Contents

Contributors ................................................................. xi

Introduction .............................................................. xv
Glen O. Gabbard, M.D., Bonnie E. Litowitz, Ph.D., and Paul Williams, Ph.D.

SECTION I
General Introduction
Section Editor: Robert Michels, M.D.

1 Freud and His Circle .................................................... 3
Daria Colombo, M.D.

2 Psychoanalysis in North America After Freud .................. 19
Jay Greenberg, Ph.D.

SECTION II
Core Concepts
Section Editor: Richard B. Zimmer, M.D.

3 Theories of Motivation ................................................ 39
Morris N. Eagle, Ph.D., A.B.P.P.

4 Unconscious Processes .............................................. 53
Anton O. Kris, M.D.

5 Transference ............................................................ 65
Steven H. Goldberg, M.D.

6 Countertransference: An Instrument of the Analysis ........ 79
Lawrence I. Brown, Ph.D.

7 Defense and Resistance .............................................. 93
Lucy LaFarge, M.D.

8 Intersubjectivity ....................................................... 105
Charles Spezzano, Ph.D.

9 Childhood Experiences and the Adult World ..................... 117
Karen Gilmore, M.D.

10 Gender and Sexuality ................................................ 133
Muriel Dimen, Ph.D., and Virginia Goldner, Ph.D.
SECTION III
Schools of Thought
Section Editor: Adrienne Harris, Ph.D.

11 Classical Psychoanalysis: Past and Present ........................................ 155
   Richard M. Gottlieb, M.D.

12 Object Relations ................................................................. 171
   Paul Williams, Ph.D.

13 Klein and Bion ................................................................. 185
   Ronald Britton, M.D.

14 Self Psychology ............................................................... 199
   David M. Terman, M.D.

15 Relational Psychoanalysis ...................................................... 211
   Lewis Aron, Ph.D., and Maria L. Lechich, Ph.D.

16 Jacques Lacan ................................................................. 225
   Jeanne Wolff Bemstein, Ph.D.

17 Infant Research and Adult Psychotherapy ..................................... 239
   Stephen Seligman, D.M.H., and Alexandra Murray Harrison, M.D.

SECTION IV
Treatment and Technique
Section Editor: Steven H. Cooper, Ph.D.

18 Transference, Countertransference, and the Real Relationship ............ 255
   Adrienne Harris, Ph.D.

19 Theories of Therapeutic Action and Their Clinical Consequences .......... 269
   Jay Greenberg, Ph.D.

20 Process, Resistance, and Interpretation .................................... 283
   Peter Goldberg, Ph.D.

21 Termination and Reanalysis .................................................. 303
   Martin S. Bergmann

22 Combining Psychoanalysis and Psychopharmacology:
   Theory and Technique ...................................................... 319
   Steven P. Roose, M.D., Deborah L. Cubaniess, M.D., and Bret R. Rutherford, M.D.
23 Technique in Child Analysis .................................................. 333
   Judith A. Yanof, M.D., and Alexandra Murray Harrison, M.D.

24 Ethics in Psychoanalysis ..................................................... 349
   Ernest Wallwork, Ph.D.

25 Psychoanalysis and Psychodynamic Psychotherapy: Historical Development and Present Relationship ............................................. 367
   Robert S. Wallerstein, M.D.

SECTION V
Research
Section Editor: Linda C. Mayes, M.D.

26 Research on Outcomes of Psychoanalysis and Psychoanalysis-Derived Psychotherapies .................................................... 385
   Rolf Sandell, Ph.D.

27 Psychoanalytic Process Research ........................................... 405
   Stuart Ablon, Ph.D., Lotte Smith-Hansen, Ph.D., and Raymond A. Levy, Psy.D.

28 Developmental Research .................................................... 423
   Patrick Luyten, Ph.D., Linda C. Mayes, M.D., Mary Target, Ph.D., and Peter Fonagy, Ph.D., F.B.A.

SECTION VI
Psychoanalysis and Other Disciplines
Section Editor: Jeffrey Prager, Ph.D.

29 Psychoanalysis and the Neurosciences ..................................... 445
   David D. Olds, M.D.

30 Psychoanalysis and Philosophy ............................................. 461
   Jonathan Lear, Ph.D.

31 Psychoanalysis and Anthropology ......................................... 477
   Waud H. Kracke, Ph.D.

32 Race, Ethnicity, and Nationality .......................................... 495
   Michael Rustin, M.A. (Oxon)

33 Psychoanalysis and Literature ............................................. 507
   Madelon Sprengnether, Ph.D.

34 Psychoanalysis and the Visual Arts ...................................... 523
   Ellen Handler Spitz, Ph.D.
Psychoanalysis and Film .............................................................. 537
Andrea Sabbadini, M.A., C.Psychol.

Psychoanalysis and Music .............................................................. 551
Alexander Stein, Ph.D.

Glossary ....................................................................................... 567
Richard B. Zimmer, M.D., Editor, Peter M. Bookstein, M.D., Associate Editor,
Edward T. Kenny, M.D., Associate Editor, and Andreas K. Kraeber, M.D., Associate Editor

Index .............................................................................................. 589
Contributors

Stuart Ablon, Ph.D.
Director, Psychotherapy Research Program, Center for Psychodynamic Therapy and Research, Department of Psychiatry, Massachusetts General Hospital; Associate Clinical Professor, Harvard Medical School, Boston, Massachusetts

Lewis Aron, Ph.D.
Director, New York University Postdoctoral Program in Psychotherapy and Psychoanalysis; former President, Division of Psychoanalysis (39) of the American Psychological Association; founding President of the International Association for Relational Psychoanalysis and Psychotherapy (IARPP); cofounder and co-chair of the Sandor Ferenczi Center at the New School for Social Research; Honorary Member, William Alanson White Psychoanalytic Society; Author of A Meeting of Minds. Hillsdale, NJ: The Analytic Press, 1996

Martin S. Bergmann
Clinical Professor of Psychology (Adjunct), Postdoctoral Program in Psychotherapy and Psychoanalysis, New York University; Training and Supervisor Analyst, New York Freudian Society, New York, New York

Jeanne Wolff Bernstein, Ph.D.
Personal and Supervising Analyst, The Psychoanalytic Institute of Northern California (PINC), San Francisco, California; Guest Professor, The Sigmund Freud University, Vienna, Austria

Peter M. Bookstein, M.D.
Assistant Clinical Professor of Psychiatry, Columbia University College & Physicians and Surgeons; Faculty, Columbia University Center for Psychoanalytic Training and Research, New York, New York

Ronald Britton, M.D.
Institute of Psychoanalysis, London, England; Fellow, Royal College of Psychiatrists, Distinguished Fellow, British Psychoanalytical Society

Lawrence J. Brown, Ph.D.
Faculty, Boston Psychoanalytic Institute and Massachusetts Institute of Psychoanalysis; Clinical Instructor, Harvard Medical School; Boston, Massachusetts

Deborah L. Cabaniss, M.D.
Clinical Professor of Psychiatry and Director of Psychotherapy Training, College of Physicians and Surgeons, Columbia University; Training and Supervising Analyst, Center for Psychoanalytic Training and Research, Columbia University

Daria Colombo, M.D.
The Seattle Psychoanalytic Society and Institute

Steven H. Cooper, Ph.D.
Associate Clinical Professor of Psychology in the Department of Psychiatry, Harvard Medical School, Boston, Massachusetts; Joint Editor-in-Chief, Psychoanalytic Dialogues: The International Journal of Relational Psychoanalysis

Muriel Dimen, Ph.D.
Adjunct Clinical Professor of Psychology, New York University Postdoctoral Program in Psychotherapy and Psychoanalysis, New York, New York

Morris N. Eagle, Ph.D., A.B.P.P.
Professor Emeritus, Derner Institute for Advanced Psychological Studies, Adelphi University, Garden City, New York; Distinguished Educator in Residence, California Lutheran University, Thousand Oaks, California

Peter Fonagy, Ph.D., F.B.A.
Research Department of Clinical, Educational and Health Psychology, University College London, London, United Kingdom

Glen O. Gabhard, M.D.
Professor of Psychiatry, SUNY Upstate Medical University, Syracuse, New York; Clinical Professor of Psychiatry, Baylor College of Medicine, Houston, Texas; Training and Supervising Analyst, Center for Psychoanalytic Studies, Houston, Texas

Karen Gilmore, M.D.
Clinical Professor of Psychiatry, Columbia University College of Physicians and Surgeons; Director, Child and Adolescent Psychoanalysis Division, Columbia University Center for Psychoanalytic Training and Research, New York, New York
Peter Goldberg, Ph.D.
San Francisco Center for Psychoanalysis, San Francisco, California

Steven H. Goldberg, M.D.
Training and Supervising Analyst, San Francisco Center for Psychoanalysis, Personal and Supervising Analyst, Psychoanalytic Institute of Northern California, San Francisco, California

Virginia Goldner, Ph.D.
Adjunct Clinical Associate Professor of Psychology, New York University Postdoctoral Program in Psychotherapy and Psychoanalysis, New York, New York

Richard M. Gottlieb, M.D.
Clinical Associate Professor of Psychiatry, Mount Sinai School of Medicine, New York, New York; Training and Supervising Analyst, Berkshire Psychoanalytic Institute, Stockbridge, Massachusetts; Faculty, New York Psychoanalytic Institute, New York, New York; Associate Editor for Clinical Studies, Journal of the American Psychoanalytic Association

Jay Greenberg, Ph.D.
Training and Supervising Analyst, William Alanson White Institute, New York, New York; Editor, The Psychoanalytic Quarterly

Adrienne Harris, Ph.D.
Faculty and Supervisor, New York University Program in Psychoanalysis and Psychotherapy, New York; Faculty and Supervising Analyst, Psychoanalytic Institute of Northern California, San Francisco

Alexandra Murray Harrison, M.D.
Assistant Clinical Professor in Psychiatry, Harvard Medical School; Training and Supervising Analyst in Adult and Child and Adolescent Psychoanalysis, Boston Psychoanalytic Society and Institute, Boston, Massachusetts

Edward T. Kenny, M.D.
Assistant Professor of Clinical Psychiatry, New York-Presbyterian Hospital, New York, New York

Waud H. Kracke, Ph.D.
Professor, Department of Anthropology, University of Illinois at Chicago, Chicago, Illinois

Andreas K. Kraebber, M.D.
Instructor in Psychiatry, Columbia University College & Physicians and Surgeons; Faculty, Columbia University Center for Psychoanalytic Training and Research, New York, New York

Anton O. Kris, M.D.
Clinical Professor of Psychiatry, Harvard Medical School, Training and Supervising Psychoanalyst, Boston Psychoanalytic Society, Boston, Massachusetts

Lucy LaFarge, M.D.
Clinical Professor of Psychiatry, Weill Medical College of Cornell University, and Training and Supervising Analyst, Columbia University Center for Psychoanalytic Training and Research, New York, New York

Jonathan Lear, Ph.D.
John U. Nef Distinguished Service Professor, Committee on Social Thought and the Department of Philosophy, The University of Chicago, Faculty, Chicago Psychoanalytic Institute, Chicago, Illinois

Maria L. Leichich, Ph.D.
Faculty, Trauma Program, and Clinical Supervisor, National Institute for the Psychotherapies, Faculty, Stephen A. Mitchell Center for Relational Studies; Adjunct Clinical Supervisor, Clinical Psychology Doctoral Program, Long Island University/CW Post, Brookville, New York

Raymond A. Levy, Psy.D.
Clinical Director, Psychotherapy Research Program, Center for Psychodynamic Therapy and Research, Department of Psychiatry, Massachusetts General Hospital; Assistant Clinical Professor, Harvard Medical School, Boston, Massachusetts

Bonnie E. Litowitz, Ph.D.
Associate Professor, Department of Psychiatry, Rush Medical School; Faculty, Chicago Institute for Psychoanalysis, Chicago, Illinois

Patrick Luyten, Ph.D.
Department of Psychology, University of Leuven, Leuven, Belgium; Research Department of Clinical, Educational and Health Psychology, University College London, London, United Kingdom

Linda C. Mayes, M.D.
Arnold Gesell Professor, Yale Child Study Center; Professor of Epidemiology (Chronic Diseases), of Pediatrics, and of Psychology, Yale University School of Medicine, New Haven, Connecticut

Robert Michels, M.D.
Walsh McDermott University Professor of Medicine, Cornell University, and University Professor of Psychiatry, Weill Medical College of Cornell University, New York, New York
Contributors

David D. Olds, M.D.
Clinical Professor of Psychiatry, Columbia University College of Physicians and Surgeons; Training and Supervising Analyst, Columbia Center for Psychoanalytic Training and Research, New York, New York

Jeffrey Prager, Ph.D.
Professor, Department of Sociology, University of California, Los Angeles, Los Angeles, California

Steven P. Roose, M.D.
Professor of Clinical Psychiatry, College of Physicians and Surgeons, Columbia University; Chairperson, Research Committee, Center for Psychoanalytic Training and Research, Columbia University

Michael Rustin, M.A. (Oxon)
Professor, Department of Sociology, University of East London, London, United Kingdom; Tavistock and Portman NHS Trust

Bret R. Rutherford, M.D.
Assistant Professor of Clinical Psychiatry, College of Physicians and Surgeons, Columbia University; Candidate, Center for Psychoanalytic Training and Research, Columbia University

Andrea Sabbadini, M.A., C.Psychol.
Fellow, British Psychoanalytical Society

Rolf Sandell, Ph.D.
Professor Emeritus, Linköping University, Linköping, Sweden

Stephen Seligman, D.M.H.
Clinical Professor of Psychiatry, Infant-Parent Program, University of California, San Francisco; Training and Supervising Analyst, San Francisco Center for Psychoanalysis and Psychoanalytic Institute of Northern California, San Francisco, California; Joint Editor-in-Chief, Psychoanalytic Dialogues: The International Journal of Relational Psychoanalysis

Lotte Smith-Hansen, Ph.D.
Postdoctoral Fellow in Psychology, Program for Psychotherapy, Department of Psychiatry, Cambridge Health Alliance; Clinical Fellow, Harvard Medical School, Boston, Massachusetts

Charles Spezzano, Ph.D.
Psychoanalytic Institute of Northern California, San Francisco, California

Ellen Handler Spitz, Ph.D.
Honors College Professor of Visual Art, University of Maryland, Baltimore County, Baltimore, Maryland

Madelon Sprengnether, Ph.D.
Regents Professor, Department of English, University of Minnesota, Twin Cities, Minneapolis, Minnesota

Alexander Stein, Ph.D.

Mary Target, Ph.D.
Research Department of Clinical, Educational and Health Psychology, University College London, London, United Kingdom

David M. Terman, M.D.
Training and Supervising Analyst and Immediate Past Director, Chicago Institute for Psychoanalysis, Chicago, Illinois

Robert S. Wallerstein, M.D.
Emeritus Professor and Former Chairman, Department of Psychiatry, University of California, San Francisco School of Medicine, San Francisco, California

Ernest Wallwork, Ph.D.
Professor, Syracuse University, Syracuse, New York; Washington Psychoanalytic Institute and Washington Center for Psychoanalysis, Washington, D.C.

Paul Williams, Ph.D.
Training and Supervising Analyst, British Psychoanalytical Society

Judith A. Yaaof, M.D.
Training and Supervising Analyst in Adult, Adolescent, and Child Psychoanalysis, Boston Psychoanalytic Society and Institute, Boston, Massachusetts; Clinical Instructor in Psychiatry, Harvard Medical School, Cambridge, Massachusetts

Richard B. Zimmer, M.D.
Training and Supervising Analyst, Columbia University Center for Psychoanalytic Training and Research; Clinical Associate Professor of Psychiatry, Weill Medical College of Cornell University, New York, New York
Disclosure of Competing Interests

The following contributors to this book have indicated a financial interest in or other affiliation with a commercial supporter, a manufacturer of a commercial product, a provider of a commercial service, a nongovernmental organization, and/or a government agency, as listed below:

Steven P. Roose, M.D.—Consultant: Medtronic;
Orexigen

The following contributors reported that they had no competing interests to declare:

Stuart Ablon, Ph.D.
Lewis Aron, Ph.D.
Martin S. Bergmann
Jeanne Wolff Bernstein, Ph.D.
Ronald Britton, M.D.
Lawrence J. Brown, Ph.D.
Deborah L. Cabaniss, M.D.
Daria Colombo, M.D.
Morris N. Eagle, Ph.D., A.B.P.P.
Peter Fonagy, Ph.D., F.B.A.
Glen O. Gabbard, M.D.
Karen Gilmore, M.D.
Peter Goldberg, Ph.D.
Steven H. Goldberg, M.D.
Virginia Goldner, Ph.D.
Richard M. Gottlieb, M.D.
Jay Greenberg, Ph.D.
Adrienne Harris, Ph.D.
Alexandra Murray Harrison, M.D.
Waud H. Kracke, Ph.D.
Anton O. Kris, M.D.
Lucy LaFarge, M.D.
Jonathan Lear, Ph.D.
Maria L. Lechich, Ph.D.
Raymond A. Levy, Psy.D.
Bonnie E. Litowitz, Ph.D.
Patrick Luyten, Ph.D.
David D. Olds, M.D.
Jeffrey Prager, Ph.D.
Michael Rustin, M.A. (Oxon)
Bret R. Rutherford, M.D.
Andrea Sabbadini, M.A., C. Psychol.
Rolf Sandell, Ph.D.
Stephen Seligman, D.M.H.
Lotte Smith-Hansen, Ph.D.
Charles Spezzano, Ph.D.
Ellen Handler Spitz, Ph.D.
Madelon Sprengnether, Ph.D.
Alexander Stein, Ph.D.
David M. Terman, M.D.
Robert S. Wallerstein, M.D.
Ernest Wallwork, Ph.D.
Paul Williams, Ph.D.
Judith A. Yanof, M.D.
Introduction

Seven years have passed since the publication of the previous edition of this textbook. Since that time, we have learned that students of many different disciplines and from many different levels of training have found the textbook useful. In addition, experienced analysts have also found portions of the book to be helpful in providing overviews of various psychoanalytic topics. Although Sigmund Freud observed that psychoanalysis can be described as a theory, a treatment, and a method of research, it has also clearly become a way of thinking about the human condition that transcends clinical settings and has broad applications to the arts, the social and biological sciences, philosophy, and the humanities.

In this new edition, we have once again attempted to reach a broad audience, one that encompasses a knowledge base from the beginning student to the seasoned analyst or academician. Two new editors have joined the project for this second edition, Bonnie Litowitz and Paul Williams, both of whom reflect the interdisciplinary nature of psychoanalytic thought today. Dr. Litowitz has a background in linguistics that has informed her psychoanalytic writing and practice, and Dr. Williams trained as a social anthropologist prior to his psychoanalytic training. Both now spend a good deal of their time engaged in clinical psychoanalytic work.

Ethel Person and Arnold Cooper, two of the co-editors of the previous edition of the text, have not been involved in the development of this volume, and we dedicate this second edition to them. We are indebted to both Drs. Person and Cooper for their leadership in shaping a vision of what a textbook of psychoanalysis should be. During the preparation of this edition of the textbook, Dr. Cooper passed away. Only a week before he died, we contacted him to let him know that this volume would be dedicated to him and to Dr. Person. He was very pleased to hear the news, and he wished us the best of luck with it. We will miss him, but he will continue to inspire our work.

We have been ably assisted in our work on this new edition by a superb group of section editors: Robert Michels for Section I, “General Introduction”; Richard Zimmer for Section II, “Core Concepts”; Adrienne Harris for Section III, “Schools of Thought”; Steven H. Cooper for Section IV, “Treatment and Technique”; Linda C. Mayes for Section V, “Research”; and Jeffrey Prager for Section VI, “Psychoanalysis and Other Disciplines.” The section editors, who themselves reflect the diversity of backgrounds and thinking in contemporary American psychoanalysis, have put their own personal stamp on the organization of their sections, including the topics and authors, and all have worked closely with their chapter authors to shape the final product. We are indebted to them for their efforts.

Readers familiar with the first edition of this textbook will note that the six categories covered by the section editors reflect a change in format for this new edition. The new format reflects our decision to focus on American psychoanalysis in the second decade of the 21st century in all its conceptual and clinical diversity. To this end, we have introduced a new section called “Schools of Thought,” and we have discontinued the section on the history of psychoanalysis that attempted to cover psychoanalytic views throughout the world. The new section titled “Schools of Thought” recognizes that American psychoanalysis today is a pluralistic endeavor. There is no “party line” anymore, and a wide variety of theoretical models are used extensively by American clinicians, often in approaches that draw aspects of different models into a private amalgam that may vary from one analytic couple to another.

It became clear to us that a comprehensive characterization of psychoanalysis throughout the world would be
a daunting task given that psychoanalysis has, during recent years, achieved a significant presence in Russia, Eastern Europe, China, and other parts of Asia. These dramatic developments in the discipline since the publication of the first edition, taking place in widely differing cultural contexts, led us to conclude that we would be hard-pressed to keep up with developments throughout every region of the world in a single textbook. Moreover, attempting to characterize the developments within psychoanalysis in even one country, such as France, or one geographical region, such as South America, in one brief textbook chapter could only offer a superficial overview of their unique histories and contributions. Hence, as noted, we decided to reorganize the text in this volume to provide an in-depth view of this current moment in American psychoanalysis. To be sure, influences from abroad are discussed throughout many chapters in light of the increasing cross-pollination between countries and theoretical models. It would be difficult to write about object relations, for example, without tracing the British influence on the theory, and similarly, one cannot write about the Lacanian point of view without taking into account French views. Chapter authors from overseas have been selected for their specialized knowledge of these contributions.

Because most psychoanalytic theories incorporate developmental components, we have made a further change to this edition by subsuming the developmental theory section from the first edition into the “Schools of Thought” section in our current edition. Developmental themes appear throughout other chapters as well. We have added a section titled “General Introduction” that includes a chapter on Freud and his early circle of colleagues as well as a contribution on developments in post-Freudian psychoanalysis to orient the reader to historical trends.

The editors wish to express our appreciation to the American Psychiatric Publishing staff for their support in a variety of ways throughout the project. Tina Coltri-Marshal handled all the correspondence and efficiently maintained a central “headquarters” for all authors and editors so that we had up-to-date information on the progress of the text. Greg Kuny was instrumental in managing the transition from a collection of submitted chapters to a finished textbook. We also wish to thank Robert Hales, APPI Editor-in-Chief, for recognizing psychoanalysis as an integral part of psychiatry.

Finally, we want to make note of the fact that psychoanalysts today compete in a marketplace that offers a variety of psychotherapeutic interventions. In this postmodern marketplace, the psychological needs of those it serves often are unmet when economic, ideological, or political priorities take precedence over clinical understanding. Hence we wish to express a special appreciation to our readers—those who practice psychoanalysis, those who are learning psychoanalysis, and those who apply psychoanalytic thinking to related disciplines—for having the courage to continue to embrace a model of the human psyche that has always been controversial, even subversive, and to believe that this model of the mind still provides our best and most comprehensive understanding of human nature.

Glen O. Gabbard, M.D.
Bonnie E. Litowitz, Ph.D.
Paul Williams, Ph.D.
SECTION I

General Introduction

Section Editor: Robert Michels, M.D.
Freud and His Circle

Daria Colombo, M.D.

In September 1909, Sigmund Freud delivered a series of five lectures at Clark University in Massachusetts at the invitation of its president, psychologist G. Stanley Hall, in honor of the institution's 20th anniversary. Prepared for his first audience in the New World (although delivered in German), the lectures were a clear and orderly exposition of the state of psychoanalysis at the time as well as a history of its origins: "I shall attempt to give you, as succinctly as possible, a survey of the history and subsequent development of this new method of examination and treatment" [Freud 1910, p. 9]. Freud described, to a general audience, the birth of his theory, warning 'complete theories do not fall ready-made from the sky and you would have even better grounds for suspicion if anyone presented you with a flawless and complete theory at the very beginning of his observations. Such a theory could only be a child of his speculation and could not be the fruit of an unprejudiced examination of the facts" [Freud 1910, p. 20]. Shaped by a rich intellectual tradition and rooted in empirical observations, Freud’s detailed and unprecedented clinical observations about psychological life and the theories generated from these observations and modified over time formed the central core of psychoanalysis.

Although the concept of the unconscious mind had surfaced in the work of the Romantic poets as well as in that of philosophers such as Schopenhauer and Nietzsche, Freud developed the first systematic, thorough, and explicit picture of how unconscious mental life extends its influence on the full spectrum of experience and behavior. His theory of the mind, which was first set forth in his work The Interpretation of Dreams [Freud 1900] and continuously modified in his later research, contained links to ideas that had long been circulating in philosophy, medicine, and literature. Yet although Freud was deeply influenced by his broad-ranging education and by the social, cultural, and artistic ideas of his era, he also was a highly innovative thinker, able to integrate his influences with clinical observations to arrive at startling and revolutionary conclusions. His work not
only synthesized many currents of thought to introduce a complex model of the mind but also shifted the field of psychology from a discipline loosely allied with philosophy to one using empirical observations to make scientific claims about the nature of consciousness, normal and abnormal psychology, and dreams.

Freud [1914] once described himself as “one of those who have disturbed the sleep of the world” [p. 21], using a phrase from Hebbel, and predicted astutely that his ideas were unlikely to be evaluated by his contemporaries with objectivity and tolerance. His insistence on the importance of childhood sexuality in psychological development and in contributing to adult neurotic symptoms proved to be indeed disturbing and largely unacceptable to most of his scientific and lay contemporaries and caused many of the central rifts as psychoanalysis developed into a system of thought as well as an institution. The considerable controversy stimulated by Freud’s ideas almost immediately led to the proposal of competing views of the etiology of emotional illness and the principles of clinical practice. In 1909 Freud credited the Viennese physician Josef Breuer, with whom he had written *Studies on Hysteria*, for the origin of psychoanalysis: Freud began his American lecture by stating, “If it is a merit to have brought psycho-analysis into being, that merit is not mine” [Freud 1910, p. 9]. Yet a footnote, added in 1923, corrects this, referring to “my remarks in ‘A History of the Psycho-Analytic Movement’ [Freud 1914], where I assumed the entire responsibility for psycho-analysis” [p. 9]. The story of his relationship with Breuer, a mentor with whom he developed important ideas and from whom he subsequently parted, is only one of the many rich encounters, both personal and intellectual, that revealed Freud’s ability to draw from others while creating a distinctly original system of thought.

Freud’s journey involved insatiable intellectual curiosity and the courage to promulgate unpopular ideas as well as a very practical need to establish a livelihood with which to support his family and, later, the drive to establish psychoanalysis as an institution as well as a science. He gathered around himself a group of students and disciples who, both in their allegiance and in their dissen, left a significant mark on the psychoanalytic corpus. The history of his alliances and breaks is a history of the ideas accrued, refined, discarded, and modified as psychoanalysis established itself both as a coherent discipline and as a formal institution during Freud’s life. Freud’s circle expanded eventually to include, in a sense, all of us who cannot consider the nature of the mind without engaging with the varied methodologies, theories, and judgments developed and promulgated by Freud.

Freud was born in 1856 to a Galician Jewish family in Freiberg, Moravia, now the Czech Republic but then part of the Austro-Hungarian Empire. His father, Jacob, was a struggling wool merchant, twice widowed with two sons before he married Freud’s mother, Amalia Nathanson, who was 20 years his junior and younger than Freud’s older half brother. When Freud was 3 years old, the family moved to Leipzig for a year and then to Leopoldstadt, the traditional Jewish district in Vienna, because of increasing financial difficulties. Freud lived in Vienna until the last year of his life. He was cherished as the brilliant eldest son, favored with his own room even as six younger siblings arrived, and marked from his earliest youth for an impressive career (Gay 1998). Always at the top of his class [Ellenberger 1970], Freud was an outstanding student enraptured in particular by the natural sciences, although his broad education in the arts would serve him well and later inform his scientific writing with culture and richness. Freud apparently was drawn to medical studies after hearing zoologist Carl Brühm recite a poem of Goethe’s, “Nature” [Ellenberger 1970]. Freud began his studies in 1873 and received a medical degree in 1881; his wide-ranging intellectual curiosity and his involvement in research caused him to take longer than the usual 5 years to finish his training (Gay 1998).

Freud’s intellectual voracity was fed by an extraordinarily rich and renowned university culture, one in which Jewish persons were increasingly, if only briefly, assimilated. Freud’s family had arrived in Vienna during a time when the role of Jews in public and professional life was growing and anti-Semitism, although still present, was less overtly constraining. The revolution in 1848 had heralded a period of increasing legal equality for Jews, with full civic rights by 1867. However, the stock market crash of May 9, 1873, the spring before Freud began his university studies, led to a resurgence of anti-Semitism and scapegoating. Freud later dated his self-awareness as a Jew to this period. “The nineteenth century . . . though the age of Jewish emancipation all across Europe, proved an uneasy interlude between the old anti-Semitism and the new” [Gay 1998, p. 20]. It was this interlude that allowed Freud’s gradual professional climb by which he eventually became one of the best-known physicians in Vienna, attaining the rank of extraordinary professor. Yet Freud’s position as an outsider
may have allowed him a certain degree of freedom in observing and critiquing the medical, social, and cultural conventions of the times. Nevertheless, his background presented a pragmatic difficulty:

The salience of Freud's Jewishness continues to be a point of contention among historians. Certainly he was troubled by his own ambivalence as well as by anti-Semitism and resented the negative impact on his career. He particularly objected to having psychoanalysis called a Jewish science, for such a label, in the Viennese ambience, was bound to harm the movement and militate against its growth. (Kurzweil 1998, p. 16)

Although anti-Semitism and financial difficulties imposed constraints, Freud's intellectual journey involved an early, unlettered engagement with the great ideas of his time. He came of age in an era shaped both by the Helmholtz school of physiology, which searched for the physical and chemical basis of natural phenomena, and by Romanticism, with its emphasis on subjectivity. He read widely, particularly in philosophy, especially admiring Feuerbach. Writing against the illusion of religion and focusing on empirical observations rather than systematic, formal principles, Feuerbach, with his Hegelian approach, had a profound influence on Freud, as did Catholic priest and philosopher Franz Brentano, with whom he studied at the university. Brentano wanted to separate psychology from philosophy and metaphysics, but he also would preserve something more than positivism and psychology for the conception of the mind, and he did so with his philosophy of intentionality. Brentano's theistic approach failed to shift Freud from his atheism, but his thinking provided Freud with a way to consider the mind that was broader than that allowed by purely materialistic principles (Gay 1998).

During his university years, Freud studied with physiologist Ernst Brücke, who represented the shift in science at that time from metaphysical vitalism to an empirically driven, positivistic approach that depended on rigorous observations and the reduction of physical and natural phenomena to underlying principles, a movement flourishing as advances were being made in physics, chemistry, and astronomy. Stemming from the 18th-century Enlightenment, with Auguste Comte as its central theorist, positivism was not a dogmatic theory but a style of inquiry, bringing the approaches and methodology of the natural sciences to the study of human psychology (Gay 1998). Freud worked for 6 years in Brücke's laboratory, from 1876 to 1882, and met Josef Breuer there, forming a deep friendship with the older man. Freud's training was in neuropathology, and he focused on studying the invertebrate nervous system. His early work on the smallest building blocks of neurological function were very preliminary steps in building a comprehensive theory of mental life, and his earliest publications concerning the nervous system of fish could be considered the prototype of his later attempts to map mental functioning.

Understanding Hysteria

Although remaining in the laboratory and making scientific discoveries would have been the surest road to becoming a university professor, and his monographs were beginning to earn him a small reputation, Freud's advancement there was blocked by a lack of openings, and he left research to pursue a private practice in clinical neurology. His move was also compelled by the need to establish an income sufficient to support a family, because he was planning to marry his fiancée, Martha Bernays. During his 3 years of hospital residency at the General Hospital in Vienna, Freud worked in several departments, including internal medicine, neurology, and psychiatry. In psychiatry he worked with Theodor Meynert, the brain anatomist. Freud studied the properties of cocaine, but rather than gain him prestige the work soon discredited him as the dangers of the drug became evident. He had little training in academic psychiatry, which at that time was not interested in the study of patients' subjective experiences and indeed might have restricted Freud's exposure to the sorts of patients and clinical mysteries that spurred his curiosity. Instead, by entering clinical neurological practice, Freud joined a general medical culture in which listening to the patient was central, and one that placed Freud in frequent contact with a type of patient commonly seen in neurological practices of the time, the hysterical.

Hysteria [literally, “wandering uterus”] at this time was poorly understood. It was thought to have an organic cause, and its mostly female sufferers were treated with a variety of ineffective physical manipulations or dismissed entirely as succumbing to a female weakness or as conjurers of a malingering’s ruse. Hysteria, Freud wrote, “has the power of producing illusory pictures of a whole number of serious diseases” (Freud 1910, p. 10). It was a common but mysterious condition, frustrating to physicians who had little power over it. Freud later wrote of the doctor encountering patients with the condition: “He regards them as people who are transgressing the
laws of his science—like heretics in the eyes of the orthodox. He attributes every kind of wickedness to them, accuses them of exaggeration, of deliberate deceit, of malingering. And he punishes them by withdrawing his interest from them” [Freud 1910, p. 12]. Freud, however, had the opposite response: he was intrigued. When he attained the rank of privatdozent in 1885, he was awarded a 6-month traveling grant that allowed him to study with one of the leading neurologists of the time, Jean-Martin Charcot, leader of the Salpêtrière School in Paris, who in 1885 was bringing new attention and understanding to hysteria.

When Sigmund Freud arrived in Paris in 1885, he found himself in a country that was pursuing important developments in what was called “new psychology.” Théodore Ribot was its most important pioneer, following positivism to argue that psychology should employ the methods of the natural sciences and rid itself of the metaphysics and religion with which it was intertwined. Ribot developed the ideas that associational tenets could be used to study psychic contents, that hereditary theories could explain mental capacities and functions, and that observations of mental disorders could provide empirical data [Makari 2008]. The French psychologie nouvelle placed phenomena previously considered mere spectacle—the amazing results observed with hypnotism and mesmerism—under a new sort of scrutiny, so that the stuff of showmanship and mystification became the object of legitimate scientific inquiry. Hysteria was reclassified as a mental disorder whose observation and understanding could be valuable. When Charcot, who had made his name as a distinguished pathologist and neurologist, shifted his attention to hysteria, he gave a stamp of scientific legitimacy to the study of hysteria and hypnotism. He first distinguished between various sorts of hypnotic phenomena, separating dynamic paralyses (consisting of hysterical, posttraumatic, and hypnotic paralyses) from those resulting from lesions of the nervous system. Charcot made new and dramatic claims for hysteria, diagnosing it as a genuine illness, stating that it could affect men, and demonstrating that it could be used for understanding and healing mental pathology. Freud was impressed by Charcot’s devotion to acute observation and amazed to see Charcot able to both cause and cure hysterical paralyses with hypnotic suggestion [Gay 1998]. By linking hypnotism with hysteria and by bringing both under clinical scrutiny, Charcot—in France at least—pushed these ideas into the realm of social and scientific acceptability.

During his months in Paris, Freud worked on microscopic studies of children’s brains and gathered data that were to be the basis of later publications on cerebral paralysis and aphasias. However, Charcot had sparked in Freud an intense and abiding interest, and Freud returned to Vienna with a desire to both promulgate and pursue these ideas. Charcot believed that the understanding of nervous disorders, and not a further anatomical mapping of the brain, was the path of the future [Makari 2008]. The future for Freud would indeed lie in the neuroses, but at the time it was an unlikely route to success. Charcot’s ideas about hysteria had pushed Freud in a novel direction, one that left him on the outside of the Viennese medical establishment. Freud became Charcot’s translator into German, something he had time to do once he returned to Vienna, having few patients in his new practice [Ellenberger 1970]. Struggling against the skepticism of his colleagues, Freud argued that the study of hypnotism could reveal much about normal psychology and promulgated Charcot’s finding that males could experience hysteria, but his lectures on these topics received chilly responses [Jones 1953], especially as Charcot himself soon came into disrepute. Charcot’s belief that only the ill could become hypnotized was revealed to be evidently untrue; the stages of hypnotism he had described were debunked. Charcot had neglected the role of suggestion in hypnotism, believing that only hysterics could be hypnotized, but a rival school based in Nancy and led by Ambroise Auguste Liébault and Hippolyte Bernheim argued that anyone could be hypnotized and that suggestion played a central and critical role in hypnosis [Gay 1998] and was a normal element of psychological life. Freud had noted the strong emotional attachment formed by patients to the hypnotist, the first hint of what he would later conceptualize as transférence. The role of suggestion, however, created a problem: if all aspects of mental life were so influenced by suggestion, it seemed impossible to find any scientific manner in which to conduct research into mental process and functioning. Yet Freud, looking back both to the Romantic emphasis on subjectivity and to his scientific training, “took subjectivity itself as the object of scientific investigation” [Auchincloss and Glick 1996, p. 3].

In accepting the role of suggestion, Freud left Charcot. Freud also distanced himself from the concept of heredity and degeneration, central both to Charcot’s beliefs and to those of his intellectual heir, Pierre Janet. Freud wrote, “You will find in Janet a theory of hysteria which takes into account the prevailing view in France on the part played by heredity and degeneracy. According to him, hysteria is a form of degenerate modification of the nervous system, which shows itself in an innate weakness in the power of psychical synthesis” [Freud 1910, p. 21].
The discomfort with degeneration theory had at least something to do with the association of degeneration with claims about Jews and with its frequent use as a vehicle for anti-Semitism. Yet by cutting himself off from a biological root cause, Freud faced other challenges. “Without heredity as the presumed biological cause of psychopathology, Freud would struggle with a long line of critics who saw his endeavors as floating in some metaphysical mind stuff that was cut loose from the material world” [Makari 2008, p. 50]. The critics would come later, at this point Freud was both being influenced by and discarding the various theories of hysteria and hypnotism he was encountering. While distancing himself from Charcot and Janet, Freud found a way to consider Bernheim’s invaluable but destabilizing findings about suggestion by turning his attention to the intrapsychic conditions that affected suggestibility and response to a physician. Freud would translate both Charcot and Bernheim, but as he did so he began to shape his own view of neurosis and hysteria, in which he was steeped as he returned to Vienna to begin his private practice.

As Freud struggled with both the content and the methodology of understanding human mental life, he was simultaneously engaging with long-standing German philosophical debates about the nature of reality and of the mind, beginning with Kant; Friedrich Schelling’s philosophy of nature, which looked to unite the transcendent and physical aspects of reality; and Johann Fichte, who dismissed the transcendent aspect of Kant’s thinking but embraced the focus on subjectivity and self-consciousness [Makari 2008]. Arthur Schopenhauer declared that inner psychic working influenced our view of the world, and physiologist Johann Müller did clinical experiments demonstrating how empirical observation was influenced by brain function [Makari 2008]. Gustav Fechner, the founder of psychophysics, tried to blend scrupulous empirical investigation with a nonreductive view of the mind as he studied how inner life responded to and perceived outer stimuli. These thinkers formed the background for Freud’s investigations and served as the springboard for his theorizing.

Foundations of Psychoanalysis

In 1886, as Freud started his practice at Bergstrasse 19, he had shifted his interest entirely from neuroanatomy to the detailed clinical observations of mental function-}

ing. His first book, published in 1891, which he dedicated to Josef Breuer, was On Aphasia: A Critical Study, and even there Freud considered psychological contributions to these conditions. He was encountering patients for whom no organic treatment was possible and saw in the ineffectiveness of the current treatment an intellectual, scientific, and practical potential:

[Like all neurologists he found that his practice would consist largely of psychoneurotics who were under the impression that ‘nerve specialists’ could cure ‘nerves’ as well as diseases of the spinal cord. Unlike most neurologists, however, he regarded this state of affairs not as a humiliating nuisance in view of their total ignorance of the subject, but as an opportunity to explore a new and fruitful field. (Jones 1953, pp. 228–229)]

As Freud struggled to help his hysterical patients, he employed the then-current technique of attempting to remove symptoms using hypnotic suggestion. Yet he found himself often unsuccessful at hypnosis and intellectually unsatisfied with the approach. Spurred by his old friend Breuer’s description of the case of Anna O., Freud moved toward ideas that would become the core of psychoanalysis:

A classic case of hysteria, the patient (actually Bertha Pappenheim, who went on to become a well-known social worker [Jones 1953]) fell into altered mental states and had multiple somatic complaints. She seemed to have two distinct states of consciousness, one apparently normal, the other that of a naughty child, between which she shifted through autohypnosis and from which she would awake in a normal state. She would relate her worries and her hallucinations to Breuer, who was astonished to see that some of her symptoms resolved once related (hence “the talking cure” or “the chimney sweep”). Breuer devoted a great deal of time to her, treating her between 1880 and 1882. She developed strong feelings for Breuer, including an hysterical pregnancy, which caused him to flee and made him reluctant to publish the case himself. He discussed the case with Freud, whose interest focused on the power of the doctor-patient relationship and on the sexual origin of the neurotic symptoms. Thinking about his own cases, what he had learned from Charcot, and the case of Anna O., Freud realized that “whatever the unknown neurological basis of hysteria might be, the symptoms themselves could be both treated and abolished by ideas alone” [Jones 1953, p. 227].

However, simply relating her experience provided Anna O. only temporary relief. It was remembering the source of the symptoms that seemed more effective.
The recollections and associations to them needed to be reintegrated with their affects, which would lead to catharsis: “our hysterical patients suffer from reminiscences” (Freud 1910, p. 16). Freud added his idea of inner psychic conflict being enough to cause hysteria. He also insisted on the importance of sexuality as the likely etiology of nervous disorders, and of sexual seduction as universal and as the cause of neuroses—conclusions with which Breuer was uncomfortable. Breuer also contributed ideas with which Freud did not agree, such as the conception of “hypnoid states” similar to that described by Janet. Breuer believed that hysterical symptoms could only arise in this state, suggesting that the splitting of the mind was due to pathological brain function rather than, as Freud held, to psychological conflict. In uneasy collaboration, Freud and Breuer published “On the Psychical Mechanisms of Hysterical Phenomena: Preliminary Communication” in 1893 (Breuer and Freud 1893), followed by Studies on Hysteria in 1895 (Breuer and Freud 1893–1895), but Freud soon distanced himself from Breuer’s ideas about hypnoid states and continued to focus on sexuality, leading to a rift between the once-close friends. Drawing ideas from Charcot, Bernheim, and Breuer, while also discarding parts of these mentors’ beliefs, Freud began to build his own distinctive system of thought. Freud was “the explorer who had had the courage of Breuer’s discoveries; in pushing them as far as they would go, with all their erotic undertones, he had inevitably alienated the munificent mentor who had presided over his early career” (Gay 1998, p. 67).

Freud found that the memories at the source of his patients’ neurotic symptoms were invariably revealed to be sexual in nature. He wrote, “I was not prepared for this conclusion and my expectations played no part in it, for I had begun my investigation of neurotics quite unsuspectingly” (Freud 1925, p. 24). Despite general skepticism, Freud became convinced that the symptoms of neurasthenia, as well as those of hysteria, were caused by sexual disturbances, setting aside the previously held view that such illnesses were a consequence of unspecified hereditary weaknesses in the nervous system. He decided that early childhood seduction, so frequently reported by his patients, was the source of the sexual disturbance. He also held that the patients’ verbal productions had meaning and that psychical as well as physical life followed the principles of determinism. Having arrived at the central principle of psychic determinism, Freud studied the productions of the mind as causally linked to earlier events, rather than dismissing them as meaningless epiphenomena (Auchincloss and Glick 1996).

With the case of Elisabeth von R., Freud had turned to the cathartic technique. The treatment, conducted in 1892 and published in 1895, was identified by Freud as “the first full-length analysis of a hysteria undertaken by me” (Breuer and Freud 1893–1895, p. 139). Freud described his method as “clearing away the pathogenic psychical material layer by layer, and we liked to compare it with the technique of excavating a buried city” (p. 139). He was unable to hypnotize the patient and abandoned hypnosis, later declaring it “a temperamental and, one might almost say, a mystical ally” (Freud 1910, p. 22). He recalled the Bernheim school, how it had been shown that people could recall what had occurred during a somnambulistic state, and he temporarily used the “pressure technique,” a pressing of his hand on the patient’s forehead to elicit memories, but “it was a laborious procedure, and in the long run an exhausting one, and it was unsuited to serve as a permanent technique” (Freud 1910, p. 23). Yet the pressure technique, with its injunction to “report to me faithfully whatever appeared before her inner eye or passed through her memory at the moment of the pressure” (Breuer and Freud 1893–1895, p. 145), led to the introduction of free association. Freud noted that at times the pressure technique would yield extensive material, whereas at others it failed to do so. Freud’s careful clinical scrutiny, combined with a stubborn confidence, led him to fascinating results. He “resolved … to adopt the hypothesis that the procedure never failed” (Breuer and Freud 1893–1895, p. 153) and indeed found that material had been present but had been held back. He wrote, “I began to attach a deeper significance to the resistance offered by the patient in the reproduction of her memories and to make a careful collection of the occasions on which it was particularly marked” (Breuer and Freud 1893–1895, p. 154). This is the first use of the term resistance, which was to become an important feature of his evolving theory of psychoanalysis.

The Freud in this early case was an uneasy blend of confident scientist using empirical observations to develop a new theory and an isolated and occasionally defensive figure. He noted at one point of his investigations, “These, incidentally, were not the kind of questions that physicians were in the habit of raising” (Breuer and Freud 1893–1895, p. 144). In his discussion, he wrote,

[I]t still strikes me myself as strange that the case histories I write should read like short stories and that, as one might say, they lack the serious stamp of science.…” The fact is that local diagnosis and electri-
Freud and His Circle

cal reactions lead nowhere in the study of hysteria, whereas a detailed description of mental processes such as we are accustomed to find in the works of imaginative writers enables me, with the use of a few psychological formulas, to obtain at least some kind of insight into the course of that affection. [Breuer and Freud 1893–1895, pp. 160–161]

At this point, this insight consisted of the belief that behavior was meaningful rather than accidental and the premise that infantile sexuality was the core of unconscious meaning that needed to be discovered. Freud had received a couch from a patient in 1890, and he retained from hypnosis the practice of having his patients recline on a sofa while he sat behind them, out of their field of vision.

**Self-Analysis and Dreams: The First Topographic Model**

Although his clinical practice began to offer Freud more financial security, he continued to be fairly isolated scientifically. In 1896, Freud’s father died, and beset by his own neurotic symptoms, Freud began a course of self-analysis and a close study of his dreams. Recalling that the Nancy school had considered hypnosis as a sort of sleep, Freud decided to use dreams as “analogous to unconscious, hypnotic hallucinations” [Makari 2008].

Always needing an interlocutor for his developing ideas, Freud developed an intense friendship with Wilhelm Fliess, with whom he corresponded intimately and frequently between 1897 and 1904. Fliess was an ear, nose, and throat specialist from Berlin who came to Vienna in 1897 and had treated Freud’s sinus problems and attended one of Freud’s lectures on neurology. He had some odd beliefs in the primary connection between the nose and genital organs, in universal bisexuality, and in a male and female periodicity, but he was a close listener and passionate friend. They soon became regular correspondents, and their letters reveal the importance Fliess held for Freud as a sounding board, supporter, and sometime critic [Masson 1985]. As Freud pursued his self-analysis and examined his dreams, it was Fliess to whom he related his thoughts and with whom he worked out his budding model of the brain. The dream of Irma’s injection, “the first dream of which he made a complete analysis with his new technique of associations” and which “was to become the prototype of a dream analysis” [Ellenberger 1970, p. 445], was linked to a patient whom Freud had treated for hysteria and on whom Fliess had carried out a botched nose operation. The dream of “Irma’s injection” eventually helped convince Freud that the unconscious could be accessed through dreams and that, as he had postulated years before, dreams could be used to reveal the inner workings of the unconscious mind.

The concept of defense (Abwehr) appeared in 1894. In 1895, Freud began to refer to his work as “psychoanalysis.” By 1896, he was setting forth a theory of neuroses, distinguishing between “actual neuroses,” caused by disturbances in sexual functioning, and “psychoneuroses.” The latter, divided between hysteria and obsessions, were thought by Freud to be caused by sexual abuse in childhood, a theory he described in a poorly received 1896 lecture to the Society for Psychiatry and Neurology entitled “The Etiology of Hysteria.”

In the fall of 1897, in a letter to Fliess dated September 21, Freud, while still identifying sexuality as the origin of hysteria and while never denying the possibility of childhood sexual abuse, abandoned the seduction theory as the universal source of neuroses. He realized that the childhood sexual seductions described by his patients were largely fantasies. Through his self-analysis and his dreams, Freud had gradually come to recognize his own intense childhood love for his mother and his corresponding jealousy of his father, a situation he termed the Oedipus complex after Sophocles’ Oedipus Rex. “This was a decisive turning point in psychoanalysis: Freud found that in the unconscious it is impossible to distinguish fantasies from memories, and from that time on he was not so much concerned with the reconstruction of events from the past through the uncovering of suppressed memories, than with the exploration of fantasies” [Ellenberger 1970, p. 488]. These fantasies would be linked to a growing understanding of the transference—that phenomena first glimpsed in the use of suggestion and then in Breuer’s young patient’s remarkable reaction to Breuer. The term transference was early defined by Freud in his postscript to the Dora case as “new editions of facsimiles of the impulses and phantasies which are aroused and made conscious during the progress of the analysis…they replace some earlier person by the person of the physician” [Freud 1905]. A growing understanding of the transference, along with a focus on it, was one of the methodological themes threaded through Freud’s theory building.

Freud’s new focus on fantasies and his intense interest in what these fantasies revealed about the complexity and intensity of childhood sexuality offered a new way to understand what had long been familiar to med-
ical and legal authorities—that is, the complex array of perverse sexual activities enacted by adults. It also helped to clarify anthropological observations, well known at the time, about the range of sexual practices encountered in other cultures. Freud’s ideas were beginning to meet with increased interest as a result of changing societal views on sexual behavior. Freud (1901) also expanded his theories into understanding commonplace events, such as slips, forgetting names, and childhood memories, in The Psychopathology of Everyday Life, advancing a claim for the applicability of his discoveries to normal as well as pathological psychology.

In The Interpretation of Dreams, published in 1899, Freud famously wrote that “the interpretation of dreams is the royal road to the knowledge of the unconscious in mental life” (Freud 1900, p. 608). He used the universal phenomena of dreams to demonstrate the fruitfulness of investigating infantile sexuality through exploring adult fantasy rather than by direct observation, a technique later employed by his daughter, Anna. He set forth a method with which this investigation could be carried out, presented his first model of the mind, and promulgated the concept of an inherent sexual energy, later to be named “libido,” thus claiming a biological basis for his new psychological theory. Freud attempted to construct a diagram of the mental apparatus with which he could explain the formation of dreams in terms of perceptions, memory, symbol formation, and the fate of images. This effort served as a conceptual bridge between his neurophysiological model and his increasing tendency to rely on purely psychological data. Because dreams were universal, Freud used sample dreams of his own as well as those of patients to elucidate normal as well as abnormal mental life while introducing a new technique, dream interpretation, that could be used in the treatment of neuroses. He described dreams as wish fulfillment and identified the method of free association as the key to their interpretation. He also described how meanings in dreams are obfuscated by mental operations such as condensation, displacement, “consideration for representation,” and secondary revision. Freud distinguished between the manifest and latent content of the dream and introduced the censor, a precursor of the superego. He argued that dreams that appeared unpleasant did not violate the principle of wish fulfillment: the wishes were disguised because of conflict engendered in the dreamer. Infantile wishes often appeared, disguised, in dreams, and uncovering their meaning was for Freud the key of dream interpretation.

In The Interpretation of Dreams Freud also proposed a hypothetical model of the mind and made an imaginative leap by claiming that this model could also explain the formation of neurotic symptoms. In this topographic model, mental contents were distributed among three systems: the Unconscious, the Conscious, and the Pre-Conscious. Although he seemed to be describing different loci or areas of the mind, Freud never intended that these divisions be thought of in a concrete anatomical fashion. The system Unconscious contains wishes from infancy and operates via primary process, a primitive way of thinking based entirely on the pleasure principle. This system is separated by repression from the other systems. The system Conscious functions according to familiar reason and logic and interfaces with the external world. The system Pre-Conscious refers to mental contents not at the moment in conscious awareness but readily accessible to consciousness. Secondary process thinking, in which the reality principle dominates, is characteristic of the systems Conscious and Pre-Conscious. In this model, the main emphasis was placed on the censorship barrier between conscious and unconscious mental activity. This emphasis was in accordance with Freud’s view of the pivotal role of repression in neuroses and with the then-prevalent focus in psychoanalytic treatment on the lifting of repression and the identification of the unconscious instinctual wishes against which repression had been arrayed. At this stage, Freud also postulated that the energy attached to repressed sexual wishes [later defined in 1905 as libido] somehow became converted, as a consequence of repression, into a toxic product, anxiety. Successful psychoanalytic treatment was thus supposed to relieve anxiety.

In Three Essays on the Theory of Sexuality, published in 1905, Freud made the point, as he had in his work on dreams, that neurotic patients merely demonstrated excesses or distortions of normal human psychology (Freud 1905). "For Freud…a neurosis is not some outlandish and exotic disease, but rather the all-too-common consequence of incomplete development, which is to say, of unmastered childhood conflicts” (Gay 1998, p. 145). Freud introduced the forerunner of libido—described in economic terms revealing Fechner’s influence as well as in evolutionary terms revealing Darwin’s—as he outlined his theories about the infantile origin of biologically rooted sexual drives. He also discussed the reasons for the amnesia of this early period and the psychological tasks necessary in latency and adolescence for the establishment of normal adult genital sexuality. It is important to recognize that in writing about sexuality, Freud was not unique: there was a great deal of literature on sexology at the time, and Freud added his voice to what was a topic of intense interest (Ellenberger 1970).

There was a crucial biological underpinning to Freud’s thinking. “Implicit in the concept of psychic determin-
ism is a system of motivation. Freud’s motivational system is based on the pleasure-unpleasure principle...the origins of the behavior lie, at least in part, in the biological nature of the organism itself...the organism is driven’ [Cooper 1985, pp. 8–9]. Conflict also played a central role in Freud’s model. Childhood fantasy combined with immature cognitive development inevitably led to fears and fantasies about the nature of sexual activity and the dangers believed to be associated with it. Later theoretical revisions would make this conflict and the ego’s handling of it more central than the mere identification of the conflict-laden wishes. At this point Freud felt that childhood development could be studied through the prism of adult fantasy rather than by direct observation of children. He introduced his ideas about female sexuality, the centrality of penis envy, and the fear of castration. Freud believed that children of both sexes mistakenly believe that every individual has a penis or has somehow been damaged by losing it. An unconscious belief in the reality of castration or the fear of its occurrence, persists long after children learn anatomical differences, and such fantasies may persist to cause distress in adulthood. Perhaps this of all the propositions Freud offered about sexuality would become the most controversial and most frequently challenged element of his theoretical edifice.

At this point, with a model of the mind and an instinct theory based on libido, Freud had a theoretical foundation rooted in a biological, deterministic conception of humankind along with a clinical armamentarium consisting of free association, interpretation, and the analysis of transference and resistance. This last principle was at the time the focus of analytic technique, with the analysis of resistance linked to the idea that unconscious meanings related to infantile sexuality needed to be uncovered. Early psychoanalysis at this point was thus defined by a search for a core meaning—the “excavating [of] a buried city” in Freud’s words—rather than by a core methodology. The subsequent shift from mental content to clinical process would eventually enable very different thinkers to claim to be psychoanalytic. The ground for this potentially divisive plurality was established as Freud gradually began to find a wider audience. Psychoanalysis developed further in a less isolated setting.

