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THE "GODDESS OF PRESENCE" AND THE BIRTH OF THE SELF IN AN ANALYTIC TREATMENT

BY VERA J. CAMDEN

The great conductor Bruno Walter proclaims in his memoir, Theme and Variations: An Autobiography *(1946) that, "Out of the countless variations of my life's experiences, [I] recognize and appraise myself as their theme" (p. vii, emphasis added). This paper considers the "uses" of Walter's memoir in the psychoanalytic treatment of a woman who had been clinically diagnosed as "pre-psychotic" and whose besetting fear was that people were only creatures, and that she herself did not have a "self." After many years of treatment, in what became a watershed in our work together, Ms. T, herself an accomplished musician, brought Walter's autobiography to me in the form of certain pages copied and highlighted from Walter's account of his brief, and remarkable treatment by Sigmund Freud. Walter's reflections upon his little known treatment by Freud's offered an inlet into the ways Ms. T and I learned to hear the variations on the theme of her self—through the seemingly intractable, psychotic symptoms that brought her into treatment. Her contribution of the Walter*

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text became a shared witness in our analytic space, even as this account of her treatment testifies to our time together.

Keywords: Self, literature, thought, Bruno Walter, Winnicott, Freud.

Bruno Walter's *Theme and Variations: An Autobiography* (1946) was written during a year of his life dedicated, he says, "to rest, … to remember, to search, and to tell of my life … . Out of the countless variations of my life's experiences, [I] recognize and appraise my*self* as their theme" (p. vii, italics added). Walter's application of this musical metaphor to the movements of his life provides me with an apt model for the telling of my work with my first patient as a new clinician beginning training as an analyst. I consider the uses of Walter's memoir in the psychoanalytic treatment of a woman—whom I shall call Ms. T—whose besetting fear was that people were only creatures, and that she herself did not have a "self." Ms. T's troubled but promising musical training and career was interrupted in her late twenties when she was diagnosed and treated as "pre-psychotic." She felt paralyzed by her inability to "think straight"—and terrified of her recent diagnosis. After many years of treatment, in what became a watershed in our work together, Ms. T brought Walter's autobiography to me in the form of certain pages copied and highlighted from his book. In particular, she was struck by Walter's account of his brief and remarkable treatment by Sigmund Freud, and the way that within the coffee houses of *fin de siècle* Vienna timeless conversations evoked what Walter calls "the Goddess of Presence" (p. 136). I sought to learn more about Ms. T's associations to the timeless, romantic, and reliable conversations of Viennese coffee houses, as well as the emergent feelings that allowed her to share with me the excerpts of Walter's encounter with Freud, which I will explore at length below. Suffice it to say, I became intrigued by this sudden revelation of an unknown "case" of Freud's—for indeed, Bruno Walter's autobiographical account of his brief treatment by Sigmund Freud in 1906 for the paralysis of his conducting arm has received scant attention in the psychoanalytic literature, since Freud himself nowhere discusses this encounter. Nevertheless, as I discovered, Walter's successful treatment has been described as an

instance of "transference cure" and noted for its effect as a "brief psychotherapy" (Garcia 1990, pp. 83-85).[1]

My intention in this paper is not to critique what psychoanalytic assessments there are on Walter's account of his work with Freud, nor to defend, or deny the clinical claims of his account. Rather, I want to show how Walter's reflections upon his treatment by Freud's offered an inlet into my work over nearly three decades with Ms. T. I have returned to his text enriched by its resonance with the rhythms of our work—themes and variations—over these years. I hope in this paper to demonstrate how the passages from Walter's memoir signaled Ms. T's birth into a new being and a "self" in our work together. It is the theme of Ms. T's "self"—her awakening to her own existence—which I hope to "recognize and appraise" out of the countless variations of our shared experiences. Walter's narrative of his highly uncharacteristic treatment with Freud, within the context of his life's story, provided a "potential space" in a very uncharacteristic psychoanalytic treatment that has stretched out over my long career as an analyst. My hope is to show how Ms. T and I learned to hear the variations on the theme of her *self*—through the seemingly intractable, psychotic symptoms that brought her into treatment. Her contribution of the Walter text became for me a kind of monument to what we have accomplished together. This paper memorializes that work, and I dedicate it to Ms. T in honor of our journey together.[2]

FEARFUL SYMMETRY

At the age of 30, Ms. T had been diagnosed as "pre-psychotic" by the psychiatrists who had begun to prepare her for a life curtailed and defined by the implications of this diagnosis. She had scant experience with talk therapy. I was about her age. As a new psychoanalytic candidate, I had met with various mentally ill patients in the psychiatric hospital where I

[1] See also Sterba, R. (1951). A case of brief psychotherapy by Sigmund Freud. *Psychoanal. Rev.*, 38:75-80.

[2] When I asked Ms. T for her permission to publish an account of our work together, she granted permission, adding that while she would never want to read this paper, she would like to think that it would be of help to other people. I would also like to thank Peter Rudnytsky for his insight and suggestions on this paper.

was "pre-clinically" training, and had been in analysis myself for two years, but had yet seen no patients in intensive treatment. There was thus a "fearful symmetry" in our positions as we started our relationship. Just beginning psychoanalytic training, I was someone who came from "outside" the mental health professions; she was a patient who had stepped "outside" conventional psychiatric treatment to take her chances with me. She started treatment with me skeptically, but with determination to understand what was happening to her. Ms. T and I were both uncertain of our way. Our work was her last chance, and my first. It was our mutual fears, I think, that characterized and clarified our relationship in this early phase of the treatment. Mystics have termed "the cloud of unknowing" that state in which one tolerates a suspension of self while inviting a state of uncertainty for the sake of increased knowledge, and an assurance of meaning. It is not, I think, far-fetched to suggest that a similar state envelops the treatment couple: for, in order for psychic change to occur, some older version of the self must be cast aside in order for a new perspective to be embraced. And in that place of unknowing before one is sure that finding something new is possible, one faces a fearful odyssey.

In his essay, "The Analyst's Fears," Warren Poland (2006) points out how the fears of the analyst are perhaps most often experienced without "surfacing to the level of conscious awareness" (p. 202). He writes, "the first hint of underlying fear is the clinician's sense of a troubled uncertainty, uncertainty about how the work is proceeding, uncertainty about what is going on" (p. 202). Ghosts of the past are revived and emboldened by the blood of the living relationship between analyst and patient. As Erik Erikson (1994[1959]) reminds us, the therapist must fulfill a paradoxical set of demands implicit in the analytic situation, recognizing on the one hand the "negative identity" of the patient while on the other hand conveying that this pathological identity is not all that there is to the patient: "[i]f the therapist is able to fulfill both of these demands, he must prove patiently through many severe crises that he can maintain understanding and affection for the patient without either devouring him or offering himself for a totem meal" (p. 146). Our work is rooted, as this metaphor reveals, in an early longing for and fear of merger, with its threat of psychic cannibalism. Donald Winnicott also employs this shocking metaphor of cannibalism to suggest the impact of an

impinging environment in the life of the developing infant, and again as a potential danger in the world of analytic attachment when language can become an instrument of destruction of an emerging, fragile self. "Rape, and being eaten by cannibals, these are mere bagatelles as compared with the violation of the self's core, the alteration of the self's central elements …" (Winnicott 1965, p. 187). I invoke these cherished psychoanalytic theorists now as a kind of consolation to my beginning analyst-self. For then, I knew not what rough beast may lie in wait when I began treatment with Ms. T; I little knew the mystery and the complexity of the terrain into which I was embarking, nor did I know what "tectonic" shifts in identity both she and I would experience in the long expanse of our time together.

MEETING MS. T

Ms. T came to me through my colleague, Dr. N, who is a psychiatrist and psychoanalyst. For decades Dr. N had treated Ms. T's mother for paranoid schizophrenia and arranged several hospitalizations. Ms. T's prior record of treatment had spanned about three years with different providers, one of whom prescribed a medication from which Ms. T experienced some relief only to be devastated when the doctor revealed that this was an anti-psychotic drug. Despairing at the course things were taking and at her sense of being doomed to her mother's terrifying mental illness, she turned to her mother's psychiatrist, Dr. N, who suggested she come to talk to me. Dr. N had become acquainted with me at our psychoanalytic institute where we were both training. Dr. N told me little of this patient's background, except that the mother had been under her care for many years, having recently been hospitalized again, and that the father refused to acknowledge his wife's mental illness. Dr. N did not believe Ms. T was schizophrenic; in fact she had asked Ms. T to sign her mother into the hospital in the most recent hospitalization, in an effort to put the daughter into a place where she might both acknowledge her father's denial of his wife's illness, while recognizing that she herself was not the heir to this affliction. I agreed to start treatment with Ms. T under supervision with a seasoned analyst who agreed that Ms. T might try psychoanalytic treatment, and take a medication hiatus on a trial basis. Ms. T and I met in the evenings after her work in a vacant

basement office of the psychiatric hospital where I rounded in the daytime. The office was vacant, sparsely furnished in the basement of the hospital, outside of which glowed a Coke machine. Often Ms. T and I both carried into the sessions a can of Diet-Coke, holding on to our respective drinks for dear life.

THE MOTHER'S FACE

A heavy set, short, plainly dressed woman of thirty, Ms. T usually wore a strained smile. She had trained as a concert violinist, but worked in various administrative jobs for local businesses. Occasionally she gave private lessons. She had no significant relationships outside of her family. She had never told anyone about her symptoms: intrusive, tormenting thoughts over which she felt she had no control and that she found so paralyzing she could think of nothing else. While suffering from the "bouts with the thoughts," she pretended to be normal, but privately was in anguish and doubted her own and other people's existence. In her first bout with the thoughts, which occurred after graduation from college, she remembers looking in the mirror and seeing her mother's face: "I was her. I was in her pain. This was my being." Winnicott's invocation of the mirror-role in the life of the baby and the distortions that follow from the mother's failure to see the infant's potential being in her looking at the baby bespoke my patient's near breakdown as she looked at herself in the mirror. When the mother cannot give back what the baby is giving her, "[t]hey look and they do not see themselves" (Winnicott 1971, p. 151). The circumstances that are too easily taken for granted, namely that ordinarily what the baby sees when he or she looks at the mother's face is himself or herself, was entirely missing in the infancy of Ms. T. She recalled a vivid fantasy from her childhood in which she would wish that she would have total amnesia, because then she could exist separate from any memory of her family. The wish went like this: If I have amnesia my family would have to like me because I would not really be myself. I would not be myself—because I would not remember all that they said that I was. I would have forgotten all that they tell me I am. I will exist in a kind of fresh ignorance of their vision of me. Maybe then I could be who I really am." She was struck, as we talked about this, how she never logically followed this thought to realize

that since her family would not have also suffered amnesia, they would remember her and thus keep her in her imprisoned identity. It never got that far, for she determined that if she did not remember what they remembered, they would have no power to determine who she was. The relief of her own longed for "not knowing" became a powerful fantasy that we co-constructed to also effect the way she viewed my perception of her: would I be able to see her for who she was? Or would I too only "remember" the sick patient who first walked in my door, diagnosis in hand?

Winnicott explains that the "environment-individual set-up" (1953, p. 222) of early impingements in the infant's exploration of his environment can lead to a reactive return to isolation and a "secret inner life" that is "truly incommunicable." From these early impingements derive the "false self" built on compliance to the environment, fostering a latent psychosis (Winnicott 1953, p. 225).[3] Like the child of Sándor Ferenczi's pioneering essay, "The Unwelcome Child and the Death-Instinct," Ms. T felt that she had come into the world as one of the "unwelcome guests of the family" (1929, p.126). She was "unplanned," being born less than two years after her older sister, who was beloved and "perfect." The story of her mother's pregnancy became a major conundrum of our work. Ms. T's mother kept a baby book in the first year of her life. This "memoir" of malady, both Ms. T's mother's and her own—is now in Ms. T's possession. It is a sustained, written record of Ms. T's "badness" as a baby. Page after page records the suspicion with which this baby is viewed even during pregnancy by her mother; her mother writes (clearly with incipient psychosis) that even during delivery the nurses whispered there was something not right with the baby; the hospital had bugs crawling on the walls; the doctors acted suspiciously during the prolonged and complicated labor. The book is continued when the baby comes home, filled with descriptions of the baby's crying, her naughtiness. Ms. T's "badness" is painted in contrast to the baby book of the "good" older sister. It must be said that, until Ms. T began her

[3] See: D. W. Winnicott (1964). The Concept of the False Self. In *Home is Where We Start From: Essays By a Psychoanalyst* (New York, NY: W.W. Norton and Company, 1986), pp. 65-70.

therapy, she had always taken the record of the baby book at face value, accepting its veracity.

I surmised that Ms. T had been the result of an unwanted, unexpected, and problem pregnancy: she had been "scripted" into a part by her mother's mental illness, and blamed for her mother's encroaching schizophrenia. The mother's psychosis might well have somehow been triggered at this time during the pregnancy, but I could not verify this because of the silence within the family, particularly the father's denial, of the mother's mental illness. Over the years, I have further considered Winnicott's essay on "Birth Trauma," in which he says that "it is a pity to be blind" (1949, p. 180) to the meaning and even memory of birth experiences that daily are brought to treatment, especially by more disturbed patients, "… the psychology of an individual is something which can be studied pre-natally and at the time of birth, … the experiences at this early date are significant" (pp. 176-77). The dramatization of "birth memories" in his patients might be disbelieved in their details but accepted in their "accompanying affect" (p. 179). Ms. T had in fact evidence of the traumatic circumstances of her birth and the record of impingements recorded by a mother for whom her very being heralded a bad omen. Such impingements at these earliest points in the life of the infant laid down the expectation of what Winnicott calls a "loss of continuity of self, and even a congenital (but not inherited) hopelessness in respect of the attainment of a personal life" (p. 180). Ms. T described herself indeed as having "no life" compared to her siblings. With bitter irony she recounted her sister's remark to Dr. N following the most recent hospitalization of her mother that now their job was to find her sister a "life." The particular humiliation of this remark underscored the pervasive way that she indeed felt: that her life was unreal.[4] Ms. T wished for a world where she might be free from the self she had constructed as cause, heir, and caretaker of her mother's mental illness. Her bringing this to me in our time together expressed a wish to explore the potential, the secret life incipient in her unfolding relationship with me.

Ms. T's father, who is now deceased, was a businessman. Entirely loyal to her mother, he refused to acknowledge any mental illness except

[4] Winnicott writes that "feeling real is more than existing; it is finding a way to exist as oneself" (Winnicott 1971, p. 117).

to say that any trouble with her mother was Ms. T's fault; she had "caused" her mother's illness and she was "the crazy one." Ms. T mother's first hospitalization occurred when Ms. T was sixteen. She remembers calling her father at work begging him to come home to take care of her mother who would be arguing with the TV characters, gesticulating madly to unseen visitors, or adamantly warning her teenage daughter about the dangers of the evil town in which they lived. [5] As a teenager, Ms. T worked very hard to keep the worst of her mother's sickness from her little sister, and feels very proud of how well she looked after her in the midst of these episodes. Ms. T remembers as a child lying in the backyard in the summer looking up at the stars and dreaming of traveling in space. Then she would stop her mind from dreaming for fear she would disappear into this world of distant space and get lost, never to return. Ms. T lamented that she had only gone through the motions of life ever since she could remember. Her high school and college years are a blur, filled with loneliness and the job of keeping her mother stable. Her mother somehow revealed most of her paranoid fantasies to Ms. T, managing to pull herself together in time for her father's return home, discrediting Ms. T's complaints. Music recitals she felt were positively torture because her mother, who had herself been a professional musician before her marriage, was unrelentingly critical about all of Ms. T's performances, despite her many honors all through college. The only place Ms. T recalls ever feeling free was with her paternal aunts who took an interest in her, complimented her on her beauty and her violin playing, and gave small gifts. Her mother was suspicious of their influence, and early in her adolescence cut off all ties with them, though her father would occasionally sneak away to visit.

Her "bouts with the thoughts" came upon Ms. T suddenly when she graduated from college. Even though it was these bouts that caused her to seek psychiatric care, she dreaded to tell me of their content for fear

[5] McDougall defines the existential challenge of existence for a patient who survives this family cluster, and especially the father's abdication of any protection of his child's emerging autonomy. "Over and beyond this complex projection of a maternal object the analyst also must accept being experienced as the father who has also failed in his task, namely, to protect the child from the implosive mother-image . . . the representation of the father then is invested as a person who refuses the nursling the right to become a separate individual and perhaps even to live" (1989, p.115).

that I too would diagnose her as psychotic. Her overwhelming anxiety about inheriting psychosis she projected onto me so that she could fight off what she "was sure" I was thinking about her. Ms. T's suspicion of me in our early years together seemingly knew no bounds. Day after day of doubt and dread filled the room, and often she kept me waiting for half the session hour and upon arrival reminded me that she did not know why she had to come to see me and what a punishment it was to sit and be stared at with such suspicion. Convinced that I did not believe her descriptions of her conflicts at home or work, she would often imagine how I was silently constructing a world in which she was destined to be either hospitalized or homeless. I certainly felt my share of despair of ever breaking through this projection in which I myself felt as housebound. And I even occasionally wondered if it was true that talking about feelings, dreams, memories and fantasies could eventually help us understand each other: was I and my "method" to be trusted? What I mean is that I wondered sometimes if I was becoming suspicious myself of our mutual enterprise and filled with doubt that the world I was trying to offer her outside of her lonely life really existed at all. And I often worried—beset with the "analyst's fears"—that I was wrong: *were* the thoughts that had brought her into treatment unrelenting and alien to analysis, and would I ever be allowed to hear them and to feel them together with her? Furthermore, the family collusion and denial of her mother's mental illness manifested in the transference relationship with me as we painstakingly lived through, for many years, her conviction that I thought that she was the "sick" one in her family. Her overwhelming anxiety about inheriting psychosis she projected onto me so that she could fight off what she "was sure" I was thinking about her.[6]

Absolutely central, therefore, to the early resistance and terror that Ms. T brought to our work was her dread of being lumped by me into the condemned chain of inheritance described by Ferenczi: "frightful confusion can … be expected when a child … comes under the

[6] Repeatedly she and I would return to the reality that Dr. N had requested that she be the one to put her mother in the hospital. With each iteration, I heard more about the precipitating incident: for example, that Ms. T's mother had threatened her with plaster scrapers and kitchen utensils, that her father would have nothing to do with Dr. N, that she would have to sneak the medicine in her mother's tea because no one trusted the psychiatrist that this was needed.

influence of a deranged, mentally ill adult … the 'wise baby' with his wonderful instinct accepts the deranged and insane as something that is forcibly imposed" (1995, p.82) so that "by way of tradition … an apparent heredity of psychosis is created" (1995, p. 50). Ms. T's maternal grandmother who had lived downstairs from them had also been psychotically paranoid, though untreated, and so terrifying a figure from Ms. T's childhood who threatened her with revealing the green men under the bed. The knowledge of her grandmother's mental illness seemed to make inevitable the inheritance of this curse.

In his essay on "The Effect of Psychotic Parents on the Emotional Development of the Child," Winnicott (1961) dispels the notions of hereditary mental illness in terms that offer liberation for a patient like Ms. T who felt scripted into psychosis not only by a family determination but also by mental health providers for whom her family history became overwhelmingly predictive fate, creating for her a providence of despair. His proclamation is worth citing at length as it offers a corrective to the extremes of contemporary diagnostic paradigms that can often feel fatalistic:

> Parental psychosis does not produce childhood psychosis. Aetiology is not as simple as all that. Psychosis is not directly transmitted like dark hair or haemophilia, nor is it passed on to a baby by the nursing mother in her milk. It is not a disease. For those psychiatrists who are interested not so much in people as in diseases—diseases of the mind, they would call them—life is relatively easy. But for those of us who tend to think of psychiatric patients not as so many diseases but as people who are casualties in the human struggle for development, for adaptation, and for living, our task is rendered infinitely complex. When we see a psychotic patient we feel "here but for the grace of God go I." We know the disorder, of which we see an exaggerated example. [pp. 104-5]

Again, such passages now illuminate our work for me and bring me a deepened conviction of the need to work (when we can) psychoanalytically even with patients who, like Ms. T seemed doomed to fulfill dreary predictions. In this early stage of the treatment, I was bolstered by my perspective, shared with those I fortuitously consulted with, that if I maintained an attitude of listening, consistently and with attunement to the unconscious, eventually, I would hear about the thoughts.

My approach, however, was far from the classical stance of the neutral, "blank screen" analyst.[7] Because I was early in my own training and anxious to sustain the relationship with Ms. T, I proffered hopeful scenarios of a day in the future when her coming to see me would feel more like building her own self and life and less like a forced duty to medical necessity. Though at the time I felt my encouragement was at best received with skepticism, in the later years of our work together Ms. T would often fit me in with her hair and nail appointments, her swimming, or her hiking to a waterfall with a friend, and her other luxurious treats like yoga; these along with her therapy were ways that she sustained self care that would have been unthinkable in the beginning of our work. I do think that my optimism and early assurances that she could safely share her thoughts with someone who would figure them out with her deeply encouraged her, kept her coming, and allowed her to hope there was a way out of the prison her thoughts had built around her mind. Likewise, though my early training would be called "classical" this first case was not conducted in any way like a classical analysis. Rather, I approached it as a psychoanalytic treatment and from the outset was flexible as to frequency of visits, starting out once a week and over the years increasing to two or three times a week according to the severity of Ms. T's symptoms balanced against the demands of her work and, eventually, school schedules. The point to address here, that is invariably asked of me when I present this clinical material, is what the practical arrangement of this treatment looked like, and what it felt like to set out on these rough and uncertain seas as a beginning analyst?

My work with Ms. T was conducted both inside and outside of my clinical training: she was not a "control" case but was, on the other hand, a patient for whom I regularly sought consultation over many years, and with whom, by the same token, I continued to work throughout the period of my supervision, and indeed beyond my graduation. Thus, in some ways my

[7] See Jacobson, J.G. (1993). Developmental observation, multiple models of the mind, and the therapeutic relationship in psychoanalysis. *Psychoanal. Q.*, 62:523-552. I had the good fortune of hearing an early version of this paper presented, accompanied with a slide presentation of infant observation to my psychoanalytic institute; Dr. Jacobson's presentation of his work was riveting and persuasive. He modeled compassionate and open-minded clinical practice for me, again, at an early and formative stage of my training.

thinking about my work with her I evolved along with my growth as an analyst. To this end, I was very fortunate to be invited to present this case to a clinical seminar lead by Professor Diana Rabinovich, a Lacanian analyst at the University of Buenos Aires in the second year of working with Ms. T. This early clinical discussion fostered my capacity to listen to the patient's language alert to unconscious meaning and my own reveries. Within this seminar psychoanalysis was taught with less attention to what Irvin Hoffman calls the medically ritualized aspects of the psychoanalytic encounter—focusing on frequency, cost and couch—and more attuned to the "liminal" space created by the analyst and patient. The attunement to this balance between ritual and spontaneity allowed me, as a young practitioner, to relax my constant vigilance to encourage a regressive transference that would be interpreted with some "transcendent potential" to resolve psychic suffering (Hoffman 2014, p. iv). As Hoffman (2014) maintains, "non interpretive interactions" (p. xv) and "interpersonal reflections" (p. 117) within the liminal space of the analytic setting must balance interpretive interventions. My willingness to interact with Ms. T authentically, respectful of the yet undetermined meaning of her thoughts—to not, that is, inhabit the position of the objectivist analyst who was "supposed to know"—saved this treatment. I am grateful to have met analysts within a psychiatric hospital setting who acknowledged the challenges, while supporting without reservation the uses of psychoanalysis as a preferred paradigm of treatment for this patient. And in many ways having Ms. T in sustained treatment throughout my training analysis allowed me to diminish the drastic distinctions between psychosis and neurosis conventional in our diagnostic training and often to agree with Winnicott that there, but for the grace of God, go I.

THE THOUGHTS

Ms T. brought me her first episode with the thoughts late in our first year together, and we were to go through several more over the course of many years. From the experience of being "with her" in these episodes, I learned that the thoughts came upon her out of the blue; they took her over so completely that she lost appetite and could not leave the house; losing concentration as she waited for them to pass. Indeed, she often took off work and forced herself to come to her sessions. At

this time she felt more like the patients I had met in the hospital: smelling of cigarettes and sweat, unkempt, and often silent. The bouts would sometimes last weeks, sometimes months, and in one especially horrible instance, lasted an entire year, in which she sometimes felt like killing herself just to get away from them. I learned that the content of the thoughts was always the same, phrased precisely, and would appear in three constellations:

1. Some day we all are going to die
2. you/I do not really exist
3. people are not people, they are only creatures of flesh and blood

These thoughts were accompanied by an empty feeling that her life was stretched out before her in endless days that only led to death. When they did go away, she would swear avidly that she would do no more complaining, quell all desire if they would just leave her alone. Though it took some time for Ms. T to allow a probing of the actual content of the thoughts, eventually we were able to think about what they actually meant. Ferenczi identifies what he calls the tendency toward "cosmological speculation" in his "unwanted" patients in a way that resonated with the stark and unrelenting pessimism contained in Ms. T's assaults. He writes of his patient:

> [h]er broodings about the origin of all living things were only, as it were, a continuation of the question which had remained unanswered, why she had been brought into the world at all if those who did so were not willing to receive her cordially? [1929, p. 127]

When she had the thoughts, Ms. T felt "there was something wrong with me from the very start, and my mother knew it." But most confusing and disorienting to Ms. T was how her mother, who was usually unrelentingly paranoid and critical of her, would soften during these times of her bouts, as if her mother somehow knew that she was descending into a darkness that they shared. Even though she had never told her of her bouts, she felt somehow her mother knew. She reported lying on her bed with a migraine, and her mother coming in to cool her forehead with a washcloth, whispering that she too wished she had a clear mind. Through an analysis of such incidents we began to surmise, among other

things, that the episodes with the thoughts, ironically, allowed her to experience intimacy with her mother as she joined her in her in a kind of mimetic psychosis.

In the transference, this mimesis of her mother's thought disorder showed itself when she nearly fainted a few days before Christmas, after a particularly close and emotional session with me in the fifth year of our treatment. Ms. T was not accustomed to using the couch, and had expressed no interest in doing so. On this evening, however, she lay down on the couch for the first time, feeling dizzy, and then suddenly shot up, fearful that I was able to read her mind. Did I know something about her that I was not telling her? When she looked at me she felt for one terrifying moment that I had changed into a woman at work, a new friend whom she had just been describing to me with real, even romantic, pleasure. This fantasy or hallucination about me terrified her. Thoughts seemed to have come alive, and for a few weeks, Ms. T found one reason or the other to cancel our sessions. Finally, upon her return, Ms. T spent subsequent sessions trying to piece together what she had seen when she looked in my face on that day. From this incident flowed an increased capacity to confront the meanings of her thoughts; they were not, "entirely," we suggested, foreign infiltrators into her mind, but products of her own memory, fantasy, and desire. This was a turning point in our work as it allowed her to understand the ways that her thoughts could mean something, and that her history could come alive in her relationship with me.

Each of her thought clusters over time has similarly shifted from the split off, wooden quality that they had assumed in her mind, to become more integrated into a sense of her history. Each cluster has revealed her sense of the torment of being both unwanted and unreal, not a person but a creature that had provoked the monstrousness of her mother's sickness. She recalled, for instance, her mother's answering her every complaint as a child with the taunting reminder that she was "only a creature of flesh and blood" and could hardly do all that was required of her. Such sayings—rather philosophical in their tenor—ended up dehumanizing Ms. T, as they drowned out memory like deafening drumbeats. Along with her mother's taunting refrain about her "creature-ness" came the memory of being challenged regularly to endure the screaming of a boiling tea kettle: "can't you take it?" Ms. T now wondered if allowing that

kettle screaming was her mother's way of drowning out the voices she heard in her head. From such questions and insights, Ms. T eventually not only constructed meaning from the thoughts, but also came to feel some compassion for her mother whose mental illness went untreated through most of her life. Yet despite such breakthroughs, it is also the case that Ms. T and I did not regularly discuss the thoughts as such; in fact, often when she would be telling me about this or that aspect of her daily life in the early years of the treatment, she would challenge me with the question: "What does all of this have to do with the thoughts?" This refrain sunk me into the doldrums of needing to remind myself and her about how all of our work has been one way or the other about "the thoughts," while the thoughts, in turn, have in one way or the other been about being an unwanted child of a psychotic mother. Ms. T's bouts with the thoughts have been dormant for well over twenty years now, and they seem to be gone for good; our work more recently is on what she calls "her life." The thoughts ironically paved the way for her to find a new way to be. What made the work viable with Ms. T, as I now reflect upon it, was the delicate balance of accepting what she felt and remembered as being "true," while at the same time tactfully bringing her closer to seeing me and our ways of talking and thinking together that could allow for new truths, and indeed the new beginnings of trust.

For Winnicott (1971) there is an "historical process (in the individual), which depends upon being seen." His explication of this very condition of human identity and creativity as outlined in his essay on "The Mirror-role" is itself very nearly poetic, capturing in its spare, simply lines the enigma of being, and the promise of becoming that for him inhered in the potential space of the analytic encounter:

> When I look I am seen, so I exist.
>
> I can now afford to look and to see,
>
> I now look creatively and what I apperceive I also perceive.
>
> In fact I take care not to see what is not there to be seen (unless I am tired). [p. 154]

I find this passage particularly suggestive in my review of the treatment of Ms. T for she, like the patient that Winnicott uses to partially explicate his generalization has in many ways, used the treatment simply and profoundly to be seen for who and what she is. And perhaps most striking of all is Winnicott's final point, enigmatically and tenderly amended by his parenthetical break: that when the child is able to look creatively and perceive, he or she does not see what is not there, unless they are tired. Even the most grounded individual may have recourse to paranoid fantasies when fatigued. Ms. T and I, in the long hours of our looking at each other, both usually pretty tired at the end of working days, learned to see ourselves in the other. We have come to the place where she can confidently know that what she sees is real, and that what she does not see is not there. She has been able to get started as a person.

In cases such as Ms. T's, the adverse factor to the infant's capacity to "going-on-being" is "so great that the individual has no chance (apart from rebirth in the course of analysis) of making a natural progress in emotional development" (Winnicott 1971, p. 189). Such reflections cohere with my sense that the work Ms. T and I have done over the years has offered a "rebirth." Such "experience of aliveness … could not be taken for granted" (Winnicott, qtd. in Phillips 1989, p. 128). The environment we had created together allowed Ms. T to feel "real."

"THE GODDESS OF PRESENCE"

By the time Ms. T came to share with me the pages from Bruno Walter's remembrances, *Theme and Variations*, she had gone back to university in her mid-forties; she had obtained an advanced degree, and was working at a secure, professional job in which she was able to use her considerable cultural knowledge, and work with children. She was proud of her accomplishments, and though still living at home taking care of her aging parents, she had friends to whom she turned for social outings. Though she did not return to performing, she cultivated deeper appreciation of the classical music that had been a passion she shared with her mother. She noticed a new biography of Walter (2007) and from this she was inspired to read his autobiography, published in 1946. The passages that Ms. T brought me from Walter's book about his life mark a

transition in the treatment as I have conceptualized it. These passages provide a counterpoint to the childhood script she so dreaded: they heralded Ms. T's new life to which I now turn.

Ms. T was taken with Walter's reflections upon the culture of the Viennese coffee house, and the spirit of human intimacy and conversation that filled these establishments. Walter celebrates what he calls the "Goddess of Presence" whose dominion in the coffee house fostered a conversational community lost in the modern world:

> The speaker's words kindle in the listener's mind new ideas, whose utterance–in contrast to the finality of the written word—… has the blessing of retractability. In our day of the telephone, the film, and radio, I still insist that the Goddess of Presence will not be dethroned and that in the playing of music, in dramatic presentations, and in conversation—and in love too—only personal presence will be able to produce the soul-moving climate in which man is spurred on to his highest potentialities in giving and taking. [1946, p. 136]

This last reflection inspired in Ms. T a feeling for what she had lacked in her family, and, conversely, an appreciation for the ways that I had been present for her in our conversations over the years. Particularly, the give and take—the retractability—of our dialog, loosened the grip that the "confusion of tongues" (Ferenczi 1955 [1932]) between herself and her parents had hardened into hypostasis. The presence that Ms. T and I could establish and eventually enjoyed allowed for the conversational give and take and the retractability that eventually dispelled the seemingly endless suspicion and doubt that filled in the room in our early years together, during which time my identity in some ways was as lost as hers, surrendered—for the session-hour—to the place that she hated so much. So it seems to me now significant that Ms. T's bringing of this text to our work together signaled the culmination of a long process of becoming an equal partner—someone who might share with me an elegant and insightful text. Someone with whom I might enjoy the pleasures not perhaps of the Vienna coffee house, alas, but of imagining such places and such times.

Ms. T was especially taken with the autobiographical passages in which Walter tells of his treatment, in 1906, by Freud, to whom he turned for help with a hysterical paralysis of his conducting arm. In his chronicle,

Walter reports that he had been convinced that his arm affliction was "psychogenetic," and precipitated by the recent attack upon him by the enemies of his musical mentor, Gustav Mahler. Even though he eventually triumphed over this band of vindictive critics, whose scapegoating had nearly driven Walter from his post at the Vienna Opera, Walter's arm went numb and limp following the vindication of Mahler. After trying everything from magnetism to mud baths, Walter wryly notes, he turned to Freud. Instead of "questioning me about sexual aberrations in infancy," (p.164) the psychoanalyst prescribed travel! Freud asked him if he had ever been to Sicily: "When I replied that I had not, he said that it was very beautiful and interesting, and more Greek than Greece itself. In short, I was to leave that very evening, forget all about my arm and the Opera, and do nothing for a few weeks but use my eyes." Walter took Freud's advice and left that evening. "When my eyes took in Mount Vesuvius, the town, and its environs, I did not die, but neither did I feel quite of this world … " He records that his "thoughts of a tempestuous past, of the monuments commemorating it, and of nature that seemed to bear its imprint agitated me for weeks and made me forget the present and my troubles. In the end, my soul and mind were greatly benefited … but not my arm" (pp. 165-166).

He returned still afflicted. Yet he narrates images and memories of curious incidents from his journey that foreshadow his ultimate recovery. In other words, he returned, "armed" with unconscious knowledge derived from his journey, the traces of which surface as if of their own accord in key vignettes narrated according to a special providence that guides him throughout his narrative, as his life.[8] Indeed, he affectionately attributes the inspiration of his autobiography to muses who inspire key vignettes in his record of his prescribed travel. Ms. T was taken with one such small but significant vignette that ended up capturing for us in the treatment a core fantasy in Ms. T's transference:

> [At Naples] I attended an evening performance of *Rigoletto* at the Teatro San Carlo, and though I was not interested in the

[8] "I have been vouchsafed the grace to be a servant of music. It has been the beacon on my way and has kept me in the direction toward which I have been striving, darkly, when I was a child, consciously later. There lies my hope and my confidence—*non confundar in aeternum*" (p. 344). "Let all material things be unreal; music's immaterial essence" brings … "harmony with myself and life" (Walter, p. 105).

> performance itself, I admired the magnificent house, enjoyed the noisy enthusiasm of the audience, and was particularly amused by a little incident that, at that time, could hardly have occurred anywhere but southern Italy. When I got up to leave my seat during intermission, my neighbors begged me to wait a bit. A few seats away from me a young mother was nursing her infant, and the Neopolitans, so noisy and unrestrained at other times, waited patiently and with sympathetic awe until the baby had drunk its fill. Then, to be sure, they crowded their way out with Neopolitan impetuosity. [p. 167]

This small but suggestive tableau presages the core attachment to Freud that would come ultimately to relieve Walter's limp and unresponsive arm when he recommences his brief therapy. This memorable vision captivated Ms. T's nascent imagination, I think with good reason. Ms. T brought me this charming scene of the Neopolitan mother and infant in recognition of how the Goddess of Presence directing Walter's narrative had allowed her to feel something of the "sympathetic awe" captured in this small scene. The picture of a simple, primal bliss protected, preserved, and admired by lovers of music, and the great Bruno Walter himself (who, incidentally, had just become a father that year), offered an affective elaboration and a literary rendering of the holding environment the therapy had provided for her over the years. In approximation of the mystery of the nursing couple, our work offered a place to come and converse, and a new beginning. Walter's Neopolitan musings, with his reverence for the nursing couple, woven into the atmosphere of the opera house, is consonant with Winnicott's description of the roots of creativity in the "positive value of illusion" (1953, p. 223) Walter's local tableau captures, with particular charm and efficiency, the "Ur" mystery of the nursing couple as they sympathetically ground the transitional phenomena of the opera house. It is as if Walter and the Neopolitan audience intuitively revere the origins of music's power to transfix.[9]

[9] Matthew von Unwerth describes Freud's resistance to music: "In a letter to Romain Rolland discussing the oceanic feeling, Freud declared, 'I am closed to mysticism [represented by the oceanic feeling] as to music.' In asserting his alienation from music, Freud equates the inspiration received from that most abstractly emotional of the arts to the mystical oceanic feeling" (2006, p. 132).

Yet when Walter returns from the pilgrimage that Freud has sent him on to Italy, still paralyzed in his body, he fears the gods of music have deserted him. It must be said however that Freud does not despair but offers, for the period of this crisis, the "veil" of his own support and protection. Freud's adjusts his technique to Walter's plea:

> I poured out my troubles to Freud. His advice was—to conduct. "But I cannot move my arm." "Try it, at any rate." "And what if I should have to stop?" "You won't have to stop." "Can I take upon myself the responsibility of possibly upsetting a performance?" "I'll take the responsibility." And so I did a little conducting with my right arm, then with my left, and occasionally with my head. There were times when I forgot my arm over the music. I noticed at my next session with Freud that he attached particular importance to my forgetting. I tried once more to conduct, but with the same discouraging result. [p. 170]

He follows Freud's advice and forces himself to conduct, first using his good arm, then feebly using his limp arm, and occasionally conducting with his head. "So by dint of much effort and confidence, by learning and forgetting, I finally succeeded in finding my way back to my profession" (p. 170).

Walter invokes what he calls the "feminine favor" of the Naples scene and the courtesy of the audience to adumbrate his description, later in his narrative, of the protective veil or curtain that he produced following a suicidal bout of self-doubt. He creates within himself a shield to cover him and to protect his love of music from the impingements of the world, as well as the punitive voice of his own despair. To shield himself from doubts of his own reality, and of his existence, a:

> veil had spread between the world and myself, a veil which has never really lifted since, comparable to the one used on the stage to lend to fabulous and fantastic scenes the illusion of distance and dreaminess. But I had learned to believe in the indubitable reality of life in the spirit and of its creative manifestations. [p. 105]

He creates a "veil" between himself and the world, forbidding the impingements of a hostile environment.

Such a veil, I believe, was drawn over my work over the years with Ms. T. The times we shared in this treatment shielded her from interruptions in thought, and eventually in play and conversation. This alone may have sufficed more than what Winnicott calls the "clever interpretation" (2005, p. 68) to give her time and space to become in the presence of an interested "Other" who trusted her and who believed what she said was "true." For this reason, perhaps, it is not an accident that the complete story of Walter's treatment by Freud does not itself—either—rely upon what one calls a conventional psychoanalytic treatment which pivots on brilliant, transference based interpretation as one might expect. And it is here that Freud's treatment of Bruno Walter takes its place among the several stories that depict Freud the healer who devoutly places the needs and the gifts of his patients before his own ambitions to prove the points of his psychoanalytic theories and techniques. Confident that Walter's love of music will triumph over his displaced rage, directed at this own conducting arm, Freud tells him to "only conduct" … sounding very much like E. M. Forster whose advice to "only connect" (1998 [1910], p. 1) proclaims a modernist credo.

DREAMING OF LOVE

Ms. T's introduction of Walter's self-chronicle brought to me an appreciation of what we have discovered about the failure of her environment, and new meanings in the particular nursing couple that we have formed over the years, fostering the moments of being that she sustains as she builds a "life." I think it is important to note that Ms. T brought me certain pages of Walter's *Memoir* because it really was those pages that mattered to this woman who was raised in a house filled as much with opera as with psychotic oppression, for, as Virginia Woolf memorably remarked: "For nothing was simply one thing" (Woolf 2005[1927], pp. 276-77). Certainly Ms. T's bringing of this vision of merger with music, with the nursing mother, and with a warm and courteous community was as much an expression of longing and loss as it was a prospect of hope, and a gesture of gratitude. Ms. T brought to me recently a dream that invokes the providence that guides her emerging self, offering a protective veil of love. The dream takes place in some kind of building,

an office or a church. It is the dream of a film that she is acting in; all of the other figures are actors. She is the only real person in the dream:

> *I am standing among strangers in a crowded room; I pass by a man in a corner who is filled with terror for me: he is a slasher from one of those horrible movies and he wants to kill me. I am paralyzed with fear and cannot get away. Then a man comes forward and it is clear that I am acting in a play of some sort. This man—I think it is Barney Miller from the TV shows—is playing my father. I explicitly think: this man is acting; he is not my father. But he is playing my father and I go up to him and put my arms around his neck in an embrace. I feel coming from me a surge of love; from here (pointing to her chest) and flowing out of me into him. He receives my love and it flows between us. I think to myself: so this is what it means to feel love and to feel loved. Then I walk past the terrorist and I think to myself (I do not speak but he knows what I am thinking) "you have no more ability to make me afraid. You cannot hurt me because of my love." What I remember thinking either in the dream or afterwards is that I do not know whether I changed this terrorist or I just am free from his terror but I know that I can walk along and am not afraid.*

Ms. T recognized the terrorist of her dream as her mother's illness and the perverse providence that her psychosis played in her life. And she recognizes that her rage at being relegated to role of bad baby and bad seed of her mother's sickness was itself sealed into her thoughts and kept her prisoner. She has acknowledged many times prior to this dream how for so long she did not accept or even understand how insistently I asked her about her own rage at both her parents, and her siblings, for keeping her in the place of the sick one, "lumped with her mother" and yet as the caretaker of both her parents. I thought that the terrorist in the dream must also somehow embody her once all consuming fear that she would be consumed by the torment of her thoughts and the fury that they encased in her mind and very being. But it must be said that in this dream, the far more present association in her recollection, was the feeling she still had from within her body of this love. It was the first time in her life she had felt such a sensation. "So this is what it feels like to be loved," she kept saying to herself. She said further that she thought it was very important that the man that she hugged was not really her father but someone playing him. "I kept thinking that it stood

for God, like God the father." My own thoughts were that as Ms. T's analyst I am "playing the father" here; I am the father in the transference that could believe her, love her, and receive her love. This is the very thing that her own father for all of his gentleness and indeed love of his daughter, could not do in his collusion with his wife's mental illness. It seems to me that this is why Ms. T felt it is so important that the figure in her dream be, precisely, an actor, a substitute. That her dream father may be interpreted as a transferential object does not make the desire any less profound in its origin. She allows, like Walter, for a Providence in this new moment of being in love. Her associations to the terrorist lead to her feelings of being entrapped in the terror of the thoughts, and especially the terror of never being free in her mind from the dehumanizing feelings that consumed her. Her strongest sense was that these terrors had no more power over her: like the witch in *The Wizard of Oz* who has no power once Dorothy finds out the secret of how to get home. It occurred to me that Ms. T had in her dream re-written the childhood script based on the providence of despair, and substituted her own version of destiny. But I did not make this interpretation, nor did I interrupt her sense that she had felt, or even encountered something of the divine in this dream. Ms. T's sense of presence in her dream allowed her to possess a creative and unchallenged, potential place to go on being. For this woman whose paranoid mother had impinged upon her psyche, directly communicating with things and people that were not there, my work was to listen, and not correct her dreams with clever interpretations that dispelled illusion; for these new dreams gave her the space to gaze not only at the stars, but at her own face, and mine.

CODA

The last stage of the work with Ms. T has involved her recognition that the bond with the psychotic parent necessitated putting her mother in a nursing home. She often visits her mother and experiences a complex mourning for now an old woman who is more kind and vulnerable, dementia having set in and the psychosis receded. It was shortly after this move of her mother to the nursing home and arranging for her own short weekend stays with her sister that Ms. T announced that she felt she wanted to stop coming to see me, to save money, focus on her work

and going to the gym. She brought me boxes of pictures taken by a renowned photographer of her parents' wedding. They looked like old movie stars. They were indeed beautiful and splendid, almost mythic and clearly a source of sadness and pride for Ms. T whose youth was permitted no such luster.

Now Ms. T returns to "check in" with me every so often: once during a tough time at work she returned every week for two months; more typically I see her two or three times a year. Ms. T's acceptance of the realistic fact of her mother's mortality has led Ms. T to express to me how it now feels to visit her mother in this vulnerable state. She thinks over with me how her life has unfolded. Here Balint's sober assessment of the realities of Ms. T's "scar" indeed resonates with the ways she and I have understood the losses, and missed opportunities she has suffered in her life she now recognizes as she looks back:

> Provided the analyst is able to fulfill most of the requirements sincerely and unreservedly, a new relationship may develop which will enable the patient to experience a kind of regret or mourning about the original defect and loss which lead to the establishment of the fault or scar in his mental structure … . The regret or mourning I have in mind is about the unalterable fact of a defect or fault in oneself which, in fact, has cast its shadow over one's whole life, and the unfortunate effects of which can never fully be made good. Though the fault may heal off, its scar will remain forever; that is, some of its effects will remain demonstrable. [1979, p. 183][10]

Ms. T has in these recent sessions wanted to review her history with me—and to face the sometimes overwhelming realization that she has never been romantically "loved" by anyone, that she has not had children, and that no one will take care of her the way she has taken care of her parents. Balint observes, in this regard, that "the absence of good objects means also that the patient, because of his neurosis, has only a limited capacity to perform the 'work of conquest'

[10] Balint reiterates in a note to this passage: "The process of mourning . . . is about giving up for good the hope of attaining the faultless ideal of oneself; a successful treatment must lead to the acceptance of the fact that one had a basic fault and to a realistic adaptation to this fact" (1979, p. 183).

(Balint 1947) necessary to change an indifferent object into a participating partner; this indicates a fairly serious basic fault in his mental make-up and character" (Balint 1979, p. 187). Ms. T has turned to religious faith and to the companionship of books. She is grateful for real friendships with men and woman that she made over the years of her treatment and admires contented couples she spends time with, and she acknowledges envying more prosperous friends while still expressing appreciation for what she has built up in her own retirement by virtue of her very good current job. She has returned to athletic endeavors of her youth and to hiking in the parks; she attends concerts, and educational lectures with friends. She goes on religious retreats. She will often send me some news by text of a success at work or an article about her achievements in a local paper. Returning to musical performance or teaching will never be possible for it conjures returning to the scene of criticism by her mother, and her failure to play perfectly.

With regard to the "thoughts" that threatened the debilitating take over of her mind and brought her into treatment so long ago in her early thirties Ms. T seems entirely free. Recently she told me of going to Mass at the same church where she experienced one of the first episodes of the thoughts and the terrifying feeling that she only saw her fellow church-goers as "creatures" and not really human. Now she reflected with some wonder, gratitude, and sadness upon this recent visit: everything was the same as it was that day. It was the same place she was sitting, the same Saint's Day, the same church, the same Mass, the same priest, now older as we all are, and many of the same people. "But *I* am different," she said. "*I* am not the same."

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On Claiming A Psychoanalytic Identity

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ON CLAIMING A PSYCHOANALYTIC IDENTITY

BY LAURENCE SPURLING

In this paper I describe how I have struggled to find a viable identity for myself as a "psychoanalytic psychotherapist." Such clinical entities have been constructed by employing a particular logic, that of using parameters, which sets up an ideal of psychoanalytic practice from which all other forms of practice are meant to deviate. I argue, by means of a clinical example, that this way of thinking distorts our understanding of the analytic process. At an institutional level it deflects from the need to map out how we actually practice (rather than how we ought to practice), which we need to know so we can address real differences in approaches and levels of knowledge and skill.

Keywords: Psychoanalytic psychotherapy, analytic identity, session frequency, parameters, analytic process.

One of the often repeated clichés I have encountered over my career as a psychoanalytic psychotherapist is that, as one develops in one's practice and experience, it is no longer our patients who are source of most of our professional troubles and grievances but our colleagues. My version of this truism is over my ambivalent and conflicted feelings about my professional identity within the analytic community as a psychoanalytic psychotherapist. The problem for me can be stated simply as this.

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Psychoanalysis is the conceptual framework, theory, and method I use in all of my work: I see myself as practising psychoanalysis. I therefore think of myself as a psychoanalyst. But my analytic training does not accredit me as a psychoanalyst but as something called a "psychoanalytic psychotherapist." Despite many years of trying to figure out what "psychoanalytic psychotherapy" might be that makes it different from "psychoanalysis," I have failed to find a meaningful or useful distinction between the two. But this leaves me in a difficult position: although in my work I count myself a psychoanalyst, in my professional dealings in the analytic world I describe myself as a psychoanalytic psychotherapist. Now I could see this mismatch as my problem, that I have not been content to accept my professional status in the analytic world. But although I recognize the powerful forces of jealousy and envy in my make up, the argument of this paper is that it is the analytic community that has activated these feelings in me for no good reason by creating and institutionalizing an arbitrary, incoherent and unnecessary entity of clinical practice called "psychoanalytic psychotherapy" as distinct from "psychoanalysis," a division which serves no good clinical or institutional purpose.

Interestingly I have found that this question of what I call myself has never been an issue for my patients. I have never yet met a patient who seemed to care whether I was a psychoanalyst, psychotherapist, or counselor. All that matters to them is that I am good at what I do and can help them. It is only if I take on a patient who is training or wishes to train that these different analytic designations matter. And it is here, when my patient and I have to locate ourselves within the analytic community as a whole, that my malaise over trying to match my professional designation (psychoanalytic psychotherapist) with what I do (psychoanalysis) becomes evident. For instance, I write books on psychoanalytic practice and publish theoretical and clinical papers in analytic journals with "psychoanalysis" or "psychotherapy" in their title. In all of this writing I am immediately confronted by a consequence of the division of psychoanalytic practice into its various components: there is no single term that encompasses all of these so-called different practices. If I choose to adopt any one of these designations – analyst, therapist, counselor – I am thereby positioning myself as only speaking to that particular group of analytic practitioners. However it has never made sense

to me why I have to restrict my intended readership in this way. In my writing I wish to address all members of the analytic community. When I first had my work published I came up with what felt like the best solution to this problem by inserting a qualifier such as "in this paper I have used the term 'analyst' and 'therapist' interchangeably." But after a time such a form of qualification felt redundant, indeed irritating – why was I having, every time I wanted to publish something, to make this qualification that I did not believe in? So after a while I adopted the device of using the term "psychoanalytic practitioner" or "psychoanalytic clinician" to mean anyone using the psychoanalytic method.

Having to resort to these rather clumsy terms is, in truth, no more than a minor irritation. But it raises the larger question of why the psychoanalytic community has organized itself in this fashion. I cannot think of any other organized practice that would choose to present itself in this fragmented way, unwilling to create a common language to embrace all of its practitioners.

One consequence of this for all those in the analytic community who are not designated as psychoanalysts is that they have constantly to situate themselves when reading papers which have "psychoanalysis" in their title. Are such papers meant for them? A good example of this for me is when I read or refer back to one of the papers I have found most valuable and inspiring in charting my own development as a clinician, "On Becoming a Psychoanalyst" by Glenn Gabbard and Thomas Ogden (Gabbard and Ogden 2009). In their paper, the authors describe a number of key maturational experiences that mark the attainment of one's identity as a psychoanalyst, such as "daring to improvise" in their clinical work. They cite the importance of affiliation to the analytic community, for instance in presenting their clinical work to a consultant, or writing analytic papers in order to discover and refine what they are thinking. The key element for them is that of "developing a voice of one's own" (Gabbard and Ogden 2009, p. 314), which they characterize in generational terms:

> In the process of becoming an analyst, we must "dream up" for ourselves authentic way of speaking that involves disentangling ourselves from our own analyst(s) as well as past supervisors, teachers and writers we admire, while also drawing on what we have learned from them. [p. 315]

In exploring this process of becoming an analyst, they turn to a consideration of the nature of the internalization by the child of the parents in the Oedipus Complex, an identification by which the child metaphorically kills his or her parents by immortalizing them. They argue that this process is not simply about the incorporation of aspects of the parents as they are, but a far richer and potentially transformative type of internalization: "that of incorporating into one's own identity a version of the parents that includes a conception of who they might have become, but were unable to become, as a consequence of the limitations of their own personalities and the circumstances in which they lived" (p. 315).

