATED EXPERIENCE, DISSOCIATION, AND ENACTMENT. By Donnel B. Stern. New York/London: Routledge, 2010. 229 pp.

Partners in Thought: Working with Unformulated Experience, Dissociation, and Enactment is Donnel Stern's follow-up to an earlier very interesting and important first volume of his.[1] In the present work, he extends his exploration of the relationship between dissociation and the theory of multiple self-states to the conceptualization of enactments, and continues to explore the implications for psychoanalysis of social constructionism and hermeneutics (the latter as particularly advanced by Gadamer[2]).

At the core of Stern's argument is the belief that "relatedness is the nexus from which experience emerges" (p. 4)—that is, that all unconscious meaning is emergent and relationally determined rather than preformed and hidden. While this view allows for a wide degree of plasticity in terms of what any given element of experience, internal or external, might be seen to mean, Stern is careful to add that not just any meaning is possible. Meanings are restricted in their range by the limits of reality, past and current, by what has come before (preexisting structures of meaning), and by the emergent influence of the present (relational) moment (p. 2).

What Stern is most concerned with clinically are the meanings that are imputed and constructed about one's state or sense of self. Thus, he repeatedly stresses the point that only those perceptions that we can stand to know about ourselves can reach the level of formulation and emerge into awareness. In this he closely follows the work of Sullivan, who organized his observations of clinical data around those self-states and self-perceptions that could be comfortably tolerated and those that could not. In Sullivanian language, which Stern adopts, these self-states and self-perceptions are designated *me* and *not-me,* respectively. This formulation provides a pragmatic tool for parsing and observing clinical

[1] Stern, D. B. (1997). *Unformulated Experience: From Dissociation to Imagination in Psychoanalysis.* Hillsdale, NJ: Analytic Press. See also Levine, H. B. (1999). [Review of] *Unformulated Experience: From Dissociation to Imagination in Psychoanalysis,* by D. B. Stern. *Psychoanal. Q.,* 68:313-316.

[2] Gadamer, H.-G. (1965). *Truth and Method,* trans. J. Weinsheimer & D. G. Marshall. London: Continuum, 2004.

data, and is the foundation and rationale for the heart of Stern's argument, which I will attempt to summarize in six primary points:

1. Rather than a unitary and integrated sense of self, each of us possesses multiple self-states of various affective colorings that are more or less closely connected and more or less accessible to consciousness. The less connected, the more likely they are to be deeply unconscious. What determines accessibility to consciousness is the extent to which we can bear recognizing a particular self-state ("me") and the qualities associated with it. Since all experience is assumed to emerge from unformulated potential and is co-constructed in context, moment to moment, from a previously unformulated but limited spectrum of possibilities, the set of potential experiences that can be constructed (i.e., that will emerge and be known) will be determined by the associated tolerable set of potential self-perceptions.

2. The mental mechanism employed to keep unwanted (intolerable) self-states and self-perceptions out of awareness is not repression, but dissociation. Freud described repression as operating by eliminating from consciousness *formulated* mental contents (i.e., contents that are verbalizable and saturated[3] with meaning). In contrast, dissociation operates by keeping *potential* mental contents from achieving verbalizability or saturation—that is, keeping them in an unformulated state.

   Stern chooses dissociation over repression as his foundational psychic defense in part, I believe, because he wishes to distinguish his ideas about the plasticity and potential of unsymbolized, unrepresented, unformulated experience from what he assumes are analysts' more common assumptions about the organizational state of unconscious fantasies. This is a subtle and complex epistemological point, one that has serious implications for our theories of mental life. The usual implied view of unconscious fantasies[4] is that they are more or less fully formed

[3] See Bion, W. R. (1970). *Attention and Interpretation.* London: Heinemann.

[4] See, for example, Isaacs, S. (1948). The nature and function of phantasy. *Int. J. Psychoanal.,* 29:73-97.

and specific in regard to organization, content, and meaning. In contrast, however, Stern does not appear to believe that the unconscious contains elements that are saturated and structured (i.e., represented and symbolized). Thus, he neither sees repression as the paradigmatic defense for the construction of the dynamic unconscious, nor even appears to believe that repression and the dynamic unconscious as described by Freud[5, 6] exist.

