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EDITOR'S INTRODUCTION

BY JAY GREENBERG

Keywords: Analyst's worry, analytic process, treatment failures, case reports, analytic outcomes.

In responding to discussions of a paper he presented, Goldberg (1999) wrote:

> One fails in the writing or delivering of a paper if the audience leaves without worry, since that, I believe, is the crucial emotion for the life of an analyst, who probably should worry her- or himself right to the grave. [p. 395]

Goldberg framed his comment as a prescription, and it is an important one. Because analysts traffic in the unconscious and in *après-coup,* we can honor our commitments to our patients and to psychoanalysis as a discipline only if we are constantly wondering, and wonder always teeters on the brink of worry. But what Goldberg says is also a description: we analysts *do* worry about our work and our theory.

Mostly we worry to ourselves or in private conversations with trusted colleagues. When we write or speak publicly, the narrative arc of our stories bends—as Mitchell Wilson notes in his commentary on Judith Fingert Chused's remarkable paper—from worry (or even despair) to relief, and perhaps to triumph, as we work through what had been disturbing and use it in the service of our patients and, ultimately, of the analytic process. In most case reports, worry is not a chronic state of mind; it is a prologue.

Chused's story, "An Analyst's Uncertainty and Fear," stands in stark contrast to the usual account of clinical work. In part this is because her story has no real ending. The analysis is terminated in the sense that Dr.

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S has moved to another continent, and so there are no longer any regular sessions; but he stays in contact via e-mail and seems to be engaged with his analyst as an inner presence—perhaps more engaged than it was possible for him to be when the two were meeting regularly in person. So we are left knowing less about the analysand's state of mind than the analyst's; and Chused is certainly worried. She worries about whether and how she failed her patient: should she have recommended analysis; should she have conducted the treatment differently; was what she did helpful to Dr. S, or at least helpful enough?

Her concerns, especially in light of the commentaries on her report, not only speak poignantly to the feeling that Goldberg suggests we should carry to our graves, but also raise crucial questions both about what analytic failure means and about the most appropriate vantage point from which determinations about a treatment's effectiveness are best made.

Green, who has perhaps written more trenchantly about analytic failure and analysts' disillusionment than anyone else, noted that such judgments may differ widely depending upon who is making them. Green notes, for example, that sometimes the analyst may feel painfully dissatisfied with the work being done, while the patient feels that treatment is succeeding. Or the situation may be reversed, with the analyst feeling that work is going well while the patient insists that nothing, or nothing useful, is happening. And at yet other times the two may be in strong agreement (either that treatment is moving forward well or that it is not), while a third party takes vigorous exception to their shared judgment. Green (2011) concludes that:

> It is questionable to speak of failure when there is no consensus about the outcome of the experience, and even when such a consensus exists . . . . The idea of failure is not really a psychoanalytic criterion, as its reliability is too uncertain. [p. 51]

I imagine that most readers of Chused's paper and the three commentaries will empathize with what she calls her "fear and uncertainty" about both the process and its outcome, and that they will also find it difficult to conclude with any confidence whether to characterize the treatment as a success, a failure, or something in between. This means

that they will come away from the experience worrying at least a bit—about this analysis, about their own work, perhaps about psychoanalysis in general. And so by Goldberg's criterion, at least, the paper is certainly a success.

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AN ANALYST'S UNCERTAINTY AND FEAR

BY JUDITH FINGERT CHUSED

The motivations for choosing psychoanalysis as a profession are many and differ depending on the psychology of the analyst. However, common to most psychoanalysts is the desire to forge a helpful relationship with the individuals with whom they work therapeutically. This article presents an example of what happens when an analyst is confronted by a patient for whom being in a relationship and being helped are intolerable.

Keywords: Analytic interaction, self-disclosure, analyst's motivation, countertransference, uncertainty, fees, analytic relationship, fear, analytic goals.

Uncertainty . . . and fear, too, have always been part of my experience as an analyst. The ambiguity inherent in psychoanalysis, the question of how to be effective when understanding is still a work in progress, makes uncertainty a constant presence in my professional life. There are moments when I wonder if what I do is truly useful, when I question whether I have made erroneous assumptions (and based interventions on them), worry that I have behaved in ways I should not (that is, been too abstinent, too gratifying, too forthcoming via self-disclosure, too intellectualized), or fear that an analysis I thought was going well was in fact just a result of my patient's compliance, without the development of any real understanding or growth. I have learned to accept these feelings (heightened during termination), painful though they be, as part of the work.

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Fear is not present in my work with every patient, but it is not uncommon. I have become fearful when a patient's talk of suicide and other self-destructive behaviors contains a threat of being put into action, when signs of a malignant regression, of loss of reality testing, threaten disaster. But there is another fear that is a bit harder to define—that is, the fear that comes when the lack of collaboration leaves me alone in the room, feeling that I do not understand what is happening, that I do not really know my patient . . . and I begin to feel despair, questioning what I am doing.

Like many others, I became a psychoanalyst because of a wish to help people . . . and its corollary, a wish to compensate for any of my own aggressive impulses. During medical school, my concern about hurting patients was relieved by the strict protocols for each diagnosis. Analytic training was not quite so concrete, but even then, the anxiety associated with doing harm was reduced by following rules laid down by teachers and supervisors. When I was a candidate, I believed what my supervisors said—particularly about the need to feel neutral towards my patients' fantasies and impulses—and so, when I felt aroused, angry, or judgmental, I read my feelings as an expression of my own neurotic conflicts. Supervisors spoke as if countertransference was an indication for more analysis, so I became worried when I felt irritated with an anorectic patient who reported, with a smile, that she was still losing weight; when I was distressed about a masochistic patient's affair with her domineering, married boss; or when I caught myself subtly flirting with an attractive patient.

When I trained, almost a half century ago, authority was still invested in those who had come before . . . in psychoanalytic circles as well as in other aspects of our culture. Teachers had the final word; if they were challenged in class, the challenger was labeled rebellious and might not be allowed to take on a second case. One learned from experience with patients, but the experience was filtered through voices from above.

Time passed, I graduated, and I found that the authority of my supervisors was now inside my head. I chastised myself when I failed to be abstinent, liked a patient too much, or felt angered by a patient's provocation. At the same time, as I experienced the frustration of interpretations "not working," of patients mistaking my abstinence for with-

drawal, I began to question the authorities whose rules had contributed to my analytic ego ideal. In some ways, my inner voices were the same as the voices patients hear inside their heads: sometimes helpful, but sometimes crippling.

When I became a teacher, although authority was no longer so revered in either the world at large or in psychoanalysis, my candidate-students wanted some certainty, some assurance that there was a way to do analysis right. In my attempt to reduce their anxiety, I spoke of the techniques I found useful, but always added that with experience they would find out for themselves what was genuinely helpful. This truism was disappointing to them; though candidates are able to accept that there is always uncertainty in the analytic moment, they want to feel confident that analysis really works, both for themselves and for their patients . . . a confidence I could not always provide. For in my experience, analysis does work—for some people, some of the time.

But there are some patients for whom analysis does not work, who may even convince us that it has hurt more than it has helped. I often disappoint patients' expectations, fail to gratify wishes (be it for certainty or for something more concrete), but that disappointment, that kind of hurt I can accept (or rationalize) as being in the service of the individual's greater growth. But I do not want to hurt someone and then find out it was not helpful, or discover too late that not only have I caused someone pain, but also that the resulting damage cannot be fixed. Klein was right; one must make reparation. So for me, the hardest part of the work is not the patients who complain of what I am doing wrong, but the patients whom I believe I have not helped enough—those who, if not damaged, have wasted years of their lives in a treatment that provided insufficient benefit.

It is less difficult to write of the gut-wrenching fears; they are easier to understand. I have been fortunate that no patient of mine has suicided . . . and yet I have had several who seemed serious about wishing for death, and I have been afraid. Nor have I ever been attacked by a patient, thought I have been threatened and been very frightened. But these fears are in the past; positive outcomes have erased the fear. What has stayed with me is the thought of patients I have not helped enough,

who got neither what they wanted nor what they needed, who left analysis not much better than when they entered.

These are the memories that haunt me, that make me afraid—not of the patients themselves, but of the limited value of what I do. For limited it is. There have been more successes than failures, more individuals who have gone on to make good use of what we have done together, whose lives have been changed for the better. But there have been failures as well. And I have the feeling it is useful to write about one of those failures, that I am not alone in the experience I wish to relate. Actually, it was only a partial failure, but it is one that still haunts me and has left me wondering what I could have done better. I learned from this patient; for his utter refusal to let himself trust, his need to control every interaction, made me aware of how essential trust is, in both analysis and in life.

As analysts, we use understanding to help patients; however, understanding is also our way of ordering the world. And just as patients "fill in the blanks" with projected impulses, thoughts, and desires when we are abstinent, so we ourselves fill in the blanks when a patient's failure to connect, to resonate with our understanding, makes the analytic situation uncertain, ambiguous. At those moments, the fantasies and conflicts that are specific to each of us take over, making us vulnerable to our most dreaded fears.

Prior to working with the patient I shall describe,[1] I had become tolerant of the uncertainty of analysis; I even welcomed those moments when a patient and I were working together to discover something that neither of us could anticipate. Even when a patient was angry or disappointed in me, if he was there with me in the struggle, then I felt comfortable, confident about the value of what we were doing.

The experience with this patient was different; with him I was always alone, for he could not tolerate "working with." His discomfort with connection led him to mishear most of what I said, to make requests I could never fulfill, and to withdraw into pain whenever I came near to understanding him. It helped me, somewhat, to understand that he was pained by connecting; nonetheless, I was often apprehensive as his hour approached, anticipating that not only would I again be experienced as

[1] Identifying information about the patient has been altered to maintain confidentiality and protect his privacy.

unhelpful, but also that my nose would be rubbed in it, and that the session would end with me angry, anxious, and—most of all—guilty.

Dr. S was fifty-six years old when he reluctantly appeared in my office, having decided that he needed therapy because of his difficulty "dealing with people." Twice divorced, he had moved to Washington, DC, to live with a woman who had been a major player in his last divorce. A former surgeon who had invested wisely in real estate, he was now retired, with insufficient activities to fill his days. His considerably younger girlfriend was still practicing, and her long hours and enthusiasm for her work upset him, for it meant that he was often alone. In addition, their changing roles, with her becoming increasingly competent and confident and him less so, made him feel inadequate and angry.

Dr. S had had several years of twice-a-week therapy when he was in his twenties because of anxiety that significantly interfered with his social relationships. It had been helpful, but now he wanted something else, he said: something to help him understand and feel comfortable with himself, not just to solve an immediate problem. He knew how to behave with people, but it all felt fake, superficial. And when he was alone—well, when he was alone, he did not like himself very much.

As Dr. S talked further about his former therapist, former wives, and assorted children, an underlying current of anger contaminated what had been a charming initial presentation, for everyone he mentioned had disappointed and hurt him in one way or another. While at first I had felt sympathetic toward his sense of isolation, I was now struck by how unaware he was of his wish to hurt—how he focused only on his sense of hurt and helplessness, his inability to get people to respond as he wished. He described himself as helpless in a number of ways: he could not use a computer, had been unable to pass a test to get a Virginia driver's license, did not have an iPod or CD player, and could not find the music he wanted on audiotape cassettes. And though he came to me expressly for analysis, the myriad of obstacles to his beginning treatment (several planned vacations, real estate projects, and a lack of transportation) seemed to overwhelm him.

Our second session began with Dr. S's telling me that I seemed tense (my voice, facial expression, and posture); he wondered how that would affect my ability to empathize with him. I responded that I was not aware

of being tense . . . but as I said that, I became conscious of feeling defensive and uncomfortably self-conscious. But then, before I could say anything else, he abruptly dropped his scrutiny of me and began to talk about his girlfriend, saying he had the fantasy that analysis would return the relationship to what it had been, but he was aware that analysis did not have that power, and he did not want the relationship to be the focus of our work.

At this point, Dr. S was speaking as if we had already agreed to work together, making me feel confused and slightly overwhelmed. As he continued, it seemed as if I were interrupting him whenever I start to speak. I felt controlled—a feeling that was only reinforced in the next session, when he said he wanted a therapist who was smart and tough, not a mushy thinker. Again I felt defensive, and I started to wonder, "Do I seem like a mushy thinker?"

I said I suspected he could talk rings around many people, including me, and wondered what a tough therapist would provide. He responded, "A tough therapist would provide me with someone I couldn't intimidate." At this point, I felt intimidated, yes, but also captivated, challenged to use the affects stimulated in me to help him.

After several more sessions—in which I felt both attracted to his mind (in addition to designing some impressive surgical techniques, he was a published poet and had been a Rhodes Scholar) and irritated by his need to control and his readiness to attack—I agreed to work with him and told him my fee. The resultant interaction, like many other exchanges we were to have throughout the four years of our work, led me to feel simultaneously insensitive, selfish, and manipulated. He said my fee was high and that another analyst he had consulted was cheaper, but he was going to choose me because he valued relationships and felt we could have one; however, it was clear that, since I was not flexible in my fee, I did not value relationships as he did. He then spoke of his enormous wealth, adding that he loved to bargain, but if I had agreed to see him for less, he would not have thought well of me.

A week after we began analysis five days a week, he said that he had said everything he had to say. When I responded, somewhat light-heartedly, "I hope not," he said—sternly and very seriously—that he had not anticipated I was one of those analysts who expect their patients to do all

the talking while they do nothing. And by the third month of analysis, it was clear that I had joined the ranks of those who disappointed and hurt him. A truly brilliant man, he interspersed talk of his accomplishments with thoughts of suicide, requests for advice, and his growing concern that I would not be able to help him.

As the work progressed, though there was increased energy in his voice and I could hear in his associations that he was becoming more fully engaged both in life and in the analysis, I began to feel overwhelmed by his controlling hostility and demandingness. He said he knew he fought with me, but fighting was his problem—and wasn't he supposed to repeat in analysis what he did in life? He also made explicit that, even though I did little that was useful, he was determined to stay in the analysis as long as *he* wanted to be there.

I felt abused, yet at the same time, I knew that underneath Dr. S's taunting criticism and needling dependency was a true hunger for nurturance. There were even moments when he could talk about wanting to yield to me and how frightened he was that I would hurt him. All this left me feeing jangled; I felt sad for him, eager to help, and at the same time frustrated, defeated again and again by his efforts to convince me I had failed him.

Believing strongly in the value of peer supervision, I spent many hours talking about Dr. S with a colleague. Both of us thought he got much gratification from his sadomasochistic mode of relating, but also that he was extremely fearful of being overwhelmed and truly helpless. I came to believe that his efforts to discombobulate me were defensive as well as gratifying; that is, if he could make me feel overwhelmed, he would be protected against feeling that way himself.

Often he would disrupt the frame of the analysis. For example, in one session, he said he needed to check flights from New York City so he could arrange to be on time for his appointment the next day. He then abruptly got off the couch, went to my desk, and used my phone to call an airline. When he finished his call and went back to the couch, he asked what I thought of his behavior. I thought he was referring to his sudden move to my phone, so I asked, "Do you mean about the phone call?" He responded, "Yes, did you think I sounded strong on the phone?"

He then wondered whether I thought well of him for arranging to return in time for his hour, whether he was intruding on my private space by using my phone without asking, and whether I thought he was physically attractive. He then said, "Of course, if I thought you were attracted to me, I'd quit." He then began a long rant against all the women in his life—beginning with his mother—who expected him to perform for them. He needed help, he had come to me for help, but only women are comfortable asking for help.

At this point, I felt I had a very limited understanding of what had just transpired. I thought he wanted to connect, was frightened of this desire, and did not want to give any control over to me (that is, by asking to use my phone), but that he was also scared of offending me, of losing me.

I wanted to work on what had happened but felt intimidated. In earlier sessions, Dr. S had talked a lot about his mother. She had told him repeatedly that men have trouble with women because they do not understand them. He had spoken with great anger of her behavior with him and his brothers, describing how she had taught her three sons about women by telling them about herself and showing them her body. In the past, I had wondered whether the tension I was feeling before Dr. S's hours, my sense of never knowing what was coming next, reflected the overstimulation he had experienced with his mother.

So I said that when he got up to use the phone and then asked me a series of questions, I felt a bit overwhelmed and did not know where to focus. I went on to say that it may have been as difficult for him to bear witness to his mother's body as it sometimes was for me to respond to him, to find words to help him integrate his experiences in my office with his inner world. In response, he blasted me with, "Nice try, Dr. Chused, but that's no excuse for not answering my questions." In retrospect, I realized I had interpreted prematurely to quell my discomfort with his sudden behavior and barrage of questions, but unfortunately this was not to be the last occasion when I was discombobulated by him.

After eight months of analysis, Dr. S began to fall behind in his payments. When I brought this up, he said it was a cash flow problem, as it was not a good time to sell stock. He added that late payments to me should not be seen as a problem, for he owed his lawyer $10,000, and

the lawyer hadn't gotten upset about it. He then brought in his bank statement to prove that he had no ready money, adding that his transference to me as someone who was demanding might be interfering with his paying me.

I said he might be right about the transference, but regardless, I expected to be paid. He laughed at that, said he liked my being honest—and paid me. However, in the next hour, he reported that he had been arrested for not having license plates on his car . . . and that the check he had given me might bounce. He said he knew he wanted to be taken care of, but felt ashamed, for he imagined that I thought he wanted me to be his mother. He recalled his mother walking in on him masturbating, imagined me graphically visualizing him masturbating, then wondered if he wanted me to visualize him. And then he started to cry, saying, "I bet you're thinking this is all just an intellectualization; my mother never took me seriously either."

When he stopped sobbing, Dr. S said he could tell I was repulsed by him. When I asked how he could tell, he said, "Well, actually, I am a puppeteer in here and you are my puppet . . . . I pull one string or another to get you to perform . . . . It makes me feel safe, but the problem is, what I get from you is worthless." I responded, "This all sounds so empty," to which he said, "You're trying to be empathic in order to trap me."

It was not that certain themes failed to emerge and solidify. Our work on Dr. S's attempts to control my behavior by acting helpless led him to regain a sense of competence (he obtained his driver's license and learned to use a computer). And our exploration of his reaction to his mother's self-centered seductiveness, her insistence that her sons fasten her bra straps or scrub her back in the tub to make them comfortable with women's bodies, helped him understand and work through some of his difficulty with women. But the work was so painful. Again and again, Dr. S retreated from collaboration to a sadomasochistic exchange. He would begin a topic, such as one day when he said he had recently become "semi-potent" because of perverse fantasies . . . and then fell silent. After several minutes—while I wondered if he wished me to ask about his fantasies—he said he was upset that I did not ask him

about them, but if I *had* asked, he would have felt that he was manipulating me, because everyone knows shrinks get excited by talk about sex.

Gradually, I began to monitor myself more and more; afraid to be spontaneous, I carefully weighed my words before speaking. I knew I was protecting myself from his attacks, but I was also trying to find a way to touch him that he could tolerate. He was aware that he was inhibiting me and, not infrequently, he would apologize and be angry at the same time, saying he knew it was his fault, that he was hypercritical, but he could not stop himself . . . and wasn't it my job to deal with it? He also said he was frightened that I was discouraged and would abandon him. And he was right; I did feel discouraged.

When Dr. S said he wanted me to love him as he had wanted his father to love him, but that the desire made him exceedingly anxious—like a scared little boy—I felt he was manipulating me. But at the same time, I believed him. When I told him of my mixed feelings, this was followed by a day of working collaboratively, and then by increased animosity on his part. When I suggested his attack was related to our having worked well together the day before, he responded that he liked that I thought we were working well together; however, he thought I was mistaken, though was reluctant to tell me so as he did not want to hurt my feelings.

Actually, he said, he had been feeling more anxious as he came into my office, for he believed the analysis was not working, but had been afraid to tell me. The problem, he said, was that he could never enjoy what he had; for example, he had once had a full professional life in surgery, with lots of different experiences of which he was now proud, but which he did not think much of at the time. He did not enjoy the house he had chosen for himself and knew he could buy a house he liked better, but had not done so because he would then feel obligated to like it, which would be a burden. He did not have any deep transference feelings for me; analysis was just another bad choice he had made.

By the third year, Dr. S seemed to be benefiting from the analysis in terms of improved relationships with his children, with women (he had left his former girlfriend and was dating someone new), and with friends. However, my frustration with him had not decreased. When he arrived early for his session one day, saying, as we began, that it had

made him uncomfortable to wait for me in the waiting room, I suggested it was painful for him to care about me and what we were doing. He immediately angrily denied that he cared, saying he felt trapped by my words, that I was taking over his experience and not allowing him to feel things authentically, and that I did not really know him.

Nonetheless, in spite of his attacks and the feeling both of us had of being misunderstood, the sense of a connection deepened as we talked of his fear of receiving anything from me. Dr. S wondered why he felt good about analysis only when he was away from it, saying, "Your words take me over. It's like with B [his new woman friend]; she asked me to go away next weekend. I don't think I'll go, though if *I* had asked *her,* it would feel entirely different. It's her expectation that turns me off, just as I feel turned off when I sense you trying to understand me."

He continued, "I feel powerful in a relationship only when I leave. I exercised power with my parents by leaving, and I wanted the power to leave A [his earlier girlfriend] when I first came here. I was needy of A; now, as I get stronger outside, I feel needy of you and want to leave you. It's so sad; I charm people so that *they* won't leave. At the hospital, I used to try to get people to give me what I wanted, and once they did, I left. If people could do their own surgery, they wouldn't have called me. No one ever really cared about me."

I responded, "It seems so bleak to have to manipulate the other to give, and to feel so threatened when someone spontaneously offers something, like B did with the weekend away."

He continued, "That's true—I particularly don't want to go because she asked me. It's like your talking to me; it feels like you're exercising power over me, trapping me, even though I know intellectually it's well intended. I used to want you to exercise power over me, but now I'm trying to stop you from having any power. I want to impress you, but then I feel inhibited because if I do impress you, I don't know what to do with that. I want to please you by talking, but the wanting bothers me . . . and that makes me not want to talk."

Increasingly, I became aware that any gratification received from another person, including the gratification of my understanding him, was experienced by Dr. S as damaging. If it were not under his control, it was almost intolerable. He said, "I want you to be empathic, not interpretive;

if you understand something that I haven't already thought of, it puts me in a submissive position." He turned all exchanges into power plays, making clear that nothing could be given or received without someone being on the bottom. To help him was to hurt him; for me to help him made him wish to fight me. He seemed determined to defeat me, just as he had defeated his parents and others by—in spite of his many accomplishments, in spite of what he and I had accomplished—having a terrible life.

By this point, his acute scrutiny of my responses to him, his careful reading of my vulnerabilities, had sharpened his capacity to unsettle me. This man knew me. He once again assumed a helpless stance, almost as if he sensed my pleasure in his having more control of his life. He told me that he could not use a cell phone or send faxes, had not mastered a word processing program, and still did not have a CD player. He planned a ski trip to Switzerland with two of his children and told me the trip was not an opportunity to have fun, but an onerous task: he had to know how to get there, how to read a map, where to rent the equipment. He said, "I want to be taken skiing—I don't like being the grownup, making the reservations."

When Dr. S returned from this trip, he reported that it was clearer than ever that nothing would ever be quite right. He knew he set himself up as victim, but the pain was real, and it hurt him that I was not interested in his pain. He denied that he was complaining about me, but wondered if perhaps people did not like him—for example, some of the nurses at his former workplace—because he was so critical. When I did not respond, he said, "I'm doing it again, aren't I? I can't look like I have anything; I'm so scared people will envy me, hate me." As he talked, I realized anew why I found work with him so frustrating: he seemed to understand and feel so much, and yet nothing seemed to provide any lasting help.

I do a great number of consultations and often refer patients for treatment other than analysis. I know analysis is neither for everyone nor for every type of problem. But during the evaluation, Dr. S had impressed me as an appropriate candidate for analytic treatment. He was thoughtful, intelligent, and introspective, and seemed aware that the pain in his life was usually of his own doing—that from an external

point of view, he had everything he needed to feel content. And yet, my working together with him, helping him resolve his difficulties, was something he would not let me do. Not that he had a negative therapeutic reaction; far from it—in many ways, his life improved through the analysis. No, it was just that he remained dissatisfied—with himself, with me, and with what we had done.

After four years of our work together, Dr. S had an opportunity to go to South America to participate in a medical project funded by the World Bank. As the time for his departure neared, he worked more collaboratively with me. When he felt uncomfortable, he tried to talk about it before attacking. He recognized that hearing me as critical allowed him to feel I was truly interested in him; that being hurt not only gave him a reason to be angry, but also allowed him to feel cared about in a way he could tolerate. However, after saying this, he added that it would be awkward if he thought I really liked him because then he would not be able to tell me what he did not like about me. In our last session before his departure, he ended with: "Well, you did your best."

After a year's absence, Dr. S returned for several sessions, pleased with the work he was doing in South America and seemingly more self-reflective, but still struggling with a fear of being vulnerable. He volunteered that he was most comfortable fighting, that anger held him together.

As he made plans to return to South America, he felt a desire to hug me, but was uncomfortable with his wish. However, rather than stay with an awareness of his own discomfort, he accused me of making our relationship "professional" to protect myself.

It is now five years since I last saw Dr. S. He calls and e-mails me periodically, and his ambivalence is still very much in evidence. For example, when I found a therapist for his son, rather than thanking me, he wrote: "Dr. C, I assume you don't need prompting from me about when it's appropriate to charge for your time and skill; so, I won't prompt."

His most recent e-mails read:

> Dr. C,
>
> Thanks for writing back; it was a pleasant surprise. I am currently in a more or less continual state of opposition to the au-

thorities at the hospital here, and that sort of anger and opposition is natural to me. Having it clearly, objectively justified feels good; it is better than being angry with you, who probably really were trying to help me; and I may be able to do something in a small way about things here. Our project is sponsored by the World Bank, although as you may suspect, what I am doing is not typical of what the World Bank does, and some of it may not completely accord with its policy. Although I do not regard our past time together as a smashing success, I do not regard it as a failure either, and I hope you do not. After all, I did manage to make career choices that I think have been good and that I doubt I could have made before I started seeing you.

* * * * * * * * *

Dear Dr. C,

You were a big help to me last night; I composed a long e-mail to you, and in writing it down carefully, I more or less resolved the problem for now, making it unnecessary to write you—thanks; it felt good. I feel a profound change in me; I now seem to live not so much by planning how to get what I want in the future, but by enjoying what I have.

* * * * * * * * *

Dear Dr. C,

About a month ago, Dr. X [his first therapist] died. I was okay with his death, but I wanted to tell you of it and couldn't because when I thought of doing so, I cried and became almost unbearably sad. Now I can tell you—I think because I understand more of what is going on. I think I became so sad at the thought of telling you because what I would really be saying to you is: please don't abandon me. I think I have a great fear of abandonment, not necessarily equated with death. I feel Dr. X abandoned me in important ways during our relationship, and not by his death. Likewise, I think my father abandoned me in important ways right up to his death. I have left many people—maybe everybody, I seem to need to do that to feel free . . .

* * * * * * * * *

Dr. C,

I certainly do challenge the hell out of people, and what you said when we last talked [about his pushing people to become

> angry at him so that he feels he controls his abandonment] is a big piece of the puzzle of why I do that, and of why sometimes I seem to feel more of an attachment to people only from some distance, and only after I have left them. Do you know any shrink to whom that applies?

One of the most painful aspects of the work with Dr. S was that his self-understanding, excellent though it was, had such a small impact on his behavior or relationships. He recognized how aspects of his past experiences with his parents and siblings had shaped his relationships with family and friends, and with me in the analysis. His seductive and self-centered mother and his competitive, angry, sarcastic father—who wanted his son to be outstanding yet less so than himself, powerful but still subservient—remained unchanged ghosts inside his head, transferred almost whole cloth to every relationship. Basically, Dr. S was not able to let go of these internal objects, whom he used defensively to protect himself against his vulnerability to trusting and having that trust betrayed.

Even now, I feel hesitant to read Dr. S's e-mails or pick up his voicemails on my answering machine. I wonder why he writes and calls, what he wants—knowing as I do that his desire to hurt, to retaliate for what he felt I promised and did not deliver (as well as to retaliate for what I *did* deliver, for what helped), continues into the present, as does, equally strongly, his wish to connect with me.

I also think he knows these things, as indicated in this e-mail:

> Dear Dr. C,
>
> I feel bad about yesterday's message; I was feeling bad and it was manipulative and impulsive. Attempted manipulation only makes things worse for me; glad I caught myself, but unfortunately it was after, not in, the act.

Did I learn from him? Yes, an enormous amount. But throughout Dr. S's analysis, our interactions created in me the feeling that I had lost control of my analyzing capacity. Since my work with him, I think I do better by my patients. I am less defensive, more direct, and more tolerant. He kept me learning—but I am thankful that not all patients are like him.

Did I help him? I think I did, but I remain sad when I think about him and his treatment. The analysis worked and yet it did not work. It is not that psychoanalysis was not the treatment of choice; it is that we could not stick with it, could not carry it through to completion. Ultimately, I felt defeated by him. I offered all I had, and he took it, used it, and then made clear that it was not enough.

I believe his analysis was the most painful one of my career—which speaks to my psychology as well as to his. Dr. S worked consistently on two fronts: first, to understand himself and achieve some measure of comfort with himself; and second, to protect himself from me, from being with me in a way that allowed us to trust in our connection. Throughout his analysis, whenever we began to work collaboratively, he would attack. For me, the pain of the work came from the repeated disappointments, the repeated experience of thinking we were working together only to have any sense of collaboration denied. Time and again, I felt the need to protect myself from being vulnerable to his attacks. What was so painful was that we could never say to each other, "We did it together."

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COMMENTS ON JUDITH FINGERT CHUSED'S "AN ANALYST'S UNCERTAINTY AND FEAR"

BY AISHA ABBASI

Keywords: Treatment failure, analyst's motivation, uncertainty, narcissistic issues, anger, analytic intervention, aggression, termination.

In this paper, Judith Fingert Chused describes her struggles with uncertainty and fear (not unusual psychic companions for an analyst at work), with special focus on work with patients who make it very difficult, if not impossible, for an analyst to forge an intimate relationship with them. She recognizes that many of us who become psychoanalysts have a wish and a need to help people within the context of intimacy. In some analyses, genuine intimacy never occurs or does so only sporadically. Patients who cannot genuinely work together with an analyst (because they cannot "tolerate 'working with'" (p. 838) often feel unhelped by the analyst and the analytic treatment, Chused writes, even after many years of analytic work. "So for me," Chused tells us,

> . . . the hardest part of the work is not the patients who complain of what I am doing wrong, but the patients whom I believe I have not helped enough—those who, if not damaged, have wasted years of their lives in a treatment that provided insufficient benefit. [p. 837]

She refers to such patients as those who "got neither what they wanted nor what they needed, who left analysis not much better than when they entered" (p. 838). Chused illustrates, through her description

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of her work with Dr. S, such a "failure" in treatment, referring to this particular analysis as "only a partial failure" (p. 838).

I am reminded here of Goldberg's (2012) sophisticated attempt to define what we might refer to as failure in psychotherapy and psychoanalysis, as well as the causes of such failure—in the patient, the analyst, the method of treatment, etc. On the very last page of this book, Goldberg writes:

> *This book may do no more than be a representative of the "failure" situation. One salient feature of the study of that situation is the resistance to its investigation.* Failure is such a dreaded experience that it is regularly ignored, denied, or displaced elsewhere. At the very least, this book may succeed in letting failure come out of the darkness and allowing its presence to be acknowledged. One must live as a failure long enough to allow a personal struggle that in turn may open up a proper objective scrutiny. Feeling a failure should not merely be an impetus to be rid of it . . . . At long last, it should be an opportunity. The success of the book rests on its embrace of failure. [p. 217, italics added]

In her paper, Chused gives us exactly the kind of opportunity Goldberg refers to: to hear in detail about a case that the analyst considers to be a certain kind of failure. I appreciate, deeply, the chance to be involved, along with other colleagues, in thinking about Dr. S and Chused's work with him—especially in the context of the analyst's uncertainty and fear when working with particular patients.

Chused clearly describes the difficulties and frustrations she experienced with Dr. S, who, while being helped in many ways by his work with his analyst, "remained dissatisfied—with himself, with me, and with what we had done" (p. 847). She notes that, as the time approached for Dr. S's externally determined termination (in order to take part in a project in South America), for some reason he began to work with her in a more mutual and collaborative way. I am not clear how this new collaborative ability on the patient's part was understood in the treatment. Was it a sort of parting gift to the analyst, or did it feel safer to the patient to work more collaboratively with Chused once he knew he would soon be leaving, or was there some other reason?

Chused tells us that Dr. S seemed to better understand at this time that thinking of his analyst as critical reassured him that she was interested in him. I wonder what had made it so difficult for him to know and feel this earlier on. I was confused by Chused's statement that "it would be awkward [for the patient] if he thought I really liked him because then he would not be able to tell me what he did not like about me" (p. 847). The reader is not told what Chused made of this curious comment.

And in the very last session, Dr. S tells his analyst, "Well, you did your best" (p. 847). Without knowing for sure, of course, I wonder if this parting comment, seemingly meant to make the analyst feel insecure and hurt, actually succeeded in doing so. I am prompted to speculate about this because, a few lines later, Chused writes that Dr. S calls and e-mails her from time to time, and

> . . . his ambivalence is still very much in evidence. *For example, when I found a therapist for his son, rather than thanking me*, he wrote: "Dr. C, I assume you don't need prompting from me about when it's appropriate to charge you for your time and skill; so, I won't prompt." [p. 847, italics added]

This suggests that Chused expected and hoped (as most people would) that the patient would thank her, and once again, Dr. S responded with condescension and a focus on money, rather than expressing his feelings about needing his analyst and her continuing help. This led to Chused feeling hurt and chagrined yet again.

To my reader's eye and analytic ear, Dr. S's comment that his analyst had done her best is very much connected to the struggles he demonstrated about his sense of himself when, earlier in the treatment, he made a phone call from Chused's office and then asked her: "Did you think I sounded strong on the phone?" (p. 841). He needed the analyst's reassurance that he was functioning as a strong and competent man (unlike the young boy who had to fasten his mother's bra straps and wash her back, feeling, as Chused writes, overstimulated, but not being able to acknowledge or show that he was stimulated).

Dr. S wanted to receive a high grade from his analyst—sometimes in order to fine-tune his narcissistic equilibrium, and at other times to

help him find a narcissistic balance that was extremely difficult from him to achieve and maintain. At the end of the treatment, this situation was beautifully expressed in Dr. S's assignment of a grade to his analyst: "you did your best" (as though she, too, needed such stroking in order to maintain her narcissistic equilibrium). It appears that he was also hoping to hurt and annoy her with the message that *her best was still not enough to help him.*

Working with a patient like Dr. S would feel difficult to many, if not most, analysts. The level of difficulty experienced would depend to a certain degree, of course, on the analyst's psychic makeup and the analyst's understanding of it. Dr. S's serious narcissistic vulnerabilities, barely masked by his patronizing and condescending attitude, and the attacking and acerbic defensive style he had adopted to survive the difficulties of his childhood, would likely stir feelings not only of fear and uncertainty in the analyst, but also of hurt at feeling deeply unappreciated and useless (in other words, all that Dr. S himself felt most of the time, in relation to himself)—and, ultimately, anger.

All this the analyst would have to feel, stay with, and then be able to step away from—enough so that useful interventions could be made to Dr. S about what the analyst thought was happening in the treatment. Chused made many such useful interventions during the course of her work with this patient. The central question I am left with, though, is: was Chused aware of her rage at her patient?

Let me explain why I raise this question. Early in the paper, Chused writes, "Like many others, I became a psychoanalyst because of a wish to help people . . . and its corollary, a wish to compensate for any of my own aggressive impulses" (p. 836). The second part of this statement is quite startling to me. I find that my own aggressive impulses have stayed with me throughout my analytic career. The only difference is that my understanding of them, familiarity with them, tolerance of them, and ability to express them more appropriately—in a way less hurtful to me and to others—has improved greatly as a result of a good enough psychoanalytic treatment. But my aggressive impulses are not being compensated for when I analyze.

I am aware that, at times, analyzing can itself become an aggressive activity, and I try to monitor this risk for the patient from within myself. At the same time, it is extremely important, I feel, that as analysts, we

allow ourselves to know when a patient's behaviors, aggressive or otherwise, are stirring aggressive feelings in us. This is what I feel is missing in Chused's description of her various feelings about Dr. S. She writes about fear, uncertainty, despair, questioning herself, feeling defensive, etc., but nowhere does she talk about feeling angry with this patient, which would be entirely expectable under the circumstances.

I wonder if this lack of discussion of any anger on Chused's part might be connected to her finding Dr. S's analysis "the most painful one of my career" (p. 850). Whenever a patient leaves treatment somewhat precipitously or because of externally rationalized reasons, as analysts, we experience a whole host of feelings. Many of these resolve over time as we come to understand their various origins. Some feelings do not resolve, and sometimes this is because we have not become fully aware of them and therefore have not been able to work on them in a useful way. Anger is missing from Chused's description of her many feelings about Dr. S, and I feel this is an important omission.

My comments, as the reader will have noticed, are not so much about whether or not this treatment was actually a complete or partial failure, but are instead about what causes an analyst to experience a particular treatment in a particular way. Some analysts might feel that Dr. S received much that he found helpful from his analyst and his analysis. In fact, Chused continues to offer profound containment to her patient, in that she receives and at times responds to his e-mails. Analyst and patient continue to work together in a way that the patient can tolerate. Chused notes, "What was so painful was that we could never say to each other, 'We did it together'" (p. 850). For me, what is remarkable is that the patient and the analyst are *still* doing it together.

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THE DESIRE FOR THERAPEUTIC GAIN: COMMENTARY ON CHUSED'S "AN ANALYST'S UNCERTAINTY AND FEAR"

BY MITCHELL WILSON

Keywords: Desire, clinical vignettes, analytic relationship, uncertainty, therapeutic gain, fear, disappointment, bias, analytic change, trust, understanding, analytic frame.

It seems that the calling card of any respectable and respected psychoanalyst must include words that convey humility and a sober assessment of the limits of what he or she can accomplish: after name, address, and phone number come the words "And please don't expect too much." Bion is said to have stated that the psychoanalyst must make the best of a bad job. It is commonplace, in short, to hear a psychoanalyst lay claim to the mantle of struggle, ignorance, and doubt.

There is something disingenuous about such a self-introduction because, at least as far as the contemporary psychoanalytic literature goes, such humility-as-inherent-limitation is, often enough, merely the first phase of what usually evolves into a favorable, often enthusiastic clinical report. The typical trajectory of the psychoanalytic case vignette takes a familiar form, and it is the form, roughly speaking, of the short story:

It is a dark and stormy night: the protagonist is in some kind of trouble.

There's a problem: the patient is difficult, or the analyst is confused.

Then something happens in which the character acts blindly and the stakes are raised.

There's an enactment, a mutually created resistance, an impasse. This part usually lasts a while.

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Finally, a veil is lifted as our hero gets new information, experiences an illumination, often of the painful variety.

> After much hand wringing and internal struggle (a key feature of the aforementioned analytic humility), the analyst understands something hitherto not seen, not understood.

The fictional short story usually ends there, at the point of the painful illumination. But the analytic short story must continue because *something new and different* ought to occur. And so, in possession of new insight, the analyst changes his or her position.[1] This change has felicitous effects on the patient and the entire analysis. *Night, in other words, has turned to day.* If not everything is right with the world, things are at least better in the analysis.

From a bird's-eye view—having, that is, read many such vignettes[2]—one cannot help but wonder: is this an accurate report of a case from a clinical practice, or a well-worn short story from the local MFA program? Sometimes it is hard to tell.[3]

But my so-called bird's-eye perspective is not, in the end, why I know the short-story tropes so well or how I have become aware that they seem to be a requirement of the contemporary psychoanalytic clinical vignette. I myself have indulged this narrative convention in *every* case vignette I have ever published. Problem, struggle, and illumination. Lather, rinse, and repeat. I had points to make, of course, positions to argue for, as most of us do when we write papers and support them with clinical illustrations. This effort at argumentation cannot be gainsaid.

At the same time, one must wonder—–seriously wonder—–about the value of a clinical literature in which the positive report, the eventually good outcome, is the norm. We know that publication bias is an endemic problem in all the sciences, especially biological and medical sciences.

[1] Or sometimes, as is made clear by the countertransference enactment literature—to which Chused has been a special contributor—action may precede insight.

[2] The author serves on the editorial boards of *Journal of the American Psychoanalytic Association* and this journal.

[3] Even, or perhaps especially, a recent quartet of papers published under the heading "The Analyst's Disappointments, Grief, and Sense of Limitation" fulfills the narrative requirements I have just outlined (Bronstein 2015; Cooper 2015; Greenberg 2015; LaFarge 2015). "Disappointment," in other words and seemingly inevitably, eventually gives way to something better.

This is true despite the fact that we are taught from the very first day in any introductory statistics class that the investigator starts from the position of the *null hypothesis:* the assumption, until data disproves it, of no significant difference between treatment groups or no meaningful co-variation between independent variables. In the end, a negative result (i.e., confirmation of the null hypothesis) simply does not sell.

If we are to seriously wonder about publication bias, perhaps we might take a more empirical approach to its ubiquity and note that, in psychoanalysis, the typical case vignette seems to take a typical form. If it is true that cases published in the literature have this shape, the question then becomes: why do they have it? It is easy to bemoan the hazards of publication bias, but harder to take its existence as a *positive indicator* of something about the human mind and human desire. Maybe, for example, the short story configuration I have described is a *formal requirement* of the human mind—a necessity of cognition to make sense, to see shapes and dynamics within a narrative. Perhaps it is a search, in other words, for the *delta:* the perceptible change from State A to State B. And the perceived change, we aver, is *caused* by specific actions on the part of the analyst.

This causal explanation is a central element in the overall structure of the psychoanalytic narrative, an explanation that we desire and that we naturally seek.[4] A related question is: do we read bias into psychoanalytic case reports? Or rather: do we *desire* to perceive therapeutic change in the case vignette, and do we therefore *require* publication bias—or at least put pressure on the text or its author to routinely describe his or her emergence from darkness into light, from impasse to illumination?

We might think of this possibility as a displaced version of *therapeutic zeal*, an attitude that presents us with all kinds of dangers in the consulting room, but that seems to have made its way repeatedly into our clinical literature—as in: "Psychoanalysis is a tough business and exacts its tolls, but in the end, by Jove, it works!"

* * * * * * * *

[4] Note how easily we can mislead ourselves into thinking that the *causal reading of therapeutic change* actually took place, especially in a linear, past-to-present fashion. The fact is that we read cause into the narrative *retrospectively*, only after having concluded that change happened.

What you have just read are thoughts prompted by Judith Fingert Chused's frank and bold paper, "An Analyst's Uncertainty and Fear." Hers is clearly not a paper in the conventional sense. There is no real argument, let alone illumination; it reads as a personal offering, an admixture of memoir and confession.[5] Chused's account of Dr. S does not, needless to say, follow the conventional progression I have outlined above: namely, problem—struggle—illumination. In fact, the case of Dr. S is long on the problem and struggle parts without much in the way of illumination.

Chused's text, in other words, alerts us to the conventions of clinical reporting, and especially to our *readerly* desire to perceive therapeutic change, precisely because the analyst herself expresses so much doubt that anything good happened. Thus, reading Chused's report caused me to ask the following questions: what happened with Dr. S? Was it really as bad as all that? Was there in fact no change, or so little change that all of us should pack up our bags and go home? Or is the delta from State A to State B visible, perceptible? Finally, if change is in evidence, as I believe it is, then why the foregrounding of disappointment, unhappiness, defeat?

These two issues—my desire to read therapeutic change into the text, and Chused's emphasis on failure—will frame the rest of my discussion.

Before trying to track down therapeutic change and link it to the analyst's actions, one must first note Chused's description of the case of Dr. S as a "partial failure" in which she wonders what she "could have done better" (p. 838). This kind of personal accounting about a given case seems as common as the day is long. Who among us has not felt these feelings more than once, even often? Quickly, though, we learn that the case of Dr. S does seem to go beyond the commonplace. Dr. S refused to trust Chused; he could not tolerate "working with" her. He would "mishear" (p. 838) most of what she said to him, make impossible requests, and often leave her feeling "angry, anxious, and—most of all—guilty" (p. 839). There is a driven, quantitative element to Dr. S's way of being that

[5] Interestingly, however—as Jamieson Webster (2011) makes clear in her original and compelling book *The Life and Death of Psychoanalysis*—scholarly work and memoir are closely, even intimately, related to one another.

Chused captures well, such that we say, "Okay, now it's clear we are in unusual, though certainly not unprecedented, analytic territory."

At this point, early in the treatment, one can see how uncomfortably affected Chused is by Dr. S. But we also notice something else. And this item is what I would designate as a key *causal* element in the therapeutic narrative I wish to tell: that Chused is "captivated" by Dr. S and is up for the "challenge" he presents to her (p. 840). Isn't this willingness to be challenged, even deep inside our very being, a feature of most psychoanalysts who take their work seriously?[6] While Dr. S made Chused feel intensely uneasy for all kinds of reasons, large and small, in the end, she is a tough customer. She is up for this challenge.

It is not accidental that the next bit of information Chused tells us is that she did not waffle on her fee. Dr. S protests, accuses her of all kinds of insensitivities, but she holds firm. Chused is strong in the face of Dr. S's attacks, a fact that Dr. S himself is said to register. The last thing a terrified patient wants to engender through his actions is terror in the analyst, such that she reacts by changing basic features of the frame.

There is a sense here as well that Dr. S, in spite of his propensity to externalize blame and responsibility and make life miserable for Chused, likes a challenge as well: "He also made explicit that, even though I did little that was useful, he was determined to stay in the analysis as long as *he* wanted to be there" (p. 841, italics in original). The episode with the phone call in Chused's office also reinforces her resilience in at least two senses: she tells him she feels "a bit overwhelmed and did not know where to focus" (p. 842). That is, this piece of self-disclosure reflects a kind of strength: she is not, she implies, overwhelmed about feeling a bit overwhelmed. Secondly, she tells him to pay his bill, which is in arrears. The complexities of the maternal transference emerge, though nothing seems to take hold, as Dr. S careens from extreme dependency to an equally extreme need to control. This careening leads Chused to feel constrained and unspontaneous, and to reasonably feel that at times Dr.

[6] I have always found Lacan's (2006) description of the analyst's position helpful, especially with difficult cases: we pay with our words (via interpretation), pay with our person (via the transference), and pay with our very being. Regarding paying with our being: when you feel you cannot go on, you do go on. As Chused says at one point: "But the work was so painful" (p. 843).

S is both speaking truthfully and manipulating her. She is often discouraged, but she keeps going.

By year three, there is progress: his relationships have improved. And the analytic relationship has deepened, if it is no less vexed. The very tools that analysts use—words—and the basic values that underwrite such use—the desire to understand—feel like traps to Dr. S. Chused's trying to understand him turns him off.[7]

Be that as it may, is there any question that when Dr. S says . . .