If there really is something called "psychoanalytic psychotherapy" which is different from "psychoanalysis," then it should be possible to construct a similar kind of developmental trajectory for the psychoanalytic psychotherapist. As the key element for Gabbard and Ogden is the capacity to acknowledge one's debt to one's tradition, as embodied in key figures such as one's teachers and key figures in the literature, while going beyond what these figures have achieved, one can wonder what would comprise the tradition of psychoanalytic psychotherapy, and who would its key figures be? I have not succeeded in identifying a tradition of thinking or practice with which I can engage which is not that of psychoanalysis. When I read Gabbard and Ogden's paper I position myself as though they are speaking directly to me, that we are colleagues working within the same tradition, using the same theories and method, and so facing the same developmental tasks in wishing to become better at what we do.

HOW "PSYCHOANALYSIS" AND "PSYCHOANALYTIC PSYCHOTHERAPY" ARE DEFINED AS DIFFERENT FROM EACH OTHER

But in implicitly claiming to be a psychoanalyst in this way, I am clearly transgressing the professional boundaries that have been erected by all psychoanalytic training and accrediting bodies. Here is how my own accrediting body, the British Psychoanalytic Council, in its public register describes what the "psychoanalytic psychotherapist" does or should be doing:

> Trained to work intensively, generally with the patient lying on the couch. A lot of the work is with interpretations (making the unconscious part of the mind conscious) and often uses the relationship between patient and therapist as the focus. The theory base is wholly psychoanalytic. [British Psychoanalytic Council, 2017a]

This definition of psychoanalytic psychotherapist is one of several other designations of analytic practitioners that all depend for their meaning on the definition of a "psychoanalyst":

> Trained to work very intensively (4 or 5 times weekly), generally with the patient lying on the couch. Most of the work is with interpretations (making the unconscious part of the mind conscious) and uses the relationship between patient and therapist as the focus. The theory base is wholly psychoanalytic. [British Psychoanalytic Council, 2017a]

The American Psychoanalytic Association describes psychoanalytic psychotherapy on its website in a similar way, as a "less intense" form of clinical practice than psychoanalysis, one "which is based on psychoanalytic theory and principles," and "utilizes psychoanalytic theories as the frame for formulation and understanding of the therapy process (APA 2018a).

Such descriptions present the psychoanalytic psychotherapist with an immediate problem. If he or she is described as using psychoanalytic theory in the same way as the psychoanalyst ("the theory base is wholly psychoanalytic,") or as "based" on psychoanalytic theories, and if we can assume that this psychoanalytic theory fully supports the practice of the psychoanalyst, then what is it that supports the practice of the psychoanalytic psychotherapist in the ways it differs from that of the psychoanalyst? What are the conceptual frameworks, clinical protocols, or principles of practice, which can account for the "less intensive" element of their practice, which constitutes the difference from psychoanalysis? Is the psychoanalytic psychotherapist supposed to be doing something *different* in this part of their practice, for instance importing non-analytic ideas? Or is it what they are not doing, or doing *less* compared to the psychoanalyst? In either case, the psychoanalytic psychotherapist would need an overarching framework, something bigger than psychoanalysis,

within which to locate that part of their practice, which is fully psychoanalytic, and that part which is not. Furthermore, within this overarching framework, they would also need concepts or protocols that could coherently link together their "psychoanalytic" practice and their "non-analytic" or "less-than-analytic" practice. Where is this framework, and what does it consist of? It certainly does not exist in any of these definitions, which seem to rest on the assumption that what is being described is internally coherent.

Another problem with these definitions is that they discriminate between "psychoanalysis" and "psychoanalytic psychotherapy" in terms of a series of practices, such as session frequency, making use of the couch and use of interpretation. For a public register this might seem a reasonable thing to do, as someone looking for treatment can readily appreciate these differences. However the definitions are hedged around with a number of *caveats* about not taking them too concretely (so the BPC acknowledges "it would be overly simplistic to say that the difference between psychodynamic and psychoanalytic work is based on frequency of sessions," [BPC 2018 b]) because the obvious objection to these kinds of definitions is that it is not simply *what* the psychoanalyst or psychoanalytic psychotherapist does but *how* they do it. In other words, a psychoanalytic psychotherapist who saw patients five times a week, used the couch and made a lot of interpretations could not then claim he or she was now a psychoanalyst, because, by definition, they would not be doing it in the right way – they would still be doing these things in an "intensive" rather than a "very intensive way," or in a way that was "based" on psychoanalytic theory rather than fully supported by that theory.

Without a clear specification of an overarching framework in which to locate the so-called differences between psychoanalysis and psychoanalytic psychotherapy, as well as a clear distinction of how the psychoanalyst works which is different to that of the psychoanalytic psychotherapist, the psychoanalytic psychotherapist is left with a flimsy and incoherent form of analytic professional identity. In effect by accepting this self-identity, the psychoanalytic psychotherapist puts himself or herself in the position so despised by Freud when he writes about mixing psychoanalysis with other approaches:

> Psycho-analytic activity is arduous and exacting; it cannot well be handled like a pair of glasses that one puts on for reading and takes off when one goes for a walk. As a rule, psycho-analysis possesses a doctor either entirely or not at all. Those psychotherapists who make use of analysis among other methods, occasionally, do not to my knowledge stand on firm analytic ground; they have not accepted the whole of analysis but have watered it down – have drawn its fangs, perhaps; they cannot be counted as analysts. [Freud 1932, pp. 152-3]

THE LOGIC OF PARAMETERS

At various times in my career I have looked to the literature on the difference between psychoanalysis and psychoanalytic psychotherapy to help me understand the need for and logic underlying this difference. The persistent theme in this literature is the wish or need to distinguish psychoanalysis from some other form of therapy that might threaten its integrity. This stems from Freud's often-stated concern to differentiate the new discipline of psychoanalysis from the existing practice of psychotherapy. By "psychotherapy" Freud meant treatments based on suggestion rather than the development and exploration of the transference as in psychoanalysis. But Freud also argued that if psychoanalysis was to become a form of treatment that was more widely available, it would need to incorporate some features of this psychotherapeutic practice in order to do so; in his much quoted words "the large-scale application of our therapy will compel us to alloy the pure gold of analysis freely with the copper of direct suggestion" (Freud 1919, p. 168). Although it is clear that what Freud mean by psychotherapy bears little relationship to the contemporary definition of psychoanalytic psychotherapy, (being more like what we might today call a non-analytic supportive counseling, based on reassurance, exhortation, and normalization) this metaphor of the "purity" of psychoanalysis being contaminated by the incorporation of the base metal of psychotherapy has become the guiding image in all subsequent attempts to create a distinction between the two.

In the 1950's the question of the "widening scope" of psychoanalytic practice became prominent in the analytic literature, and brought with it, particularly in America, a renewed attempt to establish a clear

difference between psychoanalysis and psychoanalytic psychotherapy (Gorman 2002; Rangell 1954). The aim was to make psychoanalytic practice available to a wider range of patients, particularly those suffering from narcissistic or borderline disorders, who might otherwise have been deemed unsuitable for psychoanalysis. The problem of how to preserve the purity of psychoanalysis while allowing for clinical and technical innovation to treat more disturbed patients was solved by introducing the notion of "parameters" as a way of distinguishing between different forms of psychoanalytic practice. The term "parameter" was introduced in an influential paper written in 1953 by Kurt Eissler, who used it as a way of designating deviations from a standard of ideal psychoanalytic practice. His version of this ideal standard of psychoanalysis was one in which the analyst's sole method was that of interpretation: "in the ideal case the analyst's activity is limited to interpretation; no other tool becomes necessary" (Eissler 1953, p. 107). This method, of starting with a notion of an ideal psychoanalytic practice, could then allow for modifications to be introduced and for the work to still be counted as analytic. Furthermore it provided a way of differentiating between various different forms of analytic practice in terms of how far they deviated from this ideal—the more parameters needed, the further away a particular practice would be from that of pure psychoanalysis. This is the logic that has continued to be applied in attempts to differentiate psychoanalysis from all other forms of analytic practice.

For instance Otto Kernberg, in his 1999 paper, "Psychoanalysis, Psychoanalytic Psychotherapy and Supportive Psychotherapy: Contemporary Controversies" differed from Eissler in defining the "essential features" of the psychoanalytic method as including "transference analysis" and "technical neutrality" as well as interpretation (Kernberg 1999, p. 1079). But his argument followed the same logic of defining all the other forms of analytic practice in terms of how far they deviate from this standard. Even if these deviations might be very small, so that their cumulative effect is hard to spot, the logic dictates that, over time, their effect will become evident. Kernberg puts it like this: "the *techniques* of psychoanalysis and psychoanalytic psychotherapy are essentially identical" which means that in any given session "the differentiation of psychoanalysis and psychoanalytic psychotherapy cannot be ascertained" (1999, p. 1083, italics in original), but the "quantitative

modifications" that occur in psychotherapy "create a different ambiance in psychoanalytic psychotherapy throughout time" (1999, p. 1083).

It can indeed be very helpful in clinical discussion to differentiate between the kinds of analytic work needed by different patients. So Kernberg's claim that in psychoanalysis a different "ambiance" to that of psychotherapy is created over time rests on assumptions that are common currency in clinical discussion. A particular ambiance is created by the way the practitioner manages and conducts the session, which may not be easily translatable into the application of particular theoretical ideas or the use of specific techniques. Clinicians also know that the quality of the psychoanalytic process takes time to evolve, and that time and meaning have a complex relationship to each other, with meaning often ascribed retrospectively to events and experiences that occur in the analysis. But once a decision is made to institutionalize these differences into descriptions of discrete practices, requiring different kinds of skills and competence and therefore different types of training, one has to turn these subtle and complex clinical processes into conceptual entities or criteria that will support a clear and coherent differentiation between these different types of analytic practice. This is a formidable task. Once stripped of clinical nuance and complexity, the actual deviations described that serve to differentiate the different forms of practice seem so small as to appear inconsequential if not trivial—for instance, in the designations of the British Psychoanalytic Council, how is one to tell the difference between "most of the work" is with interpretations as opposed to "a lot of the work," or "uses" the patient/therapist relationship as opposed to "often uses" the relationship?

A further problem that any contemporary organization faces in giving accounts of what a psychoanalyst does as opposed to a psychoanalytic psychotherapist is that the method employed of using parameters to measure deviations from a standard can only work where there is sufficient agreement as to what this standard is. Even in the 1950s the existence of difference analytic schools was recognized as making it more difficult to know how much common ground could be assumed between different analytic approaches. Today the recognition of the plurality of different analytic orientations across the world has inspired a number of attempts to find ways of comparing these different orientations. The findings from these comparative attempts lead to the conclusion that

one cannot take for granted that there does exist a common language between psychoanalysts from different schools (Bernardi 2002). For example the organizers of a series of clinical discussion groups involving the most senior and experienced European analysts, convened as part of the European Psychoanalytic Federation [EPF] Working Party on Comparative Methods (Tuckett 2008), reported the following:

> Since the group members mainly used the same technical language, it was assumed that the same terms also meant the same things to different people. It soon turned out that this was not the case. Terminology regarding transference, counter transference, interpretation, frames, setting, perversion, narcissism and so forth turned out to be differently interpreted by different individuals and nationality. [Boehm 2008, p. 63]

Alongside this "babelization" (Tuckett 2008) of contemporary psychoanalytic language, the members of another EPF Working Party on "Theoretical Issues" found that the theoretical language analysts employed to articulate their own practice turned out not to be a good description of what they were actually doing—in the words of Jorge Canestri, "analysts do not do what they say (and believe) they do" (2012, p. 157). In the light of these findings the organizers of both Working Parties found they needed to develop their own conceptual, theoretical, and clinical language in order to better describe how analysts think about their work and how they actually practice (as opposed to how they think they practice). In other words, not only can it no longer be taken for granted that there is only one form of psychoanalysis which represents the practice in its ideal or pure form, it can also no longer be assumed that the language used to describe this ideal practice does, in fact, describe what psychoanalysts actually do, as opposed to what they think they do or think they ought to be doing.

CONTEMPORARY DEBATES ON DISTINGUISHING PSYCHOANALYSIS FROM PSYCHOANALYTIC PSYCHOTHERAPY

How has the literature on the differentiation between psychoanalysis and psychoanalytic psychotherapy responded to these challenges? I will

take as an example a recent debate conducted by *The International Journal of Psychoanalysis* in 2010, to which three leading analysts, Fred Busch, Daniel Widlocher, and Horst Kachela, from different countries and representing different analytic schools, were invited to contribute (Blass 2010, p. 16).

For the first author, Fred Busch, the most pressing exigency for contemporary psychoanalytic practice is that psychoanalysis is in danger of becoming "a pale echo of what inspired Freud," and that "we are in danger of losing contact with the deeper motives for why people seek us out" (Busch 2010, p. 23). He sees psychoanalysis being replaced by a "psychotherapeutic culture," one "which views our patients as primarily trauma victims rather than also *victims of their own mind*" (p. 32, italics in the original). It is to preserve this radical and discomforting vision that Busch argues for the need to differentiate psychoanalysis from psychoanalytic psychotherapy. Busch writes from the perspective of someone who works both as a psychoanalyst and psychotherapist and who sees value in both (p. 23). In his view they have different aims. In psychotherapy the aim is for the patient to achieve that he calls "state knowledge," a new state of knowledge about themselves which is the basis for change (p. 25). By contrast in psychoanalysis a different form of knowledge is aimed at, the capacity for "self-analysis," in which it is the "process of knowing" rather than what is known that is paramount (pp. 25-27). Only through the self-analysis achieved through psychoanalysis can the patient reach "the deeper levels of the unconscious, where madness exists in all of us" (p. 30).

In order to reach the deeper levels of the unconscious, psychoanalysis has different aims to psychotherapy when it comes to the analysis of resistance and transference. Psychotherapy "most often leads to *identifying and overcoming* resistances rather than working them through" (p. 31, italics in original). In order to work through resistances, transference interpretations in psychoanalysis "are now geared towards understanding the patient's mind in the present, leading to the past, rather than focusing primarily on the past in the present" (p. 30). In short:

> In general, psychoanalysis leads one to be *intrigued by the mind* as the ongoing source and answer to fears and motivations, while psychotherapy leads one to *look to the past for answers* to the present. [p. 30, italics in original]

Daniel Widlocher also makes a case for distinguishing psychoanalysis from psychoanalytic psychotherapy. But rather than seeing each as having different aims, his differentiation is in terms of two different ways of listening to the patient. The wide range of patients now seeking psychoanalytic treatment has led to the development within psychoanalysis of more psychotherapeutic approaches which aim "to help the patient extricate him or herself from his or her psychic suffering." He contrasts this approach with the ideal of psychoanalysis, which he describes as "a pure associative and interpretive" listening:

> The psychoanalytic method is *per se deconstructive*, a pure discovery of the unconscious, its latent contents and process. It has no therapeutic value in itself, just knowledge of the psychic apparatus. But the major part of time during psychoanalysis is devoted to *reconstructing* the personal history of the patient, his conflicts and traumatic memories. [Widlocher 2010, p. 47, italics in original]

Unlike Busch, this does not mean an attempt "to individualize methods and forms of treatment (ranging from psychoanalysis *stricto sensu* to 'supportive' psychotherapies)" (p. 59). Instead, Widlocher argues that in actual psychoanalytic practice both forms of listening are needed:

> When we are faced with the actual patients we take into treatment, we must then decide about the specific dosage we propose of rigorous, associative and interpretive psychoanalytic experience on the one hand, and the analysis of conflicts and symptoms which make up the quest for care on the other. [p. 50]

For both Busch and Widlocher psychoanalysis is concerned with knowledge for its own sake (for Busch allowing the patient to become intrigued with his mind, for Widlocher a "pure discovery of the unconscious which has no therapeutic value") as opposed to the psychotherapeutic aim of providing cure, care, or relief from suffering. By contrast, Horst Kachele sees no value in this attempt to distinguish between truth and therapeutics (Kachele 2010, p. 36). He sees psychoanalysis defined not by its claim to a single kind of knowledge or truth but by its concern with a good therapeutic outcome, which in contemporary analytic

practice is achieved in a multiplicity of ways. He does not start from the idea of a pure standard that has to be maintained, indeed is suspicious of any such claim: "there is no longer one bible at hand and there are many prophets promoting one or other version of psychoanalysis whether or not these claims are supported by evidence – and too often they are not" (pp. 39-40). This appeal to "evidence" means a recognition of the "globalization of psychoanalysis and its treatment practices" (p. 35), in which he finds that "psychoanalytic practice covers a range of instantiations with no clear default value" (p. 38). In order to see what this "range of instantiations" consists of, Kachele looks not to some pre-existing standard but to "what psychoanalysts do in practice" (p. 38):

> Mapping out the global field of psychoanalytic practice by agreeing to basic assumptions seems to be timely. Instead of separating entities that hardly exist in real practice we might better talk about conceptual families of psychoanalytic therapies or at least close neighbours. [p. 40]

Applying this view of the psychoanalytic field to training, Kachele would "firmly reject the notion of basic, principal differences between analytic psychotherapy and psychoanalysis as not leading us where the battle really takes place," which is that of "our versatility to match patients' need and preference by applying a psychoanalytic therapy that is unabashedly therapeutic, flexible yet firm, supportive yet interpretive and deliberate yet spontaneous" (p. 41).

"PSYCHOANALYTIC PSYCHOTHERAPY" AS A LOWER FORM OF PSYCHOANALYTIC PRACTICE

While these three papers appears to be about the rationale for differentiating psychoanalysis from psychoanalytic psychotherapy, what I think emerges as the real debate is simply what is to count as psychoanalysis *per se* – as the editor of this collection of papers seems to recognize when she writes in her introduction that questions concerning the difference between psychoanalysis and psychotherapy "repeatedly re-emerge, as a variety of exigencies seem always to compel us to ask, not what psychoanalysis is, but how it is to be distinguished from psychotherapy" (Blass

2010, p. 16). Although there is clearly a lot of common ground between the three authors, the differences between the language they use and their conceptions of psychoanalytic practice are substantial. So, for example, when Widlocher writes about the "reconstructive" way of listening of the "psychoanalytic psychotherapist," it is really not clear to me whether the way Busch describes his psychoanalytic (as opposed to psychotherapeutic) practice would fall into this category or not (for instance Busch writes that transference interpretations in psychoanalysis "are now geared towards understanding the patient's mind in the present, leading to the past" – this sounds to me like a reconstructive rather than deconstructive form of listening). Here I find Kachele's argument, that it is better to speak of "conceptual families of psychoanalytic therapies" rather than seek to establish global distinctions between "psychoanalysis" and "psychoanalytic psychotherapy," much more compelling, the only one that speaks to my own clinical and professional experience of the considerable and profound differences between the different analytic orientations.

The debate about what is to count as psychoanalysis in these papers is conducted alongside, and indeed overlaps, with another argument about how to define good analytic practice. For Kachele, this is where "the real battle" needs to be, that is to try to spell out what would constitute a psychoanalytic practice that can effectively meet the needs of a diverse and challenging range of patients. But for Widlocher and Busch, the debate about what is to constitute good or excellent practice is displaced onto their formulation of a difference between "psychoanalysis" and "psychoanalytic psychotherapy," the former implicitly or explicitly described as a clinically and ethically higher form of practice.

In Widlocher's version, psychotherapy with its "reconstructive" form of listening is more concerned with offering "care" rather than the "deconstructive" form of listening in psychoanalysis, which is described as a "rigorous, associative and interpretive psychoanalytic experience" (Widlocher 2010, p. 47). Widlocher's deconstruction seems similar to Bion's well-known description of the need for the analyst to cultivate the capacity of working without memory, desire, or knowledge, which he calls an "essential discipline" in psychoanalytic work (Bion 1970, pp. 51-52). Clearly, then, for Widlocher psychotherapeutic work is seen as less rigorous and disciplined than analytic work.

Busch is even clearer in how he sees the hierarchy of practices. He characterizes the "psychotherapeutic culture" as offering no more than a "pale imitation" of the radical nature of Freud's psychoanalysis by substituting empathy for the patient's suffering rather than helping the patient learn to become curious about the workings of their own mind. In describing himself as doing both psychotherapy and psychoanalysis, it is only in the latter that real depth is achieved. So, for instance, he describes himself as doing psychotherapy in identifying and exploring resistance, but not working through their resistances, for which psychoanalysis is needed. Busch gives an illustration of what this difference in ability might look like:

> For example, inquiry into a patient falling silent will most often lead to her telling about the thought she was avoiding, rather than *the feeling that led to the thought* being avoided, which is the necessary ingredient for working through. [Busch 2010, p. 31, italics in original]

But in making this distinction (just as he differentiates between the "aims" of "psychoanalysis" and "psychoanalytic psychotherapy" in terms of intensity of transference and the depth of self-knowledge) Busch can make an informed decision as to which kind of practice he will employ at any given time with each particular patient as he defines himself as able to do both. If I, as a psychoanalytic psychotherapist, were to think of Busch's distinction as a basis for constructing my own identity as a psychoanalytic psychotherapist, I would have to define myself as doing the things Busch attributes to the psychoanalytic psychotherapist not out of choice or the exercise of judicious knowledge, but simply because *I would not know any better.*

In defining psychoanalysis as a practice or form of listening that is interested in knowledge for its own sake, as interested in truth rather than pragmatics (a distinction that cuts no ice with Kachele), Widlocher and Busch can be seen to be drawing on a well established definition of high quality work or skilled practice. For example in his book, *The Craftsman,* Richard Sennett defines craft or craftsmanship as: "an enduring, basic human impulse, the desire to do a job well for its own sake" (Sennett 2008, p. 9). In constructing a form of listening or of practice and calling it "psychoanalytic psychotherapy," these authors have

created a form of practice that, by definition, is disbarred from being a high quality practice, one in which both patient and practitioner arrive at an appreciation of the intrinsic value of self-knowledge and listening to the unconscious. And this is because the argument, however sophisticated it may seem, ends up being conducted in terms of the logic of parameters, which has to operate by setting up an ideal from which all other forms of practice are measured against.

TIME AS A SUPER-PARAMETER

This can be seen most clearly when we look at the way the so-called differentiation between psychoanalysis and psychoanalytic psychotherapy is usually presented, both in the literature that comprises this debate and in the public registers, which is to translate "intensity" into frequency of weekly sessions. So, for instance Busch appeals to what he takes to be a commonly accepted idea of the impact of time on experience in supporting his differentiation of psychoanalysis from psychoanalytic psychotherapy:

> Resistance analysis is possible in psychotherapy but limited, in part, by the infrequency of sessions. There is a necessary safety in coming upon a terrifying feeling, and knowing one can return the following day for further understanding. It is too much to ask of the human psyche to hold on to such feelings for a week or several days. [Busch 2010, p. 31]

I find it curious here that in an otherwise conceptually clear and coherently argued paper Busch here resorts to what seems to me to be a form of rhetorical pleading in order to make an important point about the need for "daily sessions." In my view this is symptomatic of the quality of argument employed in the discussions that link session frequency to different forms of analytic practice.

The most obvious flaw in this way of defining difference is that psychoanalysts cannot agree amongst themselves as to what is to count as psychoanalysis. On the American Psychoanalytic Association website, psychoanalytic psychotherapy is described as occurring "between one and four times weekly" (APA 2018a). This difference in session frequency from psychoanalysis is described as a "primary difference." In

the British Psychoanalytic Council definitions of the different forms of analytic practice, the degree of intensity is also taken as the defining feature. But here a psychoanalyst is defined as "trained to work very intensively (4 or 5 times weekly)." A psychoanalytic psychotherapist, by contrast, is trained to work "intensively," which evidently means less than four or five times a week, but more than a psychodynamic psychotherapist, who is defined by the BPC as "trained to work at a frequency of once or twice a week" (BPC 2018a). On the website of the International Psychoanalytic Association, psychoanalysis is described as occurring at a frequency of three, four or five times a week: "in order to continuously deepen the analytic process, psychoanalytic sessions preferably take place on three, four or five days a week," even adding that "a lower frequency of sessions per week or the use of the chair instead of the couch will sometimes be necessary" (IPA 2018). It is hard not to see the fact that analysts do not agree with each other over the question of session frequency as a fatal flaw. But in order to restore faith in this way of measuring differences between analytic practices, one would need a rationale for these differences. For instance one can see in the debate between Busch, Widlocher, and Kachele that the way they describe their aims and method of working would determine how they would think of session frequency. For Busch it is the actual physical presence that is important in deep analytic work, which would support his argument for daily sessions. By contrast one might suppose that a "deconstructive" form of listening that attempts to break up and disrupt narrative and coherence might favour a lesser frequency of sessions, or an approach that valued "flexibility and adaptation" would not try to set up an ideal number of sessions in the first place.

But the logic of parameters is hostile to such conceptual and theoretical arguments. All that matters is the specification of the ideal from which all deviations can be measured. This is the great appeal of using session frequency as a primary or defining feature – all one needs to do is to count. Furthermore, the appeal to session frequency has the great merit of appearing to accord with common sense understandings of the way quantitative differences in time spent on an activity can result in qualitative changes. It is widely accepted, for example, that the number of times a week one practices a musical instrument or trains for a sporting event will determine how well one can play or perform, and this

logic makes sense to patients who readily understand that session frequency will affect their experience and what they can hope to achieve.

But patients also know that length of treatment is no less important than frequency of sessions, just as we all know that practice and training need to take place over a long period of time in order to be effective. So even within its own parametric logic, why does length of treatment not figure in the APA or BPC definitions and in the way trainings are often described? All it would take would be to specify a particular length of treatment as the ideal in order to then count the deviations from it. A "very intensive" treatment could be then described as one that needs to be conducted over time period X, an "intensive" treatment as taking place over time period X-Y, and a "less intensive treatment" as X-Y-Z period of time. A clue as to why this might be problematic can be found in Busch's paper, where he does in fact make reference to length of treatment in differentiating psychoanalysis and psychotherapy when he comments "in many ways the themes and results of a 'good enough' psychotherapy are like the results of the initial phase of psychoanalysis" (Busch 2010, p. 31). We can wonder why Busch does not make any attempt to define how long this period of psychotherapy corresponding to the "initial phase" of a psychoanalysis might last, unlike with session frequency, where he invokes the needs of the human psyche to justify the need for daily sessions. The answer must be that he knows very well, as would any skilled clinician, that to spell out in advance how long this initial period needs to be risks shoe-horning the development of the analytic process, which will be different with every clinician and every patient. This is why there is such a strong objection in the analytic community to imposing any sort of predetermined time limit to analytic work (Brafman 2008).

My point in imagining an argument to support length of treatment as no less important than session frequency as a defining parameter is to try to show the arbitrariness of elevating any particular feature of the analytic setting as constituting a primary or defining difference between analytic practice. The point is not that session frequency does not make a difference. Anyone who seriously thinks it does not matter how many times a week a treatment is conducted has not understood the basic importance of the analytic setting. But what happens to our clinical understanding when we take any particular feature of the analytic setting

and turn it into a super-parameter, one which supposedly creates such a difference to the way we understand the analytic process that we can use it as a "primary" way of distinguishing between different forms of analytic practice, each backed by a different form of training and institutional organization. I will try to answer this question by taking an example from my own practice.

SESSION FREQUENCY OR ANALYTIC PROCESS?

I have been working with Mr. A in my private practice for a period now of over 13 years. He came seeking relief from severe anxieties and crippling panics attacks, which profoundly restricted his ability to enjoy his life and plan for a future. He grew up in a family in which he describes himself as the only sane figure. Despite a very traumatic and disturbed childhood he has managed with great determination to develop and sustain close personal relationships and also achieve considerable success and real satisfaction in his work life, although these achievements are continually subject to severe self doubt and are experienced as resting on very weak foundations, liable to collapse at any time.

When he began therapy with me Mr. A was clear in his mind, based on previous experiences of having therapy, that he wanted to start at a frequency of once a week, saying he could not handle anything more intense. I felt at the time that it might be important to go along with his request, at least initially, as he had indicated how difficult it was to feel safe in therapy and how he could not handle too much closeness or intimacy. After two years of once weekly therapy the degree and intensity of his anxiety lessened considerably, and Mr. A began to feel that he was starting to have more of a normal life. Although a very welcome development, the lessening of his symptoms brought about a sense of crisis in the therapy, as Mr. A then felt the spotlight was now much more on him rather than his anxiety. At the same time, particular features of the analytic setup, for example his difficulties in beginning and ending each session, which revealed his doubt that he could ever find a welcoming place for himself in my consulting room, attracted our interest and exploration. Mr. A became involved in the therapy in a different way, and started to speak of finding the gaps between the weekly sessions

harder and harder, which he felt was now interfering with his wish for the therapy to make further progress. Consequently he asked to increase the frequency to twice weekly, a change I readily supported.

Initially he found this increase in frequency, which he described as making the therapy feel much more intense and intimate, disturbing and disorienting, and for a time his level of anxiety increased. However after a period he began to settle down to the increased frequency and was able to use therapy in a different way to before, for instance being able to tolerate some transference interpretations and greater exploration of boundary issues. During this period of the work Mr. A started to make important changes in his life and began to talk of experiences of spontaneity, intimacy and relaxation, both in his life generally and in therapy which were new to him.

A further crisis in the therapy occurred after about four years, following a summer break in which Mr. A appeared to suffer a severe setback. He lost all sense of progress, finding himself once again beset with anxieties accompanied by a profound fear of going mad. In the course of making sense of this experience, which we were able to link very clearly to certain events in his childhood, which had remained hitherto in the background, he asked to increase the frequency to three times a week. The reason he gave for this was that he was now finding himself remembering events, feelings, and states of mind belonging to this past period of his life, and that coming twice a week no longer gave him sufficient time to recount, process, and digest these memories. He also found coming three times a week helped him better manage his feelings of going mad. Once he came through this period of feeling he was having a breakdown, Mr. A continued to come at a frequency of three times a week.

In this account, as is normal in all clinical discussions, I have used frequency of sessions as a way of scaffolding my experience of the progress of the therapy and the development and deepening of an analytic process. The change from once to twice weekly corresponded with a focus which now included the patient/therapist relationship as well as his symptoms, and from twice to three times a week with an experience in which past and present experiences melted into each other in such a way as to make his experience of his present life more disturbing and intense, but also more real.

However, using session frequency as a clinically useful way of marking developments in the therapy does not mean these developments would not have been able to take place without these increases in session frequency. If I were to put the emphasis on how the analytic process developed, instead of on session frequency, a different clinical picture would emerge. So looking back over the initial period of the work, I would say that when he asked to increase the frequency to twice a week Mr. A was already working in a deeper way at once a week than when he had started the therapy. The content of sessions may not have substantially changed, he was still largely speaking of his life outside the consulting room and the nature of his anxiety, but he was now doing so in a qualitatively different way, for instance in starting to discriminate more carefully between the different affects and states of mind and link them to his experience. Something was also clearly happening to his experience of the transference, as he was now finding the gaps between sessions too great. Once the therapy was experienced as having the continuity and reliability he felt he needed, Mr. A's defences lessened further, allowing or precipitating the emergence of one of Mr. A's deepest and most frightening terrors, that of going mad. Hence his request to increase the frequency to three times a week. Only when this primitive anxiety could be survived and made sense of could the analytic process develop further.

Was it the increase in session frequency that fuelled or allowed the deepening in analytic process, or was it the already developing analytic process that allowed Mr. A to make use of the increased frequency? I think this is a chicken-and-egg kind of question that can be interesting to pose, but makes little sense in actual clinical work. This is because in clinical practice time is not simply experienced as something to be measured, as in clock time, but as a framing of experience, which gives that experience particular qualities and meanings. In my work with Mr. A the changes from once to twice weekly and from twice to three times weekly were both predicated by him being able to tell me directly what he feared (more gaps, going mad) and what he wished for (more sessions, more trust, and greater intimacy). Suppose I had been unable to accommodate these requests as I had no available slots, and the therapy had continued at the pre-existing frequency. If we were to hypothesize how the therapy might have continued, it is evident that this would have

made a profound difference – but this would not simply have been because there would have been a less intensive therapy, with less time within which things could happen, but also because the time available would have taken on a different meaning. If, say, we had continued at twice a week after his request to increase the frequency, then *this twice a week work would not have been the same twice a week work that was being done before his request*. The twice a week work subsequent to his request would have come to mean certain things to Mr. A and to me (e.g. that his stated fear of going mad was too frightening or disturbing to tolerate, or that increasing the intimacy of the work was too risky), and the furthering of the analytic process would have depended on how these transference manifestations were explored and made sense of in the subsequent therapy.

In the 8th year of the therapy, Mr. A asked to reduce session frequency to twice weekly. The impetus to this request was to make time for a significant change in his life, in which, after many years of study and hard work, he was able to get a job which not only allowed him to do the kind of work he had always wanted to, but also gave him the experience, for the first time in his life, of working with a group of people with whom he felt he could be himself. I had considerable misgivings about this request, but Mr. A seemed determined to initiate this change. He said that for him the crucial thing was to come more than once weekly, as that allowed him a session to "recover" from "letting go" in the first session of the week, and so he felt that going down from three times to twice a week was something he could manage.

As this therapy is ongoing, I am still trying to evaluate the impact and meaning of this change in session frequency. In my way of thinking it does point to what I think is a serious problem for Mr. A, one we are still actively grappling with in the therapy, which is his inability (or refusal?) to mourn, to allow himself an experience of loss. In this sense it is troubling that he has not acknowledged any sense of "missing" the third session. At the same time, as far as I can tell the analytic process, far from becoming diminished, has continued to develop in terms of depth and intensity. As Mr. A has come up against new experiences which no longer conform to his expectations of failure and humiliation, he is now being forced in a much more acute and painful way than before to face up to the conflicts and dilemmas in his life which he has

hitherto avoided. This has allowed his dependence on the therapy and on me to come much more to the fore. Furthermore, something of great clinical significance occurred in the 12th year of therapy. Having struggled throughout the therapy—at once, twice, or three times session frequency—to connect up the weekly sessions in his mind, so that he would typically arrive at a session unable to remember or connect to what had happened in the previous session, he suddenly declared one day that he was now able to regard the second session of the week as a continuation of the first. His stated reason for doing so, that it had occurred to him that he was acting exactly like one of his family members whom he regarded as pathetically incapable, did not really explain to me why and how this important development had happened. I could only surmise that, now, something of the basic continuity of the analytic setting had been internalized by him sufficiently to allow for this development. The result of this significant development in the analytic process is that although, at twice a week, we have less clock time that when Mr. A was coming three times a week, the time we do have is qualitatively very different. It is a time that is continuous, which enables links between sessions to be made, unlike the more closed off and ruptured kind of time, which was in operation prior to this clinical event. In this new kind of clinical time much more is possible, for instance we can now track what is happening in the transference between sessions in a way that was not possible before.

The danger in elevating session time into a super parameter is that the meaning and quality of time, different with every patient and in different settings, becomes obscured if not lost. I think of my work with Mr. A not as doing one kind of work at once a week or twice a week, and then moving over to a different kind of work at three times a week, and then going back to what I was doing again when the sessions went down to twice a week. Instead I think of my work with Mr. A as analytic work which is all of one piece, with its own intrinsic logic and rhythm. The issue that matters to me is not: is this "psychoanalysis" or "psychoanalytic psychotherapy" (a meaningless question) but: is my work any good? How can I do better? From this perspective the ideas and conceptual distinctions Busch and Widlocher use to construct a distinction between "psychoanalysis" and "psychoanalytic psychotherapy" can be employed to help me think more critically about my work. Perhaps I could have

done more to facilitate or speed up Mr. A's newly discovered capacity to allow continuity between sessions, for instance by focusing more on how he fears becoming "intrigued by his own mind." Perhaps a more "deconstructive" form of listening may help me tune in more to the ways Mr. A constantly avoids any experience of loss, particularly in the transference. Maybe it would have been better for me to encourage, or even insist that Mr. A attend more sessions, and not have agreed to the reduction to twice weekly? These are good clinical questions that encourage me to spell out my own clinical reasoning, and to imagine different ways of conducting my work. There is no clinical need for such questions to be subsumed within a framework that creates different forms of analytic practice.

In other words, the construction of different forms of analytic practice based on the logic of parameters, which appears to be only a clinical question, can be seen to be also a political one, about the kind of analytic community we live in, as well as what Gabbard and Ogden identity as one of the elements in becoming more mature as a clinician, that is what we can "dream up" which our forebears were not able to do. Here, again, I find the work of Richard Sennett of great help in drawing a picture of a different kind of analytic community in which such distinctions between different forms of analytic practice either do not exist, or if they are taken to exist can be described in different ways.

WHAT KIND OF ANALYTIC COMMUNITY DO WE WANT?

To make and institutionalize a distinction between "psychoanalysis" and "psychoanalytic psychotherapy," as well as other forms of analytic practice, affects not only the way we think about clinical practice but also the kind of analytic community we have created. In his book *The Craftsman* Sennett makes a distinction between two forms of craft workshops, depending on whether they promote what he calls "sociable" or "anti-social" forms of professional relationships and ways of organizing work:

> There is an inherent inequality of knowledge and skill between expert and non-expert. Anti-social expertise emphasizes the

> sheer fact of invidious comparison. One obvious consequence of emphasizing inequality is the humiliation and resentment this expert can arouse in others; a more subtle consequence is to make the expert himself or herself feel embattled. [2008, p. 249]

Sennett contrasts this anti-social expertise with what he calls sociable expertise, whose guiding principles are democracy and transparency:

> Sociable expertise doesn't create community in any self-conscious or ideological sense; it simply consists of good practices. The well-crafted organization will focus on whole human beings in time, it will encourage mentoring, and it will demand standards in language that any person in the organization might understand. [2008, p. 249]

To my mind, creating an artificial distinction between psychoanalysis and psychoanalytic psychotherapy is a good example of an "anti-social" form of professional relationship. It encourages invidious comparison by creating embattled psychoanalysts, who constantly fear their work being exposed as "just" psychotherapy (in setting up workshops with senior analysts in order to compare their ways of working, Tuckett and his colleagues noted how many of them found it difficult to treat their colleagues as fellow psychoanalysts, resorting instead to supervising them or pointing out the ways their work did not correspond to proper "psychoanalysis," [Tuckett 2008]) and resentful psychoanalytic psychotherapists, who have to learn to make do with practising a watered-down version of psychoanalysis. It relies on definitions which are conceptually and clinically weak, and risk distorting our understanding of clinical practice by elevating one aspect of the analytic setting over all the others. When it comes to having to spell out its implicit logic, it comes up with differences, such as number of interpretations made or the degree of intensity of the treatment, which are vague and lack specificity, or with quantitative differences, such as session frequency, which are inconsistent and arbitrary. Based on my own experience, I would contend that these do not conform to what Sennett calls "standards of language which any person in the organization might understand." Perhaps most important of all, it militates against what Sennett calls "sociable expertise" by confusing "good practices," the specification and

exploration of which are vital to the development of psychoanalytic practice as a whole, with this arbitrary distinction between different forms of psychoanalytic practice.

In this paper I have tried to "dream up," if only in outline, a way of conducting clinical debates and organizing our psychoanalytic profession in ways which do not rely on making artificial and arbitrary distinctions between different forms of analytic practice. I have tried to describe how I have found it necessary in my own development to claim an analytic identity to which I am not entitled. I do not pretend to know how, if my arguments are sound, they can be taken forward. But a necessary first step is to recognize that there is a problem that is wider than my own personal struggles in claiming a psychoanalytic identity.

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ON BEGINNING THE TREATMENT: LACANIAN PERSPECTIVES

BY JOACHIM CAUWE AND STIJN VANHEULE

The authors examine the opening stages of the psychoanalytic process from a Lacanian perspective through the concept of logical time. We outline three key moments in Lacan's theory that elucidate the stakes of the entry into analysis. First, the subjective rectification points to the necessity of indicating the patient's own involvement in the complaint. Second, we discuss how the perspective of the Symbolic entails a double movement of retroaction and anticipation in transference. Finally, the emergence of the supposed subject of knowing is presented. These points are illustrated with the autobiographical account of Marie Cardinal's analysis.

Keywords: Transference, time, symptom, Lacan, unconscious.

Let's be categorical: in psychoanalytic anamnesis, what is at stake is not reality, but truth, because the effect of full speech is to reorder past contingencies by conferring on them the sense of necessities to come, such as

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> *they are constituted by the scant freedom through which the subject makes them present.* [Lacan 1953, p. 213]

How does a psychoanalytic treatment start? We will reflect on this seemingly straightforward question through Lacanian theory, returning briefly to Freud's sparse comments on the matter in *On Beginning the Treatment* (Freud 1913). We will argue how the development of Lacan's thinking on transference enables us to situate the stakes of the beginning of the analytic experience more clearly. In order to retrace Lacan's steps in thinking about what he eventually termed the "preliminary interviews [*entretiens*]" (1971), we will focus on two main themes in relation to transference: the question of time and the nature of the symptom. That time is involved in the beginning of analysis is evident insofar as it is implied by the term itself, suggesting a certain temporal ordering with respect to a beginning, a middle, and an end. Yet here Lacan also developed the notion of "logical time," representing a particular perspective on the link between time and the unconscious. The question of where the symptom and, more precisely, the patient's relation to the symptom is at stake is less obvious. Miller (1997-1998) contends that Lacan's definitive formulation of transference, as the supposed subject of knowing, constitutes a "special alliance between meaning [*sens*] and suffering" (p. 56). According to this view, psychoanalysis can start when the patient supposes a meaningful dimension to his/her suffering and addresses the analyst with this. We will demonstrate how Lacan came to these ideas throughout the development of his work.

THE WORDS TO SAY IT: CARDINAL'S BEGINNING

Before we embark on our search for psychoanalytic beginnings, we turn to the testimony of Marie Cardinal's analysis[1] *The Words to Say It* (1975). In this autobiographical account of her analysis with an analyst that she calls "the little doctor" and whose identity is not disclosed and could not be traced, Marie recounts her experience of a 7-year analysis. Interestingly, one of the important outcomes of the analysis seems to

[1] Marie Cardinal, who died in 2001, went on to have a successful career as a literary voice for feminism. Her account of her analysis was her sixth published work.

have been her choice to become a writer. When she first met the analyst, Marie Cardinal was in a state of despair. She had just run away from a hospital, where she sought treatment for an incessant flow of blood, and felt she was in a state of "madness" (p. 3). She describes a meeting between her uncle (an M.D.) and the psychiatrist, where a new "chemical electroshock" (p. 19) treatment[2] was suggested. "They held forth in front of me as if I were a piece of furniture" (p. 19). The bleeding and anxiety constituted the center of Marie's psychological world, preoccupying her constantly. The prospect of being taken to a psychiatric ward and being disconnected from a normal life inspired her decision: "I couldn't take it anymore. I wanted them to deliver me from fear, from the Thing, whatever the cost. However, on this particular morning in the sanatorium, I had figured out that the price was going to be enormous and that I did not want to pay it. It was decided. I wasn't going to take any more of their disgusting pills" (p. 19). Marie felt the net of the objectifying medical interventions close in on her and decided to resolve these issues. What is striking in her description of how she eventually consulted the analyst is the long odyssey through different doctors and medical institutions accompanied by a despair that absorbed her completely. How she contacted the analyst or who called him, she doesn't remember. She was referred to him by a friend: "She knew him and I had heard about him" (p. 25). In the first meeting, she talked about the blood and her palpitations. The analyst was quite silent and asked her to talk about the treatments she had already had. Then, the analyst asked her, "What do you feel when apart from your physical malaise?" (p. 13). She spoke, among other things, about fear of dying. At the end of the session the analyst proposes to start an analysis and expresses belief that he can help her. When Marie asks him what she should do should she start bleeding, he tells her to do nothing. When she came back the following day, she started the session by saying "Doctor, I am bled dry" (p. 31) appearing as pitiful as possible. His response was calm: "Those are psychosomatic disorders. That doesn't interest me. Speak about something else" (p. 32). She was flabbergasted: "The words this man had just spoken to me were a slap in the face. Never had I encountered such

[2] Before that, another specialist had diagnosed her ailment as caused by "a fibroid uterus" (p. 7), advising her "to get rid of it right away" (p. 7).

violence. Right in the face!" (p. 32). Then, a river of tears, held back for a long time, welled up. Marie's analysis started with this (metaphorical) slap in the face. We do not know the theoretical orientation of Cardinal's analyst, but no transference interpretations were mentioned (Morly 2007, p. 26) in the account and the analysis consisted of sessions at a frequency of three times a week with a fixed duration of 45 minutes.

Scarce as his interventions may be in the beginning, they nevertheless enable her analysis to take off. The bleedings were the symptom that Marie addressed to the medical establishment. These interactions had objectified her ("a piece of furniture," [p. 19]), to the point that she could only feel discarded from society. Her analyst adopted an approach that was diametrically opposed to that. He radically severed the bleedings from a medical discourse by his harsh intervention. We will come back to this intervention in due course.

ON BEGINNING THE TREATMENT

What is at stake in the opening stages of analysis? Freud devoted one of his papers to the beginning of analysis. In *On Beginning the Treatment* (1913), he discusses several aspects of how to start an analysis. He determines a set of rules for analysis, but stresses their flexibility, given the variability found in the clinic. We will not go into the diagnostic considerations[3] (i.e., the difference between neurotic and psychotic modes of functioning) that Freud discusses as part of the selection of patients and in relation to the relevance of a trial period. A considerable amount of attention is given to what we could call the material frame of analysis, in addition to matters such as money (payment), frequency and the use of the couch. Nevertheless, before the analyst can start to actively contribute to the treatment, Freud states that an "effective transference" has to be established "in the patient," "a proper *rapport* with him" (p. 139, italics in the original). Interestingly, he uses the preposition "*in*" with regard to an effective transference, thereby implying that it is not so much a relational matter. The interactional features of the relation to the doctor are subsumed under what he calls a *rapport*, a term

[3] See Cauwe and Vanheule (2018) for a discussion of transference in a case of psychosis from a Lacanian perspective.

reminiscent of his early experiments with hypnosis (Freud 1890) before the method of free association was adopted. Freud (1913, p. 139) states that, "It remains the first aim of the treatment to attach him [*the patient*] to it and to the person of the doctor. To ensure this, nothing need be done but to give him time."

Three different terms appear to indicate the way the relation between the analyst and the patient takes shape: "attachment," "transference," and "rapport." Moreover, they seem to appear automatically if the analyst refrains from interpreting too soon. Freud's view on the establishment of the transference is quite an optimistic one: just be attentive and give it some time. Moreover, as Freud's famous metaphor of the game of chess suggests, the opening moves can be calculated and learned in advance. It is only when the treatment is running its course that the analyst really becomes involved. Then, he can interpret and start with his communications to the patient. Transference first, then interpretation is thus the Freudian sequence of opening moves. Finally, the establishment of transference seems to be something that has to happen "in the patient" so to speak. A certain attitude of the analyst can foster or stimulate this, but in the end these relational aspects need to emerge *in* the patient. Freudian transferences seem very much intrasubjective and somewhat solipsistic in that sense.

Nevertheless, Freud continued to struggle with matters of time and transference, having difficulty ending the analysis with numerous patients, as is evident from his intervention with Sergej Pankejev ("The Wolf Man") where he determined a fixed limit on the duration of the treatment in order to mobilise a treatment that he considered to be stalling (Freud 1937). Pankejev remained dependent on the psychoanalytic community after his analysis with Freud (Strubbe 2016). The limit imposed on Pankejev to accelerate the analytic process paradoxically eternalised it, leaving Pankejev with no possible exit. Both the entry into analysis, as well as its ending are related to transference.

In Marie Cardinal's case, it is obvious that her analyst did not practice according to the technical advice that Freud provided. When he states that he is not interested in her blood, it is more akin to a radical cut. Marie experienced this intervention as a slap in the face. However, the effect was indeed that she became more "attached" to the treatment, albeit in a particular way. The immediate effect was that her bleeding

stopped. Hence, her symptom, hitherto entertained medically, now became involved in the analysis: her body started to speak along with the analytic conversation. This symptomatic change preceded the analytic work of remembering and putting her experience into words.

Freud pointed out the importance of transference for the start of the psychoanalytic treatment. But when can we say, "there is transference/attachment/a rapport"? And what about the time in/of analysis? Do we really just have to wait until transference is established, or is an intervention by the analyst necessary to get things going? It is to Freud's merit that he opened up a series of questions that remain pertinent to today's psychoanalytic practice. Nevertheless, answering these questions requires moving beyond Freud to conceptualize aspects of time and transference in psychoanalytic practice. Amongst others, Lacan broadened our understanding of the opening stages of analysis by developing a theory that grasps the temporal logic and modulations evident in transference. In this paper we read Lacan through Lacan, as his oeuvre itself bears witness to a development along different turning points. Lacan's conceptual tool of "logical time" will be the guide through this discussion. We outline the core ideas of the paper on logical time first, and then we turn to how this logic applies to Lacan's work pertaining to the beginning of analysis.

LOGICAL TIME AND THE ASSERTION OF ANTICIPATED CERTAINTY

Lacan's essay on logical time outlines a logical riddle: one of three prisoners is given the chance to be released from prison by the prison warden. Which of the three will be decided on the basis of a game. Each prisoner is given a disc affixed to his back. He cannot see the color of his own disk, but can see the discs on the other prisoners' backs. The warden informs the prisoners that there are three white discs and two black discs. They cannot communicate with each other. The first prisoner to leave the room and declare the color of the disc on his back correctly, and on logical grounds, gets released. Lacan discusses how the prisoners simultaneously reach the same conclusion that they have a white disc.

This outcome, the conclusion of the prisoners, can only be attained (logically) in three steps, which he calls three "evidential moments"

(Lacan 1945, p. 167): "the instant of the glance," "the time for comprehending," and "the moment of concluding." However, what is essential to reach this conclusion is that each of the prisoners has to rely on the behavior of the other prisoners to be able to reach a conclusion on logical grounds. An intersubjective approach is needed, whereby the presumed hesitations of the other prisoners are included in the reasoning. Additionally, a conclusion cannot be made solely on the basis of the original situation. There is a certain time required and two simultaneous stops by all prisoners. After the instant of the glance, where all prisoners can immediately confirm that there are no two black discs in the game, the prisoners have to make a hypothesis regarding their own color because the "data" do not suffice to immediately conclude. Assuming that they have been assigned a black disc, they will start reasoning from the perspective of how the other prisoners would move, were they seeing a black disc. This reasoning leads to the conclusion that he is indeed wearing white and to a movement towards the exit. However, to attain certainty about this conclusion, the prisoners have to stop simultaneously two times. Since the other two prisoners start moving, the prisoner hesitates and stops again to reason, as do the others. Now, the hesitation of the two others is included in the reasoning. These hesitations of the other prisoners are absolutely necessary to make a logically correct solution possible. Any of the prisoners can logically conclude that he is wearing white after two stops, based on the hesitations of the others, and on the condition that he rushes towards the door before the others can beat him to this conclusion.

An important aspect of the dilemma is that the conclusion has to be made against this background of "haste." If one does not leave after the second pause, the moment is lost, and one cannot conclude anymore as to what color one is wearing. So the mutual hesitations install haste that has to inspire an act. After the initial observation, the time for comprehending and the two suspended movements, the prisoner can utter, "I am wearing white" and explain this on logical grounds. Lacan terms this a "subjective assertion." However, it is only after the act in the moment of conclusion, that the prisoner can reach a logical certainty about his conclusion. The moment of conclusion in itself is a wager (Hoens in press), it is an anticipation of truth to come, a "precipitation of subjectivity" (Fink 1996, p. 356).

The prisoner's dilemma as developed by Lacan has been extensively commented on in the literature (see Adriaensen 2001; Blomme & Hoens 2002; Fink 1996; Hoens in press; Hook 2013; Johnston 2005; Kusters 2014). It was originally intended by Lacan as a way of reflecting on how to constitute a collectivity on a different basis than through identification with an external point (the leader as ego ideal in Freud's *Massenpsychologie*), but through mutual recognition by the constitutive elements of a group. However, in the essay, Lacan already alludes to how the thought experiment can be applied to more clinically salient matters such as "the handling of the complexes" (Lacan 1945, p. 173). The paper on logical time does not deal with transference, or with the opening sessions explicitly, but will determine the agenda for Lacan's reflection on the temporal logic of the analytic experience for years to come.