**Freud in His Community**

In 1902, Freud finally obtained a promotion to extraordinary professor at the University of Vienna, after having been a privatdozent for 17 years, an unusually long time to be fixed at that rank. He was likely hindered by a combination of anti-Semitism and the unpopular nature of his views. Edoardo Weiss, the first Italian psychoanalyst, wrote of Freud, “While his studies of the central nervous system had been well received by his colleagues, his psychoanalytical writings reduced his scientific reputation sharply...In this situation a feeling of personal loyalty towards Freud developed in a small group of his adherent—not all of them physicians” (Weiss 1970, p. 4). Freud had indeed begun to find a sympathetic audience, and in the year of his appointment as professor, he invited some local physicians to a meeting that would call itself the Wednesday Psychological Society, an idea spearheaded by local physician Wilhelm Stekel. Max Kahane, Rudolf Reitler, Paul Federn, and Alfred Adler were early members of a group that initially met informally in Freud’s study and formed the nucleus of what was to become in 1908 the Vienna Psychoanalytic Society. “The physicians in the Wednesday Society would be joined by non-physicians from the larger swirl of Viennese culture for, by 1902, Freud’s medical theories and his positions on degeneration, repression, and sexuality had begun to filter into broader debates on Austrian political and social life” (Makari 2008, p. 135)

Gradually the group became too large to meet in Freud’s study. A meeting hall was rented and more formality was instituted; Otto Rank was brought in by Adler as secretary in 1906. The site of initiation was to present a paper, after which one was accepted as a member. Members or frequent visitors eventually included Sandor Ferenczi from Budapest, the Viennese Victor Tausk, Karl Abraham and Max Eitingon from Berlin, C.G. Jung and Ludwig Binswanger from Switzerland, Ernest Jones from London, Edoardo Weiss from Italy, and A.A. Brill from the United States. “Essentially they zigzagged between exploring their unconscious, expressing their solidarity with the group, and engaging in heated polemics. And as they pooled their speculations, reported on cases, and insulted one another, the Freudians seem to have cast Freud as their oedipal father and one another as rivalrous siblings” (Kurzweil 1998, p. 37).

As Freud continued to develop his model of the mind, he did so in the context of what was becoming a burgeoning movement, with increasing tension between the tasks necessary to sustain the field’s survival and expansion and those concerned with the developments and refinements of psychoanalytic theory. As Cooper (1985) noted, Freud’s protectiveness of his ideas and his belief that the development of psychoanalysis would best be served by founding a movement rather than a forum
for open scientific discussion of competing ideas, while probably essential for the rapid triumph of psychoanalysis within Western culture, also contributed to the sectarianism of early psychoanalytic thought and the tendency for each new system to attempt completion and closure. [p. 12]

Jung andBinswanger, after visiting Freud in 1907, founded a psychoanalytic society in Zurich in 1908: “all seventeen of the first disciples, between 1902 and 1906, were Jewish, so Freud was especially pleased when Carl Jung, a Christian, not only became a psychoanalyst but started a group at the Burghölzli clinic in Zurich” [Kurzweil 1998, p. 15]. Trained in Switzerland under Eugene Bleuler, Jung early became acquainted with Freud’s work and was his passionate advocate. Freud singled him out among his followers as his heir; it was thought this was at least in part because Jung’s Christian background would enlarge the appeal and reach of psychoanalysis. The First International Congress of Psychoanalysis met in Salzburg in 1908, and in 1909 the first psychoanalytic journal, Jahrbuch für Psychoanalytische und Psychopathologische Forschungen, was founded. Freud was invited to lecture at Clark University and traveled to America with Ferenczi and Jung. In 1910, the International Psychoanalytical Association was founded at the Second International Congress of Psychoanalysis, but “the very fact that psychoanalysis was proclaimed a ‘movement’ (and not just a new branch of science) inevitably provoked opposition in psychiatric circles” [Ellenberger 1970, p. 455]. Freud found himself in competing roles, as clinician, scientist, administrator, and leader. He also was careful to delineate which ideas belonged to psychoanalysis and which would represent digressions, deviations, or repudiations. Edoardo Weiss, in his memories of Freud, wrote, “Freud himself knew that the concepts of psychoanalysis would be developed and revised. At the same time, he felt quite understandably very protective of the great field of his scientific investigation and theory he had christened psychoanalysis, and he resented any distortion or misinterpretations of his concepts” [Weiss 1970, p. 5].

Freud’s first significant break was with Alfred Adler, who developed what he called “individual psychology” with a decreased emphasis on the unconscious. Adler believed that the drive for superiority or mastery and the inferiority complex that could result were more important than the unconscious dynamics put forth by Freud. Adler left the Vienna Psychoanalytic Society with some adherents in 1911, forming a dissenting group. The next, even more momentous break in 1913 was with Jung, who was at the time president of the International Psychoanalytical Association and editor of its journal. Freud and Jung increasingly disagreed on the importance of the libido theory. Jung began to term his own theory “analytical psychology” as he extended the concept of libido to encompass general, nonsexual forces and rejected what he saw as Freud’s mechanistic view. Another important later break, in 1920, was with Otto Rank, who proposed a theory of neurogenesis based on the birth trauma and discounted the importance of childhood sexual wishes and fantasies. Brenner has noted of these various theoretical dissents that there was a striking “uniformity with which all the otherwise diverse formulations reject the idea of the importance to mental functioning and development of conflicts over sexual and aggressive wishes originating at ages three to six” [Brenner 2000, p. 608].

Theoretical Developments and the Establishment of a Movement

Freud, in his 1914 On the History of the Psycho-analytic Movement, clarified the central tenets of psychoanalysis and declared that “I consider myself justified in maintaining that even to-day no one can know better than I do what psycho-analysis is, how it differs from other ways of investigating the life of the mind, and precisely what should be called psycho-analysis and what would better be described by some other name” [Freud 1914, p. 7]. He described the secession of Adler and Jung and “reportedly wrote this essay in order to save psychoanalysis from dilution...He made an organizational decision to enforce his theoretical position about the centrality of the unconscious. From then on, followers would defend his doctrine not only against Jung and Adler’s deviance but against all those who would water it down” [Kurzweil 1998, p. 89].

With the departure of Jung and Adler, Freud relied increasingly on Abraham, Ferenczi, and Jones. Ernest Jones, who had met Freud at the First International Congress of Psychoanalysis in 1908 and was analyzed by Ferenczi, formed the London Psycho-Analytical Society in 1913 and later, demonstrating his loyalty to Freud, dissolved the London Society because of Jungian dissent, immediately reconstituting it as the British Psycho-Analytical Society in 1919. He became the key advocate for Freud in Britain and North America and was a powerful polemicist and disseminator. He did have his dis-
agreements with Freud, most notably about Freud's theories on female sexuality. He also played a critical role in later attempting to mediate between Anna Freud and Melanie Klein. Freud also supported Abraham's prominence in the movement and was influenced by his papers on the development of libido.

Freud never hesitated to use his growing psychoanalytic understanding to address world events as well as human psychology and psychopathology. World War I, with its unimaginable destruction and death, was transforming the world in which Freud was living and working as well as directly affecting his family (two sons served in, and survived, the war). He published papers on war and psychoanalysis, considering how psychoanalysis both had predicted the depth of human frailty and could offer a way to try to understand it. The incomprehensible death toll between 1914 and 1918 led Freud to attribute greater importance to aggression. Although his own aggressive wishes had never been absent from the record of his fantasies and dreams, Freud now placed aggression in a more prominent role. In 1920, in Beyond the Pleasure Principle, he proposed the idea of a death drive—that there is an urge in all living things toward death. This concept was never a well-accepted part of his theory and seemed to be at least in part a reaction to the devastation of the Great War. He saw soldiers reliving their trauma, returning to horror in a manner seemingly at odds with the pleasure principle. Freud also noticed that children at play would often play at the disappearance of a beloved figure and that patients would compulsively repeat repressed, painful material. Freud felt that this "repetition compulsion" was evidence of a drive to return to an animate state, to destroy one's self, an idea that was taken up most seriously in later years by Melanie Klein.

Even as Freud defended the core of his theory from the followers he considered dissenters, Freud himself was revising many key aspects of his theory in work he did beginning in the second half of the 1910s and through the 1920s. With his new, dual classification of the instincts, adding to Eros (the libidinal instincts) a place for aggression, Freud dropped the idea of a self-preservation drive, hypothesizing instead that there must be two biologically derived primary driving psychic forces, libido and aggression. Wishes expressing either or both of these drives could lead to intrapsychic conflict. With these modifications, Freud soon found his topographic model inadequate. Introduced in The Interpretation of Dreams, this old model was challenged by the observation that defenses against unconscious wishes are themselves unconscious and cannot be brought to consciousness by undoing repression. In addition, the analysis of melancholia and obsessional symptoms led to the observation that moral imperatives and self-punitive tendencies can also operate unconsciously (Auchincloss and Glick 1996, p. 15).

Freud abandoned the topographic model in favor of a new tripartite schema, which has come to be called the structural theory. In The Ego and the Id, Freud (1923) introduced a new conceptual language in which the mental apparatus was divided into "id," "ego," and "superego," providing him with an improved framework with which to describe mental conflicts and their clinical manifestations. The id contains instinctual drives, both libidinal and aggressive; the ego represents the executive functions of the mind and the mind's connection with external reality, and the superego encompasses moral prohibitions and ideals. This new theory allowed a critical change in how conscious and unconscious mental content had been considered; now certain aspects of ego and superego functioning were also recognized as being located in the unconscious, along with the contents of the id. This recognition allowed Freud to develop a more sophisticated picture of intrapsychic conflict and thus provide a better way to account for the clinical data.

Freud also gradually revised his theory of anxiety as growing clinical experience led him to reconsider his earlier formulations. In his earlier theories, Freud "held that anxiety appears as a consequence of accumulated, undischarged libidinal cathexes, a situation brought about by the repression of the instinctual drive derivatives" (Arlow and Brenner 1964, p. 59). In his new theory, Freud argued that whenever wishes from the id threaten to emerge in thought or action, anxiety is generated. The anxiety acts as a signal, causing the ego to mobilize repression, along with a broad spectrum of other defenses, in order to block or disguise the anxiety-provoking wish. These changes placed the ego in a more prominent position as the focus of increased analytic attention and paved the way for the later development of ego psychology, as these shifts led to an emphasis on the centrality of the ego's executive role, both in providing the signal of anxiety and in constructing the defenses which organize the characterologic and symptomatic constructions of ongoing individual life (Cooper 1985, p. 10).

As Freud continued to develop his theory and gained a growing audience, he devoted a significant amount of attention to culture, politics, and literature, with a polymath's interest in the rich cultural environment around him and with the strong belief that psychoanalytic principles could be brought to the consideration of works of art, the act of creativity, the understanding of well-known figures, and to history itself. Freud made immense claims for applied psychoanalysis, laying a path
that would be heavily traveled not only by later psychoanalysts but also by academicians. He was broadening the purview of psychoanalysis, which he also did by battling for the right of nonphysicians to be analysts. In his 1924 “The Question of Lay Analysis,” Freud [1926b] argued against psychoanalysis belonging only to medical doctors, taking sides in a debate that continued for decades and is still unsettled in some quarters. Freud strongly believed that medical training was not necessary to practice psychoanalysis and indeed could even hinder it. Some of his most prominent adherents and followers, including Lou Andreas-Salomé, Melanie Klein, and his own daughter Anna, were not physicians. The debate over lay analysis became a major source of conflict between the European and American psychoanalytic communities, with the latter taking a firm stance against it. A.A. Brill, then the head of the American Psychoanalytic Association, threatened to withdraw from the International Psychoanalytical Association over the issue. Jones led a compromise that would allow each institute to make its own decisions, and American opposition to lay analysis continued until fairly recently.

The publication in 1926 of Inhibitions, Symptoms and Anxiety [Freud 1926a] “marked a new phase in the transformation of Freud’s theories, from metapsychology to ego psychology” [Ellenberger 1970, p. 517]. Therapeutic emphasis shifted from the earlier focus on the lifting of repression and the recovery of pathogenic memories to the analysis of ego functions. Anna Freud, presumably with her father’s cooperation, published in 1936 the seminal work The Ego and the Mechanisms of Defense, in which the nature of the revised technique was clearly summarized [A. Freud 1936]. Attention was focused on recognizing, and addressing with interpretations, the various ways in which the patient’s ego was defending against forbidden wishes, instead of aiming to directly interpret those wishes, which had been prevalent in earlier practice. This clinical approach became known as ego analysis and the theoretical underpinnings as ego psychology. Although Freud’s last work pointed in this direction, the shift from id analysis to ego analysis was strongly assisted by Anna Freud and Heinz Hartmann. The latter wrote, in his introduction to Essays on Ego Psychology, that “Freud’s structural point of view, and above all his later hypotheses on the functions and the development of the ego, added a new dimension to psychoanalytic psychology. They indicated an inherent potential for growth, and their actual fruitfulness was soon realized” [Hartmann 1964, p. ix], which fruitfulness he defined as developing a theory of adaptation and understanding non-confictual modes of ego functioning as the basis of a general psychology. “While historically the major ego concepts developed as an outgrowth of drive-conflict psychology and remain intimately tied to it via conceptions of defense against drive, Hartmann’s…work introduced a significant emphasis on adaptation to the average expectable environment as well” [Pine 1988, p. 572]. The followers of Abraham followed this theoretical shift to focus on defense, those of Anna Freud and Hartmann to elaborations of ego psychology, and those of Ferenczi to Melanie Klein’s approach.

Klein, who had moved to Budapest from Vienna at age 28, there discovered Freud’s work and was herself analyzed by Ferenczi. She began to specialize in the analysis of young children, using play therapy in a departure from then-existent techniques, and developed distinct and controversial ideas about early human development, arguing that the Oedipus complex and the superego emerged far earlier than Freud believed and that the internal world of a very small child was full of destructive fantasies. In a sense, her work followed Freud’s otherwise abandoned idea of the death drive to find it inherent in the youngest children. Her ideas of child de-
development differed from those of Anna Freud, who also treated children, and the conflict between them was a significant part of the history of later psychoanalysis, with Kleinians going on to play important roles in Britain, the United States, and South America.

With various offshoots, dissenters, and rivals, the codification of clinical practice and the rules followed by psychoanalysis’ growing number of practitioners was of concern to Freud. As the field gained new adherents, the importance of clarifying it both as a theory and as an organization became increasingly important. In spite of a difficult beginning, Berlin soon became the center of a flourishing psychoanalytic community, with Karl Abraham, who had left the Burghölzli in Zurich for Berlin, at its center. Karen Horney, Helene Deutsch, and Melanie Klein trained there, and all three were analyzed (a second analysis for Klein) by Abraham, who had developed some ideas about the female libido that these three analyses would each, in different ways, challenge and modify. Sandor Rado and Franz Alexander arrived in 1921. Some of the basic precepts of analytic training, including the training analysis, the supervision, and the seminars, had been established in Berlin by 1930. The two other significant psychoanalytic institutions were in Budapest and Vienna.

Later Years

Several factors contributed to theoretical shifts during the last years of Freud’s life, including changes in the intellectual and cultural climate and new data from accumulating clinical experience. During the 1930s, the rise of fascism in Europe led to the emigration of much of the analytic community, because many analysts were Jewish and most were, by nature and inclination, intellectuals, liberals, and free thinkers. This social cataclysm promoted the growth of psychoanalytic interest in Great Britain and in North and South America. The inclusion of many talented individuals and the effect of their dispersal from the first centers in Vienna, Berlin, and Budapest fostered the emergence of new trends of thought. The earlier psychoanalytic system had favored the genetic viewpoint, which focused on the intrapsychic experience of the world rather than the maturation of drives as influenced by the environment. With Anna Freud devoting attention to a developmental framework and Melanie Klein focused on the unfolding of children’s innate predispositions, conflict arose surrounding what psychoanalysis could say about, and gain from, the earliest years of life and about whether a focus on preoedipal events was either useful or scientifically possible. Later, with the rise of linguistics, there was conflict about whether psychoanalysis is a hermeneutic discipline, “a purely psychological and linguistic effort at understanding meanings, or whether it is a scientific causal discipline with biological roots” (Cooper 1985, p. 16). Freud’s weakness in describing female sexuality led to a variety of feminist critiques of the field. In some ways, this critique pointed to Freud’s abandonment of the seduction theory, in which the shift from belief in trauma to a focus on fantasy was felt to be a denial of sexual abuse. However, more than this, it was clear that Freud’s work had significant limitations with respect to the understanding of female sexual development.

Consideration of these later trends and critiques is complicated by the difficult task of tracing the influences on Freud by his contemporaries and identifying the residues of ideas introduced by earlier dissenters. To this day, there is conflict about the legacy of these dissenters. Some thinkers, especially those who espouse some form of later theory, argue that key dissenters introduced vital ideas that Freud did not acknowledge or immediately accept but that later found their way back, their origins unacknowledged, in psychoanalytic theory. For example, it has been argued that the exiled Adler’s influence was felt in Freud’s eventual introduction of aggression into his own theoretical framework with the dual instinct theory (Ellenberger 1970). Cooper believes a similar thing occurred with Rank and Jung. Rank’s “theory of the birth trauma emphasized issues of loss and merging as the original sources of anxiety… Freud…eventually revised his own theory of anxiety to take into account the very issues which Rank had raised” (Cooper 1985, p. 10). Similarly Cooper contended that Jung’s disagreement with libido theory and focus on self-concept influenced Freud’s understanding of narcissism and played a role in the rise of ego psychology. However, the majority of mainstream psychoanalysts have seen Freud’s theoretical shifts as revisions powered by his growing clinical sophistication and as evidence of Freud’s own flexibility, creativity, and commitment to what his clinical data taught him. This view sees Freud as necessarily rejecting followers whose beliefs endangered key aspects of psychoanalysis. Defining the boundaries of the field became increasingly important as a major shift in focus from content (of memories of infantile sexuality) to methodology (analysis of the transference and of ego defenses) occurred, with disagreement among historians and analysts about the relative significance of each. This shift later allowed diverse thinkers to use psychoanalytic methodology to
reach very different conclusions about psychopathology while still considering themselves true heirs of Freud.

In 1932, Freud’s accomplishments were recognized with the Goethe Prize. He had been suffering from oral cancer for a decade, continuing to write and practice in spite of constant pain and discomfort and continuing to smoke his beloved cigars. Freud resisted leaving Vienna for years after the Nazis came to power, finally fleeing to London with the help of Princess Marie Bonaparte, U.S. Ambassador Bullitt, and President Franklin Roosevelt in June of 1938. He died there a year later, in September of 1939. W.H. Auden (1939/1973) wrote that “to us he is no more a person/now but a whole climate of opinion/under whom we conduct our different lives” [p. 745].

KEY POINTS

- Freud was influenced by the philosophical and scientific tradition in which he was educated, and in his work he both drew from and built on his intellectual predecessors and mentors.

- Freud encountered a medical world beginning to recognize that some psychological phenomena, such as hysteria, were not organic in basis and required different approaches for understanding and treatment.

- Freud developed his theories using clinical material, self-analysis, and dreams as he built his first model of the mind, the topographic model, and later the structural model.

- Freud’s theories interacted with his environment as his followers and growing popularity made him the head of a growing movement, as well as of a new and evolving psychological theory and technique.

- Nodes of dissent and disagreement marked the beginning of the various schools of psychoanalysis that would later arise.

References

AS HE BEGAN the explorations that led to his creation of psychoanalysis, Sigmund Freud found himself holding two far-reaching, stunningly different ideas about the project he was undertaking. Each announced in a foundational work and written, remarkably, in the same year, these statements speak to the fragile welding together of different levels of discourse that taken together constituted the scaffolding of his new discipline. In the first passage, from Project for a Scientific Psychology, a manuscript that vitally influenced Freud’s thinking forever despite his refusal to publish it, Freud states his hope for what his researches might accomplish: “The intention is to furnish a psychology that shall be a natural science: that is, to represent psychical processes as quantitatively determinate states of specifiable material particles, thus making those processes perspicuous and free from contradiction” (Freud 1895, p. 295).

Freud the scientist, from the beginning and forever a reluctant clinician, aimed to understand the mechanics of the mind. Such understanding, he decreed, must be formulated in the language of force and structure, but how do we go about studying minds in the first place? Borrowing from other medical specialties—and, not coincidentally, resolving his personal financial difficulties—Freud arrived at the conclusion that his best route was to examine pathological cases; that is, he would...
study the mind by treating patients. However, as soon as he began to report the data that emerged from these treatments he saw that they were a poor match for the hypotheses they were supposed to support. Thus, in *Studies on Hysteria* he wrote: “It still strikes me myself as strange that the case histories I write should read like short stories and that, as one might say, they lack the serious stamp of science. I must console myself with the reflection that the nature of the subject is evidently responsible for this, rather than any preference of my own” [Breuer and Freud 1893–1895, p. 160, italics added].

Psychology “shall be a natural science,” but his own research led to data that “lack the serious stamp of science.” Freud realized, as soon as he turned his attention to psychoanalysis, that he was challenged to hold together an unwieldy, even unstable hybrid—one part stories, one part psychic machine. Over the course of his career, some fundamental concepts—the Oedipus complex is a prime example, as is the vision of apparently self-defeating behavior driven by a need to relive early experience in the present—are drawn from one discourse. Another group of equally foundational ideas, the set of propositions that has come to be known as the metapsychology, is anchored in quite another. The years of academic dispute over whether Freud was a biologist or a hermeneut is less interesting than they might seem at first glance; he was both, from the beginning, and he knew it.

Freud’s supreme self-confidence, and the very personal ownership of psychoanalysis that he claimed publicly in *On the History of the Psycho-Analytic Movement* (Freud 1914a, p. 7), made it possible for him to insist on the coherence of his discipline; during his lifetime and for many years thereafter personal charisma was the glue that held the various parts of his creation together. His claim went even further in one startling way: Freud insisted that all of his various findings—from the idea that dreams are meaningful, to infantile sexuality, to the constancy principle, to the idea that repression is the result of a process of countercathexis—could be and had been discovered by one single method of investigation. All one had to do to probe the depths of human experience and to deduce the nature of the mental machinery responsible for the creation of that experience was to conduct a certain kind of conversation (as prescribed by the rules of the psychoanalytic situation) with a certain kind of person (analyzable neurotics). Not only was no other method necessary, ultimately none had very much to add.

The history of psychoanalysis in the seven decades since Freud’s death can, in its broadest terms, be told as the story of the collapse of these two premises. Few analysts today believe that a single discipline can generate both interesting narratives and adequately explanatory psychobiological hypotheses, and many are convinced that we tie our hands when we insist that salient data can be found only in the interaction between a freely associating patient and an analyst listening with evenly hovering attention. The bond that Freud worked so hard to create has been permanently loosened if not broken entirely. In today’s psychoanalytic world there are many competing narratives that are associated—less rigorously than Freud or his second-generation followers would have tolerated—with various models of the mind. Many analysts stick to storytelling altogether, declaring that metapsychology is uninteresting or even impossible given the data at their disposal.

As significantly, the insistence on a unitary methodology has lost much of its credibility. Freud was always skeptical about the idea that quantitative psychoanalytic research [process or outcome] has something to contribute. This is still controversial, but other independent methodologies have made decisive inroads. Perhaps the first to do so, and the only one to become influential within Freud’s lifetime, was child analysis. Subsequently, analysts have drawn on data derived from work with severely disturbed patients, those traditionally considered untreatable by standard technique. Some, although not all, theorists value the data that come from direct infant observation, whereas others integrate the still preliminary findings of neuroscientists. More mainstream is the point of view derived from the practice of psychoanalytic supervision, a perspective that was not [with the famous exception of Freud’s somewhat informal consultation with Little Hans’s father] included in the literature until the 1950s and not frequently discussed for another decade or more.

Each of these new observational vantage points generates data that could not even in principle have been available to Freud, who confined himself to what he could see from behind the couch. The very diversity of the new data, which include statistics, observation of relationships made from outside the interacting dyad, first-person internal experiences of the treating analyst that Freud had simply warned against, and images of the brain, among many others, not only lends itself to the construction of new narratives but also further loosens the bond between the story and the machine that Freud valued so highly.

The importance of this conceptual change cannot be overestimated. Freud had gone so far as to characterize metapsychology as “the consummation of psycho-analytic research” (Freud 1915b, p.181). As we will see, this shift is closely linked to the broadening of the ob-
The Nature of the Discipline

During the 30 years that followed Freud’s death, there was a clearly defined “mainstream” that dominated North American psychoanalysis. Organizationally centered on the American Psychoanalytic Association and its institutes, linked closely with psychiatry and more broadly with the medical establishment, and led intellectually by the émigrés who had fled Europe prior to World War II, psychoanalytic training, credentialing, and access to professional journals were all tightly controlled.

There were other voices to be heard, of course. Karen Horney, Clara Thompson, Erich Fromm, and others had been trained in the Freudian tradition but broke with it; each attracted followers and was involved in training institutes outside of the American Psychoanalytic Association. Harry Stack Sullivan, who was never formally trained as a psychoanalyst but once served as a vice president of the American Psychoanalytic Association, promoted his interpersonal psychiatry as a psychodynamic alternative to Freudian orthodoxy. However, all of these theorists and the organizations with which they were involved were marginalized, excluded from the mainstream conversations.

This centralization did more than exert political and economic control over psychoanalysis; perhaps even more importantly, it held Freud’s project together. Theory, even when emended, was to be expressed in the language of force and structure. Theorists could thus stay closer to Freud’s original wish to be able to theorize the mind in terms of “quantitatively determinate states of specifiable material particles” [Freud 1895, p. 295] than to his later, far less confident confession that sometimes he was forced to invoke what he called the “witch metapsychology” [Freud 1937, p. 225].

Heinz Hartmann, certainly the leading North American Freudian theorist of the 1940s and 1950s, anchored his work in the metapsychology: “We may not yet fully appreciate,” he wrote, “how fruitful it is that the foundation on which Freud built his theory of neurosis is not specifically human but ‘generally biological,’ so that for us the differences between animal and man… are relative” [Hartmann 1939, p. 28]. The scientific claims apparent in Hartmann’s thinking reflect his larger

---

1Freud himself, of course, had interests that ranged far beyond individual treatment; he wrote about art, literature, and culture. Yet he quite pointedly did not draw on these disciplines to inform his clinical work; rather, psychoanalytic principles were seen as a kind of royal road to the understanding of extraclinical phenomena.

2Freud’s (1926) strong support for lay analysis was not embraced in North America as it was in other parts of the world; see Richards [2003] for the history of North American analysts’ concern with maintaining their ties to academic psychiatry.
goal, which he shared with many of the most influential theorists of his time. Hartmann and his colleagues working within the tradition of what came to be known as American ego psychology wanted to develop psychoanalysis into what they called a "general psychology," one that would extend the scope of the theory to account not only for neurotic psychopathology but also for the most severe psychopathology and for so-called normality as well.

In pursuit of this goal, the ego psychologists added considerably to Freud's model of the mind. New concepts were introduced, including the self (Hartmann 1950), the conflict-free sphere (Hartmann 1939), adaptive functions of the ego (Hartmann 1939), and so on, and existing concepts were significantly modified. Alongside Freud's libidinal and aggressive drives Hartmann proposed what he called "primary neutral energy" as a motivational force driving nonconflictual behavior and experience, and he suggested that intrasystemic conflict as well as conflict among the three psychic structures played a dynamic role in the life of the mind. Yet none of these changes disrupted the link between narrative and metapsychology that was so central to Freud's thinking. As a result, despite the theoretical developments of the 1960s and the early 1970s, the essential nature of Freud's project remained undisturbed.

This landscape began to change dramatically in the middle to late 1970s, however. Two early developments contributed to the shift, which continued and accelerated through the 1980s and 1990s. First, there was a series of direct attacks on the link between narrative and metapsychology that Freud had hoped to establish and that his second-generation followers had labored to maintain. The titles of some important contributions from this period illustrate the direction that a new generation of theorists was taking: George Klein's (1976) chapter "Two Theories or One?"; Merton Gill's (1976) "Metapsychology Is Not Psychology"; Roy Schafer's (1976) A New Language for Psychoanalysis; Robert Holt's (1972) "Freud's Mechanistic and Humanistic Images of Man." Gill succinctly noted the central contrast between Freud's two projects and in doing so pointed to what he thought of as their fundamental incompatibility: "Typical terms of the natural-science physicochemical language are cathexis, force, energy, and topography; typical terms of the natural-science biological language are apparatus, function, structure, and adaptation. Typical terms of the psychological language are motive, meaning, goal, symbolization, and interpretation." [Gill 1977, p. 582].

Here Gill highlights the very tension that Freud had noted 80 years earlier. Yet whereas Freud had been content to acknowledge a strain and to imply that as long as he could personally contain it others need not be troubled, Gill used it as a tool that would drive apart what had been arbitrarily joined together. This was possible sociologically and politically because neither Freud nor his second-generation followers within the ego psychological tradition were alive when Gill wrote3; the centrifugal effects of generational change left the psychoanalytic culture ripe for heterodoxy.

The effect of this critique as it settled in over the years went beyond highlighting the differences between the two discourses; more importantly, it led to the marginalization of metapsychology altogether. Even at the level of theory, the focus shifted from explanatory concepts that were by design experience distant [Hartmann's "generally biological" theory, formulated in the natural science terms that Gill references] to generalizations from clinical practice that stayed closer to what the analyst and, the analyst, lived with [Hartmann's "specifically human" theory, formulated in Gill's psychological language]. Narratives were emphasized, even in theoretical papers; fewer authors showed interest in creating models of the mind.4

In addition to the impact of the attacks on the link between narrative and metapsychology, a second, roughly simultaneous development had an equally important if less direct role in shaping the nature of the psychoanalytic project. Theoretical dissent and institutional schisms had begun in North America, and especially in New York, in the years immediately after Freud's death. Between 1941 and 1945 several influential but heterodox analysts left the New York Psychoanalytic Institute and founded their own training programs. Erich Fromm, Karen Horney, and Clara Thompson left the institute together; Horney founded the American Institute of Psychoanalysis in 1941, whereas Fromm and Thompson joined Harry Stack Sullivan and Frieda Fromm-Reichmann who were working in the Baltimore-Washington area to form the William Alanson White Institute in 1943. The Columbia Psychoanalytic Institute was established in 1945 under the leadership of Sandor Rado.

3Rudolph Loewenstein, the last surviving leader of this group of analysts, had died the year before Gill’s paper was published.
4An exception during the 1970s is the work of John Gedo and Arnold Goldberg (1973). Tellingly, citations of their book in the psychoanalytic literature dropped from 43 in the decade after it was published to 17 in the first decade of the 21st century.
These early dissenters [whose arguments can be traced conceptually to the earliest schisms within Freud’s psychoanalytic circle] shared a similar sensibility; each emphasized the importance of interpersonal and/or social experience in the constitution of psychic structure, psychopathology, and human experience more generally [see Greenberg and Mitchell 1983 for a full discussion of this theoretical divide]. Lumped together and somewhat disparagingly labeled as “culturalists” [see Hartmann 1956], the ideas of these theorists were generally ignored by the orthodox community. For many decades advocates of these points of view developed their ideas in isolation.

Yet the 1970s saw the beginnings of change. Alongside the direct critiques of metapsychology, new, radically alternative conceptual systems began to emerge within the organized psychoanalytic mainstream itself. Typically initially focused on the understanding and treatment of patients who had been considered inaccessible to treatment through the classical psychoanalytic method, these theories proposed both novel story lines and alternative models of the kind of mind that could live out those life historical narratives.

The most significant North American challenge to the received orthodoxy that emerged in the 1970s came in the work of Heinz Kohut, a close personal friend of both Heinz Hartmann and Anna Freud. Deeply steeped in Freudian metapsychology and its ego-psychological elaboration [and a former president of the American Psychoanalytic Association], Kohut became disenchanted with the theory’s clinical efficacy, first with patients diagnosed with narcissistic psychopathology and eventually with all analyzable patients [Kohut 1971, 1977]. Moving away from his conceptual roots, he taught his students to look for more than just the Freudian “constellations” [i.e., narratives] and to “let the patient teach you how to analyze him” [A. and P. Ornstein, personal communication, January 2010].

Developing his ideas in conversation with a small group of colleagues in Chicago, Kohut had by 1977 created a comprehensive conceptual model that allowed for the emergence of a cohesive “psychology of the self” based upon a theory of the mind that he believed should replace the prevailing structural model. At first Kohut’s dissent led him to the same fate earlier dissidents had met; his heterodoxy led to the exclusion of self-psychological ideas from conversations within the psychoanalytic mainstream. In the last 10 years of his life [Kohut died in 1981], neither he nor any of his most important followers had an article published in the Journal of the American Psychoanalytic Association. The marginalization was even more complete than that imposed on the direct critics of classical metapsychology; during this period the Journal published several papers by Gill, Schaffer, and others who held similar points of view. The likely explanation for this is that despite their trenchant dissents, these theorists had tampered less with traditional analytic narratives than had Kohut and his followers. Their inclusion in journals and conferences suggests that even the most mainstream analysts of the time were coming to the conclusion that the metapsychology was expendable, especially if the clinical sensibility was maintained.

At about the same time that Kohut was developing his alternative model of the mind and that Schaffer, Gill, and Klein were questioning the value of metapsychological theorizing altogether, challenges to mainstream thinking were emerging in other quarters. Wilfred Bion arrived in Los Angeles from London in 1968 and remained there for 10 years until shortly before his death in 1979. Bion became a popular analyst and supervisor, attracting students who were drawn to his interpersonalization of concepts that had their roots in Melanie Klein’s theorizing, particularly the centrality of unbearable anxieties from the earliest years of life and their expression through processes of projection and projective identification.

Despite the great controversy that each stirred in their local communities, students of both Kohut and Bion travelled extensively throughout the United States, introducing the new ideas to many analysts who had been trained in and were familiar only with the classical ego psychological tradition. Klein’s ideas were also disseminated during the 1970s through the work of Otto Kernberg, who integrated her thinking about primitive anxieties and defenses into a model of mind drawn from ego psychology, especially as interpreted by Edith Jacobson [1965; Kernberg 1975]. Perhaps because, unlike Kohut, Kernberg retained the classical vocabulary of drive and structure (if not its meaning), his work was more readily accepted by the mainstream. During the 1970s, when no self-psychological articles were published in the classical journals, Kernberg’s writings appeared frequently.

[6] Of the three alternative training programs, the Columbia Psychoanalytic Institute became a member of the American Psychoanalytic Association, whereas the other two did not. However, Rado’s ideas were ignored outside his own institute. He published no papers in mainstream journals after leaving the New York Institute.
The critiques of Schafer, Kohut, and Bion led not only to theoretical debate but to personal animus as well. Participants in the debates of the time invariably report broken friendships, exclusion from privileges accorded to approved members of the establishment, and ad hominem attacks in both public and private forums.\(^5\)

By the end of the 1970s the orthodoxy that had dominated psychoanalysis in North America in the decades after Freud’s death was challenged from many directions, although there was little communication either between the dissidents and the mainstream or among the dissidents themselves. It was in this climate that Stephen Mitchell and I wrote *Object Relations in Psychoanalytic Theory* (Greenberg and Mitchell 1983). In the book we argued that Freud’s metapsychology was anchored in a vision of the mind energized by the need to satisfy urges (i.e., drives) that originated in the somatic, presocial core of the human organism. Subsequent emendations of this original vision, Freud’s own and those of his followers within the ego psychological tradition, were designed to preserve this core idea. With this in mind, we named this theoretical tradition the “drive model.”

The most important dissent from Freud’s view—Sullivan’s interpersonal theory and Kohut’s self-psychology in the United States and the object relations theories of W. Ronald Fairbairn, Klein, and Donald Winnicott in Great Britain—certainly differ from one another in crucial respects, but all shared a rejection of Freud’s fundamental premise. In place of drive as prime mover, each postulated that the mind, including its fundamental motivations, is structured in a way that reflects the developmental impact and enduring psychodynamic influence of early relationships with other people. We named this alternative vision the “relational model.”

There were, of course, differences in the ways in which the two models were organized. Theorists working within the drive model saw themselves as operating within a shared conceptual tradition; for the most part, each built upon the formulations of those who had come before. They employed a common vocabulary, belonged to the same professional groups, and published in the same journals.

In contrast, theorists working within the relational model had, for the most part, no common professional affiliations with one another; their vocabularies and many of their sensibilities differed greatly from each other.\(^7\) The idea behind creating an umbrella under which all of these theories could fit was to establish the existence and value of a psychoanalytic model that was built on premises that provided an alternative to those assumed by the North American mainstream. The umbrella had to be very large to accommodate the disparate views, but it covered terrain in which what Mitchell and I considered to be a genuinely psychoanalytic alternative to the drive model could emerge.

Along with the critiques of Schafer, the advent and dissemination of self psychology, and the increasing familiarity with the work of Klein and Bion within the psychoanalytic mainstream, the introduction of the idea of a relational model found its way into established psychoanalytic conversations. This is reflected in citations in the two most prominent psychoanalytic journals in the North American mainstream, the *Journal of the American Psychoanalytic Association* and the *Psychoanalytic Quarterly*. Four of the seminal figures of relational psychoanalysis—Fairbairn, Klein, Sullivan, and Winnicott—were cited a combined total of 206 times during the 1960s, in the 1990s the number had risen to 787.\(^8\) The work of these authors was not accepted by everyone who mentioned it, of course, but it was noticed; this contributed significantly to the breakdown of Freud’s original project.

Having defined a relational model that could be extrapolated from the work of theorists who developed their ideas independently and with different implications, by the end of the 1980s Stephen Mitchell (1988) was molding these ideas into an integrated and cohesive theory.

---

\(^5\) Anna Freud and her American allies, notably Ralph Greenson, are most often mentioned as staunch and often vitriolic defenders of the status quo. Anna Freud saw American theorists, beginning with Hartmann, as abandoning the centrality of the unconscious in favor of an emphasis on environmental influence (M. Furer, personal communication, February 2010; J. Grotstein, personal communication, January 2010; A. and P. Ornstein, personal communication, January, 2010; R. Schafer, personal communication, January 2010).

\(^7\) Arguably the theory most at odds with others grouped within the relational model was Melanie Klein’s object relations theory; her emphasis on the death instinct and endogenous aggression tie her to the sensibilities of Freud’s drive model. However, her stress on the importance of the object in modulating the destructive effects of early drive-derived phantasies prefigure and pave the way to increasing appreciation of the role of the other. The shift in emphasis is at the core of the distinction between Klein’s death instinct–based object relations theory and Bion’s emendation with its focus on the impact of an unbearable and unknowable reality, “O” ([J. Grotstein, personal communication, January 2010]).

\(^8\) These figures are drawn from a search of the Psychoanalytic Electronic Publishing database.
of his own. Drawing from the contributions of authors whom Mitchell and I had portrayed as working from relational principles, Mitchell proposed a synthesis that would “make it possible to view all psychodynamic phenomena within a multifaceted relational matrix which takes into account self-organization, attachments to others (objects’), interpersonal transactions, and the active role of the analysand in the continual re-creation of his subjective world” (Mitchell 1988, p. 8). With this integration, Mitchell created a relational psychoanalysis that was no longer an umbrella; his work led to a new meaning for the term, which came to describe a school of thought cohesive and comprehensive in its own right that competed with others in an increasingly diverse psychoanalytic marketplace (see Fosshage 2003 for a clear discussion of the different meanings of the term relational psychoanalysis as it evolved over the years).

As the 1990s began, Kohut’s self psychology, Mitchell’s relational psychoanalysis, and object relations theories derived from the work of Klein and Bion became, along with the more established interpersonal tradition, influential presences on the North American psychoanalytic scene. Many analysts who found themselves disenchanted with the theoretical and/or clinical potential of Freud’s drive model and its ego psychological emendations were attracted to the alternative points of view. Fearing, and often encountering exclusion from the dominant discourse, adherents of both self-psychological and relational thinking established their own membership organizations, training programs, journals, and conferences. In doing so, they relied on a tactic that Freud had used early on to protect his fragile discipline from assaults by a hostile and powerful medical/academic establishment: they created self-contained organizations within which ideas could be developed without having to engage the critiques of established authorities.

This is a path that was often followed over the course of psychoanalytic history; new ideas become movements (borrowing the phrase from Freud 1914a), institutions are created to protect them, and the field becomes fragmented. However, at the end of the 20th century, the outcome was different than it had been before. Historically, once groups were excluded, conversations between their members and adherents of the establishment permanently ended; Adler and Jung broke ties with Freud 100 years ago, and there is still little if any contact between their followers and more traditional analytic thinkers. Yet from the 1980s onward, the new ideas have been freely disseminated into the broader community. Representatives of self psychology, Kleinian and Bionian object relations theories, relational psychoanalysis, and interpersonal thinking have been invited with increasing frequency to present their ideas to local institutes of the American Psychoanalytic Association and even to the annual meetings of the Association itself.

These presentations did not necessarily convert their audiences to all of the ideas encompassed by the new theories. Certainly some Freudians became self-psychologists, some became object relations theorists, and others became relational analysts, but most did not; Freudian story lines continue to be widely used. What did happen, however, is that analysts adopted some principles from one or more of the new theories and integrated them into their own conceptual framework. This led to the development of what has come to be known as psychoanalytic pluralism, which describes two quite different ways of viewing the theoretical landscape.

Conservatively defined, pluralism refers to the widespread acknowledgment that a range of legitimately psychoanalytic points of view exists, whether or not there is any exchange of ideas among their adherents. More radically, it suggests that every analyst holds competing and even incompatible ideas in mind, ideas that may enrich or challenge each other. Because these ideas are entrenched in the thinking of all but the most doctrinaire, there are few, if any, analysts who work in accord with the principles—clinical or theoretical—of a single, unified theory. Instead, we live with a theoretical patchwork, and most analysts’ conceptual sets are mixtures drawn from a range of formal systems.

The trend toward pluralism more radically defined was noticed in the 1980s. In a 1983 paper that remains influential today, Joseph Sandler wrote that most analysts work with private theories that blend the possibilities of any number of formal systems (Sandler 1983). Four years later the word pluralism was used for the first time in the Journal of the American Psychoanalytic Association to describe the state of psychoanalytic theory. Arnold Cooper (1987) made note of “the deep changes in psychoanalytic theory that are now quietly taking place, ... the theoretical pluralism that is so prevalent today” (p. 83).

Analysts have many different reactions to the new, pluralistic psychoanalysis: some embrace it as a relief from our procrustean past, whereas others lament it as an abandonment of clinical and theoretical rigor. However one feels, it is clear that the more radical version of pluralism deeply and enduringly sunders Freud’s original vision of his creation. The belief that there is an inherent link between narrative structure and models of the mind can no longer be sustained.
Why this should be so is clear in two important works, both of which appeared in 1988. Fred Pine (1988), acknowledging that analysts were appreciating and employing a number of different points of view in their work with patients, argued for what he called a “four psychologies” approach. Depending on the patient or the phase of analysis that a patient was in, the analyst might choose to view things through the lens of what he called the psychologies of drive, ego, object relations, and self. Note that these “psychologies” are drawn from the major conceptual systems that by the late 1980s were competing for dominance within the psychoanalytic community, in its original form each psychology comes complete with its own narrative structure and its own model of the mind.

The same year saw the appearance of Stephen Mitchell’s integrated relational model. Mitchell’s ambitions were larger than Pine’s. Pine was content to offer a clinical mix, a sort of conceptual pantry from which analysts could take whatever ingredient was needed at the moment; this borrowing did not disturb the underlying model of any of the “four psychologies.” In contrast, Mitchell aimed at creating a more broadly applicable model, an alternative to Freud’s drive theory that not only provided clinical guidance but also had much to say about human development, the etiology of psychopathology, and human experience more generally. Unlike Pine, Mitchell (1988) recognized that his new vision would entail a repudiation of the evolved metapsychology; nevertheless, he stopped short of proposing a comprehensive model of the mind that would replace it.

Consider the fate of metapsychology in the wake of these developments. The widespread embrace of pluralism and integrative models freed clinicians to mix interpretive (i.e., narrative) threads from different conceptual systems into a blend that becomes personal and idiosyncratic to each individual analyst and to the analyst’s work with different patients as well. Arguably at least, doing this does not compromise the coherence of clinical work, under the best circumstances, it stamps each analytic encounter with a mutually constructed way of understanding the workings of the analytic dyad, and ultimately the analysand’s life history as well. Yet if multiple narratives are not only possible but inevitable, what becomes of the link between the “short stories” created by and within each analytic dyad and a model of the mind that was presumed to reflect a universal and invariant picture of a material fact?

The link is destroyed, and with it the central importance of modeling the mind itself. A pluralistic clinical practice cannot support Freud’s goal for metapsychological thinking, “to represent psychological processes as quantitatively determinate states of specifiable material particles” so that our understanding of their operations would be “free from contradiction” (Freud 1895, p. 295). By Freud’s own account the only evidence that might persuade us to support one model over another is clinical; although he sometimes expressed a hope that one day anatomical data might emerge that would confirm metapsychological speculation, for the most part he recognized this as wishful thinking. So to have any value, the models need to prescribe clinical strategies: interpret drive/defense conflict, as dictated by the structural model, address formative experiences of mirroring and idealization as required by Kohut’s vision of a bipolar self, confront the most primitive urges, the terrors to which they give rise, and the projective/introjective defenses that deal with them as the Kleinians taught; and so on.

All of the theories that Pine invoked and most of the theories that Mitchell included in his synthesis (Winnicott’s is arguably an exception) are complete within themselves and thus mutually exclusive from the others; each has its own clinical implications. So if analysts in their consulting rooms could and did move easily among narratives that were derived from incompatible models of mind, what was the value of these models in the first place? Schafer, Gill, George Klein, and others had directly and persuasively attacked the link between narrative and metapsychology during the 1970s. The clinical integrations of Mitchell and Pine during the 1980s carried things further in the same direction. Some analysts lamented this development as an abandonment of the fragile and hard-won truths that Freud and his followers had discovered; others welcomed them because they provided a framework that could contain the clinical/narrative flexibility that they had found necessary in their daily work with patients. Whether or not one agreed with any of the critiques, or was even aware of them, the tide of analytic practice was sweeping away the system building that had defined psychoanalysis for Freud and for his second-generation successors.

The marginalization of metapsychology is evidenced in a new style of clinical reporting that emerged in the 1980s, was consolidated during the 1990s, and that continues to shape the ways in which psychoanalytic conversations are conducted today. The change goes beyond style and reflects a fundamental shift in the way the psychoanalytic enterprise was conceptualized.

Prior to the 1980s, case reports centered on the nature of the analysand’s dynamics, as these could be inferred by a detached observer. The analyst’s participation was
rarely reported, so that typically there was no indication of anything he or she had said. This was true of the clinical reports coming from all theoretical traditions. Despite emphasizing the analyst’s role as a “participant observer,” Sullivan’s (1956) interpersonal narratives do not necessarily describe the nature of the analytic interaction. Rather, he painstakingly reconstructs personal history while assiduously avoiding recounting the events of treatment.

Moreover, the tone of these reports reflected an air of certainty reminiscent of what might be found in medical case histories (see Lear 2003). What today would be described as the analyst’s inferences were reported as though they were data; these focused on the interplay of structure, topography, cathexis, and so on. Experience-near formulations even including transference seemed to be of interest only insofar as they illustrated the workings of these hypothetical forces. When the analyst’s interventions were described at all, they were interpretations that, from a contemporary perspective, seem detached and intellectualized, betraying an interest in theory that overrode engagement in a clinical process. Taking this sensibility to an extreme, Hartmann never included a report of case material in any of his published writings; evidently he preferred not to compromise his theoretical abstractions with the details and the pragmatics of clinical encounters. As a result, it is difficult to know the story lines that he followed in his work with patients or to get a sense of how he saw the relationship between them and his theoretical innovations.

Clinical reporting changed dramatically beginning in the late 1980s. The language of force and structure was used less often; it was replaced by a language of meaning that evoked the short stories for which Freud apologized and a “specifically human” mode of theorizing that Hartmann would certainly have lamented. Beyond this, the phenomena to be described were radically reconceptualized; clinical reports aimed to narrate the ways in which lives were lived rather than to illustrate the ways in which minds work.

Narrating lives entails describing the matrix of relationships within which they are lived. As a result, the clinical reports since the late 1980s are populated with a variety of characters, each contributing their own desires and fears to the plot. At the same time, it was increasingly believed that the analysand’s experience was actualized in and could be best grasped through understandings of the here and now of the clinical encounter. Thus, the most powerful retellings of life histories are those that focus on the events of the analysis itself (see Schafer 1983, 1992). Transference, and countertransference as well, became the central themes of contemporary clinical reporting.

The terms one-person and two-person psychology, introduced into the psychoanalytic literature by John Rickman (1951, 1957), were used frequently beginning in the 1980s and in the past 20 years have become clichés. They have certainly been overused and even more certainly unfairly used; accomplished analysts of all theoretical persuasions have always worked with some version of a “both/and” approach to the constitution and expression of human experience. However, the truth underlying the use of these terms in what are often little more than partisan squabbles is palpable in the comparison of clinical reporting before and after the shift I am describing.

In contemporary discourse, it is expected that these reports include descriptions not only of the actions but also of the thoughts, feelings, and fantasies of both participants. Analysts writing these reports are expected to describe their personal experience during sessions, including but not limited to what is technically considered countertransference. These accounts of what would formerly have been thought to be irrelevant or worse are now considered essential not only to our grasp of the psychoanalytic process but also to our understanding of the analysand’s way of living in the world. Beyond this, reporting must include accounts of all aspects of the analyst’s participation, including any involvement in enactments that lead to violations of whatever rules of technique the analyst typically embraces. All of this drives home the extent to which conceptualizations of what is essential about the analytic project has shifted from the goal of linking narrative and metapsychology to the goal of creating narratives as an end in itself.

New Vantage Points, New Theories

In 1994, the International Journal of Psychoanalysis sponsored a conference in celebration of its 75th anni-

---

9 As an example, see the papers of Ernst Kris, which brilliantly conceptualize psychodynamics in a way that entirely excludes the analyst’s participation and are built on a metapsychological scaffolding that today seems startlingly archaic.
versary. The theme of the conference, “The Conceptualization and Communication of Clinical Facts,” was divided into five subtopics, the first of which was entitled “What Is a Clinical Fact?” The papers that addressed this question were detailed and sophisticated, but on reflection the question itself seems curious, implying as it does that there are some facts that are not clinical facts. In the context of the peculiar history of psychoanalytic inquiry, however, the question could be asked—perhaps had to be asked—because only facts that were derived from a particular observational method were considered to be “clinical” facts. As Robert Caper [1994] put it in his response to the question, “a ‘clinical fact’ is the product of a very complex and delicate observational apparatus,” namely what he termed “the psychoanalytic setting” [p. 905]. Thus, 100 years after its establishment as a discipline, Freud’s idea that the psychoanalytic situation is the only valid source of psychoanalytic data was still widely honored.

Caper’s formulation, like Freud’s, not only excludes observations made outside the consulting room but also implies a particular definition of what constitutes the psychoanalytic situation. The echoes of Freud’s charisma and authority are passed to a new generation of analysts and continue to be heard; the psychoanalytic situation is essentially what designated authorities say it is. Valid psychoanalytic data can be gathered only by an analyst following a technique anchored in the principles of neutrality, abstinence, and evenly hovering attention listening quietly to a freely associating neurotic patient who is lying on the couch.

Through the 1960s and even into the 1970s, this observational method was not so much described as presumed. Thus Rudolph Loewenstein [1958] began a paper entitled “Remarks on Some Variations in Psycho-Analytic Technique” by declaring, “I shall take the essentials of classical psychoanalytic technique for granted” [p. 202]. While it acknowledged that many analysts intuitively vary their approach with some patients, generally those falling into atypical diagnostic or psychodynamic categories, this notion that there was a “standard” technique against which such variations could be measured and through which all salient data were gathered went largely unchallenged.

The practice of standard technique and the gathering of what were considered valid psychoanalytic data were considered to be inextricably tied together; at times the linkage was justified through an unabashed use of circular reasoning. It was assumed that an analyst following proper technique would find what was there to be found, and that failure to find it would, ipso facto, discredit the methodology. Consider this comment by Leo Rangell during an important, oft-cited panel discussion on the differences between psychoanalysis and psychotherapy. Responding to a paper on the panel by Frieda Fromm-Reichmann (1954) in which she had raised questions about whether castration fears and the Oedipus complex are invariably at the core of pathogenesis, Rangell (1954) wrote:

Certain studies tend to cast doubt on the universal existence of the castration or Oedipus complexes. . . . Does not the validity of these negative findings, however, depend on the clinical reach of the investigative method employed? Does failure to arrive at confirmatory data seriously disturb existing theories when, for example, the method employed does not primarily direct itself toward the unconscious? [p. 735]

Proper technique will lead to proper findings; unexpected findings mean that the technique employed did not reach deeply enough into the unconscious. This tautology dominated the psychoanalytic landscape for a long time, making it difficult for either new ideas or new methodologies to attract serious consideration among classical analysts. Any “facts” that might be of interest to psychoanalysts [i.e., clinical facts] must originate in observations recorded by an analyst using standard technique.

The organizational and political structures of mainstream psychoanalysis supported and perpetuated the hypothesized or perhaps wished-for connection between method and findings. The certification of training analysts within the American Psychoanalytic Association, and the attendant control over training and supervised analyses entailed in this, guaranteed that approved analysts would follow approved technique and that they would arrive at approved findings. Variations in either could be cause for exclusion, a practice that to some extent continues today (A. and P. Ornstein, personal communication, January 2010).10

There is in fact an inherent connection between standard technique as the sole legitimate observational method for generating psychoanalytic data and the idea that the Oedipus complex is etiologically and psychodynamically central. It is not, however, the connection that

---

10Analyses conducted according to the principles of Kohut’s self psychology have been especially challenged over the years. From a more conceptual perspective, see Greenberg [1981] for a discussion of the reactions of “classical” psychoanalysts to the introduction of heterodox technique, especially in Kohut’s early work.
Rangell proposed, an alternative way of understanding the relationship is that constantly rediscovering the centrality of the Oedipus complex in every treatment is an artifact of the methodology itself. Consider this: if the only valid source of analytic data is what a receptive observer can hear and infer from the words of a patient speaking his or her mind, it follows that analytic theory will be, at least for the most part, a theory of experience that can be conveyed in words. This necessarily privileges experience beginning at age 3 or 4 years, when verbal memory appears for the first time, when the child can more easily be seen as an active agent pursuing structured motives [facilitating inferences about drives and fantasies], and when cognitive capacities allow and demand that the child imagine the participation of people who are not immediately present [facilitating inferences about triangulation and the Oedipus complex].

Of course from early on, Freud took account of what was not said, at least from the time when Dora toyed with her purse while on the couch, he was aware of the communicative value of what he called “symptomatic acts” [Freud 1905 [1901], p. 76]. Later he emphasized that all of our personal history can be and often is expressed through repetitive actions in the transference [Freud 1914b] and outside it as well [Freud 1920]. Yet these nonverbal eruptions can be suggestive and are useful only insofar as they convey meanings that can eventually be put into words. Ultimately, psychoanalytic data consist of what can be said. This assumption decisively shaped the course of Freud’s theorizing and that of his most influential North American interpreters; they believed that the events of the years beginning with the emergence of verbal memory constitute etiological bedrock. Whatever happens earlier is influential only through its impact on the mind of the older child.

The privileging of words as data led Freud to his seminal theoretical choices, among them the ideas that fantasy shapes experience more powerfully than does the impact of external events, including early trauma, that relations with the father, although taking center stage at a later point in development, are more likely to be at the root of neurotic psychopathology than are relations with the mother, that triangular experience is more etiologically significant than dyadic experience; and that intrapsychic conflict, which presumes the existence of reasonably stable psychic structure, is more central to pathogenesis than environmental failure.

The system begins with the assumption that the only valid source of analytic data is the classical analytic situation and that the only way to be an analyst is to do classical treatment; this perspective was enforced by the training model followed by psychoanalytic institutes through the 1950s [M. Furer, personal communication, February 2010]. Not surprisingly, the findings derived from these data support a theory that models the stably structured mind of an oedipal or post-oedipal child. Once again, observational perspective, narrative structure, and metapsychology converge.