3. Depending on the strength of the aversive potential meanings of the *not-me,* dissociation can be either "weak" or "strong," giving rise to clinical situations of resistance and enactment that Stern deems either "workable" or "deadlocked." Weak dissociation can be overcome with a shift in attention, or by more ordinary relational means:

> [In states of weak dissociation or for the enactments built upon such states,] an intervening period of living is usually enough to destabilize the relevant dissociations between the analyst's states of self, and that destabilization, in turn, by freeing the analyst to use his mind, allows the reframing of the situation and suggests a line of inquiry or interpretation. Or it just allows the analyst a different state of being-with-the-other. [p. 56]

In contrast to weak dissociations, strong dissociations are fiercely clung to and more problematic because of the greater unacceptability or threat inherent in having to accept the self-states and self-perceptions that would emerge if their meanings were to reach the level of formulation and conscious awareness.

4. Enactments occur under the exigent circumstances when dissociation fails to be effective and the not-me threatens to emerge into conscious awareness as a part of "myself." (Here again one thinks of Sullivan, who emphasized *security operations* and an endangered sense of self as a prime motivation for defense.) Stern argues that the aim of the enactment is to further isolate the

[5] Freud, S. (1915). The unconscious. *S. E.,* 12.

[6] Freud, S. (1923). *The Ego and the Id. S. E.,* 19; see p. 24.

not-me from the sense of self. He stresses the defensive role of enactments, which he sees as an unconscious set of interpersonal maneuvers that attempt to move the other into a behavioral position that will then lead to the plausible conclusion that the undesirable attributes of the not-me reside in the object and not in the self (p. 14).

Stern calls this process the *interpersonalization of dissociation* and tries to distinguish it from projective identification. He also recognizes that, although enactment is a powerful and potentially disruptive defense, it offers an opportunity for furthering the treatment:

> Even if it were possible to avoid enactments, it would usually not be desirable, because dissociated material . . . is not symbolized, but unformulated, and is therefore only available via the experience of enactment. [p. xix]

5. The reason it is important to recognize and work through that which is being enacted and/or dissociated is that such maneuvers weaken the psyche by rigidifying and constricting imagination and the range of what can possibly be thought. These limitations are related to unwanted self-perceptions of the present and to past traumatic experiences. The constrictions in thinking and perceptions that they produce are, in part, the basis for transference and countertransference reactions and for repetitive characterological difficulties.

6. Since all of us must contend with the vicissitudes of *me* and *not-me,* either party in the analysis may resort to dissociations to defend against self-states and self-perceptions that the subject must not and/or cannot bear to know about. Both analyst and patient are therefore susceptible to becoming engaged in enactments. When enactments do occur, Stern believes, they can be dissolved or disrupted by some shift in the relational positioning of the analyst or patient vis-à-vis the other. These shifts allow one or both participants to achieve new perceptions of self and other, as each de-centers himself from the need to have the previously disavowed remain not-me. True to his interpersonal roots, Stern

believes that insight tends to follow action—e.g., acts of *de-centering, relational repositioning,* etc.—rather than preceding it.

To the extent that narcissistic issues of identity and self-regard provide an important organizational perspective from which to observe the vicissitudes of self-esteem and analytic relating, Stern's formulations have the ring of useful clinical truth about them. However, I find it problematic that his arguments are narrowly rooted in the idiom and context of contemporary interpersonal/relational discourse and thinking, to the exclusion of Freud and of so much else in contemporary psychoanalytic literature. While being anchored somewhere in some theory is probably inevitable for all psychoanalytic authors, I suspect that readers who are not fully committed to an interpersonal/relational perspective may find this book constricted in scope.

Of course, my response could be taken as proof of Stern's thesis: since I operate analytically from a different theoretical perspective, I may be to some extent rejecting Stern's choice of theory precisely because it is *not-me.* With that caution in mind, I would nevertheless like to describe more fully some of what I feel this volume has not sufficiently addressed, in the hope that a more comprehensive discussion of these issues may eventually ensue.