> It's like your talking to me; it feels like you're exercising power over me, trapping me, even though I know intellectually it's well intended. I used to want you to exercise power over me, but now I'm trying to stop you from having any power . . . . I want to please you by talking, but the wanting bothers me . . . [p. 845]

. . . that things have changed, that Dr. S is changing—even though, by the next paragraph, he seems to have slid back again?

After Dr. S has ended his analysis, he sends e-mails (and voicemail messages) to Chused, some of which she shares with us. To my ear (and again, through my desire to perceive therapeutic change), these communications are complex, relatively self-reflective, and often deeply moving. In the first e-mail, Dr. S acknowledges to Chused that "[you] probably really were trying to help me." And: "Although I do not regard our past time together as a smashing success, I do not regard it as a failure either, and I hope you do not" (p. 848).

The second e-mail is explicit about how Chused has been "helpful" in a particular way; she sits in his mind as an interlocutor with whom Dr. S can meaningfully converse. "I feel a profound change in me," he writes to her. The third e-mail is poignant in the extreme: "Please don't abandon me," he writes, after telling her about the recent death of his first therapist. The penultimate e-mail we read reinforces these feelings and thoughts, this time marked with a bit of self-irony. As he describes the way

[7] This is an excellent example of something that is common in psychoanalysis: that the things we most take for granted in clinical work (such as the use of words and the value of understanding) can become sites of contest, of mutually created resistances (Wilson 2003, 2013).

he "challenge[s] the hell out of people" (p. 848) and feels "attachment to people only from some distance" (p. 849), he moves *closer* to Chused.

We might wonder why, particularly in light of the evidence for significant change I have marshaled, Chused tends to foreground the ways in which the case foundered. Immediately following the penultimate e-mail I just referenced, for example, she tells us about "one of the most painful aspects of the work with Dr. S" (p. 849), as if to remind us, again, that things did not go well. At the end of the paper, she evokes failure one more time and more forcefully: "Ultimately, I felt defeated by him. I offered all I had, and he took it, used it, and then made clear that it was not enough" (p. 850).

One can feel "defeated" only if one wants to "win." What would "winning" look like in this case? Here, I believe, we must consider the analyst's desire—what she wanted to have happen in the analysis—and the values that underwrite this desire. I have no doubt that working with Dr. S was extremely trying at times, difficult and painful. But this difficulty and pain in part speak to the ways in which this particular analyst's desire was put into play in relation to this specific patient. We find out about this desire early on in the case report. Chused values being *trusted*. She wants to feel that she and the patient are *working together* on a common project. Though she is clear that psychoanalytic *understanding* is a complex matter (e.g., it can be used defensively to make up for confusion and opacity), it is still something she values highly. Specifically, she wishes that Dr. S could utilize his self-understanding such that it had more than a "small impact on his behavior or relationships" (p. 849). Further, it is important to Chused that she not lose control of her *analyzing capacity* (p. 849), but lose it she often did. (There are, of course, other desires we can readily identify.)

Taking all the above into account, the analyst's "winning" in this particular case would involve her being satisfied that the various conditions she imposed on the patient were met (i.e., that he trusted her, listened to her without distorting her words, worked together with her, utilized his self-understanding to make lasting changes in his life, etc.).

One of the aspects of this case that makes it so universal (even though it is presented as unusual) is that we can easily identify with these

analytic wishes. I do not know a psychoanalyst who does not want to be trusted or to retain his or her analyzing capacity in the face of difficult moments with a patient. Yes. Of course. And all of us, inevitably and necessarily, impose conditions of satisfaction on patients (Wilson 2013).

But what this case demonstrates is that these desires, so much a part of our working selves that we often take them entirely for granted, seem beside the point. They seem beside the point in the following sense: each analysand moves through psychoanalysis in his or her own particular fashion. This "moving through" is as complex as it is singular. The analyst's desire for a distinct *kind* of therapeutic gain may be (and perhaps often is) *orthogonal* to how a given patient benefits from an analytic experience. Dr. S did his analysis with Chused in his own mode, in his own idiom. Perhaps he trusted Chused in the exact manner in which he can trust. Perhaps he utilized the knowledge and insight he gained from his work with her in his own singular fashion. And perhaps he learned how difficult he can be precisely through his experience of "being difficult" with Chused. How could it be any other way? I would say that it *should not* be any other way. It should not be, especially, the *analyst's* way.

Here we tread on issues of the ethical position of the analyst, issues too complex to elaborate here[8]—except to note that Chused, in my reading, maintained her ethical position. By this I mean the following: it does not appear that she changed her stance in relation to Dr. S very much; she maintained it. (This is another sense in which her case report betrays the usual conventions.) Though being Dr. S's analyst was difficult, disappointing, and just plain hard, Chused appears to have continued to be herself in her work with him. She sustained her basic stance as best she could, without any attempt to control the patient through interpretations that risked his feeling more humiliated or ashamed or trapped than he already did. Chused controlled the treatment (in our current vernacular, she maintained the frame); she did not attempt to control the patient. Though Dr. S often worried about control, in the end one can see that he was given enough freedom to move meaningfully into new emotional and personal territory. While Chused fears she did not do

[8] The terrain of an ethics of psychoanalysis was first demarcated by Lacan (1992), and more recently by Kristeva (2014) and Chetrit-Vatine (2014), among others.

her best, to my way of thinking, she did more than enough. Most important, Dr. S himself told her: "Well, you did your best" (p. 847).

It has been personally worthwhile for me to think about the issues that Chused's paper engages and the desire for particular kinds of therapeutic gain—in the analyst, the patient, and the reader—that these issues evoke. I wish to thank her for the opportunity to discuss her admirable work.

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COMMENTARY ON JUDITH FINGERT CHUSED'S "AN ANALYST'S UNCERTAINTY AND FEAR"

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Keywords: Uncertainty, bastion, fear, self-analysis, analytic relationship, splitting, bedrock, termination, countertransference, enactment, identification, seduction, projection.

Chused's lovely clinical report is not only a *cri de coeur* from the trenches by a master clinical analyst. With her honest description of her ongoing countertransference experience and her sensitivity to telling nuance and detail, she provides us with a rare document that allows us to consider the unfolding of the transference-countertransference and intersubjective matrices of the analytic process in all their messiness, complexity, and moment-to-moment unfathomability.

Chused avoids the preprocessed, neatly shrink-wrapped reports of momentary countertransference experiences, seemingly quickly thought through, sanitized of their inevitable infiltration by still-unresolved intrapsychic conflicts of the analyst, and transformed into mutative interpretations—in short, the kind of report that we sometimes see in our literature—and instead allows us to focus on a different but equally important realm of intersubjective experience: the enmeshment of irreducible or only partially reducible aspects of the analyst's and the patient's intrapsychic lives, as well as their fate in the analytic process and in the post-termination self-analytic reflections of both.

Partly because of the richness of Chused's report, and partly because of the always tentative quality of understanding that may be reached as

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we think about clinical material, it is difficult to comment on her paper without introducing broad speculations that, in the clinical situation or in collegial consultation, would be refined, modified, and further elaborated through interpersonal dialogue. At any moment, the analyst's clinical formulation is a mixture of inference and speculation, a series of interconnected ideas that are individually held with varying degrees of conviction.

In my comments, I will err on the side of broad inclusion of ideas that might well require further refinement. I hope that the reader will take this as an invitation to engage in internal dialogue with these ideas, rather than seeing them as intended to be authoritative assertions.

PATIENT AND ANALYST ENGAGE

Chused begins her report by telling us of her motivations to become an analyst, the course of her emotional development as a professional, her vulnerabilities, and the ways in which she has traditionally coped with these vulnerabilities. Like many of us, she finds the sense of uncertainty inherent in *good* analytic work painful; she has difficulty reconciling herself to the clinical limitations of psychoanalysis; she is fearful that she may do harm to her patients; and she identifies a particular fear about a sense of aloneness and disconnection from her objects and, in particular, her patients. She has used her relationship with authority, and a sometimes masochistic submission to internalized authority figures, as a way of containing her fears. Though she has struggled to break away from omnipotent aspects of those internalized authorities, she nonetheless continues to grapple with a feeling of failure when she confronts the limitations of the psychoanalytic project.

Chused's patient, Dr. S, on the other hand, is intolerant of exactly the kind of connectedness and collaboration that Chused needs in order to feel sufficiently safe from her fears to be confident in her analytic work. Dr. S does not merely withdraw occasionally into a state of disconnectedness; rather, his *unremitting* devaluation and rejection of Chused's efforts leave her feeling alone, guilty, and angry. At the same time, Dr. S uses his intellect, charm, and creativity to establish a seductive ambiance in the treatment, and Chused not infrequently finds him attractive.

Though he appears to be in control of the sessions and seems to exert a similar control in his other relationships, he complains of disappointment and hurt at the hands of all his objects—of powerful feelings of helplessness and incompetence in his relationships and in many tasks of everyday life, as well as a feeling of being overwhelmed as he contemplates entering treatment with Chused.

Quickly established from the outset, this sexualized sadomasochistic relation persists throughout the treatment; and I believe it becomes a theater for the acting out and attempted mastery of fragments of Dr. S's relationship with his overstimulating, sexually abusive, self-justifying, and possibly psychotic mother.

THE PATIENT AS TRAUMATIZED CHILD

The foregoing depiction of Dr. S's mother, I suppose, is a harsh one—different in degree, if not in quality, from Chused's vision of Dr. S's mother's "self-centered seductiveness" (p. 843). Yet I believe that thinking of Dr. S as having suffered this kind of trauma is a helpful organizing hypothesis that allows us to make sense of the relation between the history he reports and the analytic process as it unfolds. Of course, neither Chused nor I have any firsthand knowledge of Dr. S's mother, nor could any firm conclusions about the *actual, external mother* ever be drawn from the data available from the psychoanalytic situation. But though we cannot determine from analytic data which views are more accurate, I think we can make some inferential hypotheses about Dr. S's *psychic reality* in his vision of the mother. These hypotheses derive from the fact of the difference in countertransferential shadings between my sense of the mother and Chused's sense of the mother.

What I would suggest is that there is a split in Dr. S's vision of the mother, of which this difference is a manifestation, and that it manifests as well in important ways throughout the analytic process—ultimately, I believe, in Chused's experience of herself and her analytic work with Dr. S. I will present some hypotheses later on about how Chused's guilt and self-doubt may have arisen from the process set in motion by this split.

Only one childhood memory appears in the report of Dr. S's analysis. In the memory:

> She [the mother] had told him repeatedly that men have trouble with women because they do not understand them. He had spoken with great anger of her behavior with him and his brothers, describing how she had taught her three sons about women by telling them about herself and showing them her body. [p. 842]

It is a briefly stated memory, but it depicts a scene that occurred *repeatedly,* in which the mother exposed her (presumably naked) body to her young sons, asking them to fasten her bra straps or scrub her back while she was bathing, and told them that this was in the service of their feeling more comfortable with women's bodies (!)—implicitly denying any pleasure or satisfaction that she was deriving from the experience and presenting it coercively as for their own ultimate benefit, despite the psychological damage that her behavior was inflicting on them.

ENACTMENTS WITHIN THE TRANSFERENCE-COUNTERTRANSFERENCE MATRIX AND THE MASTERY OF TRAUMA

Much of the process reported by Chused can be understood as a series of enactments between Chused and Dr. S of split-off or fragmentary aspects of the scene of sexual abuse (which itself may be a screen that condenses multiple experiences Dr. S had with the mother across extended periods of time). Such enactments are an inevitable and important part of the psychoanalytic process for patients like Dr. S. The specific shape that the enactment takes is partly determined by the particular vulnerabilities and defensive styles of the analyst; these present themselves as opportunities for the patient to engage the analyst in emotionally charged interactions that the patient is impelled to repeat. In such enactments, the patient identifies either with self or object in the traumatic object relation, maneuvering the analyst to participate by playing out the role of the opposite partner. Often the enactments may condense simultaneous identifications with self and object; and this is, I think, the case in many of the double binds in which Chused finds herself placed by Dr. S.

The engagement of Chused's fear of aloneness and Dr. S's intolerance of connection becomes the theater of enactment almost from the beginning of treatment. Chused reports that:

> His discomfort with connection led him to mishear most of what I said, to make requests I could never fulfill . . . . I was often apprehensive as his hour approached, anticipating that not only would I again be experienced as unhelpful, but also that my nose would be rubbed in it, and that the session would end with me angry, anxious, and—most of all—guilty. [pp. 838-839]

Here I think Dr. S arranges for Chused to feel a piece of what he felt as a child at his mother's hands—placed in a position in which there was an implicit demand on him to offer the mother the sexual satisfaction that he could not offer, and in which he was fearful of being confronted over and over again with that demand. In this enactment, Dr. S triumphs over Chused by identification with his experience of the mother as sadistically rubbing his nose in his inability to satisfy and his fear of being called upon to do so.

Like his mother (at least in his perception), Dr. S holds out a sexual lure to Chused in the form of his charm, intellect, success, and power, but this is in the service of his sadism and exhibitionism and of his wish to frustrate and humiliate rather than satisfy Chused. In the incident with the telephone, Dr. S abruptly crosses the boundaries of the analytic situation, then asks to be admired—and desired—by Chused for his phallic strength, his ostensible devotion to her, and his masterful crossing of the boundary, at the same time warning her that he would dismiss her if he thought she was feeling the attraction he actually hoped she was feeling.

This enactment, in fact, occurred during the session after the patient had revealed the memory of abuse and overstimulation at the hands of the mother. Chused simultaneously feels "intimidated" and that she has "a very limited understanding of what had just transpired" (p. 842), but she quite accurately interprets, I think, the part of the patient's experience she has experienced through his projective mechanisms—being overwhelmed, confused, unable to think. What she does not interpret is that he defends against this feeling through a detailed identification with a well-elaborated perceived vision of the seductive, sadistic, rejecting, and self-congratulatory mother.

The result is that this identification continues to find expression in enactment, and the patient responds with "Nice try, Dr. Chused, but

that's no excuse for not answering my questions" (p. 842). This made me wonder if, despite her efforts to "train" the young Dr. S to be comfortable with women, the mother may have seemed to him to be more invested in the image of him as a clueless trainee than she was in nurturing his actual capacity for empathy with women and their sexual needs—a relation he now repeats with Chused, casting himself in the role of the mother.

Is the interpretation completely rejected, in fact, or is it taken in in such a way that allows Dr. S to maintain his position of contemptuously rejecting Chused's help while insisting on satisfaction of his boundary-violating demands? I believe it is the latter, and I will address that mechanism in further detail shortly, but first I want to comment on a further enactment that highlights Dr. S's persecutory experience of the mother, as well as the fragmentation in his sense of interpersonal reality connected with this experience.

Dr. S has fallen behind in his payments, and after some rationalization, he tells Chused that his transference to her as a demanding person might be interfering with his paying her. Chused says he may be right about that, but in fact she wants to be paid nevertheless. He says he appreciates her honesty, and he pays her. In the following session, he talks about wanting to be taken care of; he feels ashamed as he imagines that Chused might think he wants her to be his mother. He remembers his mother walking in on him while he was masturbating, imagines that Chused is imagining him masturbating, then wonders if he *wants* her to imagine him that way.

At this point, he starts to cry, saying that Chused must feel this is an intellectualization, and that his mother never took him seriously either. He then says he feels Chused is repulsed by him. When Chused asks how he knows this, he responds: "Actually, I am a puppeteer in here, and you are my puppet . . . . I pull one string or another to get you to perform . . . . It makes me feel safe, but the problem is, what I get from you is worthless" (p. 843). Chused answers: "This all sounds so empty." Dr. S responds: "You're trying to be empathetic in order to trap me" (p. 843).

There is a lot of action packed into this brief exchange, and the shifts in tone, voice, and constructions of the interpersonal reality between Chused and Dr. S are dizzying. Chused, in her intervention, I

think, is responding to the feeling of the relation between Dr. S and herself being emptied of emotional content by Dr. S's final, desperate attempt to escape the powerful and confusing affects he is feeling through omnipotent control and devaluation of Chused.

I believe, however, that it is possible to come to at least a tentative understanding of what is going on by seeing the exchange as one in which Dr. S has precipitated a conflict between himself and Chused about the fee, serving the purpose of evoking for him, in some detail, the repeated, traumatic, perverse seduction by the mother. He then tries to express the feelings he experiences and to master them through perverse sexual fantasy, identification with the aggressor—and, ultimately, when these fail, through omnipotent control and devaluation of Chused.

Dr. S's falling behind in his payments places Chused in the position of having to make a demand on Dr. S to pay her. For Dr. S, this evokes the mother's demand that he be an understanding sexual partner for her. Perhaps in the spirit of placating her by going along with her ostensible wish to help him be a more effective man, Dr. S explains that he is being effective in another way, by prudently managing his investments. Paying lip service to Chused's "ostensible" wish to help him through understanding, he makes an interpretation of his own behavior: his experience of Chused as a demanding person. As Chused points out, this interpretation is probably correct.

Chused now moves the focus from the meaning of his behavior to her realistic expectation of how he is to behave with her, which is that, in this instance, he is *properly responsible for attending to Chused's wants and needs and for making the arrangements he needs to in order to pay her bill.* Dr. S is pleased and relieved—if not that her demand for payment stands, then at least that she is honest (unlike the mother) about this demand being for her and not just about his growing up to be an effective man. He pays her, but then gets himself into trouble by being an incompetent and irresponsible little boy, getting arrested and bouncing a check. Again correctly, he interprets that he wants to be taken care of and to have a mother—maybe even in the person of Chused, who will empathize with him as the little boy he is and not make demands on him to prematurely and incestuously serve as a competent and satisfying sexual partner for her. As he says this, he feels shame and imagines

Chused perceiving his wish to have such a mother in herself, and being contemptuous of him for it, as he felt the mother was of his dependency wishes.

Dr. S then reports a memory of his mother walking in on him masturbating, and he imagines Chused visualizing him masturbating and then wonders aloud if perhaps he wants her to do so. Here, both in his memory and in his fantasy about Chused watching him masturbate, he is trying to reinstate an image of himself as phallic and potent, simultaneously triumphing over the mother's contempt of him as a man and identifying with her as a threatening sexual presence, exhibiting his naked sexuality to her and to Chused. His self-interpretations, accurate or not, are then revealed as carrying the meaning of a demonstration of his potency with Chused, but he cannot be certain whether she believes in his potency or scorns it.

"You're thinking this is all just an intellectualization—my mother never took me seriously either" (p. 843), says Dr. S, and in the moment, he becomes convinced that Chused is contemptuous of his interpretive potency and is repulsed by his impotence, dependency wishes, and pathetic attempts to look like a big man. Chused, struck by—and perhaps inadvertently confirming (in Dr. S's eyes)—his conviction about her scorn, asks how he can tell. Now he is certain he is the object of her contempt, and he responds by declaring that he has controlled everything she has thought, said, and felt about him ("I am a puppeteer in here and you are my puppet," p. 843) and devalues everything she might offer him. His final statement here, I think, sums up an essential conflict for Dr. S: he cannot trust others' empathy and concern, the very tools with which Chused is offering to help him, because with the mother they repeatedly proved to be a trap leading to her perverse, sadistic, self-justifying sexual scenario.

Obviously, I am making a lot of inferences here, and I am not asserting that every detail I have inferred is valid; but what I am suggesting is the value of looking past the surface chaos and emptiness that the patient presents and trying to imagine a detailed narrative of a trauma reexperienced through the lens of repetitive object relational configurations with rapidly shifting identifications within those configurations, and the use of primitive defenses such as splitting, projective identification, and omnipotent control of the object.

THE SPLIT BETWEEN EXTERNAL AND INTERNAL OBJECT AND THE CONSTRUCTIVE USE OF THE OBJECT

One of the striking things about Chused's report is the consistent sense that, despite Dr. S's relentless devaluation of her and his seeming inability—in the moment and in her presence—to accept the good she offers in such a way that allows her to have the experience of doing productive work together with him, Dr. S nonetheless seems to experience growing insight, self-awareness, and clinical benefit in areas outside the analysis. It is a puzzling situation, though not an unfamiliar one, I think, for many clinical analysts.

For Dr. S and patients like him, I believe that this seeming contradiction may be understood as a manifestation of the use of a particular form of splitting in order to retain some form of contact with a loved object, which is nonetheless experienced as intolerably bad, and to continue some form of emotional growth. Rather than our seeing such a mechanism as either *healthy* or *pathological* (a view that is itself a form of countersplitting), I think it is more productive to understand how it works and to see it as the best that the child (or patient) may be able to do in the face of such an object.

In this mechanism, the badness and persecutory aspects of the object are experienced as completely lodged in the external object, which is held at bay through self-protective refusal of contact with it and devaluing attacks on it. Meanwhile, partly through sexual seduction, the same object is brought close enough so that good aspects of it may be secretly taken in and used to build a good or good enough internal object that can be used for the purposes of comfort and emotional growth. In this way, the dangers of contact with the external object are warded off, while a good internal object is nurtured, communed with, and most important—because it is internal rather than external—controlled. Dr. S explicitly warns Chused early on that this is what he intends to do with her, when he informs her that he "was determined to stay in the analysis as long as *he* wanted to be there" (p. 841, italics in original). Chused correctly understands this as Dr. S's expression of a hunger for nurturance, though I would also think that he is telling her he knows how to obtain

this nurturance in a way that allows him to feel safe from the dangers of contact with the nurturer, and that he knows, or will be the arbiter of, when he has gotten either what he needs or as much as he can get.

For Chused, I think, the disparity between what she observes and cognitively understands, and what she feels through the powerful affective messages sent by Dr. S, which is a manifestation of the split, place her in a familiar but painful position of uncertainty. But I also think that this position is preferable to the desolate sense of a total lack of contact that she can feel at other times with Dr. S. And she has told us that her habitual mode of dealing with uncertainty—particularly uncertainty about whether she has hurt or insufficiently helped her objects—has been to turn to authority, external or internalized, for reassurance.

As she encounters these concerns in the face of Dr. S's confusing messages about his progress or lack thereof, I think she may turn unconsciously to regressive, somewhat masochistically tinged relations with authorities—teachers and supervisors—invested with omniscience and representing values and beliefs that she tells us she has moved away from. Examples are the idea that the goal of analysis is to cure rather than to help, that countertransferences represent a flaw in the analyst that requires further corrective analytic work, and the myth that the "fully analyzed" analyst can be countertransference-free, neutral, and objective most (and ideally *all*) of the time.

It is in the context of the mobilization of this painful, regressive, internalized relation that Chused—somewhat jarringly to this reader, as perhaps to others—seems to go far beyond common modesty when she presents this report as an example of failure (quickly amended to "only a partial failure," p. 838) of psychoanalytic work.

MAINTAINING CONTACT AND THE CONSTRUCTION OF INTERPERSONAL REALITY

Another manifestation of the split between internal and external object, and of the quantitative level of reevoked traumatic affect that this split fends off for Dr. S, is a particular relation with the experience of interpersonal reality that he draws Chused into sharing. I believe it possible

that this induces in her a focal loss of her sense of reality, so that her feeling that the analysis is a failure—or, probably more precisely, that she as an analyst has failed Dr. S—not only becomes more tortured, but is rendered less amenable to modification by dispassionate thinking or by retrospective theoretical and self-analytic reflection.

In his relation with Chused, Dr. S needs to attack her as an external object and to devalue everything she offers him in order to ward off what he sees as the potentially very real *persecutory Chused*. This malevolent version of his analyst, he fears, will use her ostensible empathy and concern for his emotional development as a lure to trap him into a relation in which he is exposed as weak, ineffectual, insufficiently masculine, and dependent on her in a way that humiliates him. She will then both scorn him for these traits and exploit him for her personal satisfaction and self-aggrandizement.

There are many indications that Dr. S has another internalized Chused whom he values, feels gratitude toward, and loves. Chused makes note of these indications, but for her they lack the reality valence of his paranoid and devaluing attacks on her. For example, when Chused helps him by finding a referral for his son, Dr. S writes to her to chide her for not charging for this service and therefore not knowing her own value. But it is clear that part of what Dr. S is saying—and in fact consciously wishes to say—is: "Thank you for helping my son. I realize this is a service that is valuable and one that you could easily have charged for; and that in not doing so, you were not only helping my son, but also giving me a gift that I understand to be a token of your genuine caring for me."

It is the depth of his splitting, and the power of his use of affect to control Chused and her affective experience, that makes the contempt and devaluation feel completely real to Chused, while the gratitude feels false and empty, whatever her cognition might have to say about the situation. My guess would be that the depth of this split for Dr. S, and the power of the projective mechanisms that accompany it, have to do with his inability to reconcile in a more integrated way two alternative experiences of the reality of his mother: one loving and nurturing, and the other cold, sadistic, castrating and sexually exploitative.

At the same time, Chused may be particularly vulnerable to these projective mechanisms because her sharing of Dr. S's experience of the

"reality" of her as an external object allows her to remain in contact with him in some way. By contrast, were she to maintain her own more integrated vision of him and his relation to her, she would be forced to acknowledge that he was relating to a highly distorted vision of her, while keeping his perception of her as caring and nurturing safely locked away in his internal world, inaccessible in the relation with her as an external object—and thus cruelly leaving her to feel unseen and utterly alone with him.

THE BI-PERSONAL FIELD, TERMINABLE AND INTERMINABLE: ACHIEVING THE CAPACITY FOR SELF-ANALYSIS

Despite his ongoing contemptuous devaluation of Chused and seeming inability to work collaboratively with her during sessions for any but the briefest periods of time, if at all, there is evidence that Dr. S benefits considerably from the treatment in a variety of ways. In fact, toward the end of the analysis and then post-termination, he acknowledges some of that benefit. Chused reports that symptomatic change occurs in the context of painful and halting analytic work—that unconscious themes did "emerge and solidify" (p. 843), and that work on some of these themes led to both a greater competence in former areas of incompetence and a greater sense of his own competence.

Exploration of his relation with his mother has appeared to improve his relations with women; by the third year, he demonstrates improved relationships with his children and has a new girlfriend with whom he appears to have a better relationship; and he and Chused are now able to more openly discuss his difficulties in receiving anything from her. He acknowledges that he has positive feelings about the analysis, but can have these feelings only in Chused's absence; he begins to explore the meanings and historical antecedents of this difficulty.

Dr. S's capacity for insight appears to be growing, yet Chused says, "I realized anew why I found work with him so frustrating: he seemed to understand and feel so much, and yet nothing seemed to provide any lasting help" (p. 846). And here I wondered if it were actually true that none of this had helped, or if Chused was simply too much under

the sway of Dr. S's devaluation of her in her presence to acknowledge that he was, at his own pace and (to some extent) secretly, consolidating considerable gains.

Dr. S's termination grows out of his decision to pursue a professional opportunity in South America, a move that he ultimately finds personally and professionally satisfying; and he credits their work together for enabling him to make this decision. During the termination phase, he works more collaboratively within the sessions and addresses some of the transference difficulties that have plagued him during the analysis. A few post-termination sessions show him to be increasingly reflective—still beleaguered by many of his old conflicts, but continuing to actively struggle with them in a reflective way. He seems to more openly feel gratitude toward and affection for Chused, though at the same time he still needs to temper these feelings with his habitual defensive maneuvers.

Dr. S's e-mails to Chused five years post-termination, to me, show continued development. Most important, I think, he tells of his ongoing self-analytic efforts; the internalized Chused continues to be a source of help to which he turns, now acknowledged though only at a distance. He reports a "profound change in me; I . . . live not so much by planning how to get what I want in the future, but by enjoying what I have" (p. 848).

In a later communication, he continues to work through, on his own, central conflicts in his relation with Chused. He feels a sense of great sadness, aware of his terror of being abandoned by her. "I seem to feel more of an attachment to people only from some distance, and only after I have left them," he says. "Do you know any shrink to whom that applies?" (p. 849).

Five years after his analysis, Dr. S continues to find satisfaction from his increased engagement in his work life, and there is a more authentic quality to his communications in the transference. He remains a work in progress, continuing to struggle introspectively in a way that is informed by an understanding of the unconscious and of his own unconscious conflicts. Ironically, Chused feels traumatized by Dr. S and leery of his ongoing wish to abuse her, and she cannot fully acknowledge to herself his gratitude or his wish not only to maintain contact, but also to keep her informed of the gains he continues to make. Chused and Dr. S, in

the end, are "together" in their inability to feel and say, "we did it together"—though in fact they did.

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In one of his last published psychoanalytic papers, Freud (1937) reflected on the clinical limitations of psychoanalysis. Freud wrote from within the paradigm of a one-person psychology, which rests on the assumption that the analyst can be, through his or her (henceforward *his*) own analysis, mostly an objective observer of the patient—only occasionally, and correctably, constrained by his own subjectivity. Thinking from this vertex sheds light on factors *within the patient* that limit what can be accomplished in analysis, but scotomizes aspects of these limitations that may arise *between* patient and analyst.

Nonetheless, toward the end of the paper, Freud takes up the matter of the analyst's inevitable personal contribution to the limitations of the analytic process. He states:

> Amongst the factors which influence the prospects of an analysis . . . we must reckon not only the structure of the patient's own ego but the personal characteristics of the analyst . . . . It cannot be disputed that analysts do not in their own personalities wholly come up to the standard of psychic normality which they set for their patients. [p. 247]

He acknowledges that the expectation that the analyst enters into the analytic process free of his own ego "abnormalities" makes "an unjustifiable demand" upon analysts, who "may be allowed to be human beings like anyone else" (p. 247).

Freud's solution to this problem is the analyst's training analysis, which "has accomplished its purpose if it gives the learner a firm conviction of the existence of the unconscious," and "enables him . . . to perceive in himself things which would otherwise be incredible to him" (p. 248). Freud emphasizes the importance of post-termination self-analysis:

> We reckon on the stimuli that he has received in his own analysis not ceasing when it ends, and on the processes of remodeling the ego continuing spontaneously in the analyzed subject, and making use of all subsequent experiences in this newly acquired sense. [p. 249]

Freud acknowledges that there are defensive processes in the analyst that he will be unwilling to relinquish through his self-analysis, and he recommends periodic reanalysis for the analyst as an antidote. Though Freud acknowledges the powerful and persistent impact of the analyst's own psychology on the analytic process, he nonetheless holds out an expectation of the analyst's at least relative "perfectability" in terms of his capacity to be an objective observer—rather than moving toward the development of a model of the analytic process that accepts and takes into account the imperfectability of the analyst as an inherent part of the process.

Current trends in psychoanalytic thinking have led to the development of new models of the analytic process that take into account the essential two-person nature of this process. These newer models are based on a view of lesser asymmetry between patient and analyst, both in terms of expectations of objectivity and of analytic goals. Baranger, Baranger, and Mom (1983) describe a phenomenon in analytic process called the *bastion,* a structure that silently crystallizes between patient and analyst and undermines the analytic process. A bastion is established when one member of the analytic pair (patient or analyst) splits off some area of his or her mental life, and this splitting-off process meets with the unconscious compliance of the other member of the pair. A particularly challenging aspect is that the bastion is often ego-syntonic for both partners, and can therefore be a source of positive attachment between them; frequently, it rests on a shared fantasy about the nature of the analytic project. For Baranger, Baranger, and Mom, the repeated development, identification, elucidation, and dissolution of these inevitable crystallizations are the essence of the analytic process.

Returning momentarily to Freud, I note that, at the end of his (1937) paper, he describes two themes in mental life that he calls "bedrock"—the wish for a penis in the woman and the dread of passively submitting to another man in men—and he states that when one of these themes is reached, "we have penetrated all the psychological strata and have reached bedrock and . . . thus our activities are at an end" (p. 252).

I believe that the discoveries of Baranger, Baranger, and Mom (1983) point to another kind of "bedrock"—one that has to do with the *process* in the bi-personal field, rather than with specific mental *contents* within

the patient. This *process bedrock* is encountered when a bastion forms between patient and analyst that cannot be identified or resolved, but instead can only become institutionalized as an ongoing enactment, because the sense of personal coherence and identity of both participants would be too endangered by the dissolution of the bastion. When this happens, the bastion, rather than becoming a tool for the exploration of mental contents and interpersonal processes, becomes an entrenched form of encryption of the split-off mental contents in both partners that have come together to form the bastion.

One might even speculate that Freud's *content bedrock* was in fact closely linked with such a process bedrock, and that his phallocentrism and authoritarianism, products both of his character and of the cultural milieu in which he and his patients were embedded, met up collusively with these particular mental contents in his patients—in a way that precluded further exploration.

In this situation, which I believe is inevitable in all analyses, termination offers an opportunity for further exploration. This is because, once the ongoing frame of the analysis dissolves, each partner is freed from the collusive participation of the other that entrenches the enactment and precludes further analytic exploration. Defensive postures might have been impossible to relinquish when the stability not only of the self, but also of the partner and of the relationship between them, seemed endangered; but these postures might well be easier to approach reflectively in private and in the absence of the need for the partner's confirmation. For this to occur, however, the capacity for post-termination self-analysis is of particular importance.

Freud indicated that the capacity for self-analysis—the result of the analyst's conviction about the existence of the unconscious and his perception of the manifestations of his own unconscious processes that might previously have been incredible to him—is the main goal of the training analysis. I would suggest that, when the inevitable, indissoluble bastion occurs, if this goal has been met *for the patient*, then the patient has gotten what he needs in order to get much of the clinical benefit that analysis has to offer.

Dr. S certainly seems to have gotten this from his analysis with Chused, and there is much evidence that, although he may not have

achieved all his own goals or Chused's goals for him during the analysis proper, his continued self-exploration brings him further emotional growth. Chused's haunting self-doubt after termination, and her inability to appreciate and take pleasure in the gains Dr. S made and continues to make, may be a manifestation of a final, unresolved bastion that—even in the absence of the external forces at play in Dr. S's life—would have necessitated termination. Yet the fact of the bastion is inescapable; it is the result of both patient and analyst, in Freud's (1937) words, being "human beings like anyone else" (p. 247)—which is a source not only of the limitations of analysis, but also of its power.

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RESPONSE TO COMMENTARIES ON MY PAPER, "AN ANALYST'S UNCERTAINTY AND FEAR"

BY JUDITH FINGERT CHUSED

Keywords: Treatment failures, self-understanding, termination, seduction, trauma, bastion, anger, analyst's motivation.

I appreciate my three colleagues' thoughtful consideration of "An Analyst's Uncertainty and Fear." When I submitted the paper to *The Psychoanalytic Quarterly,* I wrote to the Editor, Jay Greenberg, that although it did not contain anything new in terms of theory or clinical practice, I thought it might be useful for our colleagues to read of a case that did not end as desired.

Mitchell Wilson recognized my intent; as he noted in his commentary, the clinical material in our literature almost always has a happy ending. I, too, have been impressed with how few psychoanalytic papers report on failures or partial failures of psychoanalysis. We all want happy endings. But even with experience, even with the belief that psychoanalysis is the treatment of choice, sometimes an analysis does not help . . . or does not help to the extent the analyst and patient wish. And sometimes, even if the analyst knew more, did things differently, were more aware of her vulnerability, or better analyzed, the analysis still may not provide all that is wanted.

I appreciate Wilson's wish to find therapeutic change, or more change than I did, in the text. I included in the paper the e-mails that Dr. S sent me after he left analysis because I think they reveal a growing

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self-understanding and a growing pleasure in his work . . . though I still believe the analysis and his self-understanding did not result in what Dr. S had so long been seeking: the ability to take a greater degree of pleasure in relationships.

Richard B. Zimmer was right when he wrote of the patient's perception of me as wanting to seduce him into a relationship. I had hoped to establish a collaborative, working relationship, but Dr. S feared it would be a relationship in which he was used as he was by his mother. Both the patient and I were aware of our different perceptions; if we had worked on these differences more deeply, more persistently, the analysis might have benefited. But we did not—both because of his leaving the analysis, and also because almost any intervention I made that had links to genetic material led to enormous derision and denial.

As Zimmer mentioned, Dr. S continued the analysis from a distance; it was safer for him that way. Dr. S left the analysis when it became too uncomfortable, when he felt threatened by my availability, and though we both knew that and spoke of it, it did not stop him, nor did it change the outcome. What made our work together so difficult was that, although it often led to greater understanding for both of us, it was hard for him to use that understanding for change. It was not that he intellectualized; rather, he could not trust that any understanding we had was genuine or was for his benefit rather than a trap set by me that would ultimately prove hurtful.

Dr. S exerted considerable energy in trying to turn our relationship into a sadomasochistic one, and I felt it was important both to identify for him these attempts and not to participate in such a relationship. Zimmer suggests that contributing to his sadistic behavior was "a detailed identification with a well-elaborated perceived vision of the seductive, sadistic, rejecting, and self-congratulatory mother" (p. 871). Zimmer's understanding of Dr. S as a traumatized child who identified with his traumatizing mother is one that I wish I had had in mind. Whether we could have used that understanding to deepen the work, I do not know . . . but it would have added a new dimension to the work, and might have allowed him to more usefully connect his memories of his painful experiences with his mother to his difficulty with me and others. It might also have allowed me to feel more positive about the work we had done.

But as Zimmer reminds us, "the fact of the bastion is inescapable; it is the result of both patient and analyst, in Freud's (1937) words, 'being human beings like anyone else' (p. 247)—which is a source not only of the limitations of analysis, but also of its power" (p. 883). In an analysis, the relationship reveals to both participants their strengths and their weaknesses, what each of them can and cannot do. The relationship is responsible for both the force of and the flaws in the work.

Aisha Abbasi suggests that perhaps Dr. S worked more collaboratively with me once he decided to leave. I agree with her (and, certainly, that is how he understood it); it was safer to "connect" once a departure time was set. In addition, as Zimmer noted in his discussion of the bastion (as described by Baranger, Baranger and Mom [1983]), Dr. S was able to continue the work once he was away from me, having retained, internally, what was of value in his analytic relationship with me.

Where I do not agree with Abbasi is in her suggestion that I was inhibiting my anger and that the analysis encountered difficulties as a result. As I noted in my paper, I was often angry with Dr. S, which he knew and which made him alternately gleeful and remorseful. We used my anger to understand the moments when he felt he needed to create distance between us by attacking me. Getting me to be angry was, for him, a safer way to connect. However, my anger was tempered by my awareness of his enormous sadness, his loneliness, and his hunger for a connection, which was equaled only by his fear of it.

I think Abbasi may have been misled by my introductory statement that "like many others, I became a psychoanalyst because of a wish to help people . . . and its corollary, a wish to compensate for my own aggressive impulses" (Chused 2016, p. 836). Such impulses are present in all of us, and for psychoanalysts and others in the helping professions, it is part of the motivation behind our choice of profession. I suspect that both she and Zimmer were looking for a happier ending to this analysis: a "what if . . ." or "if only Chused had done this, been aware of that, then the analysis would have accomplished more." I think I myself was motivated by the same fantasy when I felt guilty that Dr. S failed to get everything he came to analysis for, holding on to the wish that if only I had done something differently, he would have had a better result. But

we all do that; it is hard to accept that psychoanalysis, as important and valuable as it is, is limited.

Would I take another patient like Dr. S into analysis? Without question. Would we have a better outcome? I hope so. What is so important and reassuring about psychoanalysis is that the opportunity to learn continues long after one finishes formal training—to learn as I have learned from these commentaries.

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W. R. D. FAIRBAIRN AND THE PROBLEM OF HOMOSEXUALITY: A STUDY IN PSYCHOANALYTIC PREJUDICE

BY HILARY J. BEATTIE

W. R. D. Fairbairn believed that the psychoanalyst's motivations and theories must ultimately be rooted in a need to resolve personal conflicts. His self-analytic and other records, now publicly available, indicate how his struggles with unacceptable sexual feelings and their symptomatic manifestations affected not only his theorizing, especially about sexuality, but also his clinical practice, as well as his personal and family life. Fairbairn's case affords a unique opportunity to document the effects of homophobia in a major psychoanalyst.

Keywords: W. R. D. Fairbairn, object relations theory, self-analysis, homosexuality, prejudice, homophobia, urinary phobia.

PREFACE

W. R. D. (Ronald) Fairbairn remains important in the history of psychoanalysis, both for his radical ideas on the developmental primacy of object relations over libidinal drives, and for his insights into how severe frustration of attachment needs can result in schizoid personality deformations. But since Fairbairn himself stressed that the psychoanalyst's "interest in psychoanalysis," as well as his "'scientific' orientation," must ultimately spring "from a desire . . . largely unconscious perhaps, to resolve his own conflicts" (1958, p. 375), it is important to understand in what ways such bold reformulations of Freudian theory were rooted in the life

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of an extremely reserved and socially conservative Scotsman born into the Presbyterian culture of late Victorian Edinburgh. I addressed aspects of that question in an earlier paper (Beattie 2003) but was left with unanswered speculations about the role of Fairbairn's early emotional and sexual development in his later thinking.

For a long time, little was known about Fairbairn as a person; he remained marginalized within the British psychoanalytic movement not just because of his geographical isolation, but also because of his failure to form close personal relationships with his London colleagues. This changed with the publication of *Fairbairn's Journey into the Interior* (1989) by John D. Sutherland, a fellow Scot who had been Fairbairn's student and analysand and then his colleague and friend. Sutherland knew the family well and was given access to Fairbairn's personal papers, including the intimate and sexually revealing "self-analytic notes" in which he explored his early psychosexual development in relation to the severe urinary inhibition that plagued his later life. Sutherland at first hesitated to use these notes, but eventually did so on the grounds that Fairbairn had preserved them as an eventual contribution to the "advancement of psychoanalytic knowledge" (1989, pp. xii-xiii).

Sutherland's remarkable biography deserves to be better known, but its main focus is on the evolution of Fairbairn's work, and the portrait of the man is curiously disjointed, alternating between a rather conventional chronicle of life events and a close discussion of the earlier set of self-analytic notes that formed the prelude to Fairbairn's theoretical innovations of the 1940s. The latter is almost startlingly intimate but reads more like a clinical case study. This bifurcation may reflect lifelong limitations to the intimacy between the author and his subject (for instance, Sutherland learned of the urinary phobia only after Fairbairn's death), as well as a patient's unresolved transference toward his former analyst, but in addition, I sensed some evasiveness, particularly around Fairbairn's early sexual and marital problems.

These questions could not be investigated until 2012, when Fairbairn's granddaughter, Caro Birtles, gave his personal papers (preserved by his second wife, Marion, and later by his daughter, Ellinor Fairbairn Birtles) to the National Library of Scotland, which already held the rest of his archive. This material, which in addition to the self-analytic notes in-

cludes early journals, appointment books, medical records, and the like, can be augmented by a few other sources, including the racy memoir *A Life Is Too Short* (1987) by Fairbairn's younger son, Nicholas. Although the latter must be used cautiously, Nicholas was close to Ronald and makes striking observations about his father's personality and troubled marriage. Michael Dawson (unpublished) conducted valuable interviews with family and some analytic colleagues in the 1980s. There are also occasional annotations (sometimes suggestive) in Fairbairn's book collection, now held by Edinburgh University Library. Finally, I am grateful for personal information kindly shared with me by Fairbairn's older son, Cosmo (C. Fairbairn 2014).

A careful examination of this material supported my earlier surmise that Fairbairn's lack of a "secure masculine identity" (Sutherland 1989, p. 82) derived not merely from early sexual trauma inflicted by his mother, but also from more profound conflicts over sexual identity and his sexual orientation, which in turn must have contributed to his negative views on sexual perversion and male homosexuality. The present paper will elucidate this connection, focusing particularly on Fairbairn in the 1950s and his later self-analytic notes, which were dismissed by Sutherland as essentially without interest. Whether or not his scruples were conscious, Sutherland acknowledged that Fairbairn's multiple roles in his own life were bound to compromise his objectivity (1989, p. x), and it is understandable that he would protect both the image of a man he revered and the feelings of his family in an era when homosexuality was subject to much greater intolerance, especially in the psychoanalytic world, than it is today.

Official resistance to homosexuals as psychoanalytic candidates and as training analysts may have waned since the end of the last century (Roughton 2002), although more slowly in Britain than in the USA (Twomey 2003). But psychoanalytic prejudices nonetheless persist in subtle, covert ways, which Fairbairn's case may illuminate. This may be our only opportunity to study directly the effects of internalized homophobia on a major analyst of that generation—as opposed to its possible effects on others, such as D. W. Winnicott, Masud Khan, and Heinz Kohut, about whom there have merely been tentative biographical speculations regarding homoerotic and/or homosexual elements in their

personalities and relationships (Hopkins 2006; Rodman 2003; Strozier 2001; Willoughby 2005).

Even Harry Stack Sullivan's obvious homosexuality was long subject to official denial and evasion, until Blechner (2005) tackled it unequivocally. Remarkably, only one reviewer of the Fairbairn biography (LaFarge 1992) pointed out a possible homosexual interpretation of his urinary conflicts, whereas others (e.g., Grotstein 1992; Mitchell 1993; Perlman 1991) either focused on his work or refrained from questioning Sutherland's analysis of his troubled life. Even Crastnopol (2001), discussing Fairbairn's analysis of Harry Guntrip, regretted a lack of information on Fairbairn's "internal and external life" (p. 126), yet did not sufficiently read between the lines either of his biography or of Guntrip's (Hazell 1996). Apparently, the profession still has something of a collective blind spot for the presence of homosexuality, despite the recent striving toward political correctness in sexual matters.

Even in a more tolerant age, the researcher faces something of Sutherland's dilemma: namely, how to balance the subject's personal privacy and that of his family against a deeper understanding of the man himself. Yet the Fairbairn family, besides making his papers publicly available, has imposed no restrictions on their use and is aware of the nature of my own findings. Moreover, since parts of Fairbairn's self-analytic notes were published verbatim by Sutherland (1989) but analyzed in somewhat misleading ways, it is important to amend the record so as better to know the man behind the theory.

As to my own transference to my subject, I, too, am impressed that Fairbairn preserved his intimate notes and drawings to the end of his life. I prefaced my reading of them by looking at his 1932 notes on "Knowledge and Self-Analysis v [*sic*] Psychoanalysis" (MS.50177),[1] in which he states that the former two are hopelessly "stultified" without the transference relationship to another human being, the psychoanalyst, which alone "provides the motive for overcoming resistance." His own analysis had lasted roughly two years in the early 1920s, after which there was no one to whom he could, or would, turn for help (Sutherland

[1] Unpublished manuscripts cited in the text of this article, designated with "MS" followed by a number or numbers, are listed in the appendix preceding the reference list.

1994). When one reads his lonely ruminations in this light, they seem almost like a posthumous plea for understanding amid painful and ultimately insoluble conflicts.

I shall first outline Fairbairn's early life in its sociohistorical context and then describe the likely role of his own analysis in the achievement of an eventually problematic marriage, as well as his growing clinical and theoretical interest in male homosexuality in the 1930s—the period during which his marriage collapsed and his urinary symptom began. Regarding Fairbairn's first self-analytic notes (MS.50169), I shall note ways in which Sutherland (1989) obscured or ignored possible inferences about both Fairbairn's life and its relation to his theoretical innovations. Even more important is the self-analytic material (drawings and notes) from the 1950s, which Sutherland effectively suppressed, for it throws light on Fairbairn's continuing attempts to formulate a theory of male homosexuality, as well as on aspects of his clinical practice.