However, beginning in the 1960s and 1970s (and continuing today), the singularity of the methodology was increasingly questioned. As analysts embraced new observational perspectives and the new data derived from them, the traditional dynamic formulations of Rangell, Charles Brenner, and others were challenged as well. Although it may not have been apparent as they were happening, in hindsight, the two changes can be seen to be inherently tied together.

These two quite different methodological shifts that contributed to the change each developed independently in the work of different theorists. Each entered mainstream conversations only amid strident criticism as well as charges that the psychoanalytic project was being threatened. Despite their enormous differences from each other, each had the effect of introducing new “clinical facts” that directed both theoretical and clinical attention to the dynamic significance of the earliest years of life.

One of these methods proposed to generate clinical facts through extraclinical observations. Beginning in the 1960s, Margaret Mahler published studies reporting on her observations of very young children in interactions with their mothers. Mahler’s observations immediately stirred controversy, because they were based on behavior viewed from outside the interacting mother-child dyad, her approach set her at odds with many colleagues at the New York Psychoanalytic Institute, who insisted that psychoanalytic data could be discovered only within the psychoanalytic process [M. Furer, personal communication, February 2010].

Mahler (1974) herself addressed the controversy about what constituted a legitimate observational base:

"It would seem as if those developmental data had something to do with psychoanalytic propositions and constructs, but they are referred to as if they were purely observational—or sociobiological at best…. Only a few of my psychoanalytic colleagues have become fully aware that, for the widening scope of psychoanalytic theory, those hypotheses that have been derived from psychoanalytic observational data of the preverbal phase have made meaningful, and indeed indispensable contributions to their own reconstructive work. [pp. 103–104]"
Here Mahler argued explicitly that her new methodology extends the reach of psychoanalytic theory; in the terms of the 1994 *International Journal of Psychoanalysis* conference, it yields “clinical facts.”

Yet Mahler’s claim was and is controversial; there is still a great deal of disagreement about whether the observation of interactions between mothers and infants or young children is a valid source of psychoanalytic data. Even today James Grotstein characterizes Mahler as “an anthropologist. She was looking from the outside at behavior. It’s very valuable but it wasn’t analytic, it wasn’t subjective” [J. Grotstein, personal communication, January 2010]. Despite the dissent, however, the methodology itself has grown explosively and has been influential among large numbers of psychoanalysts. Its application has both broadened [to interactions taking place in the earliest moments of life] and deepened [filmed records allow second by second scrutiny of interactive patterns]. Especially influential on the thinking of relational analysts, self psychologists, and attachment theorists, supporters of the usefulness of these observations argue that they illuminate individual psychodynamics, the nature of the psychoanalytic process, and the problem of therapeutic action.

At almost the same time that Mahler was drawing on observations of manifest behavior outside the clinical setting to inform psychoanalytic theorizing, other theorists were looking more deeply into the analytic process itself. Yet they were looking in a different direction than analysts had before, away from the associations of the patient and toward the experience of the analyst, toward countertransference.

Freud [1915a] famously avoided discussions of countertransference; his few published references to the possibility that analysts might harbor strong feelings for or about their patients were warnings to avoid such feelings or at least to keep them “in check” [p. 163]. There are few references to countertransference in the literature before 1950, and these repeat Freud’s concern and warnings. Not only Freudians but interpersonalists as well saw the analyst’s strong feelings as a danger and certainly as an impediment to knowing. In an article on Harry Stack Sullivan’s approach to treatment, Mary White[1977] noted that Sullivan “cautioned that a therapist who feels actual anger or irritation at a patient needs psychotherapeutic help himself” [p. 321]. Something of the same emphasis can be found in the writings of Clara Thompson, although Thompson (1952) does distinguish between what she considered “neurotic” affective reactions of the analyst and those triggered by the behavior or personality of the patient.

Beginning in the 1950s, analysts living in different parts of the world and working within different theoretical traditions began to report cases in which they had used their countertransference as a source of data about the events of the analysis and ultimately about the analysand’s world of internal objects [Heimann 1950; Racker 1957; Reich 1951; Tower 1956]. These reports were at first greeted cautiously by North American analysts, who were generally less enthusiastic about the new attention being paid to the analyst’s inner experience than were their European and Latin American colleagues. Although gathering data from the countertransference was never dismissed as non-analytic in the way that Mahler’s extraclinical observations were, using the analyst’s feelings and fantasies as anything other than a warning sign was seen by many as a risky proposition. In 1965 Otto Kernberg endorsed a limited use of countertransference data, especially in work with more disturbed patients; “countertransference becomes an important diagnostic tool, giving information on the degree of regression in the patient” [p. 44]. Even this guarded view was not universally endorsed; responding two decades later to what had become an increasing tendency to take countertransference data into account, Charles Brenner [1985] argued that it is “too often likely to prove an obstacle to one’s analytic work” [p. 162].

Gradually, however, more and more analysts came to believe that aspects of the analyst’s participation—not only what we think or feel consciously but also what is registered unconsciously and expressed via enactment—could contribute to the understanding of the patient’s inner world [Chused 1991; Jacobs 1991; Levinson 1972; McLaughlin 1991; Sandler 1976]. Including the analyst’s behavior and experience among “psychoanalytic facts” was increasingly accepted, so much so that by 1995 Glen Gabbard could characterize the belief in the value of countertransference data as an “emerging common ground” shared by analysts of varying theoretical persuasions.

Although it developed in very different settings and in the work of very different theorists, the sensibility that emerged from the inclusion of countertransference experience among “clinical facts” converged with the vi-

---

11Detailing even the most important contributions to this literature would require a chapter in its own right; in the limited space available, I note the work of Daniel Stern and his colleagues [Stern 1985]; Beatrice Beebe [2000; Beebe and Lachmann 2003]; Robert Emde [1980]; Edward Tronick [2002]; and Louis Sander [1988].
sion that grew out of the new observational stance introduced in Mahler’s work. Both Mahler, looking at development from outside the interacting dyad, and the countertransference/enactment theorists, looking from deeply within, highlighted the importance of bringing preverbal and nonverbal data to bear on the conceptual system. “Clinical facts” now included the expression of psychic contents that could not be symbolized, much less spoken about, and so could only be communicated and observed through action, interaction, and embodied experience. This led inevitably to a new emphasis on the importance of pre-oedipal development in both theory and practice. When not all data are verbal, not all formulations are oedipal.

Interest in the new narrative possibilities was widespread by the end of the 1980s. Many theorists who otherwise had very little in common had moved away from asserting the centrality of the Oedipus complex and embraced a shared appreciation of the dynamic significance of the first years of life. Mahlerian and post-Mahlerian developmentalists found their way to the pre-oedipal years through extraclinical observations, whereas others arrived at similar conclusions through countertransference analysis and awareness of enactment. In addition, there were self psychologists who claimed that their stance of empathic listening sensitized them to developmental needs dating to the beginning of life, Kleinians whose deep interpretations focused on the most archaic desires and fears, Bionians whose emphasis on the analyst’s containing function highlighted the dynamic significance of unbearable and unspoken proto-experience, Winnicottians who saw the analyst as providing a holding environment within which a nascent “true self” could emerge, feminists who set out to rectify Freud’s radical avoidance of the dynamic impact of mothers and mothering, and attachment theorists who stressed the re-creation in the analytic relationship of early experiences of recognition, affect attunement, and regulation that transcended words or even meanings.

Of course not all analysts were impressed by the argument that the deepest interpretations must address the earliest developmental eras, many retained traditional Freudian story lines organized around the Oedipus complex even as they abandoned the received metapsychology, and they continue to hold to those storylines today. This position was stated succinctly by Charles Brenner. Despite his radical rejection late in his career of the structural model that Freud and the ego psychologists had developed and to which he had contributed importantly, Brenner [2002] held tenaciously to the centrality of oedipal narratives, writing, “The way the mind functions in later childhood and in adult life represents the outcome of the conflicts and compromise formations of the second three years of life, influenced and shaped as they have been by whatever went on during the first three years as well” (p. 412, italics added).

In addition to directing attention to new narrative possibilities, the developing interest in countertransference analysis, infant observation, and pre-oedipal dynamics led to a major shift in the way that the psychoanalytic situation is conceptualized. Freud’s vision of the surgically detached, neutral analyst enjoined to remain untouched by the patient’s needs or desires—a vision he personally honored in the breach but always advocated forcefully in his published work—was based not only on his longing for scientific objectivity but also on a triangulated and phallocentric way of thinking about social relationships in general [Freud 1921]. Even as this way of understanding clinical process evolved and softened in the work of other analysts, as in James Strachey’s [1934] classic portrayal of an analysand introjecting the analyst as a benign superego, the paternalistic sensibility remained.

This view dominated analytic discourse for many decades, although alternative ways of conceptualizing analyst-analysand interactions had been around for a long time. First Ferenczi [1931], Ferenczi and Rank [1923] and then Winnicott [1955] emphasized ways in which the psychoanalytic situation shared aspects of the mother-child relationship. In North America, Hans Loewald’s [1960] important paper on therapeutic action shared Strachey’s idea that much depends on analysands’ internalization of their analyst’s attitude, but he modeled that attitude on aspects of the early mother-child relationship rather than on the relationship with the father. Years earlier, Freud [1915a] had thought it important to assert that the analyst’s participation in analysis has “no model in real life” (p. 165). Loewald, like Strachey before him, offered a more personal vision of the process. Yet both were careful to note that although earlier relationships provide prototypes that illuminate the therapeutic action of psychoanalysis, they were suggesting no modification of standard technique.

In contrast, the new appreciation of the interactive elements of the analyst-analysand engagement and in particular of the nonverbal communication of early dynamic themes led to a sea change in the way in which the psychoanalytic situation was practiced as well as in the way it was conceptualized. Analysis—which Freud had thought of as a procedure and which most of his early North American followers had viewed similarly—came to be thought of as a relationship between two participants, although this view was never formally articu-
lated. As a measure of this change, the term “analytic dyad” appeared in psychoanalytic journals only 20 times prior to 1985, mostly in the interpersonal literature. Since 1985 it has appeared at least 871 times. No aspect of clinical practice is unaffected by the changed conception, from rules of technique to the understanding of the epistemology of psychoanalytic investigation and interpretation, to the meaning of termination, to ideas about therapeutic action.

The emerging vision of a dyad that included an analyst who felt, acted, and related to the analysand as well as observed and interpreted him or her was a response to sociological as well as clinical and theoretical developments. Through the 1980s and 1990s women entered the profession in increasing numbers. More women had graduated from medical school in the 1970s and 1980s, and others sought analytic training after spending time in other academic disciplines. As a result, by the 1990s women constituted more than half of the population of candidates and recent graduates of many institutes. The women of this new generation were influenced by and sometimes influential within the feminist movement; they shared an appreciation of the developmental impact and psychodynamic importance of mothers and mothering that Freud had strikingly avoided throughout his career (see Chodorow 1978). Many were mothers themselves, and they brought a mother’s sensibility to their work with their analysands. Dramatically different from the sensibility that had originally given shape to Freud’s conceptualization of the psychoanalytic situation, the new wave of female analysts directed attention to previously ignored aspects of the clinical process, emphasizing its interactive and relational elements (N. Chodorow, personal communication, March 2010).

As a result of all these changes, as the 1990s began, psychoanalysis in North America was a complex tapestry of converging and diverging points of view that would have been daunting to the theorists and practitioners of the 1960s. The link between narrative and metapsychology that had been considered central to the psychoanalytic project was broken, leading to marginalization of models of the mind and to a greater interest in the creation of meaningful life histories and in the process through which these histories were created. The idea that “clinical facts” were accessible only via an observational method that coincided with “standard technique” was increasingly questioned by clinicians and researchers alike, and the meaning of standard technique itself was in dispute; analysts were challenged to engage data arising from a wide array of observational methods. A range of narrative possibilities was available, focusing on the centrality of different times of life and on different visions of what matters most to the individual. The rise of pluralism balkanized psychoanalysis in the sense that it led to the creation of “movements,” the adherents of which talked mainly to each other. Yet paradoxically, pluralism also loosened old institutional and theoretical ties because it allowed and even required practicing analysts to consider a range of interpretive possibilities in their daily work with patients. There were mixed reactions to this change among practicing analysts; for some it meant that the analytic commitment to pursuing truth was compromised, whereas for others it provided a conceptual framework that supported their use of private theories tailored to their work with individual patients (Sandler 1983).

Today Freud’s 100-year-old dream of a discipline that embraces shared assumptions and in which a central authority presides over both practice and the development of its theory has long since been shattered. In its place, there is a fragmented community that shares a common landscape—a dynamic field in which dyadic as well as triangular relationships play a vital role, in which the analyst’s unconscious as well as conscious participation shape the psychoanalytic encounter, in which nonverbal as well as verbal communication is powerful enough that it might lead to the creation of shared meanings or might devastate the treatment itself. Divided by their theories, psychoanalysts are perhaps united by a shared belief in the value of their project, by the unique benefits of what Josef Breuer’s first patient, Anna O., more than 100 years ago characterized as “the talking cure.”

---

12 The widespread embrace of pluralism is certainly linked to the de-medicalization of North American psychoanalysis, a trend that began in the 1980s and has gathered momentum since. Pluralistic thinking is more easily embraced by those trained in the humanities and the social sciences than by analysts whose thinking is shaped by a medical model.
KEY POINTS

- Psychoanalysis as Freud conceived it had two interrelated components: a way of narrating lives that could make sense of phenomena—neurotic symptoms, dreams, parapraxies, and so on—that had previously seemed incoherent and inexplicable; and a model of the mind that could not only explain cognitive functioning but also illuminate why we live our lives the way we do. Further, he believed that a single method of investigation, the "classical" psychoanalytic situation, could provide all the data that was needed to validate both his clinical and his metapsychological hypotheses.

- For roughly a quarter century after Freud’s death, mainstream psychoanalysts in North America embraced Freud’s vision of the nature of the discipline. Theorists who differed too sharply from either the clinical or the metapsychological theories, or who questioned Freud’s understanding of the unique power of his method, were excluded from mainstream conversations.

- Beginning in the early 1970s, three related developments challenged the cohesiveness of Freud’s creation. Some theorists directly criticized the possibility of linking narrative and metapsychological discourse; others proposed alternative narratives, some of which were anchored in new models of the mind. And many analysts embraced new methods of investigation, some extra-clinical, such as the direct observation of very young children and their mothers, and others internal to the psychoanalytic situation, such as the use of the analyst’s countertransference as data.

- Taken together, these changes led to what has been characterized as an era of pluralism in North American psychoanalysis, in which there is neither a single, dominant theoretical perspective nor a "mainstream" organizational structure. Conversations among psychoanalysts representing a wide range of theoretical traditions have replaced the more cloistered exchanges that were typical of the earlier years.

- Along with and related to these conceptual changes, there have been shifts in the sociology of psychoanalysis as both a profession and an academic discipline. With psychoanalysis no longer anchored exclusively in psychiatry, academics from other fields have contributed both clinically and theoretically. An increasing number of women have become psychoanalysts, leading to challenges to Freud’s phallocentric developmental theory as well as to his vision of the nature of clinical process.

References

Brenner C: Countertransference as compromise formation. Psychoanal Q 54:155–163, 1985
Brenner C: Conflict, compromise formation, and structural theory. Psychoanal Q 71:397–417, 2002
Racker H: The meanings and uses of countertransference. Psychoanal Q 26:303–357, 1957
Schafer R: A New Language for Psychoanalysis. New Haven, CT, Yale University Press, 1976
Thompson C: Counter-transference. Samiksa 6:205–211, 1952
SECTION II

Core Concepts

Section Editor: Richard B. Zimmer, M.D.
Theories of Motivation

Morris N. Eagle, Ph.D., A.B.P.P.

What makes the engine go?
Desire, desire, desire
The longing for the dance
Stirs in the buried life...

Stanley Kunitz

Mckay (1989) asserted that “psychoanalytic theory is above all a theory of motivation” [p. 6]. Others have made similar comments. For example, Lichtenberg (1989) stated that “psychoanalytic theory at its core is a theory of structured motivation” [p. 1], and Rubinstein (1976) observed that “in one sense, the whole of psychoanalytic theory is a theory of motivation” [p. 68]. Indeed, what is referred to as “psychic determinism” in Freudian theory is more accurately called motivational determinism. After all, one does not have to be psychoanalytically oriented to accept the idea that, like physical events, all psychological events are determined; all one needs to be is a strict determinist. The more distinctively psychoanalytic contribution to the principle of psychic determinism is the claim that all meaningful behavior [other than, say, reflexes] is motivated—by wishes and desires.

Motivational accounts constitute a primary mode of understanding oneself, others, and our interactions with others. We order and understand behaviors in terms of our own and others’ motives, aims, intentions, desires, and reasons. In ordinary discourse, the most frequent ways we account for behavior, particularly when the behavior takes the form of a purposive action, is by linking the action to the aim it is intended to accomplish. Indeed, to think of behavior as an ac-
tion is to immediately consider the reason or motive for the action—the aim it was intended to accomplish. The assumption that all complex behavior—certainly behavior sufficiently complex to merit the designation of action—is motivated is shared both by the ordinary discourse of folk psychology (Stich 1983) and psychoanalytic theory.

Definition of Motivation

I define motivated behavior as any behavior intended to accomplish a particular end or purpose. Such behavior can be understood as constituting an action. Hence, there is no such thing as purposeless action. If a behavior were purposeless, it would not be an action—that is, there would be no purpose or end that the behavior was intended to accomplish.

A psychoanalytic perspective retains this definition but extends it to include unconscious and disowned purposes and ends. Thus a neurotic symptom can be understood as at least a quasi-action insofar as it is understood as purposive—that is, intended [even if unconsciously] toward a particular end. Although the terms wish, desire, motive, reason, and intention have different denotive and connotative meanings, I use them interchangeably in this chapter in the context of describing the ends or purposes of action.

Psychoanalytic Motivational Explanation as Extension of Ordinary Discourse

In ordinary discourse, when behavior in the form of an action seems to be irrational and incomprehensible, we look for “hidden” reasons and motives as a means of making sense of it. This latter tendency or mode of thought paves the way for the positing of unconscious motives and aims as a legitimate way of understanding behavior. In this sense, psychoanalytic theory can be understood as constituting an extension of the motivational accounts of ordinary discourse by 1) admitting unconscious motives and aims into such accounts and 2) including under the rubric of motivational behavior a wide range of behaviors (e.g., dreams, neurotic symptoms, and paraptyxas) not ordinarily viewed as motivated.

Both these steps were taken early on by Freud when he accounted for hysterical symptoms not by reference to the individual’s constitutional weakness but by appeal to inner conflict. In Studies on Hysteria, Breuer and Freud (1893–1895) made clear their disagreement with Janet on that point. In “The Neuro-Psychoses of Defence,” Freud (1894) wrote that “the splitting of the content of consciousness is the result of an act of will on the part of the patient; that is to say, it is initiated by an effort of will whose motive can be specified” [Freud 1894, p. 46, italics added]. This form of hysteria to which Freud refers as “defense hysteria” is triggered when “an occurrence of incompatibility took place in their ideational life...which aroused such a distressing affect that the subject decided to forget about it because he had no confidence in his power to resolve the contradiction between that incompatible idea and his ego by means of thought-activity” [p. 47]. Thus, it was the “cornerstone” concept of repression [Freud 1914, p. 16] that both introduced a motivational account of hysteria and marked the birth of psychoanalysis. Hysterical symptoms—and later neurotic symptoms—were no longer seen as the “meaningless” and “mechanical” consequence of constitutional weakness.

Hysterical and neurotic symptoms were now understood by followers of Freud as motivated quasi-actions—as the product of conflicting motives acting on the mind, for example, conflict between the motive to avoid anxiety and threats to one’s sense of morality and identity on the one hand and the motive to fulfill and gratify one’s desires and wishes on the other. This early formulation of hysterical symptoms became transformed into a drive-defense model of the mind in which all behavior, including thoughts, feelings, fantasies, and so on are viewed as the compromise product of conflicting motives and forces [Brenner 1994].

There is another property one finds both in ordinary discourse and in more formal conceptions of motivation—namely, its arousal or energizing function. Here the emphasis is not on finding a specific aim or motive for a specific action. Rather, the assumption is made that in addition to channeling behavior in a given direction, a motivational drive state (e.g., hunger, sex) energizes behavior and leads to a generally heightened level of activity. Freud’s acceptance of this assumption is reflected in his identification of drives as the “engine” of behavior. As Freud [1900] put it, “only a wish is able to set the [psychical] apparatus in motion” [p. 598].
Two comments are in order here. First, during the 1960s and 1970s, a group of psychoanalytic theorists argued strongly that the concept of drive as well as all other aspects of Freudian metapsychology should be discarded. Arguments were based on a number of grounds: 1) that the empirical evidence contradicted much of Freudian metapsychology (e.g., Holt 1976); 2) that metapsychological concepts such as psychic energy were pseudo-scientific; and 3) that Freudian metapsychology should be rejected on philosophical grounds. As the very title of Gill’s (1976) edited volume—Metapsychology Is Not Psychology—indicates, any account of human behavior in terms of nonpsychological concepts was viewed as nonpsychoanalytic and reductionistic (see Eagle 1980, McKay 1989, and Rabinstein 1976 for somewhat different views regarding Freudian metapsychology).

Second, it must be noted that although wishes and motives may activate motor behavior, the belief that they are necessary to set the mind (or nervous system) in motion and that without a motive or wish the mind (or nervous system) would be quiescent or inactive is mistaken. Adrian (1947) noted many years ago that the brain is never inactive. Motives influence the patterning of neural activity rather than serve to turn it on or off. Recent research confirms Adrian’s view. Certain areas of the brain are even more active during the “default” state in which one is “doing nothing” than when one is engaged in purposive activity (Raichle 2010; Zhang and Raichle 2010). From this perspective, whereas the terms motive and motivate, with their root in “to move,” may be apt with regard to gross motor behavior, they are not so in relation to neural activity. The mind or brain does not need a motive or wish to be set in motion. It is perpetually in motion as long as one is alive.

Let me now turn to what this chapter covers and its main thrust. I begin with an attempt to clarify the nature of motivational accounts in psychoanalytic theory by discussing the conceptual challenges constituted by the emphasis on unconscious motives, considering the relationship between motivation and defense, clarifying the distinction between motives and needs, and discussing the influence of motivation on cognitive processes. I then take up the question of the motivational systems that are emphasized and identified as primary in different psychoanalytic “schools” or theories, followed by a discussion of the somewhat reduced role of motivational factors in contemporary theoretical developments. I discuss the limitations of motivational explanations as well as skepticism expressed regarding their explanatory legitimacy. Finally, I note the essential role of motivational accounts in any rich and adequate account of human behavior.

Let me turn now to various properties of psychoanalytic motivational accounts.

**Motivational Explanations and the Agent’s Point of View**

An essential component of a motivational explanation in ordinary discourse is that it constitutes an account of an action from the agent’s point of view. That is, his or her motive or reason for carrying out the action. As one might expect, it is this property of a motivational account that makes it especially pertinent in clinical work, where one is trying to understand various behaviors, including neurotic symptoms, from the perspective of the agent’s (i.e., patient’s) psychic reality—that is, his or her conflictual aims, desires, and wishes. In this sense, as noted, neurotic symptoms are viewed as meaningful quasi-actions rather than the automatic and “mechanical” product of purely physical symptoms (e.g., angina) of, for example, a blocked coronary artery.

However, psychoanalytic accounts focus on repressed unconscious desires, motives, and aims. A question that arises is what it means to refer to the agent’s point of view (i.e., his or her aims and motives) when these aims and motives are not only not consciously experienced but also not accessible to conscious experience (i.e., repressed). In other words, what does it mean to say that unconscious motives and wishes are from the agent’s point of view when the individual states he or she does not consciously entertain them?

**Peremptory and Driven Behavior**

Pine (2005) stated that in peremptory and driven behavior, one feels “lived by” one’s impulses and desires rather than experiencing, as an agent, a sense of “I desire” or “I want” or “my reason or motive is.” This quality of being “lived by” one’s impulses is at the heart of what Groddeck (1923) had in mind when he coined the term das es, which Freud adopted and which Strachey translated as the id (as Freud [1923] noted, “Groddeck himself no doubt followed the example of Nietzsche” [p. 23]). If one
translates *das es* more literally as “the it,” as well as *das ich* as “the I,” it becomes apparent that the former is intended to refer to “not I” ego-alien aspects of behavior and mental life, in contrast to the ego-syntonic “I” aspects of behavior and mental life.

In ordinary discourse we recognize the distinction between, say, moving forward as a result of being pushed and voluntarily moving forward to get somewhere one wants to go. Only the latter is viewed as an action with a motive or aim. Insofar as peremptory behavior is viewed as being driven by an ego-alien force analogous to being pushed, in this case by an internal rather than external force, to continue to view such behavior as from the agent’s point of view entails a disjunction between the intentional and the volitional, categories that are assumed to belong together in ordinary discourse. However, as Flew (1949) pointed out, this is precisely the disjunction proposed by psychoanalytic theory when it views a behavior, such as a phobia or obsession, as intentional in the sense of being motivated and satisfying a wish yet as nonvolitional or involuntary.

The disjunction between the intentional and the voluntary, as well as the idea that repressed and disavowed motives are nevertheless from the agent’s point of view, implies a concept of an agent [or person] that is not limited to conscious thought, intentions, desires, motives, and wishes and that therefore challenges the long-accepted Cartesian equation not only between mental and conscious but also between conscious and self.

**Motivation and Defense**

The assumption that certain motives and desires would be accessible to consciousness were they not repressed and disavowed is, of course, a statement regarding inner conflict and the operation of defense, which is itself motivated. In other words, certain motives, wishes, and desires are barred from conscious awareness and disavowed because of the dysphoric affects, such as anxiety, guilt, and lowered self-esteem, that awareness and avowal would entail. Hence, the basic motivation for defense is the avoidance of unpleasant affects. Developmentally oriented psychoanalytic accounts of defense suggest that certain wishes and desires are disavowed and denied access to consciousness because they are associated with negative affects engendered by early parental disapproval and prohibition and a variety of other subtle parental communications. Freud ([1926 [1925]] referred to the “danger situations” of loss of the object, loss of the object’s love, castration threats, and superego condemnation that are associated with these prohibited wishes and desires.

**Motives and Needs**

Although often conflated, motives and needs should be distinguished from each other. For example, we need to sleep in order to replenish our body. However, the motive for going to sleep is generally not to replenish our body but rather to respond to a feeling of tiredness or sleepiness or perhaps to escape a burdensome task. A child may want to stay up most of the night, but he or she needs to get enough sleep. The child does not know that he or she is tired or sleepy and therefore is not motivated to go to sleep, yet the child nevertheless needs to sleep. Likewise, although we need to eat to meet nutritional requirements, we are often motivated to eat not by nutritional needs but because the food tastes good or because we have a lunch appointment with pleasant company.

In the psychoanalytic literature, the conflation of motives and needs sometimes takes the form of failing to distinguish between wishes and needs. For example, Basch (1986) referred to the patient’s “need [i.e., to be perfectly mirrored and/or to merge with an idealized figure]” and contrasted that presumed need with “the patient’s wish to have the past replayed under more auspicious circumstances” (p. 411). However, as I have noted elsewhere (Eagle 1990), the presumed need for perfect mirroring is best understood as a wish to have the past replayed under more auspicious circumstances rather than an actual need. Were receiving perfect mirroring an actual need, it would be difficult to understand how the patient could benefit much from less than perfect understanding.

In adequate functioning, our basic biological needs are generally well represented in our personal desires, motives, and aims. As Lichtenberg (1989) noted, motivational systems are built around fundamental needs. However, it is not always the case that our personal motives adequately reflect or represent our fundamental needs. To take a simple example, in normal functioning, the need for nutrition is well represented in such experiences as feeling hungry, finding the feeling unpleasant, being motivated to eat, and finding eating pleasurable. However, for an individual with anorexia nervosa, there is a disjunction between the biological need for nutrition and the psychological experiences of hunger, wanting to
eat, and pleasure from eating. Now, consider a similar situation in which our basic psychological needs (e.g., need for security) are not well represented in our consciously experienced desires and motives. In contrast with biological needs, this reasoning in the case of psychological needs is perhaps more problematic insofar as there is no universal consensus regarding basic psychological needs and the nature of human nature. As noted earlier, different psychoanalytic theories (as well as different psychological theories) differ on this central issue.

Motives and Affects

Although implicit in much of this discussion, it should be noted explicitly that motives, desires, wishes, and aims are suffused with and generally mediated through emotions and affects. Early in his theorizing, Freud (1894) proposed that every experience is accompanied by a “quota of affect” (p. 60). This is especially true of motivated behavior—that is, the pursuit, fulfillment, and frustration of aims and desires are accompanied by pleasurable and unpleasant affects. According to Freud’s (1915) pleasure principle, we generally pursue motives and aims because they are pleasurable and gratifying or because we are attempting to avoid displeasure and distress (e.g., as in defense). As suggested by the earlier discussion of the relationship between motives and needs, although there is far from a perfect correspondence between the two (evolutionary selective advantages need only operate probabilistically), we are generally motivated to carry out need-satisfying behavior because such behavior entails pleasurable affect. However, when the pursuit and satisfaction of certain motives that are normally associated with vital needs become embedded in conflict and anxiety, they are no longer experienced as pleasurable although they continue to operate and make demands on the personality.

The relationship between motives and affects is bidirectional. Not only do the fulfillment and frustration of motives elicit affects, but the experience of affects generated motives. For example, the experience of fear motivates avoidance, escape, or attachment behavior, whereas the experience of joy motivates continuation of the behavior in which one is engaged. Indeed, according to Tomkins (1970), affect is the primary motivator of behavior. In this regard, Tomkins’s view is in accord with Freud’s placement of the pleasure principle at the center of motivation.

Tomkins’s proposal is supported by recent evidence from neuroscience research indicating that the brain structures involved in the experience of emotions are also involved in the organism’s motivational state and behavior—that is, pleasant emotions are associated with appetitive motivational systems and approach behavior and unpleasant emotions are associated with defensive motivational systems and avoidance or attack behavior. As Lang and Davis (2006) put it, the evidence suggests that “neural networks underlying expressed emotion include direct connections to the brain’s primary motivational systems, appetitive and defensive” (p. 4).

There is, of course, a great deal more that can be said regarding the neurophysiology of motivational systems. However, this chapter is not the place for it (see Chapter 29, “Psychoanalysis and the Neurosciences,” this volume). Suffice it to say that during the last number of years increasing efforts have been made, largely through the work of Solms (e.g., Solms and Turnbull 2002), to link findings in neuroscience and psychoanalysis.

Motivation and Cognitive Processes

Motivation and Perception

Although Freud maintained that wishes are the motive force for cognition in the sense of setting the “mental apparatus” in motion and that the influence of motives and desires on cognition is ubiquitous, the nature of that influence is complex and subtle and varies with a number of factors, including the particular aspect of cognitive or ego functioning one has in mind. In short, it would be a mistake to interpret Freudian theory as proposing that cognitive or ego functioning is enslaved to or entirely dominated by our desires and passions (id). Indeed, in the context of Freudian theory and psychoanalytic ego psychology, such enslavement of the ego to id forces would be seen as the kind of loss of ego autonomy that is characteristic of severe pathology such as psychosis.

The one area of cognitive functioning in which the influence of wishes and motives is minimal, according to Freudian theory, is perception. Freud (1900) viewed the function of the perceptual system as providing an accurate account of reality and observed that it “would be intolerably obstructed in performing its function if the remnant of an earlier connection [i.e., memory] were to
exercise an influence on a fresh perception” (p. 539). Freud's insistence that in normal functioning perception accurately reflects reality has tended to be overlooked. From a broad evolutionary perspective, one that Freud was likely to take, the primary function of perception of external stimuli is not to directly reflect one's motives, desires, wishes, and needs but rather to represent physical reality with reasonable accuracy in order to serve one's motives and desires. When that is the case, it is more likely that one's needs can be met in reality.

We do, of course, observe ordinary misperceptions that may reflect the distorting effects of motives and needs. However, no system functions perfectly and one should expect errors. In addition, these “slippages” do not contradict the idea that in order to carry out the pursuit of our motives and needs effectively, perception needs to reflect reality with reasonable accuracy and, seemingly paradoxically, not be excessively influenced by motives and needs. To take a perhaps silly example, if one wants to satisfy the hunger drive, one cannot perceive everything as food, but rather must distinguish perceptually between food and nonfood items. As noted, one can also more clearly see the influence of drive on perception and cognition in cases of failure of intact ego functioning such as psychosis.

Motives and desires are likely to influence not the percept itself but rather such selective processes as perceptual salience and focus of attention. Also, the distortions and elisions in perception with which psychoanalysis is mainly concerned, particularly in its theory of psycho-neurosis, are those having mainly to do with inner reality—that is, insofar as certain thoughts and feelings linked to, for example, forbidden sexual desires and wishes are removed from consciousness or distorted in some way, the inner reality of these sexual desires and wishes will not be adequately perceived.

**Drive Organization and Cognition**

According to the logic of Freudian theory, the everyday influence of drives (and the desires and motives with which they are associated) on cognition is seen in such phenomena as the increased perceptual salience and value of drive-related stimuli. Comparing one's food shopping behavior when hungry versus when satiated should be sufficient to convince one of the influences of drive on perceptual salience. Similarly, differences in perceptual salience of certain stimuli as a function of degree of sexual arousal are also a convincing illustration of the influence of drive on perceptual salience.

The vicissitudes of drive also result in multiple organizations of affect, cognition, and attitudes. Thus, picture one's psychic state, including the organization of affect and cognition, during and after states of intense hunger or sexual arousal. During the state of arousal, the world—particularly drive objects—is experienced in a very different way than the way it is experienced after satisfaction of hunger or sexual gratification. The actions and plans one would make, the attitudes one has, the affects one experiences, the hierarchy of salience of stimuli, and the thoughts and memories one has all vary as a function of drive arousal versus drive gratification. In a certain sense, states of consciousness during drive arousal and after drive gratification differ from each other in significant ways. However, the influence of drives upon cognition need not take the form of distorting reality or violating the reality principle. Thus, the increased perceptual salience and value of food when hungry reflects an adaptive selec-
tive influence rather than a distorting influence of drives on cognition. Sexual arousal also exerts a similar effect on the perceptual salience and interest value of certain stimuli.

The relationship between drives and perception is often bidirectional—that is, not only can, for example, increased sexual arousal influence perceptual salience, but external stimuli can trigger and intensify sexual arousal, which in turn can enhance the perceptual salience of the sexual stimuli. This is also true for other motivational systems such as hunger, which can be triggered and intensified by the sight of food, and thus enhances the perceptual salience of food.

The influence of drive organization on cognition can also be reflected in other cognitive or ego functions, such as how external stimuli are categorized. For example, under the sway of heightened aggression, one could categorize a baseball bat and a golf club as ways to hurt or kill someone rather than as, say, objects used in athletic games. However, it would involve no obvious or blatant perceptual distortion of reality or the reality principle so long as the bat could also be accurately perceived as a baseball bat and the golf club as a golf club. The intrusion of drive in cognition is seen here in the functional organization of objects rather than in the formation of the percept.

The influence of drive on cognitive organization can be subtle and complex. Let us say that an individual has no difficulty in categorizing the baseball bat and golf club as objects in athletic games. It may be the case, however, that paralleling this normative categorization are forms of unconscious organization in which the unifying principle is “sexual phallic objects” or “tools of aggression.” The evidence for these parallel forms of organization might emerge only in special circumstances such as dreams, free association, otherwise weakened ego control, or heightened drive.

Psychoanalytic Theories and Identification of Primary Motivational Systems

Although the content of what is viewed as primary and secondary varies in different theories, what has remained constant in the history of psychoanalysis is the tendency of psychoanalytic theories to posit one or two superordinate motivational systems to which other motives are secondary and subordinate or constitute indirect expressions of the superordinate motivational systems. This tendency began with Freud’s (1912, 1915) positing of the dual instincts of self-preservative or ego instincts and sexual instincts. For many American psychoanalysts, particularly those trained in the ego-psychological tradition, the second dual instinct theory, in which sexual and aggressive drives constitute the superordinate motivational system, remains the prevalent model of motivational organization.

As different psychoanalytic schools have proliferated, each school has developed around its own characteristic idea of what the superordinate motivational system is. Indeed, one can distinguish different psychoanalytic theories from each other by identifying the motives and motivational systems each theory views as fundamental and primary and which it views as secondary—that is, derived from primary motives.

As Pine (1990) observed, the motivational systems that have been viewed as superordinate in psychoanalysis are those that are linked to drive theory, ego psychology, object relations theory, and self psychology. Thus, in Freudian drive theory, sexual and aggressive impulses are viewed as primary, and a wide range of behaviors, themselves not manifestly and overtly sexual and aggressive, are viewed as indirectly linked to sexual and aggressive motives through displacement, defensive disguise, sublimation, and other processes.

According to self psychology, need for self-cohesiveness operates as a primary motive in psychic life to which other motives are subordinate. This kind of theoretical formulation is reflected in Kohut’s account of driven sexual impulses as “disintegration products” that represent attempts to shore up a fragmented self and in his account of hostility and aggression as reactions to narcissistic injury.

According to object-relational perspective, object seeking is a superordinate motive to which other motives are subordinate. For example, Fairbairn (1952) writes that sex is a “sign-post to the object” (p. 33). Finally, from the perspective of ego psychology, competence, mastery, and defense are superordinate motives.

Some have rejected this approach. For example, one of Pine’s (1990) primary objectives, as the very title of his book Drive, Ego, Object, and Self indicates, is to reject the idea that any one of these motivational systems is superordinate and encompasses the others and to argue instead for the need to consider a multiplicity of motives and motivational systems in clinical work. More generally, Lichtenberg (1989) identified five motivational systems: “[1] the need for psychic regulation of

The claims of primary or superordinate status notwithstanding, one can think of different psychoanalytic “schools” in terms of the parable of the blind men and the elephant, with each “school” identifying a different essential aspect of human behavior that has been neglected, de-emphasized, or given secondary and derivative status by other theories. Thus, for example, one can think of the emphasis of self psychology on self-cohesiveness as a corrective to theories that have ignored or de-emphasized the role of this motivational system in human functioning, without necessarily agreeing on the exclusivity of self-cohesiveness as a motive.

It makes little sense to subordinate one motivational system to another, as suggested by a number of considerations. Different motivational systems—say those linked to drive, ego, object, and self—differ not only with regard to content of motives but also with regard to how they operate and function. For example, as Modell (1975) pointed out, the motivational systems associated with object relations and ego functioning are not readily assimilated into a tension-reduction model. As Modell (1975) puts it, “If the need for an object reflects the workings of an instinct, it will have to be acknowledged that the concept of instinct here is quite different from Freud’s use of the term” [p. 61]. Thus, whereas cyclicity of buildup and discharge characterize hunger and sexuality, this does not appear to be the case for the attachment system or, say, for ego motives of mastery and competence [Hendricks 1943; White 1959].

Further suggesting the futility of attempts to subordinate one motivational system to another lies in the fact that the pursuit of motives and desires that “belong” to one motivational system at the same time entails motives and desires from a different motivational system. For example, as Klein (1976) observed, the pursuit of sexual motives not only involves discharge of tension states but also often involves self motives—an observation also made by Kohut (1984). As another example, there is evidence that individuals with an enmeshed-preoccupied attachment pattern are more likely to engage in sexual behavior as a means of assuaging their attachment anxieties.

It is often quite difficult in clinical work to identify motives as distinct expressions of one versus another motivational system. First, one’s theoretical orientation is likely to influence one’s clinical judgment in this regard. Second, given the role of multiple function [Waelder 1936] and overdetermination, a given behavior may reflect multiple motives and motivational systems. For example, the expression of intense rage may not only constitute a drive discharge phenomenon but also reflect poor ego controls, a desire to destroy the object, and narcissistic injury, all at the same time.

Consider a patient with whom I worked:

The patient’s presenting symptom was obsessive thoughts regarding whether he was homosexual. He would “test” himself all day long by imagining a homosexual scene and then monitoring his reaction. If he “passed” the test by not detecting any appreciable emotional reaction in himself, his anxiety temporarily abated—until the next “test.” If he “failed” the test by detecting an emotional reaction, his anxiety would markedly increase. In either case, further tests were always required. The symptom developed when his girlfriend began putting pressure on him to become engaged, with an eye toward eventual marriage. My patient, who was not especially psychologically minded, had informed his girlfriend about his symptoms and stated in one session, without any awareness of what he was communicating, that as long as the symptom persisted he could not possibly become engaged or get married. “It wouldn’t be fair to her,” he remarked. He also reported an extraordinarily revealing dream following an incident during which his girlfriend told him that she loved him, in which he was being “smothered” and “slipping into black nothingness.”

The patient also reported the exacerbation of his symptoms whenever his mother asked him to do things that his father used to do for her [e.g., mow the lawn; put a baking dish away on a high shelf] and when he received a job promotion. Finally, it should be noted that my patient was raised in a very religious family and believed that homosexuality was an abomination deserving severe punishment from God.

To be noted here is the convergence of different motivational systems and structures in generating and maintaining the symptom: homosexual fantasies (drive); oedipal conflicts (drive); conflict between fears of engulfment and isolation (object relations); fear of disintegration (self); inability to screen out unbidden thoughts from consciousness (ego functions); and guilt and self-punishment (superego) [see Pine 1990 for further clinical examples of the hierarchical participation of different motivational systems in the unfolding of clinical phenomena].

If a primary and superordinate motivational system that cuts across different psychoanalytic theories can be identified, I think a good candidate would be motives related to affect regulation. If one steps back from the specific details of each theory, one can see that affect regulation is common to a variety of motivational systems associated with different psychoanalytic “schools.”
Thus affect regulation is an element central to considerations of drive discharge, the nature of defense, the role of self objects in self-cohesiveness, the need for objects and object relations, and the functions of the attachment figure.

Conflict Between Different Motivational Systems

Although inner conflict has generally been understood in terms of an id-ego or drive defense model, the fact is that other conflicts between different motivational systems play an important role in biological and psychological life. An obvious mundane example is the conflict between hunger and the desire to avoid obesity. Another example among animals as well as humans is the conflict between aggression and competition on the one hand and cooperation and friendship on the other.

A prominent example of a conflict between different motivational systems in the psychoanalytic context is one between Freud (1912) referred to as love and desire (which he also referred to as the “affectionate and sensual currents”). Freud attributed the conflict between love and desire to the persistence of incestuous wishes so that the person one loves cannot also be the object of sexual desire. As Freud (1912) put it, “[W]here they love, they cannot desire and where they desire, they cannot love” (p. 183). One consequence of this conflict, Freud observed, is “psychical impotence” in men, sexual frigidity in women, and in both a failure to experience pleasure from the sexual act.

Quite apart from the question of the persistence of incestuous wishes, one can understand the conflict between love and desire, between the “affectionate and sensual currents,” in terms of the conflicting demands made on the individual by the sexual and attachment motivational systems. Whereas sexual arousal and excitement is stimulated by unfamiliarity, novelty, and the exotic, these characteristics are inimical to the establishment of attachment that requires familiarity and predictability.

Another way to put it is to note that whereas prolonged propinquity dampens the intensity of sexual interest and excitement—possibly through straightforward habituation (Fraley and Marks 2010)—it heightens the attachment bond. There is evidence that novelty plays a greater role in sexual arousal in males than in females, both in animals and humans (Symons 1979). In any case, insofar as in long-term relationships one’s attachment figure is generally also one’s sexual partner, the conflicting dynamics of the two motivational systems present an integrative challenge that individuals meet with varying degrees of success [see Eagle 2007 for further discussion of these issues].

Other examples of conflict between different motivational systems found in the psychoanalytic literature include conflict between relatedness and self-definition (Blatt 2008) and between “the regressive lure of identification and the progressive urge toward separation” (Fairbairn 1952, p. 43), which bears a strong family resemblance to the conflict between symbiosis and separation-individuation [Mahler 1968].

Motivational Explanations in Contemporary Psychoanalytic Theories

I noted at the beginning of this chapter McKay’s (1989) comment that “psychoanalytic theory is above all a theory of motivation” (p. 6). It is not clear that this continues to be as much the case in contemporary psychoanalytic theories (although there are exceptions to be taken up later).

Contemporary psychoanalytic theories differ from drive theory and its later elaboration by American ego psychologists not only with regard to the motives and motivational systems they view as superordinate but also in their relative de-emphasis on motivational factors and their increased emphasis on nonmotivational factors in accounting for human behavior, including psychopathology. For example, according to self psychology, much pathological behavior is viewed as an “automatic” product of defects in the structure of the self, without much reference to the individual’s conflicting motives and desires. As Friedman (1986) put it, according to self psychology, psychopathology can be understood as a “stunted state,” whereas according to Freudian theory, it can be understood as a conflictual “preferred state” [i.e., seeking the gratification of infantile wishes]. For example, the “disintegration anxiety” described by Kohut (1984) was viewed by him as primarily an “automatic” consequence of severe self-defects rather than a motivated symptom. On this view, such symptoms are an expression of faulty functioning due to faulty structures. There is no purpose or end it is
intended to accomplish. In addition, this perspective is what one would expect in a theoretical context that emphasizes defects rather than conflicts among competing motives and different structures of the personality [see Eagle 1990].

To the extent that motives and desires play a role in self psychology theory, it is mainly reflected in the positioning of the individual's striving to be empathically understood and to keep idealization and the grandiose self intact. Also, the positioning of a general striving for self-realization, a perspective reminiscent of the self-actualization theories of Rogers [e.g., 1961] and Maslow [e.g., 1968], is more a statement of a general organismic principle than a description of specific motives and desires.

Other contemporary psychoanalytic accounts of behavior, including psychopathological behavior, tend to place a great deal of emphasis on maladaptive relationships that are the product of the enduring effects of early learning. This tendency is reflected in such concepts as representation of interactions generalized [Stern 1985], internal working models [Bowby 1973], “unconscious pathogenic beliefs” [Weiss et al. 1986], “interpersonal structures” [Beebe et al. 1997], “relational configurations” [Mitchell 1988], and “habitual relationship patterns” [Schachter 2001]. All of these concepts have in common the idea that representations and structures were acquired early in life based on parental communications and prototypic interactions with parental figures. These structures are seen as constituting primarily relatively accurate representations of early interactions and parental communications rather than reflecting fantasies, wishes, and desires. Although constituting adaptive responses early in life, they become maladaptive insofar as they are no longer appropriate to current circumstances and assimilate new experiences into expectations, beliefs, and habitual patterns learned early in life. Although motivational factors may have played an important role in the early development of these structures, once they are formed they are relatively resistant to change and do not necessarily need to be maintained by ongoing current motives—although ongoing motives may be present.

Consider the development of an avoidant attachment pattern early in life. There is evidence suggesting that the development of an avoidant pattern represents a defensive strategy on the part of the child to avoid the pain of a caregiver’s rejection and anger and to satisfy attachment needs as much as possible. To that extent, the avoidant attachment pattern is clearly motivated. However, once established, this pattern is relatively resistant to change and need no longer be maintained by ongoing motives. It operates and influences behavior the way any learned or habitual pattern does. Although the avoidant individual may avoid intimacy because of the anxiety it elicits [in that sense the avoidant pattern may be partly maintained by the motive to avoid anxiety], insofar as this learned pattern has become part of the individual’s character structure, it need not be maintained by ongoing motives. In other words, the avoidant pattern is no longer clearly in the service of pursuing particular ends and purposes.

Limitations of Motivational Explanation

Motives have the peculiar status of constituting a form of explanation as well as phenomena that themselves need to be explained by appeal to nonmotivational processes [see Eagle 1980]. As Max Black [1967] remarked, “As soon as reasons for action have been provided, an inquiring mind will want to press on to questions about the provenance and etiology of such reasons” [p. 656]. To the extent that it is a theory of mind and of human nature as well as a form of clinical treatment, Black’s comment would also apply to psychoanalytic theory. Although reference to motives and intentions may be necessary, they are not sufficient for an adequate theory of human nature and human behavior [Eagle 1980].

The limitations of motivational explanation are nicely illustrated by findings reported some years ago by Money and Ehrhardt [1972]. The behavioral and psychological characteristics of a number of male pseudohermaphrodite and male pseudohermaphrodite female offspring were investigated. The basic finding was that these girls tended to show a variety of common characteristics: femininity, lack of interest in playing with dolls and in feminine clothes, greater interest in career than in marriage and family, and so on. There is little doubt that each of the girls studied would have offered specific reasons and motives for being interested in athletics, for not playing with dolls, and for not giving marriage and family high priority. However, given the information available, it would seem entirely appropriate to look to their intrauterine history to fully explain the girls’ motives as well as behaviors and preferences.

Broadly speaking, one can identify two primary sources of the “provenance and etiology” of our motives and desires: 1) our biological makeup as the product of evolutionary selection and 2) internalization of cultural
influences, including the influences of the family as agent and mediator of society and the socialization process. In the context of Freudian [as well as Kleinian] theory, it is the former source that is most strongly emphasized. According to Freudian and Kleinian drive theory, instinctual drives present the primary source of the “provenance and etiology” of our desires, wishes, and motives.

Freud’s instinct theory essentially proposes that certain instincts have been selected out in the course of evolution and that it is these instincts that constitute a main source of our proximal motives, desires, wishes, and fantasies. In this sense, Freud anticipated a basic foundational idea of contemporary evolutionary psychology. He specifically anticipated the “selfish gene” hypothesis to the effect that from an evolutionary point of view, we are essentially vehicles for the transmission of our genes. He wrote:

The individual does actually carry on a twofold existence: one to serve his own purposes and the other as a link in a chain, which he serves against his will or at least involuntarily. The individual himself regards sexuality as one of his ends, whereas from another point of view he is an appendage to his germ plasm at whose disposal he puts his energies in return for a bonus of pleasure. He is the mortal vehicle of a [possibly] immortal substance—like the inheritor of an entailed property, who is only the temporary holder of an estate which survives him. [Freud 1914, p. 78]

Thus, from the perspective of Freudian instinct theory, in an important sense we are “lived by” our instinctual heritage not only when one feels driven and propelled by peremptory ego-alien and unconscious impulses but also when one pursues ego-syntonic conscious motives and desires. This is true in the sense that the distal source of both our conscious and ego-syntonic as well as our unconscious and ego-alien motives and desires are to be found in the adaptations that have been selected out in the course of our evolutionary history. As Bowlby [1973] noted, many of our motivational propensities constitute adaptations to our “environment of evolutionary adaptedness” (p. 83). For example, people develop snake and spider phobias rather than, say, automobile phobias despite the fact that in contemporary urban life automobiles are far more likely to be dangerous than snakes and spiders (Breuer and Freud 1893–1895; see also Buss 2009).

A radical form of skepticism with regard to the explanatory value of motivational accounts is seen in the argument proposed by philosophers influenced by Wittgenstein [e.g., A.I. Melden and G.E.M. Anscombe] that it is a mistake to think of motives and reasons as specifying the process that precedes and leads to action. Rather, the reasons given are justifications for the action after it has already been taken. This form of skepticism is also expressed by Nietzsche [1882], who wrote: “Is the goal, the purpose not often enough a beautifying pretext, a self-deception of vanity after the event that does not want to acknowledge that the ship is following the current into which it has entered accidentally? That it ‘wills’ to go that way because it must! That is, has a direction, to be sure, but—no helmsman at all?” [as cited in Lehrer 1995, p. 172]. A similar sentiment is expressed by Freud [1923] in his horse-and-rider metaphor representing the relationship between the id and the ego: “Often a rider, if he is not to be parted from his horse, is obliged to guide it where it wants to go, so in the same way the ego is in the habit of transforming the id’s will into an action as if it were its own” (p. 25).

This Nietzschean form of skepticism appears to do away with the explanatory value of motivational accounts altogether. In this perspective, it is not simply that the specific motives and reasons the individual provides for his or her behavior may be self-deceptive. It is also not simply that nonmotivational factors influence the motives and desires we have. In both these views, motivational accounts retain at least some of their explanatory value—that is, the idea that behavior can be accounted for by referring to reasons and motives is retained even if the reasons and motives we provide are not the truly operative ones, or even if the provenance and etiology of these motives themselves need to be accounted for. On the more extreme view, however, we are propelled by impersonal forces, and any account of reasons and motives for our behavior, conscious or unconscious, self-deceptive or authentic, constitutes an illusion. On this view, the impersonal forces that propel us serve evolutionary aims, not our personal purposes and ends.

Although Freud sometimes writes as if this represented his model for human behavior [as in the horse-and-rider metaphor noted earlier], this is not and could not be his general conception, because one of its implications would be the futility of any psychoanalytic clinical work, particularly work based on the assumptions that conscious and unconscious motives and desires impact behavior and that awareness and understanding of them influence their impact.

**Conclusion**

Although motivational accounts do not constitute a sufficient explanation in the sense that one also needs
to account for the “provenance and etiology” of motives and desires themselves, one can demand of any adequate scientific theory that it does not deform the phenomena it is attempting to explain by reductionistically eliminating them.

Theories that go directly from either external stimuli or brain processes to behavior without reference to intervening psychological processes such as motives and desires run the risk of reductionistically eliminating the very phenomena that make the investigation interesting and important in the first place. That is to say, even if impersonal, distal, nonmotivational factors—say, selected out instinctual systems—influence our behavior, they are not likely to do so directly the way a program would directly influence a robot. Rather, they are likely to influence behavior through influencing what we want and do not want to do.

Explanatory accounts of behavior that include reference to motives, wishes, and desires, and especially psychoanalytic explanatory accounts, are based on a conception of mind that is rich, textured, and complex and as such provide space for such processes as transformations of meaning, self-deceptions, hidden desires and fantasies, inner conflicts, and so on. We still await a theory that will succeed in integrating contributions from not only different motivational theories but also motivational and nonmotivational factors into a comprehensive account of human behavior and its determinants.

---

**KEY POINTS**

- The patient’s affect is generally the most reliable guide to his or her unconscious desires and motives.

- The patient’s resistance and defenses are also an important guide to his or her unconscious desires and motives.

- One should be as aware of the patient’s intact ego functioning as of his or her pathology.

- The presence of conflicts among different motivational systems is not necessarily pathological. The main clinical issue is how patients deal with such conflicts.

- The therapist should try to appreciate the multiple motives people have rather than reducing them to one or two supposedly superordinate motives.

---

**References**


Eagle M: The concept of need and wish in self psychology. Psychoanl Psychol 7[suppl]:71–88, 1990
Fairbairn WRD: Psychoanalytic Studies of the Personality. London, Tavistock, 1952
Flew A: Psychoanalytic explanation. Analysis 10:8–15, 1949
Hendricks I: The discussion of the "instinct to master." Psychoanal Q 12:561–565, 1943
Waelder R: The principle of multiple juncture: observations on overdetermination. Psychoanal Q 5:45–62, 1936
Unconscious Processes

Anton O. Kris, M.D.

THE INFERENCES that unconscious mental processes determine a very large portion of our lives has proven enormously fruitful. Although the idea of unconscious mental life dates back millennia, systematic investigation of unconscious mental processes began with the clinical researches of Sigmund Freud at the end of the 19th century. Listening to patients telling their stories with the use of hypnosis (following the example of his mentor, Josef Breuer), Freud grasped the usefulness of this central hypothesis—the bedrock of psychoanalysis—that the inexplicable, irrational nature of symptoms could be understood to be meaningful if he inferred unconscious influences. The first hypothesis, in which he joined Breuer in the Studies on Hysteria (Breuer and Freud 1893–1895), introduced an explanatory mechanism, the hypnoid state, an alternated state of consciousness that at least sometimes was induced by trauma. The hypothesis included the assumption that the memories of traumatic events that occurred during a hypnoid state could be assisted to reach consciousness and to permit abreaction of dammed-up affect by talking under hypnosis. They hypothesized the occurrence of dissociations in mental life caused by damming up of affect.