LACAN RETURNS TO FREUD

To understand Lacan's take on what he eventually called the "preliminary sessions" (Lacan 1971), we have to take into account the steps he takes in his "retour à Freud." Evidently, this retroactive reading of Freud occurs in the intellectual context of the 1950s. Lacan did not embark on an exegetic journey, but used contemporary concepts and ideas to read Freud in order to move beyond Freud. With respect to the topic at hand, we will discuss ideas that remain at the heart of Lacan's reflections on the nature of the analytic experience through our "retour à Lacan." Lacan's reflection on the preliminary sessions in psychoanalysis comprises a sophistication of this notion of logical time in psychoanalysis as well as a sustained reflection on the nature of the symptom that includes the transferential dimension. Lacan's references to the opening sessions of psychoanalysis are scattered across, what he always regarded as, his work in progress. He never presented an elaborated theory of the opening sessions[4]. We will look into three evidential moments

[4] Lacan was very critical of developmental interpretations in psychoanalysis, along the lines of developmental stages or maturation as he witnessed in the post-Freudian literature regarding sexuality ("the genital paradise"). Obviously, the same goes for the analytic experience itself that cannot be regarded as a situation that has a predetermined development along different stages. We believe an analytic process has to be grasped après-coup. For this very reason, testimonies such as the one provided by

in his oeuvre where he develops concepts that are important to the development of transference in the opening sessions. In line with his theory of logical time (1945), we describe these moments as "an instant of the glance," "a time for comprehending," and the "moment of conclusion."

First, in "an instant of the glance," his 1951 paper, "Presentation on transference" constitutes an important reflection on the nature of transference, because Lacan clearly conceptualizes transference there as a series of temporally concise moments within a broader dialectical and intersubjective movement. Moreover, through his reading of the Dora case, he directs attention to the responsibility the analyst has in the position he takes, so that a "subjective rectification"[5] can occur. This paints a different picture of analysis, which more clearly indicates the analyst's involvement. Temporally, transference is linked to the present development of the analysis, not the repetition of the Oedipal past of the patient.

Lacan's "time for comprehending" could be situated in *Function and Field of Speech and Language in Psychoanalysis* (1953), where the dialectics of the analytic experience are rooted in the transindividual order of the Symbolic. The consequences of regarding analysis as a praxis rooted in speech enables a disentangling of authentic (full) speech with a symbolic character from empty speech wherein one objectifies one's self and the world in an imaginary fashion.[6] The fabric of the unconscious is symbolic. Lacan tries to formalize the essence of psychoanalysis through the prism of reflections on "the historical theory of the symbol," "intersubjective logic and the temporality of the subject" (1953, p. 239). In *Function and Field*, Lacan addresses the clinical consequences of his

Marie Cardinal are interesting, because they are instructive as to how an analysis developed for a particular patient.

[5] This term appears in *The direction of the treatment and the principles of its power* to point to this aspect of verbalizing one's involvement in suffering and the symptom, but the core idea is already presented in 1951.

[6] Informed readers will recognize here what Lacan later developed as the L-scheme. The general line of thought concerning the psychoanalytic process during the 1950s is immanent here: the Symbolic is the vector of change and determines the efficacy of the analytic endeavour, whereas the Imaginary constitutes an obstacle to the progress of the Symbolic.

famous essay on logical time (1945), where he complexified the subjective nature of time through a reflection on three "evidential moments."

During the 1960s, Lacan comes to a final formulation of the emergence of transference as the "supposed subject of knowing." Lacan's "moment of conclusion" is situated within a reflection on the nature of love and the radical asymmetry of two heterogenic positions therein: the lover and the beloved. The pivot of transference that is then termed "the supposed subject of knowing" is a symbolic structure. What is evident now, is that Lacan has cut off ties with the imaginary in his theory on transference. Transference may have all sorts of imaginary and real effects, but its underlying structure is now symbolic and can be written as the relation between two signifiers.

THE INSTANT OF THE GLANCE: DIALECTICS AND STAGNATION IN PRESENTATION ON TRANSFERENCE

The 1951 lecture that is included in the *Écrits* as "Presentation on transference" predates Lacan's *Function and Field of Speech and Language in Psychoanalysis* (1953), also known as the *Rome Discourse*, which is generally considered to be the start of his teaching. Lacan had not yet put forward the registers of the Imaginary, the Symbolic, and the Real, even though one can find implicit precursors in this text. The crux of Lacan's argument has to do with the nature of the psychoanalytic enterprise, which he wants to save from being colonized by psychology or as he renders it "the objectification of certain of an individual's properties" (Lacan 1951, p. 176). In a beautiful paragraph, we see how Lacan anticipates, a true visionary, the advent of a "homo psychologicus" (p. 178):

> For due to the very power of the forces exposed by analysis, nothing less than a new type of alienation of man will come into being, as much through the efforts of a collective belief as through the activity of selecting techniques with the formative scope of rituals. [pp. 177-178]

Psychology risks producing a reification of this *homo psychologicus,* precisely because it is a symbolic system that can be believed and provides a material framework for such belief through techniques that reinforce

the belief. The power of the forces mentioned refers to transference. Lacan evokes the question of the use of transference for other ends than an "alienation" in the image of man fostered by the human sciences.

Against a psychological interpretation of transference in terms of the Zeigarnik effect, Lacan advocates the "primacy of the subject-to-subject relationship." Analysis is then an intersubjective experience, where "the subject, strictly speaking, is constituted through a discourse to which the mere presence of the psychoanalyst, prior to any intervention he may make, brings the dimension of dialogue" (p. 176). As a true Hegelian at that time, Lacan considers truth as "the name of the ideal movement that this discourse introduces into reality" (p. 177). Analysis is hence considered as a "dialectical experience" (p. 177), relying "solely upon words" (p. 177). Moreover, as regards the symptoms that bring a patient into analysis, Lacan states that it is Freud's merit to have demonstrated "that there are illnesses that speak" (p. 177). Consequently, symptoms have a truth-value.

Through a discussion of Freud's *Dora* case, Lacan makes his central point:

> What is involved is a scansion of structures in which truth is transmuted for the subject, structures that affect not only her comprehension of things, but her very position as a subject, her "objects" being a function of that position. [p. 178]

This eventually leads to a definition of transference, towards the end of the text:

> nothing real in the subject if not the appearance, at a moment of stagnation in the analytic dialectic, of the permanent modes according to which she constitutes her object [pp. 183-184]

These stagnations are nevertheless necessary to get the dialectic going again, given that they can be surpassed. What is interesting about these propositions is that they relate transference to the development of the analytic process. For Lacan, transference occurs at certain moments, where the treatment process is stalling. His perspective at this point, of transference being wedded to resistance, hence departs radically from a lot of contemporary perspectives, especially those that frame the relation

to the analyst in terms of an object relation. These moments require interpretation in terms of the treatment dialectic, since the way transference appears (the analyst as an "object" of love or hate) is related to the progression of the analysis and has to be understood in relation to the material discussed in the analysis at that point. Lacan stresses how it is first and foremost the analyst who is the hindering factor, by letting his countertransference be the guide of his interventions. Countertransference is on the side of error, since Lacan defines it as: "the sum total of the analyst's biases, passions, and difficulties, or even of his inadequate information, at any given moment in the dialectical process" (p. 183). This outlook on countertransference is particular to Lacan and is not shared by a whole range of contemporary analytical perspectives. It is a polemical statement, intended as a critique of his contemporaries who use countertransference as a privileged window into the patient's modes of relating and as an instrument to guide interpretation.

Lacan discusses Freud's case of Dora (Ida Bauer) from the perspective of "a series of dialectical reversals" (Lacan 1951). We will discuss the first of these reversals, since it concerns Freud's answer to Dora's position early in the treatment. Lacan refers here to the beautiful soul, a figure that appears in the section on morality in Hegel's *Phenomenology of the spirit*. There, it represents a consciousness that judges the acting individual, while it does not act itself (Van Erp 2013, p. 86). The beautiful soul first of all thus reflects a moral position wherein the deplorable state of the world is lamented. Someone adopting this position excludes himself from the world. It amounts to a division of roles wherein the Beautiful soul is morally "clean" in relation to a corrupted and evil world. Now, how does this relate to the case of Dora?

Dora, a 18-year-old girl, is sent to Freud by her father, who is an acquaintance of Freud's. Dora suffers several symptoms, said to be hysterical in nature, such as a cough. At the outset of her treatment with Freud, Dora launches her indictment of her father's hypocritical walks of life. She complains that her father and Mrs. K. have been lovers for many years, but "what takes the cake is that Dora is thus offered up defenceless to Herr K's attentions, to which her father turns a blind eye, thus making her the object of an odious exchange" as Lacan (1951, p. 178) renders it. Freud is up against "a sound and incontestable train

of argument" (Freud 1905 [1901], p. 34) that could leave the analyst embarrassed before the question. "This is all perfectly correct and true, isn't it? What do you want to change in now that I've told it you?" Freud's response according to Lacan: "'Look at your own involvement,' he tells her 'in the mess [*désordre*] you complain of'" (Lacan 1951, p. 179). This commentary on the Dora case constitutes the basis for what Lacan (1958) will later term a "subjective rectification," which Miller (1999, section 4, para. 16) explains as follows:

> … the psychoanalyst doesn't give absolution, and he even cultivates the feeling of guilt. That's the condition under which a subject can analyse himself. That's what Lacan called subjective rectification: the subject comes complaining of others, he must be made to learn that it's his fault. Without that, one cannot analyse him. That means, at least at the outset, it is necessary to cultivate in him the feeling of guilt.

Subjective rectification, qua intervention makes the analyst point to the subjective involvement of the patient, and demonstrates another sequential logic than the Freudian "first transference afterwards interpretation," since this rectification is an intervention that engenders transference (Lacan 1958). Lacan hence subverts the Freudian steps.

Indeed, Lacan is critical of Freud in "Presentation on transference" since he sees Dora's premature abortion of the treatment as the effect of Freud's prejudice, and hence his countertransference. What Freud has missed, according to him is that the true question underlying Dora's suffering had to do with the mystery of femininity, as embodied in her relation to Mrs. K. Freud, however, interpreted her debilitation mostly in terms of her infatuation with Mr. K.

The obstacle in the Dora case was hence Freud's and not Dora's transference, if we follow Lacan's rendering. The analyst has to enable the patient to go through the dialectical reversals of truth, by not obstructing this dialectical progress. These "reversals" are to be understood as moments where the analytic work is at a crossroads; the work can either evolve towards what is at stake at the level of truth or where the movement of truth is obstructed by focusing on the countertransference. The analyst's task, besides refraining from letting countertransference steer his

interventions, has to seize these moments to turn to the question of how the patient is situated in what is recounted.

THE TIME FOR COMPREHENDING: THE FUNCTION AND FIELD OF SPEECH AND LANGUAGE IN PSYCHOANALYSIS

"The function and field of speech and language in psychoanalysis" (Lacan 1953) is considered to be one of the central texts by Lacan. In this seminal paper, he explains the core ideas of his approach to psychoanalysis. Inspired by linguistics, anthropology, and ethnography, Lacan elaborates the consequences of regarding man as marked by the symbol. The *Rome Discourse*, as the text is sometimes referred to, is Lacan's time for comprehending, after the instant of the glance where he noted that something was "rotten" in the state of psychoanalysis. Here, he defines his position in relation to what he considers to be deviations from the core of Freud's psychoanalysis.

Before we turn to the relevance of the *Rome Discourse* for the opening sessions, we will sketch out Lacan's basic premises regarding the psychoanalytic process.[7] Man actualizes himself as man through language, which is a transindividual synchronic and symbolic structure. The specific outlook Lacan has on the Symbolic, being this transindividual structure made of language, is of an order that connects humans in a pact. When one uses language in speech, this constitutes an exchange, based on the model of the Maussian gift, where a gift always solicits a response and the circulation of gifts defines social positions. Moreover, symbols connect a subject to history. This is the true meaning of the Freudian unconscious for Lacan, which is in a position as a "third":

> The unconscious is that part of concrete discourse qua transindividual which is not at the subject's disposal in reestablishing the continuity of his conscious discourse. [Lacan 1953, p. 214]

[7] As the *Rome Discourse* is a very elaborate and rich text, our outline is necessarily partial.

In analysis then, the subject appropriates his history through a focus on the symbols that refer to it. These symbols enable the patient to find truth again, since repression (the unconscious as "the censored chapter") leaves a trace (p. 215). Lacan, in a highly poetic passage, alludes to the work of archaeologists and historians who research traces (monuments, archival documents, legends, etc.) in relation to the work in analysis.

Analysis qua "realization of the subject" and "constitution of the object" (including the beautiful soul) is subordinate to this (Lacan 1953, p. 242). The realization of the subject happens through speech, but bumps up against objectifying (imaginary) tendencies, necessarily so. Truth remains the axis of progress and is coupled to the order of the Symbolic. Truth is a matter of expression, of realizing full speech:

> Full speech is speech which aims at, which forms, the truth such as it becomes established in the recognition of one person by another. Full speech is speech which performs. One of the subjects finds himself, afterwards, other than he was before. [Lacan 1953-1954, p. 107]

TIME AND SUBJECTIVITY

References to time are plentiful in the *Rome Discourse*. When Lacan refers to time, he means logical time, which is different from clock time or a chronological conception of time. Lacan's essay on logical time provided a constant source of reflection during the entire Seminar. In the Rome discourse, Lacan connects his interpretation of logical time to the development of the analytic process. Since the unconscious and full speech is symbolic and develops along logical time, this means that logical time is the time of the advent of the symbolic through speech.

Now, what is the connection between logical time and the developments reported in the *Rome Discourse*? Time in psychoanalysis is not the linear time of clocks but is intrinsic to how we understand the unconscious and its subject (Lewis 2005). The unconscious needs time to emerge and this time is conceptually understood as logical time. This is an application of the logical riddle to the analytic experience. The patient, as subjected to the symbolic order, has to realize his truth

through speech. This realization of truth necessarily entails transference, since it is in this intersubjective context that truth can be realized as speech addressed to another. In the analytic experience the third can emerge, transcending the mere dyadic nature of transference. Now, at first sight, the Rome discourse suggests that analysis implies a retroactive articulation of truth (symbolic) akin to acknowledging historical truth. However, as the epigraph shows, Lacan complicates matters here. Contingencies of the past are ordered because of an anticipation ("necessities to come") of their very order. Safouan (1988, p. 142) states that the certitude of a historical truth depends on a relation to what is most unforeseen [*imprévu*] for a subject, namely the signifiers of his unconscious desire. In order to be able to read the hieroglyphs to find the truth cyphered in them, the truth has to be anticipated. What is the relation between remembering and the resolution of the symptom? Safouan (1988) argues that Lacan did not propose that remembering delivers the meaning of the symptom of desire to the subject, but rather that the proximity of the subject to the meaning of his symptom conditions remembering.

TIME AND TRANSFERENCE IN THE WORDS TO SAY IT

Marie Cardinal's account of her analysis provides us with a very clear example of how the time of analysis, the symbol, and transference are tied together. She recounts how, having been in analysis for quite some time, she had always talked about events that she could remember consciously. Nevertheless, throughout this period of her analysis, she kept seeing an eye looking at her, which she calls a "hallucination" that made her feel deeply ashamed. Cardinal had been very reticent to bring this experience into the analysis "I understood very well, without needing him to tell me, that if I concealed certain images it was because of an unconscious fear they would hurt even more when brought into the light, whereas, on the contrary, it was by lancing the wounds and cleaning them all out that the pain would go away" (Cardinal 1975, p. 143). Eventually she plucked up the courage to talk about her "hallucination" (p. 143). The stakes were high: "If I didn't find an explanation for the hallucination I would never progress. I would never have a normal life"

(p. 147). When she was finished telling him about her hallucination he responded: "'Tube,' what does it make you think of?" (p. 147). She was irritated, disgusted ("you're a disgusting character"; "you stink," p. 148) and even infuriated by what she felt to be a simple allusion to sexuality. However, the analyst insists that she associate to the word: "Without even thinking, tell me what tube makes you think of" (p. 148). Marie produces a whole series of associations, while her body is shaking and she is pervaded by anxiety, that eventually lead her to a repressed memory of when she was a toddler: her father was taking pictures ("*He is holding a funny black thing in front of one of his eyes, a sort of metal animal which has an eye at the end of a* tube" [p. 152]) of her while she was defecating in the woods. At that time, her father had just come out of hospital having had tuberculosis. After this session, she felt relieved and had the feeling of being born (again). Nevertheless, her euphoria was short-lived, as what she called "the Thing" got hold of her, full force, and a marked phase of negative transference followed, where she berated her analyst during subsequent sessions.

What is noteworthy is that, through the analytic process, Cardinal had been able to connect certain events in her life which gave her the assuredness that articulating the hallucination would bring about something (knowledge/an explanation): anticipation. Moreover, the aspect of urgency is evident, as she felt that she will never be able to live normally if she did not solve that puzzle. Free association had already proven its merits for her. Nevertheless, it is the intervention by the analyst, who points to the symbolic dimension of her discourse (the word "tube"), which puts her on the path to the integration of this "censored chapter."[8] Moreover, her negative transference emerges at the point that her hallucination dissolves.

In fact, the hieroglyph that is her hallucination is only deciphered after the analyst, by insisting, manages to direct her away from the outrage. So from a transferential vantage point, there is first the reticence (fuelled by the affect of shame), then the coming out, the outrage and then the associations. The progress in the symbolic meets with resistance in the imaginary (the transference). The analyst does not respond to

[8] We will not go down another interesting avenue that is evoked by this clinical passage, namely the topics of life, death, sexuality, and the gaze.

these intense transferential feelings, but keeps the work on track by pointing to the symbolic. The work of deciphering, under transference, hence does not develop in a linear way, but is caught between anticipating meaning, experiencing the here-and-now of the relation to the analyst and a return to the past. The truth of the symptom cannot be grasped in a straightforward manner, but has to be lost in intersubjectivity first, before it can be translated and integrated into the continuity of her biography. In line with Žižek's (1991) interpretation of Lacan, "the truth arises from misrecognition." Her disgust for the filthy analyst who punctuated a word with sexual connotations turns out to be her own filth, discovered through association.

TIME IN THE ANALYTIC EXPERIENCE

Lacan discusses how the analyst is implicated in the time of the subject, through the case of Sergej Pankejev, whose time for comprehending has been cut short by Freud when he imposed a time limit. This resulted in the "alienation" of the "Wolf Man" (cfr. supra), being forever glued to the troupe of the analytic community. If we connect time and transference, then this implies that handling time means handling transference. Handling time is hence an instrument in analysis, but its use depends on a conception of the nature of analysis and the structure of the subject. The structure of obsessional neurosis is renowned for the attempts at "killing time." From Hamlet, inhibited to act upon his rage, to the modern day Ph.D. student procrastinating his way through academic eternity, the obsessional strategy of dealing with time is quite anal, holding it all in, so as not to give anything away. In analysis this can take the shape of meandering babblings about books, movies or—why not—methodology. Lacan asserts that:

> I was able to bring to light in a certain male subject fantasies of anal pregnancy, as well as a dream of its resolution by Caesarean section, in a time frame in which I would normally still have been listening to his speculations on Dostoyevsky's artistry. [Lacan 1953, p. 259]

Using time as an instrument of scansion aims at bringing out unconscious material (the fantasies of anal pregnancy and the dream, in this case), which would otherwise be lost in endless intellectualizations (cfr. "speculations on Dostoyevsky") and meandering comments that keep the unconscious at bay. As a midwife of the unconscious, the analyst cannot just remain at the sidelines in every case. Sometimes some pressure is needed in assisting the delivery.

Lacan's view on logical time in the analytic process has technical implications that are nevertheless secondary to his view of treatment as oriented towards the symbolic. Moreover, his use of the variable-length session eventually led to his break from the IPA[9]. For Lacan, the use of the variable-length session aims at conserving a temporal tension that is key to being able to reach the moment of concluding. In that sense, it aims at countering the alienation that transference could tend towards.

The *Rome Discourse* contains many traces that will set the Lacanian agenda for years to come. Interestingly, Lacan notices this himself as he added a footnote in 1966 to the following passage, indicating that it constituted a precursor to his supposed subject of knowledge:

> In fact, this illusion—which impels us to seek the subject's reality beyond the wall of language—is the same one that leads the subject to believe that his truth is already there in us, that we know it in advance. This is also why he is so open to our objectifying interventions. [Lacan, 1953, p. 254]

MOMENT OF CONCLUDING: THE SUPPOSED SUBJECT OF KNOWING

The concept of the supposed subject of knowing constitutes Lacan's definitive outline of the structure of transference, the core features of which trace back to Seminar VIII (*Transference*). While Lacan anticipated it already in 1953, his time for comprehending could nevertheless not be cut short, before reaching this conclusive notion with regard to

[9] Lacan is very critical of some of his contemporaries in the *Rome Discourse*. He criticizes analysts of the 1950s for adhering rigidly and even obsessionally to technical standards in the treatment. For a thorough reading of the historical context of this paper see Roudinesco (1999).

transference. Why did it take him ten years to explain what he had already expressed? We can look at certain developments in Lacan's thinking during the 1950s and early 1960s to answer this question.

Signifier and Object in Transference

First, in Seminar VIII on transference, Lacan reflects on the nature of love. Whereas before, love had been regarded mostly as an affect in the Imaginary, reigned by reciprocity, but essentially missing a clear symbolic structure, he reviews this thesis. Love, now, is directed towards an ephemeral, brilliant and ungraspable object that is located in the Other. Lacan denotes this by the Greek word *agalma*, which means a glory, an ornament, an offering to the gods, or a little statue of a god, a precious object in a relatively worthless box (Evans 1996, p. 128). As opposed to reciprocity and intersubjectivity, Lacan stresses heterogeneity now. Love has to do with the experience of an immanent lack, which is the very mainspring of love (Nobus 2000). We love what we lack. Obviously, this differs from a narcissistic (and imaginary) rendering of love as loving what reflects yourself in the other. Love is oriented towards difference, not sameness. This difference is fundamental and can never be remediated by love. From then on, the subject and the Other are fundamentally heterogeneous. This represents a clear break of transference from intersubjectivity (Lacan 1967). If the other is approached as *agalma*, this means that there is no direct relation to the desire of the Other. The *agalma* is what sutures the experience of lack in someone, by transferring the fantasized solution for the lack to the Other. This "fantastic"[10] object covers over the lack of the divided subject. In the same way, the supposed subject of knowing enables the patient in analysis to endure the inherently divisive procedure that is free association. The articulation of love and knowledge that is the supposed subject of knowing is a fiction, a lure. Transference love is bred in the womb of ignorance. Nevertheless, the lure is productive in that it enables the patient to question the symbolic side of symptoms. Lacan first needed a theory on love in relation to lack, before he could forge a view of transference as including an insurmountable asymmetry ("disparity").

[10] A pun on fantasy is intended here, since Lacan will later develop the object *a* as the support of the fundamental fantasy, based on his thinking about the agalma.

The agalma as an object located in the Other is a forerunner of Lacan's invention of the "object *a*," introduced in Seminar X (Lacan 1962-63). The object *a* is a remainder of an operation of subjective division that cannot be taken up in language. The subject is divided because it has to realize itself in the locus of the Other through the signifiers of this Other, and this results in a fundamentally divided subject that hinges on a remainder in the field of the Other. Lacan introduces a line of thought that he will develop in the years following Seminar X. From then on, transference is related both to the signifier as to the object. As the divided subject has lost something to the Other, it is there that it is sought. This is the foundation for "the possibility of transference" (Lacan 1962-1963, p. 337). The signifier as "what represents the subject for another signifier" (Lacan 1964, p. 157), introduces the subject as an ephemeral bearer of its own alterity, as always "in between." This subject gravitates around an irremediable loss that is the object *a*. As speaking beings, we try, by speaking, to recuperate the loss that we have suffered. Nevertheless, as this loss cannot be symbolized as such, this process is open-ended and cannot be resolved by finding the symbol that would represent or cover up for the loss. At this point, an important difference with his theory at the time of the *Rome Discourse* becomes clear: truth cannot be fully articulated anymore; full speech is a forever unattainable dream. The knowledge one gains from analysis is necessarily partial and singular, since what causes desire is outside of the realm of the signifier.[11]

Following this development closely, Lacan introduces the supposed subject of knowing in Seminar XI, hand in hand with a changed conception of the unconscious as a temporal alternation between opening and closing. The unconscious is not there, but actualizes in a flash and then vanishes again. In contrast to the Freudian model of the unconscious as a container, Lacan proposes a take on the unconscious not as an entity, but in line with the nature of the subject, that is pre-ontological (Verhaeghe 1998, p. 165). The unconscious is not a knowledge that is already there albeit hidden (nor a representational truth to be

[11] In Seminar XVII (*The other side of psychoanalysis*; Lacan 1969-1970) Lacan more clearly separates knowledge and truth. Knowledge does not resorb truth fully as the truth can only be half-said. The connection between truth and knowledge as well as their disjunction is thematized through the discourse of the analyst.

developed), but what is produced in the analytic encounter. It is here that transference comes into play. Transference as supposed subject of knowing actualizes the unconscious in a symbolic guise. Soler (2014) states that the supposed subject of knowing is "a name of the unconscious" (p. 39), that is to say that there is no unconscious without its supposition. Nevertheless, even though transference is related to the movement of opening the unconscious on the symbolic plane, it nevertheless also constitutes a closure of the unconscious insofar as "transference is the enactment of the reality of the unconscious" (Lacan 1964, p. 146). This reality, he adds, is sexual.

We will look more closely into the aspect of the supposed subject of knowing in its relation to free association, where it appears as the anticipation of meaning. Second, we will connect the supposed subject of knowing to the symptom, based on interpretations proposed by Miller (2008) and Zenoni (2003).

The Supposed Subject of Knowing and Free Association: Belief and Guarantee

The rendering of transference as the supposed subject of knowing translates the anticipation of meaning in terms of belief and expectancy. As a supposition, and bearing in mind the deceptive aspect, it is not tangible, but has a virtual character. The supposed subject of knowing constitutes an expectancy (Soler 2014) or a guarantee (Grigg 2009) that the operation of free association (that aims at producing non-sense) will produce something meaningful. Thus, far from being an attachment in terms of feelings or a personal bond, transference constitutes an attachment of the patient to the future: "it requires a special alliance of meaning [*sense*] and suffering" (Miller 1997-1998, p. 56). It is precisely this very wager that is of utmost relevance to the way analysis starts. After all, how could one expect any good from uttering whatever comes to mind? The analyst, by his presence and his intervention, supports the belief in an unconscious, that is, that there is a subject to the chain produced through the operation of free association. This belief is productive (in that it produces a singular knowledge), but nevertheless always remains virtual (cf. you have to believe in God before you can find "evidence" of his existence). As Soler (2014) points out, this makes psychoanalysis into an easy target for critics. Seminar XI paints a picture of the supposed subject of knowing in relation to the God of Descartes. This

French philosopher, renowned for his "Cogito," ultimately needed to insert God into his system of thought again, as a guarantee. "I think, therefore I am" holds true on condition that there is a God to support the truthfulness of this statement. So ultimately, reason alone cannot guarantee the Cogito. What Descartes needs is the hypothesis of a nondeceptive God. But why is this trust (Miller 1995) or belief necessary in analysis?

The fundamental rule does not suffice to start an analysis. If merely reminding the patient of the rule of free association sufficed for analysis to run its course, then there would be little need for analytic training. Moreover, psychoanalysts could be easily replaced by automated analysis-machines, who once in a while remind the patient of his associative duties. In a way, this "procedure" needs an extra element of anticipation to resort an effect. Silvestre (1987) points out that free association seems to produce therapeutic effects automatically, but nevertheless always fails. Analysis thus starts out with a paradox: the success of its procedure is the very failure of the procedure to work. It is the central notion of mental life that one succeeds where one fails. This is the meaning of Freud's interest in parapraxes and slips of the tongue. The role of the analyst then boils down to motivating the patient to go on with this continued failing. This seems to require quite a masochistic attitude from the side of the patient, faced with this repeated impossibility of saying what one wants to say.

Free association is a thoroughly paradoxical procedure in another sense as well. If you assume that you are just saying random things as they cross your mind, then it seems impossible to make sense of the nonsense that comes out of your mouth. Put differently: if you assume that free association is really free, then it does not amount to anything. This would be similar to assuming that a dream is just a random product of different neurons firing while asleep. Conversely, free association can only generate meaning if it is assumed that it is not truly "free." So, for free association to make sense, one has to believe that there is a structuring to what will come out that way in the first place. At that point, the supposed subject of knowing comes into play as the anticipated/virtual point that guarantees the sensicality of the procedure. Either the patient believes that the analyst holds the key, or the patient believes that speaking will help him/her find "something." Miller (2004) contends that

there is a double temporality at stake in the analytical session: one direction goes towards the future and represents the aspect of expectancy and the other goes from the future to the past, inasmuch as the time that lapses will continuously be inscribed in the past. He states that Lacan has read Freud's eternal unconscious as the supposed subject of knowing, hence indicating a structural illusion:

> … the illusion that the past, inasmuch as it contains everything that has been the present, including the relation the present has to the future, was there before the experience of the present itself. It is the illusion of "it has been written." [Miller 2004, p. 77]

This passage evokes a plethora of interesting avenues to explore, but what grabs our attention most is how Miller connects the experience of the analytic session, as a talking cure, to the operation of writing. As such, we interpret him as pointing to the possibility of the analytic experience for the patient to read what he has said, because through the analytic encounter the analyst incarnates the "it has been written." It is precisely this connection between reading and talking that is of utmost importance to the production of knowledge through analysis. Now, how does a speaker become a reader?

The Supposed Subject of Knowing: Time and Symptom

As Vanheule (2017) observes, patients have a reflexive relation to their symptom: they interpret some aspects as problematic or symptomatic and think about why and how it appears. Symptoms are personal constructions, not natural entities. The patient consulting an analyst does this from a similar position as the prisoner in the logical riddle. Besides the imprisonment of suffering, so to speak, the patient has something on his back that he can neither see nor read, but nonetheless knows that it is there. First, we discuss the emergence of a question about the symptom prior to the patient's consultation of the analyst. Then, we outline how analytic labour emerges on the crossroads of a therapeutic demand, a request to be helped and a desire to know (epistemic demand) following Zenoni's (2003) reflections.

Miller (2008) discusses how the supposed subject of knowing arises through three moments, that he considers to occur prior to the first

consultation with an analyst, but that can however only be reconstructed on the basis of what the patient says about them after the fact. There is a "pre-interpretation" of the symptom by the patient, which unfolds along three temporal instances, just as in the logical riddle described. Miller connects these instances to three statuses of the symptom: Imaginary, Real, and Symbolic. First, the symptom is misrecognised and is equated with the everyday reality of the patient. It is equivalent to his life as such and does not bear witness to any disruption of continuity. Miller gives the example of an obsessional who finds a regularity by meticulously satisfying imperatives from others. The first time is a smooth running of things; life is a matter of *business as usual*. In the second "stage," Miller situates "the emergence of the symptom as a solution of continuity." Here a breach occurs in the smooth running of things. Something is out of order, disrupts and constitutes a breach with the ordinary way of life adopted so far. Finally, in the third stage:

> … the demand addressed to the analyst is inscribed – a moment to conclude, supported by the symptom and which has the effect of restoring its symbolic status, i.e., its status of an articulated message from the Other. [p. 10]

Importantly, the first stage, where the patient doesn't yet have the idea that something is out of the ordinary, is often problematized afterwards.

The model that Miller proposes describes the movements that constitute the preliminary interviews. Hence, he considers the name of "preliminary interviews" as misleading, since they are "*secondary* in relation to a transference that is already there" (Miller 1995, p. 9, italics added). In that sense, analysis begins … before analysis begins. The background of this model complexifies the idea of what the symptom is. For our argument, we want to draw attention to the "solution of continuity," to the disruptive crisis that ultimately leads to what Miller terms "the precipitation of the symptom" (p. 11).

Returning to Marie Cardinal's case, this pre-interpretation shines through in her (retrospective) account as well. The symptom disabled her, but at the same time organised her entire life: everything she did or did not do was based on the bleedings. Moreover, she developed procedures for checking the flow of blood that she repetitively adopted. She addressed medical specialists with a symptom that no doubt caused her

much suffering, but at the same time became equated with her reality. As it is more of a bodily phenomenon, we would however term this as real (in the Lacanian sense), not imaginary. The bleedings constituted a peculiar form of jouissance, in that they were disturbing at one level, but satisfying at another; the symptom in the psychoanalytic sense constitutes a balance between wins and losses (Verhaeghe 2008). Nevertheless, this is shattered when the limit of medical treatment for her ailment is reached and her problems threaten to be placed into the hands of psychiatry, thus objectifying her "madness." This disruption and the drastic measures proposed by her doctors prompt her decision to make the "madness" stop urgently. It is then that she decides to try analysis, even though she is not a strong believer of analysis at the outset. Thus, the despair after the time of the crisis (what Miller calls the symptom as real) is what urges her to make the consultation. Then the symptom is brought into a transferential relation to the other as a demand. Nevertheless, a particular shape of the demand is required before analysis can be said to have started.

The symptom is not uniquely an encrypted message, but also carries a particular mix of pleasure and suffering that Lacan termed jouissance. This side of the symptom is real. In that sense, "analysis can only be therapeutic" (Demoulin 2001), because the patient has to include an element of suffering in the bet he makes on analysis. Lacan explicitly defined psychoanalysis as "a praxis" to "treat the real by the symbolic" (Lacan 1964, p. 6).

The Analytic Symptom as an Alliance of Sense and Suffering

The demand needs to bear witness to a certain subjective position before the supposed subject of knowing can occur, according to Zenoni (2003) who calls this the "entry by the symptom." Following Lacan, he states that an "analytic symptom" has to take shape during the preliminary meetings. The analytic symptom is different from a mere "epistemic demand," where the patient consults in order to get to know himself better, as well as from a "therapeutic demand," where the patient complains and asks for help. Both aspects need to be present, namely suffering and a desire to know about it, and the preliminary interviews aim to forge this particular alliance between sense and suffering (Miller 1997-98). The reasoning Zenoni follows is similar to what Miller outlined with the

idea of a precipitation of the symptom, but starts from the point of the demand made on the analyst. What is stressed in this view is the fact that the symptom needs to be put into question. There are symptoms we are perfectly happy about, because they do not cause us distress or provoke crises (e.g. a particular love partner). Other symptoms, can cause suffering, but without inspiring a desire to know. Zenoni states that an operation on the demand for analysis is needed, that motivates the analysand to engage in analytic labor. This operation is a step the analysand ultimately has to make in his discourse, connecting his suffering to an unknown.

Marie Cardinal's suffering prior to analysis is obvious from her story. The bleedings and an overwhelming anxiety occupied her around the clock. Addressing a whole series of doctors did not alleviate these problems, but rather entertained and even exacerbated them. It is but when she encountered the analyst that a subjective dimension to these problems emerged. We could say that in her case, a therapeutic demand was present at the outset, but that the response by the doctors had foreclosed her search for the epistemic aspects of what she complained about. We propose to read the intervention in the first sessions where the analyst states that he is not interested in her bloody stories ("the slap in the face") and asks her to speak about something else, as the precise point the transference take shape. She gets hooked on analysis and disconnected from her obsessive registering of the symptom. It is there that her therapeutic demand is sidestepped by the analyst and an analytic symptom can emerge. "Blood" is no longer a sign of a medical problem, but can become a signifier to explore through the analyst's response. The analyst does not play along with the jouissance of the symptom, but radically points to a possible symbolic exploration, stressing the dimension of speech ("Speak about something else"). The effect of this intervention is quite simply her analysis. In a more proximal sense, two immediate effects are striking. First, the bleedings stop. This seems quite miraculous given the long trajectory that preceded it. Nevertheless, this provides the clearest evidence that something of the real of the symptom has been touched upon. We hypothesize that it was the emergence of the supposed subject of knowing as symbolic that is accountable for this therapeutic effect, in line with the above-mentioned rendering of analysis as treating the real through the symbolic. Clearly, these early

therapeutic effects cannot be accounted for by any form of notional or representational insight. What is more, even after the analysis, Cardinal does not provide her reader with an insight into the nature and the cause of these problems. Of course, we learn about important aspects of her life history that bear a relation to these problems, but as Barnes (2018) and Bettelheim (1983) (in the postface to the English translation of the book) point out, a lot of questions concerning these issues remain open, such as the specific onset and the precise meaning of the symptom. The second effect of the intervention is that she feels hurt and immediately a negative transference unfolds, in the sense that she starts suffering because of the analyst now. The analyst is thus invested with a part of her suffering. Obviously, this is a "tricky business," since it can never be the aim of analysis to silence patients. Marie Cardinal, however, was able to tap into another mode of speech because of it.

DISCUSSION

We followed a trajectory in Lacan's work that started with the dialectical reversal discussed in the Dora case and found its conclusion in the analytic symptom as an enigma that provokes the analysand to become a worker and a reader beyond the particular demand formulated at the outset. This endpoint, in a way, brings us back to our point of departure, namely the subjective expression of suffering through speech. The common thread throughout Lacan's changing perspective on the nature of transference at the beginning of analysis is the way the articulation of a symptom creates a transferential tie that is productive in that it engenders truth, and later, knowledge (meaning).

We interpreted Lacan's work as evidencing three logical moments that he put forward in 1945. However, these moments do not overwrite each other completely; something of the previous moment remains present in the following one. They all retain a necessity and are implicated in the moment of conclusion. In that sense, all three evidential moments contain indications that are pertinent to clinical practice and are instructive with regards to the position of the analyst in the opening sessions (and in the analytic process generally). Moreover, analysis can be regarded as an accumulation of moments of evidence that cumulate in a singular knowledge. Logical time not only describes the beginnings

of the analytic process, but also is relevant to all moments where the subject has to reach a conclusion in spite of a lacking guarantee (Adriaensen 2001).

Presentation on transference, qua "instant of the glance" indicates how truth can get lost in transference if the analyst does not read the transferential moment in the context of the material that is being discussed, but from the perspective of the relation that he guesses to have vis-à-vis the patient. Moreover, Lacan points out how the analyst has to provoke the formulation of his own involvement in what is complained about. Originally, this was illustrated through Dora's complaint and Freud's management of a subjective rectification in her case. This moment of subjective rectification remains an important index for the possible entry into analysis, and the analyst needs to make this possible through his interventions. It remains the fundamental maneuver of transference in working with neurosis. The analyst hence incarnates the question of where the patient is situated in her account of what is troubling her. Interpretation qua rectification precedes transference. Lacan had put all the weight of this rectification on the shoulders of the analyst, but in the "time for comprehending" he progressively stresses the position of the analysand towards the symptom. This change has to do with the nature of the symptom that is now regarded as a cryptic message that can be objectified on the imaginary plane ("all this is factual, now what are you gonna do about it?"). The time for comprehending demonstrated the necessity of misrecognition before the truth of the symptom can arise. As was evident in Marie Cardinal's case, there is no direct access to the truth that the Symbolic contains. Nevertheless, the analyst needs to be attentive to the dimension of the Symbolic (cf. "tube"), even if transference manifests intensely in the here-and-now of the session. Moreover, time is an instrument in analytic work, albeit it is not easy to handle. On the one hand, the analyst needs to create urgency that entertains the momentum of the analytic work, without foreclosing the time for comprehending, as happened with Pankejev. The time for comprehending evident in Lacan's work in progress enables analysts to understand how the symbol ties together past, present and future and how transference constitutes the plane where a modulation (in the musical sense of going from one key to another) becomes possible.

Finally, in the moment of concluding, another aspect of the symptom appeared. As symbolic, there remains a side to the symptom that can be articulated, but this needs the supposed subject of knowing to make the link to the Other exist. A symptom gets a symbolic translation and deciphering, precisely because it is expressed to an Other in analysis. This symbolic translation results in a knowledge about the symptom that is particular to this one patient. Outside of this link, the symptom remains at the level of the imaginary or the real. The pre-interpretation of the symptom demonstrated how an imaginary rendering of the symptom can become destabilized through a subjective crisis. Finally then, the supposed subject of knowing emerges as an anticipation that the meaning of the symptom is in the Other. This sequence now includes the Real, and occurs multiple times in analysis. The supposed subject of knowing, as a symbolic link to the analyst, paves the way for the unconscious to open. Nevertheless, at the same time this process encounters a limit, because the excavation of meaning through the signifier bumps up against the limit of the real that remains outside of the symbolic. The analyst can then appear as a real presence, outside of the habitual framework the patient has to understand relations to others (Cauwe, Vanheule, & Desmet 2017). The analyst then, not only appears as a guide to the historical dimension of the patient's life history, but is also connected to her suffering and jouissance. Just as the symptom constitutes an amalgam of symbolic (language), imaginary (ego and understanding), and real (jouissance) elements, so transference bears witness to being structured in different registers. The preliminary interviews serve the purpose of forging a relation between a supposition of meaning about the symptom (symbolic and imaginary) and the suffering (real) associated with it: the analytic symptom. As real, the symptom represents a strange mixture of suffering and satisfaction, that Lacan termed jouissance. Eventually, Lacan regarded the real aspect of the symptom, jouissance, to be what gives it a consistency above and beyond everything that might be uttered about it. The truth of the symptom is not in the symbolic, but insists as jouissance. The case of Marie Cardinal provides an example of how the opening sessions enabled her to establish a symbolic link to a suffering that she repeatedly labelled as "the Thing." The effects of the analyst's words at the beginning of her analysis are baffling for Cardinal. As Barnes (2018) points out, "Marie's

words and those of her doctor were a cure for her 'madness'" (p. 143). Nonetheless, we cannot qualify her analyst's early intervention, where he utters his disinterest in her blood, as an "interpretation." We deem this intervention to be an "analytic act," in that it limits the debilitating jouissance of the problem (Bistoen 2016, p. 135) she presents with. Once the link to the symbolic is established, then transference as the supposed subject of knowing engenders interpretative effects automatically and structurally. The analyst then, needs to support this supposition in order for the patient to develop her own singular answers.

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An Allegiance To Absence: Fidelity To The Internal Void

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AN ALLEGIANCE TO ABSENCE: FIDELITY TO THE INTERNAL VOID

BY RACHEL SOPHER

The internal void or absence is often formulated in terms of the ongoing structural consequences of a profound lack in early maternal care resulting in a deficiency in psychic structure, an area of weak or non-representation. Rather than defining the psychic void solely as a lack of inner development leaving a passively experienced impoverished inner world, this paper highlights the phenomenon of libidinal investment in the original black hole in the early care-taking environment, creating an allegiance to absence, an emotional investment in a state of nothingness that actively impedes psychic growth and shuts down elaboration of the generative unconscious. Because the type of early absence comes about at a time when the difference between self and non-self is still developing, language and other types of communication that clearly define self and other may not be the most useful methods of broaching these early unformulated states. Treating an allegiance to absence requires that the primary attachment, or absence thereof, becomes actualized in the relationship between patient and analyst, the unique manifestations of which bring to life the absence in the here and now where it can be experienced and transformed.

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Keywords: Absence, neglect, void, emptiness, enactment.

JENNIE

It is the end of a session with my patient Jennie; she rocks back and forth as she speaks, her hands covering her face. We have spent the hour experiencing the depths of her despair, traveling back in time together to a harrowing episode in which her mother drove while under the influence of mind-altering drugs, crashing the car, almost killing them both. Towards the end of our time I ask Jennie how she feels. "I feel like a hole," she tells me in a tiny voice. "Like you're in a hole?" I ask her. "No, like I *am* a hole. Like there is a pit, an indentation, a negative space in the place where I am supposed to be," she answers. I wonder if my question, together with the approach of the end of the hour have left her feeling emptied out, traumatized by the experience of merger as we relived her trauma together, followed by the abrupt separation, a ripping apart into "a devastating sense of two-ness" at the session's end (Tustin 1981, p. 106). Work with Jennie is characterized by just the type of absence she describes: there is a hole in her, and in me, an emptiness that suffuses the heart of the intersubjective space between us, hollowing out our interactions at their core.

SEPARATION AND ABSENCE

Many describe encounters with patients suffused with feelings of deadness, emptiness, and lack in what has been referred to as the black hole or void in internal experience (Balint 1963; Eshel 1998; Gerson 2009; Green 1986; Gurevich 2008; Peltz 1998; Tustin 1972). Because this black hole is an often unformulated internal state defined by what is not there rather than what is, both patients and psychoanalysts lack adequate ways of communicating about this experience of early, traumatic absence and its consequences. One intention of this paper is to continue the discussion about these preverbal states, to elaborate the language for the presence of absence in treatment, both in the internal worlds of patient and analyst, and in the intersubjective overlap created in the relationship between them (Ogden 2004). The internal absence is most often conceptualized as a deficiency in psychic structure, an area

of weak or non-representation. Rather than defining the psychic void solely as a lack of internal development leaving a passively experienced impoverished inner world, this paper highlights the phenomenon of libidinal investment in the original black hole in the early care-taking environment, creating an allegiance to absence, an emotional investment in a state of nothingness that actively impedes psychic growth and shuts down elaboration of the generative unconscious.

The internal void or absence is often formulated in terms of the ongoing structural consequences of a profound lack in early maternal care, a zone of deadness or emptiness that pervades psychic space. It has been connected to early separation from the mother that traumatizes the child, bringing up overwhelming fears of annihilation. Because the infant has not yet developed the ability to symbolize the absence of the object, he is dependent on the concrete presence of the mother to feel safe. According to Winnicott (1971), if the mother is apart from the child, her image remains alive in his mind for x minutes. After x minutes, her image starts to fade; if she stays away x + y minutes the child is in distress but still has not been irreversibly transformed, but:

> in x + y + z minutes the baby has become traumatized. In x + y + z minutes the mother's return does not mend the baby's altered state. Trauma implies that the baby has experienced a break in life's continuity, so that primitive defences now become organized to defend against a repetition of 'unthinkable anxiety' … [p. 97]

When a child experiences the loss of the mother that is too sudden, too early, or too long, it brings up the "nameless dread" (Bion 1962) of catastrophic abandonment. Traumatic separation evokes "unthinkable anxiety" that must be defended against at all costs as all ensuing separations bear the threat of this paradigmatic, unendurable separateness: the gap between self and other having become an infinite, timeless void experienced as too painful to bear (Lombardi 2015).

Winnicott (1971) elaborates that from the child's perspective, there is a time when the mother is dead but can come back to life, and past that, a point when she is felt to be dead forever. As this change takes place, the child experiences a moment of anger, a protest, that is passed over then lost as the new reality of the mother's indelible absence takes

hold of his psyche. There are thus dual dangers looming, according to Winnicott: there is the menace of catastrophic aloneness threatening breakdown from without, and the unexperienced violent reaction to the original separation threatening fragmentation from within.

In order to avoid re-experiencing the trauma of early abandonment, the child may attempt to deny his separateness using omnipotent fantasy and autistic defenses, creating an unrelated shell-self built around a fragmented interior that must exert energy to plug up the hole at his vulnerable core, remaining mortally defended, isolated, and related to an enclosed world of internal objects and inanimate things (Tustin 1986). This encapsulation keeps the child safe from experiencing his separateness and from the traumatic knowledge of his need for the other.

In his discussions of internal absence Winnicott's (1971) predominant emphasis is on the structural impact of the neglectful environment of the original parenting relationship on the dependent child-victim and the way this manifests internally; that is, he foregrounds the passively experienced consequences of early abandonment and their sequelae later in life. To illustrate, he uses a quote from a patient who had suffered repeated abandonments throughout her childhood; referring to her previous analyst she told Winnicott that, "The negative of him is more real than the positive of you" (p. 23), which he interpreted to be representative of an internal world in which absence and loss served as the nucleus around which she organized her self-experience. Winnicott highlights the experiential quality of the void in the patient's psyche, the long-ranging impact of early neglect on the patient, which led her to feel that what was unavailable was more real than the immediately available objects around her. Green (1997) similarly explains that for Winnicott's patient and others like her, "The non-existence, will become, at some point, the only thing that is real" (p. 1082). These understandings illustrate one side of a self-other configuration, the position of child-victim in relation to an absent parent.

Though these formulations and others like them accurately describe the psychic experience of internal absence as inner reality, they privilege the encapsulated experience of early infancy and the long-ranging consequences of being the passive object of neglect. This construction, though eminently useful, leaves out another side of the story—the child's identification with the absent non-object and subsequent

attachment to and investment in the experience of emptiness. The originally traumatic absence becomes introjected as a libidinally-invested attachment to lack, the tie to the non-present object bringing about a sense of futility and cynicism about the power of available human bonds in favor of an internal relationship to absence. Winnicott's patient mentioned above must hold on to the nothingness, the gap having become the barrier beyond which lies certainty of annihilation. As she continued she told Winnicott, "All I have got is what I have not got" (p. 23). Her expression belies the powerful attachment to the absent object and her fidelity to what she has "not got," hence her loyalty to the absence in intersubjective relationships, including the one with her analyst. The nothingness is her everything, it is her attempt to maintain a connection with her primary objects which were defined by their non-presence through absence and neglect.

In a similar example, a patient once told me that though she had been in a harrowing situation over the weekend in which she lost control while skiing and injured herself, that she had felt "safe because *no one* was watching." In exploring this phrase it became clear that the "no one" that was watching her was her internal absent mother. This patient's mother in her lack was still the main object of attachment, the source of safety even as defined by her non-presence.

At an early stage in development, the child needs the mother's presence in order to symbolize and digest his experiences, to make them meaningful. When the mother is absent, there is no containing presence available to help the infant to understand the overwhelming affect associated with her absence. In the child's state of omnipotence, he infers that his neglected state is a consequence of the mother's desire in relation to him (Aulagnier 2001). In other words, he surmises that the mother wants him to feel her absence and neglect. The child attaches this meaning to the early experience of abandonment in order to maintain a connection to the absent maternal object—this state of affairs being more preferable than the catastrophe of having no object at all. The child makes a secret pact with the absent mother, promising to cut off his own needs to fulfill her desire for absence; this in exchange for his continued existence. The need to maintain this meaning, that the mother wanted the child to experience abandonment, creates a strong

bond with the absent object, and inhibits other experiences with present objects that might threaten this important primary link.

The allegiance to absence is analogous to Fairbairn's (1963) model of the internalization of and the attachment to the bad mother, but in this case the mother is bad because absent or neglecting (rather than angry, critical, or intrusive). In other words, the child cathects to a non-object as representative of the original absent bond with the mother. Later in life, he will continue to unconsciously look for similarly absent objects to enact (and attempt to master) the original traumatic experience of absence. The neglectful parent is not only taken in, becoming the source of the internal absence, but also libidinally invested, such that there is an emotional attachment to what wasn't there. This is a powerful devotion to absence, an allegiance to the lack that exemplified the child's early primary relationships. There is an imperative attached to the link with absence, as the persecuting absent object requires the constant presence of the child so that she may continually fulfill her wish to absent herself from him. Aloneness thus takes on the masochistic morality of allowing oneself to be absented, enacting the central primal relationship.

This allegiance to absence is a bond with nothing, a fidelity to nothingness that fills up all the internal space so that no novel experience may take root and grow. Vitality, spontaneity, and other emanations from the authentic self subsequently must be repressed as they threaten the link with the absent non-object. To break the bond with the absent object would mean suffering the original disorganizing catastrophe of her absence, as well as coping with the affective understanding of what one has given up in the maintenance of this early connection.

Patients with this type of "negative investment" are eternally drawn to what is not there, the absence haunting with a powerful hold that pervades all psychic space. The ensuing disavowal of early need leads to a state of suspended animation, the deadness fencing in the private madness of totalizing desire that might otherwise be unleashed (Green 1988; Emery 2002). As such, instead of experiencing a potentially generative bond suffused with creative possibility between self and other, there is a menacing danger perceived in the intersubjective space, one that threatens to break the bond with absence such that the original breakdown and its resultant overwhelming affect be re-experienced.

The original catastrophic abandonment becomes encapsulated, avoided as the affect it encases is indigestible; there is no way to symbolize what was not there, making it impossible to mourn.

AN UNARTICULATED NON-PRESENCE

An allegiance to absence differs from Green's (1998) dead mother in that this type of object relationship is a pre-symbolic connection to an unarticulated non-presence. Where the dead mother was once available to the child as an intelligible live object who then fades away, the allegiance to absence is a relationship to a state of lack, a more diffuse attachment to a process that defies representation. This results in a connection to an object that is defined by a state of non-generativity, a cathexis to the blanking out of the possibility of creative expansion, in order to maintain loyalty to the absent object and protect oneself from the painful knowledge of what has subsequently been lost. Attachment to a bad object that defies representation leads to a freezing of the original traumatic scene in a concrete space without the capacity to elaborate the internal object world. Instead, the opposite occurs: the absent objects must be protected by keeping the natural development of the generative unconscious in a rigid, stagnant state.