HISTORICAL AND PERSONAL BACKGROUND

Today it is easy to forget how pervasively homophobic British society was in the late nineteenth century and most of the twentieth. Male homosexuality in the Victorian era had been increasingly seen as a threat to public morality, such that all acts of "gross indecency" between men were penalized in 1885 by the Labouchère Amendment, whose most famous victim was Oscar Wilde (Weeks 1977, p. 14). While there had always been a homosexual subculture, notably in elite and literary circles, this had to be discreet, particularly after the moral panic caused by Wilde's trial and conviction in 1895. The British medical profession, squeamish even about heterosexuality, showed a resolute lack of interest in homosexuality (unlike pioneering Continental sexologists), and the first English-language book to treat it as neither disease nor crime, *Sexual Inversion* (1897) by Havelock Ellis, was seen as a shocking incitement to vice (Grosskurth 1980; Porter and Hall 1995).

These attitudes were slow to change, so that only after World War II was there a movement for reform of Britain's draconian laws governing homosexuality, met by resistance from the judiciary, the press, and the medical establishment. In 1957, the Wolfenden Committee rec-

ommended the decriminalization of homosexuality between consenting adults in private (excepting the armed forces and the merchant navy), but this became law only in 1967, and then only in England and Wales (Higgins 1996). In Scotland, concerted opposition from conservative elements in the Presbyterian Church, the press, politicians, and public opinion managed to delay this until 1980, only nine years before Sutherland's biography was published to mark the centenary of Fairbairn's birth in 1889, and sixteen years after Fairbairn's death in 1964 (Davidson and Davis 2012). And Calvinist, bourgeois Scotland of the late Victorian and Edwardian eras, in which all sexual matters were shrouded in secrecy, was the milieu in which Fairbairn grew up.

Fairbairn's childhood and adolescence sound like the ideal training ground for his idea of the schizoid personality. As the only child of older parents, he was given devoted care and the best private school education, designed to turn him into the perfect gentleman. The darker side of the picture was his parents' excessive moral strictness founded not only on their religious beliefs, but also seemingly on considerable neurosis. Fairbairn's snobbish English mother, Cecilia Leefe, had a "Victorian taboo on sex" so strong that "sexual curiosity became an anxiously preoccupying concern" for her son, while his father, Thomas Fairbairn—a self-made man and devout Presbyterian—was afflicted with a mysterious inability to urinate with anyone in the vicinity, a situation that was to dominate his son's life years later (Sutherland 1989, pp. 3-4).

Ronald grew up passive, unassertive, and mother-dominated, outwardly cheerful and conforming but inwardly mistrustful and unconfident. He first opted to become a clergyman, and on his twenty-first birthday vowed to devote himself to a "manly, healthy, whole-hearted, strong religion," while finding a balance between the "jollity and seriousness which are both essential for a presentable life" (Sutherland 1989, pp. 6-7). Sutherland observed that nowhere in Fairbairn's diary notes is there any mention of attraction to any young woman, though neither is there any expression of a "physical interest in boys or men" (1989, p. 7). I would add that Ronald's sporadic journals, kept around 1906 and from 1910 to 1913 (MSS.50230-50236), with their descriptions of school and family life and later holidays with English relatives, are all

written in formal, stilted language, betraying no deep feelings or signs of intimate friendships.

Fairbairn's early adulthood was marked by struggles against parental control and by his sometimes playing one parent against the other. Thus, when his ambitious mother supported his desire to go to Oxford University, it was paternal opposition that prevailed, so that he ended up staying home and studying philosophy at Edinburgh University. But when he wanted to enlist in the army in World War I, it was his father who supported him against his mother, so that in November 1915, following surgical correction of a scrotal varicocele (required for him to pass the army physical), he obtained a commission in the Royal Garrison Artillery.

From late 1917, Fairbairn served in Palestine, witnessing the liberation of Jerusalem from the Turks and doing some biblical sightseeing. Sutherland (1989) thought Fairbairn had enjoyed the wartime experience of close relationships with others, although this is not apparent from the brief notes in his appointment books (MSS.50108-50152). Years later, he started writing a play set in Palestine, with a three-man cast suggestive of male camaraderie, but he abandoned this after a few attempts at Act I, amid awkward dialogue that voiced some unfavorable opinions concerning the projected Jewish return to the Promised Land (MS.50246).

PSYCHOANALYSIS AND MARRIAGE

Back in Scotland and once again living at home, Fairbairn switched to studying medicine in January 1919. In 1916, he had met the legendary W. H. R. Rivers at Craiglockart War Hospital in Edinburgh—a man whose work with conversion hysteria in "shell-shocked" officers had profoundly impressed him and eventually motivated him to become a psychotherapist. Resolving his own personal conflicts with regard to "sex and conscience" (Fairbairn 1949, p. 152) was part of this, and in July 1921, he took what Sutherland terms the "unusual step" (1989, p. 7) of starting a personal analysis with Ernest H. Connell, a wealthy Australian who had trained in medicine and psychiatry in Edinburgh and had been analyzed by Ernest Jones.

Sutherland admitted that this was more than just a training analysis, and Fairbairn's appointment books show that it grew in part out of a family and personal friendship, starting in December 1919 and reinforced by many social visits until Fairbairn plunged into almost daily analysis with Connell in the summer and early autumn of 1921 (MSS.50108-50152). This was interrupted in March 1922 when Fairbairn left for clinical studies in Paris, where he fell ill with pleurisy and had to have a rib resection. Even when he resumed analysis that October, Fairbairn still maintained social contacts with Connell and his family, sometimes staying for tea after his analytic sessions.

Connell was evidently an impressive character, a "full-blooded Christian" and family man, and to judge from the frequency and boundary-crossing nature of their personal and analytic contacts, this could have been the most influential nonfamilial relationship of Fairbairn's life—particularly when it came to overcoming what Sutherland termed his "inhibited sexual development" (1989, p. 11) in ways that his own problematic father could not. According to Sutherland, the analysis, which continued for most of 1923, had a liberating effect that was reinforced by Thomas Fairbairn's sudden death in March of that year. Moreover, it may have been the intense experience with Connell as surrogate father figure that finally enabled Fairbairn to marry, and it may also have been an underlying factor in his continuing insistence on the importance of the personal bond with the analyst in the relief of suffering (Fairbairn 1958).

When he began analysis, Fairbairn was almost thirty-two and had had only a few seemingly polite relationships with young women, which petered out inconclusively. By 1926, he was becoming established in his career, with hospital and university appointments and a growing private practice, helped by Connell's analytic contacts in London. That spring, Fairbairn got to know a medical student, Mary More Gordon, who came from an old landed family in Montrose, Scotland. In May, he embarked on a whirlwind courtship, and on September 11, 1926, they were married, she being twenty-five and he thirty-seven.

Mary was an accomplished musician and was fond of a "sophisticated social life," so in the early days, they went out more than Fairbairn was

used to (Sutherland 1989, p. 10). They had a daughter, Ellinor, in 1927, and then two sons, Cosmo in 1930 and Nicholas in 1933, by which time the marriage was deteriorating badly. Mary would later tell Cosmo that they were happy only during their first five years together (C. Fairbairn 2014).

Sutherland (1989), while professing fairness, tacitly blamed Mary for resenting Fairbairn's increasing withdrawal into his work, without wondering how she might have felt at being shut out of vicarious participation in his medical career when she had willingly given up her own. Sutherland praised Fairbairn's public forbearance and loyalty at a time when he was also coping with hostility from his university colleagues. But Fairbairn's benevolent exterior, the result of an "over-powerful reaction formation" against anger, possibly had its cost, for in 1934 he began to experience the same urinary inhibition that had afflicted his father (Sutherland 1989, p. 31). This worsened in 1935 after a particularly aggressive outburst from his wife and an attack of "renal colic" with hematuria (Sutherland 1989, p. 36).

Sutherland tries to explain this as Fairbairn's defensive regression to identification with his needed father in the face of his wife's attempts to castrate his hard-won "psychological masculinity" (p. 36). His "libidinal self with primitive sadism" (p. 42) against the internal bad mother was supposedly split off and "locked up in the [urinary] phobia," so that his creative, "reparative drive" could be invested in his work, the foundation of his core self (p. 42).

But even Sutherland (who, according to Cosmo Fairbairn, "hated" his mother) conceded that Mary's hostility was fueled by her "growing feeling of 'not being treated as a person'" (1989, p. 91). Nicholas Fairbairn (1987), who claims he was "conditioned" to worship his father and despise his mother and to "see everything from his cosy point of view" (p. 13), asserts that Mary was in effect "a widow" and "a virgin" (p. 30), and that Fairbairn was "rigidly insensitive" to her emotional suffering when she retreated into "illness, loneliness, and dipsomania" (p. 36). And Nicholas hints that Fairbairn's burying himself in his work was one way to deflect his depressed wife's need for intimacy, both emotional and sexual.

HOMOSEXUALITY AND THEORY

It was during this period of worsening marital strife and the onset of his urinary symptom that Fairbairn began to develop an abiding interest in sexual perversion, notably male homosexuality. It surfaces in "Child Assault" (Fairbairn 1935), an enlightened critique of contemporary attitudes toward sexually abused children and their molesters, alerting the public to the types of sexual offenses commonly aimed at children and the appropriate treatment for both victims and perpetrators. But Fairbairn's most striking assertion in this paper is that homosexual "*offences against boys are much commoner than offences against girls*" (p. 167, italics in original)—something he thinks the public stubbornly ignores. He also claims that this can lead later to "perverse sexual practices," including exhibitionism and homosexuality.

In "Sexual Delinquency" (1939), Fairbairn, following Freud (1905), focuses more on the perpetrators, noting that the confirmed, "unashamed" homosexual has incorporated forms of infantile sexuality into the ego, whereas the so-called psychoneurotic struggles against perversion through repression, sublimation, or internalized environmental prohibitions. But he also thinks that homosexuality results not simply from a preference for the same-sex parent, but also from early hate and fear of that parent, who has to be seduced by conversion into a sexual object. Similar opinions were to resurface in his major papers of the 1940s; they suggest a concern with the vulnerability of boys to sexual predators and the potentially disastrous consequences for their psychosexual development, something that should be borne in mind when considering Fairbairn's attempts at self-analysis.

FAIRBAIRN'S FIRST SELF-ANALYSIS: 1939–1940

Fairbairn started recording childhood and adolescent memories in October 1939, early in World War II, primarily to understand his own conflicted sexuality and to construct dynamic explanations for the urinary phobia that by now limited his social life, but also in the context of gestating a developmental theory that emphasized personal relations

over libidinal impulses. Sutherland (1989) prints parts of these notes verbatim or in summary, albeit with omissions and transpositions that skew his interpretations; the account below is based on the entire self-analytic record (MS.50169) but specifies Sutherland's page references where applicable.

Fairbairn foregrounds his sexually puritanical mother as the major source of his problems, describing her early dislike of his penis and repeated prohibition of any attempt to "touch it for the sake of touching it" (Sutherland 1989, p. 67). However, this did not prevent him from once yielding in childhood to the bath- and bedtime seductions of an English girl cousin who introduced him to the intense, satiating pleasures of anal penetration. In adolescence, he suffered agonizing conflicts over masturbation, trying to subdue his frequent, tormenting erections by urinating, which in turn led to his getting sexually aroused whenever he went to the bathroom. It even aroused thoughts of sacrificial self-castration, resulting in "considerable sexual inhibition" and a "rather female attitude" (Sutherland 1989, p. 75) manifested in a pleasurable fantasy (the details of which Sutherland omits) of being a woman "in female position for i/c [intercourse]" and "lying on back with knees drawn up and legs wide apart & opening up vulva & vagina" (MS.50169). The fantasy included "having something (presumably penis but not formulated as such) thrust into gaping vagina," so as to "effect a release of tension—the sort of tension I feel when my bladder is full" (MS.50169). He likes "the idea of female masturbation" and has "always felt it would be nice to be a woman & have breasts & female genitals."

In short, Fairbairn believes that behind his urinary problem lies a "desire to have pressure . . . in the bladder relieved and the urine drawn off by the insertion of a penis into urinary (= vaginal) passage as a 'catheter'" (MS.50169)—something that actually happened after an operation in Paris in 1922. But rather than seeing his "wanting to have something put into me before I give up what is inside me" (MS.50169) as an active desire for penetration by another man's penis (possibly related to his earlier pleasure in anal penetration), he constructs a convoluted, Kleinian-sounding explanation of needing to retain urine to compensate for mother's withholding good milk from her breasts, and a consequent fear of destroying the breast/mother in retaliation.

The developmental role played by other males is something that neither Fairbairn nor Sutherland seems able to integrate into this narrative. Fairbairn's father, viewed in his childhood as a "good protective but rather ineffective figure" (Sutherland 1989, p. 66), was actually the subject of his most traumatic memory, from around age eight. The family was on a slow train, without toilets, taking them on holiday to the Highlands. His father's bladder was "very full," so in desperation he urinated on the floor of the compartment, while Ronald's mother and a female friend screened themselves behind newspapers. Ronald, sequestered on his father's side of the screen, was "aghast" at having to watch his slow, agonizingly painful "performance." Yet feeling "identified with Father" and somehow "responsible for his suffering," he then needed to urinate himself, at the seeming risk of castration, through the swaying carriage door held ajar by father.

Fairbairn breaks off this account after admitting his guilty hostility yet "secret satisfaction fr. [father's] suffering," but next switches to his own fear of the "phobic situation" of urinating before other men, or by now anyone in the vicinity, or even when alone; this he links to his "*sense of being tested all the time,*" socially and sexually, something that started in school when he felt "out of it" and "libidinally inferior" to other boys who enjoyed guilt-free masturbation (Sutherland 1989, pp. 73-74; italics are in the original manuscript but are not reproduced by Sutherland).

This preoccupation with male sexuality is clarified by Fairbairn's dream in August 1940, in which a dog "scraping at mouth of burrow" is looking for a rabbit inside (MS.50168). Fairbairn's initial associations are again to females, starting with his early seduction by his cousin into mutual touching and then "poking" of anuses. The rabbit represents his mother's secret penis inside her enormous inner hole, where it was impossible for him to get at. Envying female sexuality and ease of urination, he wants to "tear away" his own obstructing penis and insert his finger "right into bladder" to let the urine out (MS.50168).

But this and his guilty pleasure from his cousin's anal poking remind him of his embarrassment when some other girls were once talking about enemas. In his childhood, it was his father who administered enemas and suppositories for his constipation. Ronald had once been constipated for five days after arriving in the Highlands, but thinks that this occurred

after the train journey when he had to witness his father's painful urination, and when he had feared that each of them could have his penis trapped in the carriage door held open by the other. He thinks his own urinary anxiety was then displaced to fecal retention, all of which made him want to renounce "male sexuality (F's exhibitionistic situation)" and "be a woman" instead (MS.50168).

Fairbairn then describes being jealous of his son Nicholas, who was "more interested in his mother" (MS.50168) than in him (Mary was seriously ill with meningitis in the spring of 1940). But the place in the dream where his son was playing ball with another boy reminds Fairbairn of the "place where I was taken by the h/s [homosexual] man, who put his hand under my clothes and started touching my penis" (Sutherland 1989, p. 73). The man, who had encountered Ronald, age ten or eleven, walking alone in a park (Dawson, unpublished), dismissed mother's warnings and said it "did a boy good" to "play" with his penis (Sutherland 1989, p. 73).

Afraid the man would do "something dreadful" to him, Ronald eventually escaped, but after being attacked by his mother on his return home for refusing to admit that the man had touched him, he thinks he did try touching his penis "in a spirit of bravado" but soon stopped out of guilt and fear (Sutherland 1989, p. 73). It is better to be a woman with a secret penis, Fairbairn concludes, but he still envies his son's ability to escape into the "world of boys" when frustrated by his mother, whereas he himself has to find a "substitute for world of M. in the inner world" by focusing "narcissistically" (auto-erotically?) on his own penis (p. 80).

So Fairbairn makes a connection between his father's dramatically exposing his penis (and also Ronald's) during his efforts to relieve his bursting bladder and the later, equally traumatic but exciting seduction by the homosexual man, who defied Ronald's mother by encouraging him to get pleasure from his penis. A sexual interpretation of the train episode is supported by Fairbairn's own earlier assertion (1935) that the public has a "blind spot" (p. 167) for the fact that a man who publicly exposes himself may be aiming at a boy in the vicinity, not at women.

Likewise, Fairbairn's recollection of pleasure from anal penetration is directly followed by embarrassment over his father's administration of enemas and suppositories, suggesting that this repeated anal penetration

could have constituted a mutually arousing seduction that left Ronald confused, anxious, and overstimulated. Fairbairn himself later noted that this "traumatic procedure" could result in libido being "diverted" to the anus (1946a, p. 142), so perhaps his prolonged constipation after the train incident could have invited yet more enemas and suppositories. And finally, in the dream associations, the seduction scene between Ronald and the homosexual man links two parallel father–son scenes: first, Thomas with eight-year-old Ronald, and then Ronald with six-year-old Nicholas—perhaps alluding to some repressed or split-off feeling present in the two adult males with their respective sons.

Sutherland seemed blind to all this, barely mentioning the homosexual man in his discussion of the dream and inserting the details elsewhere. He assumed that Ronald's constipation was a way to control bad objects (mother's antisexual attacks), from which father's enemas afforded "relief," suggesting both the "common phantasies of father's good penis entering him" and later fantasies of relief through catheterization (1989, p. 84). Sutherland, like Fairbairn himself, always emphasized the mother's attacks on his (and presumably his father's) hated masculinity, which were repeated by his wife in the 1930s. He suggested that Fairbairn must have unconsciously identified with father in some "catastrophic fantasy" (supposedly stimulated by Klein's 1934 paper on manic-depressive states, which Fairbairn never mentions in his notes) of sadistically destroying the parents in the primal scene with floods of bad urine, which must absolutely be prevented.

But Sutherland never analyzed the sexual implications of the urinary conflict, even though Fairbairn describes his "appalling" fear of the "dangerous & destructive" urine collecting under "increasing tension" in the "alien & hostile" bladder as pointing to a "deeper anxiety," of "forces at work within oneself that threaten to destroy one" and give rise to "suicidal thoughts" (Sutherland 1989, p. 76). Yet if this pressure could only be relieved through penetration by an erect penis, albeit "not formulated as such" (p. 75), then that imperfectly repressed awareness while Fairbairn's hard-won marriage was foundering might indeed have seemed grounds for despair.

THEORETICAL INNOVATIONS

From 1940 onward—when Fairbairn rejected Freud's "hedonistic libido theory" (1949, p. 154) in favor of the idea of libido as inherently object-seeking rather than pleasure-seeking—his notions about the internalization of early problematic maternal object relations, as well as many case examples, leave no doubt that his thinking was related to his preceding self-analysis (Beattie 2003). And from the beginning, he seems concerned with sexual perversion as one aspect of schizoid phenomena, noting that the schizoid patient may present with "vague complaints" that include "perverse sexual tendencies" and other "psychosexual difficulties" (Fairbairn 1940, p. 5). He also believes that phenomena such as "exhibitionism, homosexuality, sadism, and masochism" (1941, pp. 40-41) occur only when relations with real objects (ultimately, the mother) have broken down, and the child seeks substitute satisfactions via relations with internalized part-objects (thus, the male homosexual's search for his father's penis revives the original oral relationship with the breast).

Fairbairn eventually recasts the entire "Oedipus situation" (1944, pp. 119ff) as ultimately deriving from the infant's ambivalent dependence on the mother, on which relations with the father are also patterned, so that internalized relations with exciting and rejecting aspects of both parental objects are transferred to the external world. This complex process, in which the mother, like Hamlet's, remains "the real villain of the piece" (p. 124), ultimately determines the individual's "psycho-sexual attitude" as well as the "aetiology of the sexual perversions" (p. 123).[2]

Though Fairbairn rarely refers to contemporary psychoanalytic literature other than works by Freud and Klein, his idea that homosexuality originates in early oral-stage relationships resembles that of many other analysts of this period (Lewes 2009). Unlike many contemporaries (e.g., Bergler 1944), Fairbairn has no illusions about curing homosexuals and never advocates punishment. But when discussing the treatment of sexual offenders in Scottish prisons, he again stresses the "profound dif-

[2] For further discussion of these points, see Beattie (2014).

ference" (1946b, p. 291) between the pervert and the psychoneurotic (who struggles to repress any "abnormal sexual tendencies," p. 291). He also suggests social "rehabilitation" (p. 293) of sexual offenders (among whom he singles out homosexuals) through group residential treatment, as was attempted with so-called war neurotics.

In a perceptive critique of Fairbairn's 1946(b) paper and others, Domenici (1995) argues that Fairbairn's model of desire ignores the role of the preoedipal father in development, and in effect leads to an "empty, passionless type of heterosexuality" (p. 44) that becomes both "obsessional and compulsive," maintained by "anti-homosexual thoughts and ensured by heterosexual behavior" (p. 49). But this is consistent with Fairbairn's long-held view that if the fundamental purpose of libido is to ensure a good relationship with a suitable object, then any pleasure seeking for the "mere sake of relieving [libidinal] tension" represents a regrettable "deterioration of behavior" (1946a, pp. 139-140).

RENEWED SELF-SCRUTINY: DREAM DRAWINGS

Fairbairn's work with emotional casualties of the war had been another stimulus to his creative theorizing, which gradually subsided after the war ended (Beattie 2003). Marital warfare had meanwhile been somewhat alleviated by his informal separation from his wife and consequent family division. Mary, suffering from ill health and worsening alcoholism, lived from 1941 onward at their country house in Gifford, where Fairbairn visited on weekends. The children were mostly in boarding schools, but otherwise Cosmo lived with their mother while Nicholas stayed with their father (C. Fairbairn 2014).

But in 1950, during the final dismal years of his marriage, Fairbairn suddenly renewed his introspection through a spate of dream drawings, apparently stimulated by his work begun the previous year with a new and important patient, Harry Guntrip, himself a psychoanalytic therapist (MS.50168). Guntrip's analysis included lengthy postsession talks, at first about theory but also about Fairbairn's "marriage concerns, his wife's alcoholism, and his Calvinistic conflict over divorce" (Landis 1981, p. 115)—a boundary crossing that perhaps echoed Fairbairn's own expe-

rience with Connell. Guntrip began making drawings of his dreams in 1950, after reading Joanna Field's (Marion Milner's) *On Not Being Able to Paint* (Hazell 1996), a book that Fairbairn himself reviewed favorably (1951) for its account of creative processes in terms of object relations (Sutherland 1989). Fairbairn's own dream drawings occupy thirty-four dated sheets, most from October to December 1950, with a few from September 1952 (MS.50168).[3]

Though lacking verbal commentary, the drawings show that Fairbairn's early sexual traumas and fantasies were still very much alive. One of the earliest depicts the kilted boy and the homosexual man in mackintosh and cloth cap, pressed together as they face the huge, sword-brandishing mother, as if the man is "backing up" Ronald against the murderous antilibidinal object, while the clock on the wall signals the irreversible passage of maturational time.[4] Other threatening or distorted female images abound, both symbolic (monstrous spiders, crabs, and toads) and literal (such as a hideous naked woman with urine gushing from a huge cloacal hole). Elsewhere, mother leads the same boy on a chain, while he sometimes in turn leads his dog, probably again representing his own sexuality.[5]

Father (with bald head, beard, and moustache) seems always disengaged in the drawings—sitting at a distance or with his back to the action. Activity is attributed to other males, such as the homosexual man (wearing his cloth cap), who in one scene heads down into a pit containing a phallic hand/tree, with the small boy clinging to him from behind, while on the opposite side mother restrains the same boy on a chain. And there is a turbaned male with enormous hands (identified only in later notes), standing next to a bathtub containing a small naked boy with hair erect, either in fright or excitement.

The women seem mostly to represent mother, but there is one, depicted full face and wearing glasses, who can only be Fairbairn's short-sighted and alcoholic wife, for there are bottles of wine or spirits on

[3] I regret that for technical reasons it is not possible to reproduce these drawings here.

[4] This drawing was reproduced in an earlier contribution (Beattie 2014, p. 95).

[5] For a partial reproduction of this drawing, see the following URL, administered by the National Library of Scotland (2016): www.fairbairn.ac.uk.

either side of her, while on her head and shoulders perch a bird, a rat, and a monkey. The last four drawings, dated September 13, 1952, were made two days after their wedding anniversary and toward the end of a visit from their daughter, Ellinor, with the man she was to marry the following April. These, too, depict huge, threatening women, including one with short hair and skirt and a huge knife, who may also allude to Mary, long condensed with mother (who had died in 1946) as the internalized antilibidinal object.

In the final sheet of this series, however, women are banished or confined. In the lower scene sits father in the train, exposing his huge, dripping penis, while his small son sits opposite with hair erect, and a female harpy glares through the window. Above is a strange tableau featuring a sinister prison building, from which a woman's face looks impotently through the bars while the turbaned man seen earlier bars the door. At the bottom of the central steps stands the small boy in his kilt, flanked by two much larger males. On the left stands father, with top hat and suggestively furled umbrella, looking toward the homosexual man, the only figure in motion. Could all this portray conflicted, immobilized male object relationships in which only the homosexual man is free to run off and gratify his desires?

Perhaps their daughter's prospective marriage aroused emotional turmoil in both spouses; in any event, some two weeks later, Mary Fairbairn was dead. Sutherland says merely that she died "relatively suddenly" (1989, p. 137). In fact, she had taken an overdose of aspirin after which she sought medical help, but ended up dying in hospital of multiple organ failure related to chronic alcoholism (C. Fairbairn 2014).

PERSONAL AND PROFESSIONAL RENEWAL

Fairbairn had been deeply shocked by his wife's death, but his situation gradually improved thereafter. He enjoyed more social life, as well as a growing friendship with his second secretary, who became the "good woman" whose care he needed (Sutherland 1989, p. 134). He also benefited from a more congenial professional atmosphere in Scotland, although the publication in 1952 of his collected papers, *Psychoanalytic Studies of the Personality*—despite a flattering preface by Ernest Jones

(helpfully written by Fairbairn himself, as their correspondence shows; MS.50105)—earned disappointing reviews from his English colleagues. It was even attacked by Winnicott and Khan for allegedly "knock[ing]" Freud (Sutherland 1989, p. 143).

But all this stimulated another major paper, "Observations on the Nature of Hysterical States" (1954a), in which Fairbairn consolidated his work on endopsychic structure, finalized its terminology, and clarified the relationship between repression and splitting of the ego. He illustrated it extensively with dream material to support his theory that, rather than being wish fulfillments, dreams represent the ego's struggles with internalized objects.

But here we see signs of Fairbairn's own sexual preoccupations beginning to intrude into his clinical practice—in his presentation of a patient named "Morris," who had been wounded in the war and became intensely anxious on returning home to live with his widowed mother. The only boy in his family, Morris had suffered from his mother's hostility toward his penis and felt castrated when she had him circumcised at the age of five to remedy his phimosis, which he saw as punishment for masturbation. Since his father was distant, his mother became both the exciting and the rejecting object, in fantasy holding down his penis and crushing his testicles as the condition of sexual excitement. The loss of his foreskin, representing his relationship to the breast, left him averse to marriage (having his penis "interfered with" by someone else), and his object relationships were represented through genital autoeroticism (Fairbairn 1954a, p. 39).

This case, according to Sutherland (1989), is "of particular interest because of its close fit with [Fairbairn's] own inner situation" (p. 141), and indeed it was to be used to clarify his ideas about the causes of homosexuality for the rest of his life. Early in 1954, a paper by Macalpine and Hunter (1953) inspired Fairbairn (1954b) to begin reevaluating Freud's (1911) analysis of the Schreber case. In an ensuing article (1956), based on Macalpine and Hunter's (1955) translation of Schreber's memoirs, Fairbairn rejects Freud's idea that Schreber's illness arose due to an "outburst of homosexual libido" toward his doctor, deriving from a "passive homosexual wish phantasy" toward his late father (Fairbairn 1956, pp. 46-47; see also MS.50207).

Rather, Fairbairn again insists that a man's homosexual object choice is ultimately caused by an internalized bad maternal object, although anger at the mother may also be displaced onto the father, leading to a "defensive autoerotism" which "in itself predisposes to a homosexual object choice" (1956, pp. 50-51). He finally asserts that the explanation for Schreber's psychotic fantasies of becoming a woman and for his "disguised homosexuality" is the pathogenic effect of the "primal scene," which is "more basic than the horror of incest" and the source of "greatest resistance" in psychoanalytic work (Fairbairn 1956, pp. 56-58).

Fairbairn supports this idea principally with two cases, the first being Morris, although he is not named. Morris's "horror of sexual intercourse" (participation in the primal scene) is now linked with "overt homosexual leanings," even if he is "not a practising homosexual." Morris's dream, in which he stares at the penises of some naked, statuesque young men while trying to evade detection by murderous Scottish Nationalists who would make him "join the movement" or kill him, is explained as his trying to enjoy the excitement of the denied primal scene through masturbation while avoiding its horror, which is "bound up with his sadistic attitude to his [faithless] mother" (1956, pp. 57-58). (A simpler interpretation could be that homosexual attraction in a homophobic society may be punishable by forced conformity or death.)

In a "final note," Fairbairn states that this theory also explains the doubts of schizophrenics and of schizoid personalities about the nature of their sex, since such doubts are really due to "uncertainty of identifications in the primal scene" rather than to innate bisexuality. He then cites the case of a current patient "not hitherto mentioned," a "markedly schizoid," married man with a family, who is "subject to homosexual dreams, commonly about intercourse with one of his own sons." His mother had disapproved of his being a boy and expected him to behave as a girl, despite having a penis, so that he later had difficulty urinating in public lavatories. At school, he felt "completely mystified" about his role in a community of boys. His "doubt as to his sexual role" is attributed to primal scene trauma because he had been made to sleep between his parents to prevent another conception (1956, pp. 59-60).

This case—aside from some possibly invented details—sounds rather like Fairbairn himself; it was apparently added to the paper as an af-

terthought, having been omitted from the first typed version but then appended to the original handwritten manuscript on a different kind of paper, so that it was included in the final typescript (MS.50207). Sutherland found this final section "interesting" because of "Fairbairn's own unconscious phantasies about the primal scene," which was "very much on his mind at this time" (1989, pp. 150-151).

Fairbairn's dramatic insistence on the all-important pathogenicity of the primal scene never aroused interest in the analytic community, though it may have attracted an American admirer, one Dr. Pave, who apparently sent him his own unpublished paper about curing homosexuality. This evoked a pessimistic reply (MS.50101), reiterating Fairbairn's beliefs that homosexuality is "inherently pathological" and biologically unnatural, while the "homosexual attitude" may defend against schizoid uncertainty about "whether to adopt a male or female role" (Beattie 2014, p. 90; see this source for a fuller discussion).

So why was Fairbairn so preoccupied in the mid-1950s with the idea of homosexuality stemming from primal scene trauma—possibly to the extent of linking his own gender-role confusions to the case of a male patient with so-called homosexual leanings? Some answers are suggested by his renewed attempt at self-analysis.

THE SECOND SELF-ANALYSIS: CIRCA 1955

The later notes seem to be mostly from 1955, since they contain three dated dreams from that year. But among the self-analytical notes (MS.50169) are three index cards apparently dating from 1954, on which Fairbairn compares his own dynamics with those of a similar-sounding patient. On the first, headed "*Urinary Retention: Factors Involved,*" Fairbairn lists: "Passivity . . . Attack of Anti-libidinal Ego on Libidinal Ego . . . Need to Sacrifice Oneself for Another Person & Suffer . . . ; Identification with an Object . . . Withholding . . . ; Substitution of Sado-Masochistic Automatism for Genital Object-Love (Incestuous Originally)" (MS.50169, italics in original).

The other side of this card is headed "*Specific Factors in Case of X*"—namely, a sadomasochistic relationship with a punishing mother, expressed as attacks by the antilibidinal ego (mother) on the libidinal ego

(father); exclusion of an object relationship with a consequently impotent father and identification with him; and compulsively giving oneself "Sacrificially & Masochistically to Mother" (MS.50169, italics in original).

On the second card, headed with five crosses, Fairbairn writes: "*Male Homosexuality as Attempt to Escape from Incestuous Situation with Mother*—Preferably into a Community of Other Men Who Are Also Attempting to Escape from Such a Situation" (MS.50169, italics in original). Below this are an abbreviated name and the dates June 29 and 30, 1954, evidently referring to patient sessions. This individual can be identified (from Fairbairn's lists of consultations [MSS.50157-50165, 50166] and appointment books [MSS.50108-50152]) as having started analytic treatment in April 1945, while a military officer, and staying in treatment to the end in late 1964. This patient is the only one who fits criteria for the man Fairbairn named "Morris."

So Fairbairn's thinking about the Schreber case in 1954–1955 (see Fairbairn 1956), in the context of his lengthy, ongoing analysis of Morris, apparently stimulated further exploration of his own sexual and urinary problems. The ensuing notes (which Sutherland thinks "add very little" [1989, p. 81] to the earlier ones) are more impersonal and abstract, consisting mainly of repetitive lists of "circumstances" relevant to the "Urinary Retention" (MS.50169). They read more like constrained obsessional rumination than free association and are impossible to summarize fully, but a central theme is Fairbairn's idea of his own primal scene trauma.

Fairbairn is still trying to understand the relationship between his urinary retention and his sexual functioning, for he sees his urgent yet blocked need to urinate as expressing both fear of the libidinal impulse and anger over its frustration. This, too, relates to maternal persecution, for he attempts to correlate both the exacerbations of the symptom and his fluctuations in sexual potency to his changing relationships with his wife, his mother, and his two secretaries (the "good" women who gave him support, the first in the late 1930s and the second from 1945 on).

But ultimately, it "seems Impossible to Escape" from a "Castrating Mother-Figure" (MS. 50169), as was dramatized on an occasion when Fairbairn went to the cinema to escape his wife's attacks. The film he saw, Hitchcock's romantic spy thriller *The 39 Steps* (1935), triggered a

"sudden suicidal impulse" because its threatened and hunted hero is "chained" (literally, at one point) to an "aggressive libidinal object" (the beautiful but initially hostile young woman with whom he falls in love; MS.50169).

This immediately reminds Fairbairn of his "Suicidal impulse when shut in parents' bedroom by Mother after being beaten by her," which was triggered by his "entering back-kitchen and seeing pail of blood-stained diapers" (MS.50169). This trauma was revived after his attack of renal calculus with bloody urine (January 1935), which he sees as related to "preceding Intercourse" accompanied by wife's "aggression." The original blood was seemingly connected to "secret goings-on between parents" and must be father's, given mother's "sadistic" attack on himself. So his discovery in the back-kitchen "had equivalence of penetration," and his mother's punishment of his incestuous curiosity amounted to a "Bar on Penetration of the Female Organ" (MS.50169)—which resulted in withdrawal, passivity, and martyrdom, as well as regression from the genital to the urinary sphere and "Inhibition of a Libidinal or Libidinized Function having a Direct or Indirect Reference to a Libidinal Object." This abstract circumlocution apparently refers to his difficulty desiring women, while his urinary retention is described as expressing "Inner Preoccupation & Refusal to Direct Libido towards Women as Outer Objects," as well as "Assumption of Sadistic Quality by Libidinal Attitude to Women" (MS.50169).

Fairbairn thus traces his sexual inhibitions to primal scene trauma, and since his castrated father was "cut out" of the "Oedipus Situation," he longed in vain for a "Good Father" to support him against the bad mother and to supply "Potency with Good Mother-Figure." He even imagined committing suicide so as to "rope Father in as ally" and get him to reproach mother as the cause. Mother's hostility to male sexuality is seen in other "Traumatic Incidents," including "Being Taken for a Walk by a Man," the "Railway Carriage Incident," and "Being Bathed by Indian Servant" (presumably, the turbaned man in the earlier dream drawings; MS.50169).

Mother's "Castrating Influence" is manifested in a series of taboos on "Being Sexual," whether "with Oneself," with girls, or with boys (through "talking sex" or "rough games"), thus thwarting any "~~Desire~~

Attempt [strike-through text in original] to Escape from Incestuous Situation into H/S Relationships" (he never writes out "homosexual" except on the 1954 index card; MS.50169).

But Fairbairn eventually turns to the role of other males in the genesis and perpetuation of his urinary retention, which actually started with exposure to other men in public, whether sporadically (in World War I, before his varicocele operation, when a crowd of young men entered a lavatory, or in a ward full of men after his surgery in Paris) or more persistently, beginning in the 1930s (after queuing with other men in a theater lavatory). Earlier still, he had felt embarrassed over exposing his "small" penis when urinating at school and would compare it surreptitiously with other boys' penises, envying those who were circumcised, with "penises like Father's" (MS.50169).

Once, on holiday in the Highlands, he felt anxious about urinating while "closely watched" by two other boys because of "castration-anxiety & perhaps fear of 'h/s attack.'" Later, he associates his consequent regression to pregenital urinary and anal sexuality with "Passive Attitude, manifested in Need for Catheterization and Enemas" and "Unconscious Passive H/S Tendency" (based on need of and guilt toward his father), along with a guilty "Exhibitionistic/Voyeur Tendency" (as in the train episode). Finally, he notes that other boys are "hostile" because he is "different" from them, and he associates his "Fear of attack" and "desire to be unobserved" with "Urination in lavs. w/ erection—& w/ sexual desire" (MS.50169).

So these recursive associations hint that fear of urinating before other males is linked with sexual desire, and that exhibitionistic revelation of arousal through an erect penis can invite a feared yet exciting "attack" from them. This repressed awareness is curiously foreshadowed in a diary entry from August 1913. While holidaying with family in Wales, Fairbairn was awoken early by a sense of "alien presence" in the room and feared having his throat cut with his own knife. But the "feeling of invasion" was occasioned by a "gaping Welshman" who eventually explained, with a "sickly grin," that he was "looking for the WC," then slowly withdrew, "still grinning" (MS.50236). Fairbairn belatedly recognized him as someone he had seen entering by the basement, some "strange lodger of the kitchen parts" who "might have found a better

excuse for his exploration" (MS.50236). Yet despite using the language of penetration and attack, he failed to see any sexual innuendo, whether in the man's smiling reference to the lavatory (the classic locus for a homosexual encounter) or in his own dreamlike sense of being invaded by disquieting sensations lodged in the nether regions.

THREE DREAMS

Given Fairbairn's theory that dreams resemble cinematic "shorts" (1940; 1944, p. 99) that dramatize the ego's internalized object relations, one might apply it to the three dreams he recorded from 1955. The first, in February, starts with him "waiting . . . for a signal to go to a wedding"—namely, "the release of milk along a conduit." When it begins to "come through," he sets off, in top hat, passing two other top-hatted men who are "going in opposite direction" to the church. Then he is looking for a lavatory in order to urinate before the wedding and locates a door to a "place like a hairdresser's salon." He finds a washroom where there are several mackintosh covers over objects, under one of which he discovers an old-fashioned lavatory pan containing "an enormous motion curled round like a snake" (drawn in the text). As he contemplates urinating in the pan, he hears a man "just behind" him "muttering, 'Shit.'" Turning, he sees the "assistant attendant" leaning over the frosted glass partition and then getting a "ticking off" from the head attendant (MS.50168).

This content is blatantly sexual, starting with the wedding (the destination for proper men), signaled by ejaculation of milky fluid, while the stiff top hats could signify decorous containment of sexual excitement. But the dreamer has to find a different repository for his own bodily fluids—in the mysterious hairdresser's salon, where two contrasting, lower-class men (the libidinal versus antilibidinal ego?) witness his exposure of the huge "motion": surely, an anal-genital condensation representing a "curled," flaccid penis. "Mackintosh" could be doubly charged, for the homosexual man wore the traditional flasher's garb in Fairbairn's first drawing of him, but it was also the surname of his second secretary (later his wife), hinting that marriage could "cover" proscribed sexuality.

In the second dream, in April 1955, the sadistic antilibidinal ego is apparently represented by more powerful or daring males. It starts on a

golf course, where a male acquaintance shoots at a female dummy with part of her chest missing, hitting it every time, while the dreamer then hides behind trees to escape a group of menacing horsemen. Then his "youngest son" boldly manages to poison a suspicious woman with a glass of "toast water" (a Victorian concoction for invalids; MS.50168). So the antilibidinal object (in an allusion, perhaps, to Fairbairn's wife's alcohol poisoning) is here finally destroyed.

In the third dream, of November 1955—the only one to include associations—Fairbairn is himself the aggressor. He apologetically shoots at his "unfriendly" party guests (who include some "men with bald heads" like his father's), using a revolver like one his father owned, but instead of a spray of bullets, the gun emits only a jet of water. This anticlimactic "attempt to attack one's father," he concludes, "is merely to reveal one's own impotence" (MS.50168).

Fairbairn notes, however, that the dream stimulus was a film: *Footsteps in the Fog* (1955), which he rapidly summarizes. Its handsome, scheming protagonist (i.e., the sadistic, antilibidinal ego) murders the wife he married for her money, but then he has to get rid of his blackmailing housekeeper (the antilibidinal object), who wants to marry and possess him. After first mistakenly killing a good woman in the fog, the protagonist tries to frame the housekeeper for his own murder by giving himself poison, but is caught in his own trap by an accidental overdose. Here an attempt to stage a self-murder so as to enlist support and to blame others (resembling Fairbairn's youthful fantasy of killing himself to get his father to blame his mother) turns into an expiatory suicide motivated by guilt.

FURTHER WORKING THROUGH

Fairbairn's primal scene theory of homosexuality echoes his earlier ideas about the castrating mother as ultimate antilibidinal object (1944), as well as possible antecedents in Klein (1932). Though he rarely cites other theorists, some annotations in his personal books evidence his particular interest in homosexuality in the mid-1950s. For instance, he made notes regarding Fenichel's (1954) idea that a boy missing his father can become effeminate or homosexual because of identification

with the frustrating mother, and about Jung's (1954) case of a young homosexual man who resorts to the church as a symbolic substitute for mother.

Fairbairn was also clearly fascinated by Joseph Wortis's (1954) renderings of Freud's rather inconsistent opinions about the nature and causes of homosexuality. But the overwhelming impact of the primal scene clearly became a personal obsession, essential for understanding both the homosexual's flight from the incestuous, overpowering mother and the gender confusion and "homosexual attitude" of the schizoid personality. At some point, he even toyed with the novel category of "Male Lesbian," who in contrast to the male homosexual "feels inferior in world of men & superior in inner, secret world of Mother (Women's World)" (MS.50221).

Since the primal scene idea was now "central for therapy" (Hazell 1996, p. 175), it began to pervade Fairbairn's clinical practice. He had earlier told Harry Guntrip about his own traumatic discovery of "evidence of menstruation in his mother's bed," and now annoyed Guntrip by insisting on reexamining "every activity of his [Guntrip's] life" in terms of unconscious "primal scene involvement" (Hazell 1996, pp. 126, 175-176). Yet Guntrip also played along, for on January 3, 1956, he wrote enthusiastically to Fairbairn about his "recent observation" that "homosexuality is a reaction to the primal scene," which "splits apart the element of pleasurable excitement and satisfaction on the one hand, and sadism and horror on the other, leaving the horror to the disowned heterosexual genital relationship and transferring the pleasurable excitement to the homosexual one" (MS.50100).

Guntrip claimed that this novel insight (which he himself criticized much later as a reversion to libido theory; see Guntrip [1975]) helped him clarify the dynamics of a married male patient who evidenced "homosexuality as a repressed factor" and had pleasurable dreams of passive homosexual intercourse with his analyst, not to mention getting so excited in sessions that he would urge Guntrip to "relieve him" and once went to a masseur because he did not (MS.50100).

The homosexual "factor" here hardly seems to be repressed, evidencing the denial shown by contemporary psychoanalysts when confronting same-sex desires in their male patients. But Guntrip probably

did not know that Fairbairn had himself resorted to massage at critical periods. This was provided by Willie Kerr, Fairbairn's earlier next-door neighbor in Lansdowne Crescent, who had become a masseur after being blinded in World War I (C. Fairbairn 2014). Fairbairn's appointment books show that he repeatedly sought Kerr's help in the aftermath of the renal calculus that followed his wife's "attack" in January 1935, and then a few times in 1936 and 1938 (including during a week of "rows" with his wife; MSS.50108-50152). Then the massage sessions suddenly resumed in November 1954 and continued through July 1955—on fifty-eight separate occasions, typically at the end of the workday, often before or after sessions with his patient Morris. There are no obvious correlates for these events, other than Fairbairn's gestation of his primal scene theory and renewed self-analysis in this period, so one wonders if his sessions of intimate physical contact with the blind masseur could have given him some sanctioned outlet for feelings that would consciously have been taboo.

One hint of some breakthrough of awareness comes from Fairbairn's copy of Sullivan's book *The Psychiatric Interview* (1954), in which he noted at the end of the chapter on "Problems of Communication" that it was "pleasant to read" but "difficult to follow/grasp." At one point, Sullivan describes his technique for assessing the patient's handicaps to "*using the totality of his abilities*" (1954, p. 237, italics in original). If the patient hesitantly admits to a "sexual problem," Sullivan replies, "And doubtless a homosexual problem"—whereupon the patient confesses to frequent "sexual relations with a member of his own sex" or an inability to think of such "relations with . . . the other sex" (p. 237). Fairbairn, who invariably drew one light, careful pencil line beside important passages, startlingly sidelined this whole section with five heavy, slashing black lines.

Fairbairn could not have known that Sullivan was himself homosexual, but Sullivan here refuses to pathologize homosexuality, observing that he does not treat such "alleged entities" but simply tries to find out what stands in the way of the patient's "making the conventional . . . adjustment which is regarded as normal" (1954, p. 225). My impression is that Fairbairn was caught off guard on reading this section—almost as if he himself were being interviewed by Sullivan, who had suddenly broken through his defenses.

LATER LIFE AND WORK

In 1957, Fairbairn moved his residence and his practice out of Edinburgh to a Georgian house in the nearby village of Duddingston. In 1959, he finally married his secretary, Marion Mackintosh, after she obtained her divorce (Sutherland 1989), although Nicholas Fairbairn (1987) disapprovingly claimed that his father had resisted her for fifteen years. But by now Fairbairn seemed to be declining physically, suffering severe bouts of influenza and what were referred to as occasional cerebral incidents. He grew depressed and drank heavily, sometimes even behaving erratically and having rage outbursts, according to his family doctor and others who looked after him in his final illness.