Dissociation would ordinarily not occur, because affect would ordinarily be discharged and the experience would be absorbed into the “great complex of associations.” (Subsequent revival and reformulation of that hypothesis are discussed later.) Freud’s attention, however, shifted to a more compelling inference: the delineation of repudiated unconscious wishes. The major emphasis of his subsequent work on the nature and organization of the mind elaborated on his inferences about the nature of the wishes and the motives for repudiation, that is, to unconscious conflict. Psychoanalysis became the psychology of human experience and behavior viewed from the perspective of unconscious conflict. By mid-20th century, the focus had extended beyond conflict, although conflict has remained central to psychoanalysis.

Freud’s (1894) first paper on the neuropsychoses of defense had actually appeared before the publication of the Studies on Hysteria, and Freud’s chapter on psychotherapy in the latter work refers much more to conflict than to hypnoid hysteria. Defense, particularly repression, the unconscious means of repudiation of unconscious wishes, became the inferred cause of symptom formation. (Although a concept of repression had been
widely employed in the 19th century, the idea that repression could be part of symptom formation or that bringing unconscious ideas to consciousness could serve as a therapeutic method was not a part of that concept of repression.) Along with the change of focus to conflict, Freud’s method of study shifted from hypnosis to free association, which he regarded as his “most momentous step” [Freud 1924, p. 195], the adoption of a technique “considered by many people the most important contribution made by psychoanalysis, the methodological key to its results” [Freud 1931, p. 403]. Today we are inclined to ascribe the achievement to the invention of the psychoanalytic situation as a whole, to the clinical setup of psychoanalytic treatment, and to the method of free association [Kris 1982], although, as in many psychoanalytic matters, analysts differ on their views of the constituents of the psychoanalytic situation.

Although others (of whom Pierre Janet is now the best known) were engaged in work very similar to that of Breuer and Freud together, Freud entered the uncharted territory of unconscious conflict pretty much alone. Freud summarized his view in his lectures given in the United States in 1910: “We do not derive the psychical splitting from an innate incapacity for synthesis [as did Janet] on the part of the mental apparatus; we explain it dynamically, from the conflict of opposing mental forces and recognize it as the outcome of an active struggling on the part of the two psychical groupings against each other” [Freud 1910, pp. 25–26].

**Problem of Hypotheses in Psychoanalysis**

Before proceeding with the delineation of unconscious processes, I want to call attention to the inherent problem in the hypotheses under review. They necessarily reflect the perspective of the person employing them, most often a changing perspective, as in Freud’s case. Unnoticed or implicit assumptions determine the meaning of the hypotheses, and those assumptions and meanings have changed over time, differently for different persons. To add to the complications, however, as the hypotheses continued and continue to develop, they have influenced new observations and the development of new hypotheses, especially about the participation of the analyst in the method of free association. The indeterminacy of observation and inference in psychoanalysis compromises any attempt to delineate with certainty the hypothesized unconscious mental processes that play a vital role in the work of psychoanalysts. Although philosophical justification can be adduced [e.g., Ahumada 1997], the problem poses a serious difficulty to psychoanalytic work, both in treatment and in research, because isolation of variables proves extremely difficult. Without hypotheses, on the other hand, there could be no investigation. Ultimately, the inferences and hypotheses of psychoanalysis stand on the new observations and new understanding that they facilitate.

**Studies on Hysteria and “The Neuro-Psychooses of Defence”**

The papers in *Studies on Hysteria* (Breuer and Freud 1893–1895) have exerted an enormous influence on the whole subsequent psychoanalytic enterprise. “Hysteric[s] suffer mainly from reminiscences” [p. 7], the authors famously concluded. Affectively charged memories [ideas], blocked from discharge, appeared to account for the development of hysterical symptoms. Unconscious memory has remained central to psychoanalysis. The conscious recollection of previously unconscious memory stood early as a means to verify the “talking cure.” The problem of therapeutic action has remained more elusive, but remembering the unrememberable has been an essential component of the free association method that succeeded the talking cure under hypnosis or “chimney sweeping,” as Breuer’s patient Anna O. called it. Freud also referred to it, at that time, both as the cathartic method and as abreaction.

A second, crucial discovery reported in *Studies on Hysteria* highlighted the somatic expression of memory in hysterical attacks. This understanding, that memory could appear in *action*, which has played a most important role in subsequent thinking about the therapeutic process of psychoanalysis, is discussed later. The somatic expression of memory—the phenomenon of *conversion*, one of many hypothesized unconscious mental mechanisms—held an immediate, vital place in Freud’s (1894) thinking: “In hysteria, the incompatible idea is rendered innocuous by its sum of excitation being transformed into something somatic. For this I should like to propose the name of conversion” [p. 49].
He explained “sum of excitation” at the conclusion of the paper:

I should like, finally, to dwell for a moment on the working hypothesis which I have made use of in this exposition of the neuroses of defence. I refer to the concept that in mental functions something is to be distinguished—a quota of affect or sum of excitation—which possesses all the characteristics of a quantity (though we have no means of measuring it), which is capable of increase, diminution, displacement and discharge, and which is spread over the memory-keres of ideas somewhat as an electric charge is spread over the surface of a body. (p. 60)

This hypothesis is, in turn, based on another hypothesis known as the constancy principle: a tendency to keep intracerebral excitation constant. If intense affect cannot be discharged, it necessarily finds an alternative route in the formation of symptoms.

Evidently, Freud found this combination of hypotheses regarding mental energy useful, and certainly we cannot argue with his subsequent investigative success. Nonetheless, what was useful to Freud then no longer seems equally useful to most analysts today. I do not believe that this results from our having answers to the question of how conversion takes place. It seems, rather, that the answer is not immediately required by the psychoanalytic enterprise. Neuropsychologists and neurobiologists employ methods that are far better suited for the study of this aspect of affects and the mechanisms by which ideas and affects produce somatic effects.

To illustrate the interrelationships between the observations and the hypotheses employed to understand them, the problem of obsessional neurosis affords a different view and an additional defense, later called isolation.

If someone with a disposition [to neurosis] lacks the aptitude for conversion, but if, nevertheless, in order to fend off an incompatible idea, he sets about separating it from its affect, then that affect is obliged to remain in the psychical sphere. The idea, now weakened, is still left in consciousness, separated from all association. But its affect, which has become free, attaches itself to other ideas which are not in themselves incompatible; and, thanks to this “false connection,” these ideas turn into obsessional ideas. This, in a few words, is the psychological theory of obsessions and phobias mentioned at the beginning of this paper. (Freud 1894, pp. 50–51)

A number of such defense mechanisms were described, and their significance in particular neurotic and psychotic conditions was illuminated. So, for example, projection, the unconscious attribution of one’s own thought, wish, or affect to an external object (usually a person), was seen to have a particular importance in paranoid conditions. It took much longer to recognize the importance of projection in normal development. Much later, the concept of “projective identification” (Klein 1946) became a developmental hypothesis with powerful significance in psychoanalytic treatment. I discuss this further in connection with internalization later in this chapter.

Two additional observations and the hypotheses employed to explain their operation that have remained a central part of the psychoanalytic lexicon made their appearance in the chapter on psychotherapy of Studies of Hysteria: resistance (the unconscious interference with freedom of association, often equated with obstacles to progress in the therapeutic work) and transference. Both have undergone substantial elaboration and transformation in the subsequent period of more than a century of psychoanalytic work. Their initial statement, however, illustrates the way the psychoanalytic theory of unconscious mental processes was developed to account for observations made in the therapeutic encounter:

In one of my patients the origin of a particular hysterical symptom lay in a wish that she had had many years earlier and had at once relegated to the unconscious, that the man she was talking to at the time might boldly take the initiative and give her a kiss. On one occasion, at the end of a session, a similar wish came up in her about me. She was horrified at it, spent a sleepless night, and at the next session, although she did not refuse to be treated, was quite useless for work. After I discovered the obstacle and removed it [i.e., inferred it from the patient’s associations and urged the patient to continue with her associations], the work proceeded further, and lo and behold, the wish that had so much frightened the patient made its appearance as the next of her pathogenic recollections and the one that was demanded by the immediate logical context. What had happened therefore was this: The content of the wish had appeared first of all in the patient’s consciousness without any memories of the surrounding circumstances that would have assigned it to a past time. [Breuer and Freud 1893–1895, pp. 302–303]

That is, the recollection appeared first in a tendency to action, the wish to kiss her doctor.

Twenty years later, Freud (1914a) summarized these views: “It may thus be said that the theory of psychoanalysis is an attempt to account for two striking and unexpected facts of observation which emerge whenever an attempt is made to trace the symptoms of a neurotic back to their sources in his past life: the facts of transference and of resistance” (p. 16).
The work that stood in between those two publications introduced many new observations and corresponding hypotheses of unconscious mental processes. The sexual nature of the significant repressed ideas— in “all the cases I have analysed it was the subject’s sexual life that had given rise to a distressing affect” (Freud 1894, p. 52)—led, eventually, to a theory of motivation, to the concept of [unconscious] instinctual drives, and to a profound, evolving theory of human development. It is perhaps worth pointing out that the hypotheses and the facilitating conditions of investigation also necessarily restricted the focus of analysts as they made sense of the events of analytic treatments. So Freud’s recognition of important sexual elements in the etiology of the neuroses influenced his further investigations and theorizing, but this led to a one-sided view that needed expansion and correction in his later work and in the subsequent work of other analysts.

Because the initial discoveries of psychoanalysis and the development of its body of changing hypotheses were so much the work of one man, I have tried to let Freud’s words speak for themselves. To do so beyond this initial part, however, would prove cumbersome and far too lengthy for the current purposes, so I shall present the remainder in description.

Investigation of Dreams and Assumption of Psychic Determinism

The interpretation of dreams, “the royal road to a knowledge of the unconscious activities of the mind” (Freud 1900, p. 608), afforded Freud an opportunity not only to develop hypotheses about particular unconscious mental processes but also to create a comprehensive theory of the mind, a theory that he continued to modify for nearly 40 years. Concepts and principles were developed to describe the functioning of the psychic apparatus, some of which I shall now spell out. To anchor this discussion, it is important to understand that the psychoanalytic view of dreams depends on subjecting them to the method of free association. The assumption that mental life is determined, that one association stimulates another, underlies the free association method. This hypothesis of psychic determinism permits the inference of the latent dream thoughts, the assumed, unconscious basis of the dream before it was subjected to disguise. The disguise is required because, according to the relevant hypotheses, some unconscious wishes would prove unacceptable to the conscious person. In Freud’s view, the dream was an attempt to fulfill an unconscious wish in disguise. Dreams afford an opportunity to study the means of disguise, the dreamwork, to which I turn next. We also need to address the question of how psychoanalysis accounts for the unacceptability of some wishes and the censorship that effects the requirement for disguise. Freud’s established recognition of unconscious conflict provided the basic premise for the relationship of the censorship and the wish inherent in the latent dream thoughts—that is, unconscious wishes and the censorship that limits their expression and satisfaction form an unconscious conflict.

Psychoanalysis distinguishes the manifest dream, as the dreamer recalls it, from the inferred, unconscious latent dream thoughts that are the source of the dream. In the effort to reach consciousness, the dream thoughts are disguised by the inferred dream work. The most important components of the dream work are condensation, in which two or more unconscious elements appear together in one element of the manifest dream; displacement, in which the emphasis or affect in the manifest dream appears disconnected from its location in the latent dream thoughts; visual representation of latent thoughts; and secondary revision, an attempt to create a meaningful narrative of the product of the mechanisms of disguise. In his anthropological study of magic, The Golden Bough, J. G. Frazer (1890), a contemporary of Freud, described two principles of magic: similarity and contact (contiguity). A particular person may be represented, for example, by another person with some similar characteristic such as appearance, profession, or nationality or by some possession or place with which the person had contact. These principles also apply to the manner in which the dream work represents the latent dream thoughts, but always as the product of compromise between those thoughts and the censorship.

Dreams most often include elements of day residue—references to recent thoughts or perceptions, usually of the same day as the dream. From the point of view of the clinician, such references may be helpful in orienting one’s perspective on the dream—that is, in seeing how they are represented and incorporated, the clinician may understand how the dreamwork of that dream operates. One can think of it as the grammar of the dream. From the viewpoint of theory, Freud hypothesized that the day residue links up with an unconscious wish in order to gain sufficient motivation to produce a dream.

In the attempt to interpret dreams, there is no escape from the problem of the validity of hypotheses, for interpretations are hypotheses. Freud recognized that dreams are formed by several mental threads coming
together. Like trees that have multiple roots, symptoms have multiple unconscious origins. For example, a patient was angry about an injustice done to a friend. In the dream he is writing a friendly letter. In the associations he recalled his wish to right the wrong for his friend by writing a letter. A friendly letter may be a letter for a friend, but it may also reveal a reluctance to express his anger or even ambivalence toward his friend. How can one be sure that the image actually represents any particular meanings or latent dream thoughts?

The quality of coherence in the new sense to be made of the dream offers a partial but sometimes misleading guide [Spence 1981]. The associative consequences, such as new associations, especially new recollections [e.g., remembering a forgotten event or recalling an additional piece of the dream], provide useful evidence. From another angle, the analyst's interpretations represent the analyst's associations that have been harnessed for the purpose of fostering the associative process. The interpretation of dreams, as all of clinical psychoanalysis, is the product of two minds at work and is necessarily subject to the difficulties of validity inherent in the method.

This aspect of psychic determinism adds to the problem of testing hypotheses. Do the associations and interpretations reveal the constituent elements of a symptom or of a dream, the latent dream thoughts? Or do they follow paths stimulated by the symptom or the remembered dream? No single example can bring conviction on this matter. Accumulated experience regularly reveals multiple origins for dreams and symptoms.

Another example may illustrate some of these components:

A woman in her late 20s reported a two-part dream on which we spent the session productively. Her associations flowed freely, and we were able to understand many of its elements and their relationship to continuing concerns. Toward the end of the session, however, I told her that I had heard nothing to clarify two orange images: making Grand Marnier ice cream in the first part and wearing an orange taffeta dress in the second. [Occurrence of an element twice in a dream regularly signifies an important link to the latent dream thoughts.] She recalled immediately that she had been reading about breast cancer before going to sleep. She had been frightened by an account of peau d'orange, the orange-peel skin of some advanced breast cancers. Her dream had dealt with her fear by representing it disguised as two pleasurable orange images. The dream expressed her wish that she should have nothing to fear. The fear and its denial are represented [condensed] in the two orange pictorial images. The frightening thought was temporarily repressed but returned in the compromise of the wishful images.

This very simple illustration raises a question. Why, when associations flowed so freely, did they not touch on these orange images? It seems to me that the dream had so effectively dealt with the frightening thoughts that they remained at a sufficient distance from conscious awareness throughout the analytic session in question and might have remained so, but for my question. The method of free association is designed to reveal unconscious motivations and the defenses employed against them, even when the defenses have been relatively successful. It is often sufficient, as in this instance, for the analyst to draw the patient's attention to a dream element. The subsequent associative process then leads to meaning.

Primary Process and Secondary Process, Pleasure Principle, and Reality Principle

Freud's formulation of the components of the dreamwork created a whole new view of mental life: the distinction between adult, rational thinking and the non-linear primary process. Primary process is characterized first as tending to immediate discharge of tension, which Freud equated with gratification, whereas in secondary process, delayed discharge and gratification are possible. In some ways these two processes correspond to differences between children and adults, and it is clear that in the course of development the capacity for delay, which correlates with frustration tolerance, must be developed. In this sense the distinction between primary process and secondary process accords with two modes of mental function: pleasure principle and reality principle. The pleasure principle operates without regard to reality, whereas the recognition of reality and responsiveness to it characterize the reality principle.

Alongside the different forms of tension discharge, Freud attributed profound differences in symbolic functions to the primary and secondary processes. In primary process, thought is irrational, opposites exist comfortably side by side, negation does not occur, and time may move forward or backward. Thus a single mental element may represent experiences that occurred at different times as occurring at one time. It is a common
feature of dreams that past and present are not clearly distinguished. The mechanisms of the dreamwork and of symptom formation, which create the *multiple determination* of single elements [condensation] of thought or behavior, provide the means of expression of primary process. The language of acutely psychotic patients typically reflects a shift to the predominance of primary process over secondary process thought, although elements of the latter are usually still evident as well.

Secondary process—as we may see it in conscious, rational thought; focused attention; and the exercise of judgment—operates under the reality principle. Secondary process is often infused with elements of primary process. Slips of the tongue are the simplest example [Freud 1901]. Whether one subscribes to Freud’s theory of energy and discharge or relegates it to a position of little significance, which is the view taken by the majority of analysts today, the distinction between primary process thinking under the pleasure principle and secondary process thinking under the reality principle remains extremely useful. The irrationality of dreams in the daily *regression* of sleep demonstrates that the transition between the two remains fluid throughout life. In this context, it is useful to understand that the method of free association in clinical psychoanalysis depends on a relative shift from controlled, edited thought to somewhat less controlled expression of associations from which unconscious influences may be more easily inferred.

### Unconscious Motivation and Instinctual Drives

Unconscious motivation, another of the essential assumptions of psychoanalysis, originally formulated by Breuer and Freud with the hypothesis of the need to discharge affect, begins with the effects of desire, the effects of body on mind. The concept of instinctual drives (*Trieb*) bridges the frontier between somatic stimuli and mental representation. A drive can be characterized as having a somatic source, anogenous zone, a pressure for discharge; an *aim*, an action, whether active or passive, by which satisfaction is obtained; and an *object*, whether self or other, with whom or by whom the drive achieves its aim. Yet drives cannot be observed directly. They are inferred from the mental elements and functions that they infuse. These elements, which are understood to derive their psychic force from the drives, are referred to as *drive derivatives*. In the formation of dreams, wishes—*derivatives* of instinctual drives—become the carriers of motivation.

Freud focused initially on the sexual drives (including those connected with all the enogenous zones) that formed the source of unconscious conflict, the unacceptable desires that were repudiated in neurosis. Taking the prevailing concepts of biology as his starting point, he viewed the sexual instincts (instinctual drives) in opposition to the self-preservative instincts or ego-instructs. Eventually, sexuality was reformulated under the heading of the *libido* theory. Libido was, for Freud, the energy of the sexual instincts (instinctual drives). Later, in a necessary expansion of his clinical and theoretical outlook, he separated out *aggression* (which had been included in such concepts as sadomasochistic sexuality) as a separate drive. For Freud these became, in his later considerations, representatives of life and death drives.

Although, as I have already noted, Freud’s energy concepts do not seem as compelling to psychoanalysts today as they did to him, the concept of unconscious motivation remains a sine qua non of all psychoanalytic schools of thought. *Unconscious drives*, like a restless sea in constant motion, continually encounter forces that attempt to tame them and to produce disguised compromise formations.

The investigation of neurotic conflicts led Freud very early to their sources in the child’s development. Later, after he had formulated the concept of sexual drives, it was natural to recognize the phases of development of the sexual drives: oral, anal, phallic, and, in puberty, genital. (The one-sided view of development of both genders as modeled on the development of boys took more than half a century to correct.) Eventually, sexuality was reformulated under the heading of the libido theory, and its phases of development (Abraham 1924) were gradually spelled out. Attempts to correlate developmental phases and character traits were variably successful. The most compelling of these was the description of anality and its connection to obsessive character. The theory that developmental arrest (fixation) at one or another phase of libidinal development correlated with particular disturbances, such as obsessive neurosis, presented a useful but ultimately oversimplified formulation that required revision. These phases, more fully spelled out elsewhere in this volume, lie beyond the domain of the present chapter.

A crucial challenge to Freud’s and Abraham’s account of the libido theory was introduced in a powerful variation by Fairbairn (1941) on the basis of his study of schizoid patients. His view that libido is object-seeking
rather than seeking the pleasure of drive discharge and that the central feature of drives is the object relationship they pursue at successive phases of development has played a large role in the development of the relational approach in psychoanalysis. Further extended by the work of Bowlby [1958] on attachment, this formulation has significantly influenced the psychoanalytic view of development.

Accordingly, current psychoanalytic understanding of motivation, discussed elsewhere in this volume, includes many elements. The formulation of the mind in terms of ego, superego, and id, to which I now turn, expanded and differentiated a multitude of motivations no longer exclusively attributed to instinctual drives.

Ego and Superego

From the beginning of Freud’s work, the concept of ego, adopted from contemporary usage and ambiguously formulated to correspond to the clinical ambiguities that he encountered, stood as the representative of the person’s conscious intentions. Freud’s early emphasis had delineated two systems of mental life, unconscious and conscious, with the latter having a preconscious portion of ideas that could more readily access consciousness—the so-called topographic model of the mind. So it was easy to comprehend the ego as exerting censorship on unconscious ideas seeking admission to consciousness. It was more difficult to recognize that this censorship itself operates unconsciously and represents one side of unconscious conflict, both in neuroses and in dreams; drive derivatives represent the other.

In the course of subsequent work, it became necessary to examine the development not only of the instinctual drives but also of the ego. Eventually, the uneasy theoretical relationship between the conscious-preconscious system of thought and the ego led to Freud’s new theoretical systematization of 1923, the so-called structural model, of ego, superego, and id. Conflict was now formulated in terms of structures (organizations of functions), also known as agencies, that were relatively enduring features of mental life. Aggression and libido together were seen to be involved in all mental functions, and the study of trauma, abandoned for nearly 30 years, was resumed. The formation of psychic structure and structures became a focus of interest. Whereas earlier the theoretical perspectives or points of view of psychoanalysis, known as metapsychology, had comprised the dynamic (unconscious forces in conflict), the topographic (conscious-preconscious vs. unconscious), and the economic (considerations of the distribution of energy), the structural perspective was now understood by some as an addition and by others as an entire restatement incorporating the other points of view. This revision fostered an enormous creativity in new psychoanalytic observations and significant changes in the technique of psychoanalysis and the subsequently emerging field of psychoanalytic psychotherapy. A much more complex study of character and of adaptation and therapeutics became possible with these new theoretical tools.

The structural theory had its origins in observations of the more than two decades preceding its presentation. The problematic study of narcissism, in which the ego or the self is taken as the object of the libido, had focused attention on the earliest relationship of the infant to its caretakers and on the development of the ego through processes of internalization. The psychological problem of mourning and its relationship to depressive states had illuminated the role of internalization as a response to loss. These two strands, particularly, contributed to the complex concept of superego, with its self-critical [self-reproachful] functions and its standard-setting function of ego ideal, which now became a fruitful object of investigation, especially from the perspective of its development in childhood. Again, these concepts permitted wholly new investigations of character, quite different from the earlier ones, which had been based almost exclusively on the vicissitudes of the instinctual drives.

Internalization and Mourning

A variety of processes are assumed to participate in the development of psychic structure. A number of overlapping terms—incorporation, introjection, identification, and imitation—refer to the process by which the growing individual internalizes qualities of the persons (objects) important to him or her [Schaefer 1968]. These terms illustrate some of the principal difficulties that confront psychoanalytic formulation: the multiple influences, especially developmental ones, on psychological processes; the interrelationship among formulations; the historical evolution of psychoanalytic propositions; and individual variations in the understanding and use of the
terms. So, in one view, incorporation refers to internalization at an early phase of development, before the differentiation of self and object, with an emphasis on oral ingestion and destructiveness. Projection and identification are seen as referring to more mature and differentiated forms of internalization that depend on greater differentiation of self and other, on the capacity for symbolization, and on language. Imitation, a copying of behavior, which may refer to any of these unconscious processes, may be, unlike the others, a conscious intention and action [although it may occur unconsciously as well]. All of these terms and concepts are employed to grasp the psychological means by which growing individuals actively include the characteristics and qualities of those closest to them. The interplay of these psychological processes with biological ones, as illustrated most clearly in the similarities of identical twins raised apart, has not yet received an adequate account.

Originally, Freud attended exclusively to the way in which unconscious processes, especially the resolution of unconscious conflict, led to the formation of psychic structure and functional capacities. In 1926, however, he pointed to the developmental series of phase-specific anxieties, from loss of the nurturing object through fear of the superego [Freud 1926], that does not derive from conflict resolution. Gradually the idea that some psychological functions, such as speech, had a primary autonomy and that others developed a secondary autonomy from conflict gained importance [Hartmann 1939]. Today, in light of a host of developmental studies, conflict resolution appears as only one, although a very important one, of the influences on psychic structural development.

Freud (1923) thought that “the character of the ego is a precipitate of abandoned object-cathexes [investments in or attachments to objects] and that it contains the history of those object-choices” (p. 29). In the course of development there is a constant need to relinquish old investments (cathexes) in order to permit an individual to live in the present. This requires mourning. Whereas in his earliest work Freud focused on remembering as a crucial, topographic aspect of memory (i.e., making conscious what was unconscious), his later illumination of mourning [Freud 1917] was an essential precursor to the formulation of the structural hypotheses. The process of mourning regularly takes place in an alternation of progress and regression, with the unconscious formation of identifications that appear as elements of character. Where the demands of this process, which always requires assistance in childhood, exceed the individual’s tolerance or capacity for change, symptoms or disorders of character development occur.

In her powerful understanding of earliest development, Melanie Klein introduced a number of significant innovations that have had an enormous influence on psychoanalytic thinking, particularly in bringing the pre-oedipal era of development into the center of psychoanalytic thinking. In the present context her concept of projective identification merits particular attention [Klein 1946]. Pointing out that both “good” and “bad” parts of the self must be projected into the mother—into the mother’s breast as a part-object—and then recovered, she laid the groundwork for new studies of the development of the self and the development of object relations. She emphasized the role of death drive and its derivative, hate, and the problem it posed for the infant’s mind. Here are some citations from her 1946 paper, which summarizes nearly a quarter of a century of psychoanalytic work:

I have often expressed my view that object relations exist from the beginning of life, the first object being the mother’s breast which is split into a good (gratifying) and bad (frustrating) breast; this splitting results in a division between love and hate. I have further suggested that the relation to the first object implies its introjection and projection, and thus from the beginning object relations are moulded by an interaction between introjection and projection, between internal and external objects and situations. These processes participate in the building up of the ego and super-ego and prepare the ground for the onset of the Oedipus complex in the second half of the first year.

From the beginning the destructive impulse is turned against the object and is first expressed in phantasied oral-sadistic attacks on the mother’s breast which soon develop into onslaughts on her body by all sadistic means....I enumerated various typical defences of the early ego, primarily the mechanisms of splitting the object and the impulses, idealization [of the good breast], denial of inner and outer reality and stifling of emotions. I also mentioned various persecutory fears, including the fear of being poisoned and devoured. (p. 99)

I believe that the ego is incapable of splitting the object—internal and external—without correspondingly a splitting within the ego taking place. Therefore the phantasies and feelings about the state of the internal object influence vitally the structure of the ego. The more sadism prevails in the process of incorporating the object, and the more the object is felt to be in bits, the more the ego is in danger of being split in relation to the internalized object bits.

The processes I have described are, of course, bound up with the infant’s phantasy life, and the anxieties which stimulate the mechanism of splitting are also of a phantasied nature. It is in phantasy that the infant splits the object and the self, but the effect of this phantasy is a very real one, because it leads to feel-
ings and relations [and later on thought processes] being in fact cut off from one another ...

Introjection and projection are from the beginning of life also used in the service of this primary aim of the ego. Projection, as we know from Freud, originates from the deflection of the Death Instinct outwards and in my view helps the ego in overcoming anxiety by ridding it of danger and badness. Introjection of the good object is also used by the ego as a defence against anxiety. (p. 101)

Once again, it is important to see that psychoanalytic concepts are inevitably interrelated. It is the attempt to account for complex phenomena, which may be viewed from various angles, that leads to the complexity and often to the ambiguity in psychoanalytic formulations of unconscious processes. Klein's methodological emphasis on the role of phantasy [distinguished from Freud's use of fantasy, as in the developmentally later daydreaming] is intimately connected with the early era of psychological development to which her hypotheses refer.

Further Developmental Considerations

The adult mind is the result of development from birth onward. Although Freud initially underestimated the capacities of newborn infants, he recognized their helplessness, their dependence on others, and their need to develop. As mentioned earlier, he saw that development as the consequence of conflict resolution. This developmental component of psychoanalytic theory was later elaborated by Edward Bibring (1941): "After ego-resistances, etc., have been removed, the id’s natural tendencies of development spontaneously act in the direction of cure." That is to say, at any age, psychoanalytic treatment can be seen to facilitate interrupted development.

A genetic point of view was added to the other meta-psychological perspectives in order to account for the epigenetic sequence in which successive developmental phases build upon one another. Mental functions become altered in the course of development. For example, the early development of memory is a source of great pleasure and excitement for the growing infant, but it becomes a source of terror as it leads to the recognition of mother’s absence. Similarly, the pleasurable impulsivity of earliest childhood becomes a source of danger when the child has developed the unfettered mobility of a toddler. The satisfactions of daydreaming may become the later basis of creative, innovative thought, but the two are not identical. Similarly, the use of intellectualization in adolescence may give way to the intellectual capacities of adulthood.

From yet another perspective, a developmental point of view considers the question of how the developmental stage of an individual affects the individual’s perceptions. Throughout life, but perhaps most noticeably in childhood, thinking and perception change with the development of changing biological capacities as well as with accumulated experience. Psychoanalytic understanding of unconscious mental processes always takes these matters into account. In particular, when the attempt is made clinically to infer early developmental influences, they are formulated in accord and with the mental functioning of the child. An additional problematic discovery of psychoanalytic investigation has been the recognition that experiences at one phase of development may be reinterpreted or understood differently at a later time. This can give rise to the deferred action (Nachträglichkeit) of a repressed memory. Traumatic events of childhood can assume significance in adolescence or adulthood through deferred action.

Repetition Compulsion

Repetition has been an important subject in the field of psychoanalytic observation and theory from the start. The study of obsessional neurosis, as already noted, offered important insights. The functions of repetitive rituals demonstrated unconscious mechanisms, such as displacement and isolation, with the creation of “false connections.” Other areas include the fate-neuroses, lifelong recurrent repetitions of unfortunate experiences, transference in the psychoanalytic situation, in which memory appears in action; posttraumatic dreams, which Freud [1914b] attributed to the compulsion to repeat; and children’s play, in which great pleasure is obtained from repetition. Examination of these disparate forms of repetition led Freud [1920] to question the primacy of the pleasure principle.

Two components seem always to emerge in the understanding of repetition. One is the relentless tendency of the drives to seek expression. In his later understanding of the therapeutic process in terms of the structural
hypotheses, Freud [1926] attributed a variety of resistances to ego and superego, but he regarded the compulsion to repeat as a property of instinctual drives, hence a resistance of the id. The second component in repetition is an attempt to gain mastery [elaborated in Hendrick 1942], as in children’s play, especially through turning a passive experience into an active one. The clarification of these two components reflects the advantages introduced by Freud’s structural hypotheses, which allow for phenomena to be approached from the side of the ego as well as from the side of the drives. The reformulation of the repetition compulsion proved important in reopening the study of dissociation and trauma.

Dissociation

Just as the development of the structural theory facilitated the study of trauma, it became necessary to revive interest in dissociation, largely abandoned by Freud in his study of conflict. The “hypnoid” hypothesis was reviewed and recast by Loewald (1955) in terms of the conditions of childhood experience. He concluded: “A traumatic event is one which cannot as yet be associatively absorbed, due to the immature state of the psychological functions, i.e., it cannot be integrated by the immature ego. Working through in analysis consists in the process of ‘abreaction,’ especially on the symbolic level of language, and in the ‘associative adjustment’ founded on it” [p. 210].

The study of dissociation has gained further useful elaboration in recent decades [e.g., Berman 1981; Bromberg 1996]. In the hands of these authors, it has been connected with the interpersonal aspects of psychoanalysis and the role of transference and countertransference (the psychoanalyst’s unconscious reactions to the patient). These have been increasingly at the center of psychoanalytic awareness since the end of the 1940s.

The concept of dissociation, in the modern sense, draws attention to the usefulness of observing shifting states of consciousness that represent failures of integration from early origins in development. These failures are often, if not always, the result of trauma.

Psychic Reality and Unconscious Fantasy

The unconscious is the true psychical reality, in its innermost nature it is as much unknown to us as the reality of the external world, and it is as incompletely presented by the data of consciousness as is the external world by the communications of our sense organs.

Freud 1900, p. 613

For the practicing psychotherapist and psychoanalyst, Freud’s view of the internal world in the epigraph above is bedrock. It draws attention to inferred unconscious fantasies, complex constructions that animate the patient’s mental life and that form an important object of clinical investigation. It emphasizes that what is unconscious is nonetheless real, and it promotes humility in pursuing the therapeutic enterprise.

Unconscious fantasies (and phantasies) vary in scope. For example, children’s fantasies about adult sexuality, which operate unconsciously, can have an enduring and clinically significant effect. Yet unconscious fantasies, such as childhood daydreams, may reflect evanescent reactions. The expression of unconscious fantasies in the transference, however, forms the most important basis of understanding in psychoanalytic work. The new understanding of transference-countertransference interaction has gradually led to the recognition that the process of psychoanalysis is always a combination of associative insight and action [on the part of both members of the analytic pair]. This is the heart of psychoanalytic work.
KEY POINTS

• The psychoanalytic concept of unconscious mental processes has proven to be a highly fruitful inference (hypothesis).

• The elucidation, description, and clinical correlations of unconscious processes were originally the work of Sigmund Freud. His development and use of free association permitted him to make entirely new observations and inferences, especially on the nature of unconscious conflict. This work relies on a hypothesis of psychic determinism.

• Unconscious processes first observed in clinical disorders proved to be similar to those shown in dreams, where the dream work creates compromise formations between instinctual drives and the censorship exerted by the ego and superego.

• Freud inferred systems of mental life (primary process and secondary process) and regulatory principles (pleasure principle, reality principle, and repetition compulsion) to account for some of the working of the mind.

• Developmental concepts are deeply embedded in psychoanalytic concepts, attempting to account for origins of mental processes from infancy to maturity.

• Internalization, with the development of internalized objects, leads to essential internal structures, enduring characteristics of the individual.

• Unconscious fantasies are usefully inferred determinants of behavior and experience. They play a leading role in clinical psychoanalytic work. Psychic reality, the patient’s unconscious reality, is a crucial subject of interest.

References


Hendrick F: Instinct and the ego during infancy. Psychoanal Q 11:33–58, 1942


Transference

Steven H. Goldberg, M.D.

The phenomena of transference arise from aspects of ourselves that are most quintessentially human—our capacities for love and hate and our sense of ourselves as shaped by our unique individual histories. According to Freud [1925], transference “dominates the whole of each person’s relations to his human environment” [p. 42], and as Marcel Proust [1913–1927a] expressed it with characteristic psychological astuteness, man is “one of those amphibious creatures who are plunged simultaneously in the past and in the reality of the moment” [p. 544]. In context it is clear that both Proust and Freud mean that man is living simultaneously in the realms of present and past, of conscious and unconscious experience.

Most contemporary analysts would agree that transference (and countertransference, which most analysts define as the analyst’s transferences to the patient) provides the most important window into the patient’s unconscious mental life as well as the most powerful therapeutic instrumentality available in clinical work. Less universal agreement is found if one asks such questions as, What is transference? What do we mean by the analysis of transference? Can it be only or best analyzed in relation to the analyst, or can it also be analyzed as transference to people in the patient’s life other than the analyst? And how is its analysis helpful to patients?

This chapter is neither a comprehensive historical summary nor a review of all significant geographical and theoretical points of view regarding transference. Many authors and significant points of view are excluded or mentioned only in brief. Several authors whose work provides nodal points in the interweaving strands of psychoanalytic thinking about transference are discussed at relative length. Throughout, I attempt to return to several organizing questions: What is transference? How is it experienced by both patient and analyst? And how is interpretive work with transference related to the therapeutic action of psychoanalysis?

I would like to thank Dr. Jim Dimon and Dr. Samuel Chase for helpful suggestions during the writing of this chapter.
What Is Transference?

Especially when it comes to the finer points, it seems a fact of psychoanalytic life that there are probably as many definitions of transference as there are practicing analysts. In part this is because transference is such a personal matter, infused by the analyst’s own experiences in analysis, in formative clinical work with patients, and in personally inflected reactions to psychoanalytic literature and clinical discussions. Just as all of these are career long and evolving, so too is each analyst’s view of transference and its significance.

With that caveat in mind, I offer my own definition: Transference is a universal mode of human relating in which past experiences with important people and their intrapsychic elaboration, along with archaic modes of thinking and feeling, are preserved, transformed, and brought to interactive life in present-day relationships. Transference is a boundary concept that links dimensions of past/present, unconscious/conscious, interpersonal/interpersonal, and discovered/created. Through transference, the past has a role in generating present experience, and the present transforms our experience of the past. More unconscious than conscious, transference adds dimensions of depth and intensity to human relationships, while it potentially also constrains and burdens them. Transference is present, dynamic, and shifting, although within the narrow or broader confines characteristic of each person, and it becomes a particular focus of attention and study in the psychoanalytic relationship, where it becomes a gateway to mutually arrived at understandings of unconscious mental life.

Freud

The phenomenon of transference is one in which the aura of its discovery infuses the very experience of what transference is and feels like for the practicing psychoanalyst. In his earliest discussions of transference, Freud attempted to convey not only what transference is but also something of the experience of surprise, of the mystery and awesome power of its discovery and rediscovery in every clinical hour, as a flash of insight that may alter the landscape of understanding of the patient’s inner world. Freud seemed almost immediately to grasp the centrality of transference in the therapeutic project and to sense both its enormous power and its enormous dangers. Not only did he understand that powerful feelings, fantasies, and wishes directed toward the analyst have another source in the patient’s unconscious, but he also suggested that rather than ignoring them or using them primarily in a suggestive way, the analyst could understand and analyze these transference manifestations, giving both analyst and patient unparalleled access into the patient’s unconscious mental life and the internal relationships that populate it.

For Freud, what is “transferred” involves imagos of important people from the past, along with sexual and hostile wishes toward those key figures. Writing in 1905, Freud described transferences as new editions or facsimiles of the impulses and phantasies which are aroused and made conscious during the progress of the analysis; but they have this peculiarity, which is characteristic for their species, that they replace some earlier person by the person of the physician. To put it another way: a whole series of psychological experiences are revived, not as belonging to the past, but as applying to the person of the physician at the present moment. [Freud 1905, p. 116]

The relationship between analyst and patient itself becomes the main focus of treatment—the place where the patient’s symptoms come to life, and the arena in which they are progressively understood and transformed.

Freud viewed the analysis of the transference as “by far the hardest part of the whole task,” more difficult than the interpretation of dreams and other verbal (and perhaps some nonverbal) narratives: “All the patient’s tendencies, including hostile ones, are aroused; they are then turned to account for the purposes of the analysis by being made conscious…. Transference, which seems ordained to be the greatest obstacle to psycho-analysis, becomes its most powerful ally, if its presence can be detected each time and explained to the patient” [Freud 1905, p. 117]. He later wrote:

It cannot be disputed that controlling the phenomena of transference presents the psycho-analyst with the greatest difficulties. But it should not be forgotten that it is precisely they that do us the inestimable service of making the patient’s hidden and forgotten erotic impulses immediate and manifest. For when all is said and done, it is impossible to destroy anyone in absentia or in effigie. [Freud 1912, p. 108]

Here some explanation may be in order. All of the relevant unconscious material comes alive in the rela-
tionship with the analyst and can potentially be made conscious through the interpretive act of the analyst. However, in this effort, the analyst is typically met with the patient’s resistance, because the patient insists that the experience belongs solely to the reality of the present interaction with the analyst and not to events from the distant past. Action has replaced, and blocked access to, remembering. If, however, the analyst recognizes the transferential nature of the patient’s experience, he or she can potentially interpret to the patient something of the underlying, unconscious dimension of the patient’s experience that has important connections in the past. When repetition in transference is successfully interpreted to the patient as a form of remembering, deriving from the unconscious past, a unique therapeutic effect may result. As gaps in memory are filled in, and memory replaces action and becomes more amenable to conscious ego controls, the patient is restored to improved health.

The immediate sensual experience of the analyst’s presence, in contrast to the quality of absenta or effigy that characterizes the experience of people not actually present, confers a unique power and sense of conviction to feelings and memories evoked directly in transference. The one is alive in the present moment, whereas the other frequently takes on a quality of distance and dryness. The emotional presence of the analyst takes on the function of Proust’s tea-infused madeleine, the smell and taste of which pry open an entire lost world of childhood memories and experience. For Freud, the filling-in of gaps in memory, and the improved balance of intrapsychic forces resulting from the greater scope of conscious self-awareness, were at the heart of the therapeutic project.

The patient’s positive transference renders the patient particularly amenable to suggestion and was seen by Freud as essential to the workings of hypnosis and other suggestion-based therapies. According to Freud, the analyst does make some limited use of suggestion—for example, in asking the patient to report whatever thoughts, feelings, and experiences come to mind (free association), and more generally in the suggestion implicit in the frame and setting of the psychoanalytic session (e.g., couch, quiet, consistency, availability), which pull for the patient’s investment and attachment, eventually both loving and hating, to the person of the analyst. Clearly this power implicit in transference experience may also be misused by the analyst and in extreme form may lead to boundary violations and other forms of exploitation of the patient.

Freud not only recognized the negative, hostile transference and the erotic, positive transference, but also described an “unobjectionable positive transference” that consists of the positive and friendly professional relations between analyst and patient that provide some sort of more rational basis for the success of the treatment. Although this notion was later taken up under the rubric of “working alliance” (Greenson 1965, 1967), contemporary authors have generally been reluctant to view any aspect of the relationship as immune from investigation.

Countertransference was not a main focus of Freud’s attention, except in terms of its dangers. Viewed as the analyst’s primarily unconscious responses to the patient’s transference, they were to be held firmly in check. One outcome of the analyst’s personal analysis was intended to protect the analyst from developing overly strong transferences to his or her patients. Failing that, the analyst’s clinical experience and personal analysis were to allow him or her at least to understand and control countertransferences through self-analysis. Outside of these considerations, transference was the property of the patient, and discussion of the psychology of the analyst as it played out in clinical work was left underconceptualized and undeveloped.

Ego Psychology and Beyond

“Hardest Part of Analysis”

In the course of both broadening and deepening the Freudian and immediately post-Freudian account of transference, most ego-psychological contributions take very seriously Freud’s idea that all of the patient’s pathogenic unconscious mental contents and processes enter into and take on new meanings in the transference relationship to the analyst, where they are best accessed and analyzed. Although many authors hold an important place for extratransference interpretation, it is work in the relationship between patient and analyst that is maintained as both definitive of psychoanalysis and primarily responsible for its therapeutic efficacy. All agencies of the mind, and all previous phases of development, including pre-oedipal and preverbal experiences, are increasingly seen as contributing to transference experience. More primitive transferences that arise in more disturbed and psychotic patients, deriving from earlier developmental phases of organizing emotional experience as well as more disturbed sectors in
all patients, are increasingly explored and worked with clinically. Within this tradition of thinking about transference, there is an increasing recognition of the person and contribution of the analyst and his or her transferences and of the unique crystallization of transference within a relationship with one particular analyst and his or her unique personality and psychology. In addition, in more recent discussions there is increasing emphasis on the creative and jointly created aspects of transference and countertransference in the clinical encounter.

Anna Freud (1937) emphasized the transference of defense, as for example when the analyst comes to embody the patient’s superego prohibitions, and also showed how transference is often manifested in an action mode, both within the analysis (“acting in”) and in the patient’s daily life (“acting out”). Her work with children explored the early origins of transference and provided a developmental perspective. Ernst Kris offered penetrating discussions of the nature and complexity of childhood recollection and its analytic reconstruction. James Strachey (1934) attempted to show how “mutative” interpretation was synonymous with transference interpretation, arguing that transference interpretation leads not only to the recovery of the unconscious and forgotten past but also to structural change in the form of introjection of a more tolerant superego. Strachey placed emphasis on the difficulty for the analyst of working directly in the transference, where the analyst is the target of the patient’s most intense loving and hating feelings and where his or her own unconscious and conflicted emotional reactions are likely to be stirred up.

This latter theme was powerfully picked up and evoked in Brian Bird’s (1972) classic paper, aptly titled “Notes on Transference: Universal Phenomenon and Hardest Part of Analysis.” Bird distinguished between transference manifestations, which may be fleeting and easier to deal with, and “transference neurosis,” which for Bird, as for Freud, means the activation of all of the patient’s pathogenic mental conflicts around the person of the analyst at their center. Hostile and destructive transferences are particularly avoided by analysts in Bird’s discussion, and yet they may offer a key to effective therapeutic action. Bird described compellingly how often it is just when both patient and analyst are ready to “throw in the towel” that transference is most present and at least potentially amenable to psychoanalytic work. The active emotional and conflictual engagement of the analyst is palpable in Bird’s account. Destructiveness in the patient, and at times in the analyst, must be dealt with head-on if there is any likelihood of resolving these deepest layers of transference experience.

**Influence of Hans Loewald**

With Hans Loewald, we come to what I have chosen as a second nodal point, an original formulation that transcends the bounds of previous conceptualizations and that in turn sends out many lines of continuing influence and generativity. In a series of papers, Loewald (1960, 1971, 1975, 1979, 1986) elaborated on the embeddedness of transference in a unique interpersonal relationship with the analyst. Loewald’s account of transference, like transference itself, is an artful combination of what comes to us from the past and what is uniquely created in the present. In Loewald’s work, the notion of transference as a boundary concept (past/present, unconscious/conscious, intrapersonal/interpersonal, discovered/created) comes to its fullest fruition.

Patient and analyst are involved in a real and alive relationship that combines features of the old, in the form of transference repetitions, and of the new, or what Loewald calls “novel interaction possibilities,” made possible by the analyst’s relative objectivity, familiarity with unconscious dynamics, and therapeutic attitude. The structure of the analytic situation (e.g., frame, consistency, use of the couch, relative anonymity of the analyst), in combination with the analyst’s empathic immersion in the inner life of the patient and interpretations of defenses against the unfolding of transference, allows for deepening and elaboration of the patient’s inner life as it has developed in the past and as it now becomes alive in the present of the analytic situation.

The analyst’s gradual interpretation of these experiences, particularly the ways in which the old comes alive in the new interpersonal experience with the analyst, leads not only to conscious insight about the past and about the unconscious present but also to a higher level of organization and integration of these psychological experiences. The analyst’s verbal interpretations allow for a “lifting” of the unconscious contents into higher levels of organization of thinking and feeling. Here Loewald took an important step in emphasizing not only mental contents (i.e., the past) but also mental processes—that is, levels of integration, of how thought and feeling, both past and present, are organized. In this sense, Loewald points forward to many contemporary developments in psychoanalytic thinking. A developmental perspective is also salient in this
Transference. These processes are the mainspring of the therapeutic action of psychoanalysis. As they unfold, past and unconscious mental experiences become more useful and accessible, and present experience is enriched by greater access to the intensities of the unconscious and of primitive levels of mental life. In Loewald’s (1960) famous and felicitous phrase, ghosts are transformed into ancestors.

The analyst, in this process, is empathically involved and responsive, understanding the patient’s unconscious transference reactions in large part through attention to his or her own visceral and affective reactions (i.e., countertransferences). Although the analyst feels intensely the pull of the patient’s past object relationships, he is involved in “a constant process of uninvolving” (Loewald 1971, p. 63) that enables both patient and analyst to understand each other in their involvement rather than simply living it out. Resolution of transference is redefined, the emphasis is no longer exclusively on remembering the past but now on attaining a higher, more mature level of organization. Transferences do not then disappear; rather, they become “available for development and change...in actual living” (Loewald 1975).

For Loewald (1986), transference and countertransference are “two faces of the same dynamic, rooted in the inextricable intertwinnings with others in which individual life originates and remains throughout the life of the individual in numberless elaborations, derivatives, and transformations” (p. 276). If an important indication of the patient’s accessibility to analysis resides in his or her capacity for deep and intense transference experiences, the capacity to analyze similarly depends on the analyst’s access to comparably deep countertransference experiences. The analyst inevitably does a piece of self-analytic work on his or her own transferences during the course of a far-reaching analysis, and it is this access to the depths of his or her own unconscious and inner world that allows the analyst to be convincing to the patient. Particularly in work with a more primitively organized patient, the analyst struggles both to maintain his or her own sanity and to remain open to the patient’s experience. In the analyst’s ongoing self-analytic efforts, work with the patient often takes him or her precisely where he or she has not wished to go.

Loewald (1975) likened the development of transference-countertransference experience in analysis to the joint composition of a play, referring both to a play as a piece of dramatic art and to play in the sense of children’s play. In both senses, the participants move back and forth between fantasy creation and actuality. The same is true of transference and countertransference experience, although for periods of time the fantasy character may be lost to the patient and, to some extent, the analyst. Here Loewald placed transference-countertransference in the area of Winnicott’s (1971) transitional phenomena, in an intermediate space between fantasy and reality and partaking of aspects of both.

Loewald, in his conceptualizations of transference, also shares with Winnicott (1971) an interest in the earliest moments of differentiation of mother and infant from an undifferentiated state of mother-infant as a single unit. For Winnicott, there is no such thing as an infant (without a mother); for Loewald, there is originally no distinction between subject and object, each gradually emerging out of a merged subject-object entity. For Loewald, as for Winnicott, merger experience is never entirely lost but constitutes on ongoing intersubjective underpinning of all human relationships. The intricate and subtle interplay between merger and differentiation, and the ways in which these early experiences are recreated in transference-countertransference experience, are an interest that runs through the entirety of Loewald’s work.

Among the many lines of influence and parallel development of thought, there are considerable areas of overlap between Loewald’s interest in transferences that derive from early phases of self-object differentiation and the work not only of Winnicott but also of such contemporaries of Loewald as Kohut (1971, 1977, 1984) and Searles (1975). Each of these authors shares Loewald’s abiding interest in the analyst’s empathic immersion in the patient’s inner life, the origins of experiences of psychological separateness, and the patient’s new experience of objects. In his emphasis on the old and the new, the discovered and the created, and the authentic and the playful, Loewald stands at a crossroads of many contemporary discussions within North American approaches to transference and countertransference [e.g., Chodorow 2003, 2004; Fogel 1989, Mitchell 1998]. Loewald’s contribution continues to exert considerable influence on contemporary ego-psychological, self-psychological, and American relational thinking in psychoanalysis.

The Kleinian Tradition

Klein and Bion

Melanie Klein (1945, 1946, 1952) endeavored to push psychoanalytic understanding of childhood fantasies,
anxieties, and defenses back to the earliest origins of infantile life in its first few months and years. Her work with children and adults pioneered analysts' awareness of the appearance of these early psychological experiences in the transference to the analyst. As part of these researches into earliest emotional life, she described the operation of a form of transference not previously described, which she termed projective identification. In the Kleinian formulation of projective identification, there is, in fantasy, a splitting off of certain mental contents that are then, again in the patient's fantasy, projected into the analyst, in which they are experienced as alien and yet in some way still under the patient’s omnipotent control. Often it is unconscious destructive impulses that are involved in projective identifications, although other emotional contents or parts of the self may be similarly projected. An essential aspect of transference experience consists in cycles of projection followed by introjection of aspects of the object, now distorted by the patient’s projections.

Wilfred Bion elaborated and reconceptualized projective identification as a form of transference, and it is Bion’s more explicitly interpersonal model that continues to be highly influential in contemporary psychoanalytic thinking and clinical work, Kleinian and otherwise. For Bion, projective identification was not just defensive but rather served a vital communicative function, because the analyst now actually experienced some version of what the patient has projected. It became the main way that primitive and nonverbal contents could be communicated to the analyst, who would experience them in projected form as partially alien emotional events. The model was similar to a process that took place between mother and child in infancy. In an important sense, this represented a more interpersonal version of Freud’s original insight that our own unconscious can have direct access to the unconscious of another person, without conscious mediation. It also helped fill a gap left by Freud’s misunderstanding in his belief that more primitive patients do not have analyzable transference experiences.

Both Klein and Bion were motivated by their attempts to analyze more primi-tively organized and seemingly inaccessible patients as well as, in Klein’s case, young children. These were patients manifesting incomplete self-object differentiation who had a conscious inability either to symbolize their experience in words or to tolerate feelings of frustration or loss. In developing the notion of projective identification, Klein and Bion were working creatively to further their understanding and their ability to make use of these patients' transfers-ences clinically.

Bion’s reconceptualization now took an important further step. Not only was projective identification a form of transference and a central means of communica-tion of primitive, unconscious mental life, but it became the means by which these projected contents, often unbearable for the patient, were metabolized by the analyst into a more tolerable and usable form. These could then be re-introduced by the patient. In particular, it would be the analyst’s capacity for thinking that would be gradually introjected—thinking for Bion referring to both “thinking” and “feeling.” Generally it would be through some form of interpretation, although not necessarily transference interpretation, that the analyst’s work of metabolization would be conveyed and internalized by the patient. However, in Bion’s work there is an important shift in emphasis from the therapeutic effect of recovering lost unconscious psychological contents to the therapeutic effect of altering the qualities of mind and of “thinking” in the patient whose capacities to think about and thereby tolerate his or her own experience has been compromised. Because of interpersonal pressure on the analyst to unreflectively take on what was projected, the analyst would have to do internal psychological work in order to contain and to metabolize what was projected.

Betty Joseph

The work of Betty Joseph [1975, 1985, 1989] represents the third nodal point of this discussion. Her thinking draws heavily on that of Klein and Bion, but her clinical insights and technical recommendations convey an original and now highly influential point of view that focuses the analyst’s attention on the moment-to-moment interaction between patient and analyst and on what the patient is actually doing with and to the analyst, including the way the patient makes use of interpretation. Joseph’s work relies heavily on Bion’s formulation of projective identification as an almost ubiquitous form of transference experience, involving the more primitive aspects of patients’ minds, as well as on Klein’s notion of transference of “total situations” (see Klein 1952).

As Joseph elaborated the concept, transference as total situation refers to the observation that what emerges in the transference is what is alive and accessible in the moment and embodies the totality of the patient’s internal object world, which is always present, active, and in flux in the clinical situation. “By definition, it must include everything that the patient brings into the relationship” (Joseph 1985). For Joseph, the total...
situation encompasses Freud’s unobjectionable positive transference and subsequent attempts to conceptualize a "real" relationship between patient and analyst (Greenson 1965, 1967)—it is all transference and fair game for interpretation.

Joseph focused especially on preverbal and primitive transferences, which she thought to be the ones that mainly cause emotional suffering and dominate the clinical picture with most patients until well into the analytic work. These transferences, which are synonymous with projective identifications in Bion’s sense, are not found directly in the patient’s verbal material—they are not symbolized in that sense. Rather, they are communicated in action—that is, in what the patient is trying to “do” to the analyst, as reflected in the subtle and shifting feelings and fantasies that are evoked in the analyst’s mind. In this conceptualization, the patient is constantly attempting to foist a particular response onto the analyst, who registers these pressures, these transference experiences, through monitoring of subtle shifts in his or her own inner emotional state. An example would be a patient who wishes to enter into and to control the mind of the analyst. The analyst may begin to feel that he is unable to think, that he is not quite his usual self. What the patient is “doing” through these projective identifications becomes a more reliable window into the patient’s unconscious mental life than what the patient is actually saying in words.

In Joseph’s writing, there is a de-emphasis on explicit attention to the patient’s past. This is not to say that the analyst is not aware of certain aspects of the patient’s history, which to some extent informs the analyst’s registration of projective identifications. Rather, Joseph viewed the patient’s history as subjectively held and dynamically shifting—she broke with any objectivist implications of previous psychoanalytic conceptualizations of the recovery of the patient’s past. Clinically and practically it is the total situation of the transference that contains what analyst and patient need to know. As the analyst becomes immersed in the force field of the patient’s primitive transferences (manifested mostly as projective identifications), the analyst cannot escape at times from losing his or her sense of separateness and of having “a mind of one’s own” (Caper 1997) and to some degree enacts with the patient the aspect of the internal object relationship that is being projected in the transference. If the analyst does not eventually become aware of this, either through self-analytic work or through consultation with colleagues, some sort of impasse can result. Particularly when primitive transferences involving loss of boundaries and intense interpersonal pressure are involved, it is difficult for the analyst to maintain sufficient distance from the patient’s internal object world in order to recognize and to interpret what is being transferralized projected. The analyst’s countertransference, while constituting the analyst’s main and most reliable tool for understanding the patient, is, in its pressure for enactment, often seen as a major obstacle to the analytic work. It may lead the analyst to engage in splitting and projective processes of his own. The most critical and most difficult part of transference interpretation is the internal process of registering, containing, and reflecting on what is unbearable and inaccessible to the patient.