Instead of developing new and more complex internal object relationships (Green 1993) there is a necessary withdrawal of investment in others in order to maintain the link with the original absent object. This leads to a reciprocal wish to eliminate the desire for the other in the self with an ensuing attack on internal objects. This process impairs the capacity for symbolization as new objects cannot be stably represented internally (Reed & Baudry 2005) leaving an internal void that cannot be filled. This early habituation to withdrawal of investment leads to difficulty creating and maintaining internal representations later in life, often leaving only affect and impulse as surrogates for meaningful object relations. This illustrates the way the allegiance to absence, rather than a passively experienced lack of internal structure, is an active and ongoing process of divestment from external reality that inhibits the path to mourning deemed too painful to approach, let alone bear. This allegiance to absence, rather than a passive refusal, is more often an unremitting, active process of deadening potential affective links; a

withdrawal from the possibility of what might be new and enlivening, a continuous negation of the potential to create new objects that requires a measure of energy to maintain.

In addition to a lack of representability of absence, there is often a lack of a *framework* within which to create internal representations, and which holds the capability to contain the experience of emptiness in the self (Green 1998). Because of the intensity of fear that separateness evokes, there is no structure, or experience of internal space with which to hold the absence; there is no blank background against which anticipatory fantasy can arise that spans external and internal worlds (Winnicott 1958). Without this framework, one cannot do the psychic work of *imagining* what is absent, instead shielding the self from its knowledge through denial of difference. The patient cannot conceive of the emptiness. She cannot imagine, contain or give shape to it, so she remains consumed by an undifferentiated state of internal emptiness.

The absent object paradoxically fills up all of the psychic space, pervading all so that nothing new can take root. The potential creativity of internal emptiness is unmanifested as this type of generative space would bring to light the catastrophe of the original experience of absence. The goal of treatment, then, is to begin to give shape to the patient's uniquely experienced internal absence (Gurevich 2008), to symbolize it so that it may be thought about, thus allowing the beginnings of generative emptiness to be experienced in the center of the nothingness, the creative emptiness that is the space from which internal process grows and expands to create increasingly more complex and affectively rich connections.

ABSENCE IN TREATMENT

As the traumatic severing of self from other which is being addressed here occurs before the acquisition of language, and is defined by an act of omission rather than commission, there are no words nor any meaningful actions available to the patient with which to represent what is missing. This leads to a daunting technical difficulty: not only is there an attachment to absence, but the absent object is also undeveloped and thus inaccessible to verbal representation. Because of the unformulated, preverbal nature of the absent object, language is an often inadequate

vehicle for the communication of meaning between patient and analyst. The ability to utilize language meaningfully is predicated upon the capacity to both experience and symbolize the absence of the object. For this one must be able to tolerate separation (Amir 2013). The acceptance of the ambivalence necessary for the symbolic use of language requires individuation and a tolerance for the work of mourning, as it depends both on a tie to the object as well as the capacity to release it and conjure it within.

With an allegiance to absence, language simultaneously enacts the transmission of meaning and renders it void, cutting off internal linkages and affective resonances in order to protect absent objects. Because of the split that this type of "absent language" maintains (Amir 2017), cutting off the live (absented) internal child object, in favor of giving voice to the deadened adult, one must establish a receptivity to a kind of grammar that stands outside of language, in the most basic register of concrete sensation. Specifically, for patients who have experienced preverbal, catastrophic neglect, experiences of the object primarily occur at the level of sensory experience (Ogden 1989). Furthermore, patients who maintain encapsulated or dissociated experiences of early absence are caught in a "closed, bodily world without room in which to create a distinction between symbol and symbolized" (Ogden 1989, p.131). At this level of object relating, words are experienced as things, sensations that soothe or intrude on the emergent sense of self.

The demand on the analytic relationship is thus either one of total non-engagement or of merger. It requires the work of two psyches, two bodies and minds in communion with each other to "dream up" (Ogden 2007) an absence within the analytic third of psychoanalytic treatment. What is missing must be first experienced on a sensory level, then represented in the treatment so that a deep, primary knowledge of the absence can be symbolized, accepted, and integrated in an organic way that does not call up defenses related to traumatic intrusion. A psychoanalytic patient cannot be told simply with words that he is holding on to an early absence. For an integration to occur, the piece that is missing must be accessed from a more basic register of sensory experience; this more basic register is on the level of the experiencing self, in the mode of perception over apperception (Winnicott 1967). This primary, sensory register bypasses the narrative structure imposed on

experience by the higher order intellectual functioning of the mind, which can be defensive in nature.

This undertaking is one in which what is absent becomes accessible through enactive engagement with internal objects that begin to tell the story of absence, often first coming to be known by the analyst who then makes it available, representable and thus knowable to both analyst and patient (Grossmark 2012). Communication through words, especially ones that draw attention to the separateness of the patient and analyst can attenuate the elaboration of the patient's inner experience by arousing his vigilance. As Milner (1969) wrote, "the 'other' has to be created before it can be perceived" (p. 404). The primary attachment, or absence thereof, becomes actualized in treatment in the relationship between patient and analyst, the unique manifestations of which bring to life the absence in the here and now where it can be experienced and transformed. Paradoxically the absence of connection can transform into the presence-of-absence once represented and symbolized, generating novel psychic significance.

Over the course of their process, the analytic couple comes to represent the lack of representation, the absent object manifesting itself through deep engagement with the other in the process of psychoanalytic treatment. But not only does the absence become lived out between patient and analyst, but, so too does the countervalent wish for the reparative *total presence* of the mother (Peltz, 1988). This primal wish for merger, amputated at an early age can be re-experienced in the imaginative space of the analytic frame: as Winnicott's (1971) patient mentioned above told him, "I suppose I want something that never goes away" (p. 23). Thus not only the experience of the original absence "comes to life" in the lived experience of the analytic process, but also the impossible longing for the missing experience of total presence of the maternal figure which can be surrendered to in a fantasy of completeness.

The primary link that has been missing can never be returned, but the integrative psychic work of suffering the pain of this absence can be made possible through the processes of reflection, symbolization, and attribution of meaning. The dissociated state of total dependence and its absence are both conjured up through creative imaginings, dreamed up in the transference-countertransference matrix. The conjunction of

the analytic couple who engage in dialogue verbally and non-verbally, in body and in mind, give meaning to what is being experienced, turning what once felt frighteningly meaningless into a source of meaning itself.

Through this process, the analytic dyad together creates moments of significance in which they relive and give shape to these early experiences. For example, in the vignette described above, in which Jennie described feeling like "a hole," we first felt merged together in an idealized mother/idealized baby transference-countertransference in which there was an implicit promise that our connection could hold her trauma in a way that would last forever—an experience of total presence. Asking a question that pointed to our separateness, the fact that I couldn't read her mind and was aware of the approach of the end of the session, ripped us apart into a state of two-ness that left her feeling erased from my mind—an experience of total absence—most likely causing her to retreat into the safety of absence by defensively erasing herself. Points of contact such as these can begin to articulate the presence of absence by connecting up to create a matrix that approximates the missing framework for the creation of meaning.

What follows is a continuation of this case example that illustrates the way a fidelity to a dissociated internal absence was repeatedly enacted in a treatment. The analytic framework encased repeated representations of this motif, each time from a slightly different angle, each time with a slightly different point of view. The theme of absence persistently appeared and disappeared, and was experienced and articulated at differing levels of development and of reality, creating a chain of levels (Hofstadter 1979) that became meaningful through repeated experience of enactment and representation within the therapeutic relationship. This eventually resulted in the internalization of a framework within which to imagine and give meaning to the absent object.

THE CASE OF JENNIE

When she arrived at my office for our first visit, Jennie immediately struck me as slight, and pale, with her long hair pulled back in a tight bun, and dressed in dark colors that accentuated her pallid complexion, calling to mind the image of a ghost. A thirty-two year old freelance journalist, Jennie entered into our meeting with an air of shyness, and

approached our relationship tentatively, never seeming to have been asked about her internal experience before, and never having paid much attention to it herself. From the start, she seemed detached, far away and unreachable, and I felt similarly far away from her myself.

Jennie grew up in a middle-class home in a suburban area with her father, her mother, and a brother three years older than her. She described a neglected childhood in which she felt isolated and unseen, remembering being left alone to play by herself or watch television for extended stretches of time. When Jennie was eight years old her parents divorced. After that, her father moved out of the house along with her older brother. Her father told Jennie that she had to stay behind, so that her mother would not feel abandoned. So Jennie was left alone in the house to accommodate and contend with an erratic mother who was addicted to painkillers and marijuana, depressed and constantly in and out of tumultuous relationships. She was forced to care for herself and her mother, but her most prevalent memory was of spending hours and hours alone in her room with the door shut—isolated and dejected, with her mother similarly barricaded in her own room next door.

Jennie said that she came to therapy because she felt that people seemed to lose interest in her quickly and reasoned that this was because she was "boring." She spent stretches of time following strangers who seemed "interesting" to her through the streets, buying things they bought, tasting things they ate, trying to mimic their behavior in a way that would somehow make her less "forgettable." In her attempts to fit in she emptied herself, "erased herself," as she called it, becoming a chameleon, as she drained herself of her own desires. In her attempts to understand what was missing inside she minutely reconstructed her interactions with people in our sessions, describing conversations with acquaintances, and dealings with professional colleagues at length.

As we started our three-times-a-week treatment, one of the first things she told me was that she tries to distract people by being vivacious and accommodating "over here" (pointing to herself) while what's really going on is "over there on the side" (pointing to the empty place next to her on the couch). She explained that was where there's a part of her that she didn't want anyone to see, the absent part in despair, abject, terrified and desperate for help. Though she described this other state "over there on the side" to me in a tone devoid of affect, I felt that she

was telling me something important about her inner world, and made a mental note of the imperative to keep the existence of this absent part of her alive in my mind as a vital element of our work together.

But even as she described this other, more vulnerable part of herself, Jennie came across as utterly impassive. Especially at first, Jennie appeared to be hesitant and guarded about entering into our relationship. Though the material we talked about always *seemed* rich, and we always *seemed* to be doing good work, Jennie felt far away and detached. At times I was dismayed at how unreachable she seemed, but still tried to allow and make space for what was present on a basic level, challenging her assumptions about her internal sense of badness, putting her feelings into context, and remaining especially sensitive to her unexpressed early needs, attempting to build trust and provide a holding environment in order to facilitate access to these more vulnerable states.

Jennie was both indifferent to my presence and exquisitely sensitive to any intrusion, at times even my gestures and the rhythm of my breath seemed to impinge on her ability to think. As time went on and she began to intermittently experience her affect, Jennie's feelings tended to flood and overwhelm her. She experienced intense somatic symptoms in sessions (for instance she described a feeling of despair as a burning sensation radiating out of her belly button up into her torso). Remarkably, when these acute experiences arose between us, I felt her intense internal sensations in my viscera too, her descriptions of what was going on inside of her seeming to enter into and change my own internal experience, her words physically transforming and giving shape to my feelings as if they were a pliant lump of clay.

What seemed confounding and unique to me about our work was that though we made genuine contact in these powerful and painful moments, and though these experiences seemed to erase all distance between us, our link seemed to dissolve in the very moment Jennie left my office. I started to realize that I wasn't thinking of Jennie between sessions, even after we shared intense experiences together. For example, after the session in which we relived the terrifying night of the car accident described above, I did not think of Jennie again till right before our next meeting when I reviewed my notes, internally wincing as the affective intensity of her story flooded back into my awareness. But instead of thinking of her, I remembered her, with a tinge of guilt in

terms of the *lack* of thought I was giving her; I only recalled her in her absence.

I came to see our experiences of deep connection as encapsulated pockets of aliveness—oases surrounded by long stretches of deadness in which the bulk of our meetings lacked affective intensity and the only thing binding us seemed our mutual sense of duty to one another. We were in the midst of one of these long, mutually withdrawn stretches when I started to notice that as Jennie was speaking; I often situated myself in the same characteristic position I usually find myself in when I'm with my own analyst. Though I think about my analyst when I'm with other patients, it is usually in identification with her position as analyst, as in—"What would my analyst say in this situation?" Now, with Jennie, I realized that instead of identifying with my analyst in her role as analyst, I was identifying with myself as patient, as in—"I miss my analyst. Maybe I should call her and ask for an extra session this week." I started to realize that these musings during our sessions were reflective of my dissociated needs, and perhaps of Jennie's too.

I began to wonder about this, and about what else was absent from our relationship—what aggression, what fears, what desires? Where was the vulnerable part of Jennie in the empty spot next to her on the sofa, "over there, on the side?" And why couldn't I connect to her? A potential space had opened up where it had previously been collapsed, allowing reverie to start to emerge as a symbolizing process between us (Ogden 1997). I became aware that I had been privileging the experiences in which her younger states emerged, using them as proof of our connectedness, and lost my faith in our bond the more time we spent in a state of detachment. It occurred to me that I had been thinking of her withdrawal as a defense against loss rather than the representation of a specific form of object relationship—a tie to an absent mother.

Though nothing between us changed externally, I began to get more in touch with my own loneliness and fears of abandonment, along with a deep wish for closeness with Jennie that I had previously kept out of awareness. Reinvigorated, I began to make a point of thinking about what might be happening inside of Jennie, working to consciously keep her experience in mind, at times even visualizing a live and beating heart inside of her, wondering about the inner workings of a separate

subject, with a center of gravity, an intelligence, and an internal spark all her own.

In the week following these realizations, Jennie brought in a dream: *I have this little baby and I'm supposed to feed it, but I keep losing it. I first start to feed it and then I lose it. Then I find it again and feel relieved, but then I lose it again. I keep scrambling to find it and then settle down, but as soon as I relax and start feeding it, it disappears again. It was a frantic dream.* In the discussion that followed, Jennie associated to her recent experiences of losing several of her personal effects. Over the course of two months, she had lost her phone, an expensive pair of sunglasses, and a set of keys—all of which she found again soon after. I was curious about what this losing and finding could represent. Was there some part of her without words that kept getting lost in our work together, was she attempting to alert us to the possibility that something in her was missing and needed to be found? The urgency of the experience was striking.

Thinking of her dream I said, "Maybe it feels like there is a piece of you that we keep losing and finding over and over again. A piece that is hungry and needs to be fed." Jennie nodded, then went on to tell me about the bulimic issues with eating that she had long been keeping secret from everyone, including me. She described the way she restricted her food intake for extended periods of time and then compulsively binged on rich foods that filled her up till she made herself sick. She felt ashamed of her problems with eating and connected them to the experience of the infant in the dream that she couldn't keep hold of. Jennie said that in her core, "there is this small person, my little self. She's not capable—she's too young. It's just me by myself, there's no family and it's without love. It's like a vacuum. It feels like there's hardly air." Jennie's chest started heaving as she spoke, as if gasping for air. "I can't breathe," she said.

Unsettled, I could feel the fragility of the moment but felt unsure of what to say. Eventually, Jennie's breathing began to slow down, but she remained distraught. I could sense that she felt alone with her feelings, as if her words and affect kept ricocheting back at her in an isolated space all her own. She needed something from me, but I was paralyzed, unable to think. Jennie left the session un-soothed. In the following sessions, she felt far away, deadened, intellectually engaged in reflecting on the session, and the feelings that had emerged in it, but emotionally

absent from our relationship. There didn't seem to be a way back to the affective experiences of that session.

Dismayed at what felt like a lost opportunity to build on our connection, I thought about Jennie after our session, and brought up what had happened between us in supervision. As my supervisor and I discussed the ways I kept myself from being too involved in Jennie's traumatized states for fear of intruding on or injuring her we came to a pause in our conversation; my attention became unfocused, my mind wandered. In that moment I imagined with great clarity an image of Jennie and me sitting together in my office, an inert body laid out between us. Grey, corpselike, it rested on a block with intravenous tubes coming out of each of its arms. One of the IV's ran from the prostrate body to Jennie's arm, and the other to mine, each of us connected to this lifeless mass, infusing it with our own blood, each of us feeding it, sustaining it, keeping it on life support in some limbo state between life and death.

When I imagined the corpse coming to life, I became flooded with dread. I realized then that I had been unconsciously invested in keeping something dead between Jennie and me, and that in fact we were both invested in keeping something absent, something immobilized and frozen in ourselves and in our relationship. As I mused about this image and how it reflected what was happening within and between Jennie and me, I connected it back to my childhood. I realized that because of my allegiance to my own internalized absent objects, I had been avoiding stirring up and experiencing certain feelings in our work together. It was an early attachment in which I committed myself to enlivening the dead other and remained dedicated to this impossible task, the structure of which formed the basis of our bond and as such was never meant to change. Jennie and I were holding the emptiness together, both of us committed to maintaining the connection to the absent object and thus keeping our relationship suspended in a liminal purgatory between life and death. We had entered an unconscious pact in which if one of us threatened change in the relationship, attempting to leave behind the deadened object, the other took her up again, asserting her dominion over the interactions between us. Here, because of an overlap in our internal worlds, we shared in an enactment in which we both maintained allegiance to the absent object from the past, holding on to the archaic fear that something alive and spontaneous between us could rupture the

strong attachment to the non-present primary object. The unconscious belief that liveliness would betray a primal bond, leading to catastrophic abandonment into an objectless, uncontained, disorganizing explosion of potential aggression and/or desire kept us from allowing a spontaneous, authentic connection to grow between us. Instead, we each maintained our own allegiance to absence, an isolated refuge in a state of nothingness in which no authentic interpersonal contact is allowed to flourish.

This most recent enactment helped me to see more clearly the ways I had been dropping things that came up—on a conscious level I withdrew or smoothed things out to protect Jennie, but I was also unconsciously enacting the role of the absent mother, participating in keeping the deadness alive to guard myself and Jennie from the overwhelming affect that felt certain to arise should the tie to the absent object be challenged. This new awareness of the internal resonances between us freed me to engage in a more lively way with Jennie. I felt more empowered to pursue the meanings and impact of our rupture, to keep the uncomfortable feelings open despite her anxiety and my own fears of being intrusive, and to face what might happen to our link if something new transpired between us.

In our next session, Jennie started out with an air of resignation, recounting how everyone in her office was somehow featured in an article in a local magazine, except for her. I brought up the theme of erasure and connected it to the way I had left her alone in the session when she had experienced the panicked breathing. I had left her alone by not stepping in, I told her, effectively erasing her. She looked surprised, and went back to the stark image in her mind of the little girl at the center of a vast void. As Jennie returned to this image, the feelings of panic began to rise inside of her again, her breath becoming more constricted, her body rocking side to side in an effort to self-soothe. "Jennie," I said determined to stay alive and connected, "when you look at the void, can you see its edges? How far out does it go?" "Yes," she answered, "it's like there's a pool of black but I can also see a shoreline at its edge." "Can you imagine anyone inside the void together with you?" I asked. "No," she answered, "but I guess I can visualize you on the edge of the void, looking in, wanting to join me."

The look of panic in Jennie's wide eyes began to fade, and her breath began to slow as we fell into a deep silence. We had never previously experienced such a silence together, our sessions filled up with many words, whether they were used to communicate or distance. The silence felt profound, weighty, and I found myself imagining a very young Jennie, swaddled up tightly in a blanket, nestled on my chest. Jennie seemed similarly occupied with thoughts of her own, and the silence felt alive, and grew.

In the next session, Jennie told me that being alone was a foundational assumption that she brought into every relationship and this aloneness was what felt most true. Being alone felt like less of a risk, safe, she said, like a refuge. "I can really understand that," I responded, pausing for a moment, "but maybe that's what being mothered feels like to you. Being in a room with the door shut, all by yourself, that was what it was like to be with your mother, and maybe when you start to feel need that's the kind of relationship you go back to." After a moment I continued, "But I wonder what it would have felt like for someone to come knocking on the door back then, or for me to come knocking on it now." "I probably have been wishing for that for a long time," she answered. I could feel our connection growing. We had been enacting the cycle of absence and presence, coming together and ripping apart, losing and finding, and in this moment could meet in a mutual place that suspended this cycle so that it could become a vantage point from which to reflect and a source of significance.

DISCUSSION

Of course, this was not the end of the absence that was and continues to be a main focus of this treatment, but the case illustrates the powerful hold and central place an early bond with absence can take up in the psyche. Jennie had suffered a childhood suffused with absence and neglect, and as such was devoted to maintaining an internal void in order to protect a sense of order and meaning in her life. This powerful tie, which overlapped with one of my own, manifested itself in the ways Jennie and I took turns absenting ourselves from each other throughout our work together, together taking on the task of maintaining the presence of the absent object in the analytic relationship. In this way, we

unconsciously entered a pact in which we both pledged our allegiance to absence, placing the safety of non-interaction above the possibilities of the dreaded unknown that constantly threatened to take place between us.

This work with Jennie powerfully brought to light my own unworked-through allegiance to absence. With the new awareness brought forth through the elaboration of reverie and a series of sensory experiences in our work together, I could begin to see the ways I was participating in not allowing anything new to grow in the analytic relationship. The resistance to seeing this created a powerful enactment in which our internal worlds interlocked such that authentic, generative contact between us was forbidden. I had been blind to the presence of the absent object. Coming to see my own allegiance to absence in situ created a platform for observing and understanding these dynamics (rather than remaining mired in and reacting to them), that imbued our enactment with meaning where there had been none before. From this vantage, I could see that not only was there an absence between us, but that we were each invested in maintaining this absence in fidelity to our respective absent and dead objects. This allowed me to conceive of the absence and subsequently access myself in a new way, to integrate and connect with other parts of myself and of Jennie.

The profound dread I experienced during the reverie in which the corpse between Jennie and me came to life revealed the fear of breaking this primal bond to the absent object. It is the force of this fear and the attendant feelings of disorganizing abandonment and overwhelming loss that keep vitality from manifesting interpersonally in an allegiance to absence. As the analytic process unfolded and became more symbolizable, I no longer had to hold on to the primal tie to the absent object to avoid catastrophe, new types of feelings and my own creative process were allowed to emerge in the space between us. This internal experience clued me into a similar investment in absence in Jennie's inner world. Jennie was fearful of allowing anything new to happen between us and remained loyal to the interpersonal nothingness we had both long been nursing. As the absent object became more clearly articulated, we could begin to look at the power of that attachment and the forces that kept it in place, and I could start to challenge the absence by coming to life myself.

Because the type of early absence illustrated here comes about at a time when the difference between self and non-self is still developing, language and other types of communication that clearly define self and other may not be the most useful methods of broaching these early unformulated states. The split between the articulate adult and nonverbal child selves makes it difficult to access such early affective states through verbal communications. Experiences of merger and fusion that blur the delineation between self and other create opportunities to non-intrusively reach split off parts of the self, so that a wordless or absent state can be understood from *within* that position, while also being moved into a transformative interpersonal relationship. This is similar to Winnicott's (1945) notion that a mother and child "live an experience together" (p. 141) when the pair meet in a moment in which each of their desires temporarily coincide, creating an illusion that blurs the lines between internal and external worlds. Treating an allegiance to absence requires that the story of the black hole in the early care taking environment be told in a medium that does not require the patient's self-definition.

One medium in which this can occur is through the register of enactment and bodily experience, a recreation of what is missing within the dream-like space of the transferential field. As Bion (1970) wrote, "The analyst must focus his attention on O, the unknown and unknowable … . With this the analyst cannot be identified: *he must be it*" (p. 27, italics added). With Jennie, the story of absence was communicated in the register of the enacted (Grossmark 2012), in which the absent object became embodied in and between us through our overlapping identifications. The analyst is receptive to the full range of the patient's communications, on sensory, bodily as well as affective and intellectual levels, and makes her inner contents available to be used to "become" early objects in an array of different manifestations. In this way, Jennie and I became both the absent mother, and the absented child in our work together, such that her early object history could begin to be told between us in the enacted dimension, without words. Specific internal resonances, such as the identifications with absent objects that Jennie and I shared, brought aspects of patient and analyst to the fore in the context of the intersection of two internal worlds. Accordingly, lost parts of the patient's self could be linked up, recognized and given significance. But this recognition cannot come in externally, by persuasion,

force or coercion; it is conjured organically in the overlap of two lives lived together. This requires the analyst to allow herself to be used in the service of creating the environment in which the patient's early object relationships can come to life.

This process occurs slowly through the process of elaboration of proto-symbolic material in the analyst's reverie and through the intersubjective engagement with the concrete, enactive aspects of psychoanalytic treatment. Interestingly, moments of transformation in Jennie's analysis first emerged in the form of new types of sensory awarenesses. For example, a bodily position that brought about an association to my own analysis, the visualization of a beating heart inside of Jennie, and the vivid reverie in supervision that helped bring to light some of our shared dynamics. Jennie then used the visual image of herself in the void to conjure an affective experience that evoked a powerful bodily experience, and I was able to build on this image to help find the edge of the void in which containment of the absence could become a new possibility.

Communications thus took place in language, but also spoke to more basic parts of the self through utilization of the grammar of the sensory and visual registers that don't require the work of self-other differentiation. As Aulagnier (2001) said, "The cathexis of sensory activity is the very condition of existence of a psychical life, since it is the very condition for the cathexis of the activity of representation" (p. 35). Connecting to the sensory mode of communication and utilizing it to make meaning accesses the most basic building blocks for creating internal representations. Perhaps with Jennie, nonverbal communications were necessary to first give shape to and symbolize the unique experience of internal absence before more directly challenging the ties that keep it so powerfully in place.

An allegiance to absence is an intense, pervasive bond to a non-present caretaker whose lack leaves a void in her wake. It is important that the process of recognizing, formulating, and giving shape to this inchoate object experience takes place in treatment so that the powerful tie to the absence can be addressed. The different manifestations of absence that arise in the analytic relationship can be linked up to tell the story of the each person's unique bond with absence, so that the allegiance that exerts a tight grip on the internal world can begin to be loosened. In this way, what once felt like nothingness can become the generative

emptiness from which the internal world can be allowed to expand and grow into a universe filled with possibility.

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Editor's Introduction

Jay Greenberg

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EDITOR'S INTRODUCTION

BY JAY GREENBERG

For some time now, analysts working in different parts of the world and influenced by a wide range of conceptual traditions have moved away from a reliance on the interpretation of disavowed meanings as the principle mechanism of therapeutic action. Analysts working within different traditions propose different alternative interventions, such as witnessing, empathy, recognition, affect attunement, unsaturated interpretations, and so on.

In some cases the proposed changes in technique are argued on strictly clinical grounds, in others they are part and parcel of a revised model of the mind. Throughout his career, and especially in his recent book *Formless Infinity* (2015), Riccardo Lombardi has taken the latter tack; although the book is clinical it is anchored in the radical reformulation of the relationship between conscious and unconscious mental functioning that was proposed by Bion and, similarly but independently, by Matte Blanco.

Both Bion and Matte Blanco begin with Freud, whose original distinction between conscious and unconscious contained two distinct propositions, neither of which implies or requires the other. The proposition that shaped traditional clinical practice is that the unconscious is defined by its contents, that is, by the memories, ideas, fantasies, and desires that are unacceptable to our conscious sense of who we are. These contents exert a pathogenic effect because they have been banished from consciousness; benign psychoanalytic change depends on releasing them from repression and the method for doing this is interpretation.

But from the beginning, or almost from the beginning, Freud had an even more radical vision of the nature of the unconscious, focused

not on content but on the logic of its functioning. Embodied in the distinction between primary and secondary process, the unconscious—obliterating difference through condensation, displacement, and timelessness—is potentially, the source of our richest and deepest experience. This sensibility is not typically emphasized within North American psychoanalysis, although there are important references to it in Loewald's work. *The Psychoanalytic Quarterly* is fortunate to be able to publish a brief exchange of ideas between two analysts each of whom has contributed significantly to this changing vision of unconscious processes and its clinical implications.

As Thomas Ogden notes in his commentary, Bion is the most prominent exponent of this point of view. For Bion, Ogden writes, "Psychological growth … does not involve making the unconscious conscious … but making conscious unconscious, and in so doing making disturbing lived emotional experience available to the richer thinking/feeling processes of the unconscious mind … " Clearly interpretations as they have historically been understood would not move us toward this analytic goal; we might even say that in light of the definition of the unconscious that he and Lombardi share that making the unconscious conscious in the traditional sense compromises our creative potential.

Riccardo Lombardi, developing Matte Blanco's vision of an unconscious that is defined by its logic and not at all by its contents, appreciates both the depth and the richness of unconscious mentation. But, distinguishing himself from Bion he also has a keen sense of the limits of what he characterized as "symmetrical logic," in which distinctions between individual things, thoughts, feelings, and relationships disappear (Lombardi 2016). As a result, symmetrical logic lies behind a wide range of psychological capacities, from creativity to empathy to psychotic thinking. And, if it is untouched by the "asymmetrical logic" of conscious thinking we will be left with what Ogden characterizes as "infinite registrations of potential meaning with which no productive mental operation is possible, no psychological growth is possible, no psychological work can be done."

This is what drives Lombardi's clinical vision; as he notes in his book, "The consequences of this reformulation [of the relationship between Ucs. and Cs.] do not, obviously, concern logic alone, but also the analytic relationship and the way in which psychoanalytic technique

is understood" (p. 1). The analyst's role is to facilitate points of contact between the Cs. and the Ucs., to allow asymmetrical logic to touch symmetrical logic (in Matte Blanco's terms, to create "bi-logic"), to temper the infinite with limits that are an inherent part of the finite. The aim is to create a meeting in which what Ogden calls "the mystery of the infinite unconscious" can lead to psychological growth because it is informed by the limits of conscious thinking.

In keeping with contemporary developments within other traditions, Lombardi's interventions are not directed at interpretations designed to get at unconscious meanings. As Ogden puts it, "they are comments that are based on the idea that nothing is equal to, or the same as, anything else." And in Lombardi's terms, his goal is "working through the perception of limits." This is especially striking in Lombardi's clinical material because his patient's personal (psychotic) lexicon employs the concepts of infinite and finite in ways that are quite similar to Matte Blanco's conceptual use of the terms.

In their dialogue, Lombardi and Ogden clarify the conceptual foundation on which Lombardi's work with his patient Gianni is built. The exchange highlights an important fact of life about psychoanalytic conversations in a time when conversations among analysts working within widely disparate theoretical traditions is becoming more frequent: we see the events of an analysis through a lens that is shaped by our training and the assumptions that come with it. This can lead either to creative difference or to misunderstanding.

For example, because Lombardi's base in Matte Blanco (and even in Bion) is likely to be unfamiliar to them, I suspect that many North American analysts are likely to experience many of his interventions as what we would call confrontations. Thus, at one point Gianni (an analysand of Lombardi) says, "When I'm in the infinite, I'm at peace," to which Lombardi responds in part " … it isn't the infinite that makes you feel better, but the recognition that you also need the finite … ." This could be read as a challenge to renounce a particular way of thinking, but if we keep the underlying assumptions in mind it is apparent that Lombardi means it as an invitation to bi-logic. In other words, rather than demanding repudiation he is offering his patient the possibility of joining him in using unconscious potential in the service of growth and change.

Joining Lombardi in his appreciation of the value (at least sometimes) in supplementing Bion with Matte Blanco, Ogden agrees that the analytic project cannot be limited to making the unconscious conscious; this content-based way of understanding mental structure is at best too narrow to do justice to the range of human experience. And, although coming from a different starting point he is willing to share Lombardi's caution about the dangers of too enthusiastically attempting to make the conscious unconscious. Lombardi's deep experience with psychotic patients warns him of the dangers, and he is persuasive in demonstrating them, both theoretically and in his clinical material. As a result, both authors agree that their aim is to facilitate a meeting between two ways of thinking that is essential if we are to be able to fully use our human capacities.

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Infinity, The Conscious And Unconscious Mind: A Conversation Between Thomas Ogden and Riccardo Lombardi

Thomas Ogden & Riccardo Lombardi

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INFINITY, THE CONSCIOUS AND UNCONSCIOUS MIND: A CONVERSATION BETWEEN THOMAS OGDEN AND RICCARDO LOMBARDI

BY THOMAS OGDEN AND RICCARDO LOMBARDI

Keywords: Consciousness, unconscious, interpretation, formless infinity, bi-logic.

THOMAS OGDEN: On reading Riccardo Lombardi's *Formless Infinity* (2015), a thought occurred to me regarding the place of his work in the evolving psychoanalytic conception of the relationship between the conscious and unconscious aspects of mind. For Freud (1900, 1915), the unconscious is an aspect of mind that operates under the aegis of primary process thinking, a form of thinking that does not lend itself, *on its own*, to resolving emotional problems, such as the experience of instinctual sexual urges directed at forbidden objects. Instead, there exists something of a fragile stand-off between sexual and aggressive impulses and fantasies on the one hand, and the work of repression on the other. The repressed is continually pressing for release from its unconscious confines, and very often succeeds in the form of dreams, symptoms, slips, and so on.

Freud (1911) viewed the analytic process as centrally involving the transformation of thoughts and feelings from unconscious to conscious states of mind. The preconscious and conscious mind in health, for Freud, bring to bear on formerly unconscious thoughts, feelings, and fantasies the dominance of secondary process thinking, diachronic time,

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cause-and-effect reasoning, and so on (all of which are parts of the operation of the reality principle).

Bion (1962) introduced a radical change in the analytic conception of the mind in general, and the relationship between the conscious and unconscious mind, in particular. Reversing Freud's conception of the conscious mind as the seat of the operation of the reality principle, Bion viewed the unconscious mind as the seat of the richest form of thinking in which human beings are capable of engaging. In the operation of the unconscious mind, there is a simultaneity of primary and secondary process thinking; of linear, cause-and-effect logic and intuitive, non-linear thinking; of synchronic (ahistorical time) and diachronic (sequential) experience of time; and so on. Psychic growth (including the work done in the course of an analysis) does not involve making the unconscious conscious, as Freud viewed it (Ogden 2003). Rather, psychic growth involves a process of transforming conscious lived experience into unconscious experience, and in so doing, making disturbing lived emotional experience available to the richer thinking/feeling processes of the unconscious mind, for example in the experiences of dreaming and reverie (Ogden 2004).

It is here that Lombardi, building on Matte Blanco (1975), enters the psychoanalytic dialogue concerning the relationship between the conscious and unconscious mind, particularly on the aspect of that relationship that is involved in psychological change and growth. It seems to me that Lombardi, without explicitly saying so, treats conscious thinking as a form of psychic functioning equal in importance to that of unconscious thinking. The unrepressed unconscious is "symmetrical" in that every feeling, thought, and perception is experienced as equivalent to every other feeling, thought, and perception. This symmetry yields infinite registrations of potential meaning with which no productive mental operation is possible, no psychological growth can occur, no psychological work can be done. I am reminded of Funes in Borges's (1941) fiction, "Funes the memorious," where Funes, after a fall from a horse, finds himself with infinite memory. He invents a number system in which each integer is represented by an object or person. "In place of seven thousand thirteen say (for example) *Maximo Perez;* in place of seven thousand fourteen, *The Railroad*; other numbers were … *sulphur, the reins, the whale, the gas, the caldron, Napoleon*" (p. 64, italics in the

original). The problem with this number system is that no mathematical operations can be performed with it. One cannot subtract *the whale* from *the gas*, or multiply *the reins* by *Napoleon*.

From this vantage point, the conscious mind (operating primarily by means of secondary process thinking) is the vehicle by which infinite symmetry is transformed *in part* into asymmetrical elements, thus allowing for difference, and consequently time, cause-and-effect relationships, attribution of meaning to lived experience, and so on, can take place. The upshot of the creation of an asymmetrical aspect of the unconscious mind is the creation of bi-logic, a form of unconscious thinking in which the mystery and impenetrability of the infinite enters into dialectical tension with the asymmetrical aspects of the unconscious mind. The conscious mind is not the handmaiden of the unconscious mind; rather, it is essential to the creation of a functioning bi-logic aspect of the unconscious mind by means of which psychic change may occur. This seems to me to lie at the heart of Lombardi's clinical method: interventions (often explanatory in nature) that make use of conscious thought process *which are derived from his analysis of his own unconscious thought processes*. In this way, Lombardi facilitates the patient's rendering asymmetrical his previously infinite, symmetrical experience, while retaining the mystery of the infinite unconscious.

RICCARDO LOMBARD I: I'd like to reply to Thomas Ogden's very interesting comments by means of some brief clinical fragments that may perhaps further develop his theoretical perspective in a clinical situation, showing, in particular, how one might foster an evolution that could lead to greater harmony between aspects of the conscious and the unconscious. The unconscious here takes the form of infinity (Lombardi 2016; Matte Blanco 1975): the infinite needs a point of contact with the finite—which might otherwise give rise to a paralyzing oceanic anxiety—thus creating an equilibrium with a fruitful and creative effect on mental functioning.

I'll be illustrating the case of Gianni, a 20+-year-old who began analysis with me with four sessions a week—in the context of a dangerous acute manic crisis with confusional delusions and suicidal urges to throw himself out of the window. He had to be briefly hospitalized and assisted by a psychiatrist who specialized in pharmacology. The first time this

symptom appeared without any sort of warning or conscious awareness, his family only just managed physically to hold him back from launching himself into space from their apartment. His symptoms receded in the course of a few weeks thanks to pharmacological and intensive psychoanalytic treatment, after which the patient insisted on interrupting his antipsychotic pharmacological treatment with the psychiatrist. I consented, with some hesitation, to continue the analysis despite this decision, unless another crisis arose.

We'll have a look at some examples of the working through that appeared after about a year of analysis, around the time of the first summer break. The imminence of the break seemed to act on the patient like a stimulus to working through the perception of limits, rather than as a result of the separation from me, which is often the case with patients who are better organized and developed.

The analysand began a session by proudly displaying his brand new wristwatch, to which I replied that the approach of our summer separation made him reflect about time. Gianni answered by telling me that as he was driving to the seaside he found there was lots of traffic, and was afraid that he would never get there, but in the end the trip had lasted two hours: he added that going to the sea for a little while was a way of slowing down his work rhythms, while waiting for his summer vacation. I commented that he was acting as if he were an airplane that needs to slow down before landing. The patient was clearly surprised and curious about my intervention; he reacted by visibly raising his eyes heavenwards and said:

Gianni: "*I looked at the sky, I saw the vault of heaven and I had a sense of relief… sometimes I have a sense of oppression when I'm here for a session.*"

Lombardi: (I thought that it was not unusual for Gianni to come out with a bizarre comment, that seemed to interrupt the logical flow of the conversation, but were important contributions to go deeper in the analysis.) "*Perceiving the boundaries of a space, such as those of our analytic office, make you feel hate: thanks to your recognition of hatred, you need no longer grow confused about the sky, as used to happen when you dilated about space and got into a muddle.*"

Gianni: "*Before, I would look at the sea and think it was infinite: at that point I felt sick. But now I tell myself that even the sea is finite.*"

Lombardi: "*Recognizing finiteness within the infinite allows you not to feel sick.*"

Gianni: "*I don't get lost any more in infinity the way I did before: I tell myself, this is the sky, but it's finite. I used to suffer, I don't know how to say it … from a 'shuttle effect': I'd see the sky and I was off like a shot. At that point I'd get lost. Nothing was enough for me, and I got lost in the infinite. I was a workaholic and I never rested. But now, instead, I've learned to go into my room: I close the shutters and the door, I stretch out on the bed and I relax.*"

Lombardi: "*This way you can make a distinction between the boundaries of your own self and those of the outside world, rather than becoming a wildly spinning top that confuses everything.*"

The discovery of time thus becomes for Gianni an impetus, a stepping stone for reaching a place between the infinity of the sky and the sea without losing all reference to the finite and to himself.

Let's have a look now at some sequences from right after the summer break. Gianni did not make it to the first scheduled session following the vacation, but he did phone to ask for a different time that I was unable to give him. That night I dreamt that there was someone in a helicopter who had to land on a platform. The descent was slow, with movement from side to side. There was great terror and tension because the helicopter didn't seem to be heading for the center of the raised landing platform. Finally it landed with a slight lateral displacement that caused some damage, but the pilot got out unharmed.

When I awoke I noted the anxiety inherent in the dream, and connected it to Gianni's return, which was like a difficult return to earth of his "space shuttle." When Gianni finally came for his session he looked pale and wan. He told me that he had been unwell and confused various times during the break, particularly when he stayed up late at night and didn't sleep much, so he had had to be careful not to lose too much sleep. He then immediately commented:

Gianni: "*I always look for the infinite. When I run into a limitation I don't accept it. It's kind of like the way I was unwell at the beginning of my analysis. But now there are some things that calm me down: for example, yesterday I fell asleep while I was watching a documentary about the origin of the stars: I'm always seeking the universe, the infinite.*"

Lombardi: [I thought of my anxious dream from the night before, and about how I'm in synchrony with what seems like the patient's

landing or returning to himself, in contrast to the confused vortex of infinity] "*Stars have an origin, so they're not infinite, because at least they start to exist at some point. If you're willing to accept the finite, he can allow yourself to sleep.*"

Gianni: "*I'm not infinite like a straight line, but more like a half-line.*"

Lombardi: "*The half-line includes the point where the straight line begins, a point where you can be and accept yourself, where you can have a space for yourself, instead of being everywhere and nowhere.*"

Gianni: "*Now we're starting analysis again and I'm going back to work: it's just what I need. During the vacation I discovered that it helped me to ride on the merry-go-round with its little saddles suspended on chains. The merry-go-round goes round and round very quickly and I fly. When I'm in the infinite, I'm at peace. But I'm good at it, and each time I managed to grab hold of a ring: this meant I didn't have to pay for the next go round.*"

Lombardi: "*If you manage to get hold of the ring and you win, it means that you're not just in the infinite, but also in the finite of the ring that you have to catch hold of. So it isn't the infinite that makes you feel better, but the recognition that you also need the finite, you need to grasp the ring, so as not to get lost in infinity.*"

Gianni: "*I hadn't thought of that. I have to go with a friend to a restaurant just over the bridge, when you've crossed the river. I don't know if I'll be able to find it.* [He seems to be concentrating on something.] *After the bridge I have to go straight, then to the right and then take the first left. So that's how I can find it.*"

With some effort he added the names of the streets, which I happened to know were correct, so I told him he was right, and that he was getting himself oriented in space and time after the summer's interruption of analysis. Meanwhile, I thought of the patient's commitment to reach actual space-time that would allowed him to be oriented and to find himself within himself, and in his actual analysis.

From then on the patient gradually recovered from his malaise, as bit by bit in the course of his sessions he managed to establish contact with his physical sensations, which however seemed to have again taken on a particular weight, so that they were almost unbearable, as had been the case at the start of his analysis. At the same time, for my part, I noted an increase of the weight of my own bodily sensations—what I call the *bodily countertransference* (Lombardi 2017)—and I had trouble relaxing and falling asleep. This is not a rare occurrence when I'm seeing a

patient who is in an acute psychotic phase, and it had happened at the start with Gianni, too.

During this period of particular sensory weight, both Gianni's and mine, I dreamt one night, in a context of physical discomfort and great anxiety, that I was looking after a newborn— on a little cot—who had a formless face, vaguely reminiscent of the masked figure in the horror film *Scream*. Its body had no clear outline and was covered with a semi-transparent veil. On a table next to the cot was another newborn, who, although normal, also needed particular care. Thinking it over when I woke up, I felt that the dream was an attempt to illustrate the sensory experience I was having in the course of Gianni's analysis. In other words, I was experiencing indefinable and untranslatable bodily sensations, which were psycho-physically febrile and burdensome (the physically horrific baby in the dream), contemporaneously with Gianni experiencing his actual bodily sensations as he started to abandon his stellar infinity in order to descend into his own body (the normal baby in the dream, who needed care). This second dream reminded me of my earlier one, and of the trouble I saw that the pilot was having in establishing a proper correlation between the helicopter and the landing platform: an image that seemed to embody the unease I felt concerning my problem of expressing in space the continuity between my mind and my physical sensations (as a consequence of which a certain amount of general distress was inevitable), just as it seemed difficult and upsetting for the patient to organize a continuity in time after weeks of interruption.

Taken all together, it seems to me that this phase of the analytic working through—which we got through well in a few weeks—allowed us to observe, in the double perspective of the external analytic relationship and the internal experiences of the analyst (which we may suppose to be complementary to those of the analysand), the construction of *a bridge of communication between the infinite and the finite,* from the moment that the mind recognizes its attraction to the infinite without being overwhelmed and annihilated by it. This bridge between the conscious and the unconscious appertains to the patient as well when he recognizes the boundaries of the heavenly vault without turning himself into a "shuttle" that gets lost in the sky, or who experiences "the infinite" as he flies round the merry-go-round, but at the same time grasps "the finite"

by grabbing hold of the ring, which implies the recognition of an end and the possibility of starting over again.

In my material the unconscious is also present in the mind's opening towards a contact, and towards a dialogue with the unconscious aspects of bodily sensations: sensations that are characteristically formless and untranslatable, and which *the mind cannot resolve by a conscious mental act of recognition.* It can at best just learn to tolerate their presence and the unsettling aura that accompanies them, together with the anxiety about the formlessness that is thereby evoked in the more organized and orderly levels of consciousness. This may, I feel, correspond to what Thomas Ogden describes as the creation in which "the mystery and impenetrability of the infinite enters into dialectical tension with the asymmetrical aspect of the unconscious mind," forging ahead towards conditions of internal harmony between a conscious and an unconscious that cannot be resolved into one or the other, but have to find a way of jogging along together, each with its own particular characteristics.

THOMAS OGDEN'S RESPONSE TO RICCARDO LOMBARDI'S CASE PRESENTATION AND DISCUSSION

I find Riccardo Lombardi's case discussion interesting and important in that it represents something of a "return to Freud," while at the same time, provides something quite different. What stands out for me in Lombardi's analysis of Gianni is the role that conscious thought plays in the achievement of psychological growth. His interventions are not, by and large, interpretations of unconscious meaning; rather, they are comments based on the idea that nothing is equal to, or the same as, anything else—the finite punctuates the infinite. Lombardi's work does not diminish the importance of the unconscious. He makes use of his own unconscious experience to create a quality of conscious thinking that has not lost the intensity, mystery, and disturbing quality of unconscious thinking. The interpretation of his own dreams is a principal means by which the "formless infinity" (the infinite symmetry of the unrepressed unconscious aspect of mind) is brought into dialectical tension with the assymetry of conscious, secondary process thinking—each creating and negating the other.

After a disturbing dream of his own, Lombardi, said to his patient:

> *If you manage to get hold of the ring and you win, it means that you're not just in the infinite, but also in the finite of the ring that you have to catch hold of. So it isn't the infinite that makes you feel better, but the recognition that you also need the finite, you need to grasp the ring, so as not to get lost in infinity.*

This comment relies not only on Lombardi's experience in, and understanding of, his own unconscious experience; it is also derived from Lombardi's consciously forumlated thinking (including analytic theory concerning the infinite and the finite), which he offers to Gianni in hopes that he might make *conscious as well as unconscious* use of the ideas.

To the extent that Gianni is able to make use of such interventions, he is in the process of developing bi-logic, a generative dialectical tension between symmetrical and asymmetrical forms of thinking. The structure of the sentences constituting Lombardi's intervention reflects the strong presence of secondary process thinking in his way of speaking: "*If you … , it means … you're not just … but also … you have to … you also need … So it isn't … but the … so as … "* The form of thinking and way of speaking in these sentences is explanatory in nature in that it points out the logical connections and differences between ideas already a part of the patient's conscious apprehension of his life.

Lombardi's interventions offer a potential footing in the asymmetry of conscious, secondary process thinking for his psychotic patient who is drowning in the infinite, the endless, the shapeless. Lombardi's conscious explanatory way of interpreting, informed by his analysis of his own unconscious experience and his theoretical understanding of bi-logic, serves as a life-preserver thrown to a drowning man.

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D.W. Winnicott, Melanie Klein, and W.R. Bion: The Controversy Over the Nature of the External Object—Holding and Container/Contained (1941-1967)

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D.W. WINNICOTT, MELANIE KLEIN, AND W.R. BION: THE CONTROVERSY OVER THE NATURE OF THE EXTERNAL OBJECT—HOLDING AND CONTAINER/CONTAINED (1941-1967)

BY JOSEPH AGUAYO

The author examines D.W. Winnicott's multi-layered, dialogue with the London Klein group, most particularly with W.R. Bion and their respective views on the role of the external object in terms of holding and container/contained. When Winnicott earlier on deployed Klein as both a collaborative as well as creative antagonist in evolving a thesis of maternal environment of provision, memorialized in "Transitional Objects," he expatriated himself from the Klein group by 1953.

In the wake of this split, Winnicott continued a dialogic entreaty with W.R. Bion, attempting to interest another Kleinian in the importance of the external object when he commented on Bion's papers. Bion initially maintained the Klein line of strict focus on the patient's internal, subjective, and phantasmic experience of the external object during the early period of his "psychosis papers" (1954-1957). He gradually shifted and altered his clinical focus, taking up in metapsychological terms the infant's normal development of early thinking when he posited the importance of a containing maternal object to metabolize primitive, sensuous elements into rudimentary thought. The author maintains that Bion in part appropriated aspects of Winnicott's research trajectory, obscuring this

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appropriation because of Klein's injunction that Winnicott's work not be taken up. The separatist existence of the three major schools of analytic thought in the British Psychoanalytical Society also underscored a widespread disinclination towards comparative psychoanalytic theory. As a result, Winnicott's theory of holding has stood alongside Bion's theory of container/contained until recent efforts at comparison. By 1964, Winnicott ended his entreaties to Bion and the Klein group when they continued to ignore his many contributions, memorializing it in his 1965 paper, "The Kleinian Development." The author concludes with comments on how theoretical and clinical differences between analytic theorists can be both generative and still remain antagonistic at the boundaries of passionately maintained group affiliations.

Keywords: History of comparative psychoanalysis, Winnicott, Bion, Klein, theory of maternal environmental provision, "holding," "container/contained," group dynamics.

INTRODUCTION

In recent years, British and American psychoanalytic conferences have attempted to compare the theoretical and clinical work of D.W. Winnicott, Melanie Klein, and Wilfred Bion. In the wake of the post Controversial Discussions atmosphere at the British Psychoanalytical Society, when years of inter-group rivalry and disdainful animosity between the three training groups prevailed, it has given way somewhat to thoughtful attempts to ascertain convergence and dissimilarities. These British controversies have found their counterpart in American psychoanalytic institutes with their own history of an intolerance of theoretical analytic diversity (Eisold 1994; Kirsner 2000).

In such U.K. conferences as, "A Comparative Study of Psychic Pain: Melanie Klein and Donald Winnicott," mounted by Robert Hinshelwood and Jan Abram at the University of Essex (and co-sponsored by the Institute of Psychoanalysis, London) in 2013, (Abram and Hinshelwood 2018) and "Winnicott and Bion: Holding and Containing" in 2014, (Hinshelwood, Abram, Abel-Hirsch, Figlio, and Temple 2018) the issue

of theoretical and clinical differences has been discussed and debated. On the U.S. side, there have been Anglo-American Conferences, "Clinical Bion and Winnicott: Similarities and Divergences," in Los Angeles in 2017 (Aguayo, Lundgren, Hinshelwood, Caldwell, Oelsner, and Goldberg 2018). With a few exceptions, these topics have not attracted sufficient comparative analytic attention, such as the integrative and deeply measured work of André Green (2000, 2005) and Thomas Ogden, the latter of whom has taken an ecumenical position, making considerable efforts at appreciating the distinctiveness of Winnicott's conceptual evolution and other British analysts, such as Melanie Klein and W.R. Bion (Ogden 2001, 2004, 2012).

The post-war divergences in London between Independents, such as D.W. Winnicott and Kleinians were quieter and less subject to public debate than those during the Controversial Discussions between Klein and Anna Freud. After the war, the principals mainly discussed their theoretical differences by post after Winnicott (1951a) made his differences with Klein's theories known when he gave his paper on "Transitional Objects" in 1951. In spite of the official détente occasioned by the tripartite training system, partisans of each track generally only attended scientific meetings of the groups with whom they were loyally affiliated. The result was a curious yet generally undiscussed divide of issues regarding nature and nurture, instinct and environment, and modes of observation that culminated in divergent views of the infant's early psychological life.