But by 1961 Fairbairn was declining physically, suffering frequent, severe bouts of influenza along with "signs of arteriosclerosis" (Sutherland 1989, p. 158). He was also drinking heavily, something that Sutherland (1989) cautiously ascribed to a "primitive identification with his first wife" (p. 159). Marion Fairbairn, years later, seemingly tried to minimize this by claiming he had Parkinson's disease (Dawson, unpublished), which no other source mentions. No doubt Fairbairn's depression during this period was aggravated by an awareness of declining intellectual powers, which prevented his escaping into work, his earlier salvation. Poignantly, he would tell Marion, as well as Harry Guntrip: "I have shot my bolt" (Dawson, unpublished; Hazell 1996, p. 195).[6]

Fairbairn nonetheless continued to see a few "faithful patients" (MS.50250), always including Morris, and to ponder the causes of homosexuality. In his last major paper, "On the Nature and Aims of Psycho-Analytical Treatment" (1958), he used Morris to illustrate the role of the primal scene in creating a "static internal situation" (p. 382), which forms the basis of the patient's "closed system" (p. 380) of inner reality, and from which he has to be rescued by the "actual relationship" with the analyst (p. 385). For Morris, Fairbairn noted, "sexuality and intercourse" were like an "atom bomb" (p. 383), and preventing its explosion was his only way of maintaining his enraged excitement and averting the

[6] In the future, Fairbairn's medical records (MS.50249) will throw more light on this, but they are closed under the Records Management NHS Code of Practice (Scotland) until 2041.

destruction of his internal objects. But in a reversal of the usual oedipal polarity, Morris was disturbed when newly married friends stayed overnight in his flat, for he felt homosexually attracted toward the man and jealous of the woman.

Morris finally featured in two brief essays, the first of which, "A Short Note on Castration" (MS.50212), dated 1961, was sent to Sutherland as editor of the *International Journal of Psychoanalysis* but was never published. Here Morris is evidently the second of the two anonymous patients described. After years of analysis, he was discovered to be sexually excited only by the threat of castration, inflicted first by his mother who had had him circumcised, and then through the loss of his leg, viewed as her punishment of him for his wartime escape "into the world of men with penises." This accounted for his "repressed homosexual proclivity" (MS.50212) and fear of marriage. Now the primal scene drama gives way to the earlier idea of homosexuality as a direct flight from the castrating mother into the company of other men.

The second of these papers, "A Note on the Origin of Male Homosexuality" (1964), appeared in the *British Journal of Medical Psychology,* which in 1963 had devoted an issue to celebrating Fairbairn's work. This essay (Fairbairn's last) starts from the premise that the "substitution of the penis for the breast provides the essential basis for male homosexuality" (1964, p. 31). The only case described is Morris, whose history is now given in more detail, including that he enjoyed the "all-male companionship of Army life" (p. 31), but had his left leg amputated in a German hospital following the battle of Arnhem in September 1944. Fairbairn's description oscillates coyly between minimizing and admitting Morris's homosexual behavior—e.g., Morris took baths "in the presence of a male friend" but there was passive "penis play" rather than "mutual masturbation," which "not uncommon[ly]" resulted in an "emission" (p. 31). He also had frequent homosexual dreams and masturbation fantasies.

Now the cause of Morris's strong homosexual tendency is reduced to maternal deprivation (rigid feeding and traumatic weaning), which led to self-consoling masturbation in which his penis replaced the breast as his sexual object. This was abandoned after his traumatic circumcision but resumed with homosexual fantasies after another boy initiated

him into mutual masturbation. His fear of women, with their castrating vaginas, then led him to take the penises of other men as sexual objects. "It is thus that his homosexuality arose," concludes Fairbairn (1964, p. 32). And thus Fairbairn in effect dedicated his final publication to the man who apparently served as his alter ego for two decades.

Lewes (2009) doubts that this paper would have been published had it been by anyone less eminent than Fairbairn and thinks it suggests the "repetitive quality of a good proportion of psychoanalytic theorizing" (p. 175) on the topic. Indeed, Fairbairn's obsessional need to find explanations—albeit inconsistent ones—for the causes of homosexuality mirrors the incoherent efforts of his psychoanalytic contemporaries to devise theories that support their prejudices about its harmfulness. For as Wiedemann (1962) reluctantly concluded after an exhaustive survey, the "analytic literature does not disclose any single genetic or structural pattern that would apply to all or even a major part of cases of inversion" (p. 405).

But Fairbairn's quest was also energized by his identification with a patient whose history and basic conflicts mirrored his own. It looks as if the two of them began by colluding to suppress or minimize Morris's homosexual leanings so as to keep them safely in the realm of the "psychoneurotic" and the nonperverse, but that, over time, the facts kept emerging in inconvenient ways. What this ultimately led Fairbairn to conclude about himself we cannot know, nor do we know if Morris ever learned of his appearances in Fairbairn's publications. But their bond must have been powerful, for Morris was one of only two patients who continued in treatment to the end, despite Fairbairn's decline, and he was indeed the last patient Fairbairn ever saw, on the afternoon of Tuesday, November 17, 1964. Fairbairn was subsequently persuaded by his doctors to enter hospital for treatment of his alcohol problem, after which two strokes intervened, followed by his death on New Year's Eve (C. Fairbairn 2014).

CONCLUSION

Although this picture of Fairbairn as man and theorist is inevitably somewhat speculative, it does seem that, despite his benevolent, well-man-

nered exterior and his major theoretical achievements, he must have been an unhappy man, haunted by his persistent inability to resolve his own conflicts, which undermined his attempted intellectual mastery in the domain of psychoanalysis. Possibly, he was describing himself when writing about "the psychoneurotic" individual who would "rather endure suffering than give natural expression to tendencies conflicting with a part of his personality which not only rejects them," but controls them "with no small measure of success" (Fairbairn 1946b, p. 291). Thus, all his tortured speculation about the meaning of his urinary phobia afforded no relief (he never discussed possible biological factors). It is unknown how he reacted in his later years to evidence of changing societal attitudes reflected in the work of the Wolfenden Committee, on which his friend and colleague Edward Glover had strongly advocated decriminalization of homosexuality.[7]

Clearly, Fairbairn's sexual conflicts must have played a role in the development of his major innovations to psychoanalytic theory. His early, learned distrust of genital pleasure for its own sake echoes throughout his work, perhaps fostering his insights about attachment to early caregivers as the primary force in human development, but also contributing to his disapproval of "Freud's psychological hedonism" (Fairbairn 1949, p. 152) and his insistence that sexual libido functions "essentially" as a "sign-post to the object" (1941, p. 33). If Fairbairn's struggles with his own blocked libido probably lent a perfunctory quality to his heterosexual behavior and contributed to the collapse of his marriage,[8] then they certainly also contributed to his "melancholic, perverse, antihomosexual" theory of heterosexuality (Domenici 1995, p. 45), as well as leading him eventually into the theoretical dead end of the primal scene as the ultimate source of resistance in psychoanalysis.

This ascetic one-sidedness, together with his often abstruse writing style, may be among the reasons that Fairbairn did not become as influential as Winnicott, for example. This was also true of his clinical style, according to Guntrip, who contrasted Fairbairn's "intellectually precise interpretations" and seeming severity with Winnicott's warmer, maternal

[7] Glover (1960) wrote that the "'diseased' prejudices of society" were as much a problem as the "'diseased' propensities of the individual homosexual" (p. 243).

[8] See Isay (1996) on the problems of homosexual men married to women.

presence and intuitive insights (Guntrip 1975, p. 148). Fairbairn may have stressed salvation through the personal bond between patient and analyst, but he feared, sadly, that he himself was not a "good analyst" (Dawson, unpublished)—something tacitly confirmed by Sutherland (1994) as well as Guntrip, and suspected by colleagues such as Bowlby and Rycroft, who found him "too puritanical" and "schizoid" (Dawson, unpublished).

Fairbairn himself was never able to seek help from another analyst after his treatment with Connell and apparently avoided intimate male friendships, maintaining a facade even with Sutherland (1989). Fairbairn's greatest emotional fulfillment may have come from his children, for Cosmo (his mother's favorite) describes him as a "wonderful father" who took them on weekend outings to the zoo and on idyllic summer holidays. But Fairbairn's favorite was his son Nicholas, whom he idolized, perhaps excessively so. Nicholas himself said his father used him as "the person he would like to have been" and "adored everything I did," albeit with some "defensive envy" (Dawson, unpublished). And as his father's "equal and his confidant" (N. Fairbairn 1987, p. 38), Nicholas enjoyed endless discussions with him about human motivation, including "the manifestations and causes of sexuality and homosexuality" (p. 38)—the latter, according to Fairbairn, deriving from "morbid psychopathological hatreds" (p. 50) caused by maternal rejection, from which he did his best to protect his son.

Whether Fairbairn succeeded in this is doubtful, given the strange career of Nicholas Fairbairn. He became a criminal lawyer and conservative MP who served in the cabinet of Margaret Thatcher and was knighted in 1988. Personally eccentric and highly provocative, he was renowned for his flamboyant dress and his bragging about sexual conquests, which overlaid a degree of misogyny. His political downfall came in 1982 when he failed to observe parliamentary protocol in a criminal case and had to resign as Solicitor General for Scotland. Despite retaining his parliamentary seat, he never again held government office and died of alcohol-related causes at age sixty-one (Cosgrove and Calder 1995).

In the early 1970s, Nicholas Fairbairn served as vice-president of the Scottish Minorities Group for gay and lesbian rights, but soon swung in the other direction (Davidson and Davis 2012)—eventually being re-

buked in Parliament when he denounced homosexuality and embarked on a description of sodomy (House of Commons Hansard Archives, 1994). Yet in 2014, Sir Nicholas was posthumously implicated, along with other prominent men, in a sexual abuse scandal involving underage boys—charges that are apparently still under investigation (*The Scotsman* 2014). Charles Rycroft had thought that Nicholas's sartorial eccentricity was "a caricature of something in his father's character" (Dawson, unpublished), but perhaps he spoke more truly than he knew.

Remarkably, Fairbairn's family and personal life go unmentioned in the brief autobiographical note he wrote for his 1963 Festschrift, except for a nostalgic, somewhat revealing paragraph about the Victorian era of his childhood, with its enjoyable street entertainments. There is a wistful poignancy in his description of the "excitement of seeing horse-drawn fire-engines dashing along the street with the horses galloping and smoke and flames bellowing forth from the chimney" (Fairbairn 1963, p. 462). Did he regret a lost time of innocent pleasures and heroic masculine passions, and the fire and excitement that were to be progressively extinguished by parental and societal prohibitions, as well as by his own anxious conformity? Did he sense missed opportunities and thwarted potential?

But if analysts even in the later twentieth century had to deny proscribed homosexual desires (Isay 1996; Roughton 2002), then how much harder was it for a man born into Fairbairn's time, place, and family even to recognize such desires in himself? And how unthinkable was it for his psychoanalytic biographer, John D. Sutherland (1989), to detect underlying conflicts that to later generations may seem obvious? But Sutherland still managed to say a great deal, for which we should be grateful to him, as well as to Fairbairn himself for having the courage to preserve his personal notes to the last.

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APPENDIX

In preparing this article, the following unpublished manuscripts—held by the National Library of Scotland, Edinburgh—have been utilized.

MS.50100	Letter from H. Guntrip – January 3, 1956
MS.50101	Letter to Dr. Pave, undated
MS.50105	Letters relating to *Psychoanalytic Studies of the Personality*
MSS.50108-50152	Appointment books
MSS.50157-50165	Records of consultations, 1932–1963
MS.50166	Chronological list of private patients, 1923–1952
MS.50168	Manuscripts and drawings relating to dreams, 1940–1955
MS.50169	Self-analytical notes, 1939–1955 (including three handwritten index cards)
MS.50177	Knowledge and self-analysis v. psycho-analysis, 1932
MS.50207	The Schreber case
MS.50212	A short note on castration, 1961
MS.50221, f.110	Difference between male homosexuality and male lesbianism, undated
MSS.50230-50236	Personal diary, c. 1906, 1910–1913

MS.50246	"My Play," undated
MS.50249	Personal medical records and related correspondence, 1964, 1992 (closed until 2041)
MS.50250	Recollections by Marion Fairbairn

The following items from Fairbairn's personal book collection (held at the University of Edinburgh Library Annexe) were referred to for the handwritten annotations they contain. The numbers in the left column reflect the catalog numbering specified at: http://www.fairbairn.ac.uk.

Fairbairn S.71	*The Collected Papers of Otto Fenichel,* ed. H. Fenichel & D. Rapaport
Fairbairn S.159	*The Development of Personality* by C. G. Jung, trans. R. F. C. Hull
Fairbairn S.269	*The Psychiatric Interview* by H. S. Sullivan, ed. H. S. Perry & M. L. Gawel
Fairbairn S.308	*Fragments of an Analysis with Freud* by J. Wortis

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THE DIALOGICAL SELF IN PSYCHOANALYSIS

BY FELIPE MULLER

This paper describes the shift that appears to be taking place in contemporary psychoanalysis, as reflected among intersubjective approaches, from a monological conception of the self to a dialogical one. The monological self *emphasizes the separation between mind, body, and external world, focusing on the representational and descriptive/referential function of language. In contrast, the* dialogical self *emphasizes practices, the permeable nature of relationships between subjects, and the constitutive function of language. This paper attempts to explain the growing emphasis on the dialogical self, understood from a theoretical, metatheoretical, and technical point of view, using contemporary intersubjective approaches to illustrate this shift.*

Keywords: Monological versus dialogical, intersubjectivity, object relations, language, analytic relationship, subject–subject versus subject–object, analytic third, potential space, in between space, Freud, self, rhythmicity, body-mind relationship.

> Here are two places, then, the inside and the outside of the individual. But is that all?
>
> —Donald Woods Winnicott [1971, p. 104]

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> Reading is not just a matter of considering, balancing, or even testing ideas or experiences presented by the writer. Reading involves a much more intimate encounter. You, the reader, must let me occupy you, your thoughts, your mind, since I have no voice to speak from but yours. If you are going to read this . . . [article], you must allow yourself to think my thoughts as I allow myself to become your thoughts and then neither of us can claim that thought is the exclusive creation of one.
>
> —Thomas H. Ogden [1994a, p. 1]

> Any understanding of live speech, a live utterance, is inherently responsive, although the degree of this activity varies extremely. Any understanding is imbued with response and necessarily elicits it in one form or another: The listener becomes the speaker.
>
> —Mikhail M. Bakhtin [1986, p. 68]

INTRODUCTION

Charles Taylor (1991) distinguishes between two types of acts, based on the number of agents involved. *Monological* acts are those that primarily involve a single agent, although they may involve other agents with whom some action is coordinated. For example, two soccer players can coordinate an attack: a striker runs forward while a midfielder kicks the ball to him. On the other hand, *dialogical* acts necessarily imply the presence of more than one active agent. They also show coordination but this develops because of, among other things, a common rhythm. A good example would be two people dancing together or arguing passionately. The way in which the agents experience the interaction is different in each case.

Taylor's distinction corresponds to two different conceptions of the self. A monological conception of the self emphasizes mainly the development of representations of the world, which are then projected into an inner mental space before eventually operating again in the outside world. In contrast, a dialogical conception highlights, among other things, integration into practices in which an unformulated know-how develops. In this conception of the self, representations play a secondary

role. Indeed, the role given to representations is one of the key differences between the two conceptions.

Is this distinction between dialogical and monological important for psychoanalysts? Can we speak of monological and dialogical actions in the consulting room? What is the relationship between the monological self, the dialogical self, and psychoanalysis? To what degree are psychoanalysts aware of this distinction?

I believe it is necessary to understand and reflect on this distinction, as it will allow us to establish connections between seemingly unrelated aspects of theory and practice that, when taken together, point to a shift from the monological to the dialogical in psychoanalysis. The extent of this shift will vary according to the criteria used to describe the dialogical. In disciplines such as psychology (Hermans, Kempen, and Van Loon 1992; Wertsch 1991) and psychopathology (Lysaker and Lysaker 2001; Muller 2003), the dialogical self has begun to gain significance and is therefore worth examining here.

The fact is that there are a number of distinct theoretical perspectives in psychoanalysis, and this has led to heated debates on how to organize the theories that make up our discipline. One way to do this is by distinguishing between one-person psychology and two-person psychology psychoanalytic theories (Balint 1950; Spezzano 1996)—or, in more contemporary terms, by distinguishing between the intrapsychic (or intrasubjective) and the intersubjective (Dunn 1995), or between the drive structural model and the relational structural model (Greenberg and Mitchell 1983).

Some authors have used the word *dialogical* to describe psychoanalytic theories based on a two-person psychology or to refer to certain intersubjective approaches. However, in most cases, this term is used in a very general sense to refer to something related to the conversation between patient and analyst. This gets in the way of a deeper understanding. But the dialogical conception of the self is implicitly present in psychoanalysis in a more specific sense, both in the area of theory and in contemporary praxis.

In this paper, I will develop the basic distinction between the monological and dialogical conceptions of the self. I will begin by focusing on some specific attributes of the dialogical in order to illustrate how

this shift from the monological is taking place. I will show how both the *in between* and contact between consciousnesses, as well as practices and joint actions, are central to dialogical approaches, and how these are consistent with hermeneutical and constructivist approaches. Next, drawing mostly on contemporary intersubjective approaches, I will point out some important psychoanalytic developments that have brought about a shift in the focus of psychoanalysis—with differing degrees of acceptance.

This can be seen in four different areas. First, less weight is given to the distinction between inside and outside, and there is a correspondingly greater interest in the space in between subjects. Second, emphasis has moved from the subject–object to the subject–subject relationship. Third, there has been a move away from insight-oriented therapeutic techniques based on free association to techniques based on action or relational practices and their articulation. Fourth, at a metatheoretical level, there has been a shift from foundationalist, realist, or positivist perspectives to hermeneutical and constructivist ones. Changes in these four areas are all indicative of an increasingly dialogical conception of the self in contemporary psychoanalysis.

FROM THE MONOLOGICAL TO THE DIALOGICAL SELF

The monological concept of the self, rooted in the thinking of Descartes and Locke, is characterized by four main features. First, representations play a primary role: the self has representations of the world and of others, as well as of its own goals, desires, and fears (Taylor 1991). Representations allow us to act in the world and to interact with others and with ourselves. Our set of representations makes it possible for us to imagine a scenario and then execute an action plan. This map is projected within an internal space that is supposedly independent of the influence of others (Shotter 1993). Similarly, through representation, we relate to our own bodies. Given the importance of representations, theory always takes precedence over practices in this conception of the self.

Second, mental activity is understood as something locked away within our heads and as containing our faculties (Shotter 1993). The

mind is a neutral organ that mediates between the world and us. It operates according to certain principles that are independent of the context in which they develop. We are born with a mind that we later develop, generating knowledge—i.e., representations—in the process. According to Shotter (1993), the most striking feature of the monological conception is the development of mental images arranged in the form of theories; remembering, perceiving, and attributing meanings are always individual actions and always occur within mental space.

Third, the monological conception creates a disruption between mental activity, social activity, and the body. The starting point for everything is the Cartesian subject, who is able to develop representations about the world and the body—in this case, through methodological doubt. This process, in turn, implies the possibility of developing one's own representations, independently of any contextual influence: i.e., I develop representations of other people as if they were objects, and thus I "objectivize" the other in my consciousness. In the Cartesian conception, other people are essentially objects of consciousness, not other consciousnesses. The type of relationship that results from these developments is that of *subject–object*.

Moreover, in this view, the body is separated from the mind. Descartes himself explicitly excluded the body; subjects relate to their own bodies in the same way as they do to objects in the outside world. Thus, the vision of the self that results is that of a self-contained individual who needs neither others nor a body to develop accurate representations. Hence the monological conception is understood as separating the mental, the social, and the bodily, into inside and outside and into mental and physical.

Finally, the main function of language within this approach is to frame representations (Taylor 1985a). Language is seen as a referential system, a shared code in which words and things are linked together. Language stands for things and replaces them. That is why it is said that language refers to, designates, or describes things. The meaning of a word is what it represents, be it a thing, an idea or a behavior. It is at this level that a statement can be evaluated as true or false (Austin 1955). In this sense, theories are sets of propositions that explain observed events, and knowledge cannot be anything but a correspondence between prop-

ositions and the external world. Reality is found, and theories are tools that help us understand and explain reality.

The dialogical conception of the self, in turn, originates with Bakhtin, Heidegger, Merleau-Ponty, and Wittgenstein (Shotter 1993; Taylor 1991). The problem with the term *dialogical* is the multiple ways in which it has been used (Todorov 1984; Wertsch 1998) and the various dimensions of experience that can be understood dialogically. In a broad sense, the term has been used to refer to the presence of two or more agents in an interaction in which mutual influences are assumed to be inevitable. Nevertheless, in a more restricted and specific sense, there are several attributes or features I wish to highlight here.

The first is that the dialogical self is embedded in practices in and about the world. The type of analytic knowledge we have of the world presupposes a more fundamental way of relating with it, where mind, body, and the external world seem to melt into one another. This occurs, for example, when we dance, drive a car, talk, or argue passionately about something and want to understand our interlocutor's point of view (Richardson, Rogers, and McCarroll 1998). Know-how and knowing-from-within (Shotter 1993) exist in our everyday lives and are functioning when we perceive ourselves to be more involved in the world. This knowledge is *em-bodied* or *in-corporated* and is never independent of its social and cultural context.

Another feature of the dialogical conception of the self is the central place accorded to relationships with other people. This, in turn, has different implications, one of which is the inclusion of the other within oneself. I will mention only two ways in which this idea has been developed. The first stresses how a person's sense of self is structured through the way that he/she positions his/her body in front of others, and the way that he/she walks and positions him-/herself in a public space (Taylor 1991). This sense of self includes the other: I become aware of the respect I have for someone through the way I position my body when I address that person. This is what we call *deference* and it can only be understood if we think of the mind as present within the body; it is the body that knows. This problematizes the separation between social, mental, and bodily states found in the monological conception of the self.

A different way of conceptualizing the presence of the other within one's self comes from perspectives that view thinking and other cognitive activity as internalized social processes. This was Vygotsky's great insight (see, e.g., Vygotsky 1999): that interpersonal processes are gradually transformed into intrapersonal ones. There are always others present when we think, even though their statements are silenced and they remain invisible. Each statement in our thoughts is a response to an unheard voice. Hence the nature of a person's thoughts can vary depending on the characteristics of the silenced speaker.

In this way, thinking is nothing more than a dialogue between two parties, one of whom is quiet and curtailed. The important thing is that thinking shares the same characteristics as transactions between people in the outside world (Shotter 1993). And because thinking is permeated by the "outside" world, it is impossible to identify an "inside" where thinking occurs; therefore, it can only be located on the frontier between inside and outside, between one person and another.

The same happens with memory. Sometimes I have difficulty finding something, and my partner asks: "Where did you leave it? What did you do before so-and-so? Where did you go next? Did you have it with you at that moment? Do you think you left it in the car, in the consulting room, or in your office at the university?" I answer yes or no to each of these questions, until finally we remember together. But who actually did the remembering? In these cases, it is not possible to say that it was either of the two (Wertsch 1991). It was a joint activity and, in a literal sense, the memory was recovered *between* the two of us.

The dialogical conception of the self, as we have just seen, emphasizes a *we*. Taylor (1985a) understands that most human action takes place to the extent that the agents represent and understand themselves as an integral part of a *we*. Identity cannot be defined as a set of individual properties; it exists only within a visible space and depends on our place in different dialogical actions. First we are part of a *we;* only then is there an *I*.

Another attribute of the dialogical conception of the self is responsiveness. Bakhtin (1986) claims that there is no such thing as neutral understanding; understanding is always responsive. When I understand another person's utterances, I have already formed an attitude toward

my interlocutor. This differs from the classical monological model in which a transmitter sends a message that the recipient receives and processes before formulating possible responses and selecting the most appropriate. Responsive understanding, on the other hand, pertains to a special relationship with another person, in which some quality of contact between consciousnesses is primary in the interaction.

When I am immersed in a dialogue, the other person is not the object of my consciousness but another consciousness. In this interaction, we develop the characteristic element of rhythmicity. Imagine a dialogue between two people who have just met: typically, it begins with personal introductions, a description of their jobs, perhaps, where they live, and any other information that may be relevant to the conversation, depending on context. The dialogue has the characteristic of statements sent, received, processed, and responded to; the other is held in our consciousness as an *individual* or an *object.*

However, as the relationship progresses, these two people enter another dimension of dialogue, one in which this step-like sequence no longer appears to take place. There is a certain rhythm that begins to take over the dialogue, something like a sort of hook-up between two consciousnesses. At such moments we are completely *there:* the experience is one of greater integration and lower self-consciousness. Whether we are dancing, talking, or sawing through a large tree trunk together, what takes place is a joint action based on some rhythmicity. The arrival on the scene of a third person brings the inevitable feeling that something has been broken by that person's presence.

Finally, the last feature of the dialogical conception of the self that I want to highlight is an emphasis on the constitutive function of language. Rather than describing and representing objects, language is seen as the means by which the world manifests itself to us (Guignon 1991). Moreover, language allows us to do things, as described in Austin's (1955) performative utterances. It lets us formulate things; we can take them from a diffuse state of existence to one of clarity, generating public discussion and creating standards by which to evaluate our actions (Taylor 1985a). Language cannot be thought of outside the practices in which it occurs; it is through these practices that things exist or acquire significance.

In this context, theories are no longer propositions corresponding to an independent reality, but tools that allow experience to be ordered in a certain way and that produce a certain reality: we do not find or discover reality directly; rather, we construct it as we formulate it. Hermeneutic and constructivist approaches also presuppose, or endorse, a dialogical conception of the self. Hermeneuticists object to the idea of a disengaged self that can choose freely. Rather, the self is embedded in practice, and it is here that our lives take on meaning or significance through interpretation (Richardson, Rogers, and McCarroll 1998). Hermeneuticists see their subject matter as a text whose meaning is unclear, incomplete, or contradictory (Taylor 1985b) and in need of interpretation. In this interpretive process, our lives gradually gain meaning and coherence, just as any other subject matter does.

Constructivists, in turn, emphasize the practices in which we interact with others, understanding that it is through these practices that what is talked about acquires meaning. We give meaning to our experiences and environment or we build meaning into them through the ways in which we relate to others. What we pay attention to, speak about, and think about as *objects* is determined by the practices through which we live our lives.

Dialogical and monological attributes of the self are neither mutually exclusive nor complementary. Simply stated, the self has a dialogical nature but is capable of monological acts. Until dialogical thinkers disrupted the philosophical field, drawing our attention to other aspects of the self, monological acts were seen as the prototypical human acts to be explained, giving rise to a conception of the self that ignored some of its primary and fundamental characteristics. It is true that at certain moments we act monologically and that we are capable of detaching ourselves from the world, of forming a mental map of the situation we are in, and then deciding our course of action according to this map and to our purposes, desires, goals, etc. But it is also true that this analysis leaves out many other more primary and fundamental ways of being in the world.

In summary, the dialogical conception of the self has developed in response to prevailing theories and concepts that do not involve or include more primary aspects of the self. This conception is a reaction to

the misuse and abuse of representations in understanding the self, and it emphasizes our involvement in social practices or joint actions. Furthermore, it questions the idea of a split between mind, body, and external world; instead, it embodies the mental and incorporates the other. The relationship with the outside world or with others is understood as permeable. There is an emphasis on a *we* and the area between inside and outside. In the relationship with the other, the focus is on consciousnesses in contact, rather than on the other as an object of consciousness, and a defining role is given to shared rhythmicity.

Finally, the dialogical conception of the self also stresses the self's responsive nature and points out that reality is not given but constructed between subjects. Many of these features are mutually dependent; shared rhythmicity, for example, presupposes shared action—a joint involvement in practices—and in turn a contact or "hook-up" between consciousnesses.

THE MONOLOGICAL SELF, THE DIALOGICAL SELF, AND PSYCHOANALYSIS

Freud developed his theory in a context dominated by an atomistic and monological conception of the self. The monological conception of the self, as mentioned earlier, establishes a clear division between mind, body, and the external world. In this framework, Freud (1915a) established a new relationship between body and mind. In Freud's view, it was not possible to understand mental activity without the notion of drive. Drive is rooted in the body; different psychic operations are the result of different drives, which can be traced to the diversity of drive sources in the body.

Unlike the dialogical conception, where the mental state is *in-corporated,* drive—a borderline concept between the psychic and the somatic—is here seen 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" (Freud 1915a, p. 122). Drive, or the endogenous stimuli to which Freud refers in his early work (Freud 1895), are established as the engine of mental activity.

One of the central tenets of Freudian theory is the principle of constancy: the psychic apparatus tends to keep its levels of arousal as close to zero as possible. Drive increases arousal levels, and hence to decrease them it must operate on an object that facilitates the discharge of the tension generated by instinctual/drive demands. These objects are found in the external world, and the first one is the mother's breast: "There are thus good reasons a child sucking at his mother's breast has become the prototype of every relation of love" (Freud 1905, p. 222).

While the relationship between mind and body that Freud establishes modifies the idea of the division between the mental and the physical, the very definition of *drive* as a borderline concept between the somatic and the psychic reinforces the idea of two separate domains. And like body and soul, subject and outside world are also separated (Freud 1915a).

On the other hand, drive characteristics are what allow the baby to distinguish between inside and outside, the internal and the external world (Freud 1915a). The baby may, by motor action, escape from certain stimuli originating in the outside world, but it cannot flee from drives. These generate displeasure as tension increases, and so become indicators of the baby's inner world.

In turn, the notions of identification and projection presuppose a clear distinction between *inside* and *outside*. Faced with the loss of a love object, "the most obvious reaction is to identify with it, to replace it from within, as it were, by identification" (Freud 1940, p. 193).[1] In the case of phobias, "the whole defence mechanism thus set in action a projection outward of the instinctual danger" (Freud 1915b, p. 184).

If we consider Freud's theory of libido, we note that Freud claims that individual development comes first, and that only later does the individual turn toward the outside world. To be able to interact with objects in the external world, the individual must go through certain stages in the development of the libido: the autoerotic, the narcissistic, and

[1] In mourning, the libido withdraws from the lost loved object and is displaced onto another object, whereas in melancholy, "the free libido was not displaced onto another object; it was withdrawn into the ego" (Freud 1940, p. 249). In this withdrawal into the ego, it serves to "establish an identification of the ego with the abandoned object" (p. 249).

the objectal (Freud 1914). It is evident, too, that the elaboration of this concept of mental development is based on the monological premises of Freud's time. The division between the subject and the external world makes it necessary to establish a motivational system that explains the shift in attention toward others. For Freud, this motivation has to do with the drives and the demands that they generate on the psyche.

Mental activities—attention, memory, judgment, thinking, etc.—begin to develop at a later stage, as the psychic apparatus adapts to the reality principle (Freud 1911). Initially, the psychic apparatus is governed by the pleasure principle, before it is forced to develop representations of the outside world in order to change that world, since wishful thinking is not enough. The development of such mental operations is related to the increasing importance of "external reality."

Freud points out that beneath the world of representations guiding our conscious action lies another world, the unconscious, filled with repressed and irreconcilable representations. The unconscious is founded on our instinctual drives. These drives use unrepressed representations to find means of gratification; there is another world beneath consciousness controlling the subject's waking life. Thus, to the set of representations central to the monological conception, Freud adds another—that of unconscious representations and instinctual demands that make use of conscious and preconscious representations in order to achieve gratification.

Representations take center stage in the development of Freudian theory. Already in his early psychoanalytic publications, Freud postulated a separation between quota of affect (*Affektbetrag*) and representation. Repression involves removing the quota of affect associated with unacceptable representations that cause pain. Subsequently, this affect is transposed to the body, to an external object, or—by a false connection (*Verknüpfung*)—to another, not irreconcilable representation (Freud 1894). In the first case, we find what Freud called *conversion hysteria;* in the second, *phobias;* and in the third, *obsessive ideas.*

It would not be possible to know that a drive exists were it not for its relationship with a representation, or if it did not manifest itself as an affective state (Freud 1915b). So when we talk about repression, we should first consider what our psychic apparatus has done with the representa-

tion, and second, what it has done with the drive energy or quota of affect associated with the representation (Freud 1915c). Psychoanalytic work consists of reconnecting representations with quotas of affect that have been detached by repression. The moment at which this reconnection occurs in the analytic process is known in some psychoanalytic circles as insight.[2]

In his early writings, Freud (Breuer and Freud 1895) explicitly states that his goal is to develop a theory of mind according to the natural science model. At that time, it was thought possible to establish a clear separation between subject and object, and this belief led to a scientific practice whose indispensable prerequisite for gaining objective knowledge, or truth, was neutrality. In this context, theory was understood as guiding the analyst in his or her attempt to discover the real causes of what was happening to the object in question (in this case, the patient and his or her unconscious). Also, priority was given to the descriptive referential function of language: what was transmitted corresponded to what was observed. Even when, toward the end of his career, Freud (1937) speaks of constructions, he clarifies that these must recover the historical truth of the patient, what happened and was repressed; this construction—or reconstruction—leads to the truth of what the patient experienced.

In developing his ideas about the unconscious, Freud revolutionized the existing conception of the self but retained some of its core attributes: an emphasis on the divisions between inside and outside, between the somatic and the psychic, as well as the centrality of representations and an understanding of language as descriptive and referential. However, Freud seems to have held an unspoken notion of some of the attributes of the dialogical self, as shown in his theory of analytic technique and the establishment of the analytic setting.

On the one hand, the formulation of rules by establishing a setting is an attempt to set up a starting point in the analytic process that will separate the patient from everything to which he or she has been responding dialogically. The consulting room, the couch, and the peculiar form of interaction with the analyst favor detachment from the practices in

[2] Freud never used this word.

which the patient normally participates and is embedded; the breaking up of normal speech through free association helps prevent any responsive understanding in the analyst. Meanwhile, the analyst's free-floating attention is focused on the products of the patient's free association, and this also seems to prevent responsive understanding or the type of contact between consciousnesses that typifies the dialogical. It prevents, at the conscious level, the development of rhythmicity; the psychoanalytic process is based on a necessary retreat from the world to a place where the analyst becomes an object onto which the patient transfers feelings and thoughts, and the patient—or, more specifically, the patient's unconscious—becomes an object in which the analyst intervenes.

On the other hand and at the same time, Freud promoted a very special kind of communication: one that takes place between the unconscious of the patient and that of the analyst. Among Freud's recommendations in his paper on psychoanalytic technique (1912), two are oriented toward promoting a dialogical contact between patient and analyst. If the fundamental rule of psychoanalysis pushes the patient to say whatever comes to mind in order to promote free association, Freud recommends its counterpart to the analyst: free-floating attention. According to Freud, the analyst "must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient" (1912, p. 115).

Now, although the analyst's free-floating attention prevents responsive understanding at the conscious level, it also prevents the analyst's selective attention to any part of the patient's material, because the analyst's own censorship could be at work. The metaphor Freud employed here is that of the telephone; the analyst has to adjust and accommodate to receive what is transmitted by the patient's unconscious. Freud used this metaphor of sound waves and electric oscillations to illustrate the conversion of the message from the patient's unconscious to that of the analyst.

But Freud points out another possible obstacle to the reception of the message, and consequently he formulates another recommendation. If the analyst's unconscious is to be used as an instrument, it will require "psycho-analytic purification" (1912, p. 116) so that the analyst's own complexes and repressions do not become blind spots when converting

the message sent by the patient's unconscious. So it is at this level of a direct communication between one unconscious and the other that the issue of rhythmicity could be located in Freud. The psychoanalytic cure requires this more fundamental and primary form of contact between patient and analyst. However, even if Freud had some unformulated intuition about the dialogical nature of the self, his theory remained trapped in a monological language.

In fact, characteristics of the dialogical self are mostly found in writers who subscribe to what has come to be known as a two-person psychology, or, more recently, as intersubjectivist or relational theories. However, not all these writers have a dialogical conception of the self; many explain the relational by emphasizing the representational aspect of the self in its object relations. Spezzano (1996) believes that *dialogical, intersubjective,* and *constructivist* are all terms that refer to a psychoanalytic approach based on a two-person psychology. This notion takes dialogism in its broadest sense and does not allow us to consider to what extent the dialogical conception of the self is present in psychoanalysis today.

Consequently, the dialogical must be described in terms of four changes that have taken place or are still occurring and that naturally tend to converge. The first change involves the creation of new spaces that blur the distinction between inside–outside, external world–internal world, and one–another by treating the border between them as a space in itself. The second change is the shift in emphasis from a *subject–object* to a *subject–subject* relationship. The third change marks the transition from a technique focused on free association and insight arising out of interpretation to one that emphasizes the psychoanalytic interaction, or what I will call *relational practices.* The fourth change prioritizes the constitutive function of language over its descriptive function and emphasizes two factors: first, reality as mediated by the subject's beliefs and theories; and second, the here and now of the analytic session as an inevitable part of the analytic process. This last change highlights the contribution of the analyst—the analyst's subjectivity, emotions, and behaviors—in what the patient produces.

The section that follows illustrates these changes using mostly, but not exclusively, relational and intersubjectivist literature. However, I

have not attempted to furnish an exhaustive review of the literature, and some readers will no doubt object that certain authors and proposals are missing or only partially represented. I am aware of these inevitable shortcomings, but my goal here is simply to outline the transition that has taken place from one conception of the self to another.

FROM INSIDE/OUTSIDE TO THE SPACES IN BETWEEN

As mentioned earlier, Freud made a clear distinction between inside and outside. Hence his approach is based on "a bipolar conception—on one side the libidinal subject, on the other the world" (Lacan 1988, p. 113). Nowadays, however, the *in between* inside and outside, *between* one and another, is beginning to crystallize as an area of interest. We may consider Winnicott's (1967) concept of *potential space* as a possible starting point: an intermediate area of experience that lies between the inner world and the outer world, between baby and mother, between child and family, between subjective and objective, between union and separation, between the individual and society. The thing to stress here is the importance of a third zone, different from the inside and the outside, which is *in between*.

Winnicott derives this concept from the notion of a *common ground* in the relationship between ourselves and others: that place where we live and which the terms *inner* and *outer* fail to capture. Transitional objects and transitional phenomena, the play area of the small child, cultural experience, and creativity are specific forms of potential space (Ogden 1985). In these spaces, objects are created; but, at the same time, they are already there waiting to be found; that is the essential paradox of Winnicott's theory. In favorable circumstances, this space is filled with the baby's creative imagination. In unfavorable ones, it is filled with something injected into it by someone other than the baby. Thus, Winnicott opens the door to thinking about this potential space: a common ground that develops between subjects—and, more generally, the area of the *in between*.

The notion of *inside* and *outside* arising from this new concept can account for a range of phenomena that Winnicott related to life itself,

and that other theories of his time did not consider. Winnicott agreed that by emphasizing the experience of instinctual drive and how the ego copes with it, we are able to think about the healthiness of the answers we receive and their different qualities (flexibility, etc.). But he warns that, in terms of drives and defenses, "we have yet to tackle the question of *what life itself is about*" (Winnicott 1967, p. 98, italics in original). Questions related to the baby, the feeling that life is real and worth living, require this intermediate zone, this third zone called *potential space*. This is where the questions about being take place, where "we are alive as human beings, as opposed to being simply reflexively reactive beings" (Ogden 1985, p. 133).

At about the same time, Madeleine and Willy Baranger (2008) were also considering this "space" as a new area for psychoanalytic exploration. Working in another part of the world and integrating notions from Kurt Lewin's field theory and the phenomenological philosophy of Merleau-Ponty into post-Kleinian language, the Barangers proposed what they called the *dynamic field* as a key to understanding the analytic situation. A basic assumption of this and any field is that it is always more than the sum of its parts. For the Barangers, the analytic field is a whole arising from the subjectivities of the participants and determining the actions, thoughts, emotions, and overall subjectivity of the participants. In particular, they argue that it is unconscious fantasy that structures the bi-personal field of the analytic situation.

The important thing here is that this fantasy does not belong solely to the patient. To understand this unconscious fantasy requires a deep contact with the patient and an even deeper structure created between the patient and the analyst. This is different from understanding the underlying unconscious fantasy of the dream or a symptom, where the analyst is required merely to use an adequate frame of reference and to be free of intellectual impediments. With this argument, the Barangers stress that they are not using the term in a *uni-personal* way.

The structure of the bi-personal and dynamic field is not determined by either the patient's or the analyst's instinctual impulses, "although the impulses of both are involved in its structuring" (Baranger and Baranger 2008, p. 806)—nor can it simply be considered as the sum of the two. "It is something created *between* the two, within the unit that they form in

the moment of the session, something radically different from what each of them is separately" (p. 806, italics in original).

The Barangers provide a very nice example. The patient may arrive in a calm frame of mind. The analyst, too, may have no worries and may be feeling receptive toward the patient. But when the field is established, the analyst may experience sadness and the patient may undergo intense mourning and weeping. From what the Barangers call a *uni-personal* point of view, it can be said that the patient brought a repressed mourning situation to the analyst. In this particular case, the patient was waiting for an opportunity to unleash these feelings, and the session was the time and place to do so, as sometimes happens. From the standpoint of the analytic field, however, the patient's mourning was structured in relation to the bi-personal field and cannot be thought outside the previous course of analysis. The unconscious fantasy, which is a bi-personal fantasy, has structured the mourning.

That is why the Barangers define *fantasy* as "the dynamic structure that at every moment gives meaning to the bi-personal field" (2008, p. 807). They claim that there is a gestalt in the analytic situation that produces meaning, and this is the specific field for the analyst's work. The field is dynamic because there are moments at which it closes down or crystallizes, and moments when it opens up or mobilizes. A lack of mobility in the field indicates the presence of a defensive wall around a personal *bastion*.[3]

Later, the *in between* area became the subject of various theoretical developments. Green (1986), for example—for whom potential space is a *metaphorical boundary,* existing but incapable of existing—proposes the concept of *analytic object,* something that is neither internal nor external but located between the two areas. Similarly, analytic discourse belongs neither to the patient nor to the analyst, nor is it the sum of both; it is the relationship between two discourses outside the realms of both reality and the imaginary.

The emphasis on the in between area has also led to the development of certain intersubjectivist theories, such as those of Ogden and

[3] More recently, and building on the Barangers' notion of the field in neo-Bionian language, authors such as Ferro and Civitarese have elaborated an analytic field theory (see, for example, Ferro and Civitarese 2015) .

Benjamin. Ogden's (1994b) notion of the *intersubjective analytic third* suggests that the minds of the analyst and the analysand are permeable to each other, and their coming together in an encounter between subjectivities generates an intersubjective third, which is different from either of the subjectivities in the analytic encounter and located between the two. This intersubjective third coexists alongside each participant's subjectivity in the analytic interaction because neither exists in a pure form; in fact, each creates, denies, and preserves the other. The analytic subject comes into being from the dialectical relationship between subjectivity and intersubjectivity. In this dialectical relationship, we become someone else—someone different from the person we were until then.

The analytic third is a product of the dialectic generated by both subjectivities in the analytic setting, and it is one possible form of intersubjectivity. This notion places all aspects of the analyst's mental activity within the relationship between subjectivity and the analytic third. Ogden claims that the analyst's entire experience is contextualized by the intersubjective third. No thought or emotion would be the same if it happened outside the specific relationship with the analytic third that is there and present. Thus, if the analyst finds him- or herself facing the patient and remembering something he/she has to do, that memory cannot be thought of outside the relationship with the analytic third that has been created with a particular patient. The intersubjective experience—accessible to the analyst through *reverie*—consists of the mental contents or processes that form the space between analyst and analysand and to which both contribute, albeit asymmetrically. We can say that memory is generated at the boundary between subjectivity and intersubjectivity, which is neither inside nor outside of them. Here again we see the difficulty of thinking about internal–external as separate spaces, as well as the intrinsic permeability of the self.

On the other hand, Benjamin (2004) has her own proposal for what is going on in this space. She criticizes Ogden's notion because his third, instead of creating space, might be said to suck it up, in her view. She differentiates her notion of the third not only from Ogden's, but also from Lacan's symbolic third. Her contribution emphasizes a presymbolic form of thirdness in which recognition takes place. Benjamin considers thirdness as a quality or experience of intersubjectivity. It is where we

surrender to intersubjectivity, *letting go of* the self, instead of *holding onto* it. Benjamin is interested not only in the thing we use (the symbolic, reified third), but also in the process of creating thirdness, which refers to a way of relating (intersubjectively) with its correlate in an internal mental space.

Benjamin bases her elaboration of the presymbolic form of thirdness on early nonverbal experience of shared patterns—specifically, on Sandler's findings on mother–baby interactions. She proposes a nascent or energetic third that is present very early on in the exchanges between a mother and her child. Of all the elements present in this nonverbal experience, *rhythmicity* is seen as the underlying principle in creating shared patterns in this dyad. The idea is that when "the significant other is a recognizing one who surrenders to the rhythm of the baby, a co-created rhythm can begin to evolve" (Benjamin 2004, p. 17). As this significant other accommodates, so does the baby.

Thus, not only rhythm is central here, but also responsiveness: "The basis for this mutual accommodation is probably the inbuilt tendency to respond symmetrically, to match and mirror; in effect, the baby matches the mother's matching, much as one person's letting go releases the other" (2004, p. 17). Recognition takes place through these interactions based on rhythm, accommodation, and response, which move in the direction of a deeper law of reality—in the case of Sandler's study, the law of day and night. Here the important thing is the possibility of symmetry or harmony in lawfulness.

The co-created rhythm is not reducible to action–reaction, which is the characteristic element in the experience of two-ness, of complementarity. On the contrary, rhythm constitutes the basis for the shared third, which is always experienced as a cooperative endeavor. This third is an intersubjective co-creation, an alternative to the asymmetrical complementarity of knower and known, *doer* and *done to* that characterizes the subject–object mode of relationship.

Benjamin's notion of an intersubjective thirdness considers the in between space as one of collaboration and sharing based on rhythmicity, where it is the analyst's task to create a system of sharing and mutuality. In this task, the analyst needs to find a way to accommodate that does not feel coercive to the patient. This *third of the in between* is seen as

something to be acquired through interaction, creating what Benjamin calls a *dialogic structure.*

FROM THE SUBJECT–OBJECT RELATIONSHIP TO THE SUBJECT–SUBJECT RELATIONSHIP

Psychoanalysis has mostly studied and emphasized the complementary mode of subject–object relationship, where the other is the object of a drive. Even in approaches that prioritize the relational over the instinctual, the other appears as a need-satisfying object; for example, the mother is an object of attachment and then an object of the baby's desire, as well as being the person who mirrors the baby's behavior and supports the baby emotionally. The other—in this case, the mother—is represented as the answer to the baby's needs, and is rarely seen as subject in her own right, with interests existing outside the relationship with her baby[4] (Benjamin 1988). The other is also a subject, and the relationship between subject and object must be different from that of a subject with another subject: these two ways of relating, qualitatively different from each other, have led to new theories about the subject–subject dimension. Aron (1996) refers to the subject–object mode as one of *mutual regulation,* and to the subject–subject relationship as one of *mutual recognition.*

This shift can be thought of as taking its inspiration from Winnicott, since any development that highlights *common ground* and considers *in between* spaces must also consider relationships between subjects. Similarly, any attempt to examine subject–subject relationships must inevitably take into account what is generated between subjects.

As Benjamin (1995) highlighted, Winnicott (1968) made a distinction between *object relations* and *object use.* Object relations are understood in terms of the subject's experience. This relationship involves projections and identifications, and although the subject feels enriched, the relationship is emptied. In the use of the object, object relations are taken for granted, but their nature is understood "not as a projection, but as a thing in itself" (1968, p. 88).