Bion, the Interpersonal Field, and Qualities of Thinking

Conceptualization of the Field

Although the influence of Bion’s work on projective identification was emphasized in the previous discussion, Bion’s original and highly creative thinking in a variety of areas is pervasive in a number of contemporary trends in
psychoanalytic discussion of transference and represents the fourth and final nodal point in this discussion. In examining some of these trends in this section, I review the work of Thomas Ogden and Antonino Ferro, two widely read and influential contemporary authors who explicate and offer creative readings of Bion’s often enigmatic work and in the process define their own unique visions of the psychoanalytic relationship and its healing potential. Both Ogden and Ferro are difficult to place in a particular theoretical school and are widely cited in work by authors from a variety of contemporary points of view. They share common influences not only in Bion but also in Klein, and there are important resonances of Winnicott’s work in the writing of both authors, more explicitly in Ogden, more implicitly in Ferro. Both build on Winnicott’s emphasis on early experiences of the infant-mother unit as well as his preoccupation with the actual mental state of the mother in its holding and development-enhancing functions.

In the work of these authors, significant shifts in thinking about transference and its position in the psychoanalytic process emerge; some would argue that these formulations shift attention so far away from traditional notions about transference that the concept loses its quality of specificity and wanes in importance.

The shift in focus is both toward a more radically interpersonal/intersubjective perspective and toward a greater emphasis on mental processes and a de-emphasis on mental contents—that is, mental contents (e.g., memories, wishes, fantasies, defenses, specific transference configurations) lose their privileged position in structuring the psyche and in contributing to psychopathology. The focus is instead increasingly on how the mind works with its own contents—how it experiences, processes, dreams, and metabolizes them. The aims of psychoanalytic treatment are less about recovering the past and rendering the unconscious conscious or about resolving or finding better solutions to intrapsychic conflict and more about enabling patients to better tolerate their emotional experiences—to think them, dream them, and learn from them. In part these shifts reflect clinical experience with a sicker and more primitive organically organized group of patients who have difficulties thinking, symbolizing, and processing their experiences and whose self-object boundaries and experiences of self-cohesion are less consolidated. In addition, these shifts reflect deeper insights into the more primitive, nonverbal, and unsymbolized registers of experience that are universally present for all of us.

Some of the theoretical underpinnings of this point of view derive from Bion’s positig of a mental process that transforms raw sensory and emotional experience into the rudiments of thoughts, memories, and dreams. These rudiments are then used in the generation of more complexly organized thoughts, memories, and dreams that are the stuff of our subjective experience. Dreaming is quite central in this formulation and is a continually occurring process not limited to nighttime dreams but potentially ongoing all the time. Dreaming is then a quality of thinking in which we render experience meaningful and use it for further learning and personal growth. To the extent that we are unable to dream, we are unable to think and to feel, which is equivalent to being unable to be fully alive. Psychopathology results from either difficulties in transforming raw sensory experience into rudiments of psychological experience (emphasized by Ferro) or difficulties in the process of connecting these psychological rudiments into thoughts, dreams, and complex emotional/psychological experience (emphasized more by Ogden). The former is a result of developmental immaturity; the latter is associated with either immaturity or dynamic interference, as in Bion’s “attacks on linking” (Bion 1959a). A surplus of emotionally charged rudiments that exceeds the capacity of an individual to process them constitutes emotional trauma and is another route to psychological illness.

In drawing out some implications of Bion’s work, Ogden emphasized that, for the most part, thinking requires at least two people [T. Ogden, personal communication, 2010]. At the same time, any group of two or more people takes on aspects of mental functioning that go beyond the individual contributions of each of its members [Bion 1959b]. For writers such as Ogden and Ferro, the psychoanalytic situation takes on the quality of an interpersonal field [Baranger and Baranger 2008] in which it is impossible at times to know precisely what comes from whom. Transference and countertransference become a transference-countertransference matrix, an intersubjective construction in which the contributions of patient and analyst cannot be artificially separated. The emphasis has shifted from efforts to interpret the patient’s transference to efforts to understand the unconscious contributions of patient and analyst to the construction of the field. Such understanding enables the analyst to shift his or her emotional attitudes and behavior and thus to effect shifts in the nature of the field. These shifts in turn affect the patient’s capacities to think and to process emotion and lead to the appearance of different ways of experiencing and behaving.

In Ferro, in particular, the field and its functioning or dysfunctioning—the ways in which the field promotes or undermines thinking and processing of emotional experience—are the primary objects of attention.
Transference in psychoanalytic work [Ferro 1996, 2002, 2005, 2009]. Ferro’s work draws on the generative transformative potential of the field to catalyze psychological growth. Shifts in the analyst’s state of mind can be counted on to produce potentially transformative movement in the field. Often the most important aspect of interpretation is the silent work of interpretation within the analyst’s mind and the ways in which this internal work affects the functioning of the field. Dysfunction of the field, or impasse, and its resolution by the analyst’s eventual understanding and internal shifts are, for Ferro, the stuff of everyday analytic work.

Ogden’s conceptualization is expressed differently but involves many similar considerations. Transference and countertransference mutually co-create each other and take on meaning only within an interpersonal field. Analyst and patient contribute to the formation of a third entity, or third area of subjectivity, which he terms the intersubjective third. This area of experiencing is the primary means by which each unconsciously understands and to some extent lives out the unconscious experience of the other. Ogden uses the composite term transference-countertransference to emphasize his view that it is one entity in which neither can be understood, or can even come into existence, without the other. Similarly, for Ogden, a dream does not belong solely to one participant or to the other but is in some important way contributed to by both. Psychopathology is conceptualized as an inability of the patient to dream his or her experience. The analyst uses his or her understanding from within the intersubjective third to formulate interventions that help the patient to dream what has heretofore been undreamable [Ogden 2005].

A brief clinical vignette may be helpful in illustrating the contributions of patient and analyst to the interpersonal field and the transformative shift in the field that follows from the analyst’s understanding and changed emotional position:

For some time I had struggled with feeling unable to make contact with my patient, as if we were speaking different and mutually incomprehensible languages. After a particularly frustrating session, I dreamt that I was trying to reach my young son on the phone. I dialed the number repeatedly and kept saying “It’s Dad,” only to hear a confused and unfamiliar voice at the other end. As my distress mounted and partially awakened me, it occurred to me that I must have been dialing the wrong number. Realizing that I was similarly speaking to the wrong person in my attempts to reach my patient, I was able to pull back, to understand better and to tolerate my anger and frustration, and to gain further access to some of the unconscious roots of my feelings. I could also think more clearly about the unconscious origins of my patient’s hostile withdrawal and the ways in which he was projecting into me his own experiences of feeling unable to get through and to connect. Gradually I was able to try different and eventually more successful ways of making contact. I heard unconscious references in my patient’s associations to the shift in my emotional position and noted that he was speaking less defensively not only with me but also with other people. Some time later we were able to talk more explicitly about the change in our experience of each other.

Implications for Transference

Transference is now conceptualized within the broader notion of an analytic field. What are the further implications for the concept and status of transference and interpretation of transference? For Ogden [2001, 2004a, 2004b], transference in the form of transference-countertransference continues to hold a key position in clinical thinking. Ogden views transference as a form of thinking and of experiencing in which past modes of thinking and feeling are particularly alive in the present moment of analytic experience. It cannot be artificially isolated from the total stream of thinking/feeling, any more than transference as an aspect of the relationship can be artificially isolated from the totality of the analytic relationship [T. Ogden, personal communication, 2010]. Transference-countertransference for Ogden becomes synonymous with a view of the analyst and patient engaged in psychological work in which the unconscious anxieties and hopes of both participants come to life, mutually create and define each other, and are subject to transformative understanding. If either participant ceases becoming more than what he or she was previously, then analysis has probably stalled.

Ferro refers to transference rather sparingly, and when he does use the concept, his main interest is in the ways in which transference is manifest in the projective identifications that contribute to the emotional exchanges between patient and analyst that constitute the interpersonal field. At times he also uses the term in a more narrow and classical sense, as repetition of past experiences in relationships, but in this usage it would seem to have lost much of its importance and clinical usefulness for him. In general, Ferro seldom interprets transference and countertransference experiences directly, whether he is referring to projective identifications in the field or to transference in its more traditional sense as repetition of past experience. Rather, he more often uses his understanding of transference and countertransference to effect a shift in his internal attitude.

Copyrighted material
toward a position that the patient can more readily make use of in metabolizing unbearable experience. Ferro's interest lies less in the ways in which past experience shapes present experience and more in the ways in which current emotional experience with the analyst is reflected in all of the patient’s associations, including those ostensibly about the past.

Like Ogden, Ferro (2005) is interested in transformations in the capacity for thinking rather than in decoding or recovering content. Ferro speaks of interpreting “in” the transference rather than interpretations “of” the transference [p. 42]—that is, the analyst is maintaining constant awareness of conscious and unconscious aspects of how he or she is being experienced by the patient, including residues from the past. Yet rather than interpreting this directly, the analyst will use it to effect transformations in his or her own inner state that increase understanding and receptivity and lead to generative shifts in the field. Such shifts in the field then modify all aspects of the patient’s experience of the analyst. To some degree, this formulation minimizes the distinction between transference interpretation and extratransference interpretation. Perhaps it even undermines the notion of transference interpretation itself. Ferro redefines both the nature and purpose of interpretation and hence of transference interpretation: “In my view, the concept of interpretation should be extended to any verbal or non-verbal intervention capable of generating transformations” [Ferro 2005]. It would appear that any traditional understanding of transference interpretation has been supplanted.

The degree to which an intervention is transformative has everything to do with the analyst’s state of mind, receptivity, and capacity for reverie. For Ferro, as for Ogden, the patient is constantly monitoring and always unconsciously aware of the analyst’s state of mind. It is the analyst’s reverie that not only provides access to the patient’s internal world but also allows the analyst the possibility of transforming those aspects of the patient’s emotional experience that the patient cannot process him- or herself. As in Bion, the patient re-introjects not only what has now been processed and transformed but also an increased capacity to perform that processing work. When the analyst is not in an open state of mind able to receive and to process the patient’s projected experiences, then a state of negative reverie may result, in which that which was projected is returned in a now even more toxic form. The analyst’s state of mind is in constant fluctuation because of everything that is impinging on his or her thinking/dreaming capacity, and at times what is projected by the patient may exceed the analyst’s capacity for receiving and processing.

An important unifying trend in the work of Joseph, Ogden, and Ferro is an emphasis on Bion’s elaboration of Keats’ concept of negative capability—that is, the analyst’s capacity to sustain a state of not knowing, “without any irritable reaching after fact and reason” [Keats 1817, quoted in Bion 1970, p. 125]. Understanding emerges and then recedes in processes that are beyond conscious control and bear similarity to the creative process itself. “In this state of mind, one is capable of marveling at the mystery, the utter unpredictability, and the power of the unconscious which can be felt, but never known” [Ogden 2005, p. 25]. The analyst is counseled to meet the patient each day “without memory or desire” [Bion 1967]. This represents an important shift in psychoanalytic listening. For all of these authors, there is a movement away from theory and a mistrust of what is already “known,” including a more classical conceptualization of transference. Defensive misuse of transference as something that one thinks one already “knows” as opposed to what is in the process of becoming is an ever-present danger.

### Current Controversies

#### Interpretation in the Here and Now

To what extent do interpretations of transference refer explicitly to past experiences in relationships versus remaining at the level of the current interaction? This is a point on which many contemporary analysts diverge significantly in their thinking about transference, although perhaps for most it is not an either/or question. Those preferring to remain in the here and now of the interaction [e.g., Joseph, Ogden, Ferro, relational analysts] would argue, perhaps with considerable justification, that once what is going on in the here and now is clarified, the patient will spontaneously make connections to past experience. Moreover, those same analysts might argue that transference interpretations that rely heavily on explicit references to the past are likely to be experienced as distant and sterile and are unlikely to be mutative. These considerations notwithstanding, many analysts would report moments in which explicit connection to the past as evoked in current transference experience leads to greater affective intensity and feeling of conviction, leading to a more textured and layered experience of understanding of the present analytic interaction.
Centrality of Transference Interpretation

In most of the formulations I have discussed, and certainly in my own definition and integration, listening to and interpreting transference (and countertransference experience) remain central. Although the term transference neurosis seems to have fallen by the wayside, the notion that all of the patient’s difficulties will come alive in some way in transference experience, where they are best understood and conveyed to the patient, continues to be a majority point of view. However, increasing challenges are emerging in clinical discussions. As mentioned earlier, some analysts are increasingly uncomfortable with the potential for defensive use of transference, or in fact any theoretical preconception, as a way of conceptualizing and organizing clinical material [e.g., Bion, Ferro]. These analysts advocate a more exclusive emphasis on the here and now of what is created in the uniqueness of the clinical moment. Although what is created is bound to be imbricated with resonances from past experience, privileging the transferential aspect does not seem useful to these analysts, who feel that such focus potentially distracts and provides defensive cover from the immediate affective moment. It is an interesting irony that a concept whose discovery originally opened new possibilities for the understanding and transformation of unconscious life is now viewed by some analysts as an obstacle and diversion from deeper understanding.

Asymmetry Versus Symmetry

The relationship between analyst and patient has traditionally been viewed in an asymmetric manner, in which the analyst maintains relative anonymity and, while using his or her countertransference responses to understand and formulate interpretations, does not intentionally reveal his or her internal process. Although it has long been recognized that the patient may have accurate understanding of the analyst, including aspects of the analyst’s unconscious, and may even help the analyst to better understand himself or herself (Searles 1975; Goldberg and Grusky 2004), the therapeutic and ethical emphasis is on the analysis of the patient. Quite early on, Ferenczi (1988) challenged this arrangement and experimented with varieties of “mutual analysis.” More recently, relational analysts have experimented with varieties of self-disclosure and, more generally, with adopting a less tilted, more symmetric stance in relation to the patient [e.g., Davies 2004, Pizer 1998, Renik 1993, 1998] or a stance that establishes an optimal dialectic between technique and spontaneity [Greenberg 2002, Hoffman 1998]. A number of relational analysts have placed particular emphasis on issues of genuine emotional availability and involvement as well as authenticity in the psychoanalytic encounter. From this point of view, the analyst’s “irreducible subjectivity” [Renik 1993, 1998] is embraced, and enactment becomes not only an unavoidable clinical event but an indispensable road to understanding. These analysts argue that such shifts in the direction of symmetry enhance rather than dilute access to transference experience, although this remains controversial.

Conclusion

The exploration of transference in clinical psychoanalytic work is now more than 100 years old. Readers of fiction and poetry are well aware that some understanding of the manifestations of transference in life experience has been around for many centuries in human efforts to understand and to heal self and others and in efforts to understand more deeply the nature of who we are. In psychoanalytic thinking, it is clear that transference is both an evolving and a controversial topic; for most analysts it shifts in meaning but is still central in practice. It is important to note how work with more primely organized patients has stimulated research and creative thinking about transference and concomitantly made it possible for analysts to work analytically with patients who for many years were not considered amenable to analysis, at least within mainstream North American circles. I think it is fair to say that work at the frontiers of what analysts have considered amenable to psychoanalytic understanding and change has transformed how analysts listen for, understand, and work productively with transference experience. For those analysts who still view transference as an indispensable concept and clinical tool, if the analyst is not constantly rediscovering and wondering what transference is about and how it can be used as a potent transformational agent, then analytic work is in danger of becoming devalued and rote.
KEY POINTS

- Transference is a boundary concept that links dimensions of past/present, unconscious/conscious, intrapersonal/interpersonal, and discovered/created.

- A central tenet of the Freudian view of transference is that all of the patient’s anxieties, symptoms, and other manifestations of emotional suffering will be expressed in the conscious and unconscious relationship of the patient to the analyst.

- Although transference refers importantly to the past, it becomes uniquely alive in the present relationship with the analyst. In many current discussions of clinical work, the past dimension of transference is left implicit.

- Transference is often communicated in what the patient is trying to “do” to the analyst, as reflected in the subtle and shifting feelings and fantasies that are evoked in the analyst’s mind. What the patient is doing may be a more reliable window into the patient’s unconscious dynamics than what the patient is actually saying verbally.

- Contemporary shifts in emphasis from mental contents toward mental processes are leading to new conceptualizations of transference and to new approaches to transference interpretation in clinical work.

References

Bion WR: Experiences in Groups. London, Tavistock, 1959b


Greenon R: The working alliance and the transference neurosis. Psychoanal Q 34:155–181, 1965


Ogden T: Conversations at the Frontier of Dreaming. Northvale, NJ, Jason Aronson, 2001


Ogden T: This Art of Psychoanalysis. London, Routledge, 2005


Countertransference

An Instrument of the Analysis

Lawrence J. Brown, Ph.D.

No one who, like me, conjures up the most evil of those half-tamed demons that inhabit the human breast and seeks to wrestle with them, can expect to come through the struggle unscathed.

Sigmund Freud [1905, p. 109]

[When approaching the unconscious...we, patient and analyst alike, are certain to be disturbed....In every consulting room there ought to be two rather frightened people, the patient and the psychoanalyst.

Wilfred Bion [1990, p. 4]

THERE HAS BEEN an awareness from the earliest days of psychoanalysis that the analyst is deeply, sometimes disturbingly, affected by engagement with the patient’s unconscious experience. Sigmund Freud [1910] coined the term countertransference to refer to the therapist’s unconscious reaction to the analysand’s transference and noted that handling one’s emotions toward the patient presented the analyst with a significant challenge. It was recommended that the clinician use the countertransference as a stimulus to self-analysis so that
one’s capacity to listen to the patient’s concerns could proceed without interference from the analyst’s private reactions. In this chapter, I review the development of the concept of countertransference from initially being seen as a hindrance to later perspectives that view it as a means by which to better understand the patient, thereby enhancing the therapeutic process.

In a letter to Freud dated April 7, 1909, Karl Abraham referred to taking on two new patients and remarked that with each new treatment his understanding of analysis increased. He also observed:

I have tracked down a symptomatic reaction in myself. While I am analyzing and waiting for the patient’s reply, I often cast a quick glance at the picture of my parents. I know that I always do this when I am following up the infantile transference in the patient. The glance is always accompanied by a particular guilt feeling: what will they think of me? This has of course to do with my separation from them, which was not too easy. Since explaining this symptomatic action to myself, I have not caught myself at it any more. [Abraham 1909, p. 88]

Abraham’s next thoughts are of his 2-year-old daughter, to whom he had recently given enemas and who, on each following day, expressed hope there would not be another. However, he noted that the plea was offered “with a rather arch smile. So obviously she wants to get the injection. Apart from this, she does not show any analerotic tendencies” [p. 88].

There is a sense of Abraham’s prideful accomplishment in this note to his good friend in having “tracked down a symptomatic reaction in myself” and not having “caught myself at it any more.” This has been achieved through the analyst’s observation of his reaction to the patient’s infantile transference, a reaction he has had with other patients that is considered to be a distraction from his task of listening carefully to the analysand’s associations. Abraham then engages in a piece of self-analysis: he realizes his guilt is connected to his “not too easy” separation from his parents, and this insight has subsequently freed him from similar diversions. In essence, he has succeeded in three ways: first, by recognizing his distracting personal reaction stirred by the patient’s “infantile transference”; second, by engaging in self-analysis to remove this “symptomatic reaction”; and last, by returning his attention to the analysand’s narrative.

This brief vignette is a veritable gold mine that contains within it the multitude of potential meanings given to the term countertransference from its incep-

tion as an inevitable, albeit distracting, factor in analysis to contemporary perspectives that consider it an essential ingredient of the psychoanalytic process. For Abraham and his cohort, emotions evoked in the analyst were expectable [e.g., the quotes from Freud and Bion at the beginning of this chapter] and served to foster his or her own self-reflections from which personal growth as an analyst and individual developed. It was, therefore, very clear from the earliest days of psychoanalysis that powerful, even deeply disturbing emotions were a common side effect of this work and that it was unrealistic to “expect to come through the struggle unscathed.”

If we scratch the surface of Abraham’s communication with Freud, there are many other layers of meaning that await our discovery and raise important questions about the analyst’s subjective reactions. Why, for example, does Abraham look at the picture of his parents and feel guilt precisely during the interim between interpretation and the patient’s response? Is there some sort of unconscious need for approval, and worry of making an error, that is being evoked in this analyst by this particular patient at this single moment in the analytic work? Abraham does not feel this guilt with every analysand: does his contriteness surface with all facets of the patient’s infantile neurosis or with certain themes? Does the analysand “sense,” unconsciously or not, the analyst’s anxious anticipation of the patient’s reply, and if so, might he or she withhold associations to the interpretation? Is there some ambient, although unarticulated, emotion permeating the session that has to do with being a “good” boy, analyst, or patient that is expressed in various ways, such as Abraham’s reporting to Freud that he is a dutiful analyst or that he glances at the picture of his parents? Finally, what are we to make of Abraham’s thoughts turning next to his constipated daughter and her ambivalence about the enemas? Is this an “association” that is relevant to his “symptomatic reaction” and to the analysis?

Thus, much of the “raw material” from which additional definitions of countertransference have been crafted is implicit in the letter from Abraham to Freud, and it has been left to subsequent generations to expand on it. I begin with a discussion of Freud’s views of countertransference, which were often seemingly at odds with one another, and the perspectives of the early analysts. I then discuss later contributions in order to highlight the development of our understanding of the analyst’s subjective reactions and how these are employed in the analytic encounter.
Freud and the Early Analysts on Countertransference (Pre-1940)

The question of the countertransference and how it should be handled was at first discussed informally as in Abraham’s [1909] letter and appears for the first time in Freud’s [1910] publications when he stated that such feelings arise in the analyst “as a result of the patient’s influence on his unconscious feelings [and that the analyst should] recognize this counter-transference in himself and overcome it” (p. 144, italics added) and that “no psychoanalyst goes further than his own complexes and internal resistances permit” (p. 145).

These brief quotes are very significant in that they state that 1) the countertransference results from the impact of the patient’s difficulties on the analyst’s unconscious; 2) because such emotions in the analyst are unconscious, he or she must strive to become aware of this reaction “and overcome it”; and 3) the progress of an analysis also depends on the analyst being aware of his or her own “complexes and internal resistances.” Thus, Freud is describing psychoanalysis as an intense interpersonal process in which encounters with the patient’s unconscious deeply impact the unconscious of the analyst, an effect that the clinician must overcome. Failure to do so may impede the course of the patient’s analysis and, it is implied, possibly hinder the personal growth of the analyst.

The growing realization that countertransference was an inevitable and sometimes destructive phenomenon led to the requirement that all analysts have a personal analysis as part of their education. This became one of the three pillars of training, in addition to attending seminars and seeing analyses under supervision, that was introduced by Max Eitingon [the “Eitingon Model” of training] when he founded the Berlin Psychoanalytic Polyclinic in 1920. Indeed, as Balint [1954] observed, Eitingon may have received the first “training analysis,” as described in a letter from Freud [1909] to Ferenczi, “Eitingon is here. Twice weekly, after dinner, he comes with me for a walk and has his analysis during it” [cited in Balint 1954, p. 157]. These strolls must have had a very positive effect that stayed with Eitingon and contributed to his instituting the necessity of a training analysis.

However, Freud also offered other views that suggested countertransference feelings could be of benefit in an analysis. The vignette from Abraham’s letter cited earlier points to how the therapist’s subjective reactions may be a stimulus to self-analytic work and personal growth in the analyst. In addition, Freud [1912] also recommended that the analyst “use his unconscious . . . as an instrument of the analysis” (p. 116), although he did not instruct us as to how this is achieved. In the same paper, he proposed that the free associations of the patient and the “evenly suspended attention” of the analyst are linked phenomena, however, Freud and his contemporaries only explored the impact of the analyst’s unconscious on that of the clinician, leaving aside the effect of the analyst’s unconscious on the patient. In connecting the subjective emotions of the analyst and patient, Freud may have been suggesting that the therapist can use his unconscious “as an instrument of the analysis” by paying attention to his countertransference feelings.

These early analysts also examined how successful work on the countertransference was necessary for unlocking the analysand’s life-constricting conflicts. If Abraham, in the case introduced at the beginning of this chapter, had not become aware of his “symptomatic reaction” that was stirred by his patient’s infantile neurosis and had instead blocked recognition, this denial could have thwarted the analytic progress. Freud [1910] noticed this tendency when he wrote that unrealized “internal resistances” in the analyst can limit his or her emotional freedom, thereby tying the analysand’s emotional development to the clinician’s capacity to manage his or her countertransference. Some years later, Theodor Reik [1924] expanded on this point by introducing the notion of counterresistance, which is a subtype of countertransference in response to an obdurate resistance in the patient characterized by “a decrease of interest in the case or even a change in the mode of treatment” (p. 150). Glover [1927] subsequently added that a counterresistance was an expression of the analyst’s negative countertransference—that is, aggression toward the patient.

Freud is often faulted for having advocated that the analyst should remain opaque and manifest the surgeon’s dispassionate attitude of “emotional coldness” (Freud 1912, p. 115). However, it is important to note that these first psychoanalysts struggled with the heat generated by the transference-countertransference matrix, and I suspect that the goal of “emotional coldness” was likely a fantasized state aimed at cooling down the necessary but searing emotions of the analytic consulting room. Freud [1913] seemed to be saying as much in a letter to Binswanger dated February 20 when he stated that the problem of countertransfer-
ence was “among the most intricate in psycho-analysis” (p. 112) and that the analyst must display to the patient “spontaneous affect, but measured out consciously at times” (p. 112). He implied that some patients may require more of this than others, “but never from one’s own unconscious” (p. 112). Thus, Freud appears most concerned about the heat of the analyst’s unconscious affecting the analysis negatively, hence his advocacy of "emotional coldness" is meant to help the clinician keep his or her "cool" rather than to promote an air of aloofness.

Before leaving this section, there is a statement by Freud (1912) that deserves our attention: It is as contemporary as any offered by current writers and lays the groundwork for the contributions of many recent analysts:

[The analyst] must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient...so the doctor’s unconscious is able, from the derivatives of the unconscious which are communicated to him, to reconstruct that unconscious, which has determined the patient’s free associations. [Freud 1912, pp. 115–116]

Although Freud does not elaborate on this observation, he offers a model of unconscious communication as an additional perspective from which to understand countertransference. Implicit in this vertex is the notion that the patient’s unconscious actively conveys a communication for the “doctor’s unconscious” that functions like a “receptive organ” to receive and then “reconstruct that communicating unconscious.” Perhaps Freud had in mind Ferenczi’s (1911) letter a year earlier in which he suggested that the countertransference was “being induced” (p. 253) by the patients, thus implying a purposeful function to this emotional induction.

Freud (1923) introduced the structural theory [id, ego, superego] that subsumed the previous topographic theory [conscious, preconscious, unconscious] and also outlined a new theory of anxiety [Freud 1926] that placed great importance on the role of defense mechanisms in the ego’s armamentarium for managing anxiety. This important evolution in psychoanalytic theory also signaled a shift in emphasis away from the study of unconscious [id] fantasy contents toward the workings of the unconscious ego in defense. Consequently, the exploration of countertransference, which was defined as the unconscious reaction to the analysand’s unconscious expressions, faded and tended to be seen as “unscientific” [Lothane 2006] as compared with the examination of the ego’s functioning that could be more easily observed. Ego psychology subsequently became the predominant theoretical orientation in the United States and was galvanized by the influx of orthodox Freudian analysts from the European diaspora of World War II. However, ego psychology did not achieve the prominence in Europe, and especially South America, that it was accorded in institutes under the aegis of the American Psychoanalytic Association [Brown 2009, 2010, 2011]. Consequently, most American analysts were trained to adhere to Freud’s (1910) admonition to “recognize this counter-transference and overcome it” (p. 253) even though Freud (1912) had hinted at the relevance of countertransference for understanding the patient’s unconscious communications.

Use of the Countertransference as an “Instrument of the Analysis” (1940–1960)

There was a significant shift in the understanding of countertransference during this period from viewing it as an encumbrance to treatment that must be overcome to seeing countertransference as an essential “instrument of the analysis.” The 1930s ended with Alice and Michael Balint’s paper that debunked the notion there could be a “sterile” manner of analyzing free from effects of the analyst’s personality; indeed, they argued that there was an interaction between the transference and countertransference “complicated by the reactions released in each by the other’s transference onto him” (Balint and Balint 1939, p. 228). They also observed that patients adapt to the analyst’s countertransference and go on in analysis to “proceed to their own transference” (p. 228). In addition to normalizing the presence of countertransference feelings, the Balints also brought for our consideration the effect of the analyst’s subjective experiences on the analysand; however, their view was that the patient worked around the countertransference, and they did not discuss in detail its effect on the analysand’s transference.

Robert Fliess, in his 1942 paper “The Metapsychology of the Analytic,” examined in great detail the nature of the analyst’s work ego that depended on a capacity for trial identification, which required the analyst “to step into his [patient’s] shoes and obtain in this way an
inside knowledge that is almost first hand” (p. 212). It was through this process that the analyst could use his or her countertransference as an instrument of the analysis by obtaining a “taste” of the analysand’s struggles through a transient identification in which “he becomes the subject himself” (p. 215). Now armed with the “firsthand” knowledge, the clinician may make a more accurate interpretation to the analysand; however, Fliess cautioned the analyst to take care “to guarantee that no instinctual additions of our own distort the picture” (p. 219), a view that appears to partially espouse the outlook that the countertransference is something to be “cleansed.” Nevertheless, Fliess’s perspective represents a significant departure from the first analysts who considered the countertransference as a distraction to listening to the patient, albeit a potentially helpful one to the analyst in self-analysis.

Although Fliess does not use the term analyzing instrument, he is essentially offering us an insider’s look at the process occurring in the analyst’s mind. Thus, by introducing trial identification, the work ego, and other concepts into our lexicon, contributions that, as Schafer (2007) stated, helped “launch psychoanalysis towards its contemporary form” (p. 698), Fliess expanded the range of conceptual tools to apply to our understanding of how to use the countertransference. As discussed earlier, beginning in the 1930s there was a divide between the ego psychologists’ attempts to develop techniques that sought to “cleanse” a patient’s material from being alloyed with countertransference and another group’s (the Balints, Fliess) views of countertransference as a pathway to the analyst’s empathic understanding. In my opinion, we can see in Fliess the tension between these two perspectives: his open advocacy of the relevance of the analyst’s subjective experience on the one hand and his wish to be “able to guarantee that no instinctual additions of our own distort the picture” on the other. As Jacobs (2007) commented, “One suspects that issues of loyalty to Freud, as well as fears of Ferenczi’s influence and of wild, undisciplined behavior on the part of colleagues, influenced Fliess and others who held this idealized and sanitized view of the analyst’s functioning” (p. 717).

The Kleinian School and Projective Identification

Melanie Klein (1946) introduced the term projective identification to describe how the attribution (by projection) of aspects of the self to the internal image of an object (in the projecting subject’s inner world) changes the inner experience of that object. The internal object thereby becomes identified with what has been projected into it, and the patient’s behavior toward the actual external object is governed by his or her inner experience of that object. In more disturbed patients, such as psychotic and severely borderline individuals, the distinction between inner and outer reality may be erased, whereas neurotic patients are capable of understanding their distortions that create the feeling, for example, of “it’s as if you are my father.” Klein’s followers saw in projective identification a way of explaining countertransference: that the analyst’s subjective reactions, in addition to his or her transference to the analysand’s transference (the classical explanation), may have been created by projective identification. In this regard, countertransference could be partly explained by the patient’s unconscious placement of painful emotions into the therapist, thus not only does the patient’s subjective experience of the clinician change, but the analyst is emotionally affected by what is projected.

However, although Klein did acknowledge it was sometimes difficult for the analyst to be the recipient of such projective identifications (Spillius 2007) because of his or her associated inner objects stirred by the projection, she, like Freud, stressed that the countertransference was to be dealt with by the analyst in one’s self-analysis. Despite the fact that many of her devotees regarded countertransference induced by the patient’s projective identification as a useful tool of analytic work, she remained skeptical of its relevance as a guide to emotionally understanding the analysand. She held this position firmly to the end of her career: witness her comments to a group of young analysts in 1958 (quoted in Spillius 2007): “I have never found that the countertransference has helped me to understand my patient better. If I may put it like this, I have found that it helped me to understand myself better” (p. 78).

Paula Heimann (1950), the first of Klein’s followers to apply the concept of projective identification to the study of countertransference, asserted that it “is an instrument of research into the patient’s unconscious” (p. 81) and also that it is “the patient’s creation, it is part of the patient’s personality” (p. 83). Thus she linked Freud’s (1912) recommendation that the analyst use his unconscious “as an instrument of the analysis” to Klein’s projective identification, seeing the latter as the means by which the patient’s unconscious communicates with that of the therapist. By asserting that the countertransference is a creation of the patient, Heimann also effectively explained the mechanism by which the countertransference is induced (see Ferenczi’s and the Balints’
earlier comments] as well as how the analyst becomes a part of the patient [Fless]. Perhaps Pick [1985] said it best when she noted, “The child’s or patient’s projective identifications are actions in part intended to produce [emotional] reactions” [p. 157].

Roger Money-Kyrle [1956] advanced Heimann’s ideas and elaborated them further. Like others before him, he observed that there are inevitable periods during which the analyst fails to understand the analysand, these occur when an aspect of the patient disturbingly coincides with an unanalyzed portion of the analyst’s psyche. Money-Kyrle added an original element to this situation by stating that one task of the analyst is to interpret the effect of the countertransference on the patient; however, it is important to note that he did not favor disclosing one’s feelings directly to the patient. Instead, he suggested that the analyst deal with the patient’s comment about his or her mood, whether accurately perceived or not, by interpreting it as psychic reality that has personal meaning to the analysand. Money-Kyrle’s perspective, therefore, squarely places the emphasis on the unconscious meanings both the analyst and patient attribute to their interaction. He argued that acknowledging the analyst’s conscious feelings toward the patient may “confirm” the accuracy of the patient’s perceptions, but it does little to address the unconscious meaning the patient has attached to the perception [accurate or not] of the analyst. Betty Joseph [1975] summed up this stance when she stated, “It is important to show, primarily, the use the patient has made of what he believes to be going on in the analyst’s mind” [p. 80].

Simultaneously with these applications of projective identification by Heimann and Money-Kyrle in London, analysts in Argentina and Uruguay were exploring similar territory. The cultural ambience of the Argentine Psychoanalytic Association, which was formed in 1942, was one that combined psychoanalysis [with a primary Kleinian orientation] with input from Kurt Lewin’s “field theory,” studies of dreamlike states, and probed into the nature of psychosomatic states [Bernardi 2008]. Heinrich Racker, one of the leading figures in the early days of the Argentine Psychoanalytic Association, believed, as did Heimann, that the capacity to identify with the patient is the “basis of comprehension” [Racker 1953] of the analysand. His investigation of the role of identifications in countertransference was considerably more detailed than contributions on the subject from any previous authors.

Racker [1957/1968] delineated what he termed concordant and complementary identifications that comprise important elements of the countertransference. Concordant identifications denote the analyst’s introjection of an aspect of the patient’s self (“sent” by projective identification), in which case the analyst unconsciously feels “this part of me is you” (pp. 134–135). In contrast, a complementary identification signals that the analyst has identified with an internal object of the patient. Racker, more stridently than Money-Kyrle and Joseph, asserted that the analysand is attuned to the countertransference and that the patient’s awareness of the fantasied and real countertransference is a determinant of the transference: “Analysis of the patient’s fantasies about countertransference, which in the widest sense constitute the causes and consequences of the transferences, is an essential part of the analysis of the transferences” [p. 131]. However, the clinician must be attuned to the possible development of a countertransference neurosis in which the patient, in the analytist’s unconscious, is equated with a disavowed part of the analyst. In such a situation, for example, the analysand may become identified with the analyst’s projected aggression, and with the patient now being experienced as embodying hostility, there may be a misrecognition by the analyst that guides his or her interventions.

We can see how Racker deepened our understanding of variations in the countertransference that assists the therapist in using his or her feelings toward the patient as “an instrument of the analysis.” It is important for the analyst to be able to discern whether countertransference feelings result from an identification with a disowned segment of the patient’s self [concordant] or from an identification with a figure from the analysand’s inner world [complementary]. Leon Grinberg, a colleague of Racker, coined the term projective counteridentification to describe the impact of the analysand’s violent projective identifications [discussed later] upon the analyst’s subjectivity. As we have seen, it is essential that the analyst become through a temporary identification what the patient is projecting; however, there are certain situations in which the analyst “ceases to be himself and turns unavoidably into what the patient unconsciously wants him to be” [Grinberg 1990, p. 84]. Grinberg contrasts the concept of projective counteridentification with Racker’s idea of the complementary countertransference. When the analyst is under the impact of a complementary countertransference, his or her identification with the projected internal object of the patient stirs a personal reaction based on the analyst’s idiosyncratic conflicts similar to that which is projected. By contrast, with projective counteridentification, “the same patient, using his projective identifica-
tion in a particularly intense and specific way, could evoke the same countertransference response [projective counteridentification] in different analysts” [Grinberg 1990, p. 90, italics added].

**Bion and Communicative Aspects of Projective Identification**

Wilfred Bion, a strikingly independent thinker, was trained in the London Kleinian (second analysis with Melanie Klein) tradition and creatively expanded on some basic Kleinian concepts. Grinberg’s (1990) notion of projective counteridentification was based on the idea of violent projective identification that denotes the effect on the analyst of a patient’s relentless barrage of accusations, for example, that the analyst hates the analysand. As such an attack continues, sooner or later the therapist will come to hate his or her patient independent of the analyst’s attempts to remain composed or “neutral.” Winnicott (1949) wrote convincingly about the necessity of the clinician coming to hate certain kinds of patients, which was an essential part of the treatment. Thus, violent projective identification creates an experience in the analyst of being passively taken over by a patient whose sole interest is to evacuate his or her own frightening emotions into the analyst.

Bion, who worked analytically with many psychotic and borderline patients, wrote a series of papers in the 1950s in which he described the communicative aspects of projective identification (Bion 1957, 1958, 1959). In essence he was asserting that although projective identification may serve the function of emptying out the psyche of unwanted elements, it is also a means of emotional communication from one psyche to another. In this connection, even the most violent expression of projective identification that leaves the therapist feeling bared is also a communication of the nature of the patient’s anguish. Bion deeply believed in this, a conviction that led him to claim the patient as the analyst’s best ally because even in his or her most disturbing interactions, the patient was attempting, however feebly or ferociously, to communicate something of his or her own inner suffering. Thus, Bion [1990] came to observe (cited in the quote at the beginning of this chapter) that “we, patient and analyst alike, are certain to be disturbed” [p. 4].

In proposing the communicative component of projective identification, Bion, although he did not say it directly, was in effect telling the analyst how to use his or her unconscious as “an instrument of the analysis.” Communicative projective identification, therefore, was the means by which “the transmitting unconscious of the patient” [Freud 1912, p. 115] communicated with the “receptive organ” of the analyst’s unconscious. However, we may also wonder about the fate of that which is projected into the therapist: what becomes of it once it has been successfully communicated and taken in, or introjected, by the receiving unconscious of the analyst? Bion (1958) commented that in addition to its communicative aspects, projective identification also aims to “put bad feelings in me and leave them there long enough to be modified by their sojourn in my psyche” [p. 146, italics added]. The conception that feelings are “modified by their sojourn” in the analyst’s mind became the cornerstone of Bion’s later theories and furthered our understanding of countertransference; thus, another facet of countertransference was its role in modifying what has been transmitted to the clinician’s unconscious.

Bion’s researches into how the psyche modifies the projection led to his discovery of reverie, but first a detour back to Abraham’s [1909] letter to Freud offers a useful illustration. As a thought experiment, I suggest we imagine ourselves as Abraham’s supervisor as Abraham is describing his treatment of the patient with whom he experiences the need to look over at the picture of his parents while awaiting the analysand’s reply to an interpretation. Abraham tells us that, in the classical mode, he has successfully stopped this “symptom” of gazing at the picture. Applying the notion of communicative projective identification, we may wonder whether this analyst’s [Abraham] unconscious has received some communication from the patient’s unconscious and that looking at the picture of his parents was this analyst’s unique way of unconsciously registering in his own metaphor the patient’s communication. Furthermore, we might also consider Abraham’s next thoughts about his daughter’s constipation and her “rather arch smile” about the enemas as further data, encoded in the analyst’s personal experience, about what the analysand is unconsciously communicating. Employing the analyst’s seemingly “unimportant” side remarks as his unconscious representation of the patient’s subliminal communication furthers the analyst’s ability to use his unconscious “as an instrument of the analysis.”
Further Elaborations of Countertransference: Enactments and the Concept of a “Two Person” Psychology (1960–1990)

Bion’s (1962, 1997, Ogden 2003a, 2003b, 2004) concept of reverie refers to a wide range of experiences [visual images, seemingly irrelevant thoughts, random tunes] that spontaneously come to the analyst’s mind while listening to a patient and signal that the analyst’s unconscious is quietly working to decode the analysand’s unconscious communication and “re-register” it in the therapist’s personal idioms. If the clinician applies this stance, then what we consider clinical “material” that is relevant to the patient’s difficulties is greatly broadened. Thus, within this frame of reference, Abraham’s thoughts [associations!] about his daughter’s constipation are viewed as a “legitimate” potential source of information about what the patient is communicating in this session. We may therefore formulate a hypothesis that Abraham’s glance over at his parents’ photograph for approval that is followed by thoughts about his daughter’s bowel difficulties is a reverie that indicates his unconscious reception of a communication from the analysand that is transformed into these particular thoughts. Furthermore, his unconscious may be a lightning rod for the patient’s emotions about being good [Abraham’s looking toward his parents] and being withholding [his daughter’s constipation], and perhaps an enticement to draw Abraham into some sadomasochistic struggle (the “arch smile”).

I can imagine at this point that the reader may be wondering whether these extrapolations from the analyst’s countertransference are at best extremely fanciful and at worst a gross misuse and misapplication of countertransference. Indeed, this was the objection in most American psychoanalytic circles in the beginning of the 1960s regarding the use of countertransference “as an instrument of research into the patient’s unconscious” [Heimann 1950, p. 81]. For example, Ross and Kapp (1962) wrote a very interesting paper in which they recommended that the analyst pay attention to his or her visual images stirred by listening to a patient’s dream because these images could offer clues to countertransference feelings of which the therapist was unaware. Whereas for Bion or Heimann such images might be considered vital data about the patient, Ross and Kapp considered these images as confirmations of “when a countertransference problem has already been suspected” [p. 645]—that is, information about the analyst and not the patient.

There were, however, a number of American analysts who earlier advocated using the countertransference as a means of better understanding the patient in addition to themselves, but their ideas did not gain much traction. Indeed, Theodor Reik’s (1948) book Listening With the Third Ear: The Inner Experiences of a Psychoanalyst, which argued for the value of the analyst’s subjectivity (“third ear”) in understanding the patient, was widely read among the general population but seemed to have much less impact on mainstream American psychoanalysis.

In the late 1950s and early 1960s, Otto Isakower (1957, 1963) of the New York Psychoanalytic Institute gave a series of lectures dealing with supervision in which he emphasized the importance of teaching candidates to use their countertransference as a component of the “analyzing instrument.” He reported his supervision of an analytic trainee who shared with an analysand a spontaneous visual image he experienced while listening to the analysand, which Isakower discussed as having had a positive treatment effect. This presentation was met with many negative responses from the audience [Wyman and Rittenberg 1992], including the comment by Martin Stein that questioned whether the candidate’s sharing of the visual image “has to do with some unanalyzed personal problem. To use an analogy from medieval times—when a person had a vision to tell, was the vision sent by God or the Devil?” [p. 221].

Otto Kernberg (1965) published a groundbreaking (for American psychoanalysis) paper in which he detailed two currents in thinking about countertransference: one was the “classical” definition that regarded countertransference as the analyst’s unconscious reaction to the patient’s transference and the second use was the “totalistic” one, characterized by a broader view of countertransference as something that “should be certainly resolved [and also] useful in gaining more understanding of the patient” [p. 39]. He described various countertransference difficulties that may await those who undertake the treatment of seriously disturbed patients and warned that the analyst should take care to recognize the possible development of “chronic countertransference fixation” that arises from the “reappearance of abandoned neurotic character traits” [p. 54] in the analyst triggered by primitive aspects of the patient.
It is important to note that this article was written during the time when he was investigating the intensive analytic treatment of patients with "borderline personality organization" [Kernberg 1967] and narcissistic disorders, and this publication argued that the analyst adopt the "totalistic" approach to countertransference as a necessary tool for treating such individuals. Although this paper did not offer new innovations in understanding the phenomenon of countertransference, its linkage of particular emotional reactions in the analyst to specific severe diagnostic states and the fact that it was published in the Journal of the American Psychoanalytic Association introduced most American psychoanalysts of that era, largely under the sway of then-prevalent ego-psychological models, to a broadened ("totalistic") view of countertransference.

Kernberg's advocacy of the "totalistic" approach to countertransference helped to foster an evolution from a "one-person" to a "two-person" psychology in American psychoanalysis that began in the mid-1970s. Although Modell (1984) is generally credited with coining this distinction, the term two-person psychology is first mentioned by John Rickman (1951), who defined it as "the psychological region of reciprocal relationships" (p. 219) that takes into account the interaction between the psychologies of the analyst and patient. In this regard, Joseph Sandler (1976) introduced the idea that the transference has an intended purpose of actualizing an internal object relationship of the analysand in the analytic relationship. The patient assumes a certain role in accord with an internal fantasy and also deliberately, although unconsciously, acts to evoke in the analyst a complementary role of that fantasy. Sandler emphasizes that this role responsiveness is not just a fantasy existing in the patient's psyche but an actual state of emotional affairs that permeates the subjective experiences of the analyst and analysand. He treads on familiar ground to what Racker had earlier described but emphasizes the pressure brought to bear on the therapist to behaviorally step into a role that is scripted by the patient's internal fantasy. Sandler advised the clinician to maintain a free-floating behavioral responsiveness: a receptive capacity to be placed in a variety of roles that pull him or her in the direction of specific actions delimited by the nature of the role he or she has been pushed to assume. The analyst may be placed in a role that causes some distress, and Sandler cautioned him or her not to simply view this upset as a mere "blind spot" but to consider this reaction as a "compromise formation" between the analyst's own proclivities and his or her reaction to the nature of the role forced on him or her.

Johnny, a 9-year-old boy in analysis for encopresis, began a session by announcing, "Dr. Brown, today we're going to kill women!" He motioned to the wall, said that there was a lineup of women whom I was supposed to shoot, and placed an imaginary gun in my hand. I was taken aback by this command and hesitated, offering that I did not know how to fire a weapon, but Johnny barked like an angry sergeant "Do it!" Still I hedged and said I didn't feel right killing these women, but my delaying was quickly remedied when Johnny turned me into an emotionless robot. His impatience with me grew until he held a rifle to my head and said, "It's them or you!" Reluctantly I gave in, followed orders, and shot all the women. Returning to my human form, I said I felt badly about the murders, at which point Johnny gave me a puzzled look and said, "Dr. Brown, we were only playing." Johnny needed me to adopt the role of a murderer of women, but my anxiety about assuming that position caused my resistance. This resistance arose from a "compromise formation" between the role Johnny needed me to step into and my conflicts over matricidal feelings [I knew the women represented his mother]. Furthermore, because I believed that Johnny could not tolerate owning his matricidal impulses, my "resistance" also arose from a projection of my own conflicts into my experience of him.

Sandler moved the classical analytic understanding of countertransference forward to include the patient's pressure on the analyst to take on a role in the analysand's inner world and the effect on the analysand in acquiescing. Thus, when Johnny said, "Dr. Brown, we were only playing," it was as though he implicitly understood Sandler's technical suggestion that the analyst become one of the patient's inner objects or a disowned aspect of the analysand. However, it is through the experience of "role responsiveness" that the analyst is able to gain knowledge of the patient's inner workings. Thus, Sandler expanded on the analyst's use of the unconscious as an instrument of the analysis by giving privilege to the pull on the analyst to act in a particular role that may offer insight into the nature of the analysand's inner drama that is played out in the therapeutic situation.

The emphasis in Sandler's paper on the patient's pressure for the analyst to assume a role and act it out provides a central theoretical grounding for the focus on enactments beginning in the analytic literature in the 1980s. In Sandler's concept of role responsiveness, it is the patient's inner world and its externalization into the analytic situation that spur the analyst's involvement—that is, the analyst's psyche is viewed as reactive rather than as an active participant in initiating the interaction. Beginning in the late 1970s, Theodore
Jacobs (1991) wrote extensively about the actualizing component of enactments, adding a two-person dimension that was essentially absent in Sandler’s discussion, bringing us closer to the “region of reciprocal relationships.” The patient and analyst may engage in an unconscious mutual enactment that serves resistance:

The enactments carried out by both patient and analyst… Their investigation opened the way, not only to uncovering an essential piece of history that had not yet surfaced, but to bringing to the fore certain crucial aspects of the interaction between patient and analyst that, arousing anxiety in each and strongly defended by both, had until then been insufficienly explored. [p. 40]

For Jacobs (1983), the analyst is typically drawn into an enactment because of his or her unconscious resonance with an aspect of the conflict that the patient is manifesting. Not uncommonly, the analyst identifies with an internal object of the patient who may represent a figure in the analyst’s inner world or a split-off piece of him- or herself. In this situation, personages from the analysand’s representational world (Sandler and Rosenblatt 1962) may become unknowingly linked with presences in the analyst’s mind. Invariably, however, for Jacobs an enactment and its successful analysis allow for the emergence and clarification of unconscious conflicts in the patient, thus, an enactment is considered within the framework of the classically established goal of making the unconscious conscious.

Like Jacobs, most American analysts have tended to view enactments as an avenue toward the goal of making unconscious conflicts in the patient conscious. Dale Boesky (1990) suggested an additional benefit of the analyst’s being drawn into an enactment, in that it allows the analysand to sense the analyst’s engagement with him or her: “If the analyst does not get emotionally involved sooner or later in a manner that he had not intended, the analysis will not proceed to a successful conclusion” [p. 573]. Here Boesky is making an important point about the patient’s awareness of the analyst’s countertransference: whereas Money-Kyrle (1956) addressed the unconscious meaning the analysand gives to the perception of the countertransference, Boesky is additionally underscoring that the patient may find conscious reassurance in the clinician’s emotional engagement. By the early 1990s, the role of the analyst’s subjectivity in the analytic encounter was becoming an increasingly prominent area of study, and I now turn to this development.


One of the criticisms of classical analytic technique [Mitchell 1998, Renik 1995] has been that it relied on the analyst as an “authority” figure who sifts through the analysand’s associations to discover the hidden meaning and then offers interpretive pronouncements. Renik (1993) introduced the notion of the analyst’s “irreducible subjectivity” to highlight the inevitable involvement of the analyst’s personality in his or her interpretations, stating that insight is not a commodity given by the analyst to the patient but rather “that analytic truths are co-created by analysand and patient, rather than unveiled by means of the analyst’s objective observations of the patient’s projections” [Renik 2004, p. 1056]. These comments, distilled from the study of the analyst’s involvement in enactments, further shifted the concept of countertransference away from an artifact to be “sanitized” to an “irreducible subjectivity” and thereby promoted a diminished emphasis on the analyst’s authority.

The theme of analyst and patient co-creating insight is closely allied to the exploration of the analytic field by other authors whose works are influenced by the writings of Klein and Bion (Brown 2011). These contributions derive from Kurt Lewin’s (1935) formulation of field theory, in which he proposed that a dynamic field is created from the properties of the elements of that field but that the ultimate creation is greater than the sum of its parts. This idea was first applied to the study of group phenomena by Bion (1961), who observed that a collective unconscious fantasy may appear in a group that is an expression of a shared experience by the members. In a paper that was not published in English until recently, Baranger and Baranger (2008) of Argentina connected Bion’s theory of groups to the two-person analytic situation and outlined what they call the shared unconscious phantasy of the therapeutic dyad:

This structure [shared unconscious phantasy] cannot in any way be considered to be determined by the patient’s [or the analyst’s] instinctual impulses, although the impulses of both are involved in its structuring… Neither can it be considered to be the sum of the two internal situations. It is something
created between the two, within the unit that they
form in the moment of the session, something rad-
ically different from what each of them is separately.
(p. 806, italics added)

This model of the analytic relationship adds a new
dimension to our comprehension of countertrans-
ference: the analyst’s emotional experience in the session is
a conduit to a shared unconscious experience that is
built from aspects of the patient and of the analyst. It is
“something radically different from what each of them is
separately,” or put another way, it represents “something
fascinating about the analytic intercourse; between the
two of them, they do seem to give birth to an idea” [Bion
2005, p. 22]. From this perspective, therefore, it is less
important for the analyst to sort out “whose idea was it?”
[Ogden 2003b] than to regard countertransference as
tuned into a shared emotional experience that the anal-
yst and the patient, each in his or her own way, are
attempting to come to terms with. Returning once again
to Abraham’s [1909] letter to Freud, I began the previous
section by speculating that Abraham’s looking at the pi-
ture of his parents for approval and his associations to
his daughter’s constipation may indicate that he was un-
consciously resonating with some emotion stirred by his
patient. If we add the perspective of the “shared uncon-
scious phantasy,” we may also consider the possibility
that both Abraham and his patient were under the sway
of an unconscious fantasy [i.e., a wish to receive parental
approval and defiance against that authority] that per-
meated the communal analytic mood.

The literature on the analyst’s and patient’s mutual
contribution to enactments, Renik’s [and others’]
thoughts about the co-creation of meaning [insight] in
the analytic pair, and the idea of a shared unconscious
fantasy all fall under the umbrella of intersubjectivity.
This topic is discussed in another chapter in this text-
book, but it seems important to note that the study of
countertransference appears to have been subsumed in
recent years by investigations into the nature of inter-
subjectivity [Brown 2011]. It is my impression that
countertransference still carries a somewhat pejorative
association; for example, countertransference dreams
are not generally spoken about, and candidates are loath
to discuss these in supervision [Brown 2007]. On the
other hand, the term intersubjectivity does not have the
history of stigmatizing the analyst’s feelings that coun-
tertransference carries and instead normalizes the
therapist’s experience, however troubling it may be.

Before closing, there is one last perspective on
the analyst’s experience of the analytic hour that deserves
attention: that the analyst’s experience of the analytic hour is a dream.
Bion [1992] expanded Freud’s theory of dreaming [the
reader is referred to Grotstein’s [2009c] paper dealing
with Freud’s and Bion’s dream theories] in which he
asserted that we are always dreaming while awake and
asleep. He viewed dreaming as the mind’s way of pro-
cessing raw emotional experience and giving it mean-
ing with one’s personal stamp. Ogden [2003a, 2004,
2007] has written extensively about Bion’s views on
dreaming and described how the analyst’s waking dream
thoughts [or reveries] are the means by which his or
her psyche unconsciously transform experiences of
the patient [conveyed to the analyst through projective
identification] that are too unbearable for the analysand
to “dream” on his or her own. Furthermore, not only is
the clinician transforming an unmanageable emotional
experience for the patient, but his or her waking dream
thoughts are also “unconscious work” the clinician is
doing to represent the shared unconscious fantasy active in
the analytic hour.