While this paper aims to shed light on the nature of the theoretical similarities and differences between Winnicott's (1953, 1956a, 1960) theory of "holding" and Bion's (1959, 1962a, 1962b) theory of "container/contained," its method is clinical/historical. This approach is somewhat distinctive insofar as it focuses on three important variables: the contextual, the comparative, and the chronological. As a counterpoint to say Ogden's views, which examine distinctive aspects of Winnicott and Bion's work, the current investigation also takes an alternative *comparative* path, interesting itself more in how Winnicott and Bion evolved their ideas in a strife-ridden context that punctuated collaboration, contention, and competition. In other words, rather than assuming that Winnicott and Bion lived in a hermetically-sealed off, Proustian universes where they were free to single-handedly evolve their

own original concepts, this investigation has focused on how they developed their ideas over time in the context of a rivalry-ridden, small institute context, complete with its own set of boundaries and group loyalties.

To do an impartial task of comparing theories whose partisans on both sides can and have caricatured their opponents' views and ideas is no easy task. Hinshelwood (2018) has suggested that at the core of these passionately held differences are subtle yet significant differences regarding the nature of the external object itself. From a clinical researcher's perspective, Kleinians have frequently stated that they in fact *do* take up the external object—as noted by Klein (1932, pp. 84-85)—but interest themselves primarily in the infant (or patient's) internal, subjective, and phantasmic experience of the external object. Winnicottian clinicians, on the other hand, look at the external object in terms of its objective attributes, such as those required of the "good enough mother." Thus, the nature of the external object described by both camps is defined differently. I deploy this perspectival grid in this contribution, which aims at having a reasonable debate about long-held theoretical differences. For instance, while Kleinians might say that the objective nature of the external object is attained by a patient's experiential traversing of the paranoid/schizoid position in the attainment of the depressive position and the capacity to observe whilst being observed (Britton 2003), Winnicottians might counter by saying that Kleinians immerse themselves significantly, but at times, excessively in the vicissitudes of the subjective experience and use of the external object, while paying less attention to the objective nature of the object itself. It is one aim of this contribution to push the lines of debate from the Kleinian to the Winnicottian side and vice versa.

This contribution also privileges primary sources, such as the recent archival materials that have surfaced with the publication of the *Collected Works of D.W. Winnicott* and the *Complete Works of W.R. Bion* (hereafter, *CWW* and *CWB*; Caldwell and Taylor Robinson, eds. 2016; Mawson, ed. 2013). For example, there is much to be learned in now having access to Winnicott's (1951a) unpublished version of "Transitional Objects," the actual paper over which he broke his theoretical ties to the Klein group (Winnicott *CWW*, 3, pp. 447-461). Such new publications can shed light on the well-known rivalries between Winnicott, Klein, and

Bion, especially their episodic divergences over the conceptual importance of the external object. These contextual sources help us approximate the theoretical struggles of analysts who had voted to house themselves under one institutional roof. In the move to compare rival theories, I seek to overturn old competitive animosities in the spirit of genuine pluralism and acknowledgement of a valued and necessary diversity. Last and also of importance, the issues of chronology are taken up as these controversies unfolded in real time amidst claims of originality, favoritism, and priority. These analysts all worked in close proximity to one another, yet the question of how to tease out how they impacted each other's work remains difficult to decipher. This paper ultimately details the complicated road both Winnicott and Bion took to their different versions of the important role of the external object, as reflected in their concepts of "holding" and "container and contained."

The end point of this paper occurs at the point when Winnicott formally ended his appeals to both Bion and the Klein group after he published his critique of Klein's theories in "The Kleinian Development" (Winnicott 1965). It seems that the specific occasion for Winnicott's sense that a comparative dialogue was no longer possible was in October 1964, when he heard John O. Wisdom's lecture on Bion's *Learning from Experience*, in which he thought his ideas were being marginalized yet appropriated without any acknowledgement.[1]

[1] The author is indebted to the Archives Committee of the New Center for Psychoanalysis, (formerly the Los Angeles and Southern California Psychoanalytic Society and Institutes) in Los Angeles. (Vladimir Melamed, Archivist) for making available both Winnicott's correspondence to and from members of the old Los Angeles institute as well as the audio recording of D.W. Winnicott's presentation on 4 October 1962 of "The Kleinian Development." A copy of this recording has been donated to the Winnicott Trust in London. Appreciation is also owed to the late Robert Rodman (2003) one of Winnicott's biographers, who made this tape's existence known to the author. Appreciative thanks also are owed to Joann Halford, former Archivist at the British Psychoanalytical Society for making available an audio recording of John O. Wisdom's October 1964 presentation on Bion's "Theory of Functions and Learning from Experience." She also was able to locate and forward a typed copy of Wisdom's original paper in the files of Marion Milner, another member of the British Society.

WINNICOTT'S THEORETICAL EVOLUTION ON THE ROLE OF THE EXTERNAL OBJECT (1941-1953)

I briefly recapitulate Winnicott's work on the external object during his Kleinian period after his supervision with Klein and analysis with Joan Riviere, one of her closest associates (1935-1939). In a slew of papers, Winnicott drew upon his pediatric experience in the consulting room to gather together bits and pieces regarding the importance of the actual mother in the infant and child's neurotogenesis as well as normal development. In "Infants in a Set Situation," Winnicott (1941) noted how the toddler's handling of a spatula could be influenced by subtle cues from its *actual* mother as an external object, (e.g. a disapproving raised eyebrow). When Klein critiqued and vetted this paper, (Rodman 2003, pp. 123-124) the fact that Winnicott made direct behavioral observations of mother-infant dyads and alluded to the importance of mother as an external, censuring object went by with little notice. In fact, Klein in her own unpublished work had demonstrated a similar but passing interest when she conducted an infant observation of her grandson in 1938/1939 and discussed the important role played by his mother (Aguayo 2002; Aguayo and Salomonsson, 2017).

After Winnicott's wartime experiences with hundreds of evacuated children, he increasingly accentuated the role of the actual mother's importance, as he witnessed scores of children manifesting varying degrees of pathological outcomes when evacuated from their families. In "Primitive Emotional Development," Winnicott (1945) regarded the importance of a caretaking, ministering mother as a backdrop figure for the infant. Drawing upon his Freudian background, his emphasis on the infant as combining autoerotic trends in a primary narcissistic state, underscored a view of the mother as a recipient of the infant's pleasure and pain, frustration and satisfaction. In short, during the first months of life, the infant was all together and otherwise indifferent to her as a separate external person of importance until he became somewhat libidinally attached to her. Winnicott also moved along his own work by now considering the infant's early and normal development as invariably tied to how it was realistically cared for by its mother, how it

was "… kept warm, handled and bathed and rocked and named …" (*CWW* 2, p. 362).

Klein again took little notice of this paper, as she was much more preoccupied with positing her own original theory regarding psychotic states of mind as reflective of the universal origins of the infant's psychological life (Klein 1946; Aguayo 2009). She hypothesized about the paranoid/schizoid position from work done with older children and adults. While she sympathized with Winnicott's efforts, she would never formally factor in the clinical importance of mother as an external object with her own separate attributes in her published work. To be clear: Klein never offered a formal theory of environmental mediation in the infant's development. That work was left to Bion and in the words of Elizabeth Spillius: "Bion shows not only *that* the environment is important, which Klein also stated, but *how* it is important" (2007 p. 44, italics in the original). Nonetheless, Winnicott and Klein's collaboration continued as he was still regarded as a member of her post-war group. During this time, Winnicott as a Kleinist enthusiast aimed his contributions both as support for her work as he continued to differentiate his own perspective. In "Mind and Its Relation to Psyche-Soma," Winnicott (1949a, p. 247) ran his own theory of normal development along a parallel track to Klein's theory of psychotogenesis. In the infant's healthy development, there was a "continuity of being" and it continues that way unless something disturbs it. In the perfect psyche-soma, in which these qualities and states exist in an undifferentiated form in the infant, Winnicott articulated the importance of the external object. The perfect environment and the good enough mother "… *actively adapt* to the needs of the newly formed psyche-soma" (p. 247, italics in the original). Mothers do provide active adaptation in the beginning, but then follow it up with *graduated failure of adaptation*. In his emerging narrative of disturbed development, however, there were those patients who "have needed to regress to an extremely early level of development in the transference" (p. 248). A bad environment, such as psychosis as "an environmental deficiency disease," is one that fails to adapt and becomes an *impingement*, to which the infant must *react* (Winnicott 1952a, p. 38). In less disturbed patients, there can be psycho-somatic disturbances as a function of environmental impingements resulting from excessive reactions.

Winnicott continued to gather up an emerging narrative of the mother's actual importance as he then started to articulate the clinical implications of these ideas. In an illuminating clinical illustration, Winnicott (1949a) discussed a professional and socially accomplished female analysand who, despite these attainments, felt "completely dissatisfied" and held suicidal ideas at bay since childhood. Her classical analysis had left these deep wounds untouched and unchanged. Winnicott thought she needed "a very severe regression" and let it proceed, so that she could recover her "true self" in the face of a "false self" kind of functioning. The patient had in her previous treatment thrown herself several times off the couch in a very upsetting fashion. Winnicott treated these incidents as a need to regress to a prenatal state—she needed to relive her subjective version of the birth process. And, bit by bit, this is what he thought seemed to happen. By acting out, she got at different and necessary bits of psychic reality. There were breathing changes, experiences of bodily constrictions, a birth from a depressed mother, a change from feeding from the breast to the bottle; she had sucked her thumb *in utero* (Winnicott 1949a, p. 251) She had localized a schizoid split in her head, felt as severe pressure there; as well as pressures all over her body. Winnicott dealt with these annihilatory fears—that of having her head crushed in—and her acceptance of not knowing the origins of these day terrors, and gradually they were relieved. Winnicott (1949a, p. 250) wrote: "Acceptance of not knowing produced tremendous relief." The patient's false self existence led her to establish the analyst as the one who "knows," but this situation also changed.

No contemporary at the British Society would have had any reason to think that Winnicott's theoretical path deviated in any significant way from Klein's in 1949. After all, Winnicott cited the work of W. Clifford Scott (1949), another Kleinian colleague with whom he was on friendly terms. Scott had also developed his own theory of primitive and organizing infantile states, the "Body Scheme," all as his way to add ballast to Klein's (1946) programmatic agenda to understand and treat psychotic states of mind. Scott (1948, p. 152) wrote: "I can only briefly express my indebtedness to the various writings of Melanie Klein, but nevertheless I do not wish to say that what follows (i.e. the 'Body scheme') is an attempt to state in other words what she has already published. I hope I am adding something." I think Winnicott felt the same way.

WINNICOTT'S UNPUBLISHED AND PUBLISHED VERSIONS OF THE "TRANSITIONAL OBJECTS AND TRANSITIONAL PHENOMENA" PAPER (1951, 1953)

So how did Winnicott arrive at his Rubicon with Klein over what he termed the "environmental factor"? Augmenting what Winnicott biographers like Rodman (2003) have told us, prior to the presentation of "Transitional Objects" on May 30, 1951, Winnicott evinced signs of vacillating about whether his contribution on the "environmental factor" for the 1952 Klein *Festschrift* would be welcomed (Letter to R. Money-Kyrle, June 13, 1949, *CWW* 3 p. 223). In a following letter to Money-Kyrle, (November 16, 1950, *CWW* 3 p. 385) Winnicott reported a conversation with Klein in which in spite of her support of a paper on the "environmental factor," "… she feels that what has to be said has been already said perhaps with too great emphasis (Bowlby, etc.)" In the same letter, Winnicott reported that in spite of his wishes, he could not be counted on to deliver a paper on the environmental factor. In point of fact, Winnicott had by 1951, started to take quarter with his former analyst, James Strachey, with whom he met (May 1, 1951, *CWW* 3, pp. 435-436) so that they could go over the theoretical aspects of the "Transitional Objects" paper before he delivered it (*CWW* 3: p. 1). Shored up with a slew of Freud references in the 1951 version of "Transitional Objects," (*CWW* 3: pp. 468-471), Winnicott met up with Klein at an *IJP* editorial board meeting, and when hearing Klein say that he needed to revise his paper, "…so that it more clearly incorporated her ideas. He refused; and with the manuscript under his arm, he sadly left the room. As he later told his wife, 'Apparently Mrs. Klein no longer considers me a Kleinian'" (Grosskurth 1986, p. 398).

So, what made the "Transitional Objects" paper of 1951 so objectionable to Klein and create doubts in Winnicott's mind that it led to an act of mutual rejection? With the 1951 version now in hand, we can examine Winnicott's text in terms of what underscored his side of the decision to retract its publication. This paper at last definitively *integrated* into a theoretical gestalt what had appeared in bits and pieces in previous work. Winnicott had exercised his right to pick and choose among

available theories—and he now placed the transitional object as the conceptual centerpiece that served as a bridge between Freud's views on the first six months of the infant's psychological life and Klein's views on the latter months as represented by the depressive position. Winnicott (1951a) formally proclaimed his own theory of the infant's psychological birth, privileging many of Sigmund Freud's views about primary narcissism, the early ego as a bodily ego, and an infantile existence in an "objectless" world where the only concern was with provision from a non-differentiated provider.

Winnicott now also implicated directly the role of the actual mother as it appeared in his direct observation of her *with* her infant, "… suggesting however that there is value in the close observation of infants in every respect and here is an example of something which can be observed easily in the case of every child and which may lead us to make welcome developments in psychoanalytic theory" (*CWW* 3 p. 456). Winnicott's universal theory of the infant's normal psychological development now *implicitly* objected to Klein's (1946) theory of the paranoid/schizoid position, which emanated from the study and treatment of quite disturbed adult patients. In Klein's theory, in which she collapsed normal, neurotic, and psychotic development along a unitary level of hypothesized universals, the infant *was* born with a rudimentary sense of being differentiated and somewhat object-related. While all three groups would have to traverse the paranoid/schizoid position, it was the psychotic disorders that evinced persistent and recurrent difficulties with severe, regressive fixations points (Aguayo 2009, p. 70).

Winnicott (1951a) alluded to Klein's point of view when he cited Joan Riviere's (1936) "On the Genesis of Psychical Conflict in Earliest Infancy" where she wrote: "I said that this world (i.e. the infant's early psychological life) was without objectivity; but from the very beginning there exists a core and a foundation in *experience* for objectivity… .the psyche responds to the reality of its experiences by interpreting them—or rather *mis*-interpreting them—in a subjective manner… phantasy life is never 'pure' phantasy" (*CWW*, 3: 460, italics in the original). Riviere's Kleinian perspective was more famously echoed during the Controversial Discussions in 1943 when Susan Isaacs issued the defining "Nature and Structure of Phantasy" paper (Isaacs 1948). This bedrock Kleinian paper emphasized the "principle of genetic continuity,"

(gleaned from Riviere) so that the infant and toddler's motor activities and elementary guttural utterances could be regarded as meaningful precursor experiences to elementary speech. So, the observation of behavior to inferences about unconscious mental processes reflected the interplay between psychic reality and its subjective experience of its external world. There was very little space for the importance of the actual mother's role in this intrapsychic scheme. So, to be clear: while the Kleinian point of view here emphasized the infant's subjective experience of the external object, Winnicott now also accentuated the actual objective attributes of mother as an external object.

Winnicott then deleted the Riviere reference to the infant's subjective and phantasmic experience of the external object in the 1953 version, which subtly reflected his growing interest in his own observations of the real mother over and above the Kleinian sole emphasis on the infant's phantasmic experience. This structuring omission further distanced and differentiated his own views from those of Klein and her followers. He also now favored "transitional phenomena," an interactional theory, which he postulated in the direction of what Ogden (2012) has termed a *lived experience together*, so that the infant's "primitive ruthless love" was directed at and responded to by a devoted ordinary mother who absorbed, ministered to, and survived such emotional onslaughts. Once mother began to appear more differentiated and distinct to the infant, the infant's need now grew into its desire for the "object mother." It is ironic that Winnicott's 1951 version tied the infant's need for a transitional object to its use as a way to ward off depressive anxieties, one idea that might have found favor with Klein, especially her views on internal objects and the primacy of anxiety in early development (Caldwell, unpublished). Winnicott writes, "There is one thing common to these three states, (i.e. loneliness, hunger, bed-time) namely anxiety, and it must be presumed that in the early stages of anxiety constantly threatens, and that there is natural provision for defense against anxiety" (*CWW*, 3, p. 449).

Winnicott (1951a) further displaced the hypothesized vagaries of Klein's paranoid-schizoid position. As groundbreaking as her psychoanalytic work with young children had been since the 1920s, Winnicott (1951a) now implied that she conflated what made children pathological with normal infant development as well as with what made babies ill. While Klein's primary emphasis on the child's internal world

remained somewhat alive in Winnicott's interactional view, the role of the external object in the form of maternal environmental mediation also set the conditions for the child's maturational development. There could be no baby without a mother for good or for ill. Winnicott also discussed the numerous difficulties involved in differentiating the concept of transitional object from Klein's notion of an internal object. Indeed, in the 1951 discussion of his paper, the members of the British Society found it so difficult to disentangle what Winnicott meant by the idea of the transitional object as pertaining to an external object that he had to re-title his 1953 paper to make this distinction clearer: "Transitional Objects and Transitional Phenomena—A Study of the First Not-Me Possession" (*CWW* 3, p. 171, n.1).

To a comparative textual examination with Winnicott's (1953) paper: Winnicott now elaborated more robustly on the mother's specific attributes with a fuller definition of "good enough mothering." In the 1951 version, he supplied two sentences in a very brief section entitled "Notes in Passing," where he wrote:

> For healthy development the infant must have a 'good enough' mother, i.e. one who actively adapts to the needs of the infant. This active adaptation cannot be done except through the fact of mother's love, and it depends very little at all on cleverness. [*CWW* 3, pp. 456-457]

Winnicott (1953) now thought that the infant's psychological passage from being dominated by the pleasure to the reality principle could not occur without "good enough mothering." Mother adapts to the infant's needs. Yet as the infant adapts and can increasingly tolerate frustration, it has the effect of lessening mother's preoccupation with his needs. It was through these efforts that Winnicott now made clear that he was discussing "the whole technique of mothering" (Winnicott 1953, p. 92). He also forged a sort of conceptual "in-between" space, a theoretical "transitional space" between the claims of Sigmund Freud and Melanie Klein, the two theorists he most admired. With the mother's purposeful intent of gradually "dis-illusioning" her child that he alone omnipotently invented and created his external world, he could now be successfully weaned and surmount this early critical phase in preparation for adaptation to the outer world.

WINNICOTT'S FURTHER EXPATRIATION FROM THE KLEIN GROUP: HIS RESPONSE TO WILFRED BION'S EMERGING WORK ON PSYCHOSIS (1950-1959)—THE WORK ON "HOLDING"

There were other factors at play in Winnicott and Klein's mutual theoretical distance. I have previously maintained that from the perspective of having her group's theoretical and clinical contributions formally and institutionally recognized in the British Society's tri-partite training structure, Klein was also finally in a position to expect a more thoroughgoing allegiance to her theories than ever before. This new factor buttressed her increasing need to have "all-in" Kleinian disciples who would take up her innovations in theory (Aguayo and Regeczkey 2016). Makari (2008) described a similar phenomenon in noting that Freud turned his Viennese collaborators (e.g., Alfred Adler, Wilhelm Stekel) into adversaries after psychoanalysis gained international prominence in 1909. Freud could and did demand an "all-in" allegiance to his libido theory, certainly one crucial factor that led to the eventual break with Carl Jung.

Likewise, Klein's popularity at the British Society grew in the post-World War II era with the training analyses she conducted of three new promising psychiatrists/disciples: Herbert Rosenfeld, Hanna Segal, and Wilfred Bion. This trio of analysands exemplified the new, "all-in" Kleinian. In her programmatic advocacy for the treatment of the psychoses, their loyalty to her theory would not be compromised. Yet Klein's advocacy for this new group also put her at loggerheads with members of her old cohort from years past—and here, Winnicott's recent work stood out. Long since aligned with her work, his attempts at theoretical differentiation also ran afoul of an increasing intransigence on Klein's part. His environmental emphasis now brought him into conflict with Klein's newfound need for "all-in" allegiance, especially pronounced at the time of the first "Transitional Object" paper in 1951. A similar intransigence on Klein' s part also led to the departure with another long-term Klein collaborator, Paula Heimann, over their differences regarding the countertransference after 1950 (Grosskurth 1986; Heimann 1950). Klein's increasingly strict emphasis on the child's phantasmic internal world as underlying its inherent psychological condition

acquired a defining prominence in her technique. Regardless of how evocative or truthful Winnicott's theory building vis-à-vis the infant and its mother might have seemed, it was in effect deemed clinically irrelevant to the Kleinian analytic treatment of seriously disturbed patients (Aguayo and Regeczkey 2016).

In spite of the theoretical break between Winnicott and Klein, he nonetheless attempted to dialogue with Wilfred Bion by post after 1951. In a newly published letter from Winnicott to Bion (we unfortunately do not have Bion's side of the correspondence [January 21, 1951, *CWW* 3, p. 433]), Winnicott appeared somewhat avuncular, praising Bion's graduation paper, "The Imaginary Twin," writing that he felt "very confident about the future of Bion's work" (L. Brown—personal communication). Perhaps Winnicott here wrote in a mannered way reminiscent of one public school educated Englishman appealing to another—" … eventually your contribution to the Society will be a big one. It is for us to gradually find out how to understand what you say."

In a far more theoretically substantive letter to Bion, Winnicott (October 7, 1955) gave a detailed response to Bion's 1954 paper, "Personalities," subsequently published as "Differentiation of the Psychotic from the Non-Psychotic Personalities" (Bion 1957; *CWB* IV, pp. 92-111). But here, Winnicott made a more concerted effort to separate Bion's contributions from those associated with the Klein group. His appeals to Bion were pitched in a key all too familiar to Bion, namely a critique of the Kleinian "groupishness" that Winnicott saw on display at the Society's meetings when a protective phalanx of Kleinians would surround and protect with uninterruptable commentaries the work of their fellow colleagues at the podium. Winnicott expressed hope that Bion would someday become President of the British Society if only his work could " … emerge from the Klein grouping" (*CWW* 5. p. 84). On the cusp of Bion's completed and successful analysis with Klein (1946-1953), it would seem that Winnicott's continuing appeals based on his own theory of the importance of the environmental mother fell somewhat flat with Bion.

Support for this thesis is forthcoming if one looks at Bion's "Differentiation" paper as (among other things) a response to Winnicott's entreaties. At the outset of the published paper, Bion acknowledged the environmental factor, but did not address it in the etiology of schizophrenia:

> Lest it be supposed that I attribute the development of schizophrenia exclusively to certain mechanisms apart from the personality that employs them I shall enumerate now what I think are the preconditions for the mechanisms on which I wish to focus your attention. There is the environment which I shall not discuss at this time … . [1957, p. 266; *CWB* IV, p. 93]

Instead, Bion took up the Kleinian line integral to his way of treating the psychological state of mind of his psychotic patients, a perspective that aligned itself with the work of Klein, Rosenfeld, and Segal.

Take Bion's case example: a psychotic patient ("A") talked in a verbally fragmented, elliptical, and disconnected way, almost as if he was talking to himself in the analyst's presence (Bion 1957, pp. 266). The analyst represented external reality, the meaning-maker, and structural change agent. Bion attributed psychological meaning then to "A's" sensory/motoric activity, which heretofore had existed in a non-representational realm. The analyst appeared isolated as the sole meaning-maker insofar as his interventions were subject to "A's" obstructive denials and rebuffs—dreams with no associations; no connection or interest in his physical movements on the couch.

Bion persevered in attempting to link sensory experience to the realm of psychological meaning, hypothesizing an "… ideo-motoric activity, … a means of expressing an idea without naming it." In this view, "A" had attacked his mind, damaging the communicative apparatus, so that he produced mutilated attempts at communication. Hence, no meaningful analysis, as the links had been ruptured. Another fragmented, disconnected statement by "A": "I should have rung up my mother today" represented no connective link with the analyst. Bion (1957, p. 271; *CWB* IV, p. 101) here dismissed any interest in the patient's mother as an external object with her own attributes, (and therefore of little interest in exploring what she represented in the patient's infancy and childhood, i.e. her real attributes as "A's" mother): "I may say that at the time of which I write I knew little more of his real mother than would be known by a person who had rid himself of his ego in a way I have described as typical of the psychotic personality." Bion focused his interest instead with "A's" internal experience of the analyst-as-mother in the here and now.

Bion here brushed aside what would have been the heart of the matter to Winnicott. To the patient's saying, "I should have telephoned my mother," Winnicott gave his own interpretation to Bion—it is about the patient's communication and his incapacity for making one. Winnicott here elaborated his perspective as an analytic observer of what was required of an actual external object, namely that of an attuned mother would know from her baby's gestures what it needed—and that she out of devotion would have shown she understood (*CWW* 5, p. 84). In the comment about the telephone, "A" reflected the "original failure from the environment which contributed to his difficulty in communication." (*CWW* 5, p. 85) Winnicott here implied that Bion was talking about "environment" even though he said he would not do so.

Both sides dug in: Winnicott then further differentiated his emphasis on the important role of mother's external attributes when he went public in his response to Klein's 1955 IPA Geneva paper on "Envy and Gratitude," which he discussed at a meeting of the British Society on February 1, 1956 (Winnicott 1956b; *CWW* 5, pp. 129-132). Despite regarding her contribution on the clinical understanding of envy as valuable and worthy of analytic consideration, Winnicott's critique was two-fold: she placed the envy factor in the earliest time of the infant's development, which was beyond its psychological capacities; and she again ignored the role of external object in form of the infant's mother, showing " … no evidence of understanding the part the mother plays at the very beginning" (*CWW* 5, p. 130).

According to Winnicott, Klein deployed the factor of envy as if the absolute dependency of infancy didn't exist—and all this without any reference to the actual mother. But then again, if there are such things as "good and bad" analysts, why wouldn't Klein also take up a consideration of the "mother's" capacity to adapt to the needs of her "infant"? Here Winnicott's further theoretical differentiation of the external object at the outset of life resulted in the concept of "Primary Maternal Preoccupation." Winnicott (1956a) now filled in the mother's crucial role in the neo-natal phase. Primary Maternal Preoccupation consisted of a transitory state of mind, starting with a heightened sensitivity during the later stages of pregnancy. It lasted for a few weeks after the birth of the baby and was not easily remembered by mothers once they have recovered from it. Its memory was generally repressed. Winnicott

likened it to a temporarily withdrawn or schizoid state, an illness she had to both suffer and surmount. It set the stage for the infant's constitution, so that developmental tendencies could begin to unfold, such as its "going on being" in the beginning. Once the baby's ego relatedness came into play, mother recovered from primary maternal preoccupation and the baby could build up a sense of self. On the pathological side of the diagnostic continuum, Winnicott left out the undeveloped theme of the infant's introjection of illness patterns of its mother. With faulty Primary Maternal Preoccupation, there are impingements, fears of annihilation—and much time will be spent in analysis allowing this individual a chance to recover from having had disruptions in its earliest stages (Winnicott 1956a; *CWW* 5, pp. 183-188).

Winnicott took direct issue with how Klein conflated later ego-developments in the child with those of the psychological life of the infant, critiquing such Klein (1957, p. 176) statements as: "I consider that envy is an oral-sadistic and anal-sadistic expression of destructive impulses, operative from the beginning of life, and that it has a constitutional basis." Such a conceptualization made envy appear inherent or instinctual in the infant, something that Winnicott strenuously objected to because it completely omitted the factor of the "behavior of the person caring for the infant." Winnicott (1959) instead viewed the new-born as fused with its mother, living in an unintegrated experience of omnipotent illusion—that it alone created the universe. In his interactional model, he then imagined that an envious infant would be a " … part of a very complex state of affairs in which there is a tantalizing representation of the object" The mother does something that the infant senses is good, but this experience is not sustained " … so that to some extent the infant feels deprived" (Winnicott 1959; *CWW* 5, p. 435). Such experiences would however only make sense once mother has been clearly differentiated and relied upon by the growing infant.

From Klein's (1957, p. 181, n. 2) side, there would be no conceptual reconciliation with Winnicott's work on the maternal environmental factor, no response ever to his critique. The bulk of her footnotes in "Envy and Gratitude" summarized decades of clinical and theoretical writings dating back to one of her earliest papers: "An Obsessional Neurosis in a Six-Year Old Girl" (Klein 1924 [1932]). The Kleinian infant was not the same theoretical entity as the Winnicottian baby. The

Kleinian baby was the result of decades of clinical case studies in which primitive mechanisms underscored the positing of models regarding the infant's phantasmic subjective experience of itself and its external objects. Winnicott's baby on the other hand, grew out of a tradition of babies and their mothers being directly observed *in statu nascendi* alongside analytic reconstructions. In this sense, Winnicott's work on the transitional object stood Janus-faced in terms of inner psychic reality and the external environment of provision.

From the perspective of Winnicott's further correspondence and entreaties to Bion, the next point in their implicit debate, namely Bion's (1959) "Attacks on Linking" paper, takes on greater significance. Delivered on October 20, 1957 to the British Society, Bion's paper has generally been viewed as an original explication as well as brilliant extension of Klein's ideas about the analysis of psychotic states, the utility of projective identification and the operation of envy, particularly in the analysis of psychotic patients.

It was certainly that. It also built upon Bion's (1955) earlier work on transference-inducing (and non-inducing) projective identification as well as Money-Kyrle's (1956) important paper on countertransference where the patient's disturbing projections were unwittingly taken in and led to dysphoric feelings of incompetence in the analyst. In addition, and in light of the Winnicott/Bion correspondence, I think it *also* represented Bion's between-the-lines rejoinder to Winnicott, especially as Bion finally took up the "environmental factor." After presenting a number of treated cases of psychoses, Bion took up the consequences of his failure to take in adequately one of his patient's communications—and these passages are important enough to cite fully:

> … there were sessions which led me to suppose that the patient felt there was some object that denied him the use of projective identification …. There are elements which indicate that the patient felt that parts of his personality that he wished to repose in me were refused entry by me, but there had been associations prior to this which led me to this view. [Bion, 1959. p. 103; *CWB* 4, p. 147]

Bion then looked back at the earlier development of this particular patient—and the consequences of the denial by the primary object

of normal and necessary degrees of projective identification. Bion discussed the patient's phantasy that aspects of his unbearable experience might repose in the analyst's mind, so that they might be altered there, and then safely reintrojected. But when the analyst was experienced as finding these powerful projections unbearable, the patient felt that the analyst actually evacuated such unbearable states back into the patient, a sign of what the patient would have understood as the analyst's own "hostile defensiveness." Then, in a move quite uncharacteristic in Bion's writings up to that point, he then speculated about what kind of childhood or environmental mother this patient might have had:

> I felt that the patient had experienced in infancy a mother who dutifully responded to the infant's emotional displays. The dutiful response had in it an element of impatient "I don't know what's the matter with this child." My deduction was that in order to understand what the child wanted the mother should have treated the infant's cry as more than a demand for her presence. From the infant's point of view she should have taken into her, and thus experienced, the fear that the child was dying. It was this fear that the child could not contain. He strove to split it off together with the part of the personality in which it lay and project it into the mother. An understanding mother is able to experience the feeling of dread that this baby was striving to deal with by projective identification, and yet retain a balanced outlook. This patient had to deal with a mother who could not tolerate experiencing such feelings and reacted either by denying them ingress, or alternatively becoming prey to the anxiety which resulted from the introjection of the infant's feelings. The latter reaction must, I think, have been rare: denial was dominant.
>
> To some this reconstruction will appear dutifully fanciful; to me it does not seem forced and is the reply to any who may object that too much stress is placed on the transference to the exclusion of a proper elucidation of early memories. [Bion 1959, p. 104; *CWB* 4, p. 148]

I think this was Bion's between the lines response to Winnicott. Yet like other Kleinian colleagues before him, such as his former supervisor Paula Heimann (1950), who had heard Winnicott's own paper on countertransference at the small gathering of the British Society in 1947—and then, did not cite it in her own paper on the same subject, Bion (1959) here followed suit. In my view, he drew upon ideas about the environmental mother made clear to him in Winnicott's letters, but refused to cite their author, all in keeping with Klein's injunction that Winnicott's work would not be discussed or critiqued in print (Aguayo 1999). Of course, Bion had also been accustomed as far back as his group work days to factoring in his direct responses to his patient's communications (Bion 1948; *CWB* 4, pp. 61-70). However, I also hold that Bion here finally appropriated Winnicott's quite developed trajectory about the importance of mother as an external object, but simultaneously transformed it into the patient's phantasmic experience of the analyst as external object—albeit as a projection-denying one—as he began to take up the analyst's actual objective qualities for processing the patient's unbearable states of mind. I think Bion here evinced having taken in what Winnicott had been writing to him about; and again, it all happened without any formal acknowledgement.

On the other side, Winnicott himself could have hardly cried foul in this instance, as he too was well aware of his tendency to appropriate from the work of fellow analysts, all without acknowledgement. At the outset of "Primitive Emotional Development," Winnicott confessed this point with candor:

> I shall not first give an historical survey and show the development of my ideas from the theories of others, because my mind does not work that way. What happens is that I gather this and that, here and there, settle down to clinical experience, form my own theories and then, last of all, interest myself in looking to see where I stole what. Perhaps this is as good a method as any. [1945 *CWW* 2, p. 357]

Both sides now raced ahead for theoretical definition and claims for priority. Winnicott (1960a) soon provided an overarching statement of his various conceptions of "holding," heretofore sketched out in bits and pieces in numerous papers since the end of the Second World War.

Initially, Winnicott (1947; *CWW* 3, p. 97) addressed the purely physical aspects of the mother with her newborn: she generally knows what to do, carefully warning as she gathers up the baby and picks him up. Winnicott reasoned from the mother's physical experience of literally carrying her fetus *in utero* for months, she understood what a profound responsibility it is. And just as mothers can be so sensitive to the way they hold their babies, babies are sensitive to the way they are held; they can be content with one person, fussy with another (Winnicott 1950; *CWW* 3, p. 388). Winnicott beautifully evoked these aspects of physical holding with an adult female analysand, who recalled mother always holding her too tightly as a baby, so great was her fear of dropping her. Her analysis allowed her to regress back to this point of "pressure," which she evocatively described as being a "bubble in the beginning." How unfortunate it was when the outside pressure was greater than the pressure inside the bubble. Far better when the outside pressure matched the inside pressure! (Winnicott 1949b; *CWW* 3, p. 209).

Winnicott then linked his ideas of maternal holding with his psyche-soma formulations of the new-born with its unintegrated experience—the physical could and was felt as the psychical and vice versa—and here, he made the stark statement: "We are near the well-known observation that the earliest anxiety is related to being insecurely held" (1952b, *CWW* 4, p. 56). Put differently, the maternal care provided by the "good enough" mother could ideally be experienced as a psychological process from the child's point of view. The mother's technique of holding, of bathing, of feeding, everything she did to the baby, added up to the child's first idea of mother … ' (1951b, *CWW* 4, p. 155) By managing the newborn's anger, excitements, and grief, the mother held what was not possible for the infant to hold, as it was a "human being in the making" (1954, *CWW* 4, p. 251). Again, all these were actual maternal attributes, those that could be described by a pediatrician as an external observer.

Throughout the course of the 1950s, Winnicott further refined his ideas on holding, increasingly psychologizing what initially had been in the realm of the physical ministrations evinced by mothers with their newborns. By 1960, Winnicott (*CWW* 6, pp. 141-158) then gave a summary of what years of treating and diagnosing mother-infant dyads had brought him to in his IPA Congress paper at Edinburgh. He set out with greater specificity how maternal physical gestures could resonate with

the young child's psychological experience. One key element was as Angela Joyce, (2016, *CWW* 6) has pointed out: "Mother holding infant in unintegrated state, seeing the whole person before the infant feels whole." During the last trimester of pregnancy, as mother became "primarily preoccupied" with her gestating baby, her preoccupation became merged with her baby, a deeply felt two-in-one experience where she was in a constant state of adjusting and readjusting, imaginatively elaborating upon her deeply felt bodily needs; this process would continue once the baby was born, as she continued to adapt to the specificity of her baby (Joyce 2016 *CWW* 6, pp.4-5).

Yet the primary state of unintegration experienced in the first months of the infant's life, gradually became more differentiated—infant from mother, psyche from soma—as Winnicott (1960, *CWW*, 6, p. 149) emphasized the role of the actual mother gradually presented the world in small doses as the precondition for the emergence of the baby's own ego. It is the mother who supports the baby's ego relatedness. The infant realizes that the real mother is essential in its maturation towards independence:

> The infant develops means for doing without actual care. This is accomplished through the accumulation of memories of care, the projection of personal needs and the introjection of care details, with the development of confidence in the environment. [Winnicott, 1960, *CWW*, 6, p. 149]

By the early 1960s, Winnicott specified further what the "maternal function" entailed for good or for ill:

> Holding is very much related to the actual mother's capacity to identify with her infant. Satisfactory holding is a basic ration of care, only experienced in the reactions to faulty holding. Faulty holding produces extreme distress in the infant, giving a basis for: the sense of going to pieces, the sense of falling forever, the feeling that external reality cannot be used for reassurance, and other anxieties that are usually described as "psychotic."[1964 *CWW*, 6, pp. 90-91]

Thus, as an overarching concept, holding:

> … is used here to denote not only the actual physical holding of the infant, but also the total environmental provision prior to the concept of *living with*… . It includes the management of experiences that are inherent in existence, such as the *completion* (and therefore the *non-completion*) of processes, processes which from the outside may seem to be purely physiological but which belong to infant psychology and take place in a complex psychological field, determined by the awareness and the empathy of the mother. [1960a, *CWW* 6, p. 147, italics in the original]

DENOUEMENT—WINNICOTT'S FINAL BREAK WITH THE LONDON KLEIN GROUP—"THE KLEINIAN DEVELOPMENT" (1962, 1965) AND JOHN O. WISDOM'S 1964 LECTURE ON BION'S (1962) *LEARNING FROM EXPERIENCE*

By the time of Mrs. Klein's death in 1960, Winnicott naturally felt compelled to sum up both his appreciation and critique of her work. In his obituary for Klein, Winnicott (1960b) focused primarily on her theoretical formulations and secondarily, those of the members of her group. An invitation to lecture at a number of different American institutes in 1962 provided the immediate impetus to rehearse as well as work out the details of his critique of the Kleinian development. In the archival records of the Los Angeles Psychoanalytic Society and Institute, (LAPSI) one can read evidence that in 1961/1962, Winnicott was specifically invited to give a summary critique of Klein's theories. At the time of Winnicott's invitation, there had been some concern among the senior classical members there of some of the younger members showing interest in what were termed "divergent" theories (Kirsner 2000). In a letter to Winnicott, (December 4, 1961, p. 1), Carel Van der Heide, the LAPSI Continuing Education Chairman, expressed an interest that perhaps Winnicott might address these issues:

> … I wonder whether the discrepancy between 'classical' and Kleinian views of the ego development, their overlapping and incompatibilities, would not be an ideal subject about which you would be most eligible to speak. And with this suggestion, I believe to indicate an obvious and urgent need, on the part of our candidates, presently exposed to teachings from indeed divergent points of view, outside, and, partially inside of our institute.

Van der Heide's proposal struck a responsive chord with Winnicott (1962a)—and so he agreed to the topic of "The Kleinian Development" in a letter of response on March 6, 1962:

> This would leave me free to do what I can do, whereas a more formal statement indicating a lecture on the relationship between Freud and Klein would involve me in reading the relevant parts of the literature again. Perhaps because of my temperament, I find I can talk better deliberately setting out to give my own view of the matter rather than attempting to present someone else's view. Perhaps all this amounts to the same thing, but I would enjoy giving the students my own slant on these matters. [p. 1]

So, to set the context here: Winnicott was free to say what he wished about the "Kleinian development" in an atmosphere where his thoughts were welcomed by a group of classical analysts unencumbered by old world controversies. The new world represented a liberated space in which Winnicott could freely air his views—and he took the opportunity to offer both an appreciation as well as a critique of her theories. On the one hand, Winnicott thought that Klein had opened up the world of analyzing small children with her method of the play technique with small toys, which allowed the child's imaginative configurations to "speak" for it. Klein's depressive position was an achievement that Winnicott ranked as her "most important contribution," one that rightly stood alongside Freud's Oedipus complex. Yet in spite of these enduring contributions, Winnicott's (1965, p. 174; *CWW* 6, p. 328) attention was increasingly drawn over the years of his association with her to illnesses with "… an organization of defenses belonging to the earlier times in the infant's life."

Winnicott's most well-known critique of Klein: she underplayed the role of actual mothering, particularly "good-enough mothering," which in effect "… paid lip-service to environmental provision, but would never fully acknowledge that along with the dependence of early infancy is truly a period in which it is not possible to describe an infant without describing the mother whom the infant has not yet become able to separate from a self." Winnicott's (1965, p. 177; *CWW* 6, p. 331) most famous *ad hominem* statement in this regard was that Klein was "temperamentally incapable" of paying "full attention to the environmental factor … "

Very early in the 1962 Los Angeles lecture, Winnicott moved abruptly into a frontal and emotional critique of Klein's theories, unlike anything he had publicly stated in London:

> And you can see, that if I absolutely hate Mrs. Klein's paper, on which she based her book of "envy of children," it doesn't really matter to me, I just went up Mrs. Klein after the paper and said, "I don't like that, there's something wrong with it and I don't know what it is," and I still don't know … But the fact is, that it doesn't make any difference. Mrs. Klein for me was somebody who taught me so much, and she would talk it over at any length, and hold her own views, and I still feel I have a tremendous amount to learn from Melanie Klein. [1962b, p. 3]

Winnicott here directly took a group of public listeners in Los Angeles into the acrimony that surrounded his well-known differences with Klein and her group. Yet in spite of these blistering critiques, Winnicott nevertheless continued his entreaties to Bion by post, now expressing his keen interest in the understanding and treatment of psychotic patients, a patient population that he (like Klein herself) thought was analytically treatable. As it was, both Winnicott and Bion had had ample opportunity to hear each other's work during the 1950s and 60s because as presidents of the British Society, (Winnicott from 1956-1959 and 1965-1968; Bion from 1962-1965) they had to be present at all scientific meetings held by the British Society (David Bell, personal communication). So even though neither man published very much on the work of the other, they were both certainly aware of and had personally heard each other's public presentations.

After Klein's death, Winnicott maintained interest in Bion's work that now turned towards psychoanalytic theories of thinking (*CWW* 6, pp. 125-126; p. 279). Yet at the outset, Winnicott did not seem to notice how Bion was implicitly taking up themes long since known in Winnicott's published work. Take Bion's (1962a) paper, "The Theory of Psychoanalytic Thinking," given at the same 1961 IPA Congress at Edinburgh where Winnicott was a keynote speaker. Like most contemporaries, Winnicott would have missed how Bion's writing suddenly had turned quite dense and opaque, pitched more in terms of metapsychological theory and stripped of clinical examples. In my view, Bion experienced a different sort of liberation—one occasioned by Klein's death. With the passing of the "boss," as he privately referred to her in his diaries, Bion now felt free to postulate a theoretical system that at once took into account the enduring findings of the Klein group during the period of their "psychosis papers" in the 1950s, but now theorized beyond this disturbed clinical group to inquire about the nature of thinking itself.

While Bion still subscribed to Klein's ideas, he simultaneously transformed them in directions little explored by her and members of her group. He specifically took up the metapsychological question of how thought develops in normal infants with their mother, a terrain long since clinically explored by Winnicott. Ironically, as Winnicott had done much the same, Bion did not bother himself with the citation of sources other than Freud and Klein themselves, perhaps giving rise to the impression that this was his own unique theoretical contribution. One can conjecture that Bion thought he had sufficiently incorporated Klein's ideas to the point of invisibility, but from here on in his writing, he rarely cited the work of his Kleinian colleagues—or any other contemporaries for that matter.

Bion's (1962a, p. 110) positing of a psychic apparatus that has to contend with thoughts at the outset of life led to a necessary corollary, namely a mother who exists to help the baby, who initially exists as a set of "thoughts without a thinker." Thinking is forced on the infantile psyche by the pressure of thoughts and not the other way round. At the outset of life, the infant emits "ideo-motoric" "preconception,"—gestures with which an actual mother-as-thinker had to cope with. Bion discussed these ideas in abstract terms—indeed, I maintain that one impetus

driving this sudden turn towards the opaque was Bion's need to obscure his newfound and growing responsiveness to Winnicott's postal entreaties and numerous publications about the maternal environment. In short, Bion now accommodated the conceptual importance of mother as an external object with her own attributes.

Drawing upon the two theorists also most favored by Winnicott, namely Freud and Klein, Bion emphasized different theoretical aspects. Whereas Winnicott, (1945) had preferred the Freud (1914) of "On Narcissism" and the Klein of the "Depressive Position," Bion (1962b), took his theoretical orientation from the Freud's (1911) "Two Principles of Mental Functioning," and Klein's formulation of projective identification. On the one hand, Bion extended Klein's emphasis on disturbed, infantile pathological thinking, now counterbalancing it with the infant's development of normal thinking that is attuned to the reality principle. But as other contemporaries (e.g. Guntrip 1965) would soon note, Bion creatively distorted Freud's ideas about the pleasure and reality principle, so that the Kleinian assumptions about an infant born object-related with a rudimentary sense of self and other could be incorporated into Bion's new theoretical system (Aguayo 2015).

It makes clear sense to posit that the infant described by Bion was surely not the same infant studied in thousands of actual pediatric and analytic consultations by Winnicott—indeed, there is no evidence that Bion ever saw infants and their mothers in consultation in his many years of private practice. No, this Bionian infant was (as described by Grotstein 2009) the "virtual infant" of the analytic consulting room, the one born of countless case studies conducted by Klein and her co-workers of disturbed children and adults. In Bion's new system of thought, the "virtual infant" was born into a state of rudimentary thought and object-relationship, all of which preserved and expanded Klein and Bion's work on normal and pathological projective identification (e.g. the patient-as-infant projects or "evacuates" a "bad breast" experience into a maternal object, who then has to metabolize such experiences by means of reverie, so that an attuned understanding can help the patient grow and develop its "preconceptions" into "realizations.")

Bion accomplished a great deal in his first theoretical foray after Klein's death. He expanded the Kleinian theoretical reach beyond the merely pathological into the realm of normal development (e.g. the

infant's "sense data" could be either converted into "alpha elements" with maternal assistance, or misrelated to, leading to pathological misdevelopment [Brown 2012]). Bion subtly also began to distance his own theoretical work from those of his Kleinian confreres, as references to their work now diminished; and finally, as I maintain, he incorporated Winnicott's long-standing research trajectory on the normal and pathological development of infants as ministered to by their mothers. Bion's crucial theoretical turn here now posited the importance of the actual mother as a separate psychologically processing entity, whose own variability needed to be factored into *both* normal and pathological development. And all this was accomplished without a trace of acknowledgement in his references. This type of writing may have helped to create an impression that Bion's theoretical system had been born almost as if it was like Athena bursting forth from Zeus' forehead.

Bion (1962b) then formalized his theoretical system when he issued a much-expanded monograph, *Learning from Experience*. In setting out his theory of the origin of the human psyche and its thinking capacities at birth, it was in my view an experience-distant account of how actual babies were ministered and related to by their mothers in myriad ways. It also however provided an experience-near account of how the workaday analyst drew upon his sense experience to understand his direct experience of his patients and himself, transforming this sense data into the realm of the psychical and ineffable. In other words, this was a way in which the practicing psychoanalyst might have of thinking of the actual theories he deployed in his everyday work. It provided a system of notation, so that the analyst might have some objective way of recording crucial developments in the work with his patients, but do so in such a way as to generate fresh hypotheses. This was now Bion's theoretical yet practical trajectory.

Bion's new work reflected a form of cross-modal, interdisciplinary thinking, where he borrowed ideas from other disciplines—philosophy, mathematics, and literature—and pressed them at times violently into service in fashioning a meta-theory which in effect was a thinking man's guide to how to think about the psychoanalytic situation and its theoretical underpinnings. His work now attracted the attention of other cross-modal thinkers, men like philosopher John O. Wisdom, who himself

had made a project of examining how philosophy and psychoanalytic might mutually enrich one another.

In setting out a model that might be inclusive of the most enduring findings of both Freud and Klein, Bion (1962b, p. vi) blended his preferences into concepts that could be loosely defined, "unsaturated" to use his term—neither being too specific nor too general, as this lead to a "penumbra of associations." Bion fashioned a model of the virtual infant whose immature psyche necessitated what he now termed a "maternal alpha-function," a mother who could minister to those needs in a thoughtful, containing and comforting fashion. In the face of the infant's ideo-motor activities, these were both received, processed by means of maternal reverie and returned back to the infant in the form of contained and metabolized understanding. In so doing, Bion also accepted Klein's notion of projective identification, while simultaneously altering its meaning in a communicative direction, delineating how normal development might occur within the matrix of the infant's relationship with its mother. This bit of conceptualizing work complemented Klein's predominant emphasis on the infant's phantasmic relationship to the maternal body. At the same time, Bion now integrated the role of the *actual* mother as a containing object, precisely what had been at stake when Klein and Winnicott had parted company at the time of the "Transitional Objects" paper.

Put differently, Bion transformed Klein's emphasis on the infant's pathological development in relationship to its mother, a factor she had held as a "constant" in her theoretical system: he posited a "variable mother," in this case, an analyst with such objective attributes as an emotional processing capacity that had to be factored into the matrix of the patient's psychic development. And of course, mothers, like psychoanalysts, were variable in their objective "alpha (or, α) functioning" capacities. Through his notion of "container/contained," Bion could simultaneously maintain the core of Klein's findings, (e.g. a pathological "variable baby" with a "constant," or subjectively experienced mother) but now also add how a variable infant could be either ministered (or misrelated to) by a variable mother, (someone with objectively describable attributes) thus producing different admixtures of emotional matching and mis-matching, leading to different varieties of interactional outcome (Britton 2007). So, Klein's pathological view of the infant could now be complemented by a different

model in which the infant's nascent "α-function" could be developed in relationship to a containing maternal "α-function" that the infant assimilated through a felicitous "learning from experience" ("pre-conception," "realization," and "conception").

Borrowing here from Freud's notion that the sense organs were turned Janus-faced outward in consciousness of the sense world, and inwardly towards the world of psychic reality, Bion elaborated upon "attention" as another defining factor in "α-function." It was the analyst-as-mother's objectively describable attentiveness and capacity to tolerate frustration that focused on sense impressions and emotional experiences of the patient-as-infant that led to the production of "α-elements," which were in turn suitable for storage and for the requirements of dream thoughts. When "α-function" was impaired or reversed, the postulates of Klein's pathological model obtained: sense impressions remained unchanged or "undigested," and these "things-in-themselves" were fit only to be evacuated by means of projective identification, something that Bion had formerly termed "ideo-motor activities" and now renamed "beta-elements."

At the level of model building, Bion also proposed his notion of "container/contained," which at one level were models of abstract representations of psychoanalytic realizations. There are a variety of psychical permutations possible in such a relationship—from mother and infant, mouth and breast, female and male, penis and vagina—and these relationships can be "commensal," and can be "… dependent on each other for mutual benefit and without harm to either" (1962b, p. 90). The shared activity of two individuals can become "… introjected by the infant so that the container/contained apparatus becomes installed in the infant as part of the apparatus of alpha-function" (Bion 1962b, p. 91). The infant explores the object by putting it in his mouth. Bion (pp. 92-93) cast these findings in the forms of aphorisms: "Growing container/contained provides the basis of an apparatus for learning by experience." Or: "Learning depends on the capacity of the container to remain integrated yet lose rigidity." In this growth-oriented fashion, learning becomes progressively more complex. One comes up with more and more hypotheses and this can become a basis for an external object with its own objective attributes.

So, with all these complex developments in hand—Winnicott's numerous publications on the myriad role of mother as an external

object—and specifically, his views on maternal "holding"—and Bion's emerging conceptual work on "container/contained," particularly implicating the analyst's subjective, processing "α-functioning" capacities, we are now in a position to see where these views finally clashed. The occasion was a scientific meeting at the British Society in October 1964, when John O. Wisdom presented a précis of Bion's recent views expressed in *Learning from Experience*.