[4] This leads to problems associated with recognition, which has been the subject of recent developments in psychoanalysis, among which is Benjamin's work.

There is a transition from object relations to object use: the baby must place the object outside its area of omnipotent control, thus perceiving it as something external and different from its own projections, recognizing the object as an entity in its own right. If the baby succeeds in doing so, the object will then become a *not-me* source, and the baby will be able to feed on the object. To do this, the baby needs to destroy the object and the object must survive destruction. Once outside the baby's area of control, the object is valued by the baby. As Winnicott (1968) noted, the subject says to the object:

> "I have destroyed you" and the object is there to receive the communication. From now on the subjects says: "Hullo object!" "I destroyed you." "I love you." "You have value for me because of your survival of my destruction of you." [p. 90]

Winnicott thus opens another door: the subject–subject relations and the problem of recognition.

Ogden (1994b) believes that in using the object, the baby confronts the mother-as-subject for the first time, and this happens through the destruction of a part of the baby him- or herself. The mother as a subject is found by destroying the very omnipotence projected onto the omnipotent internal object mother.

Ogden maintains that in the analytic process, the analysand is both subject and object of the analytic investigation. In turn, the analyst is not an observing subject because it is his/her subjective experience during the process by which "he gains knowledge of the relationship he is attempting to understand" (1994b, p. 4). Patient and analyst are *subjects of analysis* (Ogden 1994a). The need for a third point that would provide space led Ogden to propose the analytic third: a middle ground that supports and is supported by analysand and analyst as two separate subjects.

In his development of Winnicott's work, Ogden refers to Martin Buber's distinction between *I-Thou* (subject–subject) and *I-It* (subject–object) relationships. For Buber (1923), the I-Thou relationship is immediate and direct, not utilitarian or instrumental. In contrast, the I-It relationship refers to a field in which the other is experienced as an object that can be manipulated. The use of representations in relating to a Thou immediately turns the Thou into an It.

Benjamin (1995) emphasizes the difference between mutuality, the relationship between subjects, on the one hand, and complementarity, the relationship between subject and object, on the other. Considering the other as an equivalent center of consciousness, a separate subject, raises the same issues as those surrounding the concept of object; even if the object is considered as independent from drive—as in self psychology, for example, and in the object relations school—it is impossible to differentiate between object and other. These theories, which emphasize the early relationship with parental objects, lead us to recognize that "where ego is, objects must be" (Benjamin 1995, p. 28).

Benjamin understands that intersubjective and intrapsychic approaches coexist in a sustained tension; it is not a matter of one or the other. And it is the intersubjective dimension of the analytic process that should develop its theory and practice, so that "where objects were, subjects must be" (p. 29).

Benjamin notes that one cannot fully experience one's subjectivity unless the other is recognized as a subject. This is the postulate from which she develops her theory of intersubjectivity. She takes the notion of intersubjectivity as Habermas understands it, and focuses her mutual recognition theory on research from developmental psychology—mainly from Daniel N. Stern and his group, as well as from feminism. She also starts from Winnicott's distinction between object use and object relations to develop her theory of recognition and destruction.

D. N. Stern's (1985) work on developmental psychology provides new insights into the mother–baby relationship that are central to the development of contemporary psychoanalysis. Previously, it was thought—in accordance with Mahler's model—that the process of separation-individuation moved from an undifferentiated to a differentiated state. But studies in developmental psychology show that the baby is not in an undifferentiated state; consequently, the focus is no longer on how the infant becomes differentiated from a single unit, but on the way that we connect with and recognize others. It is not a question of how we free ourselves from the relationship with the other, but of how we interact, develop, and build a relationship with the other as subject and object at the same time.

FROM INSIGHT TO ACTION

The overall goal of a psychoanalytic process is to make the unconscious conscious. This process is achieved by a technical procedure that aims to reunite a repressed representation with the displaced quota of affect originally attached to it. Normally, when this happens, an insight is said to have occurred. But in some contemporary literature, there is a proliferation of technical work on interaction, actualization, enactment, and interpretive action. All these terms have in common the root *act*, and this would seem to indicate a certain shift toward action-oriented techniques (Aron 1996). In the process of making the unconscious conscious, the coordination of joint acts or actions seems to be gaining ascendancy, to a certain extent, over the reattachment of representation to affect.

Of these concepts, the one that has received more attention in recent decades is *enactment*. Classical, object relational, self psychology, relational, and interpersonal authors have all written extensively about it (e.g., Goldberg 2002; Hirsch 1998; Jacobs 1986; Levenson 2006; Renik 1993; Steiner 2006). Surprisingly, enactment appears as a convergent concept among different psychoanalytic schools in the theory of technique (Hirsch 1998). By now the concept has a history. It was Jacobs (1986) who first used the term, although Sandler (1976) is usually acknowledged as the first to promote it with his idea of role responsiveness. In both cases, there is an elaboration of the role of countertransference.

It seems that after accepting the inevitability of countertransference, enactment appears as a necessary element for the understanding of the transference-countertransference relationship (Schafer 1994). Enactment suggests an action whose purpose is to influence and make an impact in some way on another who is implicit in the interaction (McLaughlin 1991). To achieve this, we have resources destined to evoke certain responses in others—always according to unconscious expectations.

The use of the term *enactment* presupposes that an analyst is involved and emphasizes a collaborative process of mutual influence. The behavioral aspects of the interaction presumably provide access to latent intrapsychic conflicts around early object relations, which are then up-

dated in the interaction between patient and analyst. (At least, this is McLaughlin's understanding of this concept.)

These concepts, enactment and actualization, seem to imply the idea that there is something in the patient's behavior that leads the analyst to "hook on to it," and in some way to participate in a *joint action*—in a particular way and from a certain place in the interaction, a place corresponding to the patient's unconscious fantasies. The analyst is invited to participate in one of the patient's *relational practices*. But this participation is not a result of unconscious aspects of the patient deposited in the analyst as object (as in projective identification), but rather of the analyst's own feelings aroused by the patient.

In general, enactment is treated as a deviation to be corrected in the analytic process. There is frequent mention of the inevitability of enactment (Aron 1996; Schafer 1994), yet it is considered a deviation from ordinary technical procedure (Renik 1993). Ideally, analysts should become aware of their feelings, their countertransference, before acting them out with the patient. Renik explains this in terms of awareness and action. It is the principle of awareness rather than action that should guide the theory of psychoanalytic technique, although this is never actually possible in practice; awareness of countertransference is always retrospective and is preceded by countertransference enactment.

According to Renik (1993), the ideal analytic technique in which attention or awareness outweighs action has evolved from various notions, including, significantly, the reflex arc model found in Freud's *The Interpretation of Dreams* (1900). In this model, motivations are impulses that can follow one of two paths: the *efferent,* resulting in motor activity, or the *afferent,* resulting in fantasy through internal stimulation of the sensory apparatus. Thus, if one acts, there is no thought, and vice versa. Excluding action, therefore, promotes fantasy, which is the material of analysis.

Renik bases his work on William James's theory of emotions. For James (1890), the natural way of thinking about emotions is the following: an event is perceived, and it excites the mental affect called *emotion* which then leads to bodily expression. For James, emotions are our sensations of bodily changes that occur while the event is being per-

ceived. Common sense—based on the monological conception of self—understands that we see a bear, we are afraid, and then we run. James argues that we see a bear, we run, and *because we run* we are afraid. Based on this postulation, Renik argues that it is the perception of the analyst's actions that makes awareness of countertransference possible. But perception is inevitably a perception of the analyst's joint actions with the patient, of countertransference enactment, of relational practices in which the analyst is immersed and that he or she then organizes and interprets.

If we think of this process in dialogical terms, what we see is an unconscious, responsive understanding and a joint action, in which the analyst participates in some relational practice. The analyst responds to the patient's actions with more actions. Countertransference awareness is possible by observing these joint actions or relational practices with the patient. Contrary to the conventional division between perception and action, the idea that the act of perceiving includes a course of action is implicit. While this action is not initially conscious, we can achieve higher levels of consciousness as it is articulated, and this process involves an impact on the experience itself. The enactment implicitly involves the notion of responsive understanding (albeit initially unconscious), as well as complying with notions of dialogical practices.

TOWARD A HERMENEUTIC AND CONSTRUCTIVIST APPROACH

Traditional psychoanalytic theory builds a relationship of correspondence with the psyche that allows us to explain its structures and dynamic processes. Through the analytic method based on theoretical premises, the analyst may, among other things, reveal what has been repressed by the patient. Currently, however, theory is seen as a tool with a different function: that of providing patterns with which to organize and synthesize the analytic material. This is particularly true of hermeneutic and constructivist approaches (Mitchell 1993; Muller 2000).

Hermeneutic developments mainly emphasize two issues: first, the role of theory in organizing the analyst's experience with the patient, and second, the idea that the patient's self is thought of as a confused

and incoherent text that requires clarification, and that such clarification is achieved in the psychoanalytic process by redefining the patient's experience.

Mitchell (1993) argued that all these developments are based on the idea that the patient's experience is ambiguous. This is not to suggest that experience is obscure; rather, its elements require an active process of organization and signification. Because experience can be organized in different ways, it is open to a multiplicity of interpretations and understandings. Experience is ambiguous because its meaning is not intrinsic but depends on cognitive organizing processes; so the meaning of an event or experience is not discovered, but created or constructed as a result of such processes.

Organizing processes, in turn, cannot be thought of independently from the tools provided by a particular culture. Within psychoanalysis, this idea has been developed in narrative terms. For Spence (1982), the psychoanalytic process generates a narrative truth, which is different from historical truth. Thus, he distinguished two types of reality, one of which is narrative and produced by language. Spence developed aspects of interpretive work in psychoanalysis that had not been considered before because of the primacy of the representational model of language. Spence's approach sees the analyst as behaving more like a poet than an archaeologist, creating something rather than discovering it. The construction the analysts creates must fit the patient's life story, giving more consistency, compactness, and meaning to the patient's here and now and contributing a different truth to historical truth. Spence argued that what we struggle with in our consulting rooms is narrative truth.

Schafer (1983, 1992) claims that psychoanalytic theory is a set of codes and/or interpretive principles that generate psychoanalytic meanings—that is, just one specific type of meaning possible among others. The interpretation or clarification tries to make sense of the patient's experience, which seems confusing, inconsistent, or not very clear. Through interpretation, the patient's actions take on a different meaning as they are reformulated and included in an orderly scheme. This scheme is none other than the narrative structure that makes up every psychoanalytic theory.

In hermeneutic approaches, an interpretation is effective not because it corresponds to something external and independent—in this case, what is repressed in the patient's unconscious—but because it provides new meanings. Thus, when the patient tells the analyst something, this description is necessarily an interpretation because, from a hermeneutic perspective, there is no direct access to experience; experience is always mediated by narratives. When analysts interpret, they redescribe, reinterpret, recontextualize, and reduce what was said by the patient (Schafer 1983), following the narrative script provided by the analyst's particular theory—which can be done in terms of intrapsychic conflicts, for example, or developmental delays or preservation of the self. Whatever the case, the patient and the patient's history and symptoms are restated using the interpretive principles provided by different psychoanalytic theories.

The result is a new account of the patient's life, resulting in new meanings about the self and its actions. What is primarily redefined is the patient's approach to experience, which becomes active rather than passive. At first, it is the analyst who reformulates, but then the task becomes a joint one. When this happens, hermeneuticists understand that the patient has acquired new tools with which to signify his or her experience.

Constructivist approaches emphasize not so much theory and its role in shaping experience, but the place that the analyst occupies in the analytic experience. Constructivism holds that experience is partly indeterminate and is created through interaction (D. B. Stern 1997). The analyst as a blank screen, whose counterpart is the patient distorting reality (Hoffman 1983), is an impossible scheme; instead, countertransference is constant and analysts inevitably disclose aspects of their real selves (Aron 1991). Hence, it is impossible for the analyst to remain totally neutral. This fact forces a consideration of the various ways in which the person of the analyst contributes to the psychoanalytic process.

In an attempt to demonstrate the blank-screen fallacy, Hoffman (1983) notes the implications of the ambiguity of the analyst's conduct in the analytic situation and its contribution to transference. He also emphasizes what the analyst experiences in his or her relationship with the patient and how the relationship is perceived by the patient. Aron

(1991) complements Hoffman's work by including the impact of the analyst's subjectivity on the patient's analytic experience. Aron argues that patient and analyst influence each other, albeit asymmetrically; just as the baby needs to recognize the mother as a subject with her own inner world, the patient needs to experience the analyst's subjectivity. Thus, Aron includes the subject–subject relationship in the session. There is something in the here and now of the session and in the person of the analyst that affects the patient's transference and associations. In this constructivist perspective, this something cannot be eliminated or controlled.

DISCUSSION AND CONCLUSION

I have outlined four changes that together show how dialogical notions have come to be included in the psychoanalytic literature—specifically, among intersubjective and relational approaches. These changes reveal the presence of a dialogical conception of the self in contemporary psychoanalysis, its magnitude varying according to the clinical theory utilized.

Not all these changes have been consolidated to the same extent. For example, there has been much greater recognition of and attention to the in-between space than to the subject–subject mode of relating in intersubjectivist theories.

I have presented some of the authors and developments that show more clearly the shift to a dialogical conception of the self in psychoanalysis, although it may be possible to trace the same shift in other authors. More important, I have used certain concepts in a broad sense, such as when I differentiate between another person as another consciousness and as an object of consciousness, or when I establish a parallel between subject–object and subject–subject. Of course, these concepts are not totally comparable; nevertheless, I think I have managed to show in what ways the dialogical self is present in contemporary psychoanalysis.

The distinction between monological and dialogical could be a useful approach, a new way of giving order to the huge number of ideas that continue to flourish within our discipline. Admittedly, the shift from monological to dialogical has been uneven, and many of these ideas will

fall between these two positions. Nevertheless, the distinction between monological and dialogical could resolve, among other things, the endless debates about neutrality and countertransference. Neutrality, for example, is considered possible in approaches that start from monological conceptions of the self, but impossible for any theory that considers the self as dialogical.

I remember reading a book on Mikhail M. Bakhtin by Todorov (1984), in which the latter mentions, in passing, the presence of Bakhtin's ideas in contemporary psychoanalysis. When I read it, I recognized that this is true, but I could not specify much more, given the diversity of ideas that can be understood as dialogical. This paper is almost a reaction to the need to make sense of Todorov's statement.

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A TRICK IN A DREAM: ON THE DREAM WORK'S IMPRESSIVE CREATIVITY

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Keywords: Dreams, dream work, trickery, Freud, creativity, death, associations, oedipal issues, transference, regression, analytic process.

Over the years, I have written about unique features of the manifest content of certain dreams and what the function of such manifest inclusions might be (Mahon 2002a, 2002b, 2005, 2007, 2012). Some of the features within dreams that I have previously considered are: parapraxes, puns, the uncanny, and jokes, as well as dreams within dreams. In each of those instances, I showed that such flourishes in the manifest portion of a dream represent an extra effort, so to speak, on the dream work's behalf to keep the dreamer's and the awakener's focus on the manifest facade—the better to disguise latent dream thoughts that threaten to destroy the frame of the dream by erupting into consciousness, thereby upending one of the dream's primary functions of keeping the dreamer asleep. For instance, whereas Freud suggested that jokes in dreams are never actually funny, I brought attention to a joke in a dream that was well constructed and was a good example of successful joke construction in its own right (Mahon 2002b). I then suggested that the manifest joke was an attempt to keep the anything-but-funny latent content from being detected.

In this paper, I want to focus on a particular dream's elaborate trick that the dream work conceived and put on display in manifest content, the better to conceal the latent mischief from scrutiny altogether. Let me describe the dream.

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> The dreamer and his accomplice are staging a trick for a small audience. Three coins are hidden by the accomplice (whose role as accomplice is known only to the dreamer, not to the audience). The coins are made of gold, silver, and lead, which makes them immediately recognizable when discovered. The dreamer, who in fact does not know where the coins have been hidden, has no trouble pretending to find them since he has similar coins secreted in his pockets. When he "finds" the hidden coins, they are actually his own coins, retrieved slyly from his pockets, much to the amazement of his audience. Then the scene shifts to an outdoor location: the dreamer is now cleaning litter from his lawn, which is an elaborate piece of property beside the sea. There is a long, rectangular table on the lawn at which his 75-year-old friend and his daughter are seated. He plans to join them as soon as he has collected all the litter into his voluminous black garbage bag.

The analysis of this patient's dream over the next several analytic sessions was most productive. But some context is required to orient the reader to the spirit of the analysis that produced this dream.

Jason (let us call him) was a 50-year-old economist when the analysis began. His father had died suddenly at age fifty when Jason was fifteen, and consequently his current age was fraught with emotional significance for him. His motivation to seek analysis was a reflection of other factors, to be sure, but his concerns about his health, his constitutional endowment, how "the shadow" of his father's life and death (as he called it) had fallen across his own—all these needed to be assessed. He was an insightful man and was aware, or quickly became so in the investigative atmosphere of psychoanalysis, of how identified he was with both parents.

His mother's tendency to criticize her husband stemmed from an unanalyzed idolatry of her own father, in whose shadow all other men failed miserably by comparison. The transference could quickly assume an attitude of contempt toward or denigration of the analyst, mirroring his mother's attitude toward his father. On a deep, almost unspeakable level, Jason felt that his mistrust of his mother was at the root of another significant reason for his entering analysis: he had never married, de-

spite a great desire to do so. For Jason, relationships seemed to flourish at first, but then inevitably faltered and failed. Inevitably, he felt disappointed, and in a somewhat paranoid mood, he could feel "tricked," as if the fault were not a shared responsibility but a wound inflicted on him by the other.

"Look what you've done to me!" was Jason's initial attitude after a breakup, until he eventually became more self-reflective and could look at his own part in the failed relationship. He knew that his sensitivities were a problem that could make him feel wounded, avoidant, and self-protective, when in fact there was hurt on both sides that needed to be addressed more maturely. His identification with his father, whom he had loved deeply, could trigger masochistic, self-destructive tendencies, when survivor guilt demanded suffering and tortured enactments as opposed to cherished memories.

Teasing apart the adaptive aspects of these identifications from their pathological components was a major analytic consideration over the years.[1] These issues were often on the analysand's mind, especially when he had somatic concerns, and he had trouble sorting out hypochondria from appropriate alertness to essential somatic signals that needed medical attention.

At the time of the analysis of the dream in question, Jason was experiencing cardiac palpitations, which were being studied medically by his internist, who was also a cardiologist. His 75-year-old friend, mentioned in the dream, seemed to have no medical problems at all, nor did his analyst. This envy of the analyst's supposed perfect health was concealed until analysis of the transference exposed it. There was genuine affection for the analyst also, of course; in comparing our two professions, economy and psychoanalysis, he would sometimes slyly say, "We're both in risk management!" This was typical of his engaging sense of humor.

[1] This topic is vast and can only be briefly addressed here. To the extent that the analysis of unconscious components of identifications requires years of analytic labor, the surface of all the relevant issues can only be scratched *en passant*. I am suggesting a differentiation: that a maladaptive, self-destructive identification with mother or father may need to be vigorously addressed, whereas an identification with mother's or father's adaptive, more positive attributes—generosity of spirit, for instance—can be investigated less urgently, perhaps. In the final analysis, all aspects need deconstruction, of course.

With this brief clinical sketch as a guide, let us approach the dream again and consider how analysis eventually exposed the dream work's clever tricks and concealments.

The analysand was immediately struck by the elaborate nature of the trick in the dream. "My mother used to call my father 'trick-o'-the-loop' when she was angry at him," he recalled. He went on to explain that in his youth, his father had dabbled in amateur magical acts.

His mother, too, had been drawn to magic; she remembered the fairs of her childhood that would assemble annually in her town, where there were many performing acrobats and jugglers and a "trick-o'-the-loop" man. Jason explained this performer's trick as his mother had described it to him. After a fee was collected from each audience member—mitigated by the promise of a cash prize for anyone who could solve the visual riddle—a belt was wrapped around a snagging, pencil-like instrument. Eventually, the belt would be transformed into a figure-of-eight design and the trickster would invite his audience to identify the initial loop, the snagging instrument still in place as a marker. A discerning eye would be convinced that the primal loop around which all the subsequent loops encircled like ripples could be identified, and the prize could be claimed.

The trick, of course, was that the trickster could always unleash the belt from its many-looped shape in such a way that the original loop would never be snagged by the inserted instrument, and any "sucker" who had fallen for the trick would lose his money! So his mother calling his father a trick-o'-the-loop was not a term of endearment; indeed, when Jason remembered the parental altercations, it made him nervous, as if his own self-assertive nature was still compromised by these conflicted, ambivalent identifications.

That was the analysand's first association. More associations followed in rapid succession. His envy of the 75-year-old friend's good health led to questions about why he had introduced the friend's daughter into the dream. This made him think about the daughter's obvious oedipal attachment to her robust father. By comparison, Jason himself felt diminished, as if his concerns about his heart reflected neurotic anxiety rather than reasonable concern about his somatic health. In that context, he thought of *The Merchant of Venice* (Shakespeare 1600a) and the posses-

sive father who arranged the three-casket "trick" as a way of never having to surrender his Portia to a husband, given that he could count on the narcissism of men to always choose the gold or silver casket as emblems of their own worthiness, rather than the lowly lead one that they would automatically feel was beneath them. In fact, Jason wondered if he himself was not a male version of Portia—"tricked" by his identifications with his parents into an inhibition of his own marital ambitions. His vision of object relations as inherently treacherous was a pathological conviction of which he was trying to disabuse himself in the psychoanalytic process.

Jason had never married, although he had come close a number of times—but, as mentioned earlier, he always found a neurotic way out of the commitment. It was when friends pointed out this neurotic pattern to him that he sought analysis. He was developing a most promising relationship with a colleague at the time of reporting the dream, and he wondered what connection there might be between the two phenomena.

Further associations confirmed the assumption that relationships "never work." "Why am I not at the table with my friend and his daughter in the dream?" he wondered. He sensed that there was some hostility, some social rudeness, in his not joining them, and also some concealed hostility in the enormous black garbage bag that he was stuffing with litter. A body bag came to mind. He thought of dead soldiers returning home in body bags. Did he want to kill his friend and run off with his daughter? Was the daughter an obvious disguise for his friend's wife?

Recently, Jason had noticed a woman waiting outside the analyst's office and had imagined that she was the analyst's wife. He had quickly averted his eyes as they glanced at each other. "She's too young for him," he mused, as he imagined the analyst's age and that of the considerably younger woman outside my office. "She's more my age," he dared to consider, and then abandoned that line of thinking since it made him so anxious.

That led to a consideration of the accomplice in the dream: did this presence represent an unconscious relationship with his mother as accomplice in the trick that was being played on his father? Secretly, he was married to his mother, an unholy dyadic alliance that had dispatched the weak father. Such associations led to tears and a sense of guilt that represented itself more as somatic pain than as felt affect.

Thinking of the body bag led to a movie that Jason had seen part of in which a prisoner escaped incarceration by taking the place of his dead friend in a body bag and was then thrown into the sea, eventually attaining freedom when he escaped from the bag. This led to ideas about his identification with his father not only in life, but also in death. He wondered if all his previously failed relationships with women were a reflection of anxiety and guilt, as if he had actually given his father the heart attack that killed him. Was there a perverse loyalty to a dead man at the root of his inertia with women? Many of these themes had been the subject of analysis in the months before the dream was reported, but now the associations led to their being visited anew and more viscerally.

While the family had been worrying about the father's health and eventual death, the garden in front of the family home often went untended and became littered with papers. Such litter was associated with mourning in Jason's mind; in the dream, litter and body bag, refuse and death, seemed to share an eerie association. "Am I mourning all over again in this dream?" he asked. The answer seemed to be "yes" in the sense that Jason, by regressing to this anal preoccupation with litter and body bags, was absenting himself from the table of his own robust life. "The trick's on me," he observed with the sardonic humor that was characteristic of him, "unless I stop crawling back into the body bag after I escape."

Some of his associations were less negative. The three coins in the dream brought to mind the movie *Three Coins in a Fountain* (1954), in which three American women visit Rome and dream of finding romance there. Two of them throw coins into the Fountain of Trevi, the tradition being that this will magically lead to their eventual return to Rome.

A few weeks later, Jason had another dream, which he introduced by saying it had "more trickery in it":

> I am seated at a table with an old friend, George, a trusted colleague of mine in the world of economics. To my left is a business associate—also a colleague but not as intimate. He is asking incredulously why I am consorting with my old friend, given that he is such a persona non grata in academic circles. I am troubled by this disclosure and move away from the table to find another place to sit, but not without some guilt that I am not sticking

> up for my friend. At the new table, some colleagues say: "You should go on YouTube and get a subrimeter." In the dream, the word seemed to mean something functional.

Upon awakening, Jason was struck by the strange word *subrimeter*, which he called "real word trickery"; he was totally baffled by its meaning. In free associating to the dream content, he cited an immediate days' residue, as follows: his close colleague and friend George had sent him a critique of Jason's recent book on economics, of which Jason had read the first paragraph and then quickly put the review aside because he thought it too tentative in its praise. When he read the whole review the next day, however, he was genuinely surprised by how positive it was and not a little ashamed of his initial paranoid reaction.

"But the paranoia invaded the dream," he admitted as he worked on the various images in the dream's manifest content. He was ashamed of his disloyalty to his friend—a quality he had "inherited" from his mother, an identification he was trying to rework and revise in the analytic process. His association to YouTube was fascinating and creative: "YouTube" sounded to him like "et tu, Brute" modernized as "You tooB(rutus)." "I feel like Brutus when I identify with my mother's fickle nature," he commented.

But what Jason called *word trickery* got even more puzzling when he turned his free-associative attention to the word *subrimeter*. He had just looked up the meaning of *tromometer*, whose function is to measure seismic rumblings underground. Could a subrimeter be a gadget for measuring subconscious rumblings—the depth psychology beneath the brim of the mind? Or maybe a gadget for detecting the subprime mortgage fiasco before it happened? Of the latter, Jason quipped, "I could've used such a gadget and saved the world a disaster!"

His mind went back to the trick-o'-the-loop in the earlier dream. "The whole subprime mortgage scandal was a real trick-o'-the-loop piece of irresponsible fiscal trickery, a bubble waiting to burst and bring down the whole financial world with it," he said. (Jason had actually been one of the courageous few who cautioned management about reckless risk-taking that went beyond the usual bounds of safety and due diligence.) "But I guess it's *mental* economy we're studying," he added as he turned his attention back to the analysis.

The deepest insight he extracted from the dream work's trickery was the idea that his wish for a gadget—a subrimeter with which to plumb the depths of the unconscious—would make the analyst unnecessary. "I wouldn't need you," he said.

"Et tu, Brute?" the analyst replied in the role of the stricken Caesar. Jason, struck by the analyst's quick and comfortable assumption of the role he had been so disguisedly assigned, agreed sincerely, and his aggression, flushed out into the open by his insightful analytic probing, seemed safer than ever. His mind went back to the Fountain of Trevi and his new promising relationship that was beginning to develop staying power—even as he also joked that the three coins in the fountain were a safer financial bet than recent market gambles!

Analytic process would indeed eventually strengthen Jason's newfound ability to work in a relationship and make it last. He overcame his phobia of commitment and married the woman he loved. He learned to decipher dream trickery as a convoluted, distorted, fearful kind of communication that nevertheless had useful information embedded in it, if you put in the hours of analytic work necessary to decode it. Subrimeters could help you go down deep if you saw through their unconscious trickery.

DISCUSSION

What can be added to Jason's insightful analysis of these issues? A developmental and genetic point of view can augment these insights, I believe. To the extent that every child's exclusive love of the mother in the early dyadic climate of the first one or two years of life suffers a rude awakening when triadic conflict and the Oedipus complex assume prominence at age three to five, approximately, every child must feel as if a nasty trick has been played on him. It must feel as if the idealized mother suddenly declared the primacy of her relationship with her husband, much to the horror of her jilted lover. The child then tries to maintain a dyadic relationship with each parent, to the exclusion of the rivalrous other, in positive and negative oedipal variations on this tormented theme.

Having to negotiate the Oedipus complex must feel like a trick being played on the child, a trick that can never lead to a satisfactory

conclusion. The only solution is compromise: the child eventually (usually at around six years of age) represses his love and hatred toward his treacherous parents, identifies with their authority, and waits to find his own exclusive mate many years later. But the sense that nature has built a trick into its developmental design leaves a bitter taste forever.

The three coins in Jason's dream brought *The Merchant of Venice* to his mind—the gold, silver, and lead coins bearing a relationship to the gold, silver, and lead caskets in the celebrated play. In his paper "The Theme of the Three Caskets" (1913), Freud argued that the three caskets are a disguised representation of the "three sisters"—"the Fates, the Moerae, the Parcae or the Norns, the third of whom is called Atropos, the inexorable" (p. 296). He compared them also to King Lear's three daughters (Shakespeare 1603), whom Freud believed were a disguised representation of death. The rift that would eventually doom the Freud–Jung relationship was widening irrevocably at this point in time. Further exploration of the undoubtedly overdetermined origins of Freud's creativity would take us too far afield from the discussion at hand; suffice it to say that death wishes were on Freud's mind as he put pen to paper to compose this work, just as they seem to have been on Jason's mind also as the dream work set about concocting its disguises.[2]

In the manifest content of the dream, the dreamer triumphs since he has rigged the trick in his favor. Nature, by designing the inevitable triangle at the core of procreation, seems to trick human beings with a confounding Oedipus complex, a riddle that can never be solved. In mythology, Oedipus himself defeated the Sphinx by cracking the code of a most oedipal riddle: one that depicts the rise of man from all fours as an infant to an upright, two-footed toddler and subsequent manhood status—only to be demeaned in later life as a three-legged man who must support his two shaky legs with a third (the walking stick or cane). Indeed, the word *imbecile*, before it took on its 19th-century meaning of "feeble-minded," at first meant "feeble-bodied" or "weak-limbed"—

[2] Earlier (Mahon 1989), I argued that Freud's ambivalent death wishes toward Jung were the unconscious or preconscious triggers of "The Theme of the Three Caskets" (Freud 1913). I cited evidence from Schur's (1972) biography of Freud that suggested the paper was written just after Freud had visited an ailing Binswanger in Kreuzlingen, but had not visited the nearby Jung at the same time, which Jung took as a slur against him, later referring to the episode as the *Kreuzlingen incident*.

literally, as frail as an old man without a staff (from Latin *in-baculus,* meaning *without a staff*).

By rigging the trick in his favor, the dreamer, at least in his manifest triumph, succeeds in beating Mother Nature at her own game. Freud's favorite misquotation was Falstaff's "Thou owest God a debt," which Freud quoted as "Thou owest Nature a debt"—on a few occasions, Freud's atheism dictating the terms of the parapraxis, no doubt.[3]

In Jason's latent content, the dream thoughts may well have been:

> I know I must, out of loyalty to the father whom I unconsciously killed, identify with his suffering and death, thereby becoming the gull of my own neurotic trick. Even if I seem to have the terms of the trick figured out in my favor, in the manifest content, I will also include a scene in which I am a regressed, anal litter gatherer, while the oedipal man and woman dine at the table without me. Even if I let myself triumph over fools with the cleverness of my trick, the coins I magically produce will also represent the death I carry around with me, concealed in my pockets like three fatal caskets.

From a genetic point of view, Jason's regression to litter gatherer in the dream echoes the original childhood solution to the Oedipus complex as Freud imagined it. Not only does resolution of the oedipal dilemma call for repression, infantile amnesia, and identification, but also regression is necessary; the oedipal configuration regresses to an anal retreat, an infantile messiness, that the ego then transforms into obsessional defense mechanisms, thereby explaining the rather rigid defensive structure of latency. In child analysis, one can see this remarkable transformation *in statu nascendi:* a playful, fantasy-ridden oedipal child becomes a more rigid, industrious, intellect-driven, and cognitively advanced latency child—not overnight, of course, but quite dramatically nonetheless, as the child grows from a five-year-old into a six- or seven-year-old.

Of course, the transference and its interpretation are other features of analytic process that lend themselves to being misconstrued as

[3] Freud first made this slip in a letter to Fliess dated February 6, 1899 (Masson 1985, pp. 343, 344n).

"tricks." What analysand does not feel tricked on some level when s/he imagines that the analyst is saying that the love or hate engendered in the analytic process is not "real," since it is a transformation in the form of transference from a more primal, genetic source?

Perhaps the greatest "trick" of all is the dream work's sorcery; through the ministry of primary processes, it transforms latent dream thoughts into a disguised, fantastic version of themselves, a metamorphosis that Bottom in *A Midsummer Night's Dream* captures well when he says: "I have had a dream, past the wit of man to say what dream it was" (Shakespeare 1600b, 4.1.205-206). It is hard not to feel tricked when one awakens from a dream that has been constructed cunningly and deceptively out of primary processes that the awakener has no access to, unless he subjects the dream to a psychoanalytic method that tries to follow a myriad of free-associative clues back to the blueprints of a crafty architect (the dream work), who covers his tracks so cleverly and confoundingly. It is hard to get to the bottom of a dream that Bottom says "hath no bottom" (4.1.214).

It is only when we realize that Jason's trick in the manifest content of his dream is already a clever transformation, orchestrated by primary processes—which I am referring to as the dream work's trick—that we can approach the bottomless meanings at all. The manifest trick must lead the awakened dreamer to the original dream work trick using the psychoanalytic method as guide. Apropos the bottom of a dream, Freud's (1900) comment seems germane:

> At bottom, dreams are nothing other than a particular *form* of thinking, made possible by the conditions of the state of sleep. It is the *dream-work* which creates that form, and it alone is the essence of dreaming—the explanation of its peculiar nature. [pp. 506-507, italics in original]

Without a knowledge of the dream work's incredible inventiveness—or aesthetic trickery—dreams *do* seem bottomless and unfathomable.

If we assume that the original dream thoughts were incestuous or murderous and were leading to nightmarish fears of abandonment, loss of love, castration—the hierarchy of calamities outlined by Freud, in other words—then their transformation into a clever, if psychopatholog-

ical, trick seems to have the function of assuring the dreamer that there need never be a fear of loss as a consequence of the possessive sexual conquest of (or the murderous assault on) a parent. The trick assures the trickster that he will never be at a loss. The dream work's direction and production of the manifest movie montage is so impressive that the dreamer and even the awakener might never think of digging deeper for the dream thoughts that have been so utterly changed into such arresting images.

The dream work's trickery in Jason's subrimeter dream would seem to be of a different order entirely. The awakener is bound to have his curiosity whetted by his bewilderment at the neologism. But his curiosity will be unrewarded unless he applies the psychoanalytic method with great intensity and perseverance. Jason was a most insightful analysand, and even took YouTube as analytic fair game for a clever dissection that exposed the murderous wish in its disguise of "et tu, Brute." Similarly, it was damnably clever of Jason to dig the subprime mortgage crisis out of the word *subrimeter*—not to mention its identity as a gadget for exploring depth psychology that would make the presence of the analyst unnecessary.

Again, the death wish toward the analyst was masterfully disguised. Intense condensation would seem to be the dream work's main ally in the construction of the neologism. Displacement and representation of unconscious dream thoughts, pictorially and dramatically, seem to be the chief architects of the "three-coin trick" dream, however.

It is interesting to think of the dream work as a master tactician, a most sophisticated trickster who has turned deception into a fine art. It is impossible not to think of it as other than a most advanced ego function that the sleeping brain retains in a state of acute alertness, despite its unconscious form. It is akin to creativity itself, for the access to preconscious states is what makes a work of art so uncannily relevant and beautiful despite the baffling indirectness of its communication. The way in which dream work transforms a latent dream thought into such disguised distortions that recognition becomes impossible can be compared, perhaps, to the mastery of a jazz musician, who can take a simple, well-known melody and produce such improvised metamorphoses of it that the mind has trouble retaining the original as the variations riff on

and on so dazzlingly and dizzyingly. The melody is changed utterly as improvisation struts its stuff and beauty is born on the spot, just as in a dream.

In terms of Jason's problems with commitment to human relationships that cannot be controlled with trickery but must be entered into wholeheartedly, the seduction of the trick represented the appeal of regressive magic when reality seemed a game that was too hard to enter into without keeping a few tricks up one's sleeve. He was working hard in his analysis to fight against these regressive tendencies, and the dream depicted his conflicts very dramatically. His remembering the dreams and working on them with his considerable intelligence represented the triumph of insight over the seductions of trickery. He was choosing what Freud called the *slow magic* (Whitebook 2002) of psychoanalytic process over the processes of the seemingly fast-acting magic trickery of self-deception.

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BOOK REVIEWS

FREUD AND THE SPOKEN WORD: SPEECH AS A KEY TO THE UNCONSCIOUS. By Ana-María Rizzuto. London/New York: Routledge, 2015. 196 pp.

This book is first and predominantly a report on its author, Ana-María Rizzuto, in her ongoing dialogue with Freud. That it is a dialogue of this kind is her own description, and this has been the case in a number of her previous works, which span several decades.[1] *Freud and the Spoken Word* and this continuing dialogue are in the tradition of hermeneutics. I mean this not primarily in the modern philosophical sense in relation to a theory of textual and other forms of interpretation, but in its original sense—pertaining to the tradition dating back many centuries of commentaries and dialogical engagements by authors with important texts of their predecessors, whether sacred, philosophical, scientific, or otherwise.

While this tendency in psychoanalytic literature in relation to the works of Freud has often been the target of criticism, I think the present work offers an effective challenge to such generic doubts in that it contains a vivid, engaging, contemporary dialogue. I should add that the author's approach is one with which I have direct familiarity, having participated as a student in courses and extracurricular discussions with Rizzuto that led to a coauthored paper recounting an early part of her dialogue with Freud, on that occasion involving Freud's lifelong pursuit of the secrets of nature.[2]

[1] See, for example, the following: (1) Rizzuto, A.-M. (1989). A hypothesis about Freud's motive for writing the monograph *On Aphasia. Int. Rev. Psychoanal.,* 16:11-17; (2) Rizzuto, A.-M. (1998). *Why Did Freud Reject God? A Psychoanalytic Interpretation.* New Haven, CT/London: Yale Univ. Press; and (3) Rizzuto, A.-M. (2003). Psychoanalysis: the transformation of the subject by the spoken word. *Psychoanal. Q.,* 72:287-323.

[2] Barron, J. W., Beaumont, R., Goldsmith, G. N., Good, M. L., Pyles, R. L., Rizzuto, A.-M. & Smith, H. F. (1991). Sigmund Freud: the secrets of nature and the nature of secrets. *Int. Rev. Psychoanal.,* 18:143-163.

In the present book, the dialogue revolves specifically around Freud's pursuit of an understanding of the spoken word and how this intertwined with the development of his psychoanalytic theory and method. In a certain sense, Freud's interest in the spoken word is self-evident to any practicing analyst; immersion in the spoken associations of analysands as a primary source of data is a familiar and intrinsic element of our method. Rizzuto's exploration includes a careful consideration of this central feature of psychoanalysis, but it does not stop there. She reaches beyond the methodological centrality of free association and places at the center of her inquiry an early work by Freud, which he expressly excluded from the *Standard Edition.* This was his monograph *On Aphasia,* published in German in 1891 but fully translated and published in English only in 1953,[3] except for an excerpt included by Strachey in the *Standard Edition* as an appendix to another work.[4]

The full English translation of *On Aphasia* has been found by many, including Rizzuto, to be confusing and inadequate. No up-to-date scholarly version of the monograph yet exists in English, notwithstanding the fact that a number of commentators have considered it of central importance to an understanding of the construction of Freud's psychoanalytic theory.

Following her own careful reading of *On Aphasia,* Rizzuto assembled a number of observations that together situate the monograph as the point of departure in her dialogue with Freud about the spoken word. She found that while the monograph was written well before Freud's first psychoanalytic publications—at a time when he described his professional practice in neurological terms—it was composed after his time in Paris with Charcot, after he had learned about Breuer's treatment of Anna O (Bertha Pappenheim), and after he had begun some of his own psychotherapeutic work with "the ladies," to use Rizzuto's term, that he published subsequently.[5]

The monograph, ostensibly neurological in content and focused on a novel synthesis of the rapidly accumulating information about aphasia

[3] Freud, S. (1891). *On Aphasia,* trans. E. Stengel. New York: Int. Univ. Press, 1953.

[4] Freud, S. (1915). The unconscious. *S. E.,* 14. See Appendix C, pp. 209-215.

[5] Freud, S. & Breuer, J. (1895). *Studies on Hysteria. S. E.,* 2.

of the time, extends beyond Freud's argument for a nonlocalization hypothesis of aphasia; in fact, it offers a psychological as well as a neurological account of what he calls the *speech apparatus*. Many of the theoretical proposals offered about the speech apparatus closely resemble concepts that figure centrally in Freud's later elaboration of the *mental apparatus* and of his method centered around the spoken word.

Having considered these aspects of the aphasia monograph, Rizzuto organizes her dialogue with Freud around several questions, among them: In what ways did Freud's early and developing interest in the psychopathology and psychotherapy of hysteria influence his neurological monograph? To what extent and in what ways did his ideas about the speech apparatus in *On Aphasia* play a part in the development of his psychoanalytic theories and methods? In particular, how did Freud theorize the spoken word in the monograph, and what relevance did this have for his psychoanalytic theory of mental representation (usually, but not always, *Vorstellung*) and for his psychoanalytic method of free association?

A few more details about *On Aphasia* must be mentioned before I go on to consider how Rizzuto addresses these questions in *Freud and the Spoken Word*. As she points out, within the monograph one can find, with the help of hindsight, a protodictionary of metapsychology, including the concepts of "association, divided attention, cathexis, complex, connection, physiological correlation, impulse to speak, memory-image, primary, representation, self-observation, spontaneous speech, and transference" (p. 25). Freud describes a speech apparatus organized around auditory word presentations and object presentations (later, *thing presentations*) derived from multisensory perceptual experience. He proposes that perceptual experience is intrinsically associative, both neurologically and psychologically. Meaning—and, in Rizzuto's phrase, "the psychically meaningful word" (p. 173)—derives from a conjunction between an auditory word presentation and an object presentation. Freud posits that spontaneous speech is always stimulated by object presentations, especially visual ones.

Rizzuto pursues the questions I have listed and others according to a particular hermeneutic procedure, as mentioned earlier. This method involves a very careful consideration of Freud's written words, as well as

other contextually relevant historical source material. Links between his wording in *On Aphasia*, whether articulated and overtly claimed by him or not, are carefully weighed in Rizzuto's exegetical dialogue. Using this approach, she traverses all aspects of Freud's known work that seem to her directly relevant to the questions at hand.

What Rizzuto's method specifically eschews is a consideration of other contemporaneous sources bearing on an understanding of the spoken word, including those that may have been known to and/or influential for Freud. She also excludes the use of later contributions in this area that were not available at the time but that could conceivably provide useful conceptual tools today for the parsing and clarification of Freud's work in this area. She offers an apology for these omissions but is not deterred from her searching examination of the questions mentioned above in her dialogue with "Freud and Freud alone" (p. 8). In this way, the arguments she offers are quite different from many others in which Freud's contributions are situated in an intellectual historical context,[6] and much more in the way of contemporary influences and cross-currents is considered.

Rizzuto's approach is also distinct from that of some others who have written specifically about *On Aphasia*, in which the ideas of many contemporary contributors on aphasic phenomena are explored for their possible relevance to Freud's formulations.[7] The current work is a record of Rizzuto's engagement with the trajectory of Freud's thinking on the spoken word, and in the sense that it is a dialogue, it is a record of her dialogue alone. This aspect of its method obviously limits the scope of the inquiry in certain ways. One will not find here, as she notes, any engagement with de Saussure or Lacan—or, for that matter, with any of the many relevant strands of intellectual history and associated lines of critical thinking of the last 125 years that relate to language, speech, mental representation, or theories of perception that could be linked to the topic under consideration. For example, there is no reference to Frege, Russell, Moore, Wittgenstein, or Austin, or to Jakobson, Chomsky,

[6] See, for example: Makari, G. (2008). *Revolution in Mind: The Creation of Psychoanalysis*. New York: Harper.

[7] See, for example: Greenberg, V. D. (1997). *Freud and His Aphasia Book: Language and the Sources of Psychoanalysis*. Ithaca, NY/London: Cornell Univ. Press.

or Pinker. However, I myself would find it necessary to consider Frege's distinction between sense and reference[8] and its later ramifications in the work of a number of writers,[9] as well as the critique of private language concepts by Frege's student, Wittgenstein,[10] in exploring these questions.

What one *will* find in *Freud and the Spoken Word* is a very rich dialogue and journey in quite different ways. To those already familiar with Rizzuto's written work and her many public presentations, I suspect that the thoughtful and searching psychoanalytic intellect and imagination she brings to bear will be familiar and enthusiastically welcomed. For others, the text may offer some surprises in its density of argument and its comprehensive exploratory reach.

Rizzuto answers in the affirmative the question about the possibility of the influence of Freud's early interest in and work on hysteria on his thinking in the aphasia book. She bases this response on Freud's activities at the time of the composition of the monograph and on inferred conceptual links between his understanding of his "lady" patients' spoken words and the speech apparatus theory. Her argument is powerful and imaginative, and is an interesting one in terms of the bridges it hypothesizes. (It remains a hypothesis since, in her dialogue, we have only imaginary contributions from her interlocutor.)

One concept in the aphasia monograph that receives particularly rich and imaginative treatment by Rizzuto is that of *asymbolic aphasia*. In the monograph, Freud distinguishes two forms of aphasia:

> Number one, a first-order aphasia, verbal aphasia, in which only the associations between the separate elements of the word-presentation are disturbed; and number two, a second-order aphasia, asymbolic aphasia, in which the association between the word presentation and the object presentation is disturbed.[11]

[8] Frege, G. (1892). On sense and reference. In *Translations from the Philosophical Writings of Gottlob Frege,* ed. & trans. P. Geach & M. Black. Oxford, UK: Blackwell, 1980.

[9] For an articulation of these ramifications, see: McGinn, C. (2015). *Philosophy of Language, the Classics Explained.* Cambridge, MA: MIT Press.

[10] Wittgenstein, L. (1953). *Philosophical Investigations,* trans. G. E. M. Anscombe. Oxford, UK: Blackwell.

[11] Freud, S. (1915). The unconscious, Appendix C. *S. E.,* 14, p. 214.

The latter may be functional rather than anatomical. Rizzuto artfully extrapolates from this functional form of aphasia to Freud's later theorizing about repressive processes that underlie hysterical and other symptoms, dreams, parapraxes, jokes, and so on. Arguments along these lines are woven throughout many of the chapters of this book. We find, again, a fascinating hypothesis, and one can readily imagine the force of Rizzuto's postulations persuading an imaginary Freud, despite his exclusion of the monograph from the *Standard Edition*.