The Italian analyst Antonino Ferro [2002, 2005,
2009] also placed great importance on the concept of
“waking dream thoughts” in both the analyst and pa-
ient as indicators of the analytic couple’s fertility, which
is an important component of the analytic field and re-
lated to the question of analyzability: can this analyst-
patient dyad engage in a mutual unconscious process
that transforms unrepresented emotional experience?
One offspring of the patient and analyst’s unconscious
interaction is the appearance of new characters in
the patient’s narrative that is a barometer of the aliveness
in the analytic field. Ferro views the development of a jointly
constructed narrative as the vehicle for transformation of
the shared unconscious fantasy of the analytic field
[Ferro 2009]. He stressed that a chief task of the analyst
is to adopt a stance of transformational receptiveness,
which means that the analyst must be open to experi-
ence what the patient needs him or her to feel; only then
can the analyst use his or her reverie function to give
possible significance to the analysand’s communications.
Ultimately, analytic progress depends on “the deep emo-
tional level of the couple, on which the projective iden-
tifications are used to establish the emotional founda-
tion which needs to be narrated through the characters
and transformed by working through, and which must
be shared by way of a story” [Ferro 2002, p. 25].
Conclusion

This chapter traced the development of our current understanding of countertransference from its early roots when it was seen as an impediment to treatment (though useful to the analyst’s self-analysis) to contemporary perspectives that consider it as an “instrument of the analysis.” When viewed in the latter way, countertransference is an important tool to understanding the patient’s unconscious through the analyst’s identification with elements of the analysand’s inner world. This identification is achieved by the patient’s activity of using projective identification and the clinician’s activity of taking in (introjecting) what is projected. The analyst’s receptivity to the patient’s unconscious communications is a vital but often difficult aspect of doing analysis. Furthermore, the patient looks to the therapist to give meaning to what he or she has unconsciously conveyed. However, we have seen an evolution in how the analyst’s role is conceived as a giver of meaning through interpretation. More recent developments have emphasized the importance of the analyst being less an authority who delivers interpretive pronouncements and more a collaborator engaging creatively with the patient to jointly discover meaning, a process that in part relies on the use of the analyst’s countertransference. In this connection, countertransference may be likened to dreaming in that the analyst’s experience of the patient performs the function of transforming (dreaming) frightening emotions too unbearable for the analysand to manage (dream) on his or her own.

KEY POINTS

- Freud and his cohort tended to see countertransference as an impediment to treatment and was an unconscious reaction of the analyst to coming into contact with the patient’s infantile neurosis.

- Although these classical analysts emphasized that the analyst should not permit his or her emotional reactions to distract from listening to the analysand, they also viewed self-analysis of one’s countertransference as necessary in order for treatment to progress and stated that it could be a useful “instrument of the analysis.”

- Subsequent contributions to the study of countertransference have, in essence, elaborated the ways that the analyst’s subjectivity may be employed as an instrument of the analysis. In particular, Melanie Klein’s concept of projective identification (and its extension by her followers) has been a vital tool in understanding how emotions evoked in the analyst may be meaningful communications from the patient.

- Other authors, notably Joseph Sandler and Theodore Jacobs, have explored the behavioral aspects of countertransference in which the patient subtly lures the analyst into an enactment. In this situation, the analyst may be unconsciously prodded into playing a role scripted by the analysand’s inner object world; a role he or she is prone to adopt because of its resonance with aspects of the analyst’s personality.

- More recent developments in our understanding of countertransference have been achieved through applying Bion’s theory of dreaming to the analytic situation. The work of Thomas Ogden and Antonino Ferro has been essential in demonstrating the importance of the analyst’s reveries as his or her unconscious activity by which unrepresented emotions that permeate the shared emotional field of the analytic dyad are “dreamed,” that is, given affective significance created jointly by analyst and analysand.
References


Bion W: Differentiation of the psychotic from the non-psychotic personalities. Int J Psychoanal 38:266–275, 1957


Bion W: Experiences in Groups. London, Tavistock, 1961


Bion W: Cogitations. London, Karnac, 1992


Bion W: The Tavistock Seminars. London, Karnac, 2005


Ferro A: In the Analyst’s Consulting Room. New York, Brunner-Routledge, 2002

Ferro A: Seeds of Illness, Seeds of Recovery. New York, Brunner-Routledge, 2005


Fliess R: The metapsychology of the analyst. Psychoanal Q 11:211–227, 1942


Grotstein J: Dreaming as a ‘curtain of illusion’: revisiting the “royal road” with Bion as our guide. Int J Psychoanal 90:733–752, 2009c


Lothane Z: Reciprocal free association: listening with the third ear as an instrument in psychoanalysis. Psychoanal Psychol 23:711–727, 2006
Ogden T: On not being able to dream. Int J Psychoanal 84:17–30, 2003a
Ogden T: What’s true and whose idea was it? Int J Psychoanal 84:593–606, 2003b
Reik T: Listening With the Third Ear: The Inner Experiences of a Psychoanalyst. New York, Grove, 1948
Renik O: The ideal of the anonymous analyst and the problem of self-disclosure. Psychoanal Q 64:466–495, 1995
DEFENSE AND RESISTANCE are closely allied concepts. Defense refers to the means by which the mind unconsciously protects itself from danger from within and without. Resistance refers to the operation of defense within the analytic situation. The progression of analysis entails a deepening process for both analyst and patient: the patient's inner world of fantasies and feelings gradually becomes focused on the figure of the analyst while the patient comes into contact with previously inaccessible aspects of that inner world, and the analyst's own inner world comes alive as well in the service of coming to understand the patient. Resistance reflects the ways by which patient and analyst oppose and manage this deepening and the dangers that arise from it. The interpretation and working-through of resistance is a central aspect of analytic work and makes a major contribution to the lasting change that analysis may produce.

Because the analytic situation involves two participants and generates a process unique to the pair, resistance may be viewed from several different perspectives. From the perspective of one-person psychology—the understanding of the patient as a single individual—resistance may be seen as the way the patient mobilizes defenses in order to manage the wishes and anxieties that arise in analysis. From the perspective of two-person psychology—the understanding of the way the individual minds of analyst and patient interact—resistance may be seen as the way each participant uses the other in order to manage dangers that arise to that individual: the way the patient engages the analyst to ward off danger and, less frequently, the way the analyst engages the patient to do the same. From the perspective of the analytic field—the understanding of the way patient and analyst function together as an analyzing unit—resistance may be seen as the way the analytic pair manages and controls threatened disruptions to the pair's equilibrium. These perspectives are not mutually exclusive, and each can contribute to our understanding of the complex dynamics of the analytic process.

Pioneering Contributions

Both the concept of defense and the concept of resistance originate in the work of Freud. In his 1894 paper “The
Neuro-Psycoses of Defence,” Freud introduced the idea that the mind unconsciously but actively splits itself when it confronts incompatible ideas [e.g., experiences, feelings, and thoughts] that are distressing to the ego [Freud 1894]. The ego defends itself against the intrusion of these objectionable elements by forcing them out of consciousness. Alive in the unconscious, split-off or repressed elements could undergo further transformations, returning in disguised form as obsessional thoughts, phobias, or somatic symptoms.

If symptoms arise from the repression of incompatible ideas and affects, then, Freud argued, cure must result from their restoration to consciousness. Almost from the beginning, Freud saw that this restoration fails to achieve its desired effect if the analyst simply informs the patient of what has been excluded from consciousness; instead the analyst has to help the patient to retrace the pathway by which the incompatible idea has become repressed in order to reestablish links between the conscious and unconscious parts of the patient’s mental life. Freud [1913] soon learned, however, that the patient was not his full ally in the lifting of repression. If the patient wished for release from the suffering of illness, he or she also wished to remain ill in order to avoid the very distress that had first led him or her to keep objectionable elements out of consciousness.

The patient’s opposition, or resistance, to the analyst and the analytic task took protean forms. He or she would be unwilling, or unable, to follow the fundamental rule—the demand that he or she say whatever comes to mind. Thus the patient would use the rule and the arrangements of the analysis to conceal his or her wish to defeat the analytic process.

Most powerful among the resistances is the patient’s tendency to repeat attitudes and emotional impulses from early life instead of remembering them. In the form of the transference, these wishes and feelings come to be directed toward the analyst, and the analysis itself becomes the arena for the patient’s reliving of early experience. Freud recognized that the transference is a powerful source of help to the analysis as well as an obstacle: the patient’s reenactment of the early experience brings it to life in the analytic situation, informing the analyst about its essential nature and bestowing enormous power on the analytic experience and its ability to accomplish change. Similarly, other forms of resistance are also valuable sources of information for the analyst because they reveal both the forces that originally led to repression and the patient’s characteristic ways of responding to these forces. The analyst’s recognition that the patient has misunderstood the fundamental rule and believes that he or she is called on to tell the analyst only certain categories of thoughts, for example, can show the analyst which categories of thoughts the patient finds reason to exclude—by implication, those thought to be most dangerous—and, in addition, the patient’s particular way of managing conflict by unconsciously adjusting the rules in order to fit them to his or her wishes. The understanding and overcoming of resistances soon become the main task of analytic work [Freud 1916–1917].

As Freud’s model of the mind evolved with his development of the structural theory, the concepts of defense and resistance also became more fully elaborated [Freud 1926]. Defense was no longer synonymous with repression but came to include all the techniques used by the ego to manage conflict. Freud traced out the series of unconscious operations by which defenses come into action: faced with an instinctual impulse that threatens the emergence of a danger situation, the ego generates signals, a quantum of unconscious affect that mobilizes the defenses necessary to ward off the threatening element. Freud named four danger situations, each associated with a phase of early development: psychic helplessness, loss of the object, castration anxiety, and superego anxiety.

Within the framework of the structural theory, which centered on the operation of three psychic agencies (id, ego, and superego) and the relations among them, the concept of defense itself became more complex: defense no longer simply reflected the action of the ego against the forbidden impulse; it involved a joining of ego and impulse, a compromise by which the ego gained sufficient power to manage the demands of id and superego. In addition, resistance was no longer synonymous with the operation of defense in the analytic situation. Freud now saw five different kinds of resistance, of which only the first three—resistance due to repression, to the transference, and to secondary gain from illness—had to do with the ego. Another source of resistance was the sluggishness of libido—that is, an unwillingness to give up a former mode of satisfaction; a fifth and last resistance stemmed from the superego, in the form of a persistence of unconscious guilt and the consequent need for punishment. In one of his final papers, Freud [1937] added to the list of resistances that arose from the patient’s mental life the possibility that limitations and difficulties in analysis might arise as well from the mental life of the analyst.

Building on her father’s later work, Anna Freud [1936] laid the foundations for the systematic study of defenses and their development. She classified the mechanisms of defense available to the ego, identifying nine
that had become familiar to her father and other early analytic writers: regression, repression, reaction formation, isolation, undoing, projection, introjection, turning against the self, and reversal. To these she added a tenth, sublimation, that was more characteristic of normal than of pathological ego functioning.

Drawing on her direct observation of children in school and residential settings, as well as her experience in child analysis, Anna Freud placed defense and the experience of danger within a developmental context. Certain defenses, such as repression and sublimation, only become available to the ego with the formation of the tripartite mental structure. Other defenses are characteristic of earlier phases of ego development. The dangers that instinctual impulses bear are different at different stages of ego development as well. The very early ego, still in the process of becoming distinct from the id, fears not the specific content of id impulses but their strength, which might threaten the ego’s nascent organization. A little later, the ego itself is more stable, but the superego has not yet been internalized; now the ego fears the objective dangers of external reality. Still later, when with the resolution of oedipal conflict the tripartite mind has been formed, superego anxiety becomes the chief concern of the ego.

In clinical psychoanalysis, attention to defense is of prime importance, Anna Freud argued, because defense serves as the point of entry for the analyst to the patient’s mental life. Although all three psychic agencies—id, ego, and superego—are of equal interest to the analyst, the ego is the only one of the three that the analyst can observe directly. Id and superego impulses can only be seen as the ego responds to them, warding them off or modifying them in the service of defense. The ego’s defensive struggles are often most evident clinically as they are launched against the affects associated with instinctual impulses rather than the impulses themselves.

In the analytic situation, as in everyday life, each individual uses a relatively stable repertoire of defenses. This repertoire is reflective of the individual’s character, the system of enduring traits and defensive patterns that he or she has formed in early life as a way of managing conflict and danger. Writing in the same era as Anna Freud, Wilhelm Reich (1933) described the way character traits manifest in analysis and developed a systematic approach to their interpretation. Character resistances, Reich said, show themselves not in the content of the patient’s spoken associations but in the manner in which the patient relates these—through attitude, bearing, and personal style. These latent, or hidden, aspects of the patient’s material are actually the most important focus for the analyst’s attention because much of the transference is expressed through them and together they make up a kind of character armor that shapes and molds everything else—the framework of the patient’s neurotic symptoms. In order to be successful, the analyst must interpret not the pattern of the content of the material but the pattern of successive resistances.

Anna Freud viewed defenses as mechanisms, operations that become available to the ego sequentially over a relatively prolonged period of maturation. From another perspective, that of Melanie Klein and her followers, defenses could be conceptualized as symbolic representations, or unconscious phantasies, that are being put to a particular, protective use. Klein and her followers argued that from the beginning of life, the infant understands and represents all experiences in terms of its relationships with objects; it has no other way of seeing or knowing the world [Isaacs 1948]. Instinctual impulses are framed as phantasies of what the self wishes to do to the object or to have the object do to the self. Other mental processes are representational as well. Defenses involve the transformation and manipulation of representations of self and object. Klein introduced several defensive maneuvers that could best be seen from this perspective. Splitting involves the holding apart of good and bad representations of self and object in order to protect good representations from the incursion or dominance of the bad. Projective identification involves the removal of a dangerous piece of the self representation and its placement within the representation of the object.

In a key contribution, Klein (1935) argued that defenses operate not singly but as organized ensembles, or positions, that protect against two very early danger situations. In the earliest of these situations, the paranoid-schizoid position, which operates from the beginning of life, splitting, denial, and projective identification operate together to protect the infant from the danger of annihilation—that is, the destruction of the self from within or without. In the second situation, the depressive position, which arises a few months later, splitting, reparation, manic defenses, and regres-

1The Kleinians used the term phantasy to distinguish these unconscious representations from conscious fantasies or daydreams.
sion to the paranoid-schizoid position protect the infant from the danger of the loss of the object.\textsuperscript{2}

Concept of Defense in Contemporary Psychoanalysis

With the evolution of psychoanalytic thought, the understanding of the relationship between defenses and other ego functions, of what may constitute defense, and of the danger situations that defenses serve to ward off has been greatly expanded. The ego mechanisms that Freud and others identified as defenses also serve purposes of adaptation and gratification [Schafer 1983]. Conversely, defensive function is not solely the property of these identified mechanisms of defense; the ego can draw on any aspect of mental life to serve a defensive function [Brenner 1982]. Writing within ego psychology, Brenner added depressive affect [i.e., displeasure associated with belief that a calamity has already taken place] to anxiety [associated with a belief in impending calamity]—the kind of danger situation described by Freud. Focusing on the aims of the ego itself, Sandler [1987] showed how the ego protects itself against the danger of the unfamiliar and attempts to maintain a feeling of safety by organizing perception and action to fit with the world that has already been represented.

Contemporary self psychologists [Ornstein 2009] have argued that the entrenched defenses described by Freud and others serve primarily to protect the vulnerable self against the danger of fragmentation. For relational and interpersonal analysts, building on the foundational work of Sullivan [1954], the danger to be avoided is the intrusion on core identity of unbearable, “not-me” elements; the central mode of defense against this danger is dissociation—the holding apart, and maintenance of selective inattention to, the rejected parts of the self [Stern 2009].

Observational studies of infants and children have yielded a great deal of information about the early pre-stages of defense and the sequence in which defenses develop. Defense mechanisms originate in biologically given motor reflexes that are then internalized and given ideational form. Each defense mechanism has its own developmental history. More cognitively complex defenses develop later in childhood. Different defenses become prominent at different developmental phases and in the course of normal development become less dominant, remaining available to be regressively reactivated. The understanding of a defense precludes its use, and early defenses such as denial, which depend on immature cognition, become less effective later on [Cramer 2006].

Attachment research places the development of key modes of defense within the context of the infant’s relationship with the mother. Clarity and coherence of the mother’s representation of the child promote the child’s development of a secure attachment and consequently a coherent representation of self, the capacity for reflection on the thoughts and feelings of self and others, and the capacity to regulate affect adaptively. Disturbances in the maternal capacity to represent the child’s inner state lead the child to distort self-experience defensively in order to protect the tie to the mother and consequently to develop a disturbed pattern of attachment, a less well-integrated representation of self, and diminished reflective function and affect regulation [Fonagy et al. 2002].

Contemporary classification of mental disorders, and particularly of personality disorders, rests on the diagnosis of both the developmental level and the type of defensive operations. Kernberg [1975] brought together a Kleinian approach to the centrality of primitive object representations and defenses and an ego-psychological perspective on the development of defense to construct a structural diagnostic framework in which extremely primitive defenses, related to a lack of separation of self and object and a global failure of reality testing, were linked to a psychotic level of functioning; primitive defenses such as denial, projective identification, and splitting, with a consequent loss of interpersonal reality testing, were linked to a borderline level of functioning; and higher-level defenses, most centrally repression, were linked to a neurotic level of functioning. Current diagnostic thinking [Kernberg 1984; McWilliams 1994; PDM Task Force 2006] incorporates Kernberg’s approach and looks at two axes of defensive function. The first axis involves a Kernbergian classification of defenses according to the level of differentiation of self and object—that is, psychotic, borderline, or neurotic. The second axis describes defensive style—

\textsuperscript{2}In the Kleinian idiom, manic refers not to bipolar illness but to the use of a group of defenses, including denial and omnipotent control, to ward off the reality of loss.
that is, the kinds of defenses—obsessional, hysterical, and so on—that operate across different levels of organization.

**Concept of Resistance in Contemporary Psychoanalysis**

The concept of defense is wide reaching, describing the operation of the mind in many settings. The concept of resistance refers exclusively to the analytic situation, the way we understand resistance will depend on the way we conceptualize the events that take place in analysis.

**Resistance From the Perspective of One-Person Psychology**

When we view the analytic process from the perspective of one-person psychology (i.e., the study of the individual mind), resistance is the unique way—or, more precisely, series of ways—in which each patient's mind opposes the deepening of the analytic process, that is, the growing intensity and unfolding of the transference and the growing contact with unconscious wishes and fears as well as the painful affects that the progress of analysis entails. From this perspective, resistance is simply the manifestation of the individual's defensive operations in the analytic situation, hence many analysts who work from the perspective of one-person psychology use the terms *resistance* and *defense* interchangeably. Like defense, resistance is an unconscious operation. A focus on resistance, which occurs within the analytic hour (rather than on defensive activity outside the analysis, in the events the patient reports), enables the analyst to help the patient see the operation of defense as it occurs (Gray 1994). Perhaps more important, a central focus on resistance enables analyst and patient to observe the shifting transference as it takes shape within each hour.

The metaphors that Freud used to depict resistance were generally adversarial, even warlike. However, contemporary analysts have come to realize that the analyst's aim in approaching resistance is not primarily to overcome it but rather to understand and analyze it.

The activities the analyst identifies as resistances serve many other purposes as well: they are gratifying, adaptive, and familiar (Schäfer 1983). A resistance protects against one eventuality by turning toward another, and a full analysis of any resistance must ultimately include the understanding of what is sought as well as what is warded off. The aim of the analysis of resistance, like that of the analysis of other aspects of the patient's behavior, is to help the patient to decipher the meaning that is encoded in it.

The following examples demonstrate the way the analyst working from the perspective of one-person psychology might approach resistance.

**Resistance to Establishment of an Analytic Process**

Despite the manifest wish to begin expressed by most patients who decide to embark on analysis, all patients bring to the beginning of analysis both fears and wishes concerning the analytic endeavor. In the earliest sessions, the patient's resistances and the anxieties that underlie them are often quite generalized. As Freud observed, the patient fears the emergence of material that has heretofore been unconscious. Although early resistances have meanings that will become clear later on, it is most important at this time for the analyst to create a framework in which the patient can begin to recognize that his or her behavior has a meaning and that the analytic setting gives the patient a special opportunity to observe his or her behavior and to wonder what it means.

In the following clinical example, the analyst, working from a one-person perspective, focuses on the way the patient's defensive operations serve to protect her from the anxieties that arise at the beginning of analysis.

In her first week on the couch, Miss A filled each session with a highly organized report of the events of the preceding day, interspersed with comments about the way these might demonstrate the problems that had led her to undertake analysis. Here was an example of her procrastination; there was an example of her perfectionism. She did not pause to explore any of the issues she brought up. The analyst simply listened, making her listening presence known to the patient with minor comments and questions that did not challenge the patient's approach.

When she lay down on the couch for the fourth and last session of the week, Miss A was silent for a few moments. She said that she had arrived just on time and had not had time to "prepare" for the session. Up until now, she had put together all her thoughts and decided what to talk about before she came.
The analyst asked what Miss A imagined would happen if she did not prepare. A bit flustered, Miss A said she was afraid she would run out of things to say. She paused and then said that if she said something she hadn’t considered in advance, she might say something she would regret.

By drawing attention to an early manifestation of Miss A’s resistance—preparing what she would say in advance—the analyst began to establish the framework for an analytic process. She showed Miss A that the analysis was a special place where behavior could be observed, feelings could emerge and be explored, and alternative possibilities could be contemplated. The particular resistance that Miss A deployed had many meanings for her and was connected to important fantasies about the analyst: in addition to wishing to control her own associations, it became clear quite soon that Miss A wished to control the analyst as well, because she saw the analyst as quite critical. Much later, it became evident that with her distant, controlling behavior, Miss A also wished to deprive the analyst, whom she now saw as weak and needy—the representative of a projected weak, needy part of herself. However, at this very early phase, what was most important to establish was that Miss A’s behavior had a meaning that was worth exploring. With this initial understanding, the first resistance faded a bit, and new resistances and their meanings began to come into focus.

Resistance to Awareness and Resolution of Transference

As the patient’s thoughts and feelings begin to center more clearly on the figure of the analyst, the transference becomes the main source of both resistance and information. As he or she analyzes the transference, the analyst attempts in each instance to find a workable surface—a point of entry where transference can be observed and is close to the patient’s consciousness. Gill [1979] distinguished between two forms of transference resistance that appear and must be analyzed in succession: resistance to awareness of transference and resistance to resolution of transference.

In the following clinical example, the analyst, again working from a one-person perspective, helps the patient the way he uses his associations to express feelings toward the analyst in which he has been unaware and then the way these unacknowledged transference feelings ward off a deeper level of feelings that are quite different.

Awareness of Transference

When the analyst returned from her summer vacation, in the sixth month of Mr. B’s analysis, she found that his descriptions of his work life were very different than before she had gone away. Mr. B had previously enjoyed working at the firm where he was a rising star. Now he found all his superiors arrogant and critical. They assigned work to him with little thought for all the assignment would entail. The chief executive officer (CEO) was particularly thoughtless. He left Mr. B to work late into the night on work that was due, returning in the morning to level unfair criticism at the reports Mr. B had written.

It was immediately evident to the analyst that Mr. B had displaced his anger and disappointment at the analyst onto his boss. The transferential nature of Mr. B’s response seemed particularly glaring in that he had often complained about the long periods when his father would be away in the army reserves and how the father would disrupt the family when he returned by enforcing strict rules that were neglected while he was away. However, the analyst felt that linking the situation to Mr. B’s past, or even making a direct link between the CEO and the analyst, would not really make an affective connection for Mr. B. Instead, she observed that Mr. B was telling a much darker story than he had before she had gone away. What could that be about?

Mr. B dismissed this question, saying that it was just as well the analysis had been suspended for a few weeks when he had had so much to do. He continued in sessions to complain repetitively about the CEO, whom he described in almost a caricatured way as an angry, greedy martinet. In every interchange with the CEO, as Mr. B described it, he himself was a calm, hardworking, decent employee. The analyst now realized that the most workable surface of the transference was evident not in the content of Mr. B’s story but in the way he was telling it to her, his setting her up to be a supportive listener who would take his side against the CEO. She pointed out to Mr. B how much he seemed to want her to take his side. Mr. B agreed. He spoke of the support he felt from the analyst and how he wished his mother had made him feel supported in this way when his father had been critical.

Resolution of Transference

With this interpretive sequence, Mr. B became aware of his positive feelings toward the analyst and began to look at them and to connect them with wishes that he had had toward his mother. What would it have meant to him if his mother had sided with him against his father? Was his critical view of his father colored by that wish, as his view of the CEO appeared to have been? Why was his view of his father so black and white? Was that only to persuade the mother in an internal argument that he had long carried on?

As Mr. B explored these questions, his attitude toward the analyst shifted. Now the paternal transference that had seemed so glaring at the time of the analyst’s return from vacation came into focus. Mr. B now saw the analyst as unsupportive, arrogant, and rigid. How could she insist that the patient pay for
Resistance to Working-Through and Termination

As the termination of analysis approaches, the patient’s resistance often takes the form of a revival of themes that were prominent early in the analysis. The reworking of old themes, now seen from a new perspective informed by the work that has been done, fosters the consolidation of the analytic work; the return of these old themes also serves as a resistance to termination and the meanings that it bears for the patient.

In a final example of analysis from a one-person perspective, the analyst’s drawing attention to the patient’s defensive revival of early symptoms enables the patient, who is now well advanced in her capacity for self-analysis, to reconsider the many functions that these symptoms have served for her and to move toward termination.

Mrs. C began analysis uncertain whether she wished to have children. Married and a highly successful career woman, she felt that she would ultimately be dissatisfied if she chose not to become a mother, but she was beset by doubts about her capacity to negotiate the competing demands of motherhood and work. During a 6-year analysis, work in a predominantly maternal transference helped Mrs. C to understand how much these conflicts had to do with her relationship with her own mother, who had stayed at home and raised her three children (Mrs. C was the oldest) without pursuing a career. Mrs. C had channeled her intense competitive feelings toward her mother into a separate arena, the world of work, where she felt that she was not in direct competition. By having children herself, she would be moving into her mother’s realm. She felt triumphant and guilty at the thought that she, unlike her mother, would have it all. At the same time, she resented the idea that by dividing her time between home and career, she would fall behind her mother as a homemaker. In the course of the analysis, Mrs. C also came to realize that an intense focus on work, which followed upon an equally intense focus on school, had served as a declaration that she did not need or want her mother’s exclusive care, which she had missed sorely after her siblings were born. As these issues came into focus, Mrs. C decided to become a mother and successfully negotiated the compromises that were entailed as she began to raise two children.

At a session shortly after she had begun to discuss the possibility of termination, Mrs. C announced that there was a crisis at work. In the newly fraught situation, all the old issues came up for her again, she said. Perhaps she should leave work altogether and just stay home with the children! After all these years of analysis, she did not know what to do.

What she described certainly sounded like a difficult situation at work, the analyst said, but she was struck by Mrs. C’s saying that after all these years she did not know what to do, because she did not seem unhappy about it. The patient replied that she had been feeling glad she was still in analysis when this happened. Now she recalled that as soon as she had heard the news at work, she had thought that she would have to stay in analysis for a very long time.

Perhaps she wished for that, the analyst observed. Mrs. C agreed. In some ways, she wished she and the analyst were back at the beginning. When she thought of leaving, she realized how much she had enjoyed the time they had spent together. If they could go back to the beginning, she would not have to give that up. Also, by giving up her independence and her work identity, perhaps she would be going back to the time she had had with her mother before her siblings were born.

Under the new threat of loss, Mrs. C had revived old concerns about work in order to hold on to the analyst. As she continued, however, it became clear that her anxieties about work were also a new way of expressing her competitiveness. “I guess if I were back to square one, it would show you weren’t so great either,” she said. “All these years of analysis and you would have accomplished nothing at all!”

As Mrs. C began to deal with the problems at work, she spoke of her awareness of both her competence there and her strong wish that the analyst would tell her exactly what to do. She wanted to need the analyst, she said, both so she could justify holding on to her and also so that the analyst would continue to feel needed. She felt guilty that her life was so full and that the analyst, who was past childbearing age, would be left alone and unneeded, as Mrs. C’s mother had been after her children had left home. Once again, Mrs. C began to plan for termination, now with a sense of loss and guilt as well as accomplishment.

Resistance From the Perspective of Two-Person Psychology

From the perspective of two-person psychology—the dominant perspective in the United States at this
time—resistance is the way analyst and patient enlist each other in order to oppose the dangers posed by a deepening analytic process. This perspective builds on the understanding that the idea of the analyst as an objective observer (a fundamental assumption of one-person psychology) is at best an approximation. Just as the patient brings the whole of his or her personality to the analytic encounter, the analyst does so as well; the analyst’s own inner world comes alive as he or she engages with the patient. In response to the patient’s evolving transferences, and to the disturbances that these evoke in the patient’s inner world, the analyst develops an evolving series of countertransferences. At times, forming a concordant identification, the analyst will align his or her own inner world with that of the patient and see the world as the patient does; at other times, forming a complementary identification, the analyst will identify with one of the patient’s internal objects (e.g., the patient’s superego or one of the figures in the patient’s internal world) that the patient has projected onto him (Racker 1968). Like transference, countertransference serves as both a resistance in analysis and a highly important source of information. By analyzing his or her countertransferences, the analyst can come to understand the aspects of the patient that evoke them. In addition, it is through analysis of the countertransference (i.e., of his or her subjectivity) that the analyst can best approach the balanced perspective of a relatively objective observer.

The following clinical examples demonstrate the way the analyst, working from a two-person perspective, makes use of the countertransference and attempts to identify both the pull that the patient exerts upon the analyst’s experience and the pull that the analyst exerts upon the patient.

Transitory Resistance

From the perspective of two-person psychology, transitory resistance arises when the patient’s transference evokes countertransference reactions that the analyst can easily recognize and use to formulate interpretations. In general, the analyst is able to use the countertransference smoothly in this way when it does not touch on conflicts within him- or herself.

In the first weeks of her analysis, Mrs. D reported a series of personal emergencies. At every session, something seemed to have gone wrong that led her to be late or required immediate attention. A babysitter quit; there were issues at the children’s schools; Mrs. D developed a series of minor physical ailments, each of which required medical attention. She missed some sessions and was late for others. When she was present, Mrs. D talked only about these daily problems.

Taking the perspective of one-person psychology, the analyst might have made the observation, after acknowledging the real difficulties that Mrs. D was encountering in her life, that talking about these difficulties might also be a way that Mrs. D was able not to talk about the other things that brought her to analysis. However, the analyst was also aware of the countertransference responses that Mrs. D evoked in her. The analyst felt disrupted and unable to think in a state that seemed to her parallel to Mrs. D’s. In addition, she was aware that she felt pulled with each emergency to give Mrs. D advice, as though she were the expert in each situation and Mrs. D was not. She chose to point this out to Mrs. D: “You are wanting me to tell you how to deal with each of these situations.”

Mrs. D stopped for a moment and reflected, “That is what I do, but it’s not really just about these situations. I am hoping you’ll tell me what to do about everything in my life and how to understand everything. Isn’t that what analysis is for?”

Using her countertransference reaction as data, the analyst had been able to draw Mrs. D’s attention to the way she made use of the analyst (Joseph 1985). This brought into focus an important fantasy that Mrs. D brought to analysis: a fantasy that the analyst would do all the thinking for both of them—that the analyst, in fact, contained the projected, thinking part of Mrs. D. Now analyst and patient could begin to explore this.

“You have the idea that I’ll do all the thinking and understanding,” the analyst ventured. “Why would you want that?”

“I don’t know,” Mrs. D replied. “I guess I have trouble thinking about anything myself. My mind keeps changing, and I can’t hold on to a point of view. I feel like I’m a different person with each person I’m with.”

The analyst now became aware of a shift in her countertransference reaction: as Mrs. D became more reflective, the analyst felt much more connected to her emotionally. No longer identified with the projected thinking part of Mrs. D, which Mrs. D had taken back into herself for the moment in response to the analyst’s interpretation, the analyst could now form an identification with the broader expanse of Mrs. D’s inner world and imagine how Mrs. D might be feeling, where she might be coming from, and who she might become.

Entrenched Resistance

Resistance becomes entrenched, and impasse may occur, when the patient’s transference stirs significant conflict in the analyst. In order to work through a sticky two-person resistance, the analyst must generally accompany spoken work with the patient with silent, self-analytic work aimed at reducing the unconscious pull that the analyst exerts on the patient.
Mr. E, a man in his 30s, was successful at work but had never been able to establish a lasting love relationship with a woman. A youngest son, Mr. E had been very close to his mother growing up but was now distant from her. For several years of analysis, he remained quite solitary; then he began to date an appealing woman. Mr. E treated this woman well and appeared to have genuine affection for her; the two seemed to have much in common. After several months, however, Mr. E broke the relationship off, saying that the woman was not quite right. During this period, the analysis progressed well, focusing on Mr. E’s choice of a woman who resembled his mother and his simultaneous fear that the analyst might be jealous of his girlfriend.

Now Mr. E dated a number of women in quick succession. These relationships were of an entirely different quality: Mr. E treated the women poorly, dropping them on a whim and treating them impersonally and contemptuously. The analyst questioned the shift in the quality of Mr. E’s relating but her interventions went nowhere. She began to feel that with his totally unreflective attitude, Mr. E was expressing the same contempt toward the analyst that he expressed in other ways toward the women he was dating.

As the months passed, the analyst became aware of a persistently negative countertransference to Mr. E. She began to see him as intractably infantile. Why would he not grow up? A man of 38 should not act this way! As she reflected on this persistent countertransference reaction, the analyst gradually widened her associations to include other aspects of her countertransference to Mr. E. She realized that with Mr. E she did not have a fantasy of how he would be when he was well. With all her other patients, such a fantasy was always in the back of her mind. In effect, she did not have a background feeling of being a parent who was guiding Mr. E toward greater integration, as an analyst should (Loewald 1980). As she considered this, the analyst suddenly realized that in her silent lament about Mr. E’s age, she actually had misremembered it! Mr. E was not 38 but 36, the age of the analyst’s own son. With her perception of Mr. E as an infantile 36-year-old man, she had made him both older and younger than he was, warding off the possibility that Mr. E might evoke in her some of the same feelings that her son had—the wish to parent, and more forbidden, the wish on both sides for an oedipal romance. She reflected that her own inability to accept Mr. E’s highly conflicted oedipal transference had contributed to his own avoidance of it.

Following this piece of self-analytic work, the analyst returned to the analysis feeling much more tolerant of Mr. E and better able to recognize the complexity of his experience. She now observed to Mr. E that he had wanted to find a close relationship with a woman and to reflect with the analyst upon his experience, but it was hard for him to hold on to this; something got in the way. Mr. E now joined her in reflection, and a more productive period of analysis ensued in which Mr. E spoke of his longing to be close to the analyst and the difficulties that arose for him when he drew closer to her.

Resistance to Termination

From the perspective of two-person psychology, termination bears the special meaning of the patient’s need to relinquish the use he or she has made of the analyst. Anxiety about this step inevitably arouses resistances, and old uses of the analyst are revived. Throughout the analysis, the patient has projected parts of his or her internal world of self and objects onto the figure of the analyst in order to protect a defensive psychic equilibrium. In order to terminate successfully, the patient must take these projected pieces of the object world back into him- or herself. For some patients, the analyst serves the function, throughout the analysis, of the containing, thinking part of the patient—the part of the patient that knows and understands him or her. These patients can accept and use the analyst’s interpretations but have difficulty internalizing and integrating this function within themselves (Steiner 1993). Other patients project onto the analyst a judging figure rather than a knowing one. For this group of patients, maintaining the analyst in the role of externalized superego protects the unconscious belief that the analyst holds the power to reward them by transforming disappointments in external reality. To relinquish this aspect of the analyst would require these patients to accept the finality of disappointment and loss (Steiner 2005).

The following clinical example demonstrates the way an analyst working from a two-person model interprets the patient’s projection of parts of the self at the time of termination and the way this advances the work of mourning.

In the course of a long analysis, Mrs. D, the woman who had begun by declaring her wish for the analyst to think for her, explored the many reasons for this wish and gradually developed a stable view of her own. As she approached termination, she reported another series of emergencies of all kinds. Work, home, and children all seemed to unravel at once. Once again, Mrs. D spoke only of these current events, turning to the analyst for direction in how to handle them. The analyst interpreted Mrs. D’s return to a relationship where the analyst would think for her as a way for her to hold on to the analyst and the analysis. Mrs. D agreed. She knew as well as the analyst how to handle these situations, she said. Still, she wished the analyst would critique the way she was managing things and tell her whether she was handling them rightly.

As she reluctantly recognized her wish for the analyst to pass judgment on her solutions, Mrs. D also became more aware of her sadness at the loss of the analyst and her disappointment that the analyst had not been able to entirely transform her life. She spoke
of how sad it felt to be going on to deal alone with problems that would inevitably arise. In the last week of analysis, she reported a dream about furnishing her apartment, deciding what to keep and what to give away. In reality she and her husband had rearranged their apartment the previous day after it had been painted. She could see that the dream was about the analysis, because the central image was of an old couch that she liked. In the dream she had placed it in a prominent location where she could sit in it and look all around the apartment. She had been surprised in the dream to find that she had kept pieces of old furniture from her childhood. They were not great, but they were a part of who she was. She had expected to change more in analysis, she said, to make it as though parts of her childhood never existed, but there was a satisfaction in knowing that her history was her own.

Resistance From the Perspective of the Analytic Field

From the perspective of the analytic field, resistance may be understood as the way analyst and patient protect their functioning as an analyzing unit by warding off elements that might disrupt it. This approach, which is widely used outside the United States and is now beginning to be used here as well, is particularly helpful in understanding situations of impasse. Viewed as a single unit, analyst and patient may be seen as working together in analysis to create an evolving series of narratives of the patient’s life. These narratives, which incorporate aspects of the patient’s past that the patient has previously excluded and recast familiar aspects in a new light, provide a more robust foundation for the patient’s identity and functioning [Ferro 2006]. As they build a story together, analyst and patient maintain a sense of a shared, functioning narrative by excluding elements that are unbearable to either and glossing over the omission with an illusion of shared meaning. In the course of analytic work, the accumulation of these microfractures of communication leads to the buildup of a “bastion”—a partial or total impasse. The analyst must now take a second look at the areas of falsely shared narrative and the elements that have been excluded on both sides [Baranger and Baranger 2009].

The following example illustrates the way an analyst working from the perspective of the field understands resistance as the manifestation of subtle, chronic miscommunications between analyst and patient.

Early in her analysis, Miss F described the chaos that had prevailed at home with her mother, who had been psychotic at times during Miss F’s childhood. “All you could do was laugh!” Miss F said, with exaggerated despair.

“What was funny?” the analyst replied, imagining the frightening scene of squalor and misrule. Miss F seemed confused for a moment and then said, “I’m relieved you said that. I feel as if I am looking at it with someone else who knows how things should be.”

The material that followed cast the analyst, a man, as a wished-for father who would rescue Miss F from the feeling of unsafety she had with the mother and help her to become more autonomous. Much work was done within this narrative, and the analysis progressed very well. After a number of years, however, progress slowed, and Miss F was unable to imagine how she would ever be able to terminate; her autonomy felt unstable, and she complained of a subtle feeling of estrangement in the wider world where she had become more active.

The analyst now reflected on the nature of the narrative that had framed so much of the analysis, that of the analyst, cast as father, rescuing Miss F from the mother. It now seemed as though the analyst had avoided being cast as the mother, or even as a father who was in a complex relation to the mother. He now brought the framing narrative to Miss F’s attention.

In response, Miss F recalled the moment when she had laughed and the analyst had asked what was funny. She had felt then, for a moment, the same sense of alienation that she complained of so often now, but she had put it aside. With great sadness she spoke of the squalid scene she had described as one that was homely and familiar and how she missed that closeness with her mother, however the mother was!

Further exploration led Miss F to the idea that the instability that she felt with her good functioning reflected a wish to return to being close with her chaotic mother. Perhaps she also had more complex feelings toward the rescuing father as well. At times, in his attention to Miss F, the father had seemed to be engaged primarily in a struggle with the mother in which the rescue of Miss F was a victory and Miss F herself mattered very little.

In his silent self-analysis the analyst realized that this view of him as motivated more by rivalry and hate than by love had also been distressing for him, unconsciously throwing into question his functioning as an analyst. As a new series of narratives emerged, with different and more complex versions of the parents, the analysis began to progress once more, and termination became imaginable for Miss F.

Perspectives as Tools in Analytic Work

As the analyst views the analytic process from each of the perspectives that have been presented in this chapter, he or she brings into focus a different aspect of the
dangers that arise in the analytic process and the resistances that come into play to manage these dangers. Working from the perspective of one-person psychology, the analyst has a particularly clear view of the patient’s fantasies and the defensive strategies used to manage them. When working from the perspective of two-person psychology, the analyst’s subjectivity is a source of both data and uncertainty in the understanding of the patient; what emerges is a particularly rich vision of the way the patient’s wishful and defensive fantasies are played out in relationships with others. Using the perspective of the analytic field, the analyst is able to contemplate the complex and mysterious forces that come into play when two minds operate in tandem and the way these forces may at the same time deepen understanding and obstruct it. The three perspectives are not mutually exclusive. The analyst who is familiar with them may use all three approaches as tools in understanding the myriad complex forms of resistance encountered in his or her work.

---

**KEY POINTS**

- *Defense* refers to the way the mind protects itself from danger from within and without.

- *Resistance* refers to the operation of defense within the analytic situation.

- The concept of defense and the concept of resistance originate in the work of Freud.

- Freud observed that the analysis of resistance is the central task of analytic work and that transference operated as a key form of resistance.

- Anna Freud laid the foundation for the systematic study of defenses and their development. Wilhelm Reich added the idea of character resistance.

- Melanie Klein believed that the organization of unconscious phantasy was a key mode of defense.

- Contemporary understanding of personality disorders relies on the diagnosis of both the developmental level and the type of defensive operations.

- Viewed from the perspective of one-person psychology, resistance is the unique series of ways in which the patient’s mind opposes the danger of a deepening analytic process.

- Viewed from the perspective of two-person psychology, resistance is the way analyst and patient enlist one another to oppose the dangers of a deepening analytic process.

- Viewed from the perspective of the analytic field, resistance is the way analyst and patient join together to prevent disruption of their operation as an analyzing unit.

- The perspectives of one- and two-person psychology and of the analytic field bring different aspects of the analytic process into focus and may be used to complement one another.
References


Kernberg O: Borderline Conditions and Pathological Narcissism. New York, Jason Aronson, 1975


McWilliams N: Psychoanalytic Diagnosis. New York, Guilford, 1994


Reich W: Character Analysis (1933). Translated by Carfagno VR. New York, Farrar, Straus & Giroux, 1990


Steiner J: The conflict between mourning and melancholia. Psychoanal Q 74:83–104, 2005


Intersubjectivity

Charles Spezzano, Ph.D.

Psychoanalysis might have ended up being the simplest to describe of all psychological treatments. Patients talk as freely as they want and can. The analyst listens carefully and intervenes when he or she has something to say that has a reasonable chance of being useful to the patient—useful because it ultimately illuminates some aspect of how the patient’s mind works unconsciously. The patient, as subject, takes the analyst as object and through transference creates a phantasy analyst who will gratify wishes or be an obstacle to their fulfillment. The analyst, as subject, then takes the patient as object and applies the collective knowledge of the psychoanalytic community, in effect saying to the patient: “We know from psychoanalysis that the way your mind works to create these ideas and feelings about me and others is the following.” Then the analyst offers an interpretation.

Gradually, however, in all schools of psychoanalysis, that picture underwent a significant change. The change involved adding another layer to a full account of the analytic process. In this new layer, labeled intersubjective, the patient and analyst are both subjects. An easy way to think of this is to use a tennis analogy. In the subject-object model—taken to a pure extreme—the analyst might be viewed as a tennis coach who watches the patient hit balls being served to him or her by a machine or by a neutral person across the net. The analyst observes and comments on how the patient plays, hopefully helping the patient understand why he or she hits the ball well, hits it poorly, or misses it. If the patient implicated the analyst in her or his performance, directing loving or hating feelings toward the analyst-object, the analyst-subject could interpret what was leading the mind of the patient [now object of the analyst] to think and feel the way it was doing. In the intersubjective model, the analyst is always on the court and is always hitting the ball back and forth with the patient, even though in a coach-student type of asymmetrical arrangement. The patient might see the analyst as being helpful or as hitting too hard, not trying hard enough, or not being interested enough, among other gratifying, anxiety-laden, or angry images of the analyst. The analyst, in this intersubjective model, is encouraged to consider the patient’s view of the analyst not as being pure phantasy but as being a phantasy-observation mix or as existing on a continuum between phantasy
and observation. If the patient stopped an initial interview or a session during an analysis and said, “How did we end up talking about me in this way?” the analyst would not say, “Well, because your mind has revealed itself to work the way we are talking about it, just translated through my psychoanalytic concepts and vocabulary,” but instead would say, “Well, because our minds working together have shaped a model of how your mind operates.”

All psychoanalysts have become more aware of the intersubjective dimension of their work. For some, this means mainly paying attention to what is happening in the patient-therapist interaction (perhaps mainly as one source of evidence from which to build an interpretation about how the patient’s mind is revealing itself). For others, it might mean prioritizing moments when there is palpable tension in the analytic relationship. For still others, it goes beyond focusing attention on and prioritizing “what’s happening between us right now” to include techniques usually revolving around the analyst saying something about what the analyst believes his or her role has been in a clinical event (including disclosures of what the analyst understands about his or her emotional response to the patient and speculation about how he or she might have contributed to tension or momentary breakdown in the analytic relationship).

All three of these intersubjective perspectives have been fed not only by clinical experience and psychoanalytic theory development but also by research and theory occurring in the fields of infant development and neuroscience. I give just a few samples of thoughts about intersubjectivity currently circulating in those fields. These samples do not aim to do justice to these vast bodies of literature but only to whet the reader’s appetite with brief quotes from those literatures that illustrate why they have piqued clinicians’ interest.

In the field of neuroscience, the Italian researcher Vittorio Gallese (2009), reflecting on the type of brain cell that has come to be called a mirror neuron, suggested that such cells underlie a human capacity—embodied simulation—that offers “a model of potential interest” (p. 519) for why intersubjectivity might turn out to ground the human condition. Mirror neurons, which appear to allow us to actually produce, without motor activity, an internal facsimile of what we see someone else doing or experiencing (including what he or she is likely to be feeling), thus might be what provide the biological ground for Freud’s (1926) hypothesis that “[i]t is only by empathy that we know the existence of psychic life other than our own” (p. 104).

In infant research, Daniel Stern (2004) argued that engaging in mutually coordinated mother-baby exchanges is something we are compelled to do from birth and therefore reflects “an innate, primary system of motivation, essential for species survival, and has a status like sex or attachment” (p. 97). As Winnicott once put it: “There is no such thing as a baby…if you show me a baby you certainly show me also someone caring for the baby” (alleged to have been said during a lecture, quoted in Abram 1997, pp. 2–3).

Summing up both the neuroscience and infant development evidence for an innate intersubjective dimension of human psychology, infancy researcher and psychoanalyst Robert Emde (2009) hypothesized: “The self is a social self to begin with…. Moreover, research indicates that, from infancy, innately given brain processes support social reciprocity and the development” of a quality he calls “we-ness” (p. 556).

In this chapter I provide a brief account of the emergence of this intersubjective perspective into psychoanalysis. Starting with the introduction of the term intersubjectivity itself into the psychoanalytic literature by Stolorow, Atwood, and Ross during the 1970s and 1980s (Atwood and Stolorow 1984, Stolorow et al. 1978), the discussion then moves back in time to precursors of intersubjectivity in the writings of Ferenczi, Sullivan, Fairbairn, Winnicott, Klein, Bion, and Kohut. Then the chapter returns to the present for an overview of how this intersubjective attitude has increasingly informed analytic thinking across many schools of psychoanalysis.

Roots of the Term

Intersubjectivity in Psychoanalysis

Although the roots of intersubjectivity might be traced to Ferenczi, Sullivan, Winnicott, or Kohut, its current life within psychoanalysis was launched by Stolorow, Atwood, and Ross between 1978 and 1988. While agreeing that patients come to analytic treatments with systems of meanings and organizing principles (that influence their thoughts, feelings, decisions, and relationships) formed during development, they argued that the source of these subjective psychologies is not mainly repressed wishes waiting to be discovered by analysis of anxiety and resistance through interpreta-
tion alone. Rather, they are prereflective meaning systems that, as Stolorow put it in 1988, are lifted into awareness through an intersubjective dialogue to which the analyst contributes his empathic understanding. To say that subjective reality is articulated, rather than discovered or created, not only acknowledges the contribution of the analyst’s empathic attunement and interpretations in bringing these prereflective structures of experience into awareness. It also takes into account the shaping of this reality by the analyst’s organizing activity, because it is the analyst’s psychological structures that delimit and circumscribe his capacity for specific empathic resonance. (Stolorow 1988, p. 336)

What Stolorow was describing might be put in several related ways: the psychological phenomenon we call consciousness is the result of minds in interaction, that which each of us calls “my self” is a history of experiences created in interaction with others, it is “the recognition that the other person is central to the formation of the self” (Elliott 1992, p. 237, drawing on the work of Adorno and Marcuse); and the “pre-reflective” self is an accumulation of affective experiences, many of which have never been articulated (Socarides and Stolorow 1984). The ways in which this is and has been true for each patient will be a critical part of the analytic treatment of that patient.

The patient brings his or her idiosyncratic understanding of his or her self to the therapy. The clinician brings such a self-understanding as well but also brings a collective psychoanalytic and therapeutic self, shaped through immersion in the thinking of the community of clinicians known as psychoanalysts. Eventually, the two articulate—or, moving even further along the continuum from intrapsychic to intersubjective, we could say create—shared understandings of how the mind of the patient works unconsciously.

One might extrapolate from Stolorow that the fullest expansion of the patient’s subjectivity would be helped most by the therapist being aware of how his or her subjectivity might block the patient from completing this task. Therapeutic progress, whether it unfolds during an hour-long interview or a 10-year analysis, derives from the clinician increasingly getting out of the way, using less theory, and learning to help the patient co-narrate (Spezzano 1993) the patient’s story in his or her own way. If there are problems with the story, they will be exposed by this co-narrating. The process is less like a novice student of the Napoleonic Wars coming to see things more clearly by studying with a professor who (together with her or his colleagues) has been studying that series of events for years, and more like a novelist bringing a manuscript to a paid editor. They go over it again and again, sharing their different perspectives, asking different questions, agreeing that one way of telling the story makes most sense to both of them (or not) and repeating such processes over and over.

**Early Precursors of Intersubjectivity**

**Ferenczi**

Arguably, the first serious intersubjective analytic theorist was Sandor Ferenczi. He argued in the 1930s that patients often have had their egos’ self-reflective capacities severely diminished by the constant shocks delivered by parents and other early caretakers. The part of the ego that could make good decisions was split off and saved, but that leaves the child reliant on external egos. In other words, the decision-making ego is split off; then it is imagined to exist in some other mind, and then one subjectively experiences oneself as reliant on those minds. Ferenczi wrote in his clinical diary (published in 1995): “Without any change in the external situation or in the ego’s capacity for endurance, the return of the psychic situation can only result in disintegration and reconstruction” (Ferenczi et al. 1995, p. 182). Ferenczi, therefore, recommends “help through suggestion, when energy flags, shaking up, encouraging words” (p. 182).

This analytic attitude of “when you cannot break out of a psychic prison alone, we’ll have to do it together” was first articulated by Ferenczi. Ferenczi emphasized the affective state one person evokes in another and, applying this emphasis to the therapy situation, theorized that symptoms emerge and hide, in part, because of unconscious and inadvertent safe and unsafe contexts for those symptoms created by the analyst. The patient’s repressed and dissociated thoughts and feelings will continue to be expressed only in familiar symptoms and ways of relating until the analyst creates a possibility for them to appear in less disguised ways.

As Borgogno (2004) concluded: “This was to be the task that Ferenczi would set himself: identifying in the affective life of the patient and taking upon his own person, and upon his own body, the possible passage of suffering that produced the symptoms” (p. 7).
Sullivan

Another forerunner to the intersubjective attitude (i.e., the notion of no such thing as stand-alone one-person psychic phenomena) is found in the writings of Harry Stack Sullivan. As early as 1937, Sullivan foreshadowed the contemporary intersubjective notion that “the subjective experience of each party is inseparable from that of the other” (Natterson and Friedman 1995, p. 129): “Information can arise only from explicit or implicit attempts toward communication with other persons. One has information only to the extent that one has tended to communicate one’s states of being, one’s experience” (Sullivan 1937, p. 17). As Gerard Chrzanoski (1977) summed up Sullivan’s interpersonal psychoanalytic perspective: “Inherently human characteristics rest neither inside nor outside of the person. They are part of an ecologic unit that can never be divided” [p. 115]. This perspective led Sullivanian analysts to emphasize, intersubjectively, “What’s going on here between us?” as a key question in all therapy sessions, at least as much as they emphasize, intrapsychically, “What’s going on in the mind of the patient?”

Fairbairn

In the United Kingdom, W. Ronald Fairbairn’s work ran parallel to Sullivan’s in time (the 1930s and 1940s), but with more of an emphasis on showing how early interpersonal events lead to adult intrapsychic phantasies. Fairbairn had returned to Freud to ask why the affect of sexual excitement should be a source of universal anxiety and conflict. He argued that it was because to experience that affective state as pleasurable and to enjoy it unconflictedly, the child would need caretakers who showed excitement about the child’s excitement. Even good mothers of healthy infants will have moments of anxiety, distress, depression, or anger when their baby tries to engage them excitedly. If there are too many such moments, the infant will withdraw into a schizoid state. Then, turning to Klein’s emphasis on aggression as the source of anxiety, defense, and conflict, Fairbairn argued that if the child’s aggressive excitement is met with rejection, the child will end up depressed, because in order to form a secure engagement with the mother, the child has to give up part of his or her emotional self: his or her anger. This is a significant loss and is therefore accompanied by depression. As Fairbairn (1941) summarized the dilemma:

The great problem of the schizoid individual is how to love without destroying by love, whereas the great problem of the depressive individual is how to love without destroying by hate. These are two very different problems...it is the disposal of his hate, rather than the disposal of his love, that constitutes the great difficulty of the depressive individual. Formidable as this difficulty is, the depressive is at any rate spared the devastating experience of feeling that his love is bad. Since his love at any rate seems good, he remains inherently capable of a libidinal relationship with outer objects in a sense in which the schizoid is not. (p. 271)

Fairbairn (1952) took his understanding of the internal object relations of the depressive and schizoid personalities into the intersubjective realm at the developmental and clinical levels of psychoanalytic discourse. Developmentally, he thought that depressive and schizoid personalities result from actual excessive maternal rejection of, respectively, hate or love. He emphasized that the precursor to this intrapsychic maintenance operation is an actual interpersonal maneuver in which the child relates to the rejecting mother as though she were registering excessive hate or bad libidinal excitement from the child, and he suppresses his aggression and subdues his excitement. The actual affective self splits before the splitting is represented. So, at the clinical level of psychoanalytic discourse, the analysis of the schizoid personality has to include new experience of more recognition and acceptance of excitement about the analyst whenever that appears. Fairbairn saw (what he then believed to be all too frequent) interpretation of excitement about the analyst as damaging to the schizoid person’s residual capacity to come out of hiding and feel/show excitement about others again. In a more general intersubjective sense, he made the interesting observation that the psychoanalytic method is (as we now label it) a third thing that is needed and will be used by the first two things—patient and analyst:

In general, I cannot help feeling that any tendency to adhere with pronounced rigidity to the details of the classic psycho-analytical technique, as standardized by Freud more than half a century ago, is liable to defensive exploitation, however unconscious this may be, in the interests of the analyst and at the expense of the patient, and certainly any tendency to treat the classic technique as sacrosanct raises the suspicion that an element of such a defensive exploitation is at work. Further, it seems to me that a complete stultification of the therapeutic aim is involved in any demand, whether explicit or implicit, that the patient must conform to the nature of the therapeutic method rather than that the method must conform to the requirements of the patient. (Fairbairn 1958, pp. 378–379)
Winnicott

Donald Winnicott, too, focused on the maternal environment in which development occurred. He was especially interested in how well a mother/caregiver attended to what the infant showed interest-excitement toward and then facilitated the infant’s doing what it wanted to do with what it found in its environment—his view of early creativity. He argued that psychoanalytic technique should enhance the patient’s ability to recognize what he or she wanted to do and have in the world and with others and that the way to provide this help therapeutically was for the clinician to be used by the patient in ways the patient wanted. When these ways deviated from the psychoanalytic frame, Winnicott suggested methods that overlapped with those of Ferenczi (decades earlier): let the patient use you—that is, treat many (of course, not all) of the patient’s requests and demands to be dealt with and related to in specific ways (not what you, the clinician, might ordinarily do) as opportunities to bring alive the patient’s true self.