Nowhere was Winnicott's sudden animus towards Bion's new work displayed more vigorously than when he heard a précis of Bion's recent work by John O. Wisdom (1964), a philosophy colleague who along with Bion was a member of the Imago Society, a private group founded by Adrian Stokes in 1954 that discussed the applications of psychoanalytic theory in allied areas. Among its members were: Wilfred Bion, John Wisdom, Donald Meltzer, Marion Milner and Roger Money-Kyrle, (Letley 2014, p. 83 and p. 96). On October 17, 1964, Wisdom gave an overview of Bion's recent ideas (first given to the Imago Group on April 14, 1964) entitled: "Dr. Bion's Theories of Function and Thinking: (A Review of *Learning from Experience*)" at a meeting of the British Society. With Winnicott and others in attendance, Bion played a double role that night as President/Chair of the meeting as well as a discussant of Wisdom's paper.

In both the spoken and written presentations of Bion's work, Wisdom emphasized aspects of what he considered an innovative theory of which he thought highly: "The present work (like the previous one on Groups) is likely to become a classic…"(Wisdom 1964, p. 1). However, one can conjecture that what genuinely rattled Winnicott were remarks Wisdom made about what he regarded as true innovations, such as Bion's ideas about maternal reverie:

> Bion now returns to his question about the receptacle for the love-component of the food given to an infant—he suggests the hypothesis (p. 36) that the love absorbed by the infant is expressed by a mother's reverie. We may then conjecture what sort of receptor-organ is required for the infant to profit from reverie. [Wisdom 1964, pp. 9-10]

While Winnicott remained silent during the question and answer period, it was actually Marion Milner who made the comment of the striking resemblance between what Bion now posited as "maternal

reverie" and what Winnicott (1956a) had previously posited as "primary maternal preoccupation."

Here at last was a Kleinian discussing the objective importance of the external object! While there was no further comment on Milner's remarks, she herself occupied a unique position insofar as she was an Independent who had had extensive contact with Melanie Klein as a supervisor while having been analyzed by Winnicott (Letley 2013). As the sole Independent who was also a member of the Imago Group, which primarily consisted of Kleinians like Bion, (with whom she shared a deep love of painting) she was in a unique position to see conceptual connections between their ideas.

However, Winnicott was rankled by Wisdom's presentation of Bion's theoretical research as if it represented a complete innovation. Winnicott sensed that Bion clouded matters that he had plainly addressed for many years. Winnicott here was quite frontal in his letter to Wisdom:

> It is important to me that Bion states (obscurely of course) what I have been trying to show for 2 ½ decades but against the terrific opposition of Melanie. Bion uses the word reverie to cover the idea that I have stated in the complex way that it deserves that the infant is ready to create something, and in 'good enough' mothering, *the mother lets the baby know what is being created*.... I don't mind being shown to be wrong, or criticized or banged about. But I have done some important work out of the sweat of my psycho-analytic brow (i.e. clinically) and I refuse to be scotomized. [Rodman 1987, p. 146, italics in the original]

Winnicott strenuously objected to Bion as another Kleinian marginalizing his work and by the next year when he published "The Kleinian Development," his entreaties and attempts at dialogue with members of the Klein group came to an end.

CONCLUSION

In this survey and synthesis of a vast analytic literature, I come to the comparative aspect of this paper, namely a contextual/historical assessment of Winnicott and Bion's views on the nature of the external object.

How can we meaningfully begin to compare Winnicott's "holding" with Bion's structural concept of "container/contained" without lapsing in the usual war of school's rhetoric? One way I have attempted to surmount these types of difficulties is to set out closely the context of discovery in terms of how Winnicott and Bion arrived at their distinctive notions—and in terms each theorist would easily have understood. In so doing, I think that it results in the making of a new narrative, rendering familiar material somewhat strange and strange material familiar.

I compare my efforts with those in the existing literature, for instance Ogden, (2004) who has given us a compelling view of Winnicott's concept of "holding" that attempts to get at what is singularly defining and distinctive about his views. Drawing from many papers written by Winnicott, Ogden (2004) defines multiple facets of this complex idea, starting from the essential physical holding done by mothers with their infants at the outset of life, but in so doing, posits a vitally important maternal function—"primary maternal preoccupation" that is in one sense a "selfless" (or "subjectless state" to use Ogden's term) appearing state of mind in which mother adapts completely to the emerging needs of her new-born infant. This maternal function allows for the baby to "go on being," so that it won't feel impinged upon unduly by the external environment. So, for instance, Ogden states that the mother must be this way "… because the felt presence of the mother-as-subject would tear the delicate fabric of the infant's going on being." Another protective maternal function lies in "… her insulating the infant in his state of going on being from the relentless, unalterable otherness of time" (Ogden 2004, p. 1350). While time parameters are a human construct, its limits are meaningless to the infant who can exist only in a merged state with mother, who in turn takes on the responsibility of titrating the demands of this aspect of external reality for her infant. Sufficient experiences of this kind evince "good enough mothering," which gradually makes it possible for her to wean the infant away from both breast-feeding and living in an illusional omnipotent state, where it feels it creates all that it sees. In other efforts to define the multi-faceted aspects of "holding," Abram (1996, p. 183) also begins by defining primary maternal preoccupation as supplying the infant with "necessary ego support" as part of a total physical and psychological environment that it will need in various ways throughout its infancy.

Likewise, Mawson (2017) has recently done a similar type of what historians call "internalist history" when they take a concept, such as "container/contained" and elaborate its significance strictly from the frame of reference of the analyst's own theoretical development. In this instance, Mawson's understanding focuses on how Bion derived his ideas from his own clinical experience that originated from concepts he deployed from Melanie Klein, his analyst. In his analysis of psychotic patients, he both supported and extended Klein's ideas about projective identification, which was "… a phantasy with actual consequences, and one which operated on the idea of getting into the object and altering it, and not merely projecting onto its surface and thereby altering attributions" (Mawson 2017, p. 1527). In his analysis of Bion's (1959) "Attacks on Linking" paper, Mawson then renders Bion the sole author of the idea that the analyst as external object then had to be factored into the treatment equation when he posited that the analyst as a "projection-denying" figure.

Of course, there is truth in Ogden, Abram, and Mawson's views, but the current investigation has taken an alternative *comparative* path, interesting itself more in how Winnicott and Bion evolved their ideas in a strife-ridden context that punctuated collaboration, contention and competition with its own set of boundaries, loyalties, and group pressures.

Taking temporal factors into consideration, Winnicott's long-term evolution of his ideas about mother's objective role as an external object of importance in myriad ways—from 1941 through the 1960s—establishes his priority in postulating the importance of factoring in this variable as crucial to both neurotogenesis as well as normal development. When Winnicott's views crystalized into a formal theory of environmental mediation with the publication of the "Transitional Objects" paper in 1953, it faced staunch opposition from both Klein and members of her group because of their implicit objection that it diluted the main thrust of psychoanalysis, which was to focus on the internal, subjective, and phantasmic experience of the patient in relationship to the analyst. Klein's need for "all-in" discipleship also ran afoul of Winnicott's need for a mature theory of the infant's development in the context of maternal environmental provision. Despite Klein's passing interest in environmental factors, such as those she expressed in a sensitive infant observation when she linked her grandson's depressive states to parental

absence in the months prior to the outbreak of the Second World War, she never evolved a theory of environmental mediation (Aguayo 2002; Spillius 2007; Aguayo and Salomonsson 2017).

And apart from what the recent Winnicott literature (Caldwell and Robinson Taylor 2016, *CWW* 1, p. 4; Ogden 2012; Reeves 2016, *CWW* 2, pp. 12-16) generally agrees is Winnicott's manifesto of liberation from Klein's theories in 1945, I maintain that his synthesis of Freud and Klein in offering a delineated picture of the first months of the infant's psychological life was simultaneously a representation of his acting on the right to "pick and choose" aspects of theories that he thought most robustly reflected the infant's condition, but offered his work to Klein as a definitive account of the infant's first months of psychological life. As far as the evidence tells us, Klein (1946) hardly took notice.

It was only with Winnicott's (1951a, 1953) "Transitional Objects" paper that he crossed a theoretical divide that separated his work from what had now become Kleinian canon. I have also maintained that with Klein's group's survival during the contentious period of the Controversial Discussions, complete with an institutionalized training track, a definable "Kleinian" perspective with definite theoretical parameters, put Klein in a position to expect doctrinal loyalty from her followers. Analysts like D.W. Winnicott and Paula Heimann, who had long been supervised and analyzed by Melanie Klein—and now brought forth their own innovative extensions of ideas implicit in her work, then fell afoul of a new intransigence. Like Sigmund Freud before her, who at the IPA Nuremburg Congress said, "I define what psychoanalysis is and is not," Klein was now in a position, especially by the 1950s, to define what did and did not constitute a proper Kleinian (Aguayo and Regeczkey 2016).

It was precisely at this point that Winnicott in the two versions of the "Transitional Objects" paper, offered a viable but alternative account of the infant's initial psychological life, one that was at variance with Klein's account of the paranoid-schizoid position. In examining the textual shifts from the 1951 to the 1953 published version of Winnicott's iconic paper, he pushed the issue of further specification of the mother's environmentally mediating role, as he now extended the definition of "good enough mothering." In positing "primary maternal preoccupation," Winnicott (1956a) further highlighted the overall objective qualities of "good

enough mothering" in the last trimester of pregnancy. Such a state would operate (in an ideal or normal sense) so long as the infant existed in a state in which it needed its mother to be completely adaptive to its needs, rhythms and spontaneous gestures.

Lastly, I have maintained that Winnicott's entreaties also went beyond Klein's death in 1960 when he attempted to engage Wilfred Bion's emerging ideas, again by post. This postal debate was testimony to the sheer difficulty involved in having public discussion about intensely held differences. While Winnicott later approved of Bion as a Kleinian finally taking the role of the external environmental mother into account with his idea of "container/contained," he simultaneously took issue with research that proceeded as if his own considerable efforts had not existed.

But as our detailed examination of "holding" and "container/contained" has shown, Winnicott emerges as having clear priority in offering an experience-near account of the infant's initial psychological development in the context of either an attentive or misattuned and impinging mother. His considerable amount of writing and theorizing about the 1st year of the infant's psychological life helped to displace the vagaries of the Kleinian line of a "paranoid-schizoid position," a line that (with certain exceptions, e.g. Segal 1964) would over time wither as an actual timeline charting the infant's psychological development. However, at the same time, Bion's subsequent work on "container/contained" and reverie are most usefully understood in a different understanding of the importance of the external object, namely the subjective and processing capacities of the workaday analyst. This perspective in effect marginalizes Bion's theoretical view of the infant's early development—and more meaningfully maintains that his elaborate system of the patient-as-infant's "beta-elements" when projected into the analyst-as-mother—was a sizable boon to psychoanalytic technique. In other words, the external object of importance in Bion's understanding is not the early mother of the patient's infancy, but the "alpha-functioning capacities"—in all their variability from one analyst to the next—of the analyst in the room. In this respect, Bion justifiably deserves credit as the main inspiring source to contemporary Kleinian developments in technique (Spillius 1988).

I end by citing the note of regret and sadness that Winnicott expressed to Bion in what appears to be the final letter ever written to

him—the dialogue that Winnicott had long hoped for did not materialize. As the current President of the British Society, Winnicott struck a different tone when he wrote to Bion on July 10, 1967, after he had learned that Bion was moving to California to live and practice. California analysts would no doubt benefit from Bion's living and working there, but Winnicott then added:

> The trouble is, however, that we shall miss you a very great deal in this country. Your position here and your personality in what you stand for in the work is of the very greatest importance to us and we can ill afford to lose you. [Rodman 2003, p. 313]

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The Dream Narrative: Monitoring The Analytic Process

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THE DREAM NARRATIVE: MONITORING THE ANALYTIC PROCESS

BY FRANÇOIS SIROIS

The paper emphasizes the use of the dream narrative to forecast the unfolding of the analytic process in the early stages. Rather than attempting full interpretation that might be premature, the analyst here uses the dream as a diagnostic device to ground the opening phase.

Keywords: Dream narrative, dream analysis, analytic process, opening phase.

The central idea of the paper deals with the usefulness of the dream to appraise the analytic process. The idea is not new, but it will be shown as guiding the analyst to anticipate both the identification of the central conflict and the development of transference. I will stress how in the early unfolding of analysis the dream might be more useful to the analyst than to the patient to that effect. In that context, the telling of the dream by the patient will be presented as the choice instrument to assess derivatives of unconscious representations. As early as 1891 in *On Aphasia,* Freud showed that psychic representations could be appraised only through the sound of the speech apparatus where word presentations could link to thing presentations. The dream narrative is here presented as such acoustic device, carrying a signal function during analysis as marker of a deepening process and a forerunner of the transference.

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CLINICAL VIGNETTE

A middle-aged woman came asking for analysis—while her life appeared well organized and fruitful—to make up for what was lacking which she could not tell and to expand on her achievements. She had contemplated analysis earlier on, but kept putting it off, as she felt too busy. She pointed to an unexplained curiosity about analysis. At the end of the third session, she told me a dream, just after she had introduced some associations about her relationship with her husband. "*We sit at a table. I am facing my husband and my grandson. A kind of coach at one end asks who shall speak first. My husband says: I can start. The coach asks me: does it suit you?*" I did not say anything about that dream for two reasons. It was said at the close of the hour, and as a dream is structured as a symptom it is not to be tackled directly. I felt it represented the central issue of her unspoken demand for analysis: who shall have precedence, man or woman? In the next session, she elaborated on her relation with her husband. With a significant affect, she spoke vividly with details. While mentioning an argument with him, tinged with anxiety, she paused: "When I am vulnerable I cannot rely on him." The argument had come up while talking about a handicapped female relative. I felt she was concerned with the kind of contact she would encounter with me. "You should not be in the same situation," I replied. "I never thought I had a handicap, maybe a malady," she said. Then she drifted to an earlier circumstance where she had sought to reverse roles with him when visiting her in-laws. Her husband used to relax and keep quiet while she did the talking. She told him she wanted the opposite. I forecast she would try to take over my position.

In subsequent sessions, the patient's associations spread on various superficial topics as she stressed her tendency to sharp reactions. I only questioned her propensity. Her talking centered more and more on her husband, as if weaving a crucial conflicting knot. About fifty sessions after the initial dream, a second dream came up; it was obscure, obviously opening on some undetermined unconscious source of the verbal material scattered in the previous sessions onto an inter-subjective web. The dream arose in a context where she was asking herself whether she had hindered her husband while fostering her own ambition. That context had been worked out in the previous session where she had questioned why she was still with him:

Patient: "Should coming here drive me to separate from him, I shall be furious; for sure, I feel dissatisfied."

Analyst: "With yourself."

There was silence after which she repeated my words, adding: "dissatisfied with my choice."

Analyst: "Maybe your choice came from your own dissatisfaction."
Patient: "My self-esteem is kind of shaky," ending the session.

At the next session – where she told the second dream – she talked about how things have been reversed, and wondered why she had been mistaken about herself. She made a case to convince herself her own reactions were not geared to disparage her husband, only to prevail. She then told her "odd" dream: "*I am in a kitchen, a sink. I am with someone I don't know who asks me to clean that sink; I waver. There is a different color; the sink or the powder to clean it.*" She elaborated on cleaning the sink, which she does easily in daily life as opposed to being hesitant in her dream. "If that be only a sink," I said. She commented on the rose powder that gave a special appearance to the bottom of the sink; she associated it with a fear linked to the sink, the grinder connected to it.

Analyst: "It is dangerous for the hand."
Patient: "For sure. When I was baby-sitting my grandchildren I was afraid they put their hands too close to the grinder."

After a silence; she went back to the previous session. I said, "As it could be tied up with the dream." She talked about friends; some had remained singles, some had paired with women, as she figured how her husband fitted in her own scenario. That brought her to her wedding night when she had feared to get "wedged." I said, "As with the grinder." She replied, "That's it, the hand in the grinder." She talked about the ensuing fear of getting pregnant too soon. At the next session, she did not return to the dream, but for the first time she mentioned her being afraid of cats. I did perceive her stance as displacement of affect under the strength of repression.

A third dream came up rapidly in the following session. A rather different dream, she found; she has written it to remember but did not bring a written account into the session. The dream was lengthy and organized

as a narrative. She reported, "It's a complex dream, I am at lost with it." I felt she presented it as a challenge. Here is a short version: "*I am at a railway station waiting for an express train. To keep waiting short, I jump into the first one called. It is a local train, slow; I have made a mistake taking it. I see there is a long way to go; I will miss my meeting.*" While she intertwined the dream with the actual session, she associated the wrong train with our meeting:

Patient: "I was touched when you asked me if I were dissatisfied with myself. My father, at the end of his life, was dissatisfied with himself."

Analyst: "If you are bound to end up being dissatisfied with yourself, you are afraid you might have taken the wrong train coming here."

She then expanded on a *quid pro quo* she felt about her work with me. She first thought it would make her more appealing to others, but now was afraid it would turn against her as she might perceive herself less worthy. The following session started with a long, unusual silence. She said, "I am astonished. I do not come here to belittle myself; I feel upset. I could stand up, get angry, and abuse you. Something violent; a moment ago I felt like getting up and leave. What did you do so awful to deserve my anger? Nothing much, but I perceive it as unacceptable." When she left, she announced she would miss the next session, but tried to assure me it had nothing to do with what she had just said.

DISCUSSION

Three consecutive dreams are related over about sixty sessions at the beginning of the analysis, albeit quite different ones. The first dream appears a presentation of the central conflict and the way the patient will use the analyst in that regard. The analyst kept silent waiting for more elaboration; a more active approach at this early stage was felt inappropriate. The early unfolding of analytic material deals with her relationship with her husband. While this process weaves the conflict onto an inter-subjective frame, it enables the patient to speak about her and about the analyst in a covert way. The first dream is useful for the analyst, less so for the patient.

The second dream seems to fascinate both analytic partners. That interest is conveyed in the first intervention (only a sink?), inviting the patient to go beyond the plastic figuration. I began associating, around the representation in various ways. *Sink* can be taken as a rebus, sliding along its various meanings: to go down below her own surface, to conceal something, to excavate deeper material, to meet an unpleasant feeling, to lower herself, to fully understand what she came in for. The patient engages herself along that line until anxiety stops her. The dream here is useful to both patient and analyst, not so much to target a full interpretation, but for inducing the patient to dig out material approaching infantile unconscious sources of the central conflict presented in the first dream. Such dream alludes to a non-identified but significant psychic representation in a remote area of the patient's mind. The dream as a psychic tool working with images but reported with sounds is for the mind the metaphor of technological means for assessing hidden physical objects. Expanding on that metaphor, that second dream can be labelled a *radar-dream*, insofar as it points at an unconscious representation that is still undetermined at this stage, and plausibly related to the first dream. By contrast, the first dream could be labelled a *sonar-dream,* insofar as it shows a psychic form, as sonar carrying sound pulses, representing a central conflict without giving much more about its hidden unconscious source. At that point ends don't meet.

The third dream comes up soon after the second one. I perceived it as a signal of transference resistance. That dream was not approached as a dream but as a fantasy formulating the patient's fear of the analytic process. The lengthy narrative curtailed her free associations while serving as witness to her goodwill. The dream narrative is taken as a symptom organizing her fear of the transference. That type of dream polarizes the sliding of the conflict within the analytic rapport. That dream is useless as a dream to both patient and analyst. It is a kind of counter-phobic reaction to the earlier dream, as the latter dream is shutting doors opened by the former. Displacement carried by that third dream follows condensation carried by the second dream. It shows that anxiety is still too high to carry the analysis farther at this point. The polarizing effect of that dream on the transference induces a strong and tight affective tone to the analytic interaction. Going back to the

metaphor, it could be called a *lidar-dream,* as lidar uses powerful laser light to detect hidden objects.

That quick sketch of a beginning analysis makes a case to examine the uses of the dream narrative. The first dream foretells the major conflict; the second dream opens towards the infantile sources of the conflict; the third dream closes the previous opening by sliding the conflict into the transference. For the analyst, the prime importance of the dream is to signal psychic movements during analysis. For the patient, the dream is easily diverted to fuel resistances. Hence, at least early on, the dream does not help the patient to move the analysis forward nor to gain insight, bypassing the transference. Undoing condensation tied to dream interpretation is too fast a process if meaning alone is considered; the interpretation might not be heard. The dream is often like a geyser carrying an economic gain. A direct interpretation will bypass resistances and is akin to a psychic biopsy with traumatic consequences, often a narcissistic wound, as the analyst is seen as knowing better and ahead of the patient's position. Indiscriminate dream interpretation puts the analyst in a didactic stand choking the quantum of affect. That position might be seen as downplaying dream interpretation. Yes, if the dream is tackled from a strict hermeneutic aspect to be conveyed to the patient. No, if the dream is seen in all the versatile manners the narrative is unfolded during sessions. The analyst has to decide quickly where to assign any particular dream within a session, to make use of it or not.

To get into this last difficulty, it is useful to fall back on the distinction between the dream as experience during the night and the dream as told during the day, as Pontalis (1977) pointed out. There is a gap between these two states. Such a gap sets up a mirroring perception of one self with a conviction of an uneven overlap between these two states (Guillaumin 1979). The overlap carries an enigmatic impact as patients often add some comments before telling a dream, presenting it as odd, funny, or absurd. The dream shares with the slip of the tongue and the parapraxis the capacity to stir an *unheimlich* feeling in people when confronted with something unexpected within themselves that cannot be denied nor be totally acknowledged as theirs. This is why the dream, being told once in a while, is a better indicator during analysis than the usual associations. Given that situation, the oneiric experience lends itself to various uses according to the stages of analysis and the state of the transference.

These uses are illustrated here. The first dream is laid at the end of a session as luggage in a cloakroom. It enables the patient to elaborate on in the next session without any reference to the dream, witnessing the importance of repression. That dream gave the shape of a psychic representation, made to be seen with words but kept at distance. That type of dream has a dynamic function, mixing showing and covering a conflict. The second dream reveals the existence of a psychic object, an unconscious representation, without revealing its nature. The patient is hooked by the enigmatic gap that keeps her curious about the dream; she is thus able to associate around it. It seems here useful to work on the dream, not to get a full interpretation but to open pathways to deeper levels, contrary to the first dream. That second dream has a topographical function, inviting to look at the unknown unconscious. The patient unfolded her third dream as a film to stage her dissatisfaction. The ambiguity lies in the transposition of the affective state onto the analytic session by the mere telling of the dream narrative. The patient uses the dream here to keep the analyst in a passive dream-like position watching that film. It is a daytime reversal of a passive nighttime experience. The third dream diverts the attention from the infantile dissatisfaction, opened by the second dream, to the actual one within the transference. That type of dream has an economic function to offset the affective quantum of displeasure by bringing it into the session as to change the source of the dissatisfaction, now assigned to the analyst. It enables the patient to fight it out against the analyst.

All these dreams show a common aspect. They all are far ahead of the analytic process in each of its three areas. The first dream heralds the main conflict but transposed in the external inter-subjective reality of the patient. The second one heralds the infantile unconscious roots of that conflict, and the third one heralds the development of the conflict within the transference. For that reason, these dreams have been labelled with the metaphor of diagnostic tools detecting unseen objects at distance. The approach emphasizes their use by the analyst to appraise psychic movements within the analytic process rather than the strict pursuit of an interpretive task of the latent content. It also stresses the idea that dreams might be more useful to the analyst than to the patient, at least in the early phase of analysis. Early dreams in analysis attract the interest of the analyst, and can incite to grasp that material

faster than the patient can handle. That is why their diagnostic value has been emphasized rather than their potential for interpretation.

CONCLUSION

The labelling of different kinds of dream narratives during analytic sessions is tied to various aspects of the analytic work with dreams. The first aspect is the transposition from images to words. When crossing the gap from the night experience to the daytime narrative, the translation might be loaded different ways. The first dream shows a clear superposition of sight and sound, with apparent clarity of the manifest content and the mixture of scenes and speech in the narrative, as to minimize the gap between the night and day phases of the dream experience. The second dream relies on an enigmatic image supporting a hypothetical action, related to the central conflict - presumably an infantile sexual theory. The third dream hides the images behind an unending verbal secondary revision. The second aspect lies with the difference between the telling of the dream and its use in analysis, limiting interpretation (Freud 1925, p. 128) according to situations of high or low pressure of resistance. Should then the dream narrative be considered a symptom, as proposed initially? Braunschweig and Fain (1974) have linked the remembering of a dream to a screen memory as opposed to the dream fading away without leaving a trace.

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What Makes It Psychoanalysis?: A Commentary On The Contributions Of Dana Birksted-Breen

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WHAT MAKES IT PSYCHOANALYSIS?: A COMMENTARY ON THE CONTRIBUTIONS OF DANA BIRKSTED-BREEN

BY WILLIAM BUTLER

The Work of Psychoanalysis: Sexuality, Time and the Psychoanalytic Mind. By Dana Birksted-Breen, New York, Routledge, 2016, 283 pp.

Keywords: Sexuality, sexual identity, time, après coup, femininity, unconscious, reverberation time, penis-as-link, bi-ocularity, termination, phallus, setting, bulimia, anorexia nervosa.

Dana Birksted-Breen is a training and supervising psychoanalyst of the British Psychoanalytic Society. She has made important contributions to the psychoanalytic literature, advancing theory and practice in several domains including sexuality, gender, time, translation, interpretation, and the functioning of the analyst's mind. While Birksted-Breen's work is firmly grounded in the consulting room, her ongoing interest in "stasis and change," identity and femininity, stems form her earliest research in the area of motherhood and pregnancy (p. 2). These long held interests also touch upon related topics such as temporality, the development of symbolic capacity, and sexuality, as she details in later chapters of this book. In her introduction, she also outlines her views on the importance of stasis and change as they relate to psychoanalytic theory and professional activity in our field. She stresses the importance of a kind of theoretical pluralism, infused with a knowledge of other

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psychoanalytic cultures, based in "deep understanding" rather than superficial "knowledge" that distorts (p. 9).

The breadth and depth of Birksted-Breen's cross-theoretical and cross-cultural interests and understanding may be informed by her childhood experience of being born in the United States and then raised by Anglophone parents in European francophone countries, where she discovered Freud's works in her school library.

In addition to her clinical work and scholarly contributions, Birksted-Breen has served for many years as the Editor of the *International Journal of Psychoanalysis*, as well as in other roles with that publication. Birksted-Breen has also served as the Editor of the *New Library of Psychoanalysis* series that promotes the exchange of ideas across psychoanalytic cultures and between psychoanalysis and other disciplines.

The richness of Birksted-Breen's thinking, her vast knowledge that spans across theories, her ability to clearly and cogently present this information to the reader, her focus on some currently neglected ideas, all born out of and tied back into the consulting room, makes this a timely and timeless contribution to the psychoanalytic field, a contribution that is clinically relevant and should be read by anyone willing to question and perhaps deepen and broaden their way of thinking.

SETTING THE SCENE

In the first chapter, the author details what, for her, comprises the analytic scene, a specific setting, in which various scenarios will be "created by the patient with the participation of the analyst, with whose own scenes they will interlock" (p. 11). An "implied 'other'" is part of this scene, she notes, an "other" object and an "other" time. This implied other, she writes, is also known by various names such as "the unconscious", "phantasy," and "transference" (p. 11). The setting is designed to promote the emergence and observation of this "other" scene, according to the author.

In beautifully descriptive and evocative language, the author details various aspects of this setting. These aspects of the setting include the "rules" of analysis, the sometimes silent, sometimes very present physical setting, the mode of attentiveness particular to psychoanalysis, the

setting as a third and the setting as analytic attitude, an attitude that is different than in any other relationship (pp. 13 and 15).

Because the setting inhibits physical action, language becomes central, according to Birksted-Breen. This includes the experience of language *as* action. She notes the pre-verbal aspects of speech, the sound of it, as well as the transference related specifically to speech described by some French authors (p. 14).

She details Faimberg's understanding of the implications of Bleger's work regarding the frame to imply that there are two analytic frames, "the one maintained by the psychoanalyst and consciously accepted by the patient, the other the frame of the fantasy world, the "ghost world" on to which the patient projects" (p. 15). For the author, all aspects of the frame, "language, setting," and "mode" are inseparable (p. 15).

The author holds that the dichotomy of "insight versus experience" in the "therapeutic action" debate is also a false dichotomy (p. 15). For her, insight is not just an intellectual understanding but is also a "knowledge at different levels of consciousness" (p. 15).

Birksted-Breen also stresses the importance of an intensity of frequency of sessions. She contrasts the French approach of three times per week analysis, with it's focus on the time between sessions as an après coup time, to the typical British tradition of 4-5 times per week analysis with it's emphasis on the relationship and temporal regression rather than the "topographic and formal regression" of the French approach (p. 19).

The frame, *in toto*, she writes, is what is necessary for psychoanalysis to take place. Birksted-Breen emphasizes that "(w)ithout the 'frame' there is no psychoanalysis" and that "(t)he utterances of the psychoanalyst have meaning only within that setting" (p. 23). Many of us would do well to remember this as a check against the tendency to psychoanalyze colleagues and public figures.

In terms of the analytic attitude and neutrality, she notes that neutrality does not necessitate "a cold, unempathic 'blank screen' attitude" (p. 28). She argues that a lively engagement with the ability to take in projections is one of the motor forces of analysis. She states that although total objectivity is impossible, objectivity should still be the goal, a return to what she characterizes as a "third position" (p. 29). The author notes the importance of refraining from "taking on the role of a

good object" or "privileging the interpretation of negative transference." She also stresses the importance of an awareness of the analysis as comprised of a "field" in the sense that the Barrangers and Ferro, amongst others, have described (p. 29).

Pulling some of these concepts together, Birksted-Breen writes that "neutrality goes together with 'containment,'" it "aims to create a space which not only maximizes the expression of the patient's internal world but also 'receives' and processes it" (pp. 30-32). She goes on to the conclusion that "(t)he fact the analyst is a 'subject' and not an 'empty receptacle', and that there is no one-to-one correspondence between the mental state of the analyst and that of the patient, does not go against" the notion that an analytic stance grounded in neutrality is a critical and necessary component of the analytic attitude that aims to be "in the service of the patient" (pp. 31 and 33). While arguing for neutrality, she also notes that in her view neutrality does not mean the analyst is a blank but that she strives toward a neutrality that does not privilege any aspect of listening *a priori*, recognizing that the analyst must have a theory but that it should be a "free floating theorisation'" (p. 32). She notes that her own theory "prioritises the notion of containment" with both a paternal and maternal function. She also includes the concepts of neutrality and "evenly suspended attention/*reverie*" in her own theory (p. 33, italics in the original).

Moving on, Birksted-Breen discusses the frame of the "past in relation to the material of the session" (p. 33). She notes the difference between the Kleinian viewpoint that archaic memories are organized to an extent "in the form of unconscious phantasies" versus the view of many French authors who hold that ''there are id impulses lacking in representation" that "form the psychotic core" (p. 37). The author notes a growing interest within psychoanalysis regarding the need for the analyst's own "regression in the session" in order to capture unrepresented memories (p. 37).

The author notes that analysts seem to have lost interest in Freud's concept of the screen memory. She makes a persuasive argument for the importance of screen memories in that "(t)hey capture in condensed form a central dynamic and grouping of phantasies and affect linking past and present, describing a central structuring of the patient's psyche often connected to the primal scene" (p. 41). She states that screen

memories are not about "recovering the past in its 'material reality' so much as identifying a central phantasy and its associated dynamics which give a picture of the internal world and its infantile elements, creating a continuity between past and present" (p. 42).

In closing the first chapter, Birksted-Breen focuses on different views of the "here and now" technical approach. She states that a post-Kleinian approach "usually implies the exclusive use of interpretations which address what is happening between patient and analyst" (p. 42). She describes the variations within and between different theoretical orientations regarding what a "here and now" approach entails, especially as it pertains to the nature of the link between infantile past and present and the concept of psychic truth. She remarks that after Bion, there is now less focus on "the contents of the mind" and more emphasis on the "workings of the mind," the making of and destruction of links, "the search for knowledge and the destruction of knowledge," Kleinian position variation, dreaming and not dreaming and contained and "uncontained sense impressions" (p. 46). She argues that it is important, in her view, to maintain the ambiguity of the complex interplay between past and present in the analytic situation. For her, the play of this ambiguity is what makes up "the play of conscious and unconscious," fostering symbolization (p. 47). She states that "(f)orgetting this" leads to impasse (p. 47).

BODY, MIND AND SEXUAL IDENTITY

In her second chapter, "Modalities of Thought and Sexual Identity," Birksted-Breen describes the construction of sexual identity in the context of identity development in general. She notes that the individual is "fundamentally split," always looking to get rid of aspects of the self while at the same time trying to maintain a coherent self (p. 50).

In terms of development, Birksted-Breen states that identity construction is "rooted in the vicissitudes of bodily preverbal phenomena, the relation to primary objects and later linguistic phenomenon, in interaction with each other" (p. 50). She outlines Lacan's early theory of the infant's identification with its image in the mirror, giving it a 'false' sense of "control and wholeness," which Lacan labels the "imaginary" register (p. 51). She contrasts this with Winnicott's theory of "mirroring"

by the mother and his emphasis on the need for accurate mirroring, not unduly colored by the mother's pathology in order to mitigate the development of a "false self" (p. 51). For Lacan, according to the author, the child comes into subjective being via the symbolic order of language. In contrast, she notes, Klein believes the ego exists from birth and emphasizes "a natural tendency toward integration" and a "tendency toward splitting," with the internalization of the good breast mitigating splitting and strengthening the ego (p. 51). Birksted-Breen understands Klein and Lacan to describe "two different processes" which in actuality are "hard to completely separate" (p. 52).

Birksted-Breen outlines Aulignier's description of the development of an "I", a unified body, in the very earliest libidinal preverbal experiences of "an indistinguishable psyche-soma" prior to the experience of the other (p. 52). She adds that Aulignier, "in a Lacanian tradition," stresses the importance at a later point in development of the "I" of the infant constructed in Mother's psyche" (p.53).

As she moves from the development of identity in general to the development of sexual identity in particular, Birksted-Breen notes that there is "no agreement about even the terminology and definition of gender identity and sexual identity" (p. 55). The author relates this, in part, to "the overlap but disjunction between body and mind" (p. 56). She states that while "psychoanalysis is about unconscious desire" as Lacan emphasizes, it is never autonomous from the body, which has an ongoing influence, especially in relation to the Lacanian "lack" (p. 56). We are in a concrete way, male or female, child not adult etc. In terms of body image, Birksted-Breen stresses the difference between "internal objects as symbols and internal objects as symbolic equation," the former "experienced as representing the object" and the latter as "the actual object inside the self" (p. 57). She notes that there are also gradations between the two extremes.

Birksted-Breen, citing Green, details how in the analytic setting the psychical apparatus is transformed into a language apparatus that converts everything into language, including "thing-presentations, affects," "bodily states, compulsive manifestations, attempts at acting out, and even desire itself" (p. 59). She states that the "voice is the mode of transmitting affect" (p. 59). She notes that this approach to affect is different from Lacan's, whom she claims, "ignored affect" (p. 59). As Soller

(2016) describes in her book *Lacanian Affects*, the idea that Lacan ignores affect is an oft repeated but, and I agree with her here, incorrect view. As evidence Soller details Lacan's decades long evolving theory regarding affect, including a year long seminar he taught on anxiety, which was later published along with Lacan's other seminars. Soller provides a laundry list of the affects that Lacan discussed over the years. It may be that some of Lacan's ideas concerning affects, for example that, with the exception of anxiety/anguish/angst, they "mislead," may in some uncertain way lead to such statements as the one claiming that he ignores affect (Lacan, 2013). Certainly my experience in Lacanian seminars and in reading Lacan and other modern Lacanian writers (e.g., Moncayo 2008) supports Soller's argument and is strong evidence against the view that Lacan ignored affect.

Birksted-Breen also describes how language is run through with "bodily experience" (p. 58). She cites Ella Sharpe's idea that all words have a physical basis and that we should search for this physical experience in the analysis of the patient's speech, while at the same time keeping in mind that the analyst's speech is formed in this way too and that this will be evident in what the analyst says.

The author continues in this chapter by outlining the role of vision in thought as it relates to sexual identity. She points out that the child's early world revolves around "having and not having—whether it is the breast, the food, the toy, the mother or the penis" (p. 61). This having or not having is important in terms of sexual attributes that are based on primarily visual evidence. This makes it harder for the little girl to represent her sexual organs, more hidden as they are, and according to the author, requiring a greater capacity for symbolic thought and the toleration of "absence and loss" (p. 61). The relative capacity for symbolic thought, the author states, will in part determine the ability to negotiate the primal scene and Oedipal Complex because if it is experienced in concrete terms it will "involve actual murder and incest" (p. 62). In fact, Birksted-Breen notes, the representation of all aspects of the self in terms of masculine and feminine will be a function of the capacity to symbolize, as well as a "complex interplay of defences, projections and introjections," as well as conscious and unconscious phantasy and "somatic and relational experience" (pp. 62 and 64). She provides helpful examples of these complex phenomena.

FEMININITY

In Chapter Three, Birksted–Breen sharpens her focus to look at the unconscious representation of femininity. She notes that the question of penis envy is far from resolved if one takes an international perspective. She notes that most British Kleinians "follow Klein's original position according to which there is always an unconscious knowledge of the vagina and internal space, and a natural heterosexuality" (p. 70). This is in contrast, she states, to Freud who saw masculinity and femininity as relatively independent of biological sex. The French, she writes, influenced in part by Lacan, tend toward the view of the male and female subject as created rather than given. She notes that over time positions have become more complex and nuanced in France in terms of the inclusion of a feminine sexuality by some French Lacanians. The author also mentions the work of Chasseguet-Smirgel who sees penis envy as defense rather than primary. Birksted-Breen details the concept of gender identity as developed in North America by Stoller and Tyson. Three aspects, core gender identity, gender role, and sexual partner orientation are defined. She notes that core gender identity is seen as nonconflicted in their models, which is at odds with French and British views. Birksted-Breen explains that many current authors describe various female genital anxieties with which the girl must contend.

Birksted-Breen developed the concept of "negative femininity" to describe the duality "at the heart of femininity" (p. 73). Positive femininity refers to "specific female experiences and phantasies" and to experiences related to the "internal female organs" (p. 73). The author enumerates several such experiences, fear of penetration, fear of damage, fear of lack of control, fear of loss of pleasure-giving, loss of reproductive ability, fear of fusion, and fear of annihilation. "Negative femininity," according to the author, is "based on the experience of lack as described by Freud" (p. 73). She also emphasizes that these anxieties and defense mechanisms occur in relation to both the mother and father.

Despite Western Society's increasing acceptance and celebration of the feminine, Birksted-Breen notes that analysis still often uncovers a "denigrated image of the feminine" (p. 74). Citing a variety of authors and providing her own ideas too, she lists a number of variations on

such denigration to include, denigration due to envy of the "mother with all her riches, a desire to triumph over the omnipotent primal mother" and a way to deal with "fear of attack," "fear of the receptive position," and "fear of depression" related to the mother's feeling containment function (p. 74). Birksted-Breen notes how the phallus, as representing "wholeness and completeness" can be used as a defensive position in which there is no lack (p. 75).

The author provides a helpful clinical example in which she demonstrates how an analysand's oral and anal aggression interferes with her ability to accept and value her femininity. She notes finding this dynamic in women who "most envy men" (p. 80). She also points out that in her experience, the analysand's "giving up a masculine defensive stance did not automatically equal feeling feminine," although it can lead "towards femininity" and "rivalry and envy" in relation to the mother (p. 81). For Birksted-Breen, in contrast to Freud, the non-recognition of the female organs is not primary but instead due to severe anxiety "about the damaging potential of the female organs" (p. 81). As examples, she cites a patient who experienced an "incinerating cavity" within herself and another patient that felt that she had a "waste disposal in her abdomen" (p. 81).

SEXUALITY IN THE PSYCHOANALYTIC ENCOUNTER

In Chapter Four, continuing with the focus on sexuality, Birksted-Breen discusses sexuality in the consulting room. She begins with a brief review of some French, British and North American analytic views on the topic. Most interesting to those not familiar with their work might be Laplanche's theorizing on unconscious enigmatic sexual messages originating in the parent and impacting the child, Green's ideas on the objectalizing function of the drive and Fonagy's thoughts on perversion as not defined by the fantasy or act but by the compulsive, restrictive, and anxiety driven nature of the phenomena. Birksted-Breen notes that many authors worry about the lack of focus on sexuality in current analytic thinking. *She* certainly does not exclude the sexual but, rather, makes it central to the analytic enterprise, cogently stating that sexuality "dominates the psychoanalytic encounter" (p. 86). She describes how

sexuality "underlies the analysis at all times but manifests itself in different ways" (p. 86). The author sees it as the driving force of an analysis for both parties as well as being a force that can "paralyze" an analysis (p. 86).

What does this look like? Birksted-Breen distinguishes between two ways that sexuality manifests itself in analysis: "noisy sexuality" and "silent sexuality." What wonderfully descriptive terms, obviously grounded in clinical experience. For the author, both of these manifestations involve the Oedipal, the encounter with the Object and the primal scene.

Silent sexuality "belongs to Eros" and promotes the drive to relate (p. 86). It involves mental mechanisms such as projection and introjection, and it is involved in the "cure" (p. 86). Silent sexuality is a quiet backdrop to and "ally of the analysis" (p. 86). It "promotes links "of various kinds, links that undergird the transference, the progress of the analysis, symbolization and other mental mechanisms (p. 86). Birksted-Breen details how the mental mechanisms of projection and introjection, penetrating and receiving, "form the basic dimension of the differentiation between masculine and feminine," serve as links, and can "attach to any number of organs" (p. 87). The importance of both the receptive and penetrative functions is emphasized by the author in her statement that "(t)he bisexual functioning necessary to psychic health which develops from the identification with both positions *is* the silent sexuality at the centre of psychic functioning which combines with gendered bodily reality in various ways" (p. 87, italics added). She sees mental structures as "sexed" and provides as another example her term "penis-as-link" which refers to "the position of the child which recognizes and internalizes the triangular configuration" of the Oedipal situation. From this position, there is sexual difference and generational difference, with the child on the outside (p. 87).

Birksted-Breen provides some clinical examples of "silent sexuality" and as is the case with all of her clinical examples, she makes the analysand come alive on the page. The first is the case of Marie, an anorexic patient, whose analysis, if one looked at a transcript of a session, might seem to have little to do with sexuality. However, looking beneath the surface, the author states that, "the struggle between Eros and the death drive was what underpinned the analysis in an almost palpable way" (p. 89). The patient spoke little but hung on the analysts every word in an

"intensely libidinized atmosphere, of an infantile nature" (p. 90). As both talking and eating are common issues for the anorectic analysand, Birksted-Breen details her own and other authors thoughts on this clinical picture, perhaps most interestingly her conceptualization that "(t)here is a failure of symbolization so that the oral sphere is equated with the genital sphere rather than coming to symbolize it" (p. 90).

In comparison to "silent sexuality," which serves as a sort of critical backdrop and foundation of analysis that the analyst must work to pay attention to, "noisy sexuality," according to Birksted-Breen, confronts the analyst and must, in a fashion, be "looked beyond." The erotized transference is a case in point. The author shares an example from her practice, demonstrating the benefit of such "looking beyond." Beatrice's transference included a "painful and exquisite" (the analysand's words), romanticism as well as an exciting terror (p. 93). The "as if" quality, as is usually the case, was missing from time to time for varied periods, e.g. the patient would scream and shout at her at times. Birksted-Breen opines that in such cases, sexual desire, "noisy sexuality," is part of a desperate bid to completely control the analyst to create a situation in which the analyst totally focuses only on the analysand, annihilating the Oedipal structure and any "others," because for this type of analysand, any sense of falling out of the analyst's mind is experienced as a life and death "falling into a void" (p. 94). Birksted-Breen states that as intrusive and defensive as this transference is, it also serves as a way for the patient to attach and use the analysis and analyst, serving a linking purpose and in this way is still a motor of the analysis. Further, in terms of looking beyond the "noisy sexuality," the author found that in the case of Beatrice, the erotized transference also hid "a more silent libidinized infantile desire to touch and be touched through the various senses," which the patient found "shameful and humiliating" (pp. 94-95).

In contrast to Beatrices' noisy desperate attempts to connect and Marie's more silent attempts at connection is the author's analysand Carole. According to Birksted-Breen, her patient Carole attacks in order to protect herself from painful intrusion, a "phallic" attack itself. In this case, the author describes how the patient experiences the analytic process as a murderous attack, an intrusion into her mind that she must protect against, with a concomitant inability to take in and understand what the analyst says. The underlying sexuality in this case involves the

analysand attacking the sexual couple while idealizing a sibling couple that is more of a "narcissistic entrancement" that she relates to Freud's Nirvana" state, a state that unties libidinal connections (p. 97). This is, the author posits, in reaction to significant psychic intrusion that the analysand experienced.

Daniel is a case of Birksted-Breen's in which both silent and noisy sexuality are present. There was an "invasion" of both hetero and homosexual fantasies and a prolonged period in which the analysand's wife was characterized as wanting him to end his analysis or that she was causing him to miss sessions. After a lengthy period of the author attempting to interpret this threesome in various ways, a "masturbation fantasy in which two women are fighting" over the analysand emerged, leading to the discovery of the great deal of gratification the anaysand got from the two women, his wife and analyst, fighting over him (p. 99). Birksted-Breen states that every analysis has such a "silent" sexuality that serves as the "motor" of the analysis, it "keeps the patient coming" (p. 99).

EATING DISORDERS

Keeping the focus on what happens in the consulting room, the next chapter is entitled "Bulimia and Anorexia in the Transference." Here Birksted-Breen mentions many of the ways that eating disorders can be approached analytically, through their commonalities, level of disturbance, and through the various psychosexual stages, and dynamics involved in all symptoms. She notes that an eating disorder, as a symptom, "can be so pervasive that it becomes a way of life, or of near death" (p. 101). What I found especially useful about this chapter are the bits of Birksted-Breen's clinical wisdom that are sprinkled throughout it. I mention some of these below.

An eating disorder, the author notes, like all symptoms, is a particular symptom for a particular patient and we must have the patience to understand it as such. Issues around control might be a way to "express and avoid" the experience of "an intolerable 'too much': too much desire, too much need, too much sensation, too much intrusion" (p. 102). The author describes how anorexia is partly a "defence against sexual oral-genital impulses" while bulimia "can enact an erotized phantasy" of various sorts involving penetration and expulsion relating

to a defence against "primal scene exclusion" and/or violations of some sort (p. 103). She finds that the treatment of all eating disorder patients typically involves a battle for life of sorts, in which they are "only barely allowed to live and enjoy" (p. 105.). Part of this battle for the bulimic analysand involves the enactment of the "bulimic situation" in session, particularly once the actual vomiting has abated. Overall, in this chapter, the author emphasizes her work in the transference with eating disorder patients, an emphasis away from the symptom itself, which she finds decreases somatic acting out and facilitates symbolic thinking so that over the course of an analysis the relative balance of the life and death drives can change.

MASCULINITY

There is a shift to the masculine in the next chapter, with a focus on the "masculine element in the psyche" (p. 126). Here Birksted-Breen distinguishes between three concepts: the "penis in its purely bodily reality," the phallus, and what she terms the "penis-as-link" (p. 126). For the author, the phallus serves only one function, symbolizing "an illusory wholeness, a state free of desire," as Lacan detailed (p. 127). In contrast, the "penis-as-link" symbolizes "the mental function of linking" and involves "the knowledge of difference" that one is incomplete and needs the object (p. 128).

Birksted-Breen believes that there is *a priori* knowledge in the infant of both breast and penis, which she understands to be one of Bion's proposals, the breast representing "the link between self and other" while the penis "refers to the link between the parents," a primitive notion of triangulation with the child as the third. Unlike Klein's developmental stage model, she sees these two symbolizations as different figurations that "coexist in the unconscious" (p. 127).

The author notes that there has been criticism of her term "penis-as-link" because it allegedly privileges the penis and is a return to the "biological penis" (p. 128). For Birksted-Breen, these criticisms "conflate unconscious representation and value, body and representation" (p.128). She states that "(r)epresentations have a basis in the body" but "are not the body" (p. 128). One cannot equate body and mind but one cannot ignore the body either, according to the author. In this spirit she

is specifically interested in the "male element and its structuring role in the unconscious" as well as "the role of the father as the other object of the mother," specifically as a representation, i.e., the "father in the mother's mind which is an aspect of the mother's "bisexual mental functioning" (pp. 129, 131). Birksted-Breen notes that the "receptive and penetrative are not the prerogative of one sex or the other" and that neither male nor female "possess the phallus" and that both are effected by exclusion from the primal scene (p. 129). It seems that for the author the penis-as-link representation serves to separate the "two" of the mother-child couple, introducing the idea of a link between mother and father that excludes the child in the Oedipal configuration. The child experiences and must find a way to deal with "lack." Failure to do so results in a misguided attempt to "have or to be the phallus," a way of being that the author posits limits mental space, with the self and world then more binary: good v.bad, have v. have not, masculine v. feminine etc. In contrast, working through the three person representation and it's inherent lack leads to a more complex view in which "opposites" can co-exist, as the author notes, a complexity described by Klein in her writing on the depressive position, where the object can be felt to be "good and bad at the same time" (p. 130).

Birksted-Breen posits that it is the failure to internalize the "penis-as-link that leads to the common clinical picture of the person who" pulls away from his or her objects for fear of being engulfed but then feels abandoned and wants to get back again in a new endless to and fro" (p. 131). In this sense, the author writes, containment "involves a bisexual aspect", the mother/analyst being able to "take a perspective" on the maternal dyad, a third or paternal position (pp. 131-132). She details how the "phantasy of the phallus" is a search for "such structuring containment but that it leads to a "rigid or restricted" mental functioning, in which there is no space "for a Feminine and its specific qualities" (p. 132). In contrast to this rigidity and limitation that is related to either "fusion or fragmentation," the author describes how the containment related to a structure with a third position allows for "(m)ental space and the capacity to think" allowing for "separateness and link between internal objects, self and other" (p. 136). The author provides helpful clinical examples that detail the experience of these structures in analysis.

ALL KINDS OF TIME

In the next chapter, "Time and the Après Coup," time takes center stage as a foundational aspect of psychoanalysis. Birksted-Breen contrasts two different conceptions of time in psychoanalytic practice, developmental time and the time of après coup, that are typically associated with the British and French psychoanalytic "schools" respectively. In terms of the concept of après coup, the author outlines three different meanings of the term: 1. simply "later." 2. "(a) movement from past to future" in which an event in the past only has a specific "effect later on," corresponding to Strachey's translation as deferred action. 3. An event is perceived but only assumes a specific "meaning retrospectively" (pp. 139-140). She notes that while some French analysts use the second definition more, such as Laplanche, others more typically focus on the third "retrospective" meaning. Birksted-Breen also details why she believes that British analysts, while not using the term "après coup," nonetheless employ it implicitly in their clinical work, which usually, but not always, emphasizes "here and now" interpretation.

A "complex temporality" including après coup and transference, infuses the use of "here and now" interpretation according to Birksted-Breen (p. 142). She cautions that the use of use of "here and now" interpretation without keeping the past in mind can serve defensive purposes just as an overemphasis on relating everything to the past can serve as defense and lead to impasse. She notes that the "past" in analysis is "always a past as reinterpreted in the present" […]" only the present can be known" (pp. 142-143). Also, this "present" can "*modify the past*" (italics in original), always in a particular way depending on the specific analytic dyad (p. 143). Birksted-Breen also describes how trauma must be "experienced in the here and now" in order to eventually be worked through and put into the past tense (p. 144). More disturbed analysands, she notes, will seek "timeless" states in and out of analysis.

In terms of the development of the sense of time, Birksted-Breen posits that the first tolerable experience of time is linked to the mother's Bionian capacity for reverie. She names the time it takes for the transformation of beta elements in the mother's psyche "reverberation" time (p. 146). She writes that it is the introjection of this by the infant that leads to the development of the ability to sense and tolerate time. The

author emphasizes the importance in analysis of often lengthy periods of reverberation time, in which the analyst might have to contain the analysand's projections before the analysand develops the capacity to contain themselves.

Birksted-Breen contrasts the reassurance of time as repetition, experienced in the heartbeat, and the "rhythm of rocking and sucking" with the hatred of time as non-repetition, linked to the idea of the inevitability of loss and death (p. 148). Seemingly out of the blue, Birksted-Breen states that this "biological substrate" is something that Lacan wanted to eliminate from psychoanalysis, along with the fixed length session. She states that in her view these "facts of life," of the biological inevitability of death and limits in "interplay" with what is required for "psychic survival," is what "makes up the analytic field," linking it to the necessary presence of both developmental time and the time of the après coup in any work she would call psychoanalysis (p. 148). She details how in her view the analyst is the "guardian of time," introducing a "third element" that "stops eternal symbiosis" (p. 148). If I understand her correctly, she also implies that the fixed length session provides the consistency of time necessary for psychic survival, like the aforementioned "biological" rhythms.