Stern's assertion that the central motivation for defense is the avoidance of the *not-me* may strike some readers as a theoretical reversion to something akin to Freud's early hypotheses,[7] in which conflict was formulated as occurring between unacceptable thoughts or percepts and a "dominant mass of ideas." For many readers, such a reversion may seem to neglect too much of subsequent clinical observation and theoretical development, and to thereby sacrifice theoretical complexity. For others, it may seem ironic that in seeking to refute Freud (i.e., his theory of repression and description of the dynamic unconscious), Stern has reverted to a theory that is strikingly similar to one that was advanced and then discarded by Freud.

More important, Stern's description of the role of dissociation raises epistemological problems for his earlier and still central thesis that all that is unconscious is unformulated. If the motivation for dissociation

[7] See, e.g., Freud, S. & Breuer, J. (1895). *Studies on Hysteria. S. E.,* 2.

is anticipation of the unacceptable consequences of actualizing and embodying the not-me, then doesn't that imply that the self must have or intuit some kind of knowledge and therefore *representation* of what it wishes to avoid, or what the consequences will be of failing to avoid it? (Parenthetically, the idea of a narcissistic principle of psychic regulation—in which all that is good or acceptable is seen as *me,* and all that is bad or unacceptable is seen as *not-me*—also has roots in Freud's[8] description of the infant's *purified pleasure ego.*[9] So perhaps elements of Stern's theory owe a greater debt to Freud—or at least deserve a more careful comparison with his formulations—than Stern recognizes.)

My own preference, based on my reading of clinical data, would be a theory that includes *both* repression *and* dissociation (I would also prefer to have the nuances of dissociation discussed in relation to the concept of splitting), and that examines the complex interaction that can take place between these two psychic phenomena. I would also prefer a theory that (a) describes a more dialectical relationship between insight and action in the therapeutic process—interpretations being both communications of meaning and concrete acts at one and the same time[10]; (b) maintains a more elaborated and specific notion of signal anxiety—or at least of a *signal dysphoria*—as a motivation and trigger for defense and for actualization of aspects of one's internal world; and (c) is not so narrowly cast as to avoid a deeper engagement with contemporary authors from other psychoanalytic schools and traditions (such as Bion, Ferro, Lombardi, Matte Blanco, Tabak de Bianchedi, Cassorla, Hartke, W. Baranger and M. Baranger, Green, de M'Uzan, Aisenstein, Widlöcher, C. Botella and S. Botella, and Faimberg)—each of whom explores aspects of the unformulated, of intersubjectivity, and of enactments, but from different perspectives and in different theoretical languages.

While Stern does make reference to some of these authors, he does not treat their work in a comprehensive fashion. In failing to engage with them, Stern has, I fear, missed an opportunity to allow his very valu-

[8] Freud, S. (1915). Instincts and their vicissitudes. *S. E.,* 14.

[9] See also Faimberg, H. (2005). *The Telescoping of Generations.* London/New York: Routledge.

[10] See Levine, H. B. (1996). Action, transference, and resistance: some reflections on a paradox at the heart of analytic technique. *Psychoanal. Inquiry,* 16:474-490.

able observations and contentions about unformulated experience to enter into a more articulated discourse with other psychoanalytic systems of ideas, which do not abandon key concepts that were introduced by and remain rooted in Freud, and that for many readers remain foundational for psychoanalysis. Such an engagement would more seriously test Stern's arguments and deepen the impact of his assertions.

For example, while I find the concept of *unformulated experience* compatible and useful, I seriously question whether one can so easily dismiss the existence of repression and the repressed. I would suggest that Freud, too, saw first the unconscious and then the id as consisting of, for the most part, "unformulated experience." What else could Freud have meant when he introduced the concept of thing presentations (*sachvorstellung)* and said that they had to be united with word presentations (*wortverstellung*) in order to achieve potential access to consciousness?

Bion,[11] among others, extended this insight into a powerful formulation (*alpha function* and *container/contained*) of what creates the unconscious and structures the mind. In Freud's work, this implication is perhaps more clearly recognized in French translations, where the word *drive* appears as *pulsion*. The latter term carries a connotation of force rather than of content (i.e., a pulse or force is very different from a specific, articulated wish or desire).