Klein and Bion

Positioning Melanie Klein’s theories as part of the evolution of an intersubjective view of human psychology and of psychoanalysis requires us to focus on her notion of projective identification (Klein 1946), which launched within Kleinian theorizing an attention to unconscious affective communication and therefore to intersubjectivity (although Klein herself did not move it from the intrapsychic to the intersubjective realm of experience). This thread or potential in Klein’s thinking was realized by Wilfred Bion. The baby, as viewed by Bion, is subject to sensations and affects. These are experienced, revealed, and communicated as fragments of mental experience that he called beta elements. The mother has to take these in and metabolize them, using her alpha function. If she does this successfully and communicates her mental state back to the infant, the infant has the beginning of something he or she can, in turn, metabolize and, as cognitive development allows, reflect upon.

Kohut

Just as Bion developed his own theory out of his previous immersion in Kleinian theory, Heinz Kohut broke off from American ego psychology in the 1970s by arguing for therapy to be an experience in which patients regained access to healthy excitement and assertiveness about which they had become ashamed. In addition, he argued, when patients reject the therapist’s interpretation, the first thought of the therapist should be that the interpretation had inadvertently rejected an aspect of the patient’s self that the patient was trying to have known and accepted. Thus, breakdowns in analysis are best understood, at first, not as due to transference distortions but as empathic failures which will happen in every analysis and should not be seen as something that wrecks a therapy but as an opportunity to focus on the patient’s history of experience of empathic failures, right up to and including the analyst. For example, in his paper on the two analyses of Mr. Z, Kohut (1979) argued that the patient needed to hear the analyst say it was understandable that Mr. Z became enraged when he felt his analyst did not relate to him in the way he believed he was due. If the analyst does not find the emergence of specific bad feelings in his or her patients to be understandable, then the clinical problem is not simply the disturbing quality of the affect but also that the analyst does not understand the perspective of the patient well enough.

Contemporary Versions of the Intersubjective Attitude

Greenberg and Mitchell

Seeing these developments—variously thought about as intersubjective, interpersonal, and object relational—happening across a variety of psychoanalytic theories, Jay Greenberg and Stephen Mitchell (1983) pulled together the ideas of many theorists to argue that there were two main trends in psychoanalytic theorizing. In one, following Freud, the building blocks of the unconscious mind are endogenously arising wishes derived from sexual and aggressive drives. In the other, the building blocks of the unconscious mind are representations of relational experiences. Mitchell (1988) went on to theorize that “[m]ind has been redefined from a set of predetermined structures emerging from inside an individual organism to transactional patterns and internal structures derived from an interactive, interpersonal field” [p. 17] and that life and psychoanalysis are best
understood as what I would call team activities [Mitchell 1993, 1997]. Mitchell’s intersubjective attitude emphasized the need of each patient for a customized relationship within which psychoanalytic interpretations have an optimal chance to become useful.

The Barangers and the Bastion

During the same year, 1983, that Greenberg and Mitchell’s book was published, in South America the attitude we are calling intersubjective was clearly articulated in the work of Madeleine and Willy Baranger and Jorge Mom [Baranger et al. 1983; see also Baranger 1993]. The Barangers’ theory of the bipersonal analytic field is a seminal contribution to intersubjective thinking. In this theory, the analyst and patient define each other—in other words, they give each other the roles they will play out in the analytic field. In this field, the two characters form a new psychic structure in which they, in turn, find themselves involved in a process that has a sort of life of its own, definitely dynamic and evolving, and having the potential for creativity [not just revealing and adjusting pathology]. For this dynamic and creative process to emerge in its most positive form, the analyst must deal with a form of impasse they called the bastion:

Each of us possesses, explicitly or not, a kind of personal countertransferential dictionary (bodily experiences, movement fantasies, appearance of certain images, etc.) which indicates the moments in which one abandons one’s attitude of “suspended attention” and proceeds to the second look, questioning oneself as to what is happening in the analytic situation. These countertransferential indicators which provide the second look lead us to realize that within the field exists an immobilized structure which is slowing down or paralyzing the process. We have named this structure the “bastion.” [Baranger et al. 1983, p. 2]

So in the Barangers’ view, we have not only the psychic structure of the patient and of the analyst but also a third psychic structure in the room. The bastion, running silent, only manifests itself indirectly. It surfaces through a jointly created enactment [a dramatic scene, if you will] played out by the two characters. In this drama, the patient and analyst play some other roles than patient and analyst [e.g., father and daughter, angry lovers], but in secret. Recognizing the bastion as an intersubjective creation and interpreting its existence and its impact on the analytic process are critical.

Ogden’s Analytic Third

Although the Barangers had suggested the notion of an intersubjective analytic “third” in the 1980s, it was Thomas Ogden [1994, 2004] who labeled it and conceptualized it as a normal part of analytic work. In Ogden’s (1994) scheme, “[T]he analyst attempts to recognise, understand and verbally symbolise for himself and the analysand the specific nature of the moment-to-moment interplay of the analyst’s subjective experience, the subjective experience of the analysand and the intersubjectively generated experience of the analytic pair (the experience of the analytic third)” [p. 3]. What emerges into consciousness in the mind of the analyst during a session does not derive solely from the analyst’s empathic reception of the patient’s associations and the analyst’s countertransference but also from “the analyst as a creation of the analytic intersubjectivity” [p. 8]. The analyst has to treat that “motley collection of psychological states that seem to reflect the analyst’s narcissistic self-absorption, obsessional rumination, day-dreaming, sexual fantasising, and so on” [p. 9] as also containing potential evidence about the unconscious psychology of the patient.

In other words, when we are interacting with another person, we cannot directly receive communications from the unconscious of the other, nor can our unconscious put anything directly into our consciousness. Everything is mediated by a third unconscious subject that, during analysis, produces associations in the mind of the analyst in which are hidden clues about both the workings of the unconscious of the patient and the workings of the unconscious of the analyst.

Benjamin’s Intersubjectivity

Ogden’s ideas, as is true of all the ideas covered in this chapter, are attempts to conceptualize the ways in which when minds interact, the result is not simply the sum of its parts. Yet those parts—the two subjects interacting—also continue to draw our attention, as clinicians and theorists, as well as the attention of the interacting subjects. Jessica Benjamin (1990) wanted to balance “the complementarity of intrapsychic and intersubjective aspects of self-development” [p. 33] by highlighting the critical importance to development and psychoanalysis of mutual recognition by the subjects involved in any interaction. She wrote: “The development of the capacity for mutual recognition can be conceived as a separate trajectory from the internation-
alization of object relations. The subject gradually becomes able to recognize the other person’s subjectivity, developing the capacity for attunement and tolerance of difference” (p. 33).

The analyst and the patient will not end any analysis having a shared understanding of everything they found to be important. An equally therapeutic outcome, we might conclude, following Benjamin, is being at peace with the enduring differences about what aspects of the self of the patient and the self of the analyst have been revealed during the analysis, as well as living with the enduring differences in their stories about what happened (and what did not happen) in the analysis—especially moments when there was a breakdown in their relationship that might lend itself to ping-ponging blame but that, after a good analysis, will be seen as similar to a bunted play in a sporting event: we tried to do X, but it did not work so well at certain moments. Otto Kernberg, for example, once said to an angry patient: “Do you think that you can tolerate our working together while each of us acknowledges to the other that our views are completely different?” (Kernberg 1982, p. 521). That question is being asked in all therapies and all relationships, according to the intersubjective perspective.

Natterson’s and Friedman’s Clinical Intersubjectivity

Similarly, Raymond Friedman and Joseph Natterson (1999) reminded us that analytic events, like all human events, are ambiguous and complex. Analysts need to be aware that the “recognition of co-responsibility is the enabling event for understanding and for constructive outcome” (Friedman and Natterson 1999). All therapies have moments where patients become concerned and/or angry about how some session, period of therapy, or entire therapy did not go as well as hoped or expected. This has always been as troublesome an aspect of clinical work as a patient finding analysis and/or the analyst to be libidinally exciting. An intersubjective attitude suggests that the initial approach to this is not so much “Where are these ideas and feelings coming from in the mind of the patient?” as “How has our working together led to these [sexually excited or angry] thoughts and feelings?” If a clinician is interviewing a patient in an initial meeting [whether in an emergency department or an office] and the patient becomes annoyed and claims the therapist is not “getting it,” then the intersubjective attitude suggests that the failure to communicate is due to a mixture of how the patient is explaining the situation and how the clinician is translating and talking about it. With that attitude, the clinician would start with something like “Do you think you’re having trouble expressing what’s going on inside, or am I putting my own spin on what you’re saying in the process changing it too much? Or perhaps both?” Or he or she might say: “I’m having trouble understanding what you’re trying to tell me, or if I am getting it, then my way of putting it back to you doesn’t convey that I understand. That’s adding frustration with me to the bad feelings you came in with.”

In that scenario, the patient might be viewed as trying to use the analyst as an object, and the analyst is acknowledging that he or she has not been as pliable as the patient wants or needs. When one of us tries to use another in this way [wanting the other to be completely pliable to our imagined casting of them into a role], we are actually making the other less useful overall. The therapist knows that the patient is ultimately making him or her less useful by confining him or her to a limited role [even if at moments we might agree to be temporarily pliable in response].

Most of us know the experience of wanting another person to relate to us in some particular way, but wanting them to do so spontaneously. Winnicott (1969) wrote a paper about this in which the baby is, in the end, happy not to have destroyed the mother’s spontaneous subjectivity by its demands. The maternal object turns out to be a maternal subject as well—even better. However, we must develop to the point where we genuinely experience “even better” at the realization of the other as subject. Intersubjectivity, as a clinical theory, tries to explain how we can help patients learn to use the analyst-object’s subjectivity, or perhaps more accurately, learn how to tolerate and even take pleasure in being part of a team of subjects co-creating psychological events that are partially gratifying [libidinally, aggressively, narcissistically] for all.

Fonagy’s and Target’s Mentalization

Patients enter therapy with varying degrees of ability to be such a psychological team player. As infants develop, they experience bodily sensations and the rudiments of emotions. They are stepping out onto the dance floor of life. Others help them get into a good rhythm, back away from them, bump into them, and step on their psychic toes. If the world of others already on the dance floor
ahead of them provides adequate help, infants end up regulating and expressing their affects in ways that facilitate good dancing. If not, they might become confused by their feelings, might name them differently than most of us do, might too quickly conclude that any bad interpersonal event [the kind that leads us to sometimes say sarcastically “that went well”] is conclusive evidence of a bad self or a bad other, or might find it difficult to regulate their affective states.

Peter Fonagy and Mary Target [2007, p. 917] argued that 1) “the external world is not an independently existing given, for the infant to discover, as is sometimes implicitly assumed. Infants acquire knowledge about the world not just through their own explorations of it but by using other minds as teachers”; 2) “the experience of external reality is invariably shaped through subjectivities”; and 3) “at first the infant assumes that his knowledge is knowledge held by all, that what he knows is known by others and that what is known by others is accessible to him. Only slowly does the uniqueness of his own perspective differentiate so that a sense of mental self can develop.” There is a fundamental human paradox here. What anyone does when interacting with you is a crucial element in creating your reality. So when patients ask with frustration, “What are you doing? I don’t want to talk about that. I want to be immersed in this thought or feeling,” they [and I] are encountering the paradox of needing the cooperation of another person to maximize the subjectivity of themselves while being forced to recognize that the other person is at least partially engaged in the process of elaborating their own subjectivity.

Fonagy and his colleagues have termed this capacity—in which each of two people in the dyad remains aware that the other is representing the unfolding experience in his or her own unique way—mentallization. They [Fonagy and Target 1996, 2002, Target and Fonagy 1996] have been arguing that this capacity develops more in some people than others. Their introduction of this concept into the psychoanalytic literature was not the result of armchair theorizing. It grew out of their work with traumatized people who seemed to have significant difficulty intuiting others’ thoughts and feelings, equated their internal states with external reality [e.g., if I feel really bad, then a really bad person must have just done a really bad thing], and related to others as though what they did was like a child in pretend play and thus would have no real impact on the other. Actions counted, but mental states or words seemed to be treated as something they could discount, devalue, or make irrelevant if the analyst tried to interpret.

Mentalization is another inherently intersubjective concept. It emphasizes not only that human interactions depend on the rapid negotiation of dueling representations but also that the ability to detect and negotiate these different representations is a developmental achievement that results from practicing with adults who are themselves competent at it. It is not simply a matter of developing a capacity and then practicing it with others. It is something one can only do with others from the start.

**Hoffman’s Dialectical Constructivism**

This perspective has been developed in a unique way in the theory of dialectical constructivism created by Irwin Hoffman. For Hoffman, the experience of the patient is always contextual, including the context created by the spontaneous participation of the therapist. This participation is personal—that is, it is inevitably infused by and reveals the unconscious personality of the therapist and the therapist’s emotional involvement, which will show itself unless deliberately restrained [which Hoffman does not recommend] because “the analytic situation lends itself to a high probability that our experience within our analytic role will include intense, responsive, passionate feelings, if we open ourselves to them as we hear the details of patients’ suffering, their historical origins, and the often impressive, even heroic strivings of the patient, despite the obstacles, to survive, to live, and even to grow” [Hoffman 2009, p. 635]. Because the unconscious sources of this participation by the therapist are not self-evident, both the therapist and the patient are free to look at them as one might examine a card on a projective psychological test such as the Thematic Apperception Test. The behavior of the analyst and the internal experience underlying it are inherently ambiguous. Everything that the analyst does and says—and also a moment when the analyst does nothing or says nothing, but might have—is open to interpretation by the patient. As Hoffman [1983] argued, this makes the patient a legitimate and necessary interpreter of the analyst’s experience. The patient’s interpretations of the analyst’s experience are—as Hoffman’s mentor, Morton Gill [1983], put it—always to be treated as plausible. Its plausibility is the analyst’s starting point in taking it up with the patient. He does not mean to “assume the patient’s interpretation of the analyst is the truth, the whole truth, and nothing but the truth.” Rather, he means to “start out by treating it as plausible” and go from there.
In one of Hoffman’s [1994] case reports, a patient opened the hour by confronting him with the demand that he do something concrete and immediate to help her feel less anxious or she would quit therapy. She wanted Valium but didn’t want the hassle of a psychiatric evaluation. Hoffman also believed going that route to get the Valium would be a burden for her. She had to go to work and school that day, and her functioning would be impaired by her intense anxiety. She confronted him with the question of whether he cared more about following good analytic form or helping her. He tried to get her to reflect on the pros and cons of his responding to her demand. Believing that the analyst is always co-constructing the patient’s experience and that struggling out loud with such a dilemma rather than taking the position that analysts do not do such things, he asked her if she had an internist he might call. She gave him a name and number, as though that satisfied her, but while he was on the phone, right there during the session, she began to whisper to herself that what was happening was crazy because she could obviously have done this herself. The internist readily agreed to prescribe a tranquilizer.

Hoffman theorized that a projective identification was operative, but he hypothesized [in a two-person constructivist model] that it was his own. By refusing categorically, he would have been projecting his static version of an analyst-patient self-object representation. According to her demand, he argued, shook them loose from a projection he would have been initiating. He called her bluff and also challenged the force of his own internalized patient-analyst representation. The patient, in turn, was freed from her tendency to submit to the requirement that she do it the authority figure’s way. As a result, and more important, she could freely—not forced by the analyst’s interpretation—show an interest in the pros and cons of an interaction-enactment that she had initiated.

In addition, however, Hoffman was also unusually clear, among intersubjective theorists, in stating that the patient remains a distinct individual with an uniquely structured unconscious through which he or she experiences and responds to the analyst. Adding an existential note, Hoffman put this in terms of responsibility. In response to a mistake made by the therapist, one patient will quit treatment, whereas another will confront the therapist. If he had refused to call the internist and the patient had quit therapy, then that would have been her responsibility. Hoffman chose to view such actions not simply as inevitable expressions of each patient’s unconscious psychology but also as a matter of choice and free will.

Dissociation

The intersubjective attitude often removes repression as the quintessential defense and replaces it with dissociation, a defense that, in turn, is usually viewed as having arisen because of a developmental breakdown or trauma in the patient’s interpersonal world rather than mainly through intrapsychic conflict. Some experiences cannot be assimilated into the world as it is represented in the mind of the individual. This creates a different problem for the mind than those that repression attempts to solve. How will I express my aggression? What will I do with my sexual excitement? If ideas about acting out one’s sexuality or aggression catalyze [defendable! manageable!] anxiety, then the idea can be repressed and the feeling can be preserved. So we say, “That wasn’t my wish” or “I only meant” or “The frustration I was really angry about is,” and we substitute another idea for the original wish, meaning, or frustration. When, however, an experience would force a complete destruction of the interpersonal world as one has represented it unconsciously, then the accompanying anxiety is catastrophic, and that world can be preserved only by dissociating, or splitting off, the experience [usually also a whole category of experience].

Arguably, the most comprehensive contemporary theory of trauma and dissociation has been created by Philip Bromberg [1991, 1998]. In his formulation, each person’s individual unconscious psychology develops and is organized by both conflict and trauma. Psychological trauma, even in a mild form (if any trauma can be called mild), always precipitously disrupts self-continuity by invalidating patterns of interaction that give meaning to life and tell each of us who we are. Trauma has a “this can’t be happening to me” quality, so to preserve the “me” I have known myself as, I will split it off from the “me” to whom this is happening. The main reason why the experience cannot be reflected on and integrated into a new whole self is that the affects evoked by the experience are too intense. They disrupt the cognitive functioning that such self-reflection requires. Bromberg summed up this perspective in 1991: “Simply put, the patient is seen not as someone in need of ‘insight’ that will correct faulty reality but as someone in need of a relationship with another person through which words can be found for that which has no verbal language. As the patient finds words with which to represent his experience, he ‘knows’ himself” (Bromberg 1991, p. 419).
The traumatized patient who uses dissociation as a major defense will predictably find anything unexpected happening as severely disruptive. Events ranging from a missed appointment to an off-the-mark affective reaction in the therapist can trigger confusion, anger, an anxious need to get away from the therapist, and security-restoring thoughts about being free to leave the therapy. The last of these is an attempt by the patient to create an antidote to the inherent quality of trauma, emphasized by Bromberg as something from which there is no escape (e.g., “I couldn’t leave my abusive or rejecting mother, but I can leave you”).

Arguably, however, the core of traumatic experience—and the aspect of trauma that most strongly calls for an intersubjective focus on the part of the analyst—is an experience (or an accumulation of experiences) that remains beyond words in the mind. Therefore, a more complete account of trauma, dissociation, and intersubjectivity can be created by combining the work of Bromberg with that of Donnel Stern. Although we long emphasized the unconscious as a repository of repressed ideas, in 1915 Freud wrote: “The conscious presentation comprises the presentation of the thing plus the presentation of the word belonging to it, while the unconscious presentation is the presentation of the thing alone” (p. 201). The “thing” is not so much an idea as much as it is what Stern (1983, 1987, 1989) called “unformulated experience.” Both Freud and Stern leave an appropriate element of uncertainty about exactly what internal unconscious experience is before it is formulated verbally in consciousness.

This notion, although true to some extent for all patients, is especially true for patients reintegrating traumatologically dissociated parts (perhaps, more accurately, versions) of themselves.

When a patient is finally able to think about a previously unaccepted part of life, seldom are fully formulated thoughts simply waiting to be discovered, ready for exposition. Instead, what is usually experienced is a kind of confusion—a confusion with newly appreciable possibilities, and perhaps an intriguing confusion, but a confusion or a puzzle nevertheless. Unconscious clarity rarely underlies defense. (Stern 1983, p. 71)

The technical implication is that patient and therapist will together create the story of this lost self. For example, the therapist will see what he or she believes as possibilities that the patient’s way of narrating life events does not make clear but allows the therapist to surmise. Thus the intersubjective-relational therapist might be less concerned that a suggestion will bypass a defense than that lack of a suggestion will leave a lost version of the self out of the story. Such a therapist might say: “You haven’t said this, but the way you tell that story led me to think that such and such could have been said, and it would have fit in perfectly.”

Stern (1983, 1987, 1989) extensively developed this perspective through his writings on unformulated experience. Whatever any patient knows about herself or himself at any moment is not a static set of conscious, preconscious, and unconscious ideas but rather an internalized version of what the patient and the therapist have put into words together. That version cannot be simply a representation of a transcendent, fixed, and immutable truth about who the patient really is, but is a jointly created revision of the story about himself or herself with which the patient entered therapy.

**Conclusion**

Psychoanalysis has not, for better or worse, ended up with a single, universally embraced model of development, mind, and treatment, nor are its various schools mutually exclusive. None of the intersubjective authors talk to patients all the time as though those patients had no mind in which feeling and thinking were happening. They all do add some measure of “we” where “you” and “I” once prevailed hegemonically. In addition, they increasingly recognize that psychoanalysis tries to use what analysts know about affect (an immediate assessment of the state of the self in its interpersonal world; Spezzano 1993) and relationship (a constant conflict between the affective state of the self and that of all others in the subjectively experienced interpersonal world) to help lessen patients’ suffering and increase their well-being.
KEY POINTS

- In the intersubjective model, the patient and analyst are both subjects.

- Although the roots of intersubjectivity can be traced to the work of Ferenczi, Sullivan, Fairbain, Winnicott, Klein and Bion, and Kohut, its current life within psychoanalysis was launched by Stolorow, Atwood, and Ross between 1978 and 1988.

- According to Greenberg and Mitchell, there are two main trends in psychoanalytic theorizing: one in which the building blocks of the unconscious mind are endogenously arising wishes derived from sexual and aggressive drives; and the other in which the building blocks are representations of relational experiences.

- Mitchell’s intersubjective attitude emphasized the need of each patient for a customized relationship within which psychoanalytic interpretations have an optimal chance to become useful.

- In the Barangers’ theory of the bipersonal analytic field, the analyst and patient define each other, and the two characters form a new psychic structure.

- Thomas Ogden conceptualized the intersubjective analytic “third” as a normal part of analytic work.

- Jessica Benjamin highlighted the critical importance to development and psychoanalysis of mutual recognition by the subjects involved in any interaction.

- Raymond Friedman and Joseph Natterson reminded us that analytic events are ambiguous and complex, and recognition of co-responsibility enables understanding and helps bring about a constructive outcome.

- Mentalization, as conceptualized by Fonagy and colleagues, is the capacity to remain aware that each of us is representing the unfolding experience in his or her own unique way.

- According to Irwin Hoffman, the experience of the patient is always contextual, including the context created by the spontaneous participation of the therapist.

- The intersubjective attitude often removes repression as the quintessential defense and replaces it with dissociation.

- Arguably, the most comprehensive contemporary theory of trauma and dissociation has been created by Philip Bromberg.

- Stern emphasized that patients come to us with unformulated experiences, about which the patient and the analyst create a story. That story cannot be simply a representation of a transcendent, fixed, and immutable truth about who the patient really is, but is a jointly created revision of the story about himself or herself with which the patient entered therapy.
References

Fairbairn WR: Psychoanalytic Studies of the Personality. London, Tavistock, 1952
Gill MM: The interpersonal paradigm and the degree of the therapist’s involvement. Contemp Psychoanal 19:200–237, 1983
Kohut H: The two analyses of Mr. Z. Int J Psychoanal 60:3–27, 1979
Sullivan HS: A note on the implications of psychiatry, the study of interpersonal relations, for investigations in the social sciences [1937], in The Fusion of Psychiatry and Social Science. New York, WW Norton, 1964, pp 15–29
Childhood Experiences and the Adult World

Karen Gilmore, M.D.

In a psychoanalytic landscape of unprecedented diversity, there is a handful of fundamental principles that distinguish psychoanalytic theory from all other approaches to the human mind. Even this handful has undergone modification over the history of psychoanalytic thinking and may be differently weighted or configured depending on theoretical school. Contemporary psychoanalytic thinkers agree on the significance of most of the following ideas: the unconscious, the therapeutic power of transference/countertransference, the importance of subjectively experienced meaning, and the role of the past in determining the present. The last-mentioned one is the primary focus of this chapter.

The etiological importance of childhood experience in adult personality and psychopathology is one of Freud’s original insights and is arguably among the most enduring legacies of psychoanalytic thought. It is the foundation for the psychoanalytic orientation to the patient’s whole life history as distinct from other approaches to presenting complaints in medicine [Novey 1968]. Despite a diversity of views, most psychoanalysts consider the present illness from the vantage point of the entire biographical narrative, with special [but by no means exclusive] emphasis on the first two decades of life. The present is typically understood in the context of the past, whether it be the past of drives, infantile fantasy, mother-infant relationship, family relational patterns, or narcissistic mirroring.

Freud’s original metapsychology, which he began to articulate as early as 1898, was a set of abstract principles intended to provide “those minimal fundamental and distinctive points of view and assumptions necessary for a systematic psychoanalytic psychology” [Abrams 1977]. Some of these viewpoints, including dynamic, economic, structural, genetic, and adaptive perspectives, have diminished in importance and are rarely invoked in psychoanalytic discussions; most analysts have abandoned economic postulates, and some contemporary analysts feel that metapsychology should be entirely discarded in favor of clinical theory. However, genetic propositions, which in psychoanalytic terminology refer to the “psychological origin and development” [Rapaport and Gill 1959, p. 804] of menial life,
have remained part of most analysts’ theorizing. Closely linked to developmental postulates about universal hierarchically ordered transformations (e.g., psychosexual stages or cognitive organization in different developmental epochs) [Abrams 1977, Bader 1998, Strenger 1991], genetic hypotheses inevitably vary according to those implicit or explicit developmental theories of different schools, because each privileges certain innate given and expected progressions in individual development over others. Among analysts whose theories predate the postmodern era, such as Freudians, ego psychologists, Kleinians, contemporary Kleinians, and self psychologists, there has been a long-standing consensus about the central idea of the genetic viewpoint—that is, that these developmental transformations remain potentially active in the adult personality and can be elucidated through psychoanalytic techniques with therapeutic benefit. All of these analytic schools rest firmly on sets of universal developmental paradigms that guide their specific genetic hypotheses about a given patient. In fact, it is only in the postmodern era (with the rise of hermeneutics and intersubjective theory) that disagreement has arisen about the idea of expectable developmental transformations that can, more or less, be observed in every life story.

Postmodern thinkers suggest that the genetic approach is unnecessary or even fallacious, because the search for origins reduces the complexity and function of adult mental phenomena to infantile origins and motivations (the genetic fallacy), fails to account for the multiple idiosyncratic versions of developmental transformation, and lacks therapeutic power. These theorists favor the dynamic viewpoint, which focuses on illuminating current conflicts and their deleterious effects on mental functioning. However, dynamics and genetics are inextricably entwined, and both contribute to the depth of clinical understanding. Patients themselves seek genetic explanations for their dynamics not only to bolster their defenses or justify their behavior but also to seek coherence in their self-understanding and a sense of continuity in their lives (Gilmore 2008). These, in turn, facilitate better self-regulation, a greater capacity to mentalize (think about their own minds and the minds of others), and enhanced autonomy in future life choices. So, for patients and psychotherapists alike, the recognition of patterns, such as recurrent self-defeating choices or the consistent trigger for panic attacks, inevitably creates links to the past that in turn help to free patients from old and problematic solutions.

Nonetheless, there is considerable disagreement about what aspects of childhood experiences are significant and how they achieve their effects. Childhood trauma, such as physical or sexual abuse, neglect, or abandonment, is consistently recognized as formative, but the means by which such experiences work their effects is a subject of debate. Analysts informed by different conceptualizations of how the mind develops have different ideas about how the events of childhood shape and distort the adult personality. For example, the psychoanalyst who maintains the overarching importance of the repressed oedipal constellation in adult psychopathology will, at least in part, conceptualize the troubles of a patient differently than a psychoanalyst who focuses on narcissistic balance, attachment style and self-reflective capacity, or early infantile phantasy. All of these psychoanalysts will differ, in principle if not in the clinical moment, with postmodern analysts who maintain the preeminence of the “here and now” relationship as it takes shape in the consulting room without explicit reference to developmental experience [Docters 2008].

Most analysts who privilege early experiences have been open to findings from related disciplines, ranging from developmental and cognitive psychology to philosophy, with resulting modifications of developmental principles. Psychoanalytic thinking has always been affected by the culture at large, and today’s theory interfaces with a very different world than Vienna at the beginning of the twentieth century. Some founding principles have been challenged by present-day thinkers, ranging from feminists to empirical researchers. For example, the “assumption of an identity of a continuum of development and a continuum of pathology” [Westen 1990, p. 663] is implicit in the very common theories of developmental chronology of anxieties and defenses. These theories equate “primitive” mental operations and serious mental disturbance in the adult with the infantile mind, localizing the psychology of disorders such as borderline personality and psychosis in the mental life of the pre-oedipal child. This way of thinking is inconsistent with developmental observations and should not be equated with the importance of development in adult psychopathology. Furthermore, diagnostic entities such as psychosomatic illnesses, psychosis, homosexuality, and learning disabilities, formerly considered to have a psychological etiology, have yielded to contemporary understanding of the role of genetics, biology, endowment, and culture. This has revolutionized what is considered a “disorder” and how to think about mechanisms of causation.

However, these shifting paradigms do not necessarily affect psychoanalytic inquiry or, for that matter, the interest in tracing the vicissitudes of a given aspect of
the mind through the course of an individual’s life. For example, most psychoanalysts (especially North American analysts) no longer assume an exclusively psychological etiology for homosexuality (Auchincloss and Vaughan 2001); they assume a genetic or biological contribution and recognize healthy homosexual development. Sexuality in general is conceptualized as a complex and highly individualized aspect of mental life affected by development, family experience, peer group, and so on. The complexity of an ultimate etiology in no way diminishes the psychoanalytic interest in examining the psychological vicissitudes of evolving sexuality throughout an individual’s childhood and adolescence. The significance of personal history in explaining not why, but how (Gilmore 2008) a given patient came to be the adult person in the consulting room, with his or her specific character and psychopathology, has been, until very recently, a universal theme across the range of schools (Govrin 2006).

Contemporary knowledge has also affected the psychoanalytic search for origins in a process sense. Because we recognize that the notion of strictly linear progression through neatly defined phases is inconsistent with developmental evidence, both empirical and observational, the backward search for origins with its implicit guiding principle of psychic determinism has become a far more complex process, with inevitable—and to some, unfortunate—loss of certainty (Govrin 2006). Analysts today tend to eschew prescriptive etiological pronouncements about psychic phenomena and to incorporate complexity in their formulations. Although the classical notion that “the child is the father of the man” (Freud 1938) endures, the patronage is conceptualized in a nonlinear way that includes discontinuities and the pressure of multiple systems.

Early Psychoanalytic Theory

The emphasis on the past has its own conflictual history in psychoanalytic thinking, because the role of childhood experience was quickly embroiled in controversy about the importance of actual trauma versus infantile unconscious fantasy. Freud’s focus on childhood as the source of adult psychopathology developed early in his clinical career, and his theory continued to look to the events of childhood, both internal and environmental, as the primary etiological agents in producing neurosis. However, shifts in emphasis from external events, such as sexual seduction, abuse, and other environmental impingements, to internal experience, such as instinctual drives and fantasy, ebbed and flowed over the history of his thought. In the end, Freud’s views remained remarkably balanced, as represented in the following passage written in 1938:

It seems that neuroses are acquired only in early childhood (up to the age of six), even though their symptoms may not make their appearance till much later…. In every case the later neurotic illness links up with the prelude in childhood…. There is no difficulty in accounting for this aetiological preference for the first period of childhood. The neuroses are, as we know, disorders of the ego; and it is not to be wondered at if the ego, so long as it is feeble, immature and incapable of resistance, fails to deal with tasks which it could cope with later on with the utmost ease. In these circumstances instinctual demands from within, no less than excitations from the external world, operate as “traumas,” particularly if they are met halfway by certain innate dispositions. The helpless ego lends them off by means of attempts at flight [repressions], which later turn out to be inefficient and which involve permanent restrictions on further development…. No human individual is spared such traumatic experiences; none escapes the repressions to which they give rise. These questionable reactions on the part of the ego may perhaps be indispensable for the attainment of another aim which is set for the same period of life: in the space of a few years the little primitive creature must turn into a civilized human being…. This is made possible by hereditary disposition; but it can almost never be achieved without the additional help of upbringing, of parental influence, which, as a precursor of the super-ego, restricts the ego’s activity by prohibitions and punishments, and encourages or compels the setting-up of repressions. We must therefore not forget to include the influence of civilization among the determinants of neurosis…. And since the demands of civilization are represented by family upbringing, we must bear in mind the part played by this biological characteristic of the human species—the prolonged period of its childhood dependence—in the aetiology of the neuroses. (Freud 1938, p. 184)

Here he sketches a complex theory of pathogenesis in the first 6 years of life, including both internal and external “excitations,” a “feeble ego” due to developmental immaturity, “innate” predisposition to illness, and the requirements of civilization that demand socialization within a relatively short period of time. All of these influences establish their presence as pathogenic agents in childhood and can be triggered to produce symptoms in adulthood. This comprehensive theory
of pathogenesis, written late in Freud’s career, references all the contributions to illness we still consider today.

**Seduction Theory**

The road to this final integration has been subject to considerable debate within psychoanalytic circles, although not primarily in regard to the question of childhood etiology [Blum 2008; Lothane 2001; Masson 1984]. The focus of controversy, which has waxed and waned over the history of psychoanalysis, has been the etiological role of environmental insults. Freud’s first theoretical formulation, known as the seduction theory, attributed neuroses to childhood sexual trauma. *Studies on Hysteria*, considered by many to be “the starting point of psychoanalysis” [Breuer and Freud 1893–1895, p. xvi], reflected Freud’s growing conviction that sexuality was the crucial factor in most nervous disorders. Hysteria and obsessive neuroses were the result of prior sexual trauma; neurotic patients, under the influence of hypnagogic suggestion or simply allowed to speak freely, ultimately linked the innocuous event that precipitated their symptomatology to a childhood experience of a sexual nature.

The revolutionary idea was that a childhood event, dormant for many years, could unleash its pathogenic effect in the adult. The patient’s manifest symptom in adulthood was a “mnemic symbol” of that forgotten experience [Freud 1896]. Associative links eventually led to the recovery of memory, with abreaction, catharsis, and relief of symptoms. In this very early conceptualization of the mind, childhood experience [or its memory] was the pathogenic factor: “hysterical symptoms can only arise with the co-operation of memories” [Freud 1896]. Cure depended on uncovering the repressed event.

The seduction theory was Freud’s equivalent of germ theory [Makari 2008] and his solution to the puzzle of mental illness. Differences in the timing of the seduction affected the form of the neurosis: seduction before 4 years of age created hysteria; from 4 to 8 years, it led to obsessional neurosis; and paranoia ensued if the event occurred between 8 and 14 years. However, Freud quickly regretted what he saw as too literal an interpretation of memorial material. He began to focus on the power of infantile sexuality and wishful fantasy, opening the door to the unconscious mind.

Although there is no doubt that Freud’s exploration of the unconscious revolutionized our view of mental functioning, it has also been interpreted as a wholesale repudiation of the importance of real experiences [Masson 1984]. Throughout the subsequent history of psychoanalysis, the tension between those who attribute psychopathology to the impact of the child’s environment and those who emphasize the role of drive, fantasy, and internal conflict has polarized psychoanalysis. It has recurred in a series of incarnations, marginalizing, at least temporarily, some highly influential thinkers who were felt to privilege environmental impingements, such as Sullivan [interpersonal psychiatry], Kohut [self psychology], Mahler [separation-individuation theory] and Bowlby [attachment theory]. However, a careful reading of Freud’s thinking shows that although he did back away from the view that all neuroses are caused by sexual trauma in childhood, he continued to acknowledge the impact of seduction and other environmental insults and deficiencies as etiological factors [Lothane 2001; Morss 1993].

Freud’s clinical experience with adults led him to the conclusion that all children have sexual feelings and desires and that these inevitably succumb to repression; soon thereafter he proposed the progression of erotogenic zones known as *psychosexual development*. In this new formulation, the inner life of the child—thoughts, fantasies, and impulses—is as vulnerable to repression as traumatic experience. Children have sexual and aggressive drives and fantasies that create conflict and lead to repression; because of repression, adults universally experience childhood amnesia and cannot access the pathogenic conflicts without treatment.

**Early Conceptualizations of Memory**

Repression sets the stage for an eruption of symptoms in adulthood, but Freud quickly realized that there is no simple retrieval of an intact record of events. By 1899, his understanding of memory achieved a level of sophistication that foreshadowed contemporary understanding:

> It may indeed be questioned whether we have any memories at all from our childhood: memories relating to our childhood may be all that we possess. Our childhood memories show us our earliest years not as they were but as they appeared at the later periods when the memories were aroused. In these periods of arousal, the childhood memories did not, as people are accustomed to say, emerge, they were formed at that time, and a number of motives, with no concern for historical accuracy, had a part in forming them as...
in the selection of the memories themselves. (Freud 1899, p. 322)

In the seduction theory, early sexual trauma was considered pathogenic, not at the time of its occurrence but only through the “deferred action” of memory traces on the sexually mature psyche (Freud 1898). Moreover, remembering never reproduces actual lived events: the events and feelings of the past are inevitably “depicted from the understanding of the present instead of being kept and simply discovered in memory” (Eickhoff 2006, p. 1456). Freud’s original term, Nachträglichkeit (variously translated as après-coup, retroactivity, “afterwardness,” retroactive temporality, and retrospective attribution [Fainberg 2005]), remains of considerable theoretical interest, especially in Europe, and is central to the question of how the past affects the present. It asserts the presence of a bidirectional process: the present lives on in the present, and the present not only predicts but shapes and reconstructs the past (Hartmann and Kris 1945; Tuch 1999).

Two additional discoveries provided access to patients’ memories. Through self-analysis, Freud realized that dreams were a potent source of childhood memories because of their shared proximity to primary process thinking and to pictorial imagery (Greenberg 1970). Once untangled, dream material offered convincing affirmation of interpretive work that contained speculations about the patient’s past and often evoked heretofore unremembered details of experience. Freud’s (1905a) simultaneous discovery of transference was the second momentous contribution. Defined as “new editions or facsimiles of the impulses and phantasies” belonging to the past that are now directed toward the analyst, the transference brought childhood experience directly into the consulting room. The patient was recreating his or her history in the relationship with the analyst. There was no need to search for specific repressed memories; the past lived on in the present, and the present colored the representation of the past.

Early Theories of Developmental Progression and Characterology

Freud’s elucidation of psychosexual stages became the framework for the early psychoanalytic studies of “choice” of adult disorder, whether perversion, neurosis, or character type [Shapiro 1981]. Symptomatic disorders were the first focus of attention. In Three Essays on the Theory of Sexuality, Freud (1905b) suggested a theory of adult neurosis and perversion in which the childhood progression through erotogenic zones (oral, anal, phallic) and their component instincts created the possibility of “fixation” due to “adhesiveness of libido” in concert with environmental frustration or over gratification, forming the nidus for future illness. When developmental progress through the oedipal phase was impeded by unmanageable conflict, regression to old fixations served as the solution. If the oedipal impulses were repressed, then symptomatic neurosis was likely to ensue.

Freud’s contributions to the specific topic of character were anticipated in the Three Essays by the suggestion that the instincts and impulses that unfold in the psychosexual developmental sequence and defenses against them shape adult character. In contrast to the conflict-regression model of neurogenesis, character traits were understood to develop around fixation points and defenses against unusually strong pregenital impulses [Baudry 1983]. Anxiety was lacking because these impulses were incorporated seamlessly into deformations of personality. Freud (1913) contrasted character and neurosis as follows:

[A] sharp theoretical distinction between the two is necessitated by the single fact that the failure of repression and the return of the repressed—which are peculiar to the mechanism of neurosis—are absent in the formation of character. In the latter, repression either does not come into action or smoothly achieves its aim of replacing the repressed by reaction-formation and sublimations. Hence the processes of the formation of character are more obscure and less accessible to analysis than neurotic ones. (p. 323)

In the earliest foray into characterology, “Character and Anal Erotism” [Freud 1908], Freud drew direct links between the pleasures of the anal phase and the defenses against them, such as sublimation and reaction formation, to create the adult triad of traits of orderliness, parsimony, and obstinacy. This way of thinking about character, essentially as pregenital fixations or libidinal types, was taken up by Abraham, who examined each erogenous zone for its distinctive conflicts, qualities of drive, so-called component instincts, and type of object relations and developed an adult characterology based on these positions [Abraham 1923, 1925, 1926].

The elucidation of psychosexual stages and their lasting imprint on the adult has been an ongoing fea-
Role of the Superego

The superego takes its qualities from the child’s identifications with the parents or, more accurately, the child’s experience of them. The process of its formation is set in motion in order to manage the impulses and disappointments of the oedipal phase. Thus, the superego serves to regulate, judge, and punish as well as to guide, approve, and admire. Because it originates in identifications and is the arbiter of values and morals, the superego has a significant role in shaping character traits and typical ego attitudes. The superego imposes demands on the ego but also helps the ego negotiate the demands of the id and the external world. Furthermore it is assigned a synthesizing function that promotes its own integration into personality and facilitates the ego’s management of contradictory representations of self and objects. In ideal circumstances, the superego is seamlessly blended into the ego (Arlow 1982).

Ideas about superego development, its chronology, and its role in character and symptom formation differ according to theoretical frame. Kleinian theory places the origins of the superego in the first months of life, when it is split off from the ego to manage the power of infantile aggression. When first introduced by Melanie Klein, this early chronology was a significant departure from the Freudian position, although analysts from diverse schools have come to recognize the presence of superego precursors throughout the preoedipal period. In addition, many schools extend the natural history of superego maturation forward into young adulthood and acknowledge the influence of identification with individuals beyond the primary objects. Similarly, contemporary theorists recognize the importance of culture in shaping superego qualities, with reverberations in character. Late adolescent identifications are seen to have a decisive impact on the final shape of the superego because the superego undergoes significant remodeling throughout adolescence.

Because the superego is conceptualized as a late appearing structure, it is considered far less stable and resilient than the ego and is therefore subject to corruption or distortion by external circumstances, such as celebrity, political tyranny, excessive power, or group dynamics (Arlow 1982). Although there is a tendency to attribute this susceptibility to faults in superego development, most observers agree that even the most well-developed superego can be broken down under extreme circumstances.
“Chronology” in Theories of Anxiety and Defenses

With the structural theory, anxiety took on a new importance as a signal that mobilized the ego for defense. In Freud's original formulation, the series of childhood danger situations and their associated anxieties were roughly correlated with psychosexual development and constituted a developmental chronology of anxiety [Freud 1926]: anxiety about loss of the love object, loss of the love of the object, bodily damage, specifically damage to the genitals, and finally, with the internalization of the parental voice, anxiety about the approval of the superego. These anxieties persisted more or less in the adult, and the original defenses continued to operate despite the ego’s greater maturity and the fact that the dangers “no longer exist in reality” [Freud 1937].

Hierarchies of infantile anxieties differ according to the psychoanalytic school because the developmental schemas that distinguish the schools are organized differently. For example, although the Freudian psychosexual sequence was retained in Kleinian theory, the earlier appearance of oedipal conflict and formative mental representations of loved and hated [pair-] objects in the first year of life organize the infant’s mind. Primitive anxieties include fears of destructive impulses, annihilation, disintegration, and persecution.

In both Freudian and Kleinian theory, defense mechanisms were also assigned a developmental chronology and were seen as having a powerful impact on symptom formation and character [A. Freud 1936]. This way of thinking about defenses has been retained in many theoretical frames to this day: defenses are associated with psychosexual stages, their typical libidinal and aggressive urges, and/or they are placed on a continuum from primitive [earlier] to mature [oedipal and beyond]. The distinction is made in regard to defenses appearing before self and other are differentiated and before the capacity for repression; these are commonly designated pre-oedipal defenses. Defenses linked to the stage of development when stable mental representations are established and repression is possible (typically associated with the emergence of the superego and capacity for guilt and remorse) are commonly identified as oedipal/postoedipal. This kind of shorthand is evident across a broad spectrum of psychoanalytic theorizing, despite the differences in the timing and conceptualizations of early development. An individual’s use of one or another group of defenses is a diagnostic marker of “level” of psychopathology along the primitive-mature continuum. The idea that defenses not only signal the level of psychopathology but also point to the specific era when development went awry is a common premise of many schools of thought, even if there is disagreement on the position of specific defense mechanisms along the continuum [Willick 1983]. Thus Anna Freud’s primitive defenses were regression, reversal, denial of affect, and turning against the self, whereas Klein included denial of internal and external reality, splitting, projection, projective identification, idealization, and omnipotence. The view that repression, sublimation, isolation of affect, and reaction formation are mature defenses is widely shared.

Self psychologists, attachment theorists, some modern object-relations theorists, and interpersonal and relational theorists in the United States all offer different conceptualizations of anxiety and defenses. Despite their divergence, these thinkers share an emphasis on the role of relationships and the child’s actual experience of attuned, responsive, loving, and admiring parents. They highlight the importance of safety, parental provision of affect regulation, attunement, and affirmation; the experience of relationships is then represented in the mind and re-created. Defenses are not mechanisms of the ego but deformations of the self [Ornstein and Ornstein 1981] or dissociations within the self-system [Sullivan 1953] necessary to protect the child’s vulnerable ego from deficiencies or overstimulation in the environment and to facilitate the regulation of affect, rather than to manage internal conflicts. Defenses can thus arise in response to inadequate or unattuned mothering [Winnicott], bad introjects [Fairbairn], problematic constellations of self and object [Kernberg], failure of affect regulation by the caretaker [Bromberg 2001; Fonagy et al. 2002], shaming and criticism [Sullivan], or faulty selfobjects [Kohut]. The focus is on safety from actual failures or threats that arise in the infant’s object world and are then re-created in the transference [Cooper 1989]. For example, the need for safety and a secure attachment in relation to the parent is considered a biologically based motivator in attachment theory, on a par with or exceeding other biological drives.

Early attachment patterns create internal working models of relationships, similar to the more traditional psychoanalytic idea of mental representations that have enduring effects on subsequent relationships. Contemporary North American relationalists consider dissociation to be the primary defensive operation to avoid conflict: many eschew the notion of the unconscious in favor of multiple “not-me” self-states that are mutually dissociated from each other. Their conceptu-
Developmental Anxieties and Their Relation to Gender Identity and Gender Role Identity

Freud’s original series of anxieties culminated in the oedipal phase with castration anxiety and the establishment of the superego. The events of this period are momentous for the future personality because they leave a lasting imprint on the complex constellation of feelings associated with gender (gender identity, gender role identity, and sexual orientation) and because they result in structural change with the appearance of the superego. Both of these developments rely on processes of identification with the child’s primary love objects.

In regard to gender, early psychoanalytic theorizing asserted that until the oedipal crisis, boys and girls recognize only one genital, the penis, and are equally invested in phallic behavior (e.g., exhibitionism). It is only with the realization of the anatomical difference between the sexes that boys and girls become differentiated in terms of self-representation and gender-related traits. In Freud’s formulation, the phallic-oedipal child’s discovery of the female genital and the “fact” of castration deeply affects both boys and girls; for the girl, the effect reverberates throughout her personality, creating feelings of inferiority and deficiency and affecting superego formation (Freud 1933). The oedipal phase was therefore considered a watershed in the development of feminine traits and character (Freud 1925; Jones 1933).

Modern psychoanalytic theory has radically revised these ideas, which seem deeply influenced by the zeitgeist of the time. Although there continues to be speculation about male-female differences based on gender-specific early experience, input from the body, and the vicissitudes of early life (see Balsam 1996; Bernstein 1983), these are emphatically not embedded in a castration model. The impact of feminism on psychoanalytic thinking has led to a radical revision of much of psychoanalytic theory regarding female psychology with the recognition that the girl struggles with anxieties specific to her own body, her feminine identifications, and the variations of her superego injunctions in both universal and idiosyncratic ways (Chodorow 2000); all of these conflicts leave their imprint on adult personality.

Importance of the Oedipus Complex in Adult Personality

In the schools dominant before the advent of self psychology, the oedipal phase was the centerpiece of adult psychopathology because the Oedipal complex determined the core conflicts and solutions around the problems of sex, gender, love, aggression, jealousy, competition, narcissistic balance, identifications, and morality. The “repressed oedipal constellation” (sometimes called the “infantile neurosis”) represented the unconscious structure of the adult neurosis (Tolpin 1970). Today the oedipal phase is still granted unique importance in the organization of the adult mind by analysts from a wide range of theoretical positions (see, e.g., Greenberg 1991), because the many associated developmental achievements of this period profoundly affect the evolution of personality. These multiple simultaneous transformations are an example of the complex interaction of maturational systems, including motor coordination, self-regulation, cognition (espe-
cially the explosion in symbolic capacity and capacity to mentalize, object relations, and moral development, that creates a quantum jump in the overall state of functioning.

What is the status of the Oedipal complex in current psychoanalytic thinking? Modern ego psychologists, while still privileging the Oedipal complex as a watershed in development, take a broader view of the etiology of psychopathology and consider contributions from all developmental levels. Classical Kleinian theorists maintain the oedipal paradigm but place its origins earlier, in the first year of life, and emphasize the mental structure ensuing from relations to part-objects. As the child moves from the paranoid-schizoid to the depressive position, the familiar oedipal conflict of classical theory, involving whole objects and integration of love and hate, libido and aggression, takes over. These object relations theorists rank the importance of infantile objects over the oedipal drama, especially in regard to the evolution of severe psychopathology in adulthood.

The self psychologist Heinz Kohut and his followers, while acknowledging the ubiquity of oedipal dynamics, suggested that these are more often than not a superstructure overlaying more basic deficits—that is, disorders of the self. Threats to self cohesion—the danger of fragmentation and/or loss of vitality—occur as a direct consequence of traumatically frustrating empathic failures on the part of parents in their role as the mirroring and idealized self-objects that constitute the child's average expectable psychological environment (Tolpin 1978).

Increasingly over the evolution of self psychology, the importance of the development of healthy narcissism and a coherent self eclipsed oedipal dynamics in adult psychopathology. Many modern object relations theorists in the United States and abroad (e.g., LaFarge 2000; Steiner 1992) have suggested that both the primitive part-object representations and the more evolved oedipal objects can be observed in the same patient, typically through the transference/countertransference manifestations, depending on the clinical moment. American relational theorists and intersubjectivists, employing the “strategy of radical alternatives” (Mitchell 1984), dispense with the oedipal model and instinctual drive altogether. They insist that their emphasis on relationships as primary shapers and motivators cannot be reconciled with an emphasis on drive and structural conflict.

Contemporary Theoretical Developments

Character and Its Relation to Other Aspects of Childhood

Freud's later considerations of character development linked it to the repetition-compulsion and to identifications, both arising from childhood experience. He saw character formation as a silent, ego-syntonic process that re-creates or repeats aspects of childhood experience and relationships; in pathological cases, these deform all agencies of the mind and make their appearance in treatment as transference and resistance and in life as "inhibitions and unserviceable character traits" (Freud 1914, p. 151). Freud ultimately returned to reconsiderations of early trauma, fixations to defenses chosen in early childhood to cope with those events, and constitutional factors (Freud 1937, 1939). At this point in his theorizing, trauma was used in a broad sense to include any childhood experience that overwhelmed the immature or constitutionally weak ego and established a "compulsion to repeat." The urge to repeat or re-create trauma leads to "unalterable" character traits whose historical origins are forgotten (i.e., unconscious) (Freud 1939, pp. 75–76). Thus, in regard to character, action is often the vehicle for "remembering" the powerful shaping events from the past. Contemporary understanding of the impact of trauma on brain functioning supports the idea that overwhelming experience can create "a set of primitively encoded 'unsymbolized' or 'inflexible and invariable' stimulus primes outside of consciousness and beyond volitional control which may be automatically activated given an appropriate trigger" (Brenneis 1996). Characterological patterns can thus be automatic responses to environmental events, without memorial content.

Anna Freud's elucidation of a comprehensive diagnostic assessment of the adult personality, the metapsychological profile (Freud et al. 1965), reflects the diffuse presence of character determinants in multiple facets of the adult personality that are influenced by the history of developmental conflicts. Otto Kernberg (1970) offered an alternative classification system based on what he called "structural analysis," which cuts across diagnostic categories and identifies levels of severity of personality disorder regardless of overt symptomatology. He maintained a timetable of available defenses
designating splitting, in particular, as a pre-oedipal mental operation that is retained in severe personality disorders. The severity of psychopathology overall is correlated with the era of its origins: earlier disturbances create more severe disorder. Childhood events, both internal and external, are thus manifested in adult mental structure along a continuum from primitive to mature. Critiques of these ideas cite observational evidence that defies any timetable, again noting the universal presence of so-called primitive defenses, including splitting, into late latency [Westen 1990]. Many contemporary thinkers suggest that character undergoes modulation throughout development, with contributions from latency, adolescence, and young adulthood [Blum 1985; Novick and Novick 1994].

**Importance of Early Objects and Mental Representation**

Although the child’s primary love objects figure, more or less, in the thinking of all psychoanalytic schools, there is considerable divergence in how their role is conceptualized, in their importance relative to the drives, and in their impact as real people on the child’s development. Most theories recognize the role of mental representations—that is, internalized versions of human interaction based on the patient’s key relationships in the past that determine relationships in adulthood. Whether these representations are shaped by the patient’s internal fantasy and drives or by the actual experience of primary love objects is another point of divergence, although many have argued that ego psychologists, who are seen as diminishing the importance of the parents’ real input, were cognizant of and attentive to the contributions of the actual parents all along [e.g., Tolpin 1978].

As noted earlier, many other psychoanalytic schools draw attention directly to the child’s actual lived experience with parental figures. Despite considerable differences among them, these theories all assign special significance to the nature of the other and how it shapes mental development. These schools include contemporary British object relations theorists, American interpersonalisists and relationalists, intersubjective theorists, attachment theory integrationists, and psychoanalytically informed infant observers and researchers. These schools do differ in their ideas about the way the mind is structured around managing the early impact of the caretaker and how these effects live on in adult psychopathology. For example, attachment research shows the disorganizing impact of traumatic early experience on adults’ capacity to think and self-reflect, to form intimate adult relationships, and to create secure attachment in their own children [Hesse and Main 2000]. Analysts from a range of contemporary schools look to the present-day therapeutic relationship to understand these problematic mental representations in vivo, and many suggest that therapeutic effect can only take place in the here-and-now interaction. Prominent thinkers have suggested that recovered childhood events are “therapeutically inert….Therapeutic action lies in the conscious elaboration of preconscious relationship representations, principally through the analyst’s attention to the transference” [Fonagy 1999, p. 218].

Thus, contemporary psychoanalysts are deeply concerned with the patient’s actual experience of childhood primary objects and even with the mental life of those objects. Issues related to the childhood process of differentiation from objects, the quality of environmental nurture during childhood, parental capacity to self-reflect and mentalize, and parental attunement and misattunement are part of most analysts’ thinking about adult patients. Moreover, almost all contemporary analysts agree on the huge importance of transference for treatment efficacy, even among those who disavow the importance of linking transference paradigms to childhood experience, it is evident in their clinical material that the defining context of the past remains a central feature of their work, whether or not childhood memories themselves are deemphasized [Gilmore 2009; Govrin 2006].