Following in Rizzuto's footsteps with respect to her tracings of Freud's developing ideas, I discern here a continuity in her work. In an early book, she wrote about mental representation in Freud's theories.[12] Thinking about mental representation is also prominent in the current work in the emphasis on word and object presentations, and on interrupted symbolic representations in asymbolic aphasia. In the earlier work, she wrote: "Psychoanalysis needs a general theory of a subject capable of representing and utilizing representations, and capable also of being pathologically entangled with some of them" (p. 64 of the source in footnote 11). Further on, she added: "Psychoanalysis has not yet produced a comprehensive theoretical formulation of either the general process of representing or the particular case of representing other people" (p. 65). It seems to me that in *Freud and the Spoken Word*, with her imaginative use of Freud's concepts about word and object representation and spoken words as they relate to asymbolic aphasia, she may have discovered a "general theory" akin to what she found missing in her earlier book.

One might nonetheless wonder, it seems to me, whether such concern with a general theory about representations was as much in the forefront for Freud as it has been for Rizzuto in the course of her work. One could argue that Freud's concern tended to be much more with the role of particular symbolic representations in the functioning of the psychical apparatus (such as that of drive derivatives) than with general considerations about representation.

Rizzuto makes strong arguments for theoretical continuities between Freud's speech apparatus as described in *On Aphasia* and the mental ap-

[12] Rizzuto, A.-M. (1979). *The Birth of the Living God: A Psychoanalytic Study*. Chicago, IL: Univ. of Chicago Press.

paratus he elaborates in chapter 7 of *The Interpretation of Dreams* (1900). In her exploration of the greatly expanded apparatus of the dream book, she finds that the linguistic representational concepts of the monograph have been "replaced by thoughts and scenes in Freud's theorizing" (p. 53). Nonetheless, she finds the concept of asymbolic aphasia important to her dialogue with Freud about the growing complexities of his theory at that point. We begin to hear a new element from her side of the dialogue as she contests not only aspects of Freud's theory that bear on the spoken word, but also aspects that extend beyond that particular issue. She questions whether the regressive visual imagery of dream formation could be plausibly considered as the discrete object presentations of *On Aphasia*, and instead argues for the importance of the more global notion of *scene*. This term is elaborated in a variety of contexts throughout the book as her voice enters the dialogue in a more independently theorizing mode.

The same is the case with respect to Rizzuto's argument against formulations by Freud about what appear to her to be an overly mechanical, discharge-oriented, self-sufficient apparatus, and in favor of the necessary presence of a "self-as-agent" (p. 60). Those familiar with the widespread questioning of Freudian metapsychology, dating from the 1960s onward, may recognize this qualm.[13] She revisits this argument on a number of occasions, and I am reminded here of her earlier lamentation about the theoretical absence of a subject capable of representing. Her dialogue in the current work, it seems to me, seeks at least in part to fill that void.

Many aspects of Freud's opus are engaged in the rest of the volume—from formulations about technique in relation to the essential place of the spoken word, to fascinating accounts of Freud's own spoken words in his clinical work, according to his reports and those of others. In many of these segments, we find Rizzuto's voice entering the dialogue with observations and responses, and this articulation of herself as an agent

[13] See, for example, the following works: (1) Klein, G. S. (1975). *Psychoanalytic Theory: An Exploration of Essentials*. New York: Int. Univ. Press; (2) Schafer, R. (1976). *A New Language for Psychoanalysis*. New York/London: Yale Univ. Press; and (3) Gill, M. M. (1976). Metapsychology is not psychology. In *Psychology versus Metapsychology: Psychoanalytic Essays in Memory of George S. Klein*, ed. M. M. Gill & P. S. Holzman. New York: Int. Univ. Press.

in the exchange of words makes for a wonderfully rich and personally nuanced texture in the proceedings.

The only place where Freud explicitly returns to matters of words and mental representation occurs in his 1915 paper "The Unconscious" (see footnote 4). There, as Strachey observes, he appears to elaborate the theory of *On Aphasia* in an effort to clarify the theory of repression. Freud proposes that conscious awareness requires the presence of both thing presentations (object presentations in the monograph) and word presentations, while in the unconscious, one finds only thing presentations. Here Freud unambiguously returns to the matter of word presentations. His theory that the unconscious—"the true psychical reality" of *The Interpretation of Dreams* (1900, p. 613)—is filled with other sorts of representations might suggest (as Rizzuto did in her comments on chapter 7 of the dream book) that Freud's interest had remained predominantly focused on types of representations other than those in words.

Reflecting on this final statement on his theory about the intrapsychic function of words, Rizzuto notes that Freud left unattended their communicative significance and "the obvious fact that we use words to engage in practical and emotional interactions both with others and ourselves" (p. 130). She alludes to, but does not expand on, the fact that this issue has been pursued by others. While such explorations may be understandably beyond the scope of the current work, one's appetite is whetted for further conceptual elaboration of these matters.

In some of the later chapters of *Freud and the Spoken Word,* Rizzuto intriguingly takes up the topic of the analyst's words—not only in Freud's clinical work, but also and in particular in his theorizing about the role of words in the process of construction and reconstruction in analysis. After carefully examining the clinical context of Freud's reconstruction of the Wolf Man's primal scene, she offers some interesting conclusions.[14] The "primal scene did not come from the patient" but from Freud, who, "in his visualizing efforts," entered into—as the Wolf Man had—"a particular frame of mind, a quasi-hypnotic state of free-floating attention and *mi-*

[14] Freud, S. (1918). From the history of an infantile neurosis (the "Wolf-Man"). *S. E.,* 17.

metic ideational experience" (p. 168, italics in original). She suggests that this led Freud "to construct in his mind in a *visually hallucinatory manner* the internal representation the child *could have formed"* (p. 168, italics in original). Here we find Rizzuto using ideas from *On Aphasia* and from Freud's technical writings in conjunction with her rich clinical imagination to reconstruct Freud's way of working with the Wolf Man.

She later extrapolates from these conjectures to a more general discussion of the analytic process and of the methodological element of free-floating attention in the reconstructive process. She suggests that Freud's "technique of free-floating attention creates the conditions under which unconscious processes in the analyst's mind can be activated in response to the patient's words" (p. 178). In contrast to the position of the listener under ordinary circumstances, the "analyst's attempt to suspend such a direct function facilitates the emergence in the mind of unconscious processes which can offer some hints about what the patient is trying to suppress" (p. 178). Here, in the spirit of hermeneutic commentary, Rizzuto is articulating—and thereby extending our theoretical understanding of—Freud's clinical theory, adding provocative suggestions that creatively apply concepts of word presentations, visual and other sensory presentations, and their place in the conscious and unconscious minds of both participants in the analytic process.

Intertwined with Rizzuto's commentary on the Wolf Man is a related discussion of Freud's final paper.[15] She points out that after his career-long focus on the intrapsychic processes of the analysand, Freud here attempts to articulate the distinct roles of analyst and analysand in a new way. Expanding on the example of a model construction that Freud offers in this paper, Rizzuto emphasizes the interlocking parts played in the analyst's constructions by the subjective and the objective, by the intrapsychic and the historical, and by the subjective ego and the relational context, in order to form a "therapeutically effective 'conviction of the truth of the construction'" (p. 140). This sense of conviction depends on a connection with "this past *psychical reality*, a reality that strikes the patient as believable even if it may have left behind no apparent memories" (p. 140, italics in original).

[15] Freud, S. (1937). Constructions in analysis. *S. E.,* 23.

Later, in her concluding chapter, Rizzuto elaborates further: "The construction does not offer representations but describes the psychical and *experiential scenes,* the impact of which has affected the patient throughout life" (p. 174, italics in original). Again in the tradition of hermeneutic commentary, Rizzuto's treatment of these interconnected Freudian theoretical themes is dialectical rather than linear. In her text, many issues are taken up in multiple places, in different contexts, and in varying and even apparently self-negating versions.

Rizzuto addresses "the many functions of words" (p. 180) in her concluding chapter. She writes that "one of *Freud's core contributions*" is that:

> We can be sure of what a word means to us only when we have managed to link it to the internal representation the speaker has used to form it. Otherwise, the word may keep its *linguistic referential meaning* without revealing the true conscious and unconscious intention of the one who said it. [p. 181, italics in original]

These sentences summarize Rizzuto's conclusions about the "intrapsychic function of words in connecting segregated representations" (p. 181). The many functions of words include their roles in parapraxes, jokes, dreams, and clinical contexts associated with phenomena such as symptoms, memories, and transference. She starts with what enables us to know what a word means to us. This "us" seems to refer to analysts as listeners seeking comprehension in terms of both the conscious and the unconscious meanings of our patients' words. This is said to be enabled by linking the word to "the internal mental representation the speaker has used to form it" (p. 181). This appears to involve a private and possibly idiosyncratic intrapsychic word linkage occurring in the mind of the analysand.

Some obscurity occurs here, it seems to me, in relation to how the meaning for the listening analyst links to the private, possibly idiosyncratic meaning in the mind of the patient who is speaking. Rizzuto's statement does not seem to apply solely to latent content in the mind of the analysand, which, once consciously articulated, would include words conveying meanings common to analyst and analysand. Her statement seems rather to concern private mental representations that the speaker

uses to form words. But it seems to me that the meaning of the speaker's words becomes problematic to "us" when, as in a verbal parapraxis, that meaning in context is opaque to us. The words again become meaningful to us once we learn of unconscious meanings in the mind of the speaker to which they were associatively linked.

All this is made possible because the speaker shares with us an initial incomprehension of the words spoken in the parapraxis. The parapraxis is not an expression of a private word meaning based on private intrapsychic representations, but a breakthrough into conscious awareness of unconscious meanings associatively linked with words—all of which typically already have shared meanings with "us," however obscure they may be in the context of the unanalyzed slip. What we learn about in analyzing a slip of the tongue are unconscious wishes and fears and the like, expressed in words that we share an understanding of with the patient; this does not seem to be a matter of words that have different meanings for the analysand than they do for the analyst. These considerations appear to raise questions about Rizzuto's distinction between the *linguistic referential meaning* and *true conscious and unconscious intentions.*

Does her reading of asymbolic aphasia as described in *On Aphasia,* along with her concept of *segregated representations,* require a change in our understanding of linguistic reference? When mental content is in a dynamically unconscious state, unconnected to "word presentations," as Freud proposes in "The Unconscious" (1915), does an understanding of the analysand's intentions require a distinct and private notion of linguistic reference? Once made conscious and articulated in words, the analysand's intentions would not seem to problematize the words used by "us" in relation to linguistic referential meaning. I am left to wonder whether Rizzuto's summary statement may extend to issues about linguistic reference beyond those explicitly engaged by Freud.

If other voices were to enter the conversation on the spoken word and linguistic reference, many possible conceptual candidates for shedding light might be entertained. Lacan, of course, in his use of the quite different representational linguistics of de Saussure, offers an account of *full speech* and other varieties. One might also wonder about accounts of engagements with consciously and unconsciously meaning-laden language games in speech that emphasize concepts of expression, rather

than those of private mental representation (Wittgenstein; see footnote 10). The voices that might join this conversation are many, and dialogues of this kind, I believe, would enrich psychoanalysis.

These issues notwithstanding, I strongly recommend this book to analysts and students interested in a searching and at times brilliant consideration of the place of the spoken word in Freud's theory and method. Rizzuto engagingly pursues this topic in all sorts of unexpected corners of Freud's work, develops imaginative hypotheses about it, and in doing so exudes her own uniquely vital engagement not only with Freud, but also with her readers.

RALPH H. BEAUMONT (PORTLAND, OR)

THE LAST ASYLUM: A MEMOIR OF MADNESS IN OUR TIMES. By Barbara Taylor. Chicago, IL: Univ. of Chicago Press, 2015. 295 pp.

Every psychoanalyst can profit from reading this book—and so can anyone else who treats people with emotional disorders. Come to think of it, *anyone will profit from reading it!* It is a frank, open, honest account by an articulate, talented writer, describing what she went through as a "madwoman" who lost her grip on life. She also describes how—with a great deal of help—she worked her way out of her emotional collapse. For ten years, she shuttled back and forth among Friern Hospital, just north of London; short stays with loyal friends who refused to let her push them away, despite her outrageously destructive and (especially) self-destructive behavior; a long stretch at a mental health hostel; and, finally, a couple of brief stints at the home of a retired nurse who took in people who were recovering from severe mental illness.

Barbara Taylor's most important helpers were her very good friends, a woman psychiatrist who provided prescriptions for psychoactive medication and emotional injections of courage and optimism, and—most important of all—"Dr. V," a psychoanalyst (who was in his mid-forties when they began) who saw her five times a week at a reduced fee *for over twenty years!* She spent more than half a year as an inpatient in one of the very last public asylums to succumb to the axes of cost-conscious "public

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servants" and the bulldozers of profit-hungry land developers in Great Britain (and elsewhere).

The book begins, in fact, with a terse account of the history of Friern and other British hospitals for seriously ill mental patients, and it ends with a description of Friern's transposition (transmogrification?) into a very elegant, expensive residence compound called Princess Park Manor. Today this institution caters to the rich and famous who are eager to shut out the world, rather than being themselves shut out *by* the world in the way that earlier patients in that location had been for over a hundred years. In an epilogue, the author, now a professor at East London University and a respected author, describes the woefully inadequate services for seriously ill patients that have replaced the earlier hospitals, as well as the present-day related network of hostels for "vulnerable" adults. Taylor herself resided in one of these hostels for two and a half years after leaving Friern.

As the author informs us, this book

> . . . is, among other things, a narrative of gratitude—to the psychoanalytic process and the analyst who practiced it with me, to the many interesting people I met during my sojourn in the psychiatric world; to my friends and family; but above all to the crazy woman I once was, whose craziness in the end proved my salvation . . . . Madness is not a disease like any other. The crazy mind is no weak or failing instrument but intensely alive, bursting with inventive energy. This is a cliché of romantic ideology, but it is also true—and it presents a huge challenge to conventional concepts of treatment and cure. [pp. xiii-xiv]

Taylor tells us about her early years, growing up with two very disturbed parents who—outwardly—were idealists fighting to make the world a better place, while simultaneously creating utter havoc within their family. The relationship between her parents was just as dramatic as it was sadomasochistic. They were so oblivious to the effects of their behavior on their offspring that, although they battled furiously over each other's extramarital affairs, they invited the two people with whom they were having affairs, simultaneously, to come to dinner with the family! Taylor's mother treated her as cruelly as her husband, Taylor's father,

was treating *her*. (The father also repeatedly behaved in inappropriate ways with Taylor herself.)

At one point during her analysis, Taylor became obsessively preoccupied with her face. She kept staring at what she saw as her dirty face in the mirror, and she scrubbed it so hard and so frequently that the skin became raw and painful. Dr. V, her analyst, helped her stop doing this by telling her that what *he* saw was that she had become her mother, looking her in the face and telling her how bad and dirty she was, and she had also become the little girl who was so labeled. What *she* saw in the mirror, he pointed out, was a combination of the dirty looks her mother gave her and the dirty way her mother had made her feel about herself.

Not surprisingly, as an adult, Taylor moved thousands of miles away from her parents. She tried to distance herself from them emotionally as well, but that proved to be a much more difficult task. As a young adult, she gravitated toward men who treated her even more sadistically than her mother had. She tended to react to what they did to her by stuffing herself with alcohol and pills, instead of getting away from them and searching elsewhere for what she needed. She hungered for tender loving care, both from her female support network and from her analyst, but she did not know how to obtain it from them. Impelled by a combination of infantile grandiosity and intense ambivalence toward her objects of desire, she tried to force them to rescue her from herself, even as she prevented them from doing so.

Taylor had a group of friends who were remarkably devoted to her and who came through for her over and over. Finally, they realized both that she was too much for them and that their repeatedly pulling her back from the brink of self-destruction was not helping her. They insisted that she obtain professional help. When she did so, she assiduously tried to force both her medication-prescribing psychiatrist and Dr. V (who accepted her for analysis) to become the good, nurturing, protective parents for whom she yearned—*and,* simultaneously, the terrible, destructive parents whom she could not give up.

Taylor wrestled over whether or not to sign herself into a hospital. When she pressed her analyst to make the decision for her, it was evident to him that if he were to do so, both of them would be sorry no matter

what he said. He told her that he was not her mother and that she would have to decide for herself rather than being told what to do. He also helped her recognize that when she was with him, as when she was with her friends, she had to feel all-powerful in order not to feel totally helpless. For her, there was nothing between those two poles. He helped her see that she repeatedly brought herself to the brink of self-destruction in order to make her friends—and her analyst—worry so much about her that they would become her totally devoted servants.

Dr. V also commented to her that she was bent upon destroying the analysis in order to prove that *he* was helpless and to make him hate her—just as she felt her mother hated her and as she had come to hate herself. He was steadfast in declining to be recruited into joining with her in enacting her sadomasochistic inclinations, and he patiently but persistently led her into analyzing them instead.

Taylor brought gory dreams into her sessions—of blood, mutilation, murder, and a man's head being eaten while the man was speaking. Dr. V interpreted these dreams as her telling him that he was not helping her and that she was masochistically determined not to let him help her. Soon after this, her roommates informed her that they would no longer put up with her outrageous behavior and that she would have to move out. Unable at that time to heed the messages her analyst and her friends were giving her, she panicked, drank nonstop for a week, and drove to an analytic session while inebriated. Dr. V sent her to her psychiatrist, Dr. D, who helped her sign herself into Friern Hospital.

Neither Dr. D nor Dr. V was willing to give up on her, however. They continued to work with her while she was in the hospital. She was given permission to leave the hospital to attend her analytic sessions. Her friends did not abandon her either; they continued to visit her in the hospital and to take her out for meals and outings.

At a later point in the book, Taylor emphasizes how vitally important it is to a seriously emotionally ill person to have both personal and professional friends who will stick by her. She laments the way in which some hospital superintendents, doctors, and nurses do not believe in allowing patients to become friends with each other; furthermore, they may treat mental patients as though they are either imbeciles or helpless children—whereas instead, they should be helping them build self-

respect and self-confidence. Taylor astutely recognizes that a good many of these professionals are behaving self-protectively when they identify themselves as the healthy ones and distance themselves from those who are "sick."

I know something about what the author has written about from my experience as a U.S. army doctor. When I served as a psychiatrist in a large military hospital in Frankfurt, Germany, a number of years ago, I was placed in charge of the inpatient unit for a period of time. A good number of the patients were career officers and NCOs who were waiting, often for months, to be transported back to the States for definitive treatment of a serious emotional illness. It was difficult enough for them that they had fallen seriously ill; on top of that, they were terrified that having developed an emotional illness would wreck their careers.

I went to London and spent a bit of time at Henderson Hospital, where Maxwell Jones had developed his ideas, and then traveled to Dingleton Hospital in Scotland to confer directly with Jones himself. With his kind assistance, when I returned to the 97th Army General Hospital in Frankfurt, I converted the psychiatric inpatient service into a therapeutic community.

The cornerstone of this approach was the removal of all categorical labels, since patients and staff met daily in a large group and then in small groups in which the aim was to help each other deal with life issues. We addressed each other by first names only. During the group meetings, no one was a patient. No one was a doctor. No one was a nurse. There were no officers and no enlisted men or women. The idea of rank was temporarily suspended; we were just people helping each other.

This arrangement worked out very well for the patients. To my surprise, however, it proved to be very difficult for some of the staff members. A couple of doctors found seemingly plausible reasons to miss the large-group meeting with which we started each day. A significant number of psychiatric nurses, one by one, began to become so anxious that they themselves had to go into (outpatient) treatment. Without labels to identify who was ill and who was well, they found themselves forced to face their own problems. For me, it was quite a learning experience.

Dr. V worked with Taylor patiently and persistently to help her face and explore the meanings of her self-destructive, sadomasochistic behavior both within and outside analytic sessions. She began to realize, first of all, that she wanted to punish her parents by exposing what they had done to her and to make them pay for it (literally and figuratively). She realized partly through analysis of the dreams she brought to her analyst—in which she was subjected to various kinds of sexual violence—that she had sexualized her pain and suffering in order to obtain (dubious) exhibitionistic satisfaction and to satisfy her hunger for interest and attention. She came to see that for the first eight years of her analysis, she had fought against recognizing Dr. V as a separate, tangible person rather than an adjunct to her own existence. As she began to acknowledge his separateness and his existence outside her (illusory) control, she began to perceive herself for the first time as an intact, whole, real person with borders as well as contents. This was extremely gratifying to her, although at first it threw her into panic attacks.

Taylor gave up her self-destructive drinking bouts and stopped trying to push away her friends and her analyst by being utterly nasty and by indulging in outrageously bad behavior. She emerged from her state of "madness" and became a more ordinary analytic patient for the next twelve years. She eased herself out of the hostel in which she had been residing and, with the aid of a kind and gentle retired nurse who permitted her to move into her home for a couple of months at a time, she transitioned into a small apartment that she had purchased some time earlier. Finally, she became able to live in the apartment alone.

Taylor first worked as a volunteer at Friern and at hostels for recovering patients, teaching writing to those who were interested. Then she moved on to paying jobs, to writing books that were well received, and she eventually became a university professor. She strengthened her relationship with the good friends who had refused to abandon her, who had stored and protected her possessions during her years in the hospital and in therapeutic group homes, and who accepted her apology for having treated them badly in the past. In time, she developed a lasting romantic relationship with someone who treats her well and whom she treats well.

Taylor has done considerable research into the history and spiral evolution of the treatment of seriously mentally ill patients, especially in hospital settings, over the past few centuries in England. She has interviewed former and current hospital superintendents and head nurses who have worked in these settings. Her terse account of her findings and her ideas about the way in which shifting attitudes toward the mentally ill have shaped waves of change in the methods used to treat them is interspersed with the account of her own personal experience. Both these aspects of the book are well worth reading.

This is a well-written, fascinating account of one woman's descent into the hell of serious mental illness, followed by a remarkable recovery achieved via valiant analytic effort, in which she was assisted by an impressively capable psychoanalyst and treatment team, as well as by close personal friends. I recommend this book in particular to those who know that psychoanalysis can be an effective treatment for someone who is seriously emotionally ill, so long as the requisite motivation, psychological strengths, and a solid support system are present. And I recommend it even more strongly to those who doubt that such treatments can be successful.

MARTIN A. SILVERMAN (MAPLEWOOD, NJ)

WHEN THE SUN BURSTS: THE ENIGMA OF SCHIZOPHRENIA. By Christopher Bollas. New Haven, CT/London: Yale Univ. Press, 2015. 226 pp.

From time to time, a beam of light pierces the darkness to illuminate the one positive force that still remains in the box from which Pandora released the panoply of ills that afflict humankind. The publication of this little book represents just such an occurrence. Schizophrenia and severe manic-depressive illness are terrible diseases. The treatment offered to their sufferers, however, can be just as terrible, or even more terrible, than the disease itself. Mind-altering drugs at times can be very helpful, but at other times, especially when administered in massive doses, they can destroy the mind itself.

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There are those, on the other hand, who recognize that seriously ill people are *people* much more than they are ill. Christopher Bollas is one of those. In this slim volume, in the articulate and poetic style that has made him stand out as a singular contributor to the psychoanalytic literature, he invites the reader to accompany him on an exciting journey through time and space—as he recalls the way in which he became a proponent of giving psychotic patients a chance to use their emotional resources to pull themselves out of the darkness, with psychoanalytic assistance, at times without any medication at all. Along the way, we get to know not only Bollas, but also a number of extremely troubled but remarkable people who ultimately win our admiration and our affection.

Bollas's interest in analyzing psychotic people began when he himself became a patient. As an undergraduate at the University of California at Berkeley, he studied history and immersed himself in civil rights and antiwar activities. Suddenly and surprisingly, he found himself in the throes of acute acrophobia, accompanied by obsessive thoughts of killing himself by throwing himself down a stairwell. He pulled himself out of this with the help of a psychoanalyst who was working in the student health center, whom he saw regularly for two years.

The next step in his evolution toward becoming a psychoanalyst working with highly disturbed patients was the job he took, after graduating from Berkeley, as a therapist at the East Bay Activity Center in Oakland, California. Working with the terrified, utterly confused and confusing, at times physically assaultive, autistic and psychotic children who made up the patient population there was exhausting, dizzying, and often very frustrating. Nevertheless, it turned out to be a wonderful learning experience for him. "Chris Ball," as his young charges called him, grew to appreciate how lost the children were in their struggle to negotiate between the splintered, fragmented, idiosyncratic, and phantasmagoric emotional world inside themselves, and an external world that repeatedly struck them as just as "insane" (or even more so) than they knew themselves to be. They found themselves surrounded by adults who exhibited illogical, supernatural beliefs and by political demonstrations that spawned senseless violence.

Bollas came to understand that the children's psychotic beliefs and their frenzied physical assaults on staff members not only had meaning,

but also represented a desperate attempt to make contact with empathic adults who just might help them make sense of what was going on both inside them and in the world around them. "What I came to realize," Bollas writes, "was that almost all psychotic behavior was comprehensible if one could discover the underlying logic of thought" (p. 20).

A bit further on, he states:

> The need to believe in our sanity was perhaps the most moving, and the most fragile, feature of working with psychotic children. They had never known what it was to be sane, but they could see that we lived our lives in a much less fearful universe than the one they inhabited. Of course they differed in their orientation to this juxtaposition, from envy and contempt to anxious adherence, but they generally hoped that proximal contiguity would magic them into a better world. [p. 21]

Somewhat paradoxically, Bollas elaborates further, as follows: "It is important to make a distinction between 'psychosis' and 'madness.' Schizophrenics are psychotic but they are not mad. Indeed, they are very frightened by madness and can often be phobic about coming into contact with it" (p. 36).

I believe that one thing he means by this is that schizophrenics look for therapists who can both resonate with and empathically understand schizophrenic functioning and experience, while also being sufficiently level-headed and free enough from the strange attitudes toward others that are so prevalent in the world that they can relate to schizophrenic patients as human beings. Only then can therapists provide a pathway toward more effective functioning in the not-always-sane world in which we live—despite the emotional and cognitive defects with which a schizophrenic is burdened. What must it be like for a schizophrenic patient to be in the hands of the all-too-common mental health professionals who have a purportedly sound view of them as hopeless freaks who need no more than tranquilizing or incarceration?

Bollas was able to extrapolate a great deal from his experience with the kids at East Bay Activity Center that would help him in his later work with adult schizophrenics. He began working with a schizophrenic population after he went through psychoanalytic training in England, where

he encountered, directly or indirectly, the ideas of Winnicott, Khan, Bion, Meltzer, Segal, Steiner, and other analytic luminaries.

"Chris Ball," while working at EBAC, learned how to use his own at times disturbing resonances with the children's psychotic manifestations of emotional storm and turmoil, and with their frantic efforts to disentangle their mental knots and reduce their misery. He learned how to be spontaneous, creative, and innovative in his work with them. As a child analyst who has worked with all sorts of severely traumatized, emotionally fragile, physically eruptive, at times frantic and explosive, unevenly developed youngsters, as well as with a few autistic and psychotic children, I can readily recognize what he is telling us about.

For example, Bollas worked daily with Nick, a boy who greeted him each morning by spitting at and kicking him before charging off to select another patient as the one whom he declared he would kill that day, and then hurtling back to resume assaulting his therapist. In outdoor meetings with Nick, Bollas frequently had to wrestle him to the ground and hold him there to get him to calm down. One day the ground outside was wet, and Chris Ball was tired and physically exhausted by his efforts to restrain Nick, who weighed not much less than he did. He felt completely frazzled. Then he had an inspiration. He suggested to Nick that they sit on a bench together and make up a story instead of wrestling on the grass. "What story?" Nick asked.

I am reminded here of a nine-year-old boy, Alton, whom I treated many years ago when I was a child psychiatry fellow at Strong Memorial Hospital in Rochester, New York. For the first six months of the treatment, we lay on the floor, twice a week, while I held Alton's wrists with one hand and his ankles with the other—to stop him from trying to kill me. He finally said "uncle" when he realized that I meant it when I repeatedly told him I would neither let him hurt me nor give up on him and abandon him. The treatment then became much more traditional, and we learned together that beneath his rough and tough, rage-filled exterior, Alton—a black, inner-city child who *had to be tough* to survive in his cultural surround—was an anxious, guilt-ridden, tortured young man with a red-hot Oedipus complex!

It turned out that I had been correct in finding hope in Alton's attempt, at our first meeting, to make black marks on the white jacket I

was required to wear. During the last few months of our work together, Alton and I assembled and painted a model of a black-and-white Dalmatian dog as we continued to explore his neurotic conflicts. Eight months after our last session, on February 14, I received a Valentine's Day card from Alton on which he had written, "To my bestest friend!"

To return to Bollas's treatment of Nick, for many weeks after Bollas had proposed storytelling, the two of them worked on a story about an orange ship that sailed around the world, seeking adventures. Nick nominated Chris Ball to be the ship's captain, and Bollas assigned various children at EBAC to be crew members. Each day, the ship would enter a port of call and the crew would visit points of interest on shore. At each of their meetings, Nick could hold out for only about ten minutes before showing signs of breakdown. Bollas would then let Nick get himself under control by taking over the storytelling; Nick would regularly proceed to turn Chris Ball's peaceful tale of learning and discovery into a violent horror story. If Bollas said that three of the children sauntered up to examine something of interest on the Acropolis, for example, Nick would change it to one of them being eaten by an alligator, another falling off a cliff to her death, and the third one suddenly disappearing into thin air. Bollas tells us that:

> For months, there was no change to this structure, until one day Nick started laughing. Previously his laughter had been more like a form of screaming, but this was suddenly just ordinary. "You don't get it, do you Chris Ball?" he chanted. "I don't get what, Nick?" "I was just kidding, just kidding!" For a moment, still I did not get it. But then I realized he was telling me that the horrifying tales of destruction, which I had been taking seriously, were *now* just jokes he was sharing. He was pulling my leg. We laughed together for the first time. [p. 24, italics added]

In 1969, Bollas moved on to the University of Buffalo for graduate studies in English literature. After a while, seeing how many of the students in the classes he taught were seriously disturbed, Bollas told Lloyd Clarke, the "existential psychiatrist" who headed the Student Health Center there, that he wanted to be trained as a psychotherapist so that he might treat them rather than teach them. Clarke assigned psychotic students to him and personally supervised Bollas's treatment of them.

The interesting stories Bollas shares about his experiences there demonstrate both his intuitive understanding of what went on inside the minds of the highly troubled young people with whom he worked, and his capacity to bring impressive courage and innovation to the task.

In 1973, he relocated to England, where he enrolled in training at the Institute of Psychoanalysis in London (where he encountered some puzzling, surprisingly rigid rules, such as candidates being forbidden to read any psychoanalytic writings during their first year). He provided psychotherapy assistance to patients in the Personal Consultation Centre. The vignettes taken from his experience there are as edifying as they are entertaining to read. Two years later, he moved on to the Tavistock Clinic, and although he did not work with schizophrenic patients there, he did do so in his newly opened private office. This launched him on a career of working with psychotic patients that has continued to the present time.

In 1977, he went into full-time private practice in London. He found that more and more of his patients suffered from schizophrenia. In brief, illustrative vignettes, Bollas introduces some of these patients, as well as others whom he encountered in his several years at Austen Riggs Center in Stockbridge, Massachusetts, and in his private practice in the United States. He distinguishes between those patients who have slowly tumbled into psychotic emotional functioning from those who have experienced a seemingly sudden, cataclysmic breakdown from which they cannot easily recover. He writes:

> Slow-onset schizophrenia is characterized by occasional startling moments in which a person—usually in adolescence—finds himself having strange ideas. They come and go, and indeed many months may pass in the interval of disconcerting ideas. Those on the verge of schizophrenia may experience profound changes in their way of seeing, hearing, and thinking . . . . They will have no idea what is happening to them and will not wish to worry friends, but there is also a fear that if they reveal what is taking place it will make matters worse. [p. 75]

When these young people share their experience with others, they often seem otherwise so ordinary in their functioning that their friends view them as simply offbeat or idiosyncratic, not recognizing that alarm

bells are going off. But Bollas emphasizes that the lucky ones are those whose parents and friends *do* realize that something serious is taking place and do something about it. He observes:

> Slow-onset schizophrenia, if noticed by parents, may lead them to refer their child for intensive psychotherapy or psychoanalysis. If this happens, there is a very good chance that the adolescent will not have a full-on schizophrenic breakdown; indeed it may be reversed and the self returned to something like an ordinary course of life. [p. 78]

Young people whose emotional stability breaks and shatters more or less fully and suddenly, and who do not get the help they need, tend to be less fortunate. Bollas provides several examples of such persons. One young man in his mid-twenties recalled the beginning of his progressive slide into schizophrenia as a dramatic experience that he had had when he was ten years old. One day, on leaving school, this young man had looked up and seen the sun burst into pieces.[1] His teachers discounted the genuineness of his terror, thinking that he was making it all up, and were angry at him for hiding from danger rather than recognizing his own serious illness. He slid inexorably into a wary, vigilant paranoia that lasted ten years, after which he developed a full-scale, flagrantly schizophrenic psychosis.

Bollas shares impressions and ideas about the schizophrenic process that are intriguing indeed. One of his patients recalled being hurtfully mocked by the boy who sat in front of her in her sixth-grade class. Suddenly, she saw him growing more and more ugly. His ears then ballooned up to five times their actual size (like Pinocchio's donkey ears, perhaps?). In the ensuing months, the rest of him progressively faded from view, so that, when she sat at her desk, all she saw in front of her was a pair of monstrous ears. Bollas says:

> One of the remarkable aspects of schizophrenia is how adaptive people are. Imagine what it is like to be in this place, living in a world that is now changing its shape. One possible response is to

[1] Bollas drew upon this patient's experience when he chose his book's title, *When the Sun Bursts.*

> transform it into a mythic world, and to reconstruct one's being into a transcendent muse who can control this. [p. 80]

Bollas also recalls EBAC children who dealt with relating to people whom they found difficult by transforming them, or their disturbing characteristics, into cartoons. In this way, the children made them far less daunting and dangerous; the difficult others became simply what Bollas calls "figures of *allegorical imaginary*" (p. 81, italics in original).

The author elaborates at some length about the way in which he witnessed his schizophrenic patients rid themselves of a mind that was betraying them—or, more often, of troubling parts of the mind—via projection into inanimate objects that they felt they could control. He provides striking examples drawn from the years he spent working at Austen Riggs to illustrate this. All too often, such projections backfired; the split-off and projected aspects of the mind tended not to remain externally repositioned, instead taking on new life as disembodied voices within the mind. Patients were tortured by these voices, which leveled harsh and at times viciously critical, tormenting attacks upon them, or assailed them with terrifying injunctions to do horrible things, or enslaved them by forcing them to carry out compulsive rituals in order to maintain an illusion of safety.

Bollas explains the rationale for emptying the mind of extremely disturbing, out-of-control components in poetic terms: "Schizophrenia operates in inverse proportion to self-fulfillment. In the schizophrenic order, a self fulfilled is a self endangered. But a self intelligently emptied is a self protected" (p. 81).

Bollas describes schizophrenic mythology, in which—in the absence of an integrative capacity to endure and deal with the breakdown of the relationship between the current psychotic self and its prepsychotic past—a *mythic* prepsychotic past is invented. The need for this mythology must be respected in therapy for a long time before it can begin to be penetrated. (Is this entirely different from what nonpsychotic people do to feel better about, less guilty about, or more in control of their lives?) Bollas addresses the extent to which a schizophrenic resigns from ordinary life in the real, interpersonal world, which he cannot handle, "in favor of mythology [as] he quietly goes about creating his own collec-

tive universe. He does so by forming relationships not to people but to things. He needs the thingness of things" (p. 90).

This can progress to the concretization of words themselves, since language connects people with one another, and to a retreat to prelogical and sensorimotor thinking—or even, Bollas postulates, to the "somatoform experience and representation" (p. 152) of the intrauterine and early postpartum period of life. The aim here is to obtain a semblance of control over language, and especially over language as a medium for carrying out complex, person-to-person, emotional interaction. "When people become untrustworthy," Bollas observes, "physical objects (both animate and inanimate) can become substitutes for self-other relating" (p. 164).

This leads, of course, to painful aloneness and loneliness. Schizophrenic symptoms generally reflect in part an attempt to overcome unbearable isolation by reuniting with others, albeit via psychotically twisted logic and language. Bollas treated an immigrant man who had alarmed his co-workers by telling them that he was going to set himself on fire. When he revealed that his intention was to host a barbecue for his co-workers (with whom he rarely spoke), Bollas put this together with his having said that a voice had told him on a bus that he was offending his fellow passengers by exuding a smell. Bollas informed his patient that it seemed he wanted to cook for people—which was a principal way of meeting others in his country of origin—and that if his smell was a chef's smell, the people on the bus would actually be fortunate. (His patient not only became more social, but also cooked a delicious meal and brought it to Bollas!)

He helped another schizophrenic patient, Ernst, summon the courage to move beyond his somatoform reactions to any irritating people whom he encountered—reactions that actually arose from the "pool of anxiety and anger" lurking inside him (p. 155). The patient was encouraged to instead express annoyance to such persons in words. Bollas writes:

> Ernst's affective life bridged the sensorial and the verbal. At first, he imagined violent actions against others, then he moved into the verbal symbolic order by occasionally speaking angrily to

> people, although fortunately such outbursts were tempered. I stated that he was in search of relationships, and that for him a bad relation was better than no relation at all. He found this idea stunning. It had never occurred to him that he was seeking friendships through his imagined scenes of violence. [pp. 155-156]

Bollas observes that "disparate elements become engaged in frenzied connectedness [that] . . . betrays the unconscious effort to move away from people and especially transcend the intensity of human relations" (p. 91). Similarly, the schizophrenic may "thing" language in order to control it by reordering and reconstructing its syntactical form and structure into idiosyncratic and at times indecipherable amalgams—in a way that outdoes even the control over words shown by Lewis Carroll's Humpty Dumpty.

Bollas elaborates an intriguing concept to which he applies the term *metasexuality*. He states that the schizophrenic

> . . . has embodied sexual union, and he now presides over what is born from this form of intercourse: a strange combination that reflects his own compromised being. These activities—the eradication of history, the invention of a personal mythology and communication with the thingness of the world—can often be florid and highly disturbing to the other, but they may also be very subtle indeed. [p. 92]

Bollas's concept of schizophrenic metasexuality is thought-provoking indeed. He asserts that the schizophrenic, whose crumbling powers render him or her unable to master the requirements of relationships in the real world, resorts to a manic, grandiose reconfiguration of reality in which the conflicts, anxieties, excitements, and bewilderments of sexuality (including primal scene mysteries) become transformed and in a way desexualized. The schizophrenic, he maintains, transcends and neutralizes sexuality via a manic, grandiose, delusional belief in the power to "connect all objects in continual acts of metaphysical union" (p. 90). At first, this involves physical objects, and then mental objects as well. Hidden inside this fantastic and phantasmagoric exercise in mental gymnastics is the need to magically unite the present and the past, the

real and the unreal, and the fragmented shards of self into a universe in which

> . . . the subject has triumphed over and incorporated the mother and father and become a we-world. By virtue of this expansive action, the subject acquires super-powers. Although the body-self feels energized by the appropriation, the act of incorporative triumph desexualizes the primal scene—rather as the digestive system eliminates the taste of food . . . . Schizophrenic metasexuality finds bliss in the transcendental incorporative amalgamation of opposites. [p. 100]

Further on in the book, Bollas clarifies that with the concept of *metasexuality,* he is not referring to physical, sexual excitement or sexual urges. A schizophrenic can experience these no less than can a nonpsychotic person, of course. He is referring, rather, to the emotional, interpersonal, object relational aspect of sexuality, which is infinitely more complex and challenging than mere physical, sexual impulses and actions.

Bollas observes, with regard to schizophrenic regression to infantile, prelogical, and even sensorimotor thinking, that

> . . . the schizophrenic perceives that the idea that we are benign, well-meaning, and socially constructive is a Ponzi scheme of illusions. The schizophrenic has experienced the world differently. And, like an advance party on an expedition that encounters insurmountable challenges, he quickly retreats to base camp. [p. 104]

Bollas emphasizes the value of instituting person-to-person psychotherapy as early as possible after a full-blown psychotic process has developed—at a time when the individual still has hope that his or her mind can be repaired and that someone out there might be able to assist in effecting that repair. Otherwise, the person's mind begins to assume the proportions of an enemy, and it or parts of it are, via projection, extruded out of the self into the external world. If even that proves insufficient, what has been eliminated from the self can be encased in a manufactured, imaginary world in which it can be confined, in order to prevent it from making its way back inside the self. Of course, this makes

the suffering individual harder and harder to reach. Bollas, like Harold Searles and David Garfield,[2] is a strong proponent of taking a detailed history of the events that occurred at the time of the initial outbreak of psychotic illness, in order to keep the patient from distancing the historical self.

Bollas stresses the importance of talking—including conversing about mundane, quotidian details of the patient's life—to bring the patient's *I,* his or her acting and observing self, back into relationship with the *me,* the observed self. Early in the book, he describes his observations of psychotic children who never spoke of themselves in the first person. He also describes his observation of a psychotic child at EBAC who ran back and forth from one end of a rectangular table to the other, speaking from one end toward the other. When Bollas asked what he was doing, the boy replied, "I'm talking to myself." It dawned on him that this behavior represented more than the mere concretization of an abstract concept; he realized that the youngster was attempting to reconnect his *I* (subject) with his *me* (object), from which it had become alienated.

Later on, he recognized the importance of helping schizophrenics carry on a conversation with him in which they increasingly use the pronoun *I* as they reestablish the solidity of their *I,* and as they reconnect their *I* and their *me* as more fully united aspects of an increasingly integrated and intact mind. (Therapists who achieve success with schizophrenic patients usually do this more or less intuitively, it seems to me.)

The last chapter in *When the Sun Bursts* contains a moving description of a very successful, five-times-a-week psychoanalytic treatment that Bollas provided long distance, via Skype, for an extremely disturbed, almost totally isolated, hallucinating schizophrenic woman who was 5,000 miles away. In a condensed and modified form, this description served as the basis for a newspaper article that appeared shortly before the book was released. In the article, the author states: "It is not a coincidence that the beginning of schizophrenia is almost inevitably an event in adoles-

[2] See the following: (1) Searles, H. (1965). *Collected Papers on Schizophrenia and Related Subjects.* New York: Int. Univ. Press; and (2) Garfield, D. (2009). *Unbearable Affect: A Guide to the Psychotherapy of Psychosis.* London: Karnac. See also: Silverman, M. A. (2010). Psychoanalysis and the treatment of psychosis. *Psychoanal. Q.*, 79:795-817.

cence. The schizophrenic fails to make the transition from childhood to adulthood. Something goes wrong."[3]

During my second year of a child psychiatry fellowship, I spent part of my time at a large, general hospital that had started out as a chronic disease hospital. Family practice as a medical specialty was developed in large part at that hospital. For a number of years, in a small, self-contained, separate building, families were being provided with medical and pediatric services for many years at a time. While I was there, adolescents arrived at the hospital periodically with an acute first psychosis, usually a case of schizophrenia. Almost invariably, the youngster's parents asserted that their child had been perfectly normal until the sudden outbreak of the psychosis. A fair number of these families had been treated for years at the Family Practice Unit. Because of this, I was able to gain access to years and years of records, and I was able to see the pediatric accounts of the repeated instances of disturbed behavior, school suspension, and learning difficulty that these "normal" children had experienced on the way to a psychotic break in adolescence! What might have happened if they had received help *before* they got to adolescence?

I have written a long review of a short book. This is because good things *can* come in small packages. I strongly recommend this book to everyone.

MARTIN A. SILVERMAN (MAPLEWOOD, NJ)

SELF PSYCHOLOGY AND PSYCHOSIS: THE DEVELOPMENT OF THE SELF DURING INTENSIVE PSYCHOTHERAPY OF SCHIZOPHRENIA AND OTHER PSYCHOSES. By David Garfield and Ira Steinman. London: Karnac, 2015. 160 pp.

As far as I am aware, there is no other book like this out there. No one else has so thoroughly described the psychological treatment of psychotic patients when concepts of self psychology are utilized to apprehend the therapist's work and its efficacy. Of particular merit is the au-

[3] Bollas, C. (2015). A conversation on the edge of human perception. *NY Times Sunday Rev.,* Oct. 18, p. 7.

cence. The schizophrenic fails to make the transition from childhood to adulthood. Something goes wrong."[3]

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I have written a long review of a short book. This is because good things *can* come in small packages. I strongly recommend this book to everyone.

MARTIN A. SILVERMAN (MAPLEWOOD, NJ)

SELF PSYCHOLOGY AND PSYCHOSIS: THE DEVELOPMENT OF THE SELF DURING INTENSIVE PSYCHOTHERAPY OF SCHIZOPHRENIA AND OTHER PSYCHOSES. By David Garfield and Ira Steinman. London: Karnac, 2015. 160 pp.

As far as I am aware, there is no other book like this out there. No one else has so thoroughly described the psychological treatment of psychotic patients when concepts of self psychology are utilized to apprehend the therapist's work and its efficacy. Of particular merit is the au-

[3] Bollas, C. (2015). A conversation on the edge of human perception. *NY Times Sunday Rev.,* Oct. 18, p. 7.

thors' extensive description of clinical process, which vividly depicts how they struggled with the challenges they encountered in their work with these patients and how remarkably effective they were. The authors' extensive clinical illustrations—often including verbatim dialogue—merit close attention.

The book is organized into three parts, corresponding to each of Heinz Kohut's selfobject transferences: *Mirroring, Idealization,* and *Alikeness* (Kohut's designations for the latter are "Twinship" and "Alterego"). Several chapters in each part abundantly describe clinical work with psychotic patients, where attention to these selfobject transferences appears to yield beneficial results. The authors emphasize the value of attending to what Kohut referred to as the *leading edge* of these transferences—what has been elaborated as *forward edge transferences.*[1] Chapter 4, in part I, also illustrates the clinical relevance of Kohut's concept of the *vertical split* in working with these patients.

The authors' stated intent is that their book address not only the psychotherapy of schizophrenia, but also the development of the self during intensive psychotherapy of the psychoses. This is, in fact, their emphasis throughout. Their understanding is that self psychologically oriented analysis is effective with psychotic patients in essentially the same way that it is effective with any other patient—by strengthening the self through "facilitating self-esteem via effective engagement with the forward edge" (p. 11), that is, with sustained "HOPE" in hand (p. 12).

Kohut described a two-step process that he believed leads to analytic cure: prolonged empathic immersion in the patient's subjective experience, followed by interpretation (i.e., according to selfobject theory) of what the therapist has thereby gleaned. In 1985, I suggested that this second step was too narrow—that patients may variously experience all kinds of responses as optimally therapeutic, in addition to, or instead of, interpretation, depending upon the particular nature of their psychological needs.[2]

[1] Tolpin, M. (2002). Doing psychoanalysis of normal development: forward edge transferences. *Progress in Self Psychol.,* 18:167-190.

[2] Bacal, H. (1985). Optimal responsiveness and the therapeutic process. In *Optimal Responsiveness: How Therapists Heal Their Patients.* Northvale, NJ: Jason Aronson, 1998, pp. 3-34.