Given that Stern rejects the idea of the repressed unconscious in favor of a view of all unconscious elements as unformulated, it is ironic that further evidence of Freud's view of the unconscious as unformulated (unsaturated and detached from words) follows from the latter's comments about repression. He argued that there was a small but important subset of the unconscious—what we now call the *dynamic* or *repressed unconscious*—that, while not available to consciousness, was nevertheless organized and structured (i.e., bound to word presentations) like the secondary process elements of the system Pcs./Cs. He noted that this subset contained unconscious instinctual impulses that are "highly organized, free from self-contradiction" (1915, p. 190), are relatively indistinguishable in structure from that which is conscious, and yet "are unconscious and incapable of becoming conscious" (pp. 190-191). "*Quali-*

[11] Bion, W. R. (1962). *Learning From Experience*. London: Heinemann.

tatively they belong to the system *Pcs.* but *factually* to the *Ucs.*" (p. 191, italics in original).

The distinction that Freud seems to be making here is between the organized, articulatable yet repressed unconscious—that is, the unconscious subset of psychic elements reflecting *represented* mental states—and the much larger, not yet organized or articulatable subset of proto-psychic elements reflecting *unrepresented* mental states. He reiterates this distinction again in 1923.

Beyond Freud, there are additional approaches to unformulated experience that are described in very different theoretical systems of thought. Some examples of these are: Bion's description of beta elements as *protopsychic*—i.e., unsaturated (lacking verbalizable specificity and unable to be thought about or unsuitable to think with; Matte Blanco's[12] descriptions of the unconscious as *categories* rather than contents and the terrifying, infinitizing tendencies of the unrepressed unconscious; Green's[13] and Botella and Botella's[14] descriptions of unrepresented mental states and the void; and Lombardi's[15] description of Ferrari's characterization of the body as *concrete original object.* These formulations emphasize the centrality of language and verbalizability in their containing and structuring functions, and open up very different lines of clinical implications than those advanced by Stern.

I am not arguing here that relational positioning—an aspect of what Klein, Bion, Ferro, and others would call the analyst's psychic receptivity to the patient—is not an important factor in the therapeutic process. Rather, I am arguing that I do not believe it is the *only* factor. And while words derive their psychic meanings from the speaker's relational context, words serve, *in their own right,* a vital role in psychic transformation, organization, and development precisely because of the intersubjective,

[12] Matte Blanco, I. (1975). *Unconscious as Infinite Sets.* London: Karnac.

[13] Green, A. (2005). *Key Ideas for a Contemporary Psychoanalysis: Misrecognition and Recognition of the Unconscious,* trans. A. Weller. London/New York: Routledge.

[14] Botella, C. & Botella, S. (2005). *The Work of Psychic Figurability: Mental States Without Representation.* Hove, England/New York: Brunner-Routledge.

[15] Lombardi, R. (2002). Primitive mental states and the body: a personal view of Armando B. Ferrari's concrete original object. *Int. J. Psychoanal.,* 83:363-381.

relational context in which their meaning is embedded and from which they emerge.

Another serious question I have concerns Stern's view of how enactments may be interrupted and resolved, and what underlies their therapeutic potential. In a crucial chapter (4), "The Eye Sees Itself: Dissociation, Enactment, and the Achievement of Conflict," Stern raises the important question of how to understand our capacity to at times escape from the defensive deadlocks and limitations of perspective that result from dissociation and enactment. While his clinical descriptions ring true, his formulations of what allows one to free oneself from these constrictions—new perceptions of self and other that occur because of new relational configurations of being with the other—are problematic for me because they do not offer sufficient conceptual explanations of how and why this loosening of the traps of limitation takes place, thereby permitting new types of relationships to form or to be recognized.

Perhaps these questions of how and why deadlocks are loosened and reworked, the mystery of fully knowing the details of therapeutic action, are things that we can never really know the answer to. Perhaps it is *my* limitation that I cannot accept the uncertainty and ambiguity of not having an explanation of how and why this happens, that I would prefer a "myth" that is merely a plausible hypothesis and a pseudo-explanation. Recall Freud's comment that metapsychology was only a superstructure that could be replaced without doing damage to the main findings of psychoanalysis. Am I then seeking a totemistic belief or magical salve for my ignorance and discomfort? Or is there a place for the kind of hypotheses that I find Stern has thrown out with his dismissal of the unique role played by language in psychic functioning and in Freud's theory of the mind?