I believe that Birksted-Breen's comments on Lacan in this section are based on a misunderstanding of his position and of how most Lacanians practice. My reading of Lacan indicates to me that he *is* concerned with the biological substrate, but in terms of the patient's conscious and unconscious experience of and psychic organization around his/her experience of this "given." Soller (2016) provides specific quotes from Lacan's works regarding his inclusion of the biological substrate of the body, including that one must "include the body" in order to conceptualize affect and that "in order to enjoy, a body is necessary" (pp. 51-52). Soller (2016) also details Lacan's theorizing regarding the "imaginary" body and the "drive-ridden body" (p. 52).

Also, in my view, the variable length session, as well as the Lacanian focus on a structural diagnosis, honor both the need for the introduction of a "third element," as Birksted-Breen calls it, and the necessity of providing what is needed for "psychic survival," in this case in the analytic setting. If anything, I would see the fixed length session as running the greater risk of collusion in terms of an "eternal symbiosis," an

interminable analysis (p. 148). It may be that Birksted-Breen's perspective on Lacan is based on limited consideration of his later work and the work of other Lacanian authors. Her only Lacanian citation is the *Ecrits*, which encompasses but a small portion of Lacan's oeuvre.

Many Lacanians might agree with Birksted-Breen's view that analysis involves both types of time, developmental and après coup, a "slow maturation" across the analysis, which is in part a "restructuring of the past" in the present (pp. 149-150). As Birksted-Breen cogently puts it, "retroactive resignification is developmental progression" (p. 151).

INTERPRETATION

At the start of the next chapter, entitled "The Work of Interpretation," Birksted-Breen makes a strong argument for the importance of the analyst's use of evenly suspended attention to "catch the drift," as Freud put it, of the patient's unconscious communication "with his own unconscious" (p. 159). She cautions that the more recent focus on enactments and increased interpretive activity threatens the use of this crucial component of the analytic work. In fact, Birksted-Breen uses the phrase "work of interpretation" to emphasize this unconscious aspect of interpretation (p. 158). She sees the work of interpretation as an aspect of the analytic setting, a setting that facilitates unconscious communication between analysand and analyst. The author also includes the analyst's unspoken interpretations and "psychic work outside of the setting" as part of the analytic setting, which she notes will be uniquely created by each analytic dyad (p. 160). In Birksted-Breen's view, this sort of "feminine receptive mode" "of *reverie*, is what promotes the forward movement of the analysis" (p. 160 and 163).

Through clinical example and a rich variety of quotes from other authors, Birksted-Breen details the benefits and risks of a focus on the use of "evenly suspended attention" (p. 159). She notes questions regarding to what degree the fruits of such reverie need to be "filtered through the analyst's secondary process" before being proffered to the analysand (p. 161). She states that a "close process attention" approach to defense analysis, such as Gray proposes, does not allow the type of beneficial regression and openness to unconscious communication that "unfocused attention" can facilitate (pp. 161-162). On the other side is

the danger that the analyst, in a more regressed state of openness, confuses what properly originates within themselves for something that originates in the analysand, whether that is based on a specific countertransference, an overvalued idea, or a cherished theory. Birksted-Breen, quoting Racker, also warns that the "receptive attitude" of reverie can go too far, leading to excessive, passive reverie at the expense of "a more conscious activity which involves looking for patterns and conceptualising. There needs to be a balance …" (p. 171). For Birksted-Breen though, reverie is the creative font, the "motor of the movement forward of the analysis" (p. 172).

MORE TIME

Returning to the issue of time in the next chapter, entitled "Reverberation Time, Dreaming and the Capacity to Dream," Birksted-Breen describes how many analytic writers, starting with Freud address the development of the sense and experience of time, linking it to biological rhythms and the rhythmic interactions with the mother. In this chapter the author focuses on her idea that the mother's capacity for "reverie," in the Bionian sense, is also central to the development of a primitive sense of time and the ability to tolerate time as duration. As noted above, she calls this primitive sense of time "reverberation time" and states that it "shares its roots with the development of an apparatus for "dreaming dreams" "and is the "building block" for psychic development of the depressive position and Oedipal acceptance (p. 175). She holds that all "deep disturbances" involve problems with the experience of time (p. 175).

Expanding on the concept of "reverberation time," Birksted-Breen notes that reverberation time describes a Winnicottian "transitional space" in which what is there is "me and not me" as the mother transforms beta elements into alpha elements in the Bionian sense (p. 178-179). She also mentions that, as Bion described, the significant failure of the mother's reverie results in a "nameless dread" that is an excruciatingly timeless state of terror with no end. In this sense, Birksted-Breen writes that the mother doesn't protect the infant "against the painful awareness of time" but on the contrary, she protects the infant from a timeless "state of terror without end" (p. 181). In this

sense, the concept of containment "describes borders and limits in space and time" (p. 181).

In relation to the analytic situation, Birksted-Breen, citing Baranger et al, notes that containment involves putting a timeless "pure trauma" into the context of space and time via the historicizing process of après coup (p. 182). She writes that no matter whether the analyst is interpreting "past or present," "the time within the analytic setting is always now *and* then" (p. 183, italics in original). The reverie of the analyst is what makes this possible, she notes.

KEEPING BOTH EYES OPEN

The next chapter, "Taking Time, the Tempo of Psychoanalysis," expands on themes introduced in the last chapter. Birksted-Breen emphasizes the importance of reverie and "reverberation time" as a third temporal aspect. She argues that without these, the "here and now" interpretation method, defined by her as involving "frequent interventions aimed at describing the patient's experience and feelings toward the analyst" becomes something other than psychoanalysis and that such a method runs a higher risk of devolving into concrete thinking on the part of analyst and patient, which she associates with impasse (p. 193).

The author provides an illustrative and informative clinical example of such an impasse, a type of impasse that she believes is fairly common, in which the analyst is holding on to a "psychoanalytic view" as an overvalued idea that becomes concrete thinking while experiencing distress at the patient's alleged incapacity for symbolic "analytic" thought (p. 198). Only through the reestablishment of a capacity for reverie is the analyst able to recover her ability to actually think symbolically and move beyond the impasse. In this way temporality is reinstated in the analysis when a focus on a goal, in this case the goal of symbolic thinking on the part of the analysand, is relinquished, and the "non-chronological time of reverie" allows for thinking from a third position—what Birksted-Breen calls "theory in practice" to occur (p. 202).

While noting the variety of contents of reverie as described by various analytic thinkers, in this discussion, Birksted-Breen focuses on "the single images" that emerge spontaneously from the state of reverie of the analyst (p. 203). In a helpful clinical example she demonstrates how

a visual image can bring together the more concrete and more symbolic modes of thinking and serve as a "building block towards more complex and abstract thinking" via a meeting ground for analyst and analysand, thus avoiding prolonged impasse (p. 207). Birksted-Breen notes that a concrete sensory image that can be felt to be outside the analytic pair can be less threatening for and more useful to patients "who are intolerant of the affective closeness of the analytic relationship" and who are less capable of "complex symbolic functioning with a highly charged affective situation (p. 208). She writes that such images experienced as external to the dyad can help mitigate shame, humiliation, envy and jealousy because "analyst and patient are together" looking at a third "outside object," in a kind of "transitional space" (p. 209). For Birksted-Breen the use of a visual image by the analyst is a needed move toward concrete thinking via a "formal regression," "grounded in the analyst's affective and bodily experience," through which the analyst can meet the patient and use an image as "an elaboration" that is "concrete, metaphoric and linguistic, thus avoiding impasse" (p. 211).

In the next chapter, Birksted-Breen presents the concept of bi-ocularity, which she describes as an "essential function of the analytic setting, the aim of which is to foster symbolic thinking" (p. 213). Bi-ocularity is defined as having "one "eye" on the understanding and interpretation of defensive mechanisms, while the other "eye," unfocused, preserves a gap for a "something else" to develop" (p. 214). This "something else" occurs in a here and now that is connected to a "there" of phantasy, the unconscious, psychic reality, and the past as always reformed via après coup. It can be an explosive madness and passion that erupts in the protected here and now of the analytic setting, a setting that is both real and not real, an in-between paradox, as the author describes it. She also notes that the two different foci of bi-ocularity in itself "fosters a triangularity" in the setting, which is necessary for the development of the capacity to symbolize.

Birksted-Breen emphasizes the importance of keeping the unconscious and the non-represented in mind in a state of tension to vitiate the risk of "collapsing into a 'you and me'" as whole objects in an actual relationship "without any otherness" (p. 216). She also stresses that the processing of this experienced tension that the analyst maintains takes place on an ongoing basis, consciously and via unconscious to unconscious communication, and that it also takes time, often a long time, to

become available to analyst and analysand via reverie and the "work of interpretation," in the sense of "making sense" (p. 217).

For the author, reverie has a specific meaning linked to the work of Bion. It involves a "passive and receptive" attentiveness that is directed toward the analysand as well as the "time of sojourn""in the analyst's mind" (p. 218). Birksted-Breen understands reverie as also "mainly the unconscious process of 'dream work alpha,'" which leads to her particular interest in "visual images which suddenly appear" in the analyst's mind in that "in-between," as a function of bi-ocularity, that allows for the "something else" to develop (p. 219). The author cautions that "too much interpretive activity," too much making sense, can kill the life force of an analysis; the reverie that is Eros can "overcome repetition and deadness" (p. 220). Birksted-Breen also describes bi-ocularity in terms of two types of contact, the maternal and paternal function, i.e. "taking in" and holding, as well as "separating and taking a third position" (p. 220).

In an extended clinical example the author demonstrates how she uses her own suddenly appearing visual images and how she utilizes the "gap" of "then and now" in her work (p. 223). She also shows the reader how she uses the concept of bi-ocularity to open space for the patient, a "dream" space of multiple perspectives and multiple temporalities (p. 223).

IS IT THE END?

In the final chapter Birksted-Breen explores a specific indication of readiness to terminate, "the patient's spontaneous representation of the process of psychoanalysis" (p. 231). She links changes in both symbolic capacity and the relationship to temporality to the representation of the analytic process, and writes that the spontaneous representation of the process indicates that it has been internalized. The author points out that she uses the term representation to indicate "'idea' and 'image'," as well as "both conscious and unconscious aspects" of the representation (p. 234). She notes that as the representation is of a "process," it necessarily involves a temporal experience" of time as duration" (p. 234).

Through clinical examples, Birksted-Breen demonstrates several manifestations of the representation of the analytic process. She

summarizes by explaining that the "representation is of an ebb and flow of progress and regression as a constant feature of life, of time as necessary for working through" (pp. 244-245). She states that it is the toleration of frustration and loss, the "toleration of time," "that leads to representation" (p. 245). In addition, the author notes that good endings typically come with the sense of being alive, not just surviving. In her view, it is a kind of pleasure that gives meaning to life.

In summary, in this outstanding volume, about half of which is previously published but revised journal articles and half new material, Birksted-Breen shows us the depth and breadth of a fully engaged, thoughtful psychoanalytic thinker who, as she describes, has done her "own 'psychic work' over a number of decades" (Acknowledgments page, not paginated). The result is a book that is clinically near while bringing new theoretical ideas to life. Birksted-Breen, through her commentary on and inclusion of a range of thinkers, British, French, Italian, Canadian, South American, and American, past and present, encourages the reader to think beyond the "narrows" of any one particular school or epoch. Of particular value, I believe, is her emphasis on the unconscious and sexuality, two critical foci that have waned in importance for many analysts in recent years. Her writings on time and her understanding of what makes for a psychoanalytic stance in the consulting room also introduce new and clinically helpful ideas. This book should be of interest to seasoned clinicians looking to be challenged to think beyond their own ways of working. This book will also be of interest to candidates and training programs because of its detailed, sophisticated consideration of the basic tenets of setting, sexuality, the unconscious and time—some of the foundational aspects of the work we do.

I appreciate and agree with Birksted-Breen's emphasis on the need to think beyond any one school of thought, not on a superficial level but in a deeper way. I recall meeting a senior colleague who, despite being a well-known and highly respected clinician, supervisor, teacher, and author within one school, sought out formal affiliation with another institute to broaden and deepen his understanding. I was impressed with his desire to undertake such an endeavor. While I imagine there are not many of us who would commit to something of that scope, I do believe that it takes much more than reading widely or attending a conference to truly deepen ones understanding in a way that has a significant impact

on our thinking and practice. I believe that one has to immerse oneself in some fashion in the "culture" of another way of thinking. I was trained in a fairly eclectic IPA program with exposure to a variety of ways of thinking. Since then I have had the opportunity to immerse myself in a Lacanian training program, not as a formal candidate but as a student nonetheless, taking seminars, hearing case presentations and getting supervision on cases. While I am not a Lacanian, I have found such an experience of a profoundly different psychoanalytic culture to be enormously refreshing and enriching to my thinking and clinical work. I have been struck by how welcoming this Lacanian program has been to an outsider and how such flexible inclusiveness seems to benefit the visitor as well as teachers and candidates. Perhaps this type of inclusiveness is something that more programs and societies might consider.

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Anderson: The Wisdom of Lived Experience: Views from Neuroscience, Philosophy, and Metaphysics (J. A. Wheeler Vega)

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BOOK REVIEWS

THE WISDOM OF LIVED EXPERIENCE: VIEWS FROM NEUROSCIENCE, PHILOSOPHY, AND METAPHYSICS. By Maxine K. Anderson. London: Karnac, 2016. 146 pp.

This is a book about polarization in psychoanalysis that is likely to be polarizing, and in ways that reflect perennial divisions in the field. Anderson has previously written about the development of the self, enactment, Shakespeare, concrete thinking, and clinical theory and technique; from her earliest writing, she has used ideas drawn from object relations theory and, in particular, the work of Bion. This book integrates many of her previous interests along with some that reach well beyond psychoanalysis.

Anderson's book is very ambitious and covers a lot of ground in 146 pages from cover to cover. Her main theme, approached from diverse angles, is that an orientation to the world that privileges representing, predicting, and controlling it—what she calls *left-brain* thinking—is fundamentally mistaken, and needs to be corrected by shifting towards an opposing orientation—that of the *right-brain*—which privileges feeling over thinking and intuition over rationality. In eight chapters, Anderson introduces and then fills out ideas about hemispheric specialization, dialectical thinking, personal identity, concreteness, and disavowal. She also explores work on implicit and explicit memory, unconscious fantasy, and hallucinatory phenomena. She looks at the relevance of poetry and metaphor to the structure of the human mind, and discusses some personal experiences in her quest to learn more about the topics of "being" and "becoming," including her work in an interdisciplinary study group.

The subtitle of the book, *Views from Psychoanalysis, Neuroscience, Philosophy, and Metaphysics*, states her interdisciplinary sources but also introduces an ambiguity that either supports or undermines her project as a whole, depending on one's point of view. It is at first unclear why

Anderson would distinguish *philosophy* and *metaphysics* as separate subjects. Metaphysics is usually considered to be a part of philosophy, the group of topics gathered together by Aristotle: the nature of being as such, causation, unity and plurality, kinds of objects, and in recent centuries such questions as the relationship between mind and body. As such, works on metaphysics are to be found sprinkled among the shelves in the philosophy section of a large bookshop. Such bookshops, however, sometimes also have another section called *metaphysics*.

I remember as a student wondering what was in that section that wasn't over with the rest of the philosophy books, and noticing that it looked quite different. Such a section might contain books on subjects like alchemy, aliens, astrology, clairvoyance, divination, energy healing, Kabbalah, parapsychology, reincarnation, shamanism, Tarot, and Wicca, to name but a few of a large miscellany. Their authors may use the term *metaphysical* in a sense both literal and esoteric to mean things "beyond the physical." These texts play by their own rules and usually eschew conventional religious, scientific, and philosophical vocabularies, though they may cleave to their own idiosyncratic vocabularies within recognizable patterns.

On reading through Anderson's book, the apparent redundancy in its subtitle begins to make sense as a kind of slip-of-the-pen. While she generally stays in her sources with writers who are usually found in the philosophy or psychology sections, I think Anderson is drawn towards that other part of the store. In terms of polarizing reactions, I think the book is more likely to appeal to readers who might browse that section than to people who would not give it more than a glance. I will say more about these two broad groups below.

Left-brain and Right-brain

The central theme of the book is polarization, and in particular the contrasted characters and functioning of the two cerebral hemispheres in humans. This contrast, between left-brain and right-brain, is made throughout. In Chapter 1, Anderson introduces the work of McGilchrist. His book, *The Master and His Emissary,* is based around differences in lateralization of function. The left hemisphere is characterized as responsible for "focused attention, fine motor co-ordination, development of language, manipulation of objects - in short those qualities that allow for the exploration and conquering of nature and her secrets" (Anderson,

p. 6), and for "processing input in a more sequential fashion … focused exploration, domination, and power, relating to anything outside of its own efforts as something to master, to manipulate, or to dismiss" (p. 7). In contrast, the right hemisphere produces "intuitive, implicit, mostly unconscious, sensory-based experience, in the moment, which remains open, receptive, and wide-ranging" (p. 5) and whose operation is "open, compassionate, non-judgemental, and patient, reminiscent of a sturdy compassionate parent" (p. 6). Anderson's main argument in her book is that psychoanalysts have, like everyone else, overvalued the functions of the left-brain—language and logical thought—and undervalued the functions of the right: emotion and intuition.

In Chapter 2, she fills out McGilchrist's ideas further and brings the work of others to bear on her claim that, "we are fooled by the allure of the left [hemisphere] in its promises of clarity, and have overlooked for centuries the quiet depth and *wisdom* offered by the right hemisphere" (p. 25, italics added). She asserts that, contrary to appearances, it is in fact the right that is the dominant cerebral hemisphere, and furthermore that, in many ways, it should be:

> Noting the title of McGilchrist's book, the right hemisphere is the very quiet Master (affect) and the left hemisphere is the noisy Emissary (cognition) who carries out the will of the Master by giving him voice and representation, but that it might be easy to lose sight of who is master and who is Emissary, because the (noisy) products of cognition offer themselves as evidence of being primary, and, thus, as being the Master … while the true Master remains imperceptible … until it has been given voice and representation by the Emissary. [p. 34]

Anderson also gives a lot of weight in Chapter 2 to the first-person account (*My Stroke of Insight*) by neuroanatomist Bolte-Taylor of her left-hemisphere stroke (I think as much because of its personal nature as for her impersonal knowledge as a brain scientist). Bolte-Taylor observed and characterized her left-brain function as it was returning to be "judgemental … obsessive … and 'chatter'" (Anderson, p. 40). On the other hand, she asserted that, "at the core of my right hemisphere consciousness is a character that is directly connected to my feeling of deep

inner peace. It is completely committed to the expression of peace, love, joy, and compassion in the world" (p. 41). Anderson comments: "It is evident that she has become a right-brain advocate" (p. 40).

Although Anderson makes some nods towards balance in her book, noting at points the importance of integrated left-brain and right-brain functioning, she is also clearly a right-brain advocate; or, perhaps better, an anti-left-brain campaigner. For example, where Anderson writes of "the tyrannical hold of the power-based left-brain function" (p. 78) we clearly hear (sagittal) lines being drawn and sides being taken.

Part of Anderson's anti-left-hemisphere activism is a now somewhat worn anti-theoretical stance: "While theories are important as scaffoldings for learning and as ways to structure experience, they also parse the flow of experience, as does language" (p. 113). Anderson goes on more specifically: "Ways to categorize certain psychic phenomena, such as 'transference' or 'resistance', aids in organizing, but also inevitably contributes to freezing the frame. This is similar to the mother's label 'yellow' for the patch of sunshine on the nursery wall, closing down the child's wonder about the sun" (p. 114). The notion of "parsing experience" implies a contrasting base of human experience independent of language, which could be carved up another way. It may be argued otherwise, that language is *constitutive* for almost all distinctly human experience: without "yellow" and "ray" and lots of other words and concepts a child will never be able to "wonder" "about" "the sun," in the way that you and I can, but will be left staring at the wall in confusion. *Pari passu* for concepts like transference and resistance that *constitute* the analytic frame: without explicit theories we are left to draw upon implicit ones—and these may amount to our idiosyncratic moods and prejudices, personality and temperament, as much as anything.

The Tender and the Tough

In his *Pragmatism*, William James argued, "The history of philosophy is to a great extent that of a certain clash of human temperaments … . Plato, Locke, Hegel, Spencer, are such temperamental figures."[1] (p. 11).

[1] James, W. (1975). *Pragmatism* and *The Meaning of Truth*. Cambridge, Mass.: Harvard Univ. Press., p. 11.

Before laying out new terms for these differing tempers, James refers to the traditional core division between *rationalism* and *empiricism*: "'empiricist' meaning your lover of facts in all their crude variety, 'rationalist' meaning your devotee to abstract and eternal principles" (p. 12). James lists a number of other contrasting pairs of character traits or qualities (several of them technical or archaic) and groups them under two banners, extending the original contrast, as "'tender-minded' and 'tough-minded'" (p. 13) respectively. Some *tender-minded* traits include idealism, optimism, religiosity, and dogmatism, while in the other camp, some *tough-minded* counterparts are materialism, pessimism, irreligion, and skepticism.

James also notes a characteristic antagonism between personalities who belong markedly to one or the other group: "The tough think of the tender as sentimentalists and soft-heads. The tender feel the tough to be unrefined, callous, or brutal." (p. 14). He then adds a further psychological observation which he does not elaborate: "Each type believes the other to be inferior to itself: but disdain in the one case is mingled with amusement, in the other it has a dash of fear" (p. 14). Though not spelled out, it is implied that the tough look down upon the tender with derision, and the tender regard the tough with apprehension. Why might this be? For the tough, the tender may seem childish, fantastical, and silly. For the tender, the tough-minded may appear unrestrained by sentimental considerations and so liable to domination and violence.

Hegel is a rationalist philosopher *par excellence* and Anderson introduces a Hegelian concept in Chapter 1 that she uses throughout her book, *Aufhebung*—often translated as sublation or sublimation—drawing from McGilchrist and the scholarly integrative work of Jon Mills. Here is Anderson's outline of Hegel's idea:

> This concept provides a guide for a universal process of evolution and transformation involving the simultaneous alteration and preservation of vital aspects of what has gone before. Hegel suggests the model of the flower bud transformed into the blossom and then into the fruit as suggestive of the model of alteration and preservation in the carrying forward of vital biological processes. [p. 7]

She comments also on the key element of progress in the concept: "preservation and elevation of aspects of each phase by the process" (p. 8), "elaboration and growth" (p. 8), which is a notably *optimistic* view, amongst other things. She gives various examples throughout the text, for instance: "the annihilation of the self in Buddhist tradition might be the dissolving of the boundary of one's individuality by pouring oneself out into a larger vessel, as it were. As bud into flower into fruit (*Aufhebogen*) [sic] one is transformed or mingled into the more complex manifestations of an ultimate unity" (p. 107).

Bertrand Russell, to whom I will refer further shortly, discusses what were at his time called "evolutionary philosophies." He means specifically the philosophies of progress propounded by Hegel, Herbert Spencer, and others. Russell describes the conception: "A process which led from the amoeba to Man appeared to the philosophers [of evolution] to be obviously a progress … . Hence the cycle of changes which science has shown to be the probable history of the past was welcomed [by them] as revealing a law of development towards good in the universe."[2] In Hegel's version of *idealism*, this is the notion that all being progresses inevitably through sublation to an eventual perfected unity in the Absolute. *Das Absolute* is Hegel's concept of the unity of mind and world, the wholeness of being, which his complex historical-dialectical method was intended to demonstrate. Russell argues that these philosophies commit the error of overgeneralizing the concept of evolution from its proper empirical domain of biology and transforming it into a general metaphysical principle that applies to everything. As James notes, "Absolutism has a certain sweep and dash about it … " which can be quite intoxicating.[3]

Another way that the tough-versus-tender division tends to emerge in psychoanalysis is in matters of technique. For instance, where Anderson gives brief clinical examples informed by her ideas, a couple of terms that she uses are "recovery" (p. 43) and, more frequently, "rescue." For example: "For the rescuing [therapist's] mind to function,

[2] Russell, B. (1918). *Mysticism and Logic and Other Essays.* London: Longman's, Green and Co., p. 24.

[3] James, W. (1975). *Pragmatism* and *The Meaning of Truth.* Cambridge, Mass.: Harvard Univ. Press., p. 17

these disturbing arousals must be received, registered, and represented as images and words" (p. 68); "These ongoing references to the rescuing mind, and the seeking of such even amid the ravages of considerable psychic trauma, echo Bion's preconception of in-born searching for the receptive mind" (pp. 72-3).

These metaphors of rescue and recovery owe partly explicit debts to Bion's concept of container-contained. This is one place in the book where Anderson acknowledges a necessary balance of left- and right-brain functions. As another locus for polarization, however, tender and tough temperaments are likely to line up quite differently in relation to Anderson's language of "rescuer" as the central role and identity for the therapist.

Mysticism and Logic

In his essay *Mysticism and Logic*, Russell focuses more closely than James on the opposed roles of *intuition* and *intellect* in the history of philosophy. The title of his essay is ambiguous: It names two different approaches to understanding, on the one hand, and it also links mysticism with the logical method that it sometimes uses to get itself shelved with the philosophy books. For Russell, mysticism is, essentially "a certain intensity and depth of feeling in regard to what is believed about the universe"[4] (p. 10) and is paired with "the belief in *insight* as against *discursive analytic knowledge*: the belief in a way of *wisdom*, sudden, penetrating, coercive, which is contrasted with the slow and fallible study of outward appearance by a science relying wholly upon the senses."[5] He contrasts such thinkers as the empiricist philosopher Hume and the Romantic poet Blake in this light; he notes of the latter, "in Blake a strong hostility to science coexists with profound mystic insight."[6] This is the first of the senses of "mysticism" and "logic" in his title.

In Chapter 5, Anderson equates the *Enlightenment* and *Romanticism* with left-brain and right-brain functions respectively. There she outlines

[4] Russell, B. (1918). *Mysticism and Logic and Other Essays*. London: Longman's, Green and Co., p. 10.

[5] Russell, B. (1918). *Mysticism and Logic and Other Essays*. London: Longman's, Green and Co., p. 14, italics added.

[6] Russell, B. (1918). *Mysticism and Logic and Other Essays*. London: Longman's, Green and Co., p. 9.

the work of Tweedy, whose book *The God of the Left Hemisphere* discusses the poetry of Blake as a champion of the "right" against the forces of the "left." Referring to Tweedy's account, Anderson writes, "Blake portrayed 'Urizen' ('your reason'), which we would think of as left hemispheric function, to gain God-like status *in its own eyes*, purely by its capacities of division, abstraction, and categorization" (p. 86). Differences about the function of poetry and the role of poets may arise here: is it the work of poets to make us *feel* something, or to *reveal* things to us?

Russell suggests that mystical beliefs arise:

> … with irresistible force in certain moods, which are the source of most mysticism, and most of metaphysics. While such a mood is dominant, the need of logic is not felt, and accordingly the more thorough-going mystics do not employ logic, but appeal directly to the immediate deliverance of their insight. But such fully developed mysticism is rare in the West. When the intensity of emotional conviction subsides, a man who is in the habit of reasoning will search for logical grounds in favour of the belief which he finds in himself.[7]

While a more direct or thorough-going mystic may simply assert revelatory knowledge—*this has come to me and thus is true*—most of the mysticism encountered in philosophy is of the variety Russell terms *logical mysticism*, "which appears, so far as the West is concerned, to have originated with Parmenides, [and] dominates the reasonings of all the great mystical metaphysicians from his day to that of Hegel and his modern disciples."[8] This is the second meaning of "mysticism and logic" in the title of his essay: the union of intuition with rationalization, by which a belief arrived at in a "certain mood" is subsequently supplied with "logical grounds."

The structure of Anderson's book as a whole is "logical" in that it musters a great variety of apparently scientific evidence and philosophical ideas to support her beliefs about the opposing values of *affect* and *cognition*, and *intuition* and *reason*. In many places, however, difficult

[7] Russell, B. (1918). *Mysticism and Logic and Other Essays*. London: Longman's, Green and Co., p. 21.

[8] Russell, B. (1918). *Mysticism and Logic and Other Essays*. London: Longman's, Green and Co., p. 13.

terms and concepts are used with little direct explanation, as if they were common knowledge or the terms were self-interpreting.

Unsaturated and Obscure Ideas

Many of the concepts in Anderson's book remain difficult even after close reading, including such key terms as *wisdom* and *lived experience*. For instance, Anderson offers a manifesto in her Preface, full of opaque concepts that remain so through the end of the book:

> In the past several years, my own search as a psychoanalyst has been for ways to understand *deeper realities* initially inspired by Wilfred Bion's notations about "*becoming*": that we cannot approach the *deeper aspects of reality* by intellectual and verbal means; the *ever present flow of such realities* that *evade the grasp of thought* and conscious observation can only be *approached* as we can *trust* in our *more primary modes* of *embodied, lived experience*. [p. xvi, italics added]

Lived experience is a term used often by Ogden[9] with associations to Bion's work on learning.[10] Though she uses the term in the title of her book, and refers in several places to Ogden's works, Anderson does not make this lineage as explicit as one might expect. And though the concept is *used* it is never actually *defined* in the book. The reader may wonder, for example, with what is *lived experience* to be contrasted? Unlived experience? Dissociated experience? Potential experience?

There are many other examples of ideas that remain difficult though appearing several times in the book: Anderson writes of the need for "trust and faith" (p. xxiii, p. 93, p. 104) in psychoanalytic work; in a short clinical example she writes, "*impatience* amid *doubt* (my initial defensive startle) may give way to *patience* amid *awe* (an *opening of the mind* via expansion of *inner space*) as *the path* toward the *deeper reaches of reality*" (p. 106, italics added); similarly with: "the process of coming alive" (p. xx), "awakening" (p. xx), "becoming" (p. xxii), "trust and awe"

[9] See Ogden, T. H. (1988). Misrecognitions and the fear of not knowing. *Psychoanal. Q.*, 57: 643-666.

[10] See Bion W. R. (1962) *Learning from Experience*. London: Heinemann.

(p. xxiii), "vitalizing function" (p. 15), "true dialogue" (p. 98), and "freezing the frame" (p. 114).

Here are two ways to interpret difficulties understanding these terms. The first uses Bion's notion of *unsaturated* ideas, extended and applied to analytic technique by Ferro.[11] A *saturated* concept or interpretation specifies, delimits, differentiates, excludes, makes definite. In contrast, an *unsaturated* one is inviting, open, generative, continuous, and fuzzy. It is the work of the mother's or analyst's saturating alpha function to give meaning to the infant's or patient's unsaturated beta elements. In both cases too much—*oversaturation* we might say—may be as bad as too little. On this interpretation, Anderson is using *unsaturated concepts* that open up rather than closing down the creative reader's possibilities and potential for making meaning from the text.

The other interpretation uses the language of *obscurity*. I recall seeing Derrida lecture on the subject of the death penalty at The New School around 1999-2000. I was struck by a characteristic way of dealing with questions. Someone would ask, *Professor D., you say so-and-so, but what about Justice or whatever?* Derrida would reply something like, *You want me to talk about Justice or whatever, but the concept of Justice or whatever is obscure. Next question.* I remember thinking at the time that this was a rather cheap way of disposing of earnest graduate students. Yet, it was brilliant rhetoric, and also pointed up a problem with venerable concepts such as Justice or Wisdom, whose meaning and usefulness may be taken for granted *even in philosophy*, whose business is to take nothing for granted.

Anderson offers some of her own final insights near the end of the book, in Chapter 7: "*Faith … might simply be trusting more in our intuition than in our intellect*, and that faith might be sorely tested by the allure of the intellect and the unsettling of doubt" (p. 121, italics in the original); "Privileging the receptive, intuitive aspects of the right hemisphere invokes the process of *being* rather than *thinking about* reality" (p. 121, italics in the original). Anderson ponders, "Are these musings in themselves explorations into the nature of reality? Are they glimpses of the wider reality beyond our usual view?" (p. 121). These at least are clear

[11] See Bion W. R. (1962) *Learning from Experience*. London: Heinemann.; Ferro, A. (2002). Narrative derivatives of alpha elements. *Int. Forum Psychoanal., 11*(3): 184-187

questions and ones to which I think readers are likely to give polarized answers.

William Burroughs recites: "Just checking your summer recordings. When you spliced yourself in with another recorder, you activated all … recordings in me, and at the same time deactivated the recordings in yourself, and transferred them to another machine. A glimpse of wisdom … such wisdom in gusts, drifting down a windy street, half-buried in sand."[12] We may *feel* something, maybe something intense, when reading this or, better, hearing Burroughs speak these words in his parched, sibilant drawl. We may *associate* to these words, perhaps to the analytic situation or other relationships. But have we *learned* anything from this experience; has something been *revealed* to us? Of the many difficult ideas in Anderson's book, *wisdom* remains the most mysterious of all.

JASON A. WHEELER VEGA (NEW YORK, NY)

IMMIGRANTS AND REFUGEES: TRAUMA, PERENNIAL MOURNING, PREJUDICE, AND BORDER PSYCHOLOGY. By Vamik D. Volkan. London: Karnac, 2017. 118 pp.

Vamik D. Volkan has been writing about migration since the early 1970s, and ironically we find that the subject is more relevant today than ever. While there is little in this slim book that is new, it is most timely at this point, when the world is grappling with a refugee crisis the likes of which we have not seen since the end of the Second World War.

Volkan is the right person to tackle this subject because of his vast experience with it, both professional and personal. He has authored, coauthored or edited over fifty psychoanalytic and psycho-political books, and over four hundred scientific papers, or book chapters. His experience in international relations is extensive. He has garnered numerous awards for his work and even been nominated for a Nobel Peace Prize

[12] Burroughs, W. S. (1981). *Nothing Here Now But The Recordings*. Industrial Records.

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Volkan: Immigrants and Refugees: Trauma, Perennial Mourning, Prejudice, and Border Psychology (S. Richman)

Sophia Richman

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questions and ones to which I think readers are likely to give polarized answers.

William Burroughs recites: "Just checking your summer recordings. When you spliced yourself in with another recorder, you activated all … recordings in me, and at the same time deactivated the recordings in yourself, and transferred them to another machine. A glimpse of wisdom … such wisdom in gusts, drifting down a windy street, half-buried in sand."[12] We may *feel* something, maybe something intense, when reading this or, better, hearing Burroughs speak these words in his parched, sibilant drawl. We may *associate* to these words, perhaps to the analytic situation or other relationships. But have we *learned* anything from this experience; has something been *revealed* to us? Of the many difficult ideas in Anderson's book, *wisdom* remains the most mysterious of all.

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on several occasions. His *About the Author* section is quite impressive and daunting; it reads like a Wikipedia page.

As with so many of us, Volkan's research interests are influenced by his personal experiences. Born in Cyprus to Turkish parents, he came to the United States as a young man after having completed his medical education in Turkey. He arrived here prepared to begin advanced training in psychiatry and had a position as a medical intern already waiting for him. This privileged position distinguishes him from most of the immigrants and refugees that we encounter today who face an uncertain future.

We are all influenced by our personal experiences. My own history as both a refugee and an immigrant sensitizes me to some important distinctions between these two categories of migrants. Although Volkan acknowledges a difference between voluntary and forced migration, I wish that he was more explicit about the complex differences and implications of coming to America as an immigrant in search of a better life, versus as a refugee, asylum seeker, or survivor of violence, who is fleeing from persecution. It is my understanding that these categories are not interchangeable and cannot be lumped together because they lead to vastly different psychological experiences with major implications for life in the host country.

My personal experience highlights the differences between these categories of migration. As a child Holocaust survivor, I arrived in Paris with my parents immediately after the war, and five years later we left France for America, under very different conditions. As refugees, my parents were desperate to get out of Eastern Europe, had no financial resources, and little sense of choice about fleeing Europe. Their longing was not for the world left behind; it was for their early life before the war. Their mourning was less for loss of country and more for loss of family and friends. As immigrants to America, five years later, we were no longer fleeing or desperate. We had some resources and we were making a deliberate choice to improve our lives. We relaxed and shifted from a survival mode to living life as fully as we could.

While Volkan recognizes that dislocation can range from forced immigration to voluntary immigration of individuals seeking a better life, in my view, he does not do justice to the effects of these

different states of migration on either the migrant or the receiving country. His emphasis seems to be primarily on the degree of success of adaptation characteristic of voluntary versus forced migration. "However situations of forced exile and other traumas, including life threatening ones, will complicate mourning and adaptation" (p. 8). This general statement, while true, fails to take into consideration the complexity and existential implications of leaving one's country of origin when one's life is in danger versus making a choice to improve one's life. Additionally, the attitude towards the newcomer can vary greatly depending on his immigration status. In the words of the writer, activist, Viet Thanh Nguyen, who as a child, had fled to the US with his parents after the fall of Saigon in 1975:

> I was once a refugee, although no one would mistake me for being a refuge now. Because of this, I insist on being called a refugee, since the temptation to pretend that I am not a refugee is strong. It would be so much easier to call myself an immigrant, to pass myself off as belonging to a category of migratory humanity that is less controversial, less demanding, and less threatening than the refugee … I was born a citizen and a human being. At four years of age I became something less than human, at least in the eyes of those who do not think of refugees as being human.[1]

Despite my quibble with Volkan for blurring the categories of immigrants, refugees, asylum seekers, and torture survivors, I do feel that this book is a wonderful, valuable, and well-timed contribution to a subject that has a major presence in our current social and political landscape. The book is well organized and very informative: it integrates many years of research and practice, presents theoretical and clinical ideas with clarity and vitality. It is divided into two parts, each providing a different perspective on immigration—Part I that of the newcomer and Part II, the host country. In both, he reviews many of his own contributions that he has made over the years. He lays out the theoretical basis for his ideas, presents case material to illustrate mental health issues caused by

[1] Nguyen, V. T. (2018). ed. *The Displaced: Refugee Writers on Refugee Lives*. New York: Abrams Press, p. 11.

uprooting, and he identifies group identity issues that influence the adjustment of the newcomer, as well as the response of the host culture.

In the first part, Volkan reviews psychoanalytic theories on immigrants and refugees. He reviews concepts that he himself had created many years ago, such as *perennial mourning*, *linking phenomena,* and *living statues*. These concepts are meant to describe how immigrants/refugees cope with loss of country, family, identity, and nostalgia. Through case examples, and illustrations of his personal experiences, Volkan describes ways in which refugees and immigrants hold on to small remnants of the lost world—whether physical possessions (*linking objects*) or mental images (*linking phenomena*). Another powerful way of bringing the past into the present is captured in his concept of *living statues*. When parents unconsciously "deposit" their traumatized self and object images related to dislocation into the second generation, they unconsciously use the child to perpetuate their experience. This form of transgenerational transmission of trauma has a long-term intergenerational effect, which relates not only to the individual family, but has an impact on the host culture and affects responses of host communities to the newcomers.

In the second part, Volkan takes on the complicated responses of host communities to the newcomers. I find this second part of the book to be a creative, insightful contribution to our understanding of our current political climate, which is so fraught with conflict and divisiveness. Volkan analyzes our response to immigrants and examines the irrational and developmental sources of prejudice that result in the perception of the immigrant as "Other."

The author introduces the concept of large-group identity, which consists of common shared linguistic, societal, religious, cultural, and ideological factors. Migrants, who belong to another large-group identity, represent the Other. The Other can become the repository of unwanted aspects of the self projected through the mechanism of externalization. In that capacity, the Other is a threat to the large-group identity of the host country and thus becomes a shared target.

I find Volkan's discussion of border psychology and large-group processes particularly helpful in understanding the current political climate of anxiety and prejudice towards immigrants, refugees, and asylum seekers. His writing offers us some insights into violent group hatreds, xenophobia,

and racism during these current political times. Volkan's book ends in the beginning of 2017, with a mention of Donald Trump's election and his preoccupation with border security and his intention to build a wall at the border. In January 2017, when Trump took office, we did not yet have a firm or clear idea about how Trump's isolationist campaign policy would ultimately affect immigration. Since his election, we have been constantly struggling with issues like the Muslim travel ban against people from certain countries, the financing of a border wall, proposed changes in legal immigration policies, and most recently in the summer of 2018, a horrifying new policy of forcibly separating families at the Southwest border by ripping children from the arms of their parents as they seek asylum in America. Using the rhetoric of dehumanization, Trump has characterized immigrants as "vermin" and "animals" from "shithole" countries, which somehow he sees as justification for this heartless, immoral policy. After a harrowing journey to escape violence, asylum-seeking families arrived on our shores only to be ripped apart. Over 3,000 children, some as young as just a few months of age, were forcibly taken from their parents, and then were surreptitiously sent to undisclosed locations all over the United States. Soon it was learned that no plans had been made for reunification of these families once their immigration status was determined. Trump's message to asylum seekers was clear: "Don't come to this country or we'll take your children away."

How can we understand these unprecedented inhumane actions? There is a great political divide in our country and the racist dehumanizing rhetoric of the President fuels it. While obviously he is supported in these actions by part of the country (a majority of Republicans), the rest, as the minority in all branches of government, are horrified but powerless to take meaningful decisive action. Trump's own preoccupation with immigration is notable and begs for explanation. Notwithstanding the dangers of analyzing a public figure, I would like to offer some speculations about the origin of Trump's obsession with the subject of immigration, and do so in the context of Volkan's stimulating ideas about the *transgenerational transmission of migration trauma* as defined in this book. Based on information available in the media and from my perspective as a witnessing professional, I offer some tentative hypotheses about the psychological motivation behind Trump's extreme position on issues of immigration.

Volkan maintains that traumas, which are rooted in the experience of immigrants and refugees, tend to be passed down through the generations:

> Through being reservoirs of deposited images and the tasks given to them in order to deal with these images, children's psychology becomes linked to the history of their families and often these families' ancestors' histories, especially the traumatic ones and various types of prejudice. [p.88]

How did the traumas relating to immigration, which his family endured, eventually impact and possibly shape Donald Trump's attitudes towards immigrants? Here are some hypotheses on the basis of Volkan's theories as laid out in his section on Hosts. According to Volkan, prejudice about the Other who belongs to a different large-group identity evolves during developmental years leading to shared prejudice. Children come to identify with parents' prejudicial attitudes. They become the reservoir of deposited images of trauma, and they are charged with certain tasks such as regaining the self-esteem of parents, or being assertive and taking revenge for family injuries perceived or real (p. 88). The large-group needs to have allies and enemies (p. 89); "the Other belongs to another large-group identity and can become a shared target when unwanted aspects of self are projected through the mechanism of "externalization" (p. xix). Certain groups, who have very different characteristics, are suitable targets of externalization; Muslims, for instance, qualify because of their vastly different ethnic, religious, or ideological beliefs. The *Us* and *Them* division becomes clearer and unfortunately more malignant as well. When Trump refers to the proliferation of migrants as an *infestation* of pests and sub-human species, he stokes what Volkan sees as the greatest fear of the host country, namely, the contamination of large-group identity by the identity of the Other.

Past victimizations allow group members to feel entitled to perform horrifying immoral acts to reverse their sense of victimization. The administration's policy of tearing families apart at the border seems to be an instance of such a reversal. Those whose families were once powerless and seeking to enter the country, are now in control of whether or not others can enter. The traumatized of previous generations are now the perpetrators that turn away families seeking asylum. These

immigrants are not seen as human and so the inhumane treatment is acceptable to advance their agenda.

As an important public figure, Trump's life has been documented, and there are certain facts that are generally known about him and his family of origin. From published reports, we know that his grandparents on his father's side came to the United States from Kallstadt, a small town in Germany during the mass migration at the turn of the 20th century.[2] His grandfather Friedrich Trump came in 1885 in search of economic opportunity, then went back to his hometown to find a bride, and returned to the United States with her. After a short time, she became intensely homesick and they went back to Germany, but the German authorities would not let them resettle there because Friedrich had failed to enlist in the military, as was required of young German men. Hence, they were forced to return to America, which became home to future generations of Trumps.

His mother's family came from Tong, a small fishing village in Scotland. Mary Anne MacLeod, Donald Trump's mother, grew up among poor islanders in a two-bedroom rented cottage crammed with her and 10 siblings.[3] At eighteen, with less than a high school education, she followed her siblings to New York, became a domestic servant, and met Donald Trump's father, a successful real estate businessman. According to her biographer, although the trappings of wealth were very important to her, she had a powerful attachment to the tiny village where she was born, and so year after year, she returned, lapsing into Gaelic—her native language—the minute she arrived.

Thus both sides of the family came from modest beginnings and undertook immigration in order to improve their lot in life, which they succeeded in doing either through marriage or through hard work. Despite their material successes, the women on both sides of the family struggled with a

[2] See: Goodyear, S. (September 25, 2015). The immigrant roots of nativist Donald Trump. *CityLab*. Retrieved from: https://www.citylab.com/equity/2015/09/the-immigrant-roots-of-nativist-donald-trump/407215/

[3] Burleigh, N. (December 28 2017). Donald Trump's mother, Mary Anne Macleod, is key to understanding the President's deep insecurity. *Newsweek*, Opinion. Retrieved from: https://www.newsweek.com/trump-mom-mary-anne-macleod-insecurity-deep-president-white-house-ivanka-758644

deep attachment to their country of origin, and one can reasonably assume that perennial mourning was a prominent experience in this family.

We also know that there was considerable prejudice against Germans in America, particularly following the Second World War, when Donald was born. People spoke about Germans and other immigrant groups in much the way that Trump speaks about Mexicans today. It is a documented fact that the Trump family lied about their German roots for many years, posing as immigrants from Swedish descent.[4] One wonders if this experience of the past has found its expression today as Trump declares: "Why do we want these people from all these shithole countries here? We should have more people from places like Norway." Is he reenacting the split between the bad country – Germany, that his ancestors came from, versus the good country – Sweden, that his family pretended to come from?

His family's rejection of their true identity, the hiding and lying that was an integral part of their lives, is reflected in Trump's propensity for lies and his penchant for creating confusion for defensive purposes. His profound insecurity and his constant boasting meant to compensate for his sense of inadequacy seems fairly transparent. It is reasonable to speculate that Trump's grand aspirations and insatiable need for wealth and power reflect a pervasive and deep shame about who he is and where he comes from. Like his mother, who seemed to be obsessed with the trappings of class and luxury, Donald Trump has "built himself a miniature Versailles, his gold and marble triplex in Trump Tower—designed by another immigrant with queenly tastes, first wife Ivana Trump."[5]

It is noteworthy that Donald Trump, who was surrounded by immigrants since he came into the world, chose to marry women who are also immigrants – two of his three wives immigrated to the US in adulthood. One wonders if there is a reenactment here of a theme which he can't escape; Is he doomed to repeat the trauma of migration as he recreates it in his own generation and the next?

[4] Goodyear, S. (September 25, 2015). The immigrant roots of nativist Donald Trump. *CityLab*. Retrieved from: https://www.newsweek.com/trump-mom-mary-anne-macleod-insecurity-deep-president-white-house-ivanka-758644

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Notwithstanding the dangers and controversy of analyzing a public figure, I have found it helpful to think of Trump as a living example of some of Volkan's conceptual formulations. My contention is that whatever insights can help us to better understand these chaotic and dangerous times in our country's history, are welcome and these hypotheses are offered in that spirit with appreciation for Volkan's seminal ideas which have inspired them.

SOPHIA RICHMAN (NEW YORK, NY)

PSYCHODYNAMIC DIAGNOSTIC MANUAL, 2ND EDITION. Edited by Vittorio Lingiardi and Nancy McWilliams. New York: Guilford Press, 2017. 1078 pp.

In 2006, the *Psychodynamic Diagnostic Manual* (PDM) was introduced to dynamically oriented clinicians as an alternative to the theoretically "atheoretical" but actually heavily biological DSM-IV. The latter is categorical, whereas the PDM is dimensional, and thus more accurate in coping with the complexity of patients in real-world treatment, as contrasted with the needs of researchers to minimize variables in selecting volunteers for their research needs. The first PDM was a welcome contribution from the late Editor-in-Chief Stanley Greenspan. His co-editor was Nancy McWilliams. She serves as co-editor of this second edition of the PDM, along with Vittorio Lingiardi. The first PDM, like the second edition, highlights the enormous amount of research that supports psychoanalytic theories. It was criticized by a minority of analysts who reject diagnosis and quantitative research as irrelevant to a psychodynamic framework. The research sections of the book will be of special interest to colleagues who conduct research. For the rest of us, it can help sharpen our assessment skills, whether at the evaluation stage, or much later, when unforeseen obstacles arise in psychotherapy or analysis. As the manual admits, "Some of the [research] tools we describe are also time-consuming, and this feature may discourage their use in routine clinical practice" (p. 891). The research focus may indeed enhance the legitimacy of the psychodynamic perspective in mental health fields. All royalties from this best-selling book will help fund future research.

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Lingiardi and McWilliams: Psychodynamic Diagnostic Manual(R. M. Waugaman and M. Korn)

Richard M. Waugaman & Miriam Korn

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There are 18 chapter editors, and "Consultants" too numerous to count. Half of the chapter editors live outside the United States, which may help shield them from undue influence by Big Pharma (which seems to control DSM). So one reads here, for example, that antidepressants are ineffective for patients with depressive personality styles. There is also an "Honorary Scientific Committee," and ten "Sponsoring Organizations." The first edition of PDM has not received as much attention as it deserves; we hope this second edition will receive wider recognition and readership. It is encouraging that mental health clinicians in New Zealand have received their government's permission to use PDM in lieu of DSM when submitting insurance claims.

Ten psychodynamically oriented organizations from the United States and abroad sponsored this book. The excellent introduction provides a cogent rationale for the PDM, in both its first and second editions. It "aspires to be a 'taxonomy of people' rather than a 'taxonomy of disorders,' and it highlights the importance of considering *who one is* rather than what one has" (p. 2). Although DSM aspired to assist psychiatric research, its latest edition was highly criticized by a former Director of NIMH for being seriously flawed as a research tool. PDM-2 also hopes to be a useful tool in research, and it offers a broader view of emotional disorders to capture the complex variables that need to be studied in psychiatric research. Past studies have shown the limited therapeutic benefit of treatments that focus too narrowly on discrete symptoms or behaviors. By contrast, measures such as the "SWAP-200" (the Shedler-Westen Assessment Procedure) have shown their reliability in assessing change in the complex measures of psychological functioning that are the focus of psychodynamic treatments. Despite the hype about CBT, some studies[1] have documented the greater effectiveness and more lasting improvement from such psychodynamic therapies.

The co-editors' introduction is full of wisdom. They note that, in the DSM, "the whole person has been less visible than the disorder constructs on which researchers can find agreement" (p. 4). Despite the hegemonic success of DSM, they underscore the irony that "reliability and validity data for many DSM disorders are not strong" (p. 4). They

[1] E.g., Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist, 65 (2)*, pp. 98-109.

criticize mental health research methodology for adopting methods from other sciences that are poorly suited for our field. So they champion the scientific value of case studies, in order to begin with sound descriptions of the conditions to be studied. They note that the much celebrated technique of CBT is less effective than claimed. For example, improvement generally stops with treatment, whereas with psychodynamic treatment, improvement continues after termination.

They single out younger colleagues who "feel lost in a biomedical diagnostic world" and who "keenly … feel the lack of a more psychologically articulated system … One of our prime motives is thus to be useful to beginning therapists" (p. 9). The introduction also clarifies that PDM-2 diagnoses are "prototypic," since they do not assume that diagnostic categories are merely a compilation of symptoms. Even where PDM-2 echoes DSM, it highlights the patient's subjective experiences much more than does DSM. In order to capture the full complexity of clinical conditions, PDM-2 assesses three dimensions for all patients: personality syndromes; a profile of mental functioning; and the patient's as well as the therapist's subjective experience of the patient's symptom patterns. Modestly, it admits that, "Any clinician who gets to know a patient intimately finds that over time, that person no longer seems to fit a clear-cut diagnostic construct; the person's individuality eventually becomes more salient" (p. 27).