In further contributions,[3] this view was expanded to include as a function of empathy the process of discerning the responsiveness that the patient might need from the therapist; and that therapeutic possibility depended upon the potential of the particular therapist–patient dyad in the moment and over time. I also suggested that a variety of psychoanalytic constructs might relevantly come into play within the unpredictable specificity of that analyst–patient process. In effect, Garfield and Steinman's actual work with their patients seems to reflect such an expanded approach.

The authors' declared position, however, is that effective treatment of psychosis is based upon the application of self psychology theory, even though their clinical work and their related discussions of many other theories indicate that they utilize much more. I also think they underplay the effects of their own personal capabilities.

Much of this is vividly illustrated in a clinical vignette in which Steinman's patient Judith responded in a surprising way to his angry explosion when she cut herself in his waiting room. He told her that this cutting was not okay, that there was no reason to do this, that no matter what she felt, no matter what her imaginary figure told her to do, she should not act on it but rather call him right away, so that he could help her work through her feelings.

He then took her to the emergency room to have her cuts sutured and to arrange for a short hospital admission. The medical doctor who attended the patient there called Steinman to let him know that he had

> . . . never seen a happier patient . . . . She was almost bragging about how you swore at her and told her she could never cut herself again. She told all the nurses and me how worked up you got. She's been positively beaming about it. [p. 21]

Steinman was initially astonished to hear this. And he could not know at the time that Judith would never cut herself again. He had identified his response to Judith as a spontaneous countertransference reaction whose positive effect, he writes, was due to its evoking a "mirroring selfobject experience"—that Judith felt "noticed, affirmed, and

[3] For example: Bacal, H. & Carlton, L. (2010). Kohut's last words on analytic cure and how we hear them now—a view from specificity theory. *Int. J. Psychoanal. Self Psychol.*, 5:132-143.

important" (p. 21). His first comment about it, though, was a feeling that "[my] outburst showed her that [I] really cared about her" (p. 21).

Let us take a closer look at this. From the point of view of self psychology theory, the evocation of Judith's apparently significant therapeutic experience is not wholly encompassed by the concept of a mirroring selfobject. Her therapeutic experience is also due—and, arguably, is primarily due—to a vitalizing idealization when she discovered that her doctor was really an authentically caring figure. These experiences were specific to what she deeply needed, which she had never believed she could have—rather, we might surmise, quite the opposite.

We might also note that the effectiveness of Steinman's response was not only unpredictable; it was also not an interpretation. Yet his reaction appears to have been therapeutically optimal. In this regard, we could view the positive effect of Steinman's intervention over time—that the patient never cut herself again—as an instance of the operation of a construct offered by Sampson and Weiss: that the disconfirmation of a pathological expectation is significantly therapeutic.[4]

In retrospect, Steinman could see how he may have contributed to Judith's earlier view of him. He recalls that in his prior explorations of her suicidality, he maintained what he calls a psychiatric detachment, and he considers that perhaps the patient's action was an unconsciously organized test about whether he cared about her; and that her view of his uncaring nature was authentically disconfirmed in the moment of his angry outbursts, which she experienced as so caring.

In effect, then, to reduce the theoretical understanding of this therapeutic effect to a mirroring selfobject experience triggered by a countertransference reaction may give insufficient substance to other ways of understanding how it happened. This perspective also does not take into account the therapeutic specificity of emergent process between that therapist and that patient, which offers a new conceptualization of transference and countertransference.[5] In this regard, what may be at

[4] Sampson, H. & Weiss, J. (1986). *The Psychoanalytic Process.* New York: Guilford.

[5] See the following two sources: (1) Bacal, H. (2011). *The Power of Specificity in Psychotherapy: When Therapy Works—and When It Doesn't.* Lanham, MD: Rowman & Littlefield; and (2) Bacal, H. (2015). Beyond transference and countertransference: the dyadic specificity of psychoanalytic process. Paper presented at the 38th annual conference of the International Association of Psychoanalytic Self Psychology, Los Angeles, October 17.

least as therapeutically significant as the application of self psychology and other constructs to the treatment of patients described in this book is Steinman's ability to be with these particular patients empathically and to respond to them optimally. I will say more about this in a moment.

In contrast to the book's unique assertion that psychosis can be effectively treated by applying self psychology concepts, it is generally known—although the authors do not mention it—that Kohut regarded borderline patients as untreatable. Kohut was implying that, with such patients, one cannot carry out the necessary first step—that is, adequately empathizing with the patient's subjective experience—because borderline patients are too fragmented. Psychotic patients, by implication, would be even less accessible due to their severely fragmented states.

From the evidence presented in this book, Kohut would seem to have been wrong. When he asserted that such patients could not be treated with his approach, he was likely thinking of himself as the treating clinician and perhaps of his sense of his colleagues' limitations. But he had presumably not yet met anyone as intuitively empathic as Steinman.[6]

Interestingly, Garfield and Steinman quote Kohut's declaration that: "If you really can achieve empathic access to psychosis, psychosis in one sense has ceased to exist" (p. xxiv). Is it possible that Steinman is not only an unusually empathic therapist, but also someone who can respond therapeutically to such patients? I suggest that the latter ability constitutes a separate skill. The two—empathic attunement and optimal responsiveness—are not necessarily identical, as I shall describe and as Steinman's clinical examples illustrate.

A central—and remarkable—message that Garfield and Steinman seem to be conveying to psychotherapists who would treat psychotic patients is that, if the clinical approach is based on self psychological concepts, not only could all such patients be cured, but also that all therapists could effect such cures. The authors tell us, for example, that the skill required to speak schizophrenese and to make sense of psychotic productions (such as through the ability to understand the patient's sym-

[6] While both authors of this book offer illustrations of their clinical work, Steinman's appear much more prominently; my comments on clinical work described in this book are based upon his illustrative examples.

bolism in hallucinations and delusions[7])—which Steinman illustrates—is essential in treating these patients effectively, and that it is an easily acquired skill.

With all these points, I must respectfully disagree—at least with regard to my own experience, as well as the experiences of many bright colleagues and of many capable students whose work I have supervised over the years. I worked with Kohut in the late 1970s and studied with a number of his first-generation self psychology colleagues for several years. Self psychology has continued to usefully inform my treatment of a wide range of psychological disorders, and I have never been dissuaded by Heinz's pessimism that his new self concepts were ineffective with seriously fragmented patients. On the contrary, I have applied them with some success in working with these patients.[8] Yet not infrequently, I have found myself struggling to attend affectively, and/or to respond effectively, to psychotic patients. I suspect that more than a few well-trained—even self psychologically well-trained—analysts (besides Kohut himself) cannot do this work at all.

I will not invoke the extreme caveat offered by those who, after demonstrating amazingly impressive accomplishments, may caution, "Do not try this at home!" On the contrary, there is ostensibly no reason for any of us not to try applying Garfield and Steinman's promising ideas in our own clinical work. Nevertheless, it may be that Steinman has a special ability for this that is not only remarkable, I suspect, but also relatively uncommon—and possibly essential—in order to treat these patients effectively, although he identifies a number of other clinicians who are, famously, skilled in similar ways.

There are multiple explicit indicators about how and with whom Steinman's skills in working with these patients were nourished and honed, and about what may have strengthened his professional self[9]

[7] The authors regard delusion from the perspective of self psychology—that is, as an attempt to repair a narcissistic deficit.

[8] Bacal, H. (1981). Notes on some therapeutic challenges in the analysis of severely regressed patients. *Psychoanal. Inquiry,* 1:29-56.

[9] In the following source, see the description of the strengthening of the therapist's *professional ego* through significant interpersonal contact: Balint, E. (1967). Training as an impetus to ego development. *Psychoanal. Forum,* 2:255-270.

to enable him to persist in responding to situations that many, perhaps most, psychodynamically oriented therapists would experience as beyond what they are able to tolerate and/or too disruptive to address therapeutically. In addition to having extensive, wide-ranging clinical experience with psychotic people, Steinman has worked and studied with some of the most prominent clinicians and theoreticians in the field in the United States and Great Britain, over many decades.

Furthermore, Steinman is not only especially talented, trained, and tolerant when it comes to interacting with psychotic people and helping them reclaim their wholeness; he was also a virtual self psychologist even before he encountered and assimilated Kohut's selfobject theory. "[I learned] that there was a whole person who needed to be treated . . . . To me, the self was supraordinate" (p. xix), he writes. His grasp of self psychology concepts would seem to have effectively expanded and to some extent structured his understanding and responsiveness to these patients.

Although self psychology concepts usefully inform my own work, as mentioned, they are not the only ones that emerge with central relevance. Let me provide some clinical material to illustrate this. I have been seeing a paranoid schizophrenic woman several times a week for a number of years.[10] She attends her sessions regularly and clearly values our relationship, which both of us experience as warm, respectful, friendly, and carefully close. Dina is interested and curious about me and my family, some of whom she sees from time to time, since my office is next to my home. I have had no difficulty answering questions Dina has about them, and she clearly appreciates my responses.

During most of her time in treatment with me, Dina has not been overtly psychotic. To all appearances, she is an eccentric, clever, nice, middle-aged lady who is a bit reclusive, somewhat sensitive, and a little "paranoid." A few years ago, however, when Dina was refusing to take medication, she became suicidal and acutely psychotic, with the most florid persecutory delusions and hallucinations—in every sensory modality—that I have ever witnessed, including during the years I worked on locked psychiatric wards.

[10] For a more detailed account of this treatment, see pp. 94-100 of the first source in footnote 5.

Now Dina's demons stay mostly in the background, but they are not gone; and I believe she would be right back in hospital if she were not now regularly taking a fairly high dose of Clozaril. While she is somewhat plagued by the possibility of impending calamity, and must sometimes take Klonopin at night, she feels much safer than before. What has emerged as pivotal for Dina in her experience of my helping her is not the relevance of selfobject transferences, but rather her sense that I understand her struggle to allow the relational intimacy she longs for with people, and the particular dangers she faces in attaining this. I touch on this in our sessions as it manifests in the transference, but only lightly, because keeping the optimal psychic distance/closeness in relation to Dina feels to me to be crucial. It is centrally important to Dina that I apprehend how a deep-going "self-sensitivity" to certain behaviors of others—the ways in which she is affected by certain kinds of people—makes life hard for her.

Harry Guntrip (arguably, a self psychologist in the way that Steinman was, early on[11]) would have framed Dina's plight as a kind of *schizoid dilemma*. She lives alone and for the most part stays alone, except for coming to her sessions, visiting her sister occasionally, driving to the market once a week, and getting her hair done. Her hairdresser has become a long-standing "nonfriend friend"—that is, someone with whom she especially experiences her central conflict.

When Dina feels the wish to reach out for close relatedness, she experiences a serious threat to her sense of self due to the conviction that she would either be ignored or overwhelmingly invaded by the other's needs, or materially robbed by them (when she was psychotic, perceived invasion of her was by poisonous toxins that were destroying her flesh via bizarre conduits). An intense conflict has been constituted by the usurping threat to the integrity of her self in allowing others to come close—especially certain people to whom she is particularly drawn—and by the terrible aloneness consequent upon her need to self-protectively withdraw from interpersonal connection. One might say that Dina lives a "manageably" lonely life.

[11] Bacal, H. & Newman, K. (1990). *Theories of Object Relations: Bridges to Self Psychology*. New York: Columbia Univ. Press.

In retrospect, I saw that when Dina fled into suicidal psychosis, she was unable to manage—without medication—the painfully disruptive intensity of a deep but completely unacceptable longing for intimacy with me, nor could she handle her despair that I could neither fully validate the concrete reality of her delusions nor adequately apprehend the pain inflicted by her persecutors. Furthermore, I would not help her escape in the only way possible—by doing away with herself.

Because of her severe suicidality and her refusal to take medication, Dina's outpatient therapy was interrupted and she was hospitalized. She returned to me some time later, in remission after having received ECT and now taking Clozaril.

There are indications, from our conversations and from Dina's feelings and mine in various contexts, that mirroring, idealization, and twinship selfobject experiences continue to come therapeutically into play—that they are helping Dina develop a more coherent, enhanced sense of self. Yet I also believe that maintaining the stability of our relationship is of equal importance. This depends both upon her continuing to take Clozaril and upon our tacit recognition that we need to proceed wisely and judiciously, considering very seriously the limitations we may have to accept regarding her wish to establish close relationships that are safe as well as self-enhancing.

It is not only so very important that we, as psychoanalytic therapists, are able to *empathize* with the subjectivity of our patients—even sometimes to the point that they can feel we feel what they feel, as Garfield and Steinman recognize[12]—in order to be truly therapeutic, but also that we can *respond optimally* to the patient's therapeutic needs. Our ability to do both, in the moment and over time, will be specific to the capacity of the particular patient–therapist couple. My sense is that the authors of *Self Psychology and Psychosis* may be optimistically generalizing the capacities of their colleagues both to empathize and to respond optimally to psychotic patients.

I am certain that I have not fully empathized with or responded to the complexities of this fascinating book. And I have not been able to

[12] Herzog, B. (2016). Establishing the therapeutic impact of empathy through "affect sharing." *Int. J. Psychoanal. Self Psychol.*, 11:152-168.

answer adequately one of the cardinal questions required of a reviewer: do the authors convincingly demonstrate their apparent intent with this book—in this case, that a self psychologically based treatment is the most effective way of working with psychotic patients?

The richness of the book's clinical examples suggest to me that much more is going on therapeutically that cannot be completely conceptualized in terms of selfobject transferences. In order to validate their thesis, we need to find out, as psychoanalytic therapists, whether we can repeat—or even come close to—the authors' impressive accomplishments by utilizing self psychology concepts in our own work. My central questions remain: how much of their success is due to the application of self theory and other constructs (which they do utilize), and how much to the talent and tolerance of a particular therapist (such as Steinman) and to the therapeutic possibilities of the particular patient–therapist pair?

This book is relatively short in its page count: 146, plus additional pages that make up the preface, introduction, prelude, and entre. Nevertheless, it is so abundant in theory and clinical data that it feels like a big book that demands close study if its precepts are to be adequately tested, even by clinicians who have experience doing psychotherapy with psychotic people. Those who would like to apply the approaches utilized by Garfield and Steinman might wish to consider consulting directly with the authors around their own patients. We then need to hear from these therapists, too, in order to get a sense of how much Garfield and Steinman's remarkable work with such patients is usable, and whether other clinicians can achieve such positive results by applying self psychology constructs in treating their own psychotic patients. Systematic outcome research, of course, would also be welcome.

HOWARD BACAL (LOS ANGELES, CA)

CONTEMPORARY PSYCHOANALYSIS AND THE LEGACY OF THE THIRD REICH: HISTORY, MEMORY, AND TRADITION. By Emily A. Kuriloff. New York: Routledge, 2013. 200 pp.

The human race, throughout the course of its history, has suffered periods of unspeakable savagery and abomination. This book is about the

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The human race, throughout the course of its history, has suffered periods of unspeakable savagery and abomination. This book is about the

well-documented and much-studied period of large-scale terror and sorrow that constituted the Holocaust.

Emily Kuriloff, an analyst trained in the interpersonal/relational school of psychoanalysis, begins with a personally meaningful thesis: that there has been denial among immigrant Jewish psychoanalysts of the effects of the Holocaust and that this denial created rigidity and authoritarianism in postwar psychoanalytic theory, particularly ego psychology. The book is also a very personal account of someone who has seen, heard, and sensed the misery wrought by Holocaust trauma in families, colleagues, and patients. Its methodology involves interviews with a number of analysts in several parts of the world, as well as the scholarly study of original and secondary source material on a variety of historical, social, and psychoanalytic topics.

The author begins with an early awareness of the pitfalls of overgeneralization:

> To apply any single interpretation to a complex period in history, including the interpretation that European psychoanalysts dissociated the impact of the Holocaust, discourages freedom of inquiry. Moreover, it tends to result in a bogus psychohistory in which an interpretive template is simply slapped over the data, willy-nilly. [p. 4]

Kuriloff includes in her methodology the importance of reading between the lines, and she levels a steady and perceptive gaze at the offhand comments and marginalia with which she comes in contact. She feels that offhandedness and informality result in candor. In her experience with source material and interviews, she has found that safe moments of openness occur regularly, as compared to their relative infrequency in structured interviews and transcripts, where defensive walls tend to be present. The author also asserts that revelation of hidden or warded-off information is optimized in the interpersonal and relational mode of psychoanalysis, which uses such tenets as co-construction and interactional engagement. She feels that, in contrast, classical theory and technique are top-heavy, clichéd, and expectable, and restrict rather than free up discourse.

Kuriloff is open about the personal nature of her motivations that led to the writing of this book. Using her experience of her own family, as well as conversations with other analysts and their patients, she feels that analysts who denied the effects of the Holocaust used an unchanging theoretical rigidity to protect themselves against memories of traumatic change and to survive in the new cultures to which they escaped. The leitmotif is that émigré analysts, for reasons of trauma—and, to a smaller extent, the cultural expectations of the time—chose to emphasize adaptation and optimism, so as to embrace a safe but new world; but just as surely, they chose to disavow their collective and individual trauma.

This is an ambitious and at times absorbing work. Along with its principal thesis, it touches on many of the great issues of our time: the lingering effects of massive trauma; links between trauma and adaptation; the historical and cultural roots of psychoanalysis; the influence of American society and culture on analysts who came from the Old World; theory-building as mastery of personal trauma; the multinational, multicultural, and multigenerational roots of Jewish life; and the theory wars in contemporary American psychoanalysis. A valuable bonus is the book's guided tour of European history and sensibilities.

The writing is eloquent, scholarly, and highly personal. The carefully researched notes and addenda, which are invariably pertinent and pithy, are a particular pleasure for readers who want to follow up on one or another detail.

Of immediate interest to the reader are the author's interviews with many well-known analysts. They include Martin Bergmann, Harold Blum, Jack Drescher, Edgar Levenson, Otto Kernberg, Anton Kris, and Anna Ornstein, and several others in France, Germany, and Israel. The interviews are notable for open dialogue and sometimes quite detailed histories of survival and personal triumph against tall odds. All the interviewees are generous in reflecting on their professional and personal life trajectories. Notably, almost all caution the author against drawing definitive conclusions by underscoring the complexity of lived lives, as well as the interplay of cultural, social, and adaptive issues and the psychological pressures that shape each individual.

The lives and ideas of Heinz Kohut, Otto Fenichel, Heinz Hartmann, and Henry Krystal round out the examination of analysts who either res-

olutely identified themselves as traumatized, or who equally resolutely saw their Jewish identity as secondary to a host of cultural, linguistic, and national identities. The author examines in detail the need to forget and disavow, as well as to engage in life-sustaining mythopoiesis—specifically, mythic experiences of being above the fray, she contends, or of imagining an all-too-perfect world that existed before the Nazi scourge began. Although empathic and understanding of the plight of all those affected by the Holocaust, the author's admiration and sympathies lie primarily with those who openly acknowledge their traumatic past.

Kuriloff's chapter on methodology considers the perils of psychobiography. It contains a pithy survey of relational theorists and their contributions to meaning making in the crucible of a relationship. She takes to heart the many possible criticisms of the book's thesis and gently reminds the reader that, based on her own findings, her hunch about the power of denial is still valid. Some may find her ideas speculative, but all will find them intriguing and thoughtful. For example, the author speculates that the death drive was minimized—sanitized by émigré analysts eager to meld with the positivist American outlook and to leave behind the darker forces they had escaped in the homeland.

She writes at length about anti-Semitism as fueling the Controversial Discussions between Anna Freud and Melanie Klein and their respective followers. This fiercely fought battle was, on the surface, all about theory and technique. But the uninvolved observer could say later on, from the author's perspective, that the emperor in the Controversial Discussions did not have on many clothes! German bombs were going off right next to them, anti-Semitism was rife and barely held in check in their adoptive country, English language and culture were moderately oppressive, and even the rules of debate were a mystery to the émigré analyst. Kuriloff feels that immigrant pathos, alienation, and fear were papered over by lofty yet bitter battles about what was "psychoanalytic," as if both parties to the controversy were holding on to a glorified past.

These ideas are stimulating, disturbing, and plausible. Much of the evidence is based on individual recollection or comments. The evidence for hidden anti-Semitism is quite convincing, while I find less convincing the evidence for concluding that the Freud–Klein controversy was in part based on the scourge so close to home.

A section of the book tackles the complexities of understanding second- and third-generation analysts and of the multiple cultural identities that individuals may take on in a given society. German and Israeli analysts speak about postwar affiliations and marriage between Jews and Germans, for example, and the complicated efforts of patients and analysts to separate personal and historical facts in finding a balanced yet reality-based relationship with one another and with history.

Similarly, the author finds analysts making public pacts with Nazis, yet privately supporting and even saving the lives of Jewish colleagues and friends. This book shows that long before the advent of globalization and the creation of the media-driven individual with contingent identities, the European of the last century was shaped by a host of both intrapsychic and external factors—just as individuals are today. In the era immediately after the Holocaust, common to this challenge to the integration of the personality were strivings toward upward mobility, the need to make the right social and political connections, and the wish to live life in an expectable way, without—as happened for many—a terrifying darkness suddenly taking away everything.

Amidst this rich and nuanced material, I found certain methodological issues of concern. The author's assumptions seem popular or intriguing, but on closer examination are worthy of more research. She assumes that Holocaust trauma is always traumatic to a modal individual of the time; yet such an individual does not exist, even by her own account. There are individuals whose trauma was sharply delineated by class upheaval; others by displacement into foreign lands; others by incalculable personal losses; and some by experiences of cruelty and physical privation. The findings in this book parallel—not unsurprisingly—the psychoanalytic findings that an anthropologist friend of mine, upon hearing about the very personal and idiosyncratic nature of each analysis, pronounced an example of *radical particularism.*

In the domain of psychoanalytic theory, Kuriloff makes the assumption that Hartmann's ego psychology, and ego psychology in general, is authoritarian, but she does not provide evidence of this. She occasionally equates drive theory with a lack of empathy or seems to feel that ego psychological and interpersonal approaches are incompatible. For this reviewer, these issues of apparent differences among theories call for a

more careful attempt at integration of language and concepts, both in this book and more generally in psychoanalytic theorizing.

Contemporary Psychoanalysis and the Legacy of the Third Reich will make every reader ponder once more the cultural and personal matrix in which he or she grew up. It is a reminder of the sacrifices of our analytic forbears and the need to honor them by critiquing their theories gently as well as honestly.

DWARAKANATH G. RAO (ANN ARBOR, MI)

KARL ABRAHAM: THE BIRTH OF OBJECT RELATIONS THEORY. By Isabel Sanfeliu; translated by Kate Walters. London: Karnac Books, 2014. 368 pp.

When Karl Abraham died on December 25, 1925, he was forty-eight years old. On that day, the international psychoanalytic movement lost one of its most important people: the president of the *Internationale Vereinigung Psychoanalytische* (the International Psychoanalytical Association) and of the *Berliner Psychoanalytische Vereinigung* (the Berlin Psychoanalytic Society). Abraham was one of the most valuable training analysts of the latter organization; among his trainees were Edward Glover, James Glover, Karen Horney, Melanie Klein, Carl Müller-Braunschweig, Sándor Radó, Theodor Reik, and Ernst Simmel. Abraham was also a member of the so-called Secret Committee, an avid explorer of the early stages of libidinal development and character formation, a respected clinician, and a fine theorist interested in the study and treatment of major depressive psychopathology. To express his deep regret at this profound loss, Sigmund Freud wrote to Abraham's widow: "I have no substitute for him, and no consolatory words for you."[1]

I started to study the life and work of Abraham in the 1970s, when his scientific papers were translated from German into Italian,[2] and

[1] Falzeder, E., ed. (2002). *The Complete Correspondence of Sigmund Freud and Karl Abraham, 1907–1925*. London: Karnac. Quotation is from p. 568.

[2] Castiello d'Antonio, A. (1981). *Karl Abraham e la psicoanalisi clinica.* [*Karl Abraham and Clinical Psychoanalysis*]. Rome, Italy: Bulzoni.

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When Karl Abraham died on December 25, 1925, he was forty-eight years old. On that day, the international psychoanalytic movement lost one of its most important people: the president of the *Internationale Vereinigung Psychoanalytische* (the International Psychoanalytical Association) and of the *Berliner Psychoanalytische Vereinigung* (the Berlin Psychoanalytic Society). Abraham was one of the most valuable training analysts of the latter organization; among his trainees were Edward Glover, James Glover, Karen Horney, Melanie Klein, Carl Müller-Braunschweig, Sándor Radó, Theodor Reik, and Ernst Simmel. Abraham was also a member of the so-called Secret Committee, an avid explorer of the early stages of libidinal development and character formation, a respected clinician, and a fine theorist interested in the study and treatment of major depressive psychopathology. To express his deep regret at this profound loss, Sigmund Freud wrote to Abraham's widow: "I have no substitute for him, and no consolatory words for you."[1]

I started to study the life and work of Abraham in the 1970s, when his scientific papers were translated from German into Italian,[2] and

[1] Falzeder, E., ed. (2002). *The Complete Correspondence of Sigmund Freud and Karl Abraham, 1907–1925*. London: Karnac. Quotation is from p. 568.

[2] Castiello d'Antonio, A. (1981). *Karl Abraham e la psicoanalisi clinica.* [*Karl Abraham and Clinical Psychoanalysis*]. Rome, Italy: Bulzoni.

when his daughter Hilda published an "unfinished biography" of him.[3] During that period, his work was translated and republished in English in two volumes[4] and later in French. More recently, Ernst Falzeder edited a new version of the letters exchanged between Freud and Abraham, publishing a book of more than 600 pages (see the source in footnote 1). Although an earlier collection of these letters had been published, it was incomplete.[5]

The author of *Karl Abraham: The Birth of Object Relations Theory,* Isabel Sanfeliu (whose full name is Isabel Sanfeliu Santa Olalla), is a psychologist and psychoanalyst. This book derives from her doctoral thesis at the Universidad Autónoma de Madrid in 2000. It examines the broader aspects of the evolution of psychoanalytic thought, focusing on Abraham's contribution to the development of object relations.

The work is divided into four sections, the first of which contains a comprehensive analysis of the historical and cultural context in which Abraham lived (a theme taken up again in the final pages via a series of biographical sketches of the leading analysts of the time) and to a quick survey of Abraham's personal life. His time in Zurich (1904–1907) and his residence in Berlin—the city where he became the first analyst to engage in regular clinical practice—are discussed. Passing over the World War I years, the author moves to the opening of the Berlin Psychoanalytic Polyclinic in February 1920—though after this period, only minimal biographical information is provided.

The second section of the book is devoted to Abraham's theoretical contributions, which formed part of the background of the vicissitudes of the international psychoanalytic movement. Here attention is paid to Abraham's works in the area of applied psychoanalysis—i.e., his studies on mythology and linguistics, as well as a psychoanalytic biography of the painter Giovanni Segantini.

[3] Abraham, H. C. (1974). An unfinished biography. *Int. Rev. Psychoanal.*, 1:17-72.

[4] Abraham, K. (1955). *Clinical Papers and Essays on Psycho-Analysis.* London: Hogarth, 1979; and Abraham, K. (1927). *Selected Papers of Karl Abraham, M. D.* London: Hogarth, 1988.

[5] Abraham, H. C. & Freud, E. L., eds. (1965). *A Psycho-Analytic Dialogue: The Letters of Sigmund Freud and Karl Abraham, 1907–1926.* New York: Basic Books.

Following these short chapters, some comments are provided on the work of Abraham within the *Berliner Psychoanalytische Vereinigung* and his activities as a training analyst and supervisor. With much more detail, Sanfeliu examines his work on the evolution of libidinal stages. This work, dating back to an early paper,[6] is viewed as the basis for the development of object relations theory. Perhaps not everyone would agree that the roots of object relations theory can be traced to such an early time, instead finding the true foundations of this theory in Abraham's later work on the very early stages of pregenital libidinal development, which was published simultaneously with the third edition of a landmark contribution of Freud's.[7] In fact, Abraham's most important contributions are often deemed to be those written between 1916 and 1924, seen as a bridge to later elaborations of object relations theory.

The final part of Sanfeliu's book, entitled "Abraham, the Object, and Psychoanalysis," offers the reader a view of Abraham's work as the precursor of object relations theory. Sanfeliu writes:

> With Abraham, psychoanalytic clinical practice probably reached its most refined moment. Only a simplistic reading of his works could cause us to describe his proposals as static. On the contrary, he skillfully interlinked deficits and conflicts; he distinguished between different levels in development and points of debate within a certain level. Furthermore, in any of these clinical formulations, it is possible to trace and follow the vicissitudes of the object. [p. 281]

Renewing scientific interest in Abraham's work is definitely a very good idea. However, some limitations of Sanfeliu's study must be noted. Sanfeliu scants a number of Abraham's important contributions to psychoanalysis. He called attention to the central role of aggression and ambivalence in early human development. He separated the oral phase into sucking and biting subphases, and he emphasized the significance of splitting and projection of destructive impulses in early development.

[6] Abraham, K. (1907). On the significance of sexual trauma in childhood for the symptomatology of dementia praecox. In *Clinical Papers and Essays on Psycho-Analysis*. London: Hogarth, 1979.

[7] Freud, S. (1905). *Three Essays on the Theory of Sexuality. S. E.*, 7.

As Klein's analyst, he encouraged her to undertake an exploration of the earliest, ambivalent relationship between mother and baby, which led her to elaborate her major theoretical and clinical observations. Abraham also contributed to our understanding of melancholia and schizophrenia.

Furthermore, the book's bibliographical sources are limited in that the author did not take into account contributions by others who wrote about Abraham in German and whose work has not been translated. These include not only the contributions of leading contemporary psychoanalysts such as Johannes Cremerius, but also the many interesting writings published in the *Internationale Zeitschrift für Psychoanalyse* at the time of Abraham's death. The latter were authored by the most important analysts of the time, such as Eitingon, Radó, Reik, and Sachs. Sanfeliu has neither examined the many exchanges and debates between Abraham and other analysts concerning theoretical and clinical problems discussed during those years, nor—with one exception—has she taken into account references to Abraham's work in psychoanalytic dictionaries and encyclopedias.[8] Moreover, she does not mention the numerous writings of Abraham himself that have not been translated and are therefore available only in German.

I also feel that Sanfeliu placed insufficient emphasis on Abraham's professional background, in that he was one of the few analysts of the first generation to have had direct experiences with hospitalized psychotics (during his activities at a psychiatric clinic in Zurich, the *Burghölzli*), which allowed him to make decisive contributions on the psychodynamics of profound manic-depressive states. He also framed what was then called *dementia praecox* in a different, original light with respect to Jung's formulation.

When we consider classical psychoanalysis today, the first name that comes to mind (after Freud's, of course) is Abraham's. But seeing him as merely "orthodox" would be a great mistake (an error that, incidentally, was not made in regard to Ferenczi, whose work has been reassessed in recent decades). In fact, Abraham, whose published scientific work was

[8] The exception is the following source, which Sanfeliu cites: Laplanche, J. & Pontalis, J.-B. (1967). *The Language of Psychoanalysis,* trans. D. Nicholson-Smith. London: Hogarth, 1973.

not particularly voluminous, consistently started from his clinical experiences in building his theoretical ideas. He developed broad concepts and lines of inquiry far more extensive than his more specific contributions to what would later be called relational theory.

In my view, despite the noteworthy contribution by his eldest daughter, Hilda (see footnote 3)—herself a psychoanalyst—and despite Sanfeliu's book, Abraham and his work have yet to be thoroughly examined and appropriately placed within the broader psychoanalytic literature. An account of his very interesting professional relationships with colleagues, especially Ferenczi,[9] would only enhance a comprehensive analytic tribute of this type.

ANDREA CASTIELLO D'ANTONIO (ROME, ITALY)

THE PROMISE: WHO IS IN CHARGE OF TIME AND SPACE? By Leonard Shengold. London: Karnac Books, 2015. 192 pp.

A distinguished figure in psychoanalysis, Leonard Shengold is the author of a number of publications detailing his extensive clinical practice. In particular, he is well known for his conception of *soul murder* (the consequence of early trauma or severe deprivation) as a pervasive element in the histories of severely troubled patients—and, indeed, of many sufferers who do not or cannot benefit from psychoanalytic therapy. The present collection of essays covers a wide spectrum of personal experience, ranging from an unusual measure of autobiography (unusual for a psychoanalyst, that is) to exercises in literary criticism, opera, and classical philosophy—revealing him to be a diversified scholar as well as a humane therapist, all in the Freudian tradition.

Much of the author's attention is devoted to description of the normal developmental process from birth (or even earlier) through early narcissism, fostered ideally by the infantile relationship with the mother at her breast, followed by the process of separation-individuation

[9] Castiello d'Antonio, A. (1983). Note storiche sull'attività scientifica e organizzativa di Karl Abraham e Sándor Ferenczi [Historical remarks on the scientific and organizational activities of Karl Abraham and Sándor Ferenczi]. *Giornale Storico di Psicologia Dinamica,* 7(14):71-87.

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(without credit to Margaret Mahler, incidentally) and the growing engagement of the father, leading, as in the classical schema, to the evolution of the Oedipus complex and its ultimate resolution. It is, Shengold maintains, the all-too-frequent deviation from this normative pattern that is accountable for most psychic disorders, from neuroses to the profound, often untreatable level of soul murder.

Characteristic of Shengold's critical judgment is his psychobiographical chapter on Virginia Woolf. He has clearly read all she published, together with a wide range of critical and biographical material. The consequence is a sensitive interweaving of literary and psychoanalytic observations, concluding with his own reflections on the theme that pervades his work: the central and universal role of the Oedipus complex and infantile rage in both clinical and literary constructions, into which he incorporates both Woolf's writings and her tragic, suicidal end.

Equally impressive is Shengold's extensive survey of the life and work of Vladimir Nabokov, whose contempt for Freud and psychoanalysis does not deter him. He points out numerous appearances of oedipal situations in the author's writings (most notably, of course, in *Lolita*[1]). Clearly, Shengold respects and admires Nabokov as a literary master, but takes pains to point out his "murderous impulses" "displaced onto . . . creative competitive fraternal rivals," such as Saul Bellow and John Updike—and, occasionally, even Dostoevsky and Shakespeare (p. 74). In the end, however, Shengold concedes that, Oedipus or no, "alongside being a good hater, Vladimir Nabokov could be a good, loving man" (p. 75).

Several chapters are devoted to discussions of the effects of holidays—civil and religious, Jewish and Christian—on the analytic situation in general and on the author and his patients in particular. The intensity of the transference and countertransference in the context of holiday interruptions makes these events appear extremely delicate, even hazardous—perhaps generating in the younger-analyst reader a measure of anxiety that is likely, in most cases, to subside with experience. And one wonders at the frequency suggested by Shengold of the arousal of primal scene memories or fantasies in children watching the traditional 4th of July fireworks, usually in the company of their parents.

[1] Nabokov, V. (1955). *Lolita.* New York: Random House, 1989.

In essence, *The Promise* is a thoughtful, richly articulate, and often lyrical expression of the life and work of a very practiced and learned analyst eager to bring to his colleagues, young and old, the fruit of both his professional and personal life. One might wish for him to engage in an extended discussion of his views on the respective merits of the classical Freudian system, to which he is clearly devoted, and those of some of the more recent theoretical and clinical approaches that now pervade the psychoanalytic world. But for this we can but wait.

AARON H. ESMAN (NEW YORK)

THE GIRL WHO COMMITTED HARA-KIRI AND OTHER CLINICAL AND HISTORICAL ESSAYS. By Franco Borgogno; translated by Alice Spence. London: Karnac Books, 2013. 430 pp.

Scholarly books and papers are written at least in part to stimulate discussion among the author's peers. In this book, that intention is taken a step further, as Franco Borgogno, following the presentation of one of his early cases, responds to commentaries he has requested from a number of well-known psychoanalytic thinkers on the clinical material presented. This is an unusual and potentially interesting approach as it allows the reader to appreciate the thinking of such psychoanalysts as Neil Altman, Alina Schellekes, Theodore Jacobs, and Carlos Nemirovsky, among others, as they consider Borgogno's work and offer their own perspectives.

As a read, this is a wonderful opportunity to be in the trenches with other psychoanalysts, listening to the clinical material and observing the evolution of Borgogno's theoretical perspective. My single complaint is that at times the material feels tedious and repetitious, in part because so many of the contributors seem quite close to each other in their outlook and psychoanalytic bent.

In perhaps an unintended consequence, *The Girl Who Committed Hara-Kiri* serves to highlight how far many contemporary analysts, both here and abroad, have strayed in their practices from a "classical" Freudian perspective. In the course of treating his patient, M, a severely

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In perhaps an unintended consequence, *The Girl Who Committed Hara-Kiri* serves to highlight how far many contemporary analysts, both here and abroad, have strayed in their practices from a "classical" Freudian perspective. In the course of treating his patient, M, a severely

depressed and withdrawn young woman, Borgogno becomes increasingly focused on redressing what he terms *interpsychic* trauma, with the aim of restoring her basic trust in herself, in him, and in others. Admittedly, taking into account M's initial presentation, she is greatly aided by the analysis, but due to the exclusive focus on *psychic restoration*, her treatment appears nonetheless to represent only a partially successful outcome. As Jacobs puts it in commenting on Borgogno's clinical approach:

> [This] reparative stance fosters . . . vitality, joy, warmth . . . [but] cannot replace what has not developed in childhood, and in that sense cannot be truly corrective . . . . [However, it can] . . . allow for the . . . integration of new . . . values and help modify the older negative views of self and others. [p. 73]

For its author, *The Girl Who Committed Hara-Kiri* represents a long psychoanalytic journey. It is clear that Borgogno, like many of us who take this special life task seriously, has thought deeply about his patients and sought to understand the sources of their distress. The treatment of M, occurring early in Borgogno's career, forced him to make clinical and theoretical decisions that would profoundly and decisively alter his thinking. As he puts it, M was for him a special patient—"undoubtedly a source of inspiration [who represented] a fundamental crossroads on my developmental journey as a man and an analyst" (p. xxi).

M was a 25-year-old woman who came to see him in a state of deep depression, saying, "My life . . . has been invaded by something macabre, a shadow or a black hole." Although Borgogno notes that her academic studies had previously come to "a complete standstill . . . and she had felt very 'blocked and lonely'" (p. 5), he marks the beginning of her illness as concomitant with a fall from a horse in which she sustained a pelvic fracture.

In her first session, M brought in the following dream:

> A Japanese person of uncertain identity was committing harakiri in a cloister and wanted me to see it. So I started to run but this person followed me, and every now and then caught up with me, arch after arch, collapsing on the floor with the intestines coming out. I was horrified and disgusted. [p. 6]

Borgogno reports that following this initial encounter, M became, for the better part of the next four years, virtually mute and massively noncommunicative. The analysis, other than the patient's reports of a few dreams and some unusual dramatic daydream material, consisted of profound silences punctuated only by her groans and bodily movements on the couch. As might be imagined, Borgogno describes his intense frustration, mimicking M's in the manifest dream, as he attempted to engage his patient using only his intuition of her unspoken affective state.

Early on, in large part as a result of this first dream, Borgogno had the idea that M was convinced she was not supposed to have been born. Later, he learned that both her parents had lost their fathers in early infancy, as had their own parents. In Borgogno's view, this shared, unspoken parental fantasy/*idée fixe* regarding the consequences of M's birth would have profoundly influenced their capacity to love their child. Mother, herself a silent and withdrawn woman, had tried several times to abort her babies; both parents, as characterized by M, seemed too beaten down, too depressed and financially oppressed to reflect any real joy in M's existence. Borgogno diagnosed M as suffering from a deep schizoid withdrawal caused by her parents' inability to offer what he calls "parental transmuting reverie" (p. 8).

As Borgogno struggled with this difficult patient, he increasingly came to feel that interpretations made from an intrapsychic, "classical" or Kleinian perspective were simply ineffective. Clinical impasse in the face of what he understood to be centrally a consequence of severe early trauma and deprivation led him to seek out other psychoanalytic models, beginning with the work of Ferenczi and moving on to that of Winnicott, Bion, Balint, and others.

It was Ferenczi who first underscored the link between a patient's *psychic reality* and his *actual reality,* and who emphasized the effects of pathological identification in severely traumatized patients. In Borgogno's words:

> 1. What patients want and what some of them literally need—as was stated by Ferenczi in his *Clinical Diary* (1932b) and after him by Bion in *Cogitations* (1992)—is to experience "live" during the treatment how the analyst feels, manages, and

works through the interpsychic events at the root of their affective and mental suffering;

2. This type of experience is needed especially for those schizoid patients who, during childhood, were profoundly deprived on an affective level. [p. 4]

It became Borgogno's strong conviction that M (and other patients similarly damaged) required an experience of him as a *real object*—a real, flesh-and-blood person beyond his "mere" existence as her analyst. This meant to him that he needed to fully bear M's rage, aggression, and pain and to endeavor to use his own "innards" to digest her distress, until such time as she could do this for herself. For him to remain in a classically neutral position, rather than being helpful or curative, would be "algogenic" (p. 244).

As he worked with M, Borgogno identified a dominant, intense, oscillating "role-reversal" transference, which he felt to be typical of the deeply traumatized, "wise-baby" patient. At one moment, Borgogno is M as a child—abandoned, scarcely alive, un-listened to, and despairing; at another, he is the abandoning, seemingly sadistic, and cruel mother/father, demanding that M be the shadow model child—amorphous, unseen, and unheard. Both these constellations, Borgogno states, were the result of massive projections and identifications with the malignant mother-object from whom the patient had been unable to separate.

Borgogno writes that his *being real* is his "calling card" and what he wants his fellow psychoanalysts to consider in their own work. It is this emotional honesty to which M responds when—in an explosion of frustration and exasperation at a renewed bout of her negativism and isolating hatred—Borgogno expresses his feelings to her. He writes:

> Was I doing something wrong? . . . She had to help me, to give me a hand . . . . She had really identified with her mother who, M knew, hated life, while I . . . had to carry on trying to change her mother and helping her recover . . . . In reality this was not at all possible. Analysis was limited. I too had my limits. [p. 16]

Borgogno is surprised, moved, and encouraged when M responds to his plea for an alliance by saying: "If you discover that you have an effect

on people, you feel real; you feel you exist: therefore, others also exist for you and are real. This is what you give to me" (p. 16). Although this represents only one clinical moment, for Borgogno, it heralds a turning point in the slow development of M's genuine trust in her analyst, concomitant with her ability to see Borgogno as a real person with feelings of his own.

In the second half of *The Girl Who Committed Hara-Kiri,* Borgogno elaborates his theoretical perspective, which is nowhere clearer than in chapter 8, "Little Hans Updated." Here the author offers new, or at least generally unknown, information about the *actual* parental situation of Freud's little patient.[1] By several accounts, his mother, Olga Honig Graf, was borderline at best, with marked and repetitive depressive bouts. Hans's father, albeit an enthusiastic admirer and supporter of Freud, beat his children and likely sexually abused his daughter—which in turn, one might infer, contributed to her ultimate suicide. Freud, it is intimated, knew such details but chose to ignore them, using Hans's pathology to provide support for "the thriving sexuality of children and the Oedipus conflict" (p. 260).

Borgogno challenges us to consider how different our understanding of the giraffe episode in this case would be if it were considered in light of the actual physical violence to which Hans was exposed. Borgogno further implies, drawing on an interview conducted much later in Hans's life, that Freud's unwillingness to work with the patient's actual reality left him a "ghost" character—improved but condemned to exist as a shadow man, unable to embrace his own potential presence in the world. Thus, as stage director of the Metropolitan Opera house, the former "Little Hans," Herbert Graf, became "the invisible man . . . who . . . has learned 'to stay behind the scenes and leave the spotlight' to the star performers" (p. 245).

At the end of this chapter, Borgogno passionately argues that psychoanalysis is still "under construction." He writes that via a new way of listening and being with the patient, one that incorporates an interpsychic or intersubjective perspective, we can "better balance out and sift

[1] Freud, S. (1909). Analysis of a phobia in a five-year-old boy ("Little Hans"). *S. E.,* 10.

through the role played by the unconscious fantasies and history of the patients and that played by the unconscious fantasies and history of their parents, in theory and practice" (p. 263).

In general, the book's commentators on the case of M offer little of substantive controversy. Altman wonders about the role of personal history in the development of this unusual shared parental fantasy of death following birth, while Jacobs questions Borgogno's avoidance of any interpretation of M's substantial aggression. But aside from a few of what Borgogno refers to as "theoretical tics" (p. 39), there is general unanimity with his clinical outlook.

As a reader, I have my own perspective on psychoanalytic work: one that privileges the concept of psychic determinism. In general, intersubjective and interpersonal approaches have trouble incorporating the notion of intrapsychic conflict leading to symptom formation. To me, the unaddressed issue is *why M fell from her horse* and *why she subsequently appeared to fall ill at this time*. M was twenty-five when she, an accomplished horsewoman, suddenly fell from a horse. Borgogno states: "This accident, following several previous accidents that had physically afflicted *other* members of the family, triggered a depressive breakdown that had been latent" (p. 5, italics in original). It turns out that a close friend of M's had also broken her pelvis but, as M clearly stated, the friend had suffered from a congenital defective hip. Could this be an instance of "just a cigar," or does this instead suggest a masochistic enactment intended to deal with internal conflict arising in the course of M's development? To what extent was her injury an identification with parental suffering, or perhaps as well a renunciation of her desirous self, or a rivalrous/punishment response to her "sibling's" injury? In other words, what roles are played by sexual desire, self-condemnation, or competitive strivings in this woman?

My curiosity about all this finds an echo in the comments of one contributor to the book, Giovanna Regazzoni, when she writes:

> I was particularly struck by the fact that M's analysis began just after she had fallen off a horse, breaking her pelvis . . . . I considered . . . the pelvis being also that "space" which connotes feminine pleasure and fertility . . . . In M's life, it seems that there is no pleasure . . . . [I was struck] . . . that there is not

> even movement. However, inertia on horseback is impossible, and . . . the very idea of mounting on horseback would be inconceivable to someone afflicted with that [degree of] sickness of soul [claimed by Borgogno]. [p. 149]

Regazzoni goes on to wonder about why such an activity might be threatening to M and might need to be "aborted."

Borgogno hears M's initial manifest dream and thinks of her "suicidal" identification with her mother (p. 29), but what about associations to the "Japanese person"? The dream's apparent setting, Japan, makes me wonder about the patient's defensive need to move the "seat of action" to another land, which is echoed in much of the later fantasy/daydream material—a land dominated by rigid cultural norms, rules of self-control, and struggles with shame and pride. What can we make of a person "of uncertain identity"? Is this a possible self-image . . . does M identify herself as a man, a Samurai warrior who needs to disdain fear of death while omnipotently orchestrating his annihilation? (At one point, M tells Borgogno of her childhood fantasy of herself as Alexander the Great.) What about the word *disgusted,* which could apply equally to M's reactions to her intestines and her womb? Is this dream, then, centrally about M's conflicted feelings about femininity and procreation?