In the latter, when direct drive satisfaction is not available, the press of the drives for relief via representation becomes an imperative, and when significant trauma has occurred, the wounds and psychic disorganization it has produced press for redress and recognition through the repetition compulsion. For Bion, there is an assumption that the patient's mind needs "truth" in the same way that one's body needs alimentation; hence his belief that dream work (i.e., the exercise of alpha function) is a homeostatic necessity, and the reason that the human

psyche experiences a continual pressure towards psychic representation. Botella and Botella have similarly offered a theory in which *figurability*, the movement toward psychic representation, is necessary for psychic homeostasis, survival, and well-being. While Stern is clearly aware of some of these alternative formulations, he does not engage with them as fully as he might.

Each of these alternative formulations is inherently tied to language, words, and verbalization, and this has implications for analytic technique. Stern's wish to privilege relationship at the expense of insight and interpretation may have led him to neglect their value in the analytic process. Rather than dismissing interpretation and insight as levers in the disruption and working through of enactments and dissociated states, as Stern has done, I would welcome recognition of the dialectical nature of the interpretive act as concrete action (which includes a relational action), as a conveyer of information, and as a relational signifier.

I would also have preferred a more nuanced sense of working through and its relationship to the resignification and retranscription of meaning and memory (*nachträglichkeit*). As Baranger, Baranger, and Mom[16] have noted, the analytic process is a very complex matter, and "insight" consists of much more than just learning new information or communicating new meaning:

> Reliving a trauma is useless if it is not complemented by working-through, if the trauma is not reintegrated into the course of a history, if initial traumatic situations of the subject's life are not differentiated from the historic myth of his origins . . . . The analytic process rewrites in some measure the subject's history and at the same time changes its meaning. The moment when we can observe this change, in which the subject simultaneously re-assumes a piece of his history and opens up his future, is the moment of "insight." [pp. 74-75]

This appreciation of the complexity involved in insight and working through, of the dialectical nature of temporality in psychoanalysis, and

[16] Baranger, M., Baranger, W. & Mom, J. (1983). Process and non-process in analytic work. In *The Work of Confluence: Listening and Interpreting in the Psychoanalytic Field*, by M. Baranger & W. Baranger, ed. L. G. Fiorini. London: Karnac, 2009.

of the complex action of words in structuring the psyche seems overlooked in Stern's theory. While reliving in the form of actualization of the old and the creation of "new beginnings"[17] is an essential part of a successful analytic process, so, too, are the instantiation of psychic elements into temporal sequences[18] and the verbal articulation of elements of the present (transference interactions) and the past. Thus, while new and meaningful salutary relationships are essential for therapeutic progress, I do not feel that they are entirely sufficient. Sometimes, in its enthusiasm for pointing out the once-neglected relational dimension, relational theory seems to scant the role of insight by failing to sufficiently recognize the importance, sometimes the existence and the dialectical connection, of the self-reflective, which is profoundly rooted in language and words.

Perhaps Stern's argument against insight is too focused upon a certain kind of interpretation—a genetic reconstruction of past events that can tend toward intellectualization and divert the patient from the affective immediacy and intensity of the transference relationship—and does not sufficiently take into account the tremendous value of the moment-to-moment construction that comes from naming and tracing the emotional consequences of affective events in the here and now. I believe that the latter *interpretive* processes can provide a foundational underpinning for the creation of causality, continuity, and coherence in one's sense of identity. This movement of recognition of and learning about and from one's experience is transformational, psychically structuring, and particularly important in the treatment of primitive personality disorders and the psychotic portions of the mind, as it leads to a solidification of one's sense of self.

Regrettably, although I am in strong sympathy with Stern's attempt to work out the implications of unformulated experience for psychoanalytic theory and technique, and am very much in agreement with parts of his theory, I feel that for myself and for other readers already

[17] Ornstein, A. (1974). The dread to repeat and the new beginning: a contribution to the psychoanalysis of the narcissistic personality disorders. *Annual of Psychoanal.,* 2:231-248.

[18] Levine, H. B. (2009). Time and timelessness: inscription and representation. *J. Amer. Psychoanal. Assn.,* 57:333-355.

familiar with and engaged in the issues that Stern addresses, but who do not see themselves as thinking and working solely in the interpersonal/relational tradition, Stern may have limited the potential scope and impact of his contribution by failing to rise to the challenge of providing a more comprehensive, comparative presentation of his views. Given the precision of his thinking, the range of his scholarship, and the breadth of his clinical experience, one can hope that these issues will be more fully addressed in what surely will be his future important contributions to these matters.