DSM is omnipresent in PDM-2. Much of the time, PDM-2 reads like a commentary on DSM-5, citing it at length. E.g., "Interestingly [sic], DSM-5 diagnostic changes could have implications for older populations. DSM-IV-TR criterion D for anorexia nervosa, requiring amenorrhea, has been deleted from DSM-5; criterion B now permits diagnosis in the absence of fear of gaining weight … " (p. 849). DSM is treated as authoritative, with PDM-2 adding clinically relevant commentary. At times, we were disappointed to read more about DSM and about its nondynamic perspective than we read about relevant psychological factors. For example, the section of "Persistent Complex Bereavement Disorder" is careful to include references to "alterations in neural systems involved in emotional regulation" (p. 844), etc., but it omits Freud's crucial insight that a highly ambivalent relationship with the deceased person increases the risk of pathological mourning. The reader gets the sense that such exclusions occur not out of the authors' lack of awareness of dynamic underpinnings, but rather a deliberate withholding in an

attempt to ward off further criticism about PDM's dearth of empirical support. In our estimation, this is a needless suppression of psychoanalytic wisdom. We would have liked more "P" in the PDM.

Although the PDM-2 does not suffer from neuromania as does DSM-5, it does not ignore biological factors. For example, in the discussion of anxious personality syndrome, it offers the helpful advice to be cautious about prescribing benzodiazepines, since such patients are more likely to abuse them. It might have added that the *British Medical Journal* published a large study of the chronic use of benzodiazepines, and documented a disturbingly increased risk of Alzheimers disease in that cohort.

The book's 1078 pages offer a thorough psychodynamic exploration of clinical evaluation and diagnosis. The first five "Parts" explore five developmental stages (in somewhat random order); the sixth deals with assessment and clinical illustrations. We can hope that the PDM-2 may help mental health clinicians loosen their grip on the neuromania that infects psychiatry, spreading to all mental health practitioners. We like the references to pathogenic beliefs about self and others, for example (and we are disappointed not to find the phrase in the book's index). Such beliefs sound like the conscious derivative of core unconscious fantasies, which are increasingly downplayed.

The organization of the book's six Parts is not chronological, since it begins with Adulthood, moves back to Adolescence, backwards again to Childhood and Infancy, only then to jump forward all the way from infancy to "Later Life," otherwise known as old age (it is the first major diagnostic manual to have such a section). Instead of including mostly articles by leading psychodynamic clinicians as the first edition did, PDM-2 instead focuses more on research literature that validates the psychodynamic perspective.

Robert Michels recently discussed the history of diagnosis in the mental health field.[2] He said the goal has been to identify disease entities that would clarify etiology, prognosis, and optimal treatment. He said this effort was inspired by "spectacular success in the study of infectious diseases … Kraeplin … thought that general paresis of the insane [neurosyphillis] was the prototype [of psychiatric diagnoses], but perhaps it was the exception. Most major psychiatric disorders reflect a

[2] Michaels, R. (2017). A 21st century perspective on psychiatric nosology of the 19th Century," *American Journal of Psychiatry* 174:1140-11441.

complex mixture of genetic, environmental, psychosocial, and developmental factors" (p. 1141). PDM-2, unlike the DSM, abandons the infectious diseases model.

Co-editor Nancy McWilliams has called for more "practice-based evidence," to complement the focus on evidence-based practice. It is good to read something similar from Abraham Nussbaum, who wrote three DSM-5[3] pocket guides. Nussbaum calls for a patient-centered approach to clinical practice. "He shows how quality improvement, evidence-based medicine, and other well-intentioned paradigms to improve health care can paradoxically squeeze virtue and patient-centered care out of medicine."[4]

Much of the book will appeal most strongly to those who suffer from what we might label "nosolophilia," or the pathological love of systems for classifying illnesses. Chapter 1, on adult personality syndromes, plausibly includes borderline as both a level of personality organization *and* a P-axis personality style. Despite some inherent messiness in this dual usage, clinging to traditional psychoanalytic parlance (e.g. using "histrionic" personality style to describe patients who would be diagnosed as having Borderline PD in the DSM) may confuse the reader, who in all likelihood has been exposed to the sizable literature that uses the term "Borderline" to describe the character style rather than a level of character organization. This acceptance of commonly used diagnostic terminology, however far it may have strayed from its analytic origins, coupled with an attempt to integrate it into a more classically analytic framework, is one of the many strengths of the PDM-2. In contrast, co-editor NancyMcWilliams' *Psychoanalytic Diagnosis* remains loyal to the more historic usage, and uses "borderline" solely describe a level of personality organization on the border between neurotic and psychotic. This has its merits in imparting a psychoanalytic scaffolding for case

[3] Super Bowl LII approaches as we write. It is interesting that the editors of DSM-5 decided to leave Roman numerals behind in an effort to seem more up to date. Or perhaps they lack confidence in the Roman numeracy of their readers, in contrast with footfall fans. Readers of this review are probably aware that this journal, in fact, continues the proud tradition of using Roman numerals for volume numbers.

[4] Michael Redinger's review of Abraham M. Nussbaum's *The Finest Traditions of My Calling: One Physician's Search for the Renewal of Medicine*, *Am. J. of Psychiatry*, 174(10):1004.

conceptualization, but it also creates something of a quandary for trainees trying to learn about patients that their supervisors and colleagues referred to as having Borderline Personality Disorder.

There are excellent sections on mentalization, and its development from infancy on. A secure attachment to caregivers fosters an optimal development of this capacity to read the other person's psychological states accurately. It can begin much earlier than we once thought. For example, a 20-month-old toddler well known to us had watched an animated DVD for children called "Classical Baby," with a child in diapers conducting an orchestra of animals. Afterwards, she pointed to herself and said "classical baby," then pointed to her mother and said "classical Mommy." Her mother had not seen the DVD. So, seeing her mother's puzzled look, the child explained, "Joke!"

Differential diagnosis sometimes gets short shrift in the PDM-2. Yet it is intimately connected with the question of diagnosis which is this book's subject. One way to refine a diagnosis is to distinguish it from disorders whose signs and symptoms overlap. For example, Greenspan's proposed regulatory disorders of young children is presented in multiple subtypes. But even when these syndromes include marked self-absorption, hypersensitivity to stimuli, and stimming, there is no discussion of how to distinguish these children from those with autism spectrum disorders. More esoterically, children who "may not notice pain" (p. 679) are not differentiated from those who have the neurological condition of congenital insensitivity to pain.

Part II, on adolescence, lists self-esteem as an altogether positive trait. For example, the authors state that self-esteem is related to school performance. There are always exceptions to any such generalization. One cross-cultural survey found that American students rated themselves very high on math knowledge, but tested far below the performance of students in Asia, who tended to rate themselves far lower than their actual performance. Part II also differentiates between normal identity crises of adolescence, and the more severe syndrome of identity diffusion, which is "indicative of personality pathology" (p. 325). Unstable identity can also reflect the subjective experience of being in intensive treatment. A 17-year-old adolescent who had been an inpatient at Chestnut Lodge once complained to his psychotherapist, "This place makes you lose track of who you are!"

Chapter 6, on adolescents' subjective experience, wisely notes that treating an adolescent can revive the therapist's adolescent conflicts. This can occur with patients of any age, of course, but many people try to steer clear of their memories of painful adolescent experiences. We especially enjoyed and learned from the clinical vignettes illustrating the treatment of adolescents. We wish there were more such vignettes throughout the book. We all hunger for narratives that make more an impression on us than does the presentation of facts.

We have a special clinical interest in dissociation and dissociative disorders.[5] Dissociative identity disorder (DID) receives a good description, but it then seems "dissociated" from the many diagnoses with which it can be confused (e.g., borderline personality; schizophrenia; bipolar disorder, especially with "rapid cycling"). This illustrates the more general neglect of differential diagnosis in the manual, as we have noted. Many relevant passages do not appear in the index entry for dissociation. This book, like our field in general, has not yet fully absorbed and integrated our knowledge of dissociation. There is a good description of disorganized attachment in childhood, which correlates with adult dissociative disorders. For example, the child learns that the parental attachment figure who protects her can also be the same person who threatens her safety. For example, one of us treated a woman with DID who vividly recalled a pivotal nightmare from when she was 14 years old. In her dream, she was trying to escape someone who was trying to kill her. She felt enormously relieved when she ran into her kitchen and found her mother standing at the sink, with her back to the patient. But, when her mother turned around, she immediately realized it was her mother who was trying to kill her.

Often, patients with DID get confused with those with borderline personality. E.g., "A consequence of splitting [in borderline patients] is a failure to integrate aspects of identity [think alters] into a coherent whole … Such patients may look quite different on different occasions, as different compartmentalized aspects of their identity emerge" (p. 22). Borderlines' characteristic pathogenic beliefs are said to include, "I

[5] Waugaman, R. M. and Korn, M. (2012). in *The Treatment of Dissociative Identity Disorder: A Relational Approach*, by Elizabeth Howell. *Journal of the American Psychoanalytic Association* 60:626-631.

inhabit dissociated self-states rather than having a sense of continuity" (p. 814). This strikes us as a better description of DID than of borderline personality.

The therapist is said to feel his or her mind is being taken over by the borderline patient's projective identifications. This can more usefully be conceptualized as the result of the patient's various alters eliciting self-states in the therapist's complementary or concordant countertransference. The valuable discussion of the therapist's vicarious traumatization in working with trauma survivors could have been strengthened by conceptualizing the emergence of the therapist's traumatized self-states.

Boundary violations may result when a therapist's erotic self-states take over, especially when a therapist is unaware that the patient has DID. Significantly, up to 88% of borderline patients are said to have "unresolved trauma" (p. 509); severe childhood trauma, especially when perpetrated by a trusted caretaker, is characteristic of DID. The discussion of gender incongruence in borderline patients omits the relevant fact that a substantial percentage of patients with DID have at least one cross-gender alter.

One of the numerous research tools described is the Adult Attachment Interview. It is a semi-structured interview that "examines the structural and discourse characteristics of adult autobiographical narratives about attachment experiences and relationships" (p. 908). The interview must be assessed by trained scorers, limiting its role in clinical practice. Notably, two of the five resulting categories are forms of disorganized attachment, which increases the likelihood of dissociative identity disorder. In these categories, one may see "lapses into confusion and silence" or "oscillations between two or more attachment states of mind" (p. 909; cf. self states and alters). The authors fail to clarify, however, that disorganized attachment in infancy is far more predictive of the corresponding adult attachment style than are avoidant or anxious attachments in infancy.

There are a bewildering array of assessment instruments that are described, many of which are poorly suited for general clinical use. So it is helpful to learn that "[Anthony] Bram and [Mary Jo] Peebles (2014) consider the MMIP-2, TAT, Rorschach, and Wechsler Adult Intelligence Scale (WAIS) as constituting the core battery of personality assessment" (p. 920). It is ironic to learn that the Rorschach test has become something of an inkblot itself, coming "to be seen in multiple ways" (p. 931); "it is not a diagnostic tool … [but it] can be used to refine differential

diagnoses because certain superficially disorders have contrasting underlying dynamics" (p. 933). Perhaps because of the declining focus on psychodynamics in psychology graduate programs, both the Rorschach and the Thematic Apperception Test (TAT) are being taught less widely than they once were. Helpfully, an extended clinical example (pp. 943-956) from Anthony Bram illustrates how some dozen different assessment tools were used to evaluate a severely depressed 19-year-old student, and how these tools in turn shaped treatment recommendations.

For future editions of PDM, we suggest a single chart directing clinicians towards the respective assessment instruments based on what they seek to measure (e.g. symptoms, personality, cognitive capacity, etc.), followed by an appendix in which each measure is listed once and explained in detail. This would provide both clarity and concision.

We would have liked to see some discussion of translating the findings and recommendations of psychological testing into our psychotherapeutic work. One psychologist admitted that when he had tested his own patient, he was surprised by how difficult it was to follow his own advice as to optimal treatment. It may be a matter of wearing two different hats, as tester and as therapist, respectively. Both roles involve a mixture of identifying with the patient, and looking at the patient more objectively. But it may be a different mixture in those two roles.

We appreciated that this new edition of the PDM integrates psychotherapy outcome research throughout, in contrast to the first edition, which siloed its review of psychotherapy research by limiting it to a single chapter. Weaving empirical findings into diagnostic descriptions conveys that conceptualizing patients is both an art and a science. For instance, we found it illuminating to read about neuropsychological findings alongside descriptions of cognitive and emotional changes during adolescence. Another difference from the first edition, which sought to debunk common assumptions about so-called empirically supported therapies and the randomized control trials which provide proof positive of their efficacy, is that the authors appear to have adopted a more "depressive-position" stance on manualized treatments. We were pleased to see CBT recommended as an effective treatment for specific diagnoses, such as childhood anxiety disorders and body dysmorphic disorder. Likewise, the assessment section yielded recommendations featuring a variety of treatments, including family systems, cognitive-behavioral,

psychodynamic/psychoanalytic, and a developmental framework. It is our hope that the authors' openness to multiple modalities will invite a wider range of readership and thereby promote eclecticism, dialogue, and integration among clinicians practicing in a variety of styles.

Overall, we were pleased with PDM-2's de-pathologizing patients who present with gender incongruence (termed "Gender Dysphoria" in DSM-5) and describing points of intersection and differentiation between gender and sexuality. Yet the execution of this laudable stance featured some missteps. On p. 327, in a description of gender expression, the authors note that "in early adolescence (12-14 years), some girls either hide themselves in baggy clothes or wear overly revealing outfits. Some boys may either become overly focused on evidencing masculinity or withdraw into a more cerebral stance." Similarly, the authors state that in middle adolescence, heterosexual adolescents tend to fear being homosexual and homosexuals tend to feel marginalized and estranged (p. 284). These statements gave one of us flashbacks to public school sex education class in the early 2000s, where lessons like "If a girl is promiscuous, she'll be branded a slut, but a guy who sleeps around is praised for being a 'player'" reinforced damaging heuristics. Statements like these in the PDM-2 would benefit from a citation or several, so as not to appear stereotyped and outdated.

Similarly, we were pleased that the authors caution clinicians to not presume heterosexuality during an intake with an adolescent (or with an adult patient, we might add). They suggest the more open-ended query, "is there someone special in your life?" (p. 444). However, for many adolescents, sexual feelings towards others may have never been acted upon. We have found that patients even into their 20s commonly report attraction to the same sex, but a hesitation to identify as queer (or gay, or bi) because the feelings or fantasies have never been actualized. To that end, we have found it useful to: (a) use an intake form that asks adolescents to describe their sexuality (and gender) in their own words, rather than a forced choice between labels; and (b) ask about feelings of attraction, crushes, and "hook ups" rather than official romantic relationships – as these former categories may be comfortable expressions of sexuality where formal dating is not.

We were surprised to find so little on internet and smartphone usage in the section on adolescents, except the inclusion of Internet

Addiction Disorder (IAD), which is not listed in DSM-5 due to lack of empirical research. A recent study revealed that teen suicide and depression are on the rise, and correlate with time spent on smartphones and social media.[6]

Alexithymia is contrasted with psychological mindedness. We would add that it often occurs in autism spectrum patients. Among its characteristics is "minimal interest in dreams" (p. 111). We are tempted to connect this with the declining role of dream courses in many psychoanalytic institutes. Due to our own alexithymic or Asperger traits?

In the child section, there are separate scales for rating the child or infant's relationship to the caregiver. Winnicott's axiom, "there is no such thing as a baby" comes to mind, as does more modern research and theory regarding the temperamental fit of caregiver and child as it relates to attachment style, development, and observable pathology. We might add a relationship *between* caregivers (if there is more than one at home) measure, to capture an even fuller picture of the child's or infant's formative environment.

Despite an adherence to consistent format in other chapters that borders on obsessive,[7] we were vexed to find that the case studies for

[6] Twenge, J.M., Joiner, T.E., Rogers, M.L., et al. (2017). Increases in depressive symptoms, suicide-related outcomes, and suicide rates among U.S. adolescents after 2010 and links to new media screen time. *Clinical Psychological Science, 6 (1):* pp. 3-17.

[7] We found ourselves coping with this feature through the following satire: Diagnosophilia. This disorder is characterized by a pathological interest in inventing new diagnoses, along with a microscopic examination of meaningless distinctions with alternative diagnostic schemes. This disorder does not appear in PDM-1 or PDM-2, or in DSM I, II, III, IV, or 5. Nor does it appear in ICD-9 or 10, and it is unlikely to be listed in ICD-11, possibly because the authors of those manuals suffer themselves from this very condition. Among its common features is lack of insight into the presence of the disorder. Affective states are generally absent, while underlying rage is often projectively identified into the reader. Relationship patterns show a preferential interest in associating only with others who have the same disorder. Differential diagnosis includes obsessive-compulsive disorder. Hoarding, collecting compulsions, and trichoschizia (hair-splitting) are often co-morbid conditions. When associated with stamp collecting, patients characteristically try to collect ten versions of each stamp, showing a variety of post-marks, in addition to one uncancelled stamp; use of a magnifying glass will assist in differentiating among the ten versions. All stamps are treated with the same adhesive on the back, to ensure interrater reliability when blind taste tests are conducted. The subjective experience of the reader will frequently include sleep attacks, which are often mistaken for narcolepsy, and inability to take in written information, which may be mistaken for a reading comprehension learning disability.

each respective age group were markedly different in style and structure. The authors warn at the beginning of the chapter that each case is presented by a different clinician, so some variability is inevitable. Even given this, the reader would benefit from, for instance, *all* the cases including a course of treatment section—the result is that some patients feel far more vividly depicted than others. Though perhaps one benefit is the suggestion that whether after the intake or during a long-term therapy, the PDM measures can be used to capture the clinician's impressions of the patient at any given time.

We were struck again and again by the clinical wisdom contained in this book. Although the characteristics of personality syndromes are spelled out in great detail, we are cautioned against any rigid (obsessive-compulsive?) compartmentalization, when most patients have features of more than one of these personality types (as the attentive reader is likely to discover through introspection). The first edition of PDM acknowledged this contrast between a diagnosis manual and clinical practice.

The book ends with four illustrations of using the PDM profiles to evaluate actual (disguised) cases from early childhood; adolescence; and old age. "Paul," for example, is a four-year-old whose healthy development got derailed by his mother's complicated course with a younger sibling. Paul's symptoms began during that pregnancy, with night terrors and oppositionality. He grew worse when his mother had to be hospitalized for up to 15 days during her pregnancy. We were pleased by the psychodynamic focus—for example, mother's over-reaction to Paul's aggressive behavior was primed by her fears that he would become like her aggressive father and brother. Given his age and dynamics, conjoint therapy with both of his parents was wisely recommended. Many of the authors of this book are Italian, and we are given a lovely case example of an 85-year-old woman, whose history intersects in fascinating ways with the cultural history of Italy over the course of her life. Through supportive weekly therapy lasting six months, she came to realize that her presenting complaint of being afraid she might lose her memory masked her compulsive self-criticism, based on identification of the lost object—during the 15 years since her husband's death, she castigated herself in just the ways her husband did. She was from a lower social class

than him, but she earned more than him when she fulfilled her life-long dream of owning a bookstore.

The 38-page index has numerous omissions. Every reader will find examples in areas of special interest to them. We noticed them with regard to disorganized attachment; countertransference; differential diagnosis; and dissociative identity disorder. Countertransference is usefully addressed in far more places than the subset listed in the index. It is disappointing that Asperger's is not mentioned in the differential diagnosis of schizoid personality.

All in all, this is a book that we heartily recommend to all mental health clinicians.

RICHARD M. WAUGAMAN (CHEVY CHASE, MD)
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THE MOTHER-INFANT INTERACTION PICTURE BOOK: ORIGINS OF ATTACHMENT. By Beatrice Beebe, Phyllis Cohen, and Frank Lachmann, Illustrated by Dillon Yothers. New York: W. W. Norton, 2016. 255 pp.

The Mother-Infant Interaction Picture Book is a wonderful example of engaged scholarship—bringing the results of highly technical research to those who can best make use of it. After years of study, in plain and direct language, Beebe and her colleagues reach out to a wide audience that includes clinicians, parents, and any others who have an interest in infant development and the significance of caregiver-infant interaction. In an experience near style of writing, the authors bring the readers right into the research lab allowing us to feel the mothers' joys, anxieties, and dreams and the infants' laughter, hope, and distress.

In many ways, the book is a product of recent psychoanalytic times. With their emphasis on the significance of relationships in giving rise to identity and their attention to the way in which mothers and infants co-regulate emotional states, the authors situate themselves in the

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Beebe, Cohen, and Lachmann: The Mother-Infant Interaction Picture Book: Origins of Attachment (W. Winograd)

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In many ways, the book is a product of recent psychoanalytic times. With their emphasis on the significance of relationships in giving rise to identity and their attention to the way in which mothers and infants co-regulate emotional states, the authors situate themselves in the

relational school and within attachment theory. Following from Ainsworth,[1] Bowlby,[2] and Stern,[3] and similar to other "baby-watchers," such as Trevarthan and Aiken and Tronick and Reck,[4] they observe the behaviors and interactions of mothers and infants and use micro-analytic techniques to study the data they collect. At the same time, they are reminiscent of Winnicott[5], whose attention to the mother-infant dyad yielded a wealth of information about the relationally-based, progressive development of a fully dependent infant into a human being with an identity and self.

The Mother-Infant Interaction Picture Book aims not only to present research findings from decades of observation of infants and mothers, but also to offer the reader a unique look into the research process itself. In effect, readers of the book are treated to an introduction to Beebe's research methods as she teaches us how and what to observe. Indeed, as the title suggests, much of the book is comprised of a collection of images taken from countless hours of video that have been digitally altered by illustrator Dillon Yothers to protect the privacy of the research subjects. The book also includes a short DVD, which, along with the introductory text, teaches readers how to discern aspects of mother-infant interactions that Beebe and her colleagues have determined significant in the development of attachment styles.

In the introduction, Beebe et al. offer a rationale for what the reader will see and experience in the subsequent chapters—a very close and detailed look at implicit, non-verbal communication between mothers and their 4-month old infants. Using hours of split screen video, in

[1] See Ainsworth, M. (1979). Infant mother attachment. *American Psychologist. 34*(10), 932–937.

[2] See Bowlby, J. (1988). *A Secure Base Parent-Child Attachment And Healthy Human Development.* New York: Basic Books.

[3] See Stern, D. N. (1985). *The Interpersonal World Of The Infant.* New York: Basic Books.

[4] See Trevarthan, C. & Aitlen, K. J. (2001). Infant intersubjectivity: research, theory and clinical applications. *Journal of Child Psychology and Psychiatry, 42*, 3–48.; and Tronick, E. & Reck, C. (2009). Infants of depressed mothers. *Harvard Review of Psychiatry, 17*(2), 147–156.

[5] See Winnicott, D. W. (1960). The Theory of the Parent-Infant Relationship. *International Journal of Psychoanalysis, 41*:585–595; and Winnicott, D. W. (1965). *The Maturational Processes and the Facilitating Environment.* New York: International Univ. Press.

which they observe infants' and mothers' facial expressions, gestures, and verbalizations simultaneously, they analyze the subtle ways in which these mother/infant pairs come together, break apart, and mutually regulate affect. In previously published research, Beebe et al. assert that they can predict a baby's attachment pattern at one year on the basis of mother-infant face-to-face communication at 4 months.[6] In this book, she and her colleagues walk the reader through process by which they arrived at the stunning conclusion that from just 2 1/2 minutes of video at 4 months, they predict infant attachment at one year.

The book is divided into two sections. Part 1, "How Does Mother-Infant Face-To-Face Communication Work," begins by outlining the authors' assumptions about infancy and the power of microanalysis and ends with an extended discussion of the nature of patterned communication between mothers and infants. In Chapter 1, Beebe et al. review research on infant development that has shown that infants are social and communicative at birth. Referencing the work of Meltzoff,[7] they introduce the reader to the concept of correspondences, noting that "as early as 42 minutes after birth, infants can imitate gestures of the experimenter … [and can] perceive similarities (correspondences) between their own behaviors and the behaviors they see the experimenter perform" (p. 13). Moreover, they note, "infants have intrinsic motivation to detect pattern, order and sequence" (p. 14) and detect *contingency*. Infants are therefore able to predict maternal behavior. This is significant, say Beebe et al., because "when the adult partner does provide, on average, predictable responses to infant behaviors, then the infant develops a form of interactive *agency*" (p. 14). These are the fundamental processes underlying the development of attachment, and are critically important as attachment style predicts self-esteem, resiliency, self-regulation, social adjustment and school performance.

[6] See Beebe, B., Jaffe, J., Markese, S., Buck, K., Chen, H., Cohen, P., Bahrick, L., Andrews, A., & Feldstein, S. (2010). The origins of 12-month attachment: a microanalysis of 4-month mother-infant interaction. *Attachment and Human Development, 12*(1–2):3–141.

[7] See Meltzoff, A. (1990). Foundations for developing a concept of self: the role of imitation in relating to self and other and the value of social mirroring, social modeling, and self practice in infancy. In eds. D. Cicchetti & M. Beeghly, *The Self In Transition: Infancy To Childhood*. Norwood, NJ: Ablex. pp. 1–30.

Chapter 2 introduces readers to Beebe's research protocols, focusing on how she codes communications between mothers and infants. The chapter serves as a primer for the reader, who is becoming a researcher along with Beebe. As Beebe and her research team monitor the interactions in the split screen, they can observe how mothers and infants communicate through mutual gaze, looking away and back, orienting their heads toward and away from each other, and revealing affect in facial expressions. They also code verbal utterances and touch. Inferences are drawn about underlying dynamics that give rise to certain kinds of mother-infant interaction. For example, since gazing into someone's eyes is highly stimulating, averting one's gaze is understood to be a way to regulate arousal. Infant "look-away," then, suggests that an infant is over-aroused and attempting to down-regulate. In one sequence, which they term the "chase and dodge," a mother struggles to allow her infant to look away, perhaps because of her own anxiety over abandonment or broken connection, so she chases the connection by increasing her stimulation. In such circumstances, the infant dodges, looking further away and turning his head. When the infant is not permitted to avert his gaze, he is robbed of his only means of emotional regulation. Too much chase and dodge is associated with an insecure, resistant attachment.

Chapter 3 delves into how mothers and infants communicate, focusing on matched moments as well as disruption and repair. They explore maternal/infant rapport and explain the importance of matching at the midrange and the significance that behavioral correspondences have in deepening the relationship between mother and infant. "The joint ability of mother and infant to co-create patterns of correspondence is so important because these correspondences contribute to attachment security and the capacity for intimacy" (p. 31). Philosophers Baron-Cohen[8] and Rudder-Baker[9] refer to "shared attention," as a significant factor not only in the development of agency but in human communication and relationship and in the development of empathy. Similarly,

[8] See Baron-Cohen, S. (1995). *Mindblindness: An Essay On Autism And Theory Of Mind.* Cambridge, MA: MIT Press.

[9] Rudder-Baker, L. (2011). Beyond the Cartesian self. *Phenomenology and Mind, 1*(5):59–71.

Beebe et al. observe, "as partners match each other's facial expressions, each recreates a psychophysiological state in him- or herself similar to that of the partner" (p. 34). They are beginning here to theorize about the origins of empathy. Their attention to the minute details of mother-infant communication may, in fact, be the scientific evidence that substantiates Winnicott's theory of infant development.

Readers learn that patterns are laid down and stored as procedural or implicit memories. We learn how to recognize the behaviors in mother-infant pairs that signal the development of such implicit memories. I am left wondering, though, what we can do with these implicit memories. They note, "these expectances of early interactions are encoded in nonverbal, procedural, imagistic, acoustic, visceral, and temporal modes of information, and they continue to guide behavior in this procedural format" (p. 43). If, as they suggest, mothers who fail to recognize and match their infants' emotional states, who intrude with a chase and dodge when their infants need a moment to down-regulate, are, themselves, struggling with their own procedural deficits, it seems unlikely that reading about it, even if a mother is able to recognize her own deficits, would result in enough structural change in the mother to alter her behavior with her child. Perhaps the best we can hope for is that therapists and parents who read the book may become more attuned to potential pitfalls and able to intervene earlier, with deep, psychoanalytically informed therapy, to help a mother deal with her own unconscious conflicts and deficits in hopes of becoming more successfully attuned to her infant's needs.

Part II, "Drawings of Mother-Infant Patterns of Communication and Commentaries" is the heart of the book. Here, readers are treated to hundreds of images taken from hours of film and illustrating the many different co-created and co-regulating observable behaviors in mother-infant pairs. Beebe et al. begin by teaching the reader what to look for in the drawings and discussing what kinds of behaviors predict secure v. insecure attachment styles. They conclude this introduction by stressing two organizing principals about relating. The first is a regulating principal in which "the very availability of the mother, her sensitivity, consistency and predictability, and the ways that the infant reciprocally responds … [constitutes] the organizing process" (p. 60). The second regulating principal is disruption and repair, which "organize

experiences of coping, effectance, rerighting, and hope … [and which demonstrate that] interactions are represented as reparable" (p. 61). Indeed, as they demonstrate in subsequent chapters, the ability to repair a rupture is, perhaps, the most important structure-building interaction between mothers and infants.

Chapters 4–7 offer a close reading of the pictures of mothers and infants on the way to secure attachment. Using a frame by frame analysis, the authors demonstrate how infants and mothers use facial mirroring, disruption and repair, infant look away (secure pattern), and maternal loom and repair in a mutually beneficial manner, one that leads to secure attachment. In addition to pictures with detailed captions, each section includes a commentary in which the authors analyze what might be going on in the minds of securely attached mothers and infants. For example, in the section on disruption and repair, Beebe et al. comment:

> The sequence illustrates maternal management of infant distress by joining the infant's distress. The mother exactly matches her infant's "uh-oh" expression of the bottom lip pulled in … The infant's eyes are closed during this moment. But we can see that the mother joins the exact quality of the infant's distress, exquisitely sensing the infant's state … Then both participate in the repair, reaching for each other … They then gradually build back up to the original positive engagement. [p. 84]

The remaining chapters focus on mother-infant patterns that lead to problematic attachments. Chapter 8 and 9 illustrate the development of insecure-resistant attachments in infants whose mothers struggle to tolerate any separation and insecure-avoidant attachments in the infant look away pattern. In an analysis of a chase and dodge sequence, Beebe et al. introduce the reader to a mother who was too anxious to tolerate her infant's need to look away to regulate stimulation. Instead of trusting that, in time, the infant would re-engage, this mother "often reacted to the infant's avoidance maneuvers with fleeting but marked signs of negative affect: sobering, grimacing, biting her lip, jutting out her jaw, and expressions of sadness" (p. 137). They speculate that "because of their histories of not being able to trust attachments, mothers of infants on the way to resistant attachment feel more comfortable when the

attachment system is activated, to be sure that their infants need them … [and they theorize that] perhaps these mothers … feel abandoned or unimportant" (p. 140). They further note that, sadly, the result of this chase and dodge sequence is that "the infant's experience becomes organized by expectancies of misregulation without repair" (p. 138). While Beebe et al. offer visual evidence of the presence of unconscious processes and how they affect mother-infant interactions, the research itself does not address the problem of working with such unconscious processes. And while it may be beyond the scope of this book to address the matter of the clinical relevance of these findings, I found myself wondering how I might make use of such insights in a therapeutic encounter, where I might be working with a patient suffering from such anxiety or a patient who is a new mother and on her way to repeating a pattern of insecure attachment in her own infant. The authors offer the research findings but leave it to the reader to make the link between research and practice.

Chapters 10–12 focus on the most disturbed of attachment styles: disorganized attachment. In these chapters, Beebe et al. address the problems that arise when mothers are emotionally disconnected, cannot tolerate infant distress, or become surprised, angered, or disgusted by their infants. Chapter 13, perhaps the most disturbing, illustrates maternal sneer in disorganized attachment patterns. All of the chapters in Part II offer close readings of the pictures, an analysis with speculation about what the mothers and infants have in mind or are thinking and feeling, as well as a review of relevant research.

What is both fascinating and frustrating about the book is its insight into preverbal and unconscious communication. While the authors are focused on such communications between mothers and infants, they note in their conclusion that such communications are occurring all the time between all of us. "To understand our research is to understand that, in face-to-face communication, we are always influencing each other, often on a split-second basis, and often out of awareness" (p. 232). What is fascinating is that they have offered scientific evidence for what Winnicott was suggesting theoretically many years ago, that our very identities are rooted in and continuously shaped by our relationships with significant others. They have allowed us to enter into the world of a mother-infant dyad and see what is transpiring as a human

being comes to life. What is frustrating is keeping in mind that "Emotional communication is also based on direct brain activation in response to the perception of emotions in others, *which is also largely out of awareness*" (p. 231, italics added). Microanalysis may allow us to see what is happening and even to predict future problematic attachments. However, the fact that so much of what is transpiring is, indeed, unmentalized and out of awareness leaves me struggling to know how to make use of this knowledge to better serve my patients and their children.

In the tradition of many of the infant watchers of our time, Beebe et al. have demonstrated the reality that infancy is a time of powerful interactions that are preserved in memory and played out in relationships throughout life. They have succeeded in their goal of putting "these preverbal, unmentalized, action-sequence dialogues into words … [thereby making it] possible to think about them, to understand their importance …" (p. 231). They remind us in a powerful way how vitally important the first weeks and months of life are. At the same time, implicit in the very nature of their findings—that so much of what transpires is out of awareness and implicit in our ways of being in the world and in relationships—is the reality that changing such patterns of relating is a daunting prospect, indeed.

WENDY WINOGRAD (CHATHAM, NJ)

DREAM HOUSE: AN INTIMATE PORTRAIT OF THE PHILIP JOHNSON GLASS HOUSE. By Adele Tutter. Charlottesville and London: University of Virginia Press, 2016. 285 pp.

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Tutter: Dream House: an Intimate Portrait of the Philip Johnson Glass House (B. Collins)

Bradley Collins

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Johnson's Glass House was inspired by Mies van der Rohe's plans for the Farnsworth House in Chicago, but Johnson's building was completed before Mies's. The name "Glass House" is misleading because it can refer as well to the other structures that Johnson subsequently built on his five acres in New Canaan, Connecticut. These include the Brick House, Painting Gallery, Sculpture Gallery, Lake Pavilion, and Study. A patron did not commission the Glass House complex. Johnson designed everything by himself and for himself. This allows Tutter to treat the Glass House as more of a direct reflection of Johnson's psyche.

Johnson's personality as it emerges from Tutter's portrait involves several contradictions: confident and ambitious yet deeply insecure, inventive yet ambivalent about originality, grandiose yet self-effacing. One doesn't have to look far for the sources of insecurity in Johnson's childhood and adolescence. He was born in Ohio to a wealthy lawyer and a cultivated mother. But she disliked children, traveled when they were born, and left them with nannies. His father disdained him as a "mama's boy" and only had contempt for his artistic interests. Adding to these difficulties was the death of his five-year old brother, Alfred, when Philip was two. Although Johnson distinguished himself at prep school and was admitted to Harvard, he took seven years to graduate as a result of periodic mental breakdowns. Much of his distress had to do with his attempts to grapple with his homosexuality.

One of the most enigmatic episodes in Johnson's life was his infatuation with fascism. This was all the more bizarre given his very cosmopolitan experiences before becoming fascinated with Nazism. After graduating from Harvard, where he studied classics and philosophy, he befriended Alfred Barr at the Museum of Modern Art and became the institutions first director of the Department of Architecture. At MOMA, he curated seminal exhibitions such as "Modern Architecture-International" and wrote the influential book, *The International Style: Architecture Since 1922*, with H. R. Hitchcock. But shortly thereafter in 1932, he attended a Nazi rally in Potsdam and was overwhelmed by Hitler's magnetism. Back in America, he and a friend, Alan Blackburn, fell under the influence of the homegrown fascist, Lawrence Dennis, and founded a national political party with the slogan, "One Party for the Nation." Johnson and Blackburn called their new group the "grey shirts," which recalls P. G. Wodehouse's ridiculous Roderick Spode and

his "black shorts." However, Johnson's subsequent behavior was not so fanciful. He admired Huey Long and Father Coughlin and returned to Germany as a foreign correspondent. In Berlin he enthusiastically reported for right wing American publications on Hitler's rise. He found the burning of Warsaw and the bombing of Modlin a "stirring spectacle" (p. 90).

How could an extremely sophisticated gay man with Jewish friends become so seduced by the brutal irrationality of fascism? Johnson had traveled extensively in Germany and was fluent in the language. His father, Homer Johnson, had shared his Germanophilia with his son and Philip had German nannies. Hitler, moreover, had a taste for monumental architecture, which appealed to Johnson. But, the strongest motivations were psychological, not cultural. Tutter suggests that Homer Johnson's contempt for Philip had given him such a profound sense of inadequacy that he desperately needed a means of compensating for it. In Tutter's words, Johnson "sought out the company of strong, influential, and powerful men with whom he could more successfully identify, and from whom he could gain, by association, a degree of masculinity and manly potency that he failed to share with his father" (p. 94). According to Tutter, Hitler and other authoritarian fascist leaders fulfilled Johnson's need for a "powerful Other, to enhance his sense of power, self-worth, and masculinity" (p. 94).

These needs were also fulfilled in Johnson's relationship with Mies van der Rohe. Mies was twenty years older and an accomplished architect when Johnson first met him in 1930. Johnson did an enormous amount to establish Mies's career in America. He helped Mies and Marcel Breuer come to the United States to work. He championed Mies when Barr and Hitchcock preferred Gropius. He organized the first retrospective of Mies's work and he became so identified with Mies that he was nicknamed "Mies van der Johnson." But in a sort of repetition compulsion Johnson found in Mies a father figure nearly as dismissive of him as his own father. Not only was Mies aloof and imperious, but also he told Johnson that one of his first architectural efforts – a Miesian courthouse in Cambridge – was "terrible" (p. 172). And he refused to read Johnson's catalogue essay for the retrospective he mounted at MOMA. Yet Mies also resurrected aspects of Johnson's mother, Louise. Although she had rejected Philip as an infant, she took great care of his

education when he was older and shared with him her interest in art, architecture, and design. As Tutter puts it, "there was something reminiscent of [Johnson's] austere, didactic mother in Mies's taciturn hauteur and pedantic humorlessness" (p. 41).

As a substitute for both his father and mother, Mies would inevitably have aroused intense ambivalent feelings in Johnson. And we can see this expressed in his design for the Glass House. Johnson would refer to the Glass House as merely a "bad copy" of Mies's Farnsworth House, but there were many ways in which he rebelled against his master (p. 42). One of the more subtle departures from Miesian aesthetics was to include a chair rail or wainscot painted the same color as the load-bearing piers. This broke Miesian proscriptions against purely ornamental elements and against making decorative structures look like functional ones. A more substantial act of independence was to include an internal brick cylinder that contained a fireplace on one side and a bath on the other. This cylinder, which pierced the roofline, was made out of the same brick that was used for the floor and the "plinth" on which the Glass House rests. The building was thus anchored from top to bottom by brick instead of consisting of a Miesian set of independent planes. In this way, he also rejected the impersonality of Miesian modernism. In place of a floating glass box he had created a house that met the human need to be grounded and contained.

In this transgressive brick cylinder, Tutter finds one of the most over-determined structures in the Glass House and it is fascinating to see her trace all of the connections to Johnson's various experiences. Johnson himself claimed that the cylinder was inspired by "a burnt wooden village I saw once where nothing was left but foundations and chimneys of brick" (p. 102). This recalls the wreckage he would have witnessed in Eastern Europe while he was a guest of the Third Reich. So is the Glass House, as Peter Eisenmann believed, an attempt at atonement for past sins? Or is it a symptom of his amorality as Vincent Scully wondered: "what is this thing [the cylinder] doing here? … Is Johnson exorcising [his fascist past] all through art, as we might like to believe? Or, more likely, is it merely the amoral working in him of the artistic process ruthlessly making use of whatever is useful to itself?" (p. 102).

Not surprisingly, the true meaning of the cylinder for Tutter can be found not just in Johnson's conscious account, but also in its

unconscious sources. One of these is the Megaron in the destroyed Citadel of Mycenae, which was famously excavated by Heinrich Schliemann. The Megaron also had an off-center circular chimney that rose above its roof. This similarity is part of the very close correspondence that Tutter finds between the individual structures and general layout of the Citadel and the Glass House complex. Tutter argues that structures such as the Painting Gallery, the Sculpture Gallery, the circular pool, the Donald Judd sculpture, and the Entry Gate all have roots in the ancient citadel. But, strangely, Johnson only overtly acknowledges the influence of Mycenae in his Painting Gallery, which closely resembles the tholos tomb called the Treasury of Atreus. He also cites the Acropolis and Teotihuacan as influences while ignoring the Citadel. Why this denial? According to Tutter, it is a question of loss, absence, and suppressed violence:

> Was there something vital, then, something reassuringly permanent about the Acropolis, the ghost city of Teotihuacan, and the Tomb of Atreus, one of the Citadel's few extant structures – the heights still intact, their enclosed spaces still defined – that made them more accessible, more tolerable to Johnson's conscious mind? It was a mind beleaguered by memories of things he would "rather forget," no doubt including his own involvement with violence and death … In contrast, the skeletal remains of almost all of the Citadel, buried for millennia and only recently exhumed when Johnson saw them, are but potential structures; their rooms leveled, their volumes violated, they are most notable for their absence … And would not any recollections of his brother's death stirred by the rent and ravaged seat of the accursed House of Atreus be better left interred – let alone the premonition of future losses and his own inevitable mortality? I suggest that this nexus – the unspeakable specter of death, violence, and devastation, and all its interwoven mythical and personal allusions – drove the fraught memory of the Citadel deep into Johnson's designing mind. [pp. 156-157]

Returning to the cylinder, Tutter finds another source closer to home. Surprisingly, Johnson's mother's cousin, Theodate Pope Riddle, was one of the first female architects in America. Her greatest

achievement was her design of the Avon Old Farms School and on that campus one encounters a brick water tower that closely resembles Johnson's cylinder. Robert M. Stern described Theodate's water tower as a "high cylinder … a hulking mass that looks like a medieval castle keep" (p. 49). Such a distinctive structure was sure to have caught Johnson's eye when he visited the construction site in 1925. But, like the Megaron, Johnson never acknowledged the water tower's influence on his Glass House. This denial had its roots in Theodate's relationship with Johnson's mother, Louise. Presumably out of envy, Louise disdained Theodate. The latter was wealthier, more accomplished, better connected in the higher reaches of the artistic and literary worlds, and had a better art collection. This would have stung Louise as she had artistic pretensions of her own and, as mentioned, carefully supervised Johnson's education in art history and architecture. In his younger days, Johnson shared his mother's contempt for Theodate and wrote Louise that Avon Old Forms was "the purest mess you ever saw … I had a good talk with [Theodate] and … pronounced her thoroughly cracked" (p. 47). So the cylinder was a form closely associated with his mother's greatest rival. And to include it in the Glass House amounted to a repudiation of at least two parental figures – Mies and Louise.

Tutter's deep examination of the cylinder is just one example of many sensitive readings of aspects of the Glass House and its neighboring structures. She is particularly adept at teasing out the various meanings for Johnson of the one painting in the Glass House – Nicolas Poussin's *Landscape with the Burial of Phocion* (like Johnson himself the painting's authenticity has been questioned). And Tutter's interpretations follow her own criteria for psychoanalytic accuracy: "… *repetitive internally consistent* and *overdetermined themes* and *patterns*" (p. 20, italics in the original). One of *Dream House*'s most significant virtues is that it is not a hagiography. Psychobiography is inherently demystifying. But Tutter is especially attuned to Johnson's lapses and failures in life and work. Early on, Tutter states: "It thus remains the case that, to the best of my knowledge, no depth psychological study has examined, in detail, a single structure or group of structures in the context of its relationship to its designer" (p. 16). With *Dream House*, Tutter has splendidly answered the need for such a work.

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Koellreuter: What is this Professor Freud Like?: A Diary of an Analysis with Historical Comments (A. D. Richards)

Arnold D. Richards

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WHAT IS THIS PROFESSOR FREUD LIKE?: A DIARY OF AN ANALYSIS WITH HISTORICAL COMMENTS. Edited by Anna Koellreuter. New York: Routledge, 2016. 140 pp.

Anna Koellreuter, Ph.D. is a psychoanalyst and clinical psychologist who practices in Zurich, Switzerland and writes about the analysis of women by women and other feminist psychoanalytic subjects. Her grandmother, Anne Guggenbuhl, traveled from Switzerland to Vienna in 1921 for psychoanalysis by Sigmund Freud, four months of six times weekly sessions for a total of 80 sessions. More than 28 years ago, seven years after her grandmother died, a letter from Freud to Anne Guggenbuhl, which discusses the conditions for the analysis, was discovered. And shortly after the letter was discovered the diary was found as well. The book tells the story of the diary, includes the diary itself (93 pages), visual material relating to Anna Guggenbuhl's life, notes by the author about the analytic process, and comments by Karl Fallend, Ernst Falzader, and Andre Haynal.

Karl Fallend is a professor of social psychology at the August Aichorn Institute in Graz, Austria, who wrote about the history of psychoanalysis, and its rapid development after World War I. He refers to the triad of "internalization, institutionalism, and professionalism of psychoanalysis" in the early 1920s, which also followed the ascendancy of Austro-Marxism in Red Vienna.

The mass movements of these revolutionary times also concerned Freud, who was probably working on *Group Psychology and the Analysis of the Ego* during Anna Guggenbuhl's analysis. Fallend believed that Anna Guggenbuhl went to Vienna not only to be treated by the famous Freud but also because "she could expect to meet with more tolerance, understanding and openness for the particular problems there" (p. 78).

He contends, "She was drawn to the great social movements raised by the workers and the youth, especially to the international women's movement" (p. 78). For the first time in Austrian history women were granted the status of citizens. This was attractive to Anna G. as was the revolutionary experiment in the Soviet Union. She, like Freud, was also

drawn to Arthur Schnitzler, the playwright and spokesperson for sexual liberation. But Freud maintained his distance from Schnitzler for fear that the similarity in their views would make some question Freud's own originality. Schnitzler's play, which opened in Vienna in 1921, was met with anti-Semitic protests and it is likely, according to Falzeder, that Anna G. "experienced an open everyday anti-Semitism" (p. 78). However, there is no mention about anti-Semitism in the diary. Was this considered a taboo subject in the analysis? Harold Blum has written that Freud did not write about the anti-Semitism that his patients encountered in his case histories.[1]

Ernst Falzeder is a prolific contributor to the literature on the history, theory, and technique of psychoanalysis, and his *Psychoanalytic Factions: Mapping the Psychoanalytic Movements* is a monumental contribution to our understanding of the relationships of the founders of psychoanalysis to their disciples. Falzeder points out that there is a lot of evidence that Freud did not follow his own technical rules.[2] There is a lot of information about how Freud actually practiced from memoirs of former analysands, interviews with former analysands, and reports in secondary literature. The list of Freud's former analysands who have written about their analysis is long. We will subsequently consider an account by H.D. and compare it with the diary of Anna Koelreuter's grandmother.

In the second category, interviews with former analysands, the most extensive works are the interviews of Paul Roazen with 25 of Freud's former patients.[3] Falzeder contrasts Freud's recommendations for restraint and abstinence with his reacting "in a spontaneous, moralistic, hurt, angry, loving, teasing or effervescent manner" (p. 91). In another paper, Richards and Lynch have written about how a psychoanalyst develops a technique to counter his own anti-therapeutic tendencies. For example, we contend that Kohut stressed empathy to counter his own narcissism. Freud stressed abstinence to counter his own activism and his wish to

[1] Blum, H. P. (2010). Anti-Semitism in the Freud case histories. In *The Jewish World of Sigmund Freud: Essays on Cultural Roots and the Problem of Religious Identity*, ed. A. Richards. Jefferson, NC: McFarland Books. p. 83.

[2] See Falzeder, E. (2015). *Psychoanalytic Factions: Mapping the Psychoanalytic Movements*. New York: Routledge.

[3] See Roazen, P. (1993) *Meeting Freud's Family*. Amherst, MA: Univ. of Massachusetts Press.

intervene in the lives and affairs of his patients. And with the Rat Man, Freud wrote, "He was hungry and was fed."[4] Also, there is evidence (Kardiner, Grodek, Doolittle) that Freud preferred the paternal to the maternal transference role.

Freud was also willing to make financial compromises in the treatment of his patients. He supported the Wolf Man financially when he lost his fortune and he promoted the establishment of the free clinics where patients were treated without fees. Freud's rule was that every analyst should donate one free analysis or the money from one of his paying patients. Freud did the latter.[5] The "bottom line," according to Felzeder, is that Freud was more liberal in practice in contrast to his conservative stance that he recommends in his writing on technique: "Freud broke his own prohibitions. He also allowed his students to break the rules as long as what the analyst did was not in the service of personal gratification for the analyst but was in the interest of the patient!"[6]

I think we need to consider how the rigidity and slavish attention to rules about setting, frequency, and interventions—developed in American psychoanalysis during the forties and fifties—was promoted by the émigré analysts, many of whom had been close to Freud. Two explanations have been offered. The first is that the émigré analysts were relatively silent, and said very little, because they were not fluent enough in the language of their patients. The second is that these two decades were the psychoanalysis of plenty, with plenty of candidates, and plenty of patients if the analyst and the analysand were aware, and there were many candidates/patients waiting to replace them if they complained about the austere atmosphere.

The third discussion is by André Haynal, a Swiss psychoanalyst who was the supervising editor of the Freud/Ferenczi correspondence. Haynal addresses the "Guggenbuhl case study" more directly. Haynal's contribution is a meditation on the treatment, which he considers more a psychoanalytic psychotherapy than a psychoanalysis. He notes the

[4] Freud, S. (1909). *S.E. 10*, p. 303.

[5] See Danto, E. (2007) *Freud's Free Clinics: Psychoanalysis and Social Justice 1918-1938*. New York: Columbia Univ. Press.

[6] Blum, H. P. (2010). "Anti-Semitism in the Freud case histories" by Harold P. Blum. In *The Jewish World of Sigmund Freud: Essays on Cultural Roots and the Problem of Religious Identity, ed. A.* Richards. Jefferson, NC: McFarland Books. p. 95.

absence of transference and countertransference and of "affective exchange," and believes that Freud will look to Ferenczi to introduce more of the interpersonal dimension. He faults Freud for being too influenced by his own concepts and theories, looking for their validation in the material presented by his patient rather than getting closer to her own concerns and experiences. The central hubs of his theory built around the Oedipal complex are the "father, Oedipal jealousy, the wish to substitute the same sex parent, fear of castration, bisexuality" (p. 106).

And the larger methodological problem looms large over the diary. How accurately does the patient remember what happened and how veridical is her account of what Freud said and interpreted? I think readers will have to answer this for themselves as they read Chapter 2, Diary of an Analysis, April 1921. This chapter is followed by the illustrations and Chapter 3, by the editor Anna Koellreuter herself, "Being Analyzed by Freud 1921—Note about the Analytic Process." The editor had a close relationship with her grandmother who hardly talked about her analysis. After she found the diary she had to struggle with the question of whether the grandmother would have wanted her to publish parts of the diary. She concluded that she would. Her grandmother had a clear idea about what her goal was in the analysis: whether or not after seven years of engagement whether she really wanted to get married. Anna Koellreuter comments on her grandmother's willingness to talk about sexual matters, and she was clearly familiar with Freud's writings about sexuality. Her copy of Freud's *Three Essays on a Theory of Sexuality* was "so well thumbed that it nearly came apart" (p. 56).

Anna Koellreuter offers three takes on Freud's interpretations: they are suggestive, leading, symbolic, and deductive. She discusses five extracts that show the way Freud works, which seem to me counter to Haynal. Freud did interpret the transference although he focused more on the then and there, rather than the here and now. Anna Koellreuter also tells us something about the outcome of the short treatment. Her grandmother returned to Zurich, called off her wedding, and then joined her brother in Paris and got a position in a psychiatric clinic. She married a sculptor from Brienz, Anna Koellreuter's grandfather, in 1923, had four children, and they stayed together for 60 years until her death. She returned to Zurich after the war broke out in 1939. Anna

Koellreuter wonders why her grandmother did not become an analyst herself. I do as well.

But it seems clear she had a good life. Her brief analytic encounter with Freud was a success. Was it the relationship or Freud's interpretations that made the therapeutic difference? My sense is that the case illustrates the dictum offered by Charles Brenner that the best way to establish a therapeutic alliance is an apt interpretation.[7] I think in this account we sense Freud the interpreter and Freud the caring, engaged person. A good take away from this account for all.

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[7] Brenner, C. Personal Communication.

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