Borgogno writes about M as a case of *interpsychic* trauma, uses the label *schizoid,* and argues that analytic work on her conflicts must be postponed. Repeatedly, he states that M is incapable of symbolization and awaits the birth of such a capacity; meanwhile, metaphorical thinking must be performed *by her analyst* as he processes his deep appreciation of her distress in *his* mind and viscera.

Yet M produces dramatic and organized dreams while sharing with him a series of striking daydreams and fantasies. The subjects of these

> . . . included crusades of underfed and starving children and mothers, violent medieval wars where someone was imprisoned in a dungeon . . . [and] the appearance of horrible and grotesque Martians disguised as kindly hosts who would suck one's brain out, or others who were innocent but had been wrongly accused. [p. 9]

Thus, M's images of strange, "tenebrous monasteries and bleak castles" (p. 9), their dungeons and themes of torture and courage within—aside from their clear transference references—speak to an *extraordinarily rich inner life*, and by themselves do not seem consistent with Borgogno's diagnosis.

In sum, *The Girl Who Committed Hara-Kiri* represents Borgogno's strong advocacy for a perspective that recognizes the centrality of trauma—whether in the form of overt physical abuse or simply as the effect of poisonous parenting—in the development of mental illness. In this, he takes up the cause of Ferenczi, who strongly maintained that psychoanalysis, in its preoccupation with *only* the intrapsychic, had ill served many patients. It is crucial for such a traumatized patient to have a real "other" to validate his distress and help him "disidentify himself from the depriving object" (p. 25).

There is no question that Borgogno's humanity and steadfast kindness toward M were crucial in her recovery. However, I find myself only half satisfied with his conceptualization of this case. In my view, M presented herself for treatment after arranging a masochistic genital injury in what I understand as most likely a punishment for presumed unconscious hostile and incestuous thoughts toward her rival mother and her father. Mother's masochism and M's status as a specifically unwanted child would likely make sexuality and competition exceedingly frightening; the associated affects would feel totally unacceptable for this beaten-down girl, which in turn would stimulate her love-hate bond with her depressed rival. One can understand M's fantasy of being Alexander the Great, along with her horseback riding, as part of a frantic rebellion—a counterphobic, "to-hell-with-them" stance intended to defend her instinctual life. M had clearly shown signs of despair previously, but at some point, this defensive fantasy collapsed, requiring her to fall and inaugurating her acute illness. Precisely because of a tenuous and untrusting relationship with her objects, and her severe superego sadism and a resultant fragile ego structure, M can be understood to have abandoned adult genitality while regressing to pregenital, perverse solutions, seeking masochistic injury and sadistically pushing away her object(s) of desire.

The Girl Who Committed Hara-Kiri is a valuable contribution to our psychoanalytic conversation about our work with damaged and traumatized patients. However, initial emphasis on empathy and reparation must ultimately give way to the task of uncovering and metabolizing hidden and unacceptable desires. It is through acceptance of our least appetizing and most objectionable parts of ourselves that we can achieve maximal self-expression and erotic efficacy in our lives.

DOUGLAS J. VAN DER HEIDE (NEW YORK)

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ABSTRACTS

PSYCHOANALYSIS IN CHINA: AN ESSAY ON THE RECENT LITERATURE IN ENGLISH

By David E. Scharff

Using extensive quotation, the author reviews the introduction and current state of psychoanalysis and psychoanalytic psychotherapy in China from the vantage point of recent publications in English. Psychoanalysis was briefly introduced to China before the Communist era, then forbidden, and has experienced an accelerated reintroduction since the late 1980s. The author briefly summarizes the cultural and historical background of China relevant to the introduction of psychoanalysis, the traumatic history of China, and the deep structure of thought and philosophical differences from Western culture that challenge a simple imposition of psychoanalytic ideas and practice, and some psychological effects of rapid cultural change throughout China. Training programs in China, the general enthusiasm for analysis among the Chinese, and a number of notable contributions by Western and Chinese authors are discussed. Also surveyed are the use of distance technology for training and treatment, the personal experience of Chinese senior and junior colleagues, and ongoing challenges to the continuing growth of psychoanalysis and analytic psychotherapy in China.

Keywords: China, psychoanalysis, psychoanalytic psychotherapy, psychotherapy training, cultural change, social trauma, distance technology.

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The resurgence of interest in psychoanalysis in China during the last thirty years has in some ways run counter to the attacks on psychoanalysis in the Western world. In China, beginning more than twenty years ago, specific programs to introduce psychotherapy into the mental health system were established by German and Norwegian analysts, who introduced a mixture of psychoanalysis, family systems therapy, and behavioral therapies in an evenhanded way. What seems to have inspired the Chinese mind most were psychoanalytic ideas and therapies.[1]

Psychoanalysis continues to be an exciting new venture for many Chinese professionals, both in the mental health field and in higher education. To be sure, the dominant treatment of mental illness in China, as in psychiatric fields around the world, is a biological approach featuring somatic and drug therapies. Nevertheless, interest in psychotherapy and specifically psychoanalytic therapy has been inspiring to many Chinese psychiatrists, psychologists, and counselors.

As we begin this survey, we should remember that the enormity of the Chinese population, even that of the Chinese middle class, makes this a fertile new area for the introduction of psychoanalysis. However, the introduction of analysis to any region with different ways of thinking has inevitably changed psychoanalysis itself in ways that often challenge the fundamental tenets of the day, and at the same time such an exchange brings richness that could not have been imagined in launching such ventures.

In this essay, I will survey the introduction of psychoanalysis to China programmatically and ideationally by reviewing and quoting recent publications, dividing my focus into themes that will allow the reader to see trends both in the introduction of psychoanalysis as a clinical practice with training programs that have supported it, and themes that have emerged in recent years related to the challenges of introducing an essentially Western practice into a culture with a different deep structure of thought. I will do this by reviewing some of the articles published in the last fifteen years in an attempt to abstract what they have had to say about the practical and philosophical challenges, and to cover some

[1] For a succinct summary of the factors that form the context for the introduction of psychoanalysis into China, see D. E. Scharff (2014).

areas of clinical exploration that make the introduction of psychoanalytic thinking into China such an interesting and challenging endeavor.

Although there is now a journal devoted to the topic—*Psychoanalysis and Psychotherapy in China*, which as of the publication of this essay is publishing its second volume—this venture is in its infancy. Therefore, while I will draw on that journal, I will also rely on other publications that augment this journal and have been precursors to its establishment.

This essay is divided into sections to inform the reader about: (1) the context of Chinese culture—its recent history and the current climate of rapid change; (2) the complexity and richness of Chinese thought; (3) changes in Chinese psychology and family structure; and (4) challenges and findings as non-Chinese analysts teach, supervise, and learn from Chinese students and colleagues.

THE INTRODUCTION OF PSYCHOANALYSIS INTO CHINA

Psychoanalysis was introduced to China early in the twentieth century, with Chinese translations of some of Freud's works and other early publications on psychoanalysis. China's first psychoanalytic therapist, Bingham Dai, trained in sociology in Chicago and was influenced by Harry Stack Sullivan, Leon Saul, and Karen Horney. He undertook a personal psychoanalysis before returning to China in 1935, when he began teaching and writing about psychoanalysis. He was the most visible spokesperson for analysis until he was forced to leave China in 1939 because of the Japanese invasion (Blowers 2004).

Once the Communist Party secured control of China, and especially during the Cultural Revolution from 1966 to 1976, psychoanalysis and all things Western were taboo, so its nascent influence was buried. It was not until the period of opening up after Mao's death in 1976 that it once again became possible to talk or write about psychoanalysis. Real influence began with the introduction of psychoanalysis in a more formal way in the latter part of the 1980s, and then especially with the introduction of formal training programs in the 1990s. The most important of these programs early on were the Sino-German training program under the leadership of Alf Gerlach, and later the Sino-Norwegian pro-

gram chaired by Sverre Varvin. These centered in Shanghai, Beijing, and Wuhan.

Later, the China-American Psychoanalytic Alliance (CAPA), spearheaded by Elise Snyder, became the largest of these programs, and the first to introduce the use of distance technology in the training of psychotherapists. Only then did it became possible to teach weekly classes, introduce supervision, and offer treatment to a number of trainees (Fishkin and Fishkin 2014; Gerlach and Varvin 2011; Huang Hsuan-Ying 2015; Kirsner and Snyder 2009). More recently, other programs in psychoanalytic psychotherapy in other hospitals and cities have been introduced, from Great Britain and the United States, and presentations in various other Chinese cities have made knowledge of psychoanalysis in at least a rudimentary form more widely available.

Some years ago, the International Psychoanalytical Association introduced formal training programs, at first in Shanghai and then in Beijing, made possible by the involvement of geographical Training Analysts who took up residence in these cities and offered training analyses to a small number of Chinese candidates, accompanied by classes taught by visiting members of the IPA. The first of these candidates have now graduated and are becoming a major influence in the evolution of psychoanalysis inside China.

THE HISTORY AND INFLUENCE OF TRAUMA IN CHINA

China is a multiply traumatized society. Social trauma began in the nineteenth century with the opium wars inflicted by Western countries that insisted on selling opium to the Chinese as a way of exploiting their military and governmental weakness. Mass trauma continued with Japanese invasions in the late nineteenth century and mid-twentieth century and with the collapse of the Qing Dynasty in 1907, which was followed by internal battles between the Communist Party, led by Mao, and the Kuomintang, led by Chang Kai-shek. After the Communist victory in 1949, Mao introduced the industrial "Great Leap Forward" and a program of agricultural reform that resulted in widespread starvation, followed by the anarchy and trauma of the Cultural Revolution from 1966 to 1976 (D. E. Scharff 2014).

Psychoanalyst Thomas Plaenkers and his colleagues at the Sigmund Freud Institute in Frankfurt, Germany, have written extensively about this (Markert 2011; Plaenkers 2011, 2014a, 2014b). Plaenkers has been deeply involved in teaching psychoanalysis in China from the beginning of the Sino-German program, and has overseen the only empirical research program into the effects on personality development of widespread trauma among the Chinese. He has also examined the nature of prejudice (Plaenkers, in press)—not specifically in relation to China, but more about prejudice encountered in his own clinical practice in Germany, although his writing is designed to have clear significance for the Chinese clinical audience when it is not possible to comment directly on such matters in a journal designed for distribution in China.

In an earlier publication on Chinese trauma, Plaenkers (2014a) wrote that Mao, who held sway over one-fourth of the world's population, was responsible for the largest famine in human history between 1958 and 1962, when approximately 35,000,000 to 45,000,000 people died. Then the Cultural Revolution began in 1966, resulting in mass mortality (the exact number of deaths is unknown), chaos in the near elimination of professional and leadership classes, and annihilation of much of China's traditional culture. More than 1,000,000 Tibetans died. All in all, more than 70,000,000 people died during Mao's leadership, a period in which there was no war in China.

Nevertheless, Plaenkers concluded that, despite the widespread and long-lasting series of scourges,

> . . . uniform collective trauma does not exist in China . . . . It may be a more adequate conceptualization to talk about the broad social effect of mass individual trauma. The qualitative study of individual cases facilitates a deeper understanding of individual traumatization . . . . We can say: (1) There are no secure living conditions for the majority of Chinese. (2) There is no public culture of remembering the Cultural Revolution, hence no publicly supported empathy and grieving. Support for inner and outer reconciliation could enhance a process in which the events of the Cultural Revolution could be integrated into a reconstructed collective history. Yet critical public debate is not part of Chinese tradition. The government believes that it would

> explode the system. Therefore the entire country avoids general recollection. (3) Social integration of the victims of the Cultural Revolution would require enhanced perception of the prevalence of social violence and its anomic structure during the Cultural Revolution. These have led to widespread disintegration in Chinese society, which is still cemented together by the official grip of one-dimensional thinking seen, for instance, in slogans such as "harmonic society." In his request for harmonious relationships, Confucius (551–479 BC) gave direction to the notion of psychic balance. Therefore the Chinese also named their country "Zhongguo," meaning "the middle kingdom." They have long lost this middle. Recovering the language of a history that has been so traumatic for so many could enable China with its long history of advanced civilisation to arise once again as "the middle kingdom." [2014a, p. 42]

Trauma remains largely undiscussed and undiscussable in China. Movement toward renewed opening up early in this century has been succeeded recently by a more emphatic closing down of discussion and freedom of thought under the current administration, which is sponsoring a revival of Mao's reputation and thought. This instills a renewed sense of threat that cannot fail to impinge on the freedom of thought invited by psychoanalytic thinking.

THE STRUCTURE OF CHINESE THOUGHT

Probably the biggest obstacle to the introduction of psychoanalysis to China is the failure by Western psychoanalytic teachers to understand the essence of the structure of Chinese thought. While there were government-sponsored attacks on traditional thinking during the Maoist era, Confucian, Taoist, and Buddhist principles continue to underlie Chinese psychic structure. Consequently, understanding these ways of thinking is crucial in the same way that understanding Western philosophy and theology, along with Western individual development and mental structure, is essential to psychoanalytic understanding, even though it is not specifically taught in psychoanalytic training.

Several recent contributions to the literature serve to introduce Western readers to elements of Chinese philosophy and thought (Li Ming 2014; Lin Tao 2015; Ming Dong Gu 2006; Saporta 2014; D. E.

Scharff and Varvin 2014). Interestingly, the idea that we need to be steeped in these cultural differences is rebutted by Snyder (2014). Although Snyder argues that cross-cultural differences are not essentially important in the availability and conduct of psychoanalytic treatment, the preponderance of opinion is that it is crucial to understanding the makeup of the Chinese mind, with its Confucian, Taoist, and Buddhist underpinnings, if one is to apply psychoanalytic thinking to China. Perhaps the most thorough explorations of this issue can be found in Bollas (2013; see also D. E. Scharff [2013] and Usuelli [2015]).

Bollas hypothesizes about complementary differences between Eastern and Western thought, which he sees as referring to *different parts of the mind:*

> The maternal order refers to the forms of knowledge conveyed to the self as fetus, neonate, and infant, prior to the acquisition of language. This is presentational knowledge . . . . The paternal order refers to those categories of communication that are language dependent. These convey the views of the father and, later, the assumptions and laws of society . . . . Put simply, that Eastern mind favors preverbal or nonverbal forms of being, thinking, and relating in [the maternal order] . . . while the Western mind generally relies on articulate verbal expression in order to communicate itself and functions in accordance with the paternal order. [2013, p. 3]

Bollas concludes:

> Freud may well have received a gift from the East of which he was unaware. Now that Western and Eastern psychotherapists and psychoanalysts have begun in earnest dialogue with one another, one hopes that the Eastern aspects of psychoanalytical praxis may be appreciated by Western clinicians, lest it remain repressed to the disadvantage of all. [p. 134]

SOCIAL CHANGE AND ITS EFFECT ON PSYCHIC ORGANIZATION

Several articles, mainly published outside the psychoanalytic literature, have documented the rapid evolution of Chinese society and the im-

plications for psychic and family organization. The Communist Party's attack on the Chinese family in favor of loyalty to the party and to Mao, its insistence on the equality of women ("Women hold up half the sky"), and its ownership of the right to marry or divorce severely challenged a culture founded on loyalty to fathers and eldest sons in large families.

But then the imposition of the "One Child Policy" in the early 1980s ended millennia of large families and dominance of sons, introducing instead small families, drastic shrinkage in kinship networks, and a striking imbalance in the male–female ratio of the generations born after 1980. As a result, girls and women have been empowered as now (almost) equals, and there are large numbers of single men for whom the failure to marry is a social disaster. This excess of essentially unmarriageable males affects the rural population more than the urban middle class, but it frequently enters into the consideration of couple therapy and of the treatment of men who pine for a son in this era of only children (D. E. Scharff 2014; Shi Qijia and J. S. Scharff 2011). On the other hand, women feel further empowered in the modern era.

Nicholas Eberstadt (2013, 2015), a demographer at the American Enterprise Institute, wrote:

> China today faces staggering demographic problems, including a shrinking pool of working-age men and women and a rapidly aging population that will slow economic growth, perhaps severely. The traditional family structure will be tested by, among other things, a growing army of unmarriageable men, a consequence of rampant sex-selective abortion in the One Child era. To the extent that the policy has "succeeded," it has made each of these demographic problems more acute.
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> Yet even if Beijing repudiated all forms of population control tomorrow, these problems would persist for the generation to come. Practically everyone who will be in the Chinese workforce in 2030, or the Chinese marriage market in 2035, has already been born under the current restrictions. No variations in population policy today can change this part of the country's future. [Eberstadt 2013, p. A15]

When the Chinese Communist Party changed to a two-child policy in 2015, Eberstadt (2015) reiterated his statement that it was too late to make a difference to their looming social and economic crisis.

There are other, far-ranging and unintended consequences of these policies, such as the freeing of sex from the shackles of reproduction that the Communist Party had imposed as the only justification for sexual relations. Pan Suiming (2006) concluded that there is

> . . . increasing separation of sex from procreation; the increasing recognition of the significance of sex and marriage; the growing understanding that love is superior to traditional conceptions of the institution of marriage; the growing freedom of sexual desire from the constraints of romantic feelings; and the generational shift in the nature of female sexuality. [p. 40]

This adds up to new sexual freedom and a trend toward sexual equality, but also to increased confusion about the role and proprieties of sexual behavior.

These are not the only areas of rapid social change that impinge on psychic structure. Vanessa Fong, an anthropologist at Amherst College, has drawn on her field work in China to write vividly about the changes in status for women (Fong 2002) and about confusion in the minds of parents of the current generation of children about their children's loyalties and how they should behave (Fong 2007). Modern Chinese parents have the old values of family loyalty in mind, at the same time that they recognize the need for their children to be entrepreneurially active in pursuing their own interests. Fong's research in Dalian, China, documents that such parents give their children mixed messages, often urging them to look out for themselves while at the same time imploring them to honor the old value of putting the family first:

> Recognizing that their society was an uneasy mixture of Confucianism, socialism, and capitalism, parents I knew in Dalian tried to teach their children values that would enable them to fulfill all the roles that would be expected of them. They would have to be excellent and self-reliant enough to make their way to the top of the neoliberal world system, but still sufficiently devoted to their duty to bring their families and society with them in their uphill march. They would have to rely on themselves alone to excel in a competitive stratification system, but they would also have to remain responsible to their families and social networks and obedient to their elders and superiors. What parents

> feared, however, was that their children would also learn the undesirable aspects of all of these values: obedience could stifle their excellence; caring/sociableness could limit their ambition; independence could encourage them to refrain from creating and maintaining family ties and social networks; excellence could encourage them to assert their own superiority and distance themselves from peers, parents, teachers, employers, and state authorities that they deemed inferior. It was difficult for children to develop only the desirable aspects of the values their parents promoted, as these desirable aspects were inextricably connected with undesirable consequences. [Fong 2007, p. 110]

Psychoanalytically, such mixed loyalties vie with each other during development and surface during psychoanalytic treatment.

IS PSYCHOANALYSIS SUITABLE FOR CHINA?

In the light of these deep-structure cultural differences, and of the rapid evolution in Chinese society and the Chinese psyche, many Chinese have raised the question of whether psychoanalysis is really a philosophy and treatment that fits Chinese temperament. The current literature contains articles by both Western and Chinese authors who examine this question in probing ways.

Antje Haag (2014), one of the first Western teachers on the scene, draws on her long experience teaching psychotherapy in China to conclude that:

> Psychoanalysis is a wonderful tool for understanding human nature. I believe it can help, more or less, throughout the whole world. However, it would be a mistake to apply it without adaptation to respective cultures . . . . I'm afraid that Western analysts—including me—have not so far considered these differences appropriately. It is time for a new transcultural debate. [p. 31]

More specifically, Varvin and Rosenbaum (2014) discuss conflicting ideas of individualism, independence, and interdependence in Chinese culture compared to Western culture. They particularly address the Chinese principles of change, contradiction, and relationship in regard to differing mentalities between cultures:

> We saw that the embeddedness of psychoanalytic concepts and theories in the Western "Aristotelian" culture implied challenges when "translating" these into a "Confucian-Taoist" context. We hold that this implies that collaborative and extensive work will be required by western and Chinese analysts before a solid foundation for psychoanalytic theory may be achieved for the Chinese context. [p. 135]

Two of the first Chinese graduates of the IPA's psychoanalytic training have written about what is involved in crossing the cultural divide. Wang Qian (2013), from Beijing's Anding Hospital, described cultural issues in learning to develop a "sense of trust in doubt," and Liu Yiling (2013), also in Beijing, examined how "slow psychoanalysis is helpful for fast developing China."

Anne-Marie Schlosser (2009), one of the veteran teachers in the Sino-German program, wrote:

> Of all the countries known for their fake copies, China tops the list. Is it possible to copy psychoanalysis in much the same way as a bag by Louis Vuitton features in markets that sell counterfeit products? Most definitely not. Nowadays we accept the universality of the psychoanalytic theory on the structure of the human mind, the impossibility of exerting influence on the subconscious, and the general applicability of psychic mechanisms by which the ego attempts to halt inner homeostasis.
>
> Yet the contents would appear to differ: many more suppressed affects, particularly the anger that has to be concealed under the blanket of reciprocal commitment, decency, adaptation, assiduity, and striving for a career . . . . The culturally anchored denial of and desisting from mental disease means that such disease blossoms furtively, presenting itself in an archaic manner . . . . Possibly this might all result in consequences for techniques of treatment, something we should think about. We are still in the early stages here . . . .
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> In China, there is a great need for a broadening of people's own thinking and feeling, such as can be offered by psychoanalysis. Nevertheless, inner conflict can be triggered by a clash with traditional structures with which we need to be familiar if we want to pass on our knowledge . . . . Not only are those people interested in psychoanalysis, but also China as a whole is histori-

> cally on the move. A gradual change is the aim . . . . It is not a boycott that can be the method of choice, but rather an ever-greater integration coupled with an acknowledgment of the differences. [pp. 223-224]

These findings are given clinical substance by Zhong (2011). Another of the original candidates in psychoanalytic training in Beijing, Zhong found that his patient's ambivalence about psychoanalytic therapy itself—which the patient voiced as a conflict between loyalty to her old ways of thinking, including family loyalties, and the pull of psychoanalytic treatment toward autonomy and individuation—echoed a debate that he identified within himself as a candidate in training:

> Although it seems that in the twenty-first century, cultural conflicts between psychoanalysis and Chinese culture are still intense, the application of psychoanalysis to Chinese patients has not been rejected in Mainland China . . . . Instead, the seeds of psychoanalysis have gradually grown since the 1990s. As a Chinese, my own experience with psychoanalytic training and practice has begun to stimulate my thinking about how psychoanalysis best works in China despite the cultural conflicts. I believe we need more time to understand the conflicts between psychoanalysis and Chinese culture, which should neither be ignored nor regarded as defenses in the psychotherapeutic or psychoanalytic situation.
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> As a Chinese psychoanalyst, it is not easy to identify both with psychoanalysis and with Chinese culture . . . . I think Chinese patients are each unique, not only because of the contrast with western religion and philosophy, but also because of internal cultural diversity. Perhaps it is lucky both for psychoanalysis and for many Chinese that not all Chinese are quite so loyal to the basic philosophy of *oneness*, as more of them now choose *pragmatism* as their basic philosophy. [2011, p. 225, italics in original]

CLINICAL APPLICATIONS OF PSYCHOANALYSIS

In addition to Freudian traditions, other psychoanalytic approaches, such as Jungian and Lacanian, are now being offered in China.

First let us consider the application of clinical practice in the Freudian tradition. Huang Hsuan-Ying, a Taiwanese-trained psychiatrist and Harvard-trained cultural anthropologist, gives an extensive recent history of the introduction of analytic psychotherapy into China (Huang Hsuan-Ying 2015). He documents the history of the introduction of training programs and the embrace of analytic therapy, as well as some significant recent changes. These include the rise of a registry system that began about ten years ago; an increasing differentiation between professional and popular purposes and courses; an increase in younger participants in training programs; and increases in the numbers of both clients and clinicians. A major problem is that people with inadequate training—or even no training—hang up shingles and declare themselves to be psychotherapists. This is now being addressed by professional organizations, however. Hsuan-Ying concludes:

> In the near future . . . [psychotherapy] could maintain its dual identity as a popular movement and a new profession and continue to evolve on both fronts . . . . It is important to remember that the development of psychotherapy in China has never met with a straightforward reception. Instead, it has a meandering trajectory deeply entangled with, and affected by, the social, political, and economic transformations during the past century. [Huang Hsuan-Ying 2015, p. 21]

Specific descriptions of the development of training programs have been contributed by many authors. See Xu Yong (2015); Varvin and Gerlach (2014) on the Sino-German and Sino-Norwegian programs; Fishkin and Fishkin (2014) on the China-America Psychoanalytic Alliance (CAPA) experience, which introduces analytic therapy from an American point of view; Gerlach (2014a) on the development of training in group psychotherapy; and Gullestad (2014) on a model of supervision and teaching in China.

Students of psychotherapy have also contributed to this literature. Gao Jun (2014), Qi Wei (2014), and Liu Yiling (2014) have all written about their experience in learning and beginning to apply analytic psychotherapy in China. Sehon (2014) wrote of her experience teaching in a more remote hospital with no previous exposure to analytic thinking.

Alexander-Guerra (2015) documented her experience in successfully supervising candidates from the United States in China.

MODALITIES OF PSYCHOANALYTIC THERAPIES

The psychoanalytic therapies now offered stretch beyond individual psychoanalytic psychotherapy or formal psychoanalysis. I have previously cited Gerlach (2014a) on the development of group analytic training in Shanghai as part of the Sino-German program. Xu Yong (2015) documents the implementation of the practice of interpretation in group therapy at the Shanghai Mental Health Center. These two articles serve to introduce a major concept in the practice of group psychotherapy—projective identification—to a Chinese audience:

> Projective identification is not just a defence mechanism; it is the vehicle for powerful unconscious interpersonal communication, as seen so clearly in psychodynamic group therapy. It is important for patients to understand the processes of projective identification and for the therapist to use their understanding as a pathway to help patients re-own their projections and contain them. Psychodynamic group psychotherapy offers an effective environment for improved mentalizing, the emergence and exploration of projective identification, and better containment, thus facilitating personal growth. [Xu Yong 2015, pp. 62-63]

Jill Scharff and I have applied psychoanalysis to the treatment of families and couples in China, launching a training program in 2010, originally under the auspices of Peking University and the Beijing Mental Health Association, which now runs independently in collaboration with Fang Xin, Director of Counselling at Peking University. This program is designed to train advanced clinicians in the conduct of psychoanalytic couple therapy and family therapy. In conjunction with the program, we and our colleagues have written a series of papers introducing these modalities (J. S. Scharff and D. E. Scharff 2011, 2015; Shi Qijia and J. S. Scharff 2011; Wanlass 2014).

One of these contributions (J. S. Scharff and D. E. Scharff 2015) describes a brief intervention with a Chinese family whose daughter

was suicidal, where the mother was painfully humiliated by her loss of face because her daughter, in attending the school in which the mother taught, had problems that were known to many of the teachers but not to the mother herself. This intervention took place over a period of five days in front of our Beijing training group, and it resulted in lysing the suicidality and the secrecy brought on by the family's fear of loss of face. We wrote:

> When family therapy offers an opportunity to dissolve the shared tensions of growing trauma in a family, turning pain and self-inflicted harm into a positive experience for the family, therapists feel hopeful. This family showed us the potential for shared self-exploration, mutual support and concern, and trust in the therapeutic experience, despite the unusual barriers of being translated and observed. We left the situation feeling that the family would do well in ongoing family therapy with a Chinese therapist. [J. S. Scharff and D. E. Scharff 2015, p. 48]

One of the personal highlights of my own work in China is the chance to learn from my colleagues there about Chinese culture, and to see specifically just how much and how often cultural differences come into clinical play. In the case of the brief intervention mentioned above, the case turned on the mother's *loss of face,* a term I used interpretively during the intervention after I had tried the word *humiliation* and found that she could not make use of it. Our interpreter, Gao Jun (2015), who is also a sensitive clinician, contributed a discussion of this case that addressed the differentiation between qualities of humiliation and shame in China. This discussion considerably augmented the value of our contribution. Gao Jun wrote:

> Since China has been regarded by many scholars as a "shame culture," it is not surprising that the emotion of shame is quite important here in China. Unlike English, which only has a few words to describe the concept of shame and its gradations—for instance, embarrassment or humiliation—there are many Chinese words to differentiate aspects of shameful intense negative feeling about one's self. The Chinese translation of the word "humiliation" is "chi-ru." Chi-ru describes a situation in which a person feels that because of his/her wrongdoing—usually se-

vere moral transgressions or major personal failures—he/she is looked down upon by others. The contempt and disgust implied in this word is strong, and the consequence can be fatal: he/she may lose reputation and respect from others completely, and may even run the danger of being expelled by his/her group. The word "humiliation" may also indicate a strong sense of aggression from others. The image of a bad, disgusting self is forced upon the person by others, either in reality or in one's imagination.

On the other hand, the phrase "losing face" is far less negative and painful compared to the word "humiliation." There are two differing translations for the phrase "loss of face." One is "diu mian zi" and the other is "diu lian." There is a subtle but important difference between the two. The meaning of the first (diu mian zu) is similar to the English word "embarrassment," usually indicating a social inadequacy or mistake that one makes in front of others, and indicates that these faults or inadequacies do not fit for the status or the role one occupies in his/her social network. The second (diu lian) is more negative in the sense that it indicates a more severe social inadequacy, or even a moral transgression.

Another difference between "humiliation" and "loss of face" concerns the personal reaction toward these shameful experiences. In Chinese, we have phrases such as "earn face" or "win back your face," indicating that if a person tries to repair his/her wrongdoings afterward or correct his/her social inadequacy, he/she can restore his/her reputation and be accepted once more as a worthy member of the group. In this sense, when a Chinese person feels or is told that he/she has lost face, he/she is usually quite motivated to get it back. However, it is far more difficult to "wash away your humiliation with others' blood," as the Chinese phrase indicates. Besides, to get rid of your humiliation also implies quite a lot of aggression towards those people who made you feel humiliated. [Gao Jun 2015 p. 52][2]

Like Xu Yong's (2015) article on group therapy, these clinical writings offer basic introductions of clinical concepts and skills in the extension of psychoanalytic treatment to families and couples, as well as an op-

[2] *The Psychoanalytic Quarterly* regrets that it is not possible to replicate the Chinese characters contained in the source of this quotation.

portunity for understanding cultural similarities and differences. There is a sense of urgent clinical need in China as family structure and psychic organization are undergoing rapid changes that result in both personal distress and intrafamilial tensions.

DISTANCE ANALYTIC PSYCHOTHERAPY

China is a vast country and, while many of its population centers are condensed, the availability of competent psychotherapy exists in only a few large cities. In addition, there are relatively few trained therapists, including even those trained at rudimentary levels of competence, and almost all these are located in large urban centers. Of course, the need for psychotherapy exists all around the country, and there are also many Chinese patients overseas who seek psychotherapy from a Chinese-speaking therapist.

Furthermore, the need to train psychoanalysts and analytic psychotherapists in China outstrips the availability of the few experienced therapists on the Chinese mainland at this point. Consequently, the use of distance communication technology for training, supervision, and treatment is widely implemented.

Fishkin and Fishkin (2011, 2014) wrote the first discussions on the use of distance technology for training and psychoanalytic therapy in China. They commented that: "CAPA [China-American Psychoanalytic Alliance] has undertaken the challenging task of educating Chinese mental health professionals in psychoanalytically oriented psychotherapy and treating them in psychoanalysis . . . . CAPA, in this challenging work, had to grapple with issues of geographical distance, cultural differences, and technological naïveté" (2014, p. 214).

Various other authors have written on the use of the telephone and of Voice Over Internet Protocol (VOIP) platforms, such as Skype. One such author is Lin Tao (2015), the first Chinese graduate of the IPA's psychoanalytic training program, who now lives in London. Irmgard Dettbarn (2015), who served as a training analyst in Beijing in the first wave of the IPA's formal training program, has also contributed to this literature, having continued analysis with many of her candidate patients over Skype since returning to her home in Germany. She describes the

experience of feeling that technology becomes another character in the analytic setup:

> Technology is a tool that reduces the workload and increases possibilities: it leads to experiences and facilitates processes that without devices would be not simply weakened, but would not exist at all. On the downside, the goal of media technology seems to be global reach rather than improved performance (Kramer 1998). So much interaction across distance in real time is now possible, but . . . sitting at our computers and speaking to each other on Skype, . . . how do we differentiate and adapt the technology to our use without fooling ourselves? . . . Does technology, the third uncanny party, remain a threat? Technology as a device or apparatus, however useful in some ways, creates artificial worlds. [2015, p. 148]

In a more confident tone, Alexander-Guerra (2015) describes her experience supervising psychotherapy candidates in the CAPA program:

> Supervision using Skype over 8,000 miles can, nonetheless, engender an intensity of transference (and countertransference). The supervisee, Blossom, experienced some of the same wishes that I've noted in face-to-face supervision, for example, the wish that the supervisor, more collegial, more didactic, less opaque, might replace the supervisee's analyst or therapist. [pp. 156-157]

This topic was considerably expanded upon by Li Zhen and Li Hongya (2015). Li Zhen has established a service that matches patients with competent clinicians whom the service has vetted for adequacy of training and reputation. Li Zhen and Li Hongya note that the program has provided a much-needed platform for connections that are often accomplished through the use of distance technology. While distance analysis is controversial, especially in Europe, there is no doubt that this constitutes a significant area of expanding usage of psychoanalytic therapy and of serving patients who seek it—many of whom would not otherwise have access to these services. Li Zhen and Li Hongya write:

> As more therapists come online, I could see the establishment of a comprehensive database of the best-trained Chinese psychotherapists. We are particularly excited that such a database will

> be instrumental in creating industry standards for China, as well as opening up opportunities for research, such as evidence-based psychotherapy. My hope is that what is happening in China will not only bring relief to the millions in need of psychotherapy, but will also offer insights and practices that the rest of the world will find valuable and inspiring. [2015, p. 162]

Gordon, Tune, and Wang (in press) surveyed CAPA therapists who rely on videoconferencing technology to treat and supervise Chinese students. These authors write:

> 60% of CAPA therapists overall considered delivering psychodynamic psychotherapy with VCON (videoconferencing) favorably. However, we wanted to explore the characteristics and concerns of those few therapists who were most critical of psychodynamic treatment over VCON. These results suggest that therapists who rate psychodynamic psychotherapy over VCON low (i.e., "Much less effective than in person" and "Less effective than in person") than higher raters (i.e., "Slightly less effective," "No difference," "slightly more effective," etc.) believe that the psychodynamic constructions are not effectively translated over VCON as compared to in-person treatment. The issues of symptom reduction, exploring mental life, working with transference, working through relational problems, working with resistances, privacy concerns, and countertransference issues were all considered negatively affected by online work. Low raters felt that exploring the mental life of the patient was most affected by VCON, and working on transference was least affected by VCON . . . . Nevertheless, low raters of effectiveness and higher raters of effectiveness agree that treatment over VCON is valuable, since it offers high-quality treatment to underserved or remote patients, and it is valuable when the patient is house-bound or travel would be impractical.

SPECIAL CLINICAL PICTURES UNIQUE TO CHINA

China has many subcultures and fifty-five distinct minorities, despite the fact that 95% of Chinese are of the Han majority. But 5% of 1.3 billion is a minority population of approximately 65,000,000, nonetheless. And

there are many regional differences, as in any large country, resulting in, among other things, distinct clinical pictures that are unknown in the West. Cultural anthropology can help clinicians here.

One such clinical picture was described by Gerlach (2014b), who investigated a mass epidemic of male hysteria known as "Koro." In this psychogenic hysterical emergency, young men become terrorized that their penises will shrink and withdraw into their bodies, leading to fatal consequences. Gerlach wrote:

> Cultural studies and my own observation . . . endorse the conclusion that fantasies of feeding and orality shape Chinese notions of sexual intercourse. The orality that is given such importance in Chinese childhood seems to last all through life, with regressive and defensive potential . . . . This ideal of reciprocal oral care, however, is still threatened by projective fears of exploitation, of "being drained." I believe it is particularly true for the Chinese male, whose yang essence is considered to be limited, so that his need for nourishment is greater. He seems to be the weaker of the partners, more obviously dependent on continuous oral nourishment and care.
>
> The image of the female fox demons [who cast this spell] in the "Koro" epidemics illustrates particularly well the sexually seductive but overpowering characteristic of women that drains men of their masculinity. The fear of being thus drained that was felt during the "Koro" embodies a regression to orality with a revival of sensual experience, but also with defences derived from unconscious aggressive and libidinous desires towards mothers and avoidance of the oedipal conflict with the father. This oedipal avoidance and related castration anxiety is supported by the son's veneration for his father required by the Confucian tradition. The filial duty of the son, however, conflicts with the need for deference on the part of the father, who after death will be dependent on the deference of the son's ancestral worship. Hence both the son's oedipal aggression and the father's unconscious hostility are culturally embedded in a system of reciprocal reticence . . . . In the "Koro" epidemics, these institutionalized conflicts are articulated in intrapsychic and psychosocial manners. The men's concealed envy of female sexuality and the life-giving drive of the women are particularly noticeable in the "Koro." [2014b, pp. 107-108]

REGIONAL VARIATIONS

Less has been written about the state of psychoanalysis in Hong Kong and Taiwan than in Mainland China. In fact, there is little or no psychoanalysis in Hong Kong, a situation explored by Busiol (2015). Whereas most Western psychotherapies are practiced in Hong Kong, analysis is simply not well recognized, Busiol found, although it is not seen as incompatible with local culture. In Taiwan and Mainland China, Western analysts have simply been more active in introducing concepts and offering training. Liu Chia-Chang (2013) described the "Formosa model" of the active development of analysis in Taiwan. The Taiwan Center for the Development of Psychoanalysis was established in 2004 and became an IPA-allied center in 2006, with active support from the IPA (Liu Chia-Chang 2013).

At the same time, there has been considerable Jungian influence in all three regions—particularly in Hong Kong, with its absence of Freudian analysis, and in Taiwan. There are also pockets of Lacanian influence on the mainland, but I have not found articles in English describing its work.

There is a mixture of articles written from the Freudian perspective and the Jungian perspective in the literature that explores psychoanalysis in China—a mixture that does not often exist in the Western analytic literature. Cai Chenghou (2015) draws on the Jungian point of view in discussing the mass trauma triggered by the Sichuan earthquake of May 2008, as well as in his clinical exploration of a depressed woman (Cai Chenghou, in press).

Tibaldi (2015) wrote of her experiences in supervising in China and Hong Kong. She also coauthored a book with Chinese colleagues on the introduction of Jungian analysis into Hong Kong (Tibaldi et al. 2016). Jungian analysis is flourishing in Taiwan as well, with many members of the Taiwan Institute for Psychotherapy opting to train in the Jungian tradition, and some going to London for more extensive training.

ESSAYS FROM DISCIPLINES THAT EXPAND PSYCHOANALYSIS

The journal *Psychoanalysis and Psychotherapy in China* has begun a tradition of featuring the work of authors from outside the realm of psycho-

analysis who offer information that illuminates psychoanalytic work. For example, Richard Wu (2015, in press), a Chinese-Australian artist and art historian as well as an analytic psychotherapist, has written about *xieyi* painting as a culture of therapy. His work introduces an ancient Chinese tradition of painting that was used to express politically forbidden opinions and feelings in coded form, something that is still often required in China today in the face of recurrent governmental repression of dissent. This also became a form of self-therapy, he notes, and he demonstrates its overlap with principles of psychoanalytic psychotherapy, as well as the way that he has introduced this art form into his own practice:

> Resonance can thus be found between *xieyi*'s imagery and the practice of psychotherapy, despite one being a visual culture spanning a millennium, and the other a dialogue in the therapy room. To understand this resonance . . . [I propose] that a *scene-dialogue* exists between one's inner and outer realities. In a *xieyi* painting, this is captured in *yijing*, or *mind-scenes*, characterized by elements of *leaving space, hidden metaphors,* and *rhythm* . . . . [There are] correlates to these elements in psychotherapeutic literature, in particular, the writings of William James, Donald Winnicott, Russell Meares, and Howard Gruber. [Wu, in press]

Several Chinese colleagues note their expectation that psychoanalysis will acquire Chinese characteristics. Zhang Peichao and Chi Xinli (2013) explicitly propose this, holding that "the adaptation of forms of psychotherapy from the West in China, such as psychoanalytic psychotherapy, should include the rich cross-fertilization with traditional Chinese medicine (TCM)" (p. 366). In their view, categories from TCM such as "reinforcing/reducing," which operate to balance yin and yang, overlap with the idea of a balance between supportive and expressive approaches in psychotherapy. In describing a method that they call *talking acupuncture,* they write:

> The methodology of acupuncture in TCM is also based on the reinforcing and reducing category . . . . This dialectical and dynamic way of thinking can be used in psychoanalysis and psychodynamic psychotherapy, especially with patients with borderline

personality organization, which can be seen as a mixture of deficiencies and excess. On the one hand, their self is rather weak and needs to be reinforced. On the other hand, their pathological defenses need to be reduced. [Zhang Peichao and Chi Xinli 2013, p. 366]

ESSAYS BY INFLUENTIAL FIGURES IN CHINESE PSYCHOANALYSIS

A number of Chinese and Western figures have been particularly influential in the introduction and refinement of psychoanalysis in China, some of whom have already been cited in this essay. Influential Chinese colleagues come mostly from the group of those trained in programs organized by the Norwegians and Germans, also mentioned earlier. Among those Chinese featured in the English-language literature thus far are Yang Yunping (2011, 2013, 2014), Jia Xiaoming (Jia Xiaoming and Varvin, in press), Shi Qijia (2015), and Tong Jun (in press).

Yang Yunping, from Beijing's prestigious Anding Hospital, has published on training in China (2013) and has written on psychic trauma in Chinese families (2014). She has also employed a historical perspective in examining the challenges to professional identity for developing Chinese clinicians. She writes:

> One important element in psychoanalysis, which is derived from Western culture, is individualization: the independency and autonomy of an individual are highly valued. However, one of the significant essences in Chinese culture is that the collective interest transcends the individual interests, and the interests of social groups are more important than those of families. Therefore, when learning and practicing psychoanalytic psychotherapy, Chinese clinicians inevitably experience conflicts derived from this difference in cultural values. [Yang Yunping 2011, p. 733]

Tong Jun (in press), vice-president of Wuhan Mental Health Center, writes about women's identities and mothering, examining the relationship between childrearing practices, ideologies about development, and the self-denigration that is woven into Chinese women's identity.

Some contributions to the literature are personal. For example, Jia Xiaoming—a professor at the Beijing Institute of Technology and vice-chair of the Committee on Psychoanalysis of the China Association for Mental Health—conducted an interview of Sverre Varvin, founder of the Sino-Norwegian Training Program and current chair of the IPA's China Committee. This interview (Jia Xiaoming and Varvin, in press) offers a deeply personal view of Varvin's commitment to psychoanalysis and to its development in China, as well as insights into the thinking of Jia Xiaoming. A small slice of the exchange between these two conveys its flavor:

JIA XIAOMING: You have mentioned different learning cultures. Did you have any observation of the possible relationship between psychoanalysis and Chinese culture? Does Chinese culture raise any challenge for psychoanalysis?

SVERRE VARVIN: I think there are some similarities in that, also in psychoanalysis, there has been an authoritarian tradition: candidates should only listen and not ask critical questions. It was almost like that when I trained as a psychoanalyst . . . . There is the critical interest in development of interdisciplinary dialogue, like between psychoanalysis, CBT, and so on. I think this tension has been important in psychoanalysis. This tension is also within the Chinese culture, between Confucianism and Taoism. I think Taoism is a dynamic way of thinking where things develop in tension between different forces.

Of course, in psychoanalysis, especially Freud taught us that there are continuous tensions, continuous conflicts. Things will never be harmonious. This makes it a bit different from the Taoist tradition that things should be harmonious. But it is important that the tradition of thinking in a dialectical way is very much similar to psychoanalysis, the theory and thinking in psychoanalysis. This is why I think you understand psychoanalysis so quickly and easily. [Jia Xiaoming and Varvin, in press]

Shi Qijia, president and director of Wuhan Mental Health Center and a major national figure in the spread of psychoanalytic psychotherapy, has written about cultural issues in the treatment of patients. Regarding a couple whom he had treated who embodied issues of rapid cultural change in China, as well as conflict between partners who came from quite different subcultures within the country, he and his coauthor wrote:

> In traditional China in the Confucian tradition through the nineteenth century, women had to obey their fathers when they were girls, obey their husbands when married, and obey their sons when old. This reflected the subordinate and dependent status of women. In family hierarchies, females were submissive to males, and younger generations to older ones. Male respect to females was demonstrated by respecting the man's mother and older women. In fact, men looked down on women. Confucius said that women and servants are the most difficult to deal with. In those times, women were forbidden at the supper table and could not take part in important family ceremonies for fear of bringing bad luck. In the early twentieth century, the May Fourth Movement liberated Chinese mentality. Women no longer needed to bind their feet and people could choose their spouses freely. After the founding of New China in 1949, women's liberation covered a wider scope. In urban China today, most women have jobs, go outside the family, earn a living, build their own social circle, and have their own opinions. As male–female relationships change further, men often care for the children and share household duties, but they are still expected to earn more than their wives, to achieve at school, and move up at work beyond menial jobs.
>
> This couple's conflict is embedded in these generational social changes. It is common for men to cling to the old values and the inheritance of being the privileged boy. Meanwhile, women move rapidly towards a modern ethos of gender equality. Personal issues then come to embody these social issues. [Shi Qijia and J. S. Scharff 2011, pp. 212-213]

In a more personal vein, Shi Qijia (2015) describes his own journey toward psychoanalysis:

> Luxun said that tragedy is destroying the beautiful things. Psychotherapy can lead you into the deep side of your soul and

help you to find the way back to your real home. But this process requires you to endure loneliness, frustration, and suspicion, requires that you tolerate negative moods, and requires you to keep the hope of beautiful humanity alive and to deliver this hope to your clients.

Psychotherapy after tragedy finds the clean and silent calm that can occur after extreme sadness. Then there is room for love.

Psychotherapy can help you learn to do that. [p. 116]

CONCLUSION

The psychoanalytic literature in China and about China is young and still relatively limited. Chinese authors are generally inexperienced, unused to producing the kind of articles that we find in Western psychoanalytic literature. This will change, and like everything else in China, it is likely that it will change quickly. There will be more journals and books devoted to topics that convey the effect on Chinese practitioners and patients of introducing psychoanalysis, and in a reciprocal way, of changes that will occur in psychoanalysis itself as, worldwide, it is infiltrated by Chinese influence. Although we see intimations of the directions that these changes will take, what is most likely is that they will take resourcefully unpredictable directions.

In other areas of the world into which psychoanalysis has been introduced, innovative changes have been wrought for psychoanalysis in general. I have no doubt that this will be true in China, but as with all such changes, I also have no doubt that many of them will meet with skepticism in confrontations with Western psychoanalysis. It is up to all of us to see that the creative mix of cultures results in both maximal growth of psychoanalysis in China and maximal benefit of the Chinese experience for those of us in the West.

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