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PSYCHOANALYSIS AT THE MARGINS. By Paul E. Stepansky. New York: Other Press, 2009. 357 pp.

Paul Stepansky, a firsthand witness to the near demise of psychoanalytic book publishing and the fractionation of psychoanalysis into competing enclaves with little interchange or dialogue, has written a serious scholarly warning about the present state of our profession. It is hoped that his warning will be heeded, and some remedial action will be taken to remedy a declining view of the psychoanalytic enterprise. Considering the present state of disrepair, paradigm warfare, and rivalries in the field—frequently of a personal nature—the task to repair the problem is daunting.

The author provides accurate testimony to psychoanalytic events of the last four decades. As the managing director of The Analytic Press publishing house for many years, and before that an editor at International Universities Press, he tells a sobering and truthful story of the present declining state of book and journal publishing in the United States. I can confirm the truthfulness of Stepansky's claims, as my own career in psychoanalytic journal and book review editing and publishing covers the same years as his.

We are reminded that, during the past thirty years, regular trade publishers and major university presses—such as Harvard, Yale, and Chicago—have withdrawn from publishing psychoanalytic books. The task of publishing has been left to a handful of small, specialized publishers, such as The Analytic Press, with limited print runs and high prices, who

must show a clear profit to survive. And things are hardly better in the realm of academic psychology texts, where psychoanalysis has been marginalized, demonized, or written out of the text completely, with Freud viewed as a historical artifact. When one considers that a million or so college students take an introductory psychology course each year, and that few professors at either the graduate or undergraduate level have a psychodynamic orientation, the case for decline is clear.

All of the above is in sharp contrast to the way things were at one time. Stepansky has done some valuable research on book sales during a glory era of book publishing in the United States following World War II. Menninger's *The Human Mind* was an all-time bestseller, Erikson's *Childhood and Society* would sell over 750,000 copies, and even Fenichel's *The Psychoanalytic Theory of Neuroses* sold close to 100,000 copies. There were many other bestsellers, including Brenner's elementary textbook. Theodor Reik, Karen Horney, Edmund Bergler, Harry Stack Sullivan, and Erich Fromm were all popular authors published by major trade publishers.

Although some later psychoanalytic authors sold well, they did not achieve the success of the earlier period. The explanation is easy to come by: the earlier writers wrote for a general audience and for a relatively integrated and cohesive psychoanalytic audience, one that was not fractured into competing ideas, rivalrous training facilities, and cult figures.

Similar comments can be made about psychoanalytic journal publishing. Stepansky argues correctly that, from the beginning, there have been many "part" journals representing particular theories—journals that excluded ideas that strayed from their basic principles. His scholarly history of the emergence of journals is complete, and historians of psychoanalysis will find it valuable reading. In the United States today, the *Journal of the American Psychoanalytic Association, Psychoanalytic Psychology, The Psychoanalytic Quarterly,* and *The Psychoanalytic Review* showcase a variety of ideas, but a number of part journals remain; we have Jungian, interpersonal, relational, and self psychological journals, most with a diminishing subscription base, to name just a few subtopics. Contrast this situation with that of medical specialty journals, and the splits in our field are highlighted.

There are other valuable sections of this book besides those on publishing, but I emphasize publishing here because I see the separate realms of journal publishing, with their often gate-keeping road blocks, as serious obstacles to the opportunity for analysts to really talk to each other. If this is the way analysts speak to each other in print, they will find it difficult to speak to each other in person. When theory change occurs by fiat, or when proof is offered by assertion rather than as a result of meaningful evaluation, the possibility of advancing psychoanalysis is remote.

Other chapters of the book discuss seduction theory, the problem of pluralism, and the role of other healing professions and their growth, and all are written with the author's pronounced intelligence and historical sense. In a concluding chapter, there are recommendations for advancing psychoanalysis in the larger community through outreach and by acquiring public respect. This is a book that raises questions that most have thought about, but that must be addressed directly if psychoanalysis is to have a future.

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