**Construction, Reconstruction, and Co-Construction**

Although childhood experiences and childhood conflicts are at the heart of almost all theories of pathogenesis, the central importance of memories of childhood as pathogens in the adult is clearly a different matter. Do memories need to be recovered to restore personal continuity and resolve neurotic suffering?

Freud’s evolving views about the memories emerging in treatment—therelclusiveness, unreliability, and distortions, their relationship to the current transference, and their inevitable modification in the telling—led to an important technical development. Originally called construction [Freud 1937], it is today more commonly referred to as reconstruction. In “Constructions in Analysis,” [Freud 1937] stated decisively that “what we are in search of is a picture of the patient’s forgotten
years that shall be alike trustworthy and in all essential respects complete” [p. 258]. In this work, Freud offered an archaeological metaphor for the work of analysis: we are like archaeologists excavating an ancient site, but to our advantage, we are dealing with something that is “still alive” [p. 259], present in memory fragments, dreams, and transference. The analytic task is to piece together these artifacts and to offer an integrated picture of the past that illuminates the determinants of the present-day disturbance. With the shift away from a pure trauma model of neurogenesis, reconstruction was conceptualized as an attempt to clarify the “relevant dimensions of the patient’s childhood from the traces left behind” [Blum 2003, p. 500] or the childhood “atmospheric affective and ego states” [Brenneis 1996, p. 1165] rather than as a search for specific lost memories.

However, the position of reconstruction as the premier treatment technique is increasingly challenged today. The dangers of suggestion, the possibility of false memories “constructed” in treatment, and the distinction between mental truth, historical truth, and narrative truth all color the process of restoring continuity and understanding to our patients’ lives through remembering or realizing the links to the past. In addition, as noted earlier, the therapeutic value of this practice is controversial.

New information about memory from cognitive neuroscience has also had an impact on contemporary views of reconstruction and, more broadly, on the understanding of the unconscious mind and the mechanism of repression as a ubiquitous defense in adult neurosis. The idea of two memory systems, one procedural and the other declarative, episodic, or autobiographical, has been enthusiastically incorporated into the thinking of a range of theorists. Declarative memory is narrative, can be conscious or capable of becoming conscious, and involves knowledge about things that can be put into words. Procedural memory [sometimes referred to as implicit or enactive representational knowing [Lyons-Ruth 1999]] is unconscious but not part of the “dynamic unconscious”; it is knowledge about how to do things that is nonverbal and often not verbalizable. It is nonsymbolized, implicit, and derived from very early experience, before the capacity for declarative memory is developed. Procedural memory can be inferred to be operating in behaviors that have been traditionally described as the repetition-compulsion, defenses, and, of course, transference (Clyman 1991). Many contemporary thinkers suggest that most significant pathogenic early experience is recorded not in episodic, narrative form but in this enactive representational form that is unformulated, unsymbolized, and unavailable to retrieval through the lifting of repression and verbalization. As the term enactive knowing implies, early experience is enacted in all the ways the patient interacts with the analyst; therefore, the relationship to the analyst is the medium of transformation, because the patient’s “ways of being-with-the-other” are reproduced there and reverberate in the analyst’s emotional responses or reverie but are neither verbalized nor linked to specific childhood memories.

Delineation of two different kinds of remembering corresponds to a useful conceptualization of the way the past is represented in adult psychopathology introduced by Joseph and Anne-Marie Sandler at the Anna Freud Centre, whose theorizing bridges classical ego psychology with object relations theory. They suggest that there is a past unconscious, which represents the “the inner world of the child within the adult,” and a present unconscious, positioned closer and more accessible to consciousness, which maintains the present equilibrium [Sandler and Sandler 1984]. The past unconscious contains the immature object representations, mentation, defenses, and peremptory wishes of the infant; it can only be known in derivative form as it is filtered through or defensively managed by the present unconscious. Each “unconscious” is constrained by censorship, but the present unconscious is accessible through interpretive work. The focus of interpretive work is on the present unconscious as manifested in the transference; examination of the latter familiarizes the patient with the main intrapsychic conflicts of his or her inner world, a process facilitated by reconstructing the past unconscious.

The Sandlers’ description of the mutual influence and interaction of the two unconscious systems is in keeping with recent integrations coming from cognitive neuroscience that challenge the idea that the two memory systems operate independently. In the intact brain, mental representations are multimodal, consisting of [a] constellation of associated semantic, sensory and emotional components, with links to a wide array of other such constellations ...and exist as potentials for activation....Networks can include generic knowledge (facts), episodic knowledge (remembrance of specific events), procedural knowledge [how to knowledge or skills], affects, and motives. [Westen and Gabbard 2002, p. 103]

This is a more flexible, interactive conceptualization of the dual memory systems, suggesting a cascade of neural networks that selectively activates depending on the stimulus. The operation of memory is continu-
ously reconfigured and reworked in the context of different current triggers.

In general, then, rethinking the importance and structure of memory has contributed to the contemporary conversation about the nature of pathogenesis and the value of reconstruction of autobiographical memories as the vehicle of therapeutic action. Interestingly, despite the shift away from the classical model and the diversity of new developmental models and theories of pathogenesis, childhood remains, in almost all these theories, the defining experience in creating the structure of the self or of the mind.

**Hermeneutic Tradition and Memory**

Hermeneutics is another trend in contemporary psychoanalysis that bears on the question of childhood experience and its role in adult psychopathology. Hermeneutics in psychoanalysis, derived from the philosophy of Gadamer, Wittgenstein, Heidegger, and others, arose in tandem with its ascendance in other social sciences as an argument against the empirical and positivist traditions that sought alignment with the natural sciences. Influential psychoanalysts such as George Klein, Robert Holt, Donald Spence, and Roy Shafer questioned the mechanistic model of the mind epitomized by Freud's metapsychology and emphasized the alternative, humanistic aspect of Freud's writings and clinical theory. The latter is concerned with the idiosyncrasies of each personality and the importance of meaning in human living, whereas the former emphasizes common features and quantification without regard for meaning or value (Holt 1972). The aspect of this trend that bears on the role of personal history is the sharp dichotomy between historical truth and narrative truth (rooted in Freud's struggle between the seduction theory and the role of the unconscious): does the psychoanalytic process uncover fact or fantasy (Morris 1993)? Is reconstruction an approximation of historical events or a “myth” created by the interaction between analyst and patient?

The hermeneutic trend within psychoanalysis, linked to the emerging postmodern paradigm of relativism and two-person psychology, is a challenge not only to the status of psychoanalysis as a science but also to the relevance of the actual events of the patient's childhood to adult psychopathology and cure. So-called historical facts or historical truth (also called “material” facts or truth—that is, the actual events of a life that can be assigned dates and sequence) exists in inchoate and nonverbal form that is only organized in the therapeutic encounter. Inevitably, veracity is eclipsed by the analytic agenda of co-creating a coherent narrative that has therapeutic power, thus establishing “narrative truth.”

Hermeneutic psychoanalytic theorizing has been critiqued as a misreading of its philosophical foundation (Sass and Woolfolk 1988), which, in contrast, embraces the presence of patterns and meaning in actual real-time experience, not only in the retrospective examination, and recognizes universals and shared meanings, not just idiosyncratic experience. Furthermore, the hermeneutic stance has been decried as an artificial disavowal of widely accepted (scientific) knowledge about human development (Stengler 1991) and as part of a postmodern trend to delink the past and present, arguably the core concept of psychoanalysis (Gilmore 2009, Govrin 2006).

Interestingly, the controversy about truth was adumbrated by Freud in “Constructions in Analysis” (1937) and again in Moses and Monotheism (Freud 1939). He refined his notion of historical truth, recognizing that such “truths” are distorted in memory and thus at variance with “material truth” (the objective facts) but contribute to a coherent narrative reconstruction. Freud also observed that in the analytic process a patient often recalled details related to a reconstructed event but not the event itself, such fragmentary memories are dissociated and “pre-narrational” (Morris 1993). This suggests the work of defensive operations other than repression (e.g., disavowal and dissociation) and implies that meaning can be better discovered in “narrative enactments” (which inevitably involve the analyst) rather than in the form of episodic memory.

**Conclusion**

The topic of this chapter touches on all of psychoanalysis, so inevitably this overview has short-changed some important contributions. Every trend and school within the field has its unique perspective on the way that childhood experience is represented in/colours/shapes/determines adult personality and psychopathology. The hermeneutic tradition and two-person psychology theories (like intersubjectivity) emphasize co-construction in the treatment relationship and the impossibility of considering any manifestation of psychology (e.g., mental organization, dynamics) in isolation from interactions...
with objects. These theories suggest that the patient’s
childhood experience is not the focus or even the back-
drop in the analytic enterprise, because it is not in the
remembered events but in the here and now of the inter-
action that history lives and works its deleterious effects.
A range of postmodern theorists challenge the value and
importance of knowledge of development, because observ-
ational and research data are “irrelevant for psychoana-
lysis as a psychology of meanings, unconscious ideas and
hidden motives” (Wolff 1996, p. 387).

Nonetheless, a perusal of clinical material from these
theorists not only makes evident the gradual elucidation
of the patient’s childhood relationships through the work
in the transference [thereby confirming the bidirec-
tionality of history and current functioning] but also demon-
strates the analyst’s ideas about how the mind develops.
No doubt the links between the mental life of the adult
patient and his or her childhood experience are complex,
profoundly reworked as development proceeds, and at
times obscure and nonverbal, and any claim for direct
correlations between the infant and the adult are sim-
plistic at best. Nonetheless, it is almost impossible to
think about a patient’s mental life without making refer-
ence to personal history, inevitably relying, in the pro-
cess, on contemporary knowledge of development and
theoretical persuasion (Gilmore 2008).

---

### KEY POINTS

- From its earliest origins, psychoanalysis has concerned itself with the role of childhood experience in shaping personality and psychopathology.

- The classical debate between environmental trauma versus inner conflict and fantasy as active agents from childhood has been replaced by a contemporary recognition of the complex, multilevel, dynamic nature of development.

- Similarly, the current debate between here-and-now versus memories of childhood experience as sources of vital clinical data is likely to resolve through the recognition that both are essential.

- Despite an ongoing tendency to order anxieties, defenses, and types of psychopa-
thology on a developmental continuum, most modern psychoanalysts recognize that personal history is unique to each patient.

- Nonetheless, every psychoanalyst is oriented by his or her theory of development, which informs his or her clinical thinking and illuminates the path to cure.

---

### References

- Abraham K: The influence of oral erotism on character-
- Abraham K: Character-formation on the genital level of libido-
development. Int J Psychoanal 7:214–222, 1926
- Abrams S: The genetic point of view: antecedents and trans-
- Anlow J: Problem of the superego concept. Psychoanal Study
Child 37:229–244, 1982
- Auchincloss El, Vaughan S: Psychoanalysis and homosex-
uality: do we need a new theory? J Am Psychoanal Assoc
49:1157–1186, 2001
- Bader MJ: Postmodern epistemology: the problem of valida-
tion and the retreat from therapeutics in psychoanalysis.
Psychoanalytic Dialogues 8:1–32, 1998
- Balsam RH: The pregnant mother and the body image of the
- Baudry P: The evolution of the concept of character in


Hartmann H, Kris E: The genetic approach in psychoanalysis. Psychoanal Study Child 1:11–30, 1945
Jones E: The phallic phase. Int J Psychoanal 14:1–33, 1933
Sandler J, Sandler A-M: The past unconscious, the present unconscious, and interpretation of transference. Psychoanal Inq 4:367–399, 1984
Shapiro T: On the quest for the origins of conflict. Psychoanal Q 50:1–21, 1981
Gender and Sexuality

Muriel Dimen, Ph.D.
Virginia Goldner, Ph.D.

Unlike any other great theory of mind, Freud’s invention of psychoanalysis placed the category of sexuality and the question of gender at theoretical ground zero. As a result, despite its oft-documented limitations, psychoanalysis remains a point of origin—and of return—for generations of investigators concerned with the relations between soma and psyche and psyche and culture.

Not surprisingly, given its shared preoccupations, feminism has been part of the psychoanalytic backstory from the beginning, serving as its sometimes muffled, sometimes obstreperous interlocutor. Almost 100 years later, although the content of the controversies has shifted from questioning the nature of women to questioning the very category of gender itself, the tensions still swirl, and the stakes, remarkably, seem as high as ever.

Thus, it is important to make clear from the outset that however neutral and descriptive they may appear, psychoanalytic theories about sexuality and gender never lie flat on the page. They remain freighted with a history of the painful affects of unresolved conflict. Perhaps because the history of these debates, both doctrinal and political, has been written so often and so well, this topic renders transparent how theories are never innocent or detached, how concepts do not mirror reality so much as construct it.

Ever since the 20th-century revolution in the sciences met up with the postmodern turn in cultural studies, uncertainty has been on the rise and authority in decline. Because there is no “above and outside” from which to make our claims, no one can see reality through a lens free from the imprint of his or her own subjectivity and milieu—ourselves included. As a consequence, the credibility of authorial expertise requires transparency, not omniscience. Thus, in introducing the ideas that comprise this chapter, we try to specify our personal coordinates rather than seek to transcend them.

Having written and practiced at the intersection of clinical psychoanalysis, feminism, and their multiple, cross-disciplinary interlocutors for the past 30 years, we are committed to a perspective that honors the founding position of Freud by seeking to dislodge his radically dis-
ruptive vision and method from the normative, misogynistic framework in which it was originally embedded. Such a project necessitates building bridges to other kinds of scholarship, where questions of gender and sexuality have also been critically engaged. Our chapter tells the story of this collective effort, which unfolded over the course of the past century and shows no signs of slowing down in this new millennium.

**Gender**

**Gender Conflated, Critiqued, Deconstructed, Reassembled**

The terms *sexuality* and *gender* have had distinct conceptual and lexical histories in psychoanalytic theory and in the culture at large. Sexuality was not articulated as a unique aspect of individual psychology until late in the 19th century (Katz 1996), whereas the concept of gender (although not yet the term itself) emerged as a site of critical awareness much later, with the publication of Simone de Beauvoir’s *The Second Sex* in 1949 (Young-Bruehl 1996). It was not until John Money’s empirical work on hermaphroditic children in the 1950s (Money et al. 1955) that gender and sexuality were formally conceived as separate and distinct categories of analysis and experience.

The term *gender* comes even later to psychoanalysis. Although it was obviously central in and to Freud’s thinking, it is not to be found in the *Standard Edition* or in *The Language of Psycho-Analysis* (Laplanche and Pontalis 1967/1973), a canonical reference work of psychoanalytic concepts. Indeed, gender does not emerge as a psychoanalytic category in its own right until Robert Stoller (1968), elaborating and extending Money’s research into the clinical domain, conceptualized it as a central dimension of self-organization, thereby launching the contemporary field of empirically grounded psychoanalytic gender studies.

**Psychoanalytic Feminism**

The psychoanalytic study of gender became increasingly multidisciplinary when Dinnerstein (1976), Chodorow (1999), and Benjamin (1988) introduced into psychoanalytic theory the conceptualization of gender as an analytic and social category, not merely a psychological one. As cultural, philosophical, literary/linguistic, and sociopolitical theories intersected with those being developed in clinical psychoanalysis (see Stimpson and Person 1980 for an early, still classic interdisciplinary collection), it became a major challenge and source of enrichment to hold the tension between “theoretical gender” as it has been constructed in the academy and the “psychological gender” of lived experience as it was being theorized in the clinic (Chodorow 1999a).

Throughout history and across cultures, gender categories (male/female, masculine/feminine) have been almost universally construed as mutually exclusive oppositions, each side defined by what the other was not. Feminist theorists critiqued this principle of gender polarity, reconceptualizing gender as a culturally instituted, normative ideal (Butler 1990) that sexes the body and genders the mind. Butler (1990) argued that gender actually creates subjectivity itself, because “persons only become intelligible through becoming gendered,” and thus “gender and sexual identities that fail to conform to norms of cultural intelligibility appear only as developmental failures or logical impossibilities” (p. 16). One of the core projects and accomplishments of psychoanalytic feminism has been to articulate the clinical implications of this regulatory regime as lived experience.

Chodorow’s (1999b) early work situated gender in the object-relational matrix of mothering rather than in psychoanalytic original discourse of the sexual instincts. Beginning with the obvious but untheorized fact that women are children’s primary caregivers (“every infant’s first love, first witness and first boss”; Dinnerstein 1976, p. 28), Chodorow considered the implications of the fact that (only) “women mother” (the first two words of her text). She showed how this culturally mandated kinship arrangement produced and reproduced gender patterns, such that masculinity is defined by the “not-me” experience of difference (from mother and mother’s femininity), whereas femininity could never escape its origins in the “part of me” sameness with the mother.

Benjamin’s (1988) initial contributions focused on gender domination, arguing that psychoanalysis took “women’s subordination to men for granted, [making it] invisible” (p. 6). Claiming that the polarity masculinity/femininity is established and reproduced in each individual mind by the pathogenic action of splitting, she also demonstrated how the gender binary serves as template for the positions of master and slave, subject and object. Goldner (1991) subsequently argued that the either/or structure of the gender paradigm should be understood as a universal pathogenic situation that induces a traumatically compliant false-self system, which results in a multitude of symptoms and innumerable forms of suffering, unrecognized as such.
The Postmodern Turn

By the last decade of the twentieth century, studies had focused in on feminist theory’s original critique: the monolithic, transhistorical category of gender itself. Cultural studies and queer theory established that gender is not a ubiquitous principle of polarity, unmoored from the conditions of its making, but is actually constituted and stabilized by other binary oppositions, especially those of race (black/white) and sexuality (gay/straight). [See, e.g., Domenici and Lesser 1995, Layton 1998, Leary 1997, and historian Sander Gilman 1995 on the symbolic slippage among the categories of race, gender, and sexuality in Freud’s theory of mind.]

As postmodern academic theorists set about deconstructing the notion of gender as a pre-given, a timeless cultural imperative, postmodern psychoanalytic clinicians began to shift the question from “Gender, what is it?” to “Gender, is it?” For example, Dimen [1991] argued that gender is “less a determinative category, than a force field [of dualisms] consisting not of essences, but of shifting relations among multiple contrasts” (p. 43). Harris [1991], following Lacan, called gender a “necessary fiction”; Benjamin [1992], following Marx, called it a “real appearance”; and Goldner [1991] characterized it as a paradoxical “false truth.” Each of these metaphors makes the point that although gender is not an identity or essence at the core of a person, it is still a core experience that comes to constitute identity. The challenge is neither to essentialize gender nor to dematerialize it.

More recently, the theoretical focus of psychoanalytic gender studies has shifted from deconstructing gender to “reassembling” it [Harris 2000] in ways that do not re-essentialize it [see also Kulish 2000]. In some of these approaches, gender is being reformulated as an intersubjectively constituted “compromise formation” [Goldner 2003; Harris 2000]; in others, the emphasis is on psychic representations of gendered embodiment [Bassin 1996; Elise 1997]. Yet all contemporary perspectives emphasize that gender is a multilayered, dynamically inflected “personal idiom” [Bolas 1989], and theoreticians of varying persuasions have come together around the idea that psychological gender is assembled from the gender tropes that each family, culture, and historical period make available [Chodorow 1994; Harris 2000; Layton 1998; Person 1999]. In this theoretical turn, gender has become a “symbolic resource” [Gagnon 1991] that not only acts “on” us but also is available “to” us.

Freud’s Legacy

Many commentators have shown that in his revolutionary opus Three Essays on the Theory of Sexuality, Freud [1905] set out in one direction only to subvert that trajectory in his footnotes and commentary [see, e.g., Bersani 1986; Dimen 1999; Marcus 1975, May 1995]. In the text Freud wrote that heterosexual reproductive coitus was the inevitable goal of sex and the ultimate statement of maturity while at the same time countering that there was nothing inevitable about the developmental outcome of sexual object choice. Freud stated that gender splitting (masculinity = activity, femininity = passivity) was necessary for procreative purposes [resulting from active, genital masculine heterosexuality and passive, genital feminine heterosexuality] while also maintaining that “every individual…displays a combination of activity and passivity whether or not this tallies with their biological [sex]” and that there is nothing inherent “procreative” from other kinds of sex [Freud 1905, p. 220].

The two positions continually interrupted and undercut each other in a dialogue Freud himself thought was unfinished and unsatisfactory. “[I] am under no illusion as to the deficiencies…of this little work,” he wrote. “It is my earnest wish that it [it] may age rapidly—that was once new in it may become generally accepted, and that what is imperfect in it may be replaced by something better” [Freud 1905, p. 130].

Nominal Gender, Subjective Gender, Ideological Gender: “The Anatomical Difference”

Although Freud did, of course, write continuously about masculinity and femininity, he was not systematic or self-conscious about theorizing gender as a category or construct, tending to “oscillate…between the construction and deconstruction of gender categories” [Benjamin 1998, p. 38]. Yet he was ultimately constrained by his early theorizing, rooted in anatomical difference, which concretized masculinity and femininity as expressions of an individual’s “mental sexual character”—an unwieldy phrase that nevertheless captures the conflation that has dogged the thesis ever since.

This fixation on genital difference undergirds the practice of “sex assignment” in most [but not all] cultures, the foundational act of categorization through which we are named and name ourselves “boy or girl,”
“man or woman.” It has been a staple of feminist theory to demonstrate how this seemingly neutral cultural ritual is actually a form of social regulation that cramms the sexes into two mutually exclusive categories. “Male and female it creates them,” wrote Gayle Rubin [1975, p. 178] in an instantly classic paper, “and it creates them heterosexual.”

Freud further confounded the already conflated categories by defining sexual difference and psychological gender solely in terms of the have/have not status of the penis and the “castration complex” its presence or absence engendered. He ultimately made “penis envy” [female] and “castration anxiety” [male] biologically irreducible “bedrock.”

The Oedipus Complex

Ideological Gender and the Oedipus Complex

The oedipal narrative that dominates classical psychoanalytic theory tracks the boy’s (and girl’s) emergence into heterosexual masculinity (femininity) from his (and her) early embeddedness in what Freud—and later with more theoretical fervor, Lacan—deemed a presymbolic, precultural maternal universe. The trip from pre-oedipal symbiosis and later romance to the patriarchal order of reality/civilization is framed as cautionary tale, illustrating how repression serves the needs of culture by instilling the incest taboo in each mind and family. The prohibition prevents romantic/sexual love from flowering at the wrong time [between a child and his or her parents], the wrong place [inside instead of outside the family], and toward the wrong type of person (of the same sex instead of the opposite sex).

The Oedipus complex, as theory and as lived experience, is the psychodynamic narrative that accords personal meaning and social legitimization for the cultural imperative that links the binary system of gender to the obligatory status of heterosexuality and to the implicit (“less articulated,” in Rubin’s [1975] words) prohibition of homosexuality. The tortuous oedipal journey Freud laid out for pre-oedipal boys and girls, whose nominal gender [male/female] had not yet taken on the ideological and psychologically charged meanings of masculinity and femininity, was designed in accordance with this invisible cultural a priori: gender must be an exclusionary [either/or] category that “brings about” procreative heterosexuality, as in “opposites attract.”

The oedipal drama is launched by the child’s discovery of sexual difference, which, as we have seen, is the moment of realization that the girl is “castrated.” The alignment of femininity with passivity begins here, with the girl’s horror at her genital mutilation. This equation results in penis envy and hatred toward her mother for being deficient, which leads her to repudiate/repress her active [phallic, masculine, homoerotic] romantic tie to her mother and turn to her father. Tellingly, this “turn to the father” is already marked by the daughter’s desexualization because it is fueled not by desire but only by the goal of possessing Father’s penis for herself in order to undo the narcissistic humiliation of her “castration.” When she finds out she cannot have it, she defaults to passive feminine heterosexuality to have a (boy) baby who will be its substitute.

By contrast, the boy’s oedipal odyssey tracks the underground path of his desire, whose repression is linked to his genital narcissism. Incited by his fear and disgust at the female genitals, the boy abandons his wish to overthrow or displace his father, repressing his romantic love for his mother until puberty. Having renounced his oedipal rivalry by identifying with his father’s [hetero] masculinity, it will eventually become “his turn” to possess a woman like his mother, a woman of his own [see Lewes’s [1988] description of 12 possible oedipal constellations for the boy, only 1 of which conforms to this universalized, normative developmental narrative].

Feminist Critiques of the Oedipal Paradigm

The Oedipus complex was a magnet for debate from the moment of its inception, and it continues to be a nodal point of contention among contemporary psychoanalytic traditions. Even Freud acknowledged that the circuitous route to what he called “femininity” was likely to fail, leaving the girl with a “masculinity complex.” The term referred to the daughter’s refusal to give up her active, pre-oedipal bond to the mother, which would fuel her ongoing penis envy [understood in psychological as well as anatomical terms]. In another unfortunate but all-too-common outcome, Freud [1905] described

1 Empirical support for this thesis has been established by Kessler [1990], who showed how decision-making processes concerning surgical options for intersex children were uncritically directed toward ensuring their physical conformity with a binary, heterosexual system of gender relations.
how girls would experience a “break on [their] sexuality” (p. 137) at puberty, prompting a retreat into sexual inhibition and revulsion. Because women possessed “a weaker sexual instinct” (p. 192) to begin with, it was no wonder that the ordeals of femininity left so many of them in a hysterical state in which symptoms took the place of their sexuality.

Horney’s (1924, 1926) critique of Freud’s convoluted oedipal thesis revealed that the masculinity Freud idealized was not so much a state of excellence as it was the grandiose fantasy of a vulnerable male child (“What I have is great, what you have is nothing”). “Freud’s devaluation of the female genital,” she concluded, “differs in no case by a hair’s breadth from the typical ideas that the little boy has of the little girl” (Horney 1926). She challenged the view that there was only one worthy genital. Ernest Jones (1935) agreed: “I do not see a woman … as a permanently disappointed creature struggling to console herself with secondary substitutes alien to her nature” (p. 495).

Femininity and Masculinity

Primary Femininity

Both Horney and Jones refused Freud’s phallic monism, arguing for the girl’s “innate” femininity, which they believed was an expression of her innate, pleasure-oriented heterosexuality, brought into awareness by early vaginal sensations (an awareness Freud and his loyalists disputed). As their perspective evolved at the time and over the next half-century, it became elaborated into a countervision of “primary femininity,” which has documented and theorized the obvious fact that girls, as well as boys, have a primary awareness of and positive cathexis toward their genitals that precede their awareness of sexual (genital) difference.

In contrast to the original Freudian conception of femininity as grounded in castration and progressing toward passive, vaginal heterosexuality, the postclassical primary femininity tradition has engaged the project of developing theoretical categories that establish “linkages between body sensation, body ego, and gender identity” (Lasky 2000, p. 1385). This strategy traces the experiential and psycho-symbolic contours of a specifically female developmental line, grounded in the anatomical female body, with its particular pleasures and dangers.

The approach re-theorizes feminine psychosexual development, shifting from the phallic focus on the girl’s genital “lack” to elucidation of her fear of losing or damaging what she already possesses and initially cherishes—her unique body and genitals. For example, in a classic paper, Mayer (1985) described both the little girl’s initial narcissistic fantasy that “everybody must be just like me” (having an opening and an “inside space”) and her later “castration anxiety,” which Mayer creatively redefined as the fear of being “closed up” like boys—physically and mentally.

The feminist impulse at work here also involves a particular critique of terms such as castration anxiety and penis envy, which are derived from imagery of the male body. It is argued that these phallocentric categories can obscure, if not erase, the particularity of female embodiment, rendering it theoretically and psychically unrepresentable (Bassin 1982; Goldberger 1999; Kulish 2000). This critique has led to the development of new terms and refinements of old ones, such as Kestenberg’s (1982) “inner genital,” Bernstein’s (1990) replacement of “castration anxiety” with “genital anxiety,” and Elise’s (1997) substitution of primary “femaleness” for “primary femininity.”

The French psychoanalytic tradition of l’écriture féminine (“writing femininity”) proffers a literary strategy for representing the unrepresentable condition of embodied femininity. In this approach, language is used evocatively (“semiotically”) rather than symbolically (Kristeva 1981). For example, Irigaray (1977) described the labia as “two lips which embrace continually” (p. 345).

A central critique of this theoretical perspective has been its tendency toward essentialism: the presumption that a particular sexed anatomy “results” in or produces a particular gendered psyche. Many contributors to this approach have themselves addressed this issue, some enhancing the critique itself, which has resulted in more complex formulations of the relations between embodiment and gender [see, e.g., Elise 1997; Kulish 2000].

Phallic Masculinity/Personal Maleness

Freud’s idealization of phallic masculinity not only erased and debased femininity as a category and as a lived, embodied self-experience but also delayed the theorization of masculinity in all its specificity and multiplicity. As Corbett (personal communication, 2004) has observed, men, like women, can be clinical subjects in psychoanalysis, but unlike femininity, masculinity has rarely been taken up as a theoretical problem beyond Freud’s original classical paradigm.

Phallic masculinity has been, in essence, “beyond analysis.” Rather than a phenomenon to be explained,
it has been an ideal to be achieved. Indeed, any maleness that doesn’t “measure up” jumps the gender binary, becoming a degraded varietal of femaleness (i.e., “effeminity”). (Chodorow 1998 and Corbett 2001a elaborate the mechanisms for this process, describing how the defensive construction of masculinity as “not femininity/not mother,” “not small/not boy,” “never loser/only winner,” can default into aggressive homophobia.)

Chodorow (1999b) and Benjamin (1988), building on the work of Stoller (1968), began the project of problematizing masculinity as a cultural category, identity position, and psychic phenomenon. Chodorow (1999b) showed that, under the routine social conditions of father absence or distance, boys tend to seek identification with the category of [hyper] masculinity as a means to make a symbolic ("positional") connection with a father who is not personally available. This transference to, and identification with, the phallic imagery of masculinity eventuates in a familiar hypermasculine stance, a version of manhood that Ross (1986) eloquently critiqued as “a screen, a sheath, an artificially aggressivized brittle, cardboard creation [pointing toward] the unavailability early on of the father as a libidinal object and figure for internalization and identification” (p. 54, see also Kattal 1991, on the pathogenic consequences of father-absence/hunger, and Pollack 1995, on the traumatic consequences of the cultural pressures requiring boys to separate too soon and too absolutely from the mother).

The premature abandonment of boys by their mothers and fathers and by a culture that valorizes the phallic illusions of machismo produces men who tend to be lacking in empathy, are unskilled in relationality, and are unable to relate to others outside a dynamic of domination. These psychological wounds and deficits have serious social ramifications. It is a statistical fact that men and boys, not women and girls, engage in the vast majority of individual, domestic, and collective acts of violence. These behaviors are rooted in the affects of shame, humiliation, and narcissistic threat. Chodorow (1998) argued that humiliation from men (the man/boy dichotomy) and fears of feminization (the male/female dichotomy) are central ingredients fueling the rage driving male social violence (see Goldner 1998 on the gender dynamics of domestic violence).

Trans

The prefix trans serves as an umbrella term for all gender-variant persons who locate themselves on a trans, as opposed to a gay or queer, continuum. Loosely speaking, transsexuals seek to manifest the primary and secondary characteristics of the “opposite” sex and to live as a member of that sex, modifying their bodies with surgeries and hormones to achieve that end. By contrast, persons who consider themselves transgendered relate to gender as a continuum rather than as a dichotomy that creates options for highly individualized gender trajectories.

Trans may be uncommon, but gender variance itself is not rare. Throughout all cultures and historical periods, gender diversity, along with rudimentary forms of gender body modification, has always existed. It is important to understand that transgressive gender behavior is produced by the same processes—psychic, social, and cultural—that have constituted normative gender as an oppositional binary. In the either/or taxonomy of gender dimorphism (where masculinity and femininity are constituted as mutually exclusive oppositions), gender confounding is inevitable. Indeed, trans creates a productive category crisis by introducing “neither/nor” and “both/and” alternatives to the gender binary.

Moreover, and more importantly, trans also constitutes a paradigm shift within the category of gender itself. Think of trans as not so much an additional gender position (a kind of “third sex”) but rather a novel gender stance, one that constitutes gender as a process rather than a thing in itself, a gerund rather than a noun or adjective, a continuous work in process rather than a fixed, unchanging fact.

By studying trans, the exception, we can see the action of gender normativity, the rule. Although some trans technical interventions may be more extensive, and all are more self-conscious than commonplace acts of gender self-improvement, it is also true that doing normative gender well is also a time- and money-consuming disciplinary technology of the self that requires diet, exercise, makeup, and surgeries, all deployed in a regimen of continuous, anxious self-scrutiny. The real difference is that for some individuals there has been a defensively based, societally encouraged tendency to approve, indeed applaud, any and all efforts at excellence in masculinity and femininity that “improve” on the gender that is concordant with one’s sex assignment at birth while fearing and despising any gestures toward confounding that gender or crossing over to the “other” one.

It is not that gender crossing is never a symptom or defense secondary to psychic trauma or a cause for suffering in and of itself. It is a challenge, however, to distinguish between the pain of gender cross-identification associated with trauma and the pain caused by the trans-
phobic stigma foisted on gender-variant individuals. To experience gender as permanently unsettled, to deploy gender categories as consciously provisional, to know as fact that gender is socially constructed, and to live it as personally assembled are all something new under the sun.

A Fork in the Road

Until recently, the primary demarcation distinguishing psychoanalytic gender theories lay between those that “analyzed the gender divide in terms of the structural relationship to the phallus, [and those that privileged] the object relation to the mother” (Benjamin 1998, p. 43). The latter object relations theories privilege the early, active primacy of the mother in shaping the child’s subjectivity, grounding gender in processes of attachment and identification with her and implicating gender in mechanisms of separation-individuation from her. On this view, oedipal relations are still considered crucial to the psychic construction of masculinity and femininity, but they are now regarded as “superimposed” (Person and Ovesey 1983) on the earlier processes of gender formation that Freud did not recognize.

Freud, as noted, rooted gender in the discovery of sexual (genital) difference, which he believed occurred at around age 4. Researchers have since established that genital awareness, labeling, and symbolization begin much earlier, during the second year of life (DeMarnelle 1997). Moreover, Person and Ovesey (1983) argued that gender self-designation precedes the child’s discovery of the sexual distinction, and thus, reversing Freud, they argued that genital experience does not create gender but rather that the child’s rudimentary sense of gender shapes the experience of genital awareness and the personal meaning of sexual difference. However, subsequent research by DeMarnelle (1997) investigating the cognitive sequencing of gender and genital labeling in very young children (15–36 months) suggests that the coordination of conceptions of genital difference with those of gender difference follows no universal fixed sequence.

Attachment-Individuation Theories of Gender

Core Gender

Speculating that all infants initially identify with their mother’s [female] gendered body and psyche, Stoller (1968) theorized an initial phase of “proto-femininity” for both boys and girls. With this move he was reversing Freud yet again by substituting a version of primary femininity for the phallic monism of primary masculinity, thus making masculinity, not femininity, the second, more precarious sex.

In the classical account, it is the girl whose gender development is doubly challenged, because she has to switch her love object from mother to father in order to abandon active masculinity in favor of passive femininity. In Stoller’s (1976) account, it is the boy whose gender is doubly challenged, because he must abandon his “primordial” identification with his mother’s femininity in order to become “male” like his father. Neither schema is theoretically adequate or plausible, because each proposes an essentialist theory of one gender and a constructionist theory of the other. In the classical trope, “Man is born, woman is made,” in the revisionist account, “Woman is born, man is made” (Person 1999).

Person and Ovesey (1983), in their historically influential critique, maintained that neither gender is “original,” “natural,” “innate,” or “primordial” that masculinity and femininity should therefore be theorized as “parallel constructs.” They also disputed Stoller’s (1968) notion that boys would need to “dis-identify” (Greenson 1968) from the mother in order to establish their masculinity. In line with Money (1973), they maintained that core gender (one’s self-designation as male or female) is cognitively and experientially constructed in conformity with sex assignment and rearing, whereas the later development of gender role identity [the self-evaluation of one’s maleness or femaleness: “I am masculine,” “I am feminine”] was a “psychological achievement... fraught with conflict” (Person and Ovesey 1983, p. 226). Since the catastrophic failure of Money’s most famous case of sex reassignment became public (Colapinto 2000), there has been a reevaluation of the role of prenatal hormones in establishing core gender as well as a reconsideration of the relational psychodynamics shaping gender role identity (Fast 1999a, 1999b; Harris 1999).

Gender as a Symbolic Resource and Relational Strategy

In Person and Ovesey’s (1983) schema, gender role identity is not the product of a simple process of identifying with the nominal gender of the “same-sexed” parent; it is a work in progress, evolving in and through the rough and tumble processes of separation-individuation. From their perspective, gender does not simply unfold along its
own developmental pathway, because it gets implicated in and is inflected by those early conflicts and losses. They illustrate this phenomenon by discussing how both boys and girls can manifest “excessive femininity” as a psychic strategy to master separation anxiety. Being feminine “like” mother becomes a symbolically embodied means of both “being” and “having” her [within].

Chodorow [1999a] and Benjamin [1988] described and theorized how the child’s experiences of and desires for likeness and difference with the parents get mapped onto the gender binary, while Goldner [1991] explicated how these moves, which take many forms, could be understood as relational strategies for establishing, maintaining, or denying crucial attachments. For example, whereas Coates’s [1990] work on melancholic boyhood femininity highlights a “sameness” strategy, Chodorow’s [1999] description of how boys deploy the category of masculinity to separate from and repudiate the mother shows the use of a “difference” strategy: “I am not like my mother, I am not female.”

In these formulations, it is important to note that gender is being theorized as more than “psychological achievement” [a constructionist but still static concept]. Without any fanfare, and perhaps without theoretical self-consciousness, Person and Ovesey [1983] introduced a critical aspect of gender’s protean dimensionality into the discourse of psychoanalytic gender studies. To use Gagnon’s [1991] term, they showed how gender is a “symbolic resource” that can be deployed by the subject as a means to express and/or magically resolve psychic conflict and trauma. This conceptualization of gender as a vehicle, rather than an entity—and thus a means rather than an end in itself—was an unheralded critical moment in the early development of object relations gender theory, one that shifted the discourse away from gender essentialism and reification (see also Coates 1997).

Benjamin’s [1988, 1995, 1998] relational theory of gender has brought this approach to profound fruition by showing how gender is not simply an individual strategy [deployed by mother, father, or child] to facilitate wishes for separation or merger but also a critical aspect of the intersubjective processes of recognition and negation circulating among them. In her thesis, the defensive use of the gender binary, concretely applied, does not exhaust its psychic possibilities. Her counterintuitive concept of “identification with difference,” for example, conveys how the preoedipal girl seeks to identify with her father “homoerotically,” as another “like subject” who embodies and represents self-originating desire, agency, and the “exciting outside.” Benjamin’s crucial contribution is the intersubjective dimension, which highlights the significance of the father’s recognition of, and identification with, the child as a subject like himself. Because a daughter often represents her father’s disclaimed feminine identifications, fathers are less likely to recognize likeness in their daughters than in their sons. In Benjamin’s view, the father’s negation/refusal of the girl’s identifying love—her “homoerotic love for like(ness)”—is a key factor in the development of penis envy.

It is only a short step from thinking of gender as a dyadic process to thinking about it as an intersubjective matrix emerging in the crosscurrents of family relations. As Harris [2000] put it, there is a “unique dialectic [tying the] parent’s experience of body, gender identity, and desire with the child’s rudimentary sense of self-body-gender-desire. This bi-directional tension creates the relational matrix into which the child’s gender comes into being and into use” [p. 243].

The child’s multilayered experience and presentation of gender are tied to sustaining his or her primary object relations. Where gender becomes a heightened symbol of unrest and disquiet, the child’s gender development can result in splitting and false-self operations [Goldner 1991]. On the other hand, the child’s gender can also “be a vehicle for a particular skilled task that a child needs to resolve…the securing of stable interactions, and the internal stability in another person. In the goal of keeping an internal object world alive [and originally an external scene alive and vital], gender can [also] be the brilliant solution” [Harris 2000, p. 244].

**Toward a Decentered Gender Paradigm**

**Gender “Over-Inclusiveness”**

Fast’s [1984] child observation studies led her to describe a period of “gender over-inclusiveness” following the phase of separation-individuation, during which children inventively deploy gender identifications as a means of formulating unarticulated aspects of their developing sense of self. They imaginatively identify with the traits and capacities of both [parents’] genders.

---

2 See Coates 1990 for an exegesis of the relational dynamics of extreme boyhood femininity, and Corbett 1996 for a critical perspective that theorizes effeminacy in relation to the normative regime of phallic masculinity.
and resist the cultural requirements of gender and sexual dichotomization.

With the advent of the oedipal period, when the either/or terms of the gender binary can no longer be evaded, Fast described how children cope with the loss of "having it all" by defensive repudiation or envy of what the other sex "has." She regarded the renunciation of psychic bisexuality (gender multiplicity) as a necessary loss of omnipotence that will eventually be ameliorated by the fantasy, and ultimately the reality, of heterosexual love.

An alternative perspective, put forth in closely related arguments by Aron [1995], Bassin [1996], and Benjamin [1995], contends that the multiplicity of gender identifications established in the pre-oedipal period can be a continuing source of psychic enrichment in adult life, just as it was for the developing child (see also Breen 1993 on gender as "out-of-focus"). Looking beyond oedipal complementarity to a post-oedipal position, these authors argued for the symbolic "recuperation of early bisexuality, gender overinclusiveness, [gender discordant] body-ego representations and cross gender identifications [Bassin 1999, p. 13; see also Elise 1997].

The psychic and theoretical issue is not therefore gender per se, but how rigidly and concretely it is being used in an individual mind or family context and what psychic and intersubjective work it is being deployed to do. The question is whether the subject experiences himself or herself as personally investing gender with meaning or whether gender is a "meaning happening to her (him)" [see Aron 1995; Sweetnam 1996].

Gender as a Personal Idiom

These arguments reflect a contemporary strategy/position in psychoanalytic gender studies that seeks ways to subvert the gender order rather than to transcend or defy it.3

Psychoanalytic feminism began by documenting the pathogenic processes and effects of psychological conformity to the culturally ubiquitous gender binary. Postmodern gender theories see through such compliance, showing how resistance to the either/or of gender is already present, under the radar, in psychic and cultural life (see also Dimen 2003). Thus, it is not enough to delineate how the dictates of gender or sexuality are traumatically "absorbed" through various mechanisms of compliance. We must also be able articulate how the subject engages these categories, indeed talks back. Gender, in other words, does not only act on [against] us, it is also a cultural trope available to us, one that can actually be deployed by the subject in the service of its own aims, including the subversion of gender imperatives themselves.

The protean complexity of gender that has been unpacked in these pages gives the lie to the commonsense view of gender as an unremarkable aspect of character that "speaks for itself." Rather gender is better understood as a social category, a psychic identity position, that is simultaneously a site of injury and a creative, potentially defiant idiom of the self. The tension between these two perspectives suggests that it can be thought of as a compromise formation held in the tension between the pressures of conformity and compliance on one hand and the individual's continuous project of self-creation and self-protection on the other. Gender is thus culturally mandated but individually crafted, permeable yet embodied, simultaneously inventive and defensive, and crucially relational in its design.

Chodorow's (1999a) work on "personal gender" shows how every individual creates a uniquely personal, dynamically driven, multilayered, relationally savvy version of gender assembled from the gender tropes that each culture and historical period make available. Put another way, gender is a uniquely personal and conscious/unconscious interpretation of a cultural archetype, an embodied expression of the statement "This is what I mean by femininity [masculinity]."

Once we have established that gender is psychodynamic and indeterminate, it becomes obvious that the ideal of a unified gender identity makes sense only as a "resistance in terms of treatment, and an impoverishment in terms of character" [May 1986]. As Person (1999) wrote, "[A]gainst what appears to be a 'dichotomously, categorical expression of gender,' there exists in each person a complicated, multi-layered interplay of fantasies and identifications, some 'feminine,' some 'masculine.'...In essence, conscious unity and unconscious diversity co-exist" [p. 314]. If there is a goal toward which to aspire, why should it be the "hegemony of one, consciously coherent, sex appropriate view of oneself" [May 1986, p. 183] as opposed to the capacity to "tolerate the ambiguity and instability of these profoundly personal and ideologically charged categories of experience" [Harris 1991, p. 205]?

Sexuality

Sex Revived

As we shift gears from gender to sexuality, it is important to note how the historical narratives of gender and sexuality contrast. As we have seen, psychoanalysis started with sex, and its early definitions, which Freud had hoped, even in 1905, would be revised, soon came to be taken for granted as fact. It is only through the critique of gender (effected, as has just been recounted, from both within and without the field) that sexuality becomes (re)problematized. Thus, in the 21st century, we approach sex not only as a fact but also as an idea with its own reality and whose relation to the world it intends to illuminate can also be deconstructed. It goes without saying that gender and sexuality are inextricable—“interimplicated,” to use Butler’s (1990) felicitous coinage. They are extricated here only for the purposes of exposition. In this section we see that although the term sexuality is no less complex than that of gender, the debates about it are much less thickly layered, its intellectual history patchier.

Libido, Drive, Instinct

Libido

Ideas about sexuality are nested in other sets of ideas. Indeed, the psychoanalytic, feminist, and cultural debates not only on gender but on self, body, language, and transference and countertransference reveal psychosexuality—and its problems—as controversial in unforeseen ways. For example, libido, Freud’s (1905) cardinal concept of sexual desire, has one set of meanings in Freud’s original model of the mind. However, these meanings change when the concept is viewed from an object-relational perspective. According to Person’s (1986) admirable summary of Freud’s view, libido is not only an appetite demanding satisfaction. It also has psychological power, drawing on the body but registered in the mind, driving individual developmental process and behavior. Libido is a force that registers sexual instincts in the mind and thereby partners the emotion of sexual longing. An energy that accumulates to produce “unpleasure,” it mounts, surges, and seeks release. Existing outside awareness, libido nevertheless serves to excite consciousness, there to be transformed into something the psyche wishes to get rid of, because pleasure, in Freud’s view, consists in the reduction of unpleasure, that is, of tension.

About 50 years after Freud’s Three Essays, psychosexual theory took an unexpected turn when object-relational models reconceptualized libido as obtaining between individuals. Libido, argued Fairbairn (1954), is not an impersonal force. Rather, it is personal, seeking not discharge but objects. If we think of the need for objects as the root of psyche, or self, then we need to reinterpret pleasure. No baby develops outside its relation to an object. (Winnicott 1953). In this view, mind is inherently interpersonal, or at least the manifest divide between intrapsychic and interpersonal is no longer self-evident. Mind, in this perspective, develops not within an individual skin but between persons; psychic process and structure emerge out of early object relations. Likewise, pleasure inheres in attachment, issuing not from tension discharge but from object relationships themselves. To put it more schematically, libido, circulating between as well as within persons, is a two-person phenomenon.

Drive, Aim, Object

The argument that sexuality is interpersonal and intersubjective as well as intrapsychic applies also to psychosexual development. In the classical view, sexuality arrives in pieces rather than all at once and comprises three innate but initially disparate elements: drive, aim, and object. “Drive,” according to Laplanche and Pontalis (1967/1973), refers to a dynamic process in which a pressure directs an organism toward an “aim.” Deriving from a corporeal “source,” the drive aims to purge the tension this stimulus creates, whereas the “object” serves as the means by which this aim may be achieved.

By thus formulating the relations among drive, aim, and object, Freud challenged prevailing consensus. Generally, the object—the loved one—was thought to be the stimulus that, at puberty, awakened the drive and directed it toward its aim of heterosexual and reproductive intercourse. Freud argued instead that the sexual instinct, albeit innate, lacks an inborn aim and object. Rather, aim and object are acquired, and pleasure can take many forms. Aims are therefore multiple.

---

4 One can recall, at this juncture, how the already discussed historical “convergence of psychoanalysis and feminism” (Benjamin 1984) resulted in establishing the ineluctable twoness of psychic structure by recognizing the presence and subjectivity of the mother in early object relations (Benjamin 1988; Chodorow 1999b; Dinnerstein 1976).
and fragmented, and objects are “variable, contingent and only chosen in...definitive form in consequence of the vicissitudes of the subject’s history” [Laplanche and Pontalis 1967/1973, p. 215]. [We might note parenthetically how important, even in this classical formulation, is personal “history” to psychosexuality.]

Component Instincts

Psychosexual development is “biphasic”: if the first phase, infantile sexuality, is “polymorphously perverse,” the second, puberty, concludes psychosexual development by using genital heterosexuality to “soldier” together drive, aim, and object. These “transformations of puberty” also unite what have hitherto been the severally emerging component instincts or partial instincts that sequence sexual development. Each of these has two parts: a bodily source and an aim. Even though, in Freud’s ultimate view, the entire body is an erogenous zone, the mucus membranes, such as the mouth, anus, vagina, or urethra, are fundamental: “we must regard each individual as possessing an oral erotism [or instinct], an anal erotism, a urethral erotism, etc.” [Freud 1905, p. 205, n. 1]. These partial instincts are partnered by aims, for example, the scopophilic instinct, the instinct to master, and so on [Laplanche and Pontalis 1967/1973].

Serving, in Freud’s view, as elements of foreplay, the component instincts remain disconnected from one another until brought under the sway of genital erotism. After this point, when the genitals gain functional and experiential dominance due to the emergence of the reproductive aim, all preparatory pleasure that results from the satisfaction of other erotic zones translates into genital excitement. In summary, then, “a new sexual aim appears, and all the component instincts combine to attain it, while the erotogenic zones become subordinated to the primacy of the genital zone” [Freud 1905, p. 212].

Yet even erogenous zones and component instincts may have object-relational functions. Corporeal erotogeneity, Fairbairn (1954) argued, flames as much from relatedness as from body chemistry. Likewise, psychosexual stages are not just corporeal but also interpersonal moments. Sullivan’s (1953) example is the most familiar and famous: the mouth is an erogenous zone not because its mucosity innately situates excitement but because nursing makes it a primal site of attachment. Oral erotism, experienced within and by the individual organism, has roots and resonances in relationships: it is exciting to get together with mother and get fed. Likewise, the anus is arousable because it situates toilet training power struggles. Out of this phase of parent-child relatedness, which makes matters of control and will primary, anality acquires its close link to the component instincts of sadism and masochism.

Sex and the Single Narrative: Development and Identity

The Feminist Critique

Objects, it may be argued, are present, albeit on the backburner, in classic psychosexual theory. The moment of genital union is also the moment of oedipal resolution, when, to use Kernberg’s [1995] formulation, body-surface erotism and total object relations come together. Even if the oedipal narrative were an inevitable unfolding of biological destiny, still it accounts for psychosexual development in terms of critical object relations [Fairbairn 1954]. In Freud’s view, sexual interests evolve from birth until they become the target of inhibitions during the fifth year; then they reemerge in puberty, at which time they are not polymorphous but are ready to enter reproductive service. This process is described by the oedipal narrative, which, as we have seen, can no longer be uncritically accepted as veridical account or accurate prediction of psyche, culture, or history.

These critiques, stemming from within classic psychoanalytic theory itself as well as from object-relational revisions and the feminist attention to gender, complicate the single narrative that constitutes Freud’s original story of sexuality. Even within that narrative, as we have noted, there are already two routes to adult sexuality: one for males, the other for females.

As it turns out, however, no one story of male psychosexual development exists either. It is not only that, among men as well as women, sexuality takes at least two forms, heterosexual and homosexual. Differences abide even within these categories. Among homosexual men, as Corbett [1993] demonstrated, masculine gender identity may remain intact whether the sexual aim is active [i.e., the wish to care for another man, the wish to fill up the other’s erotogenic zones] or passive [i.e., the wish to be cared for by or have one’s erotogenic zones filled up by the other]. Reminding us, furthermore, that it is from fantasy rather than behavior that we are to deduce sexual orientation [A. Freud 1952], Corbett [1993] proposed that masculinities may be “differently structured” (p. 347): a man may alternate between passive and active aims—he may, in sex, be
inserter or insert-ee—but nevertheless experience himself as male. Certainly the same sort of variation must apply to heterosexual masculinity.

**Heterosexuality and Homosexuality**

As has been shown with regard to gender, the very terms we use to describe sexuality are the terms that create it. Far from being transparent (Schafer 2002), these terms are always culturally constructed as well as personally significant. Let us examine heterosexuality and homosexuality. Traditionally in psychoanalysis, “homosexuality” has usually been regarded not as a sexuality in its own right but as a neurotic distortion of a fundamental, normal, and natural heterosexuality. Yet “heterosexuality” itself is, as Dimen (2003, p. 179) said of gender, “a dense weave of significance”; in particular, as soon as it is invoked, so is procreativity, even though not all heterosexual people procreate or (wish to) become parents.

In revealing Freudian psychosexual theory’s masculinism, the feminist critique also unveils its normative heterosexual bias. Sexuality as described in Freud’s [1905, 1924, 1925, 1931, 1933] writings presumes, as has been described earlier, a heterosexual outcome. Notably, he began *Three Essays* with Chapter 1 on “Sexual Aberrations.” Here and elsewhere he argued that sexual desires for acts exceeding and transgressing reproductive heterosexual intercourse are ubiquitous if also generally unconscious; as demonstrated by Chapter 2 (“Infantile Sexuality”), we are all more polymorphously perverse than otherwise. Each of us has homosexual as well as heterosexual wishes; indeed, we are bisexual from the start. However, our sexual multiplicity must, in the end, become uniform. In *Three Essays*’ final narrowing [Person 1986], sanity, society, and the survival of the species all in the end depend on puberty’s transformation of diffuse, diverse sexual aims into the reproductive discharge of semen into the vagina.

**Sexuality, Illness, and Normality**

Psychoanalysis, changing in response to contemporary social critiques [Roughton 2003], has begun to attend to a foundational contradiction. Freud [1920] famously wafted on sexual normality: sometimes you have to be heterosexual to be mentally healthy; sometimes you can be homosexual. One lesbian patient, he confided in a footnote, was “in no way neurotic” [p. 158, n. 1]. As he [Freud 1935] famously wrote in the letter to the American mother about her gay son, homosexuals are no more or less ill than anyone else; indeed, they have contributed greatly to civilization. Recent contributions pick up the thread; as Schafer (2002) said, “Many heterosexual analytic patients show the same or similar conflicts [found in homosexual or perverse patients], even the same intensity of conflict and defense, and the same or similar disturbing developmental circumstances” [p. 30; see also Isay 1989]. In 1973, psychoanalysis finally returned to its native intellectual and civil open-mindedness when the American Psychiatric Association removed homosexuality from DSM as a result of intense lobbying by [homosexual] activists and some progressive voices from within the association itself as well.

Even though much prejudice quietly persists, this shift in psychosexual thinking mandates the recognition that there cannot be one single route to adult sexuality. In Coates’s [1997] view, the concept of developmental lines, confining rather than expanding understanding, should be jettisoned [see also Corbett 2001b; Schuker 1996]. “Normal” sexuality must always be written in quotation marks, because object choice can only be compromise formation: “Any heterosexuality [like any homosexuality] is a developmental outcome [that] results from fantasy, conflict, defenses, regression, making and breaking relationships internally and externally, and trying to constitute a stable self and maintain self-esteem” (Chodorow 1994, p. 62). There is no other psychoanalytic way to view the matter: despite his allegiance to Darwin [Schafer 1977], Freud is writing a *psychology*, not a biology, of sex.

**A New Narrative of Sexuality**

**Sexual Idiom**

As clinical practice attests, patients have sexual problems [Green 1996], but the paths to and outcomes of sexual development are multiple, not unitary [Breen 1993]. Desire itself is, to put it in different language, idiomatic. What Bolas [1989] wrote of the personal idiom altogether must hold true for sexual desire in particular: “a set of unique person possibilities specific to this individual and subject in its articulation to the nature of lived experience in the actual world” [p. 9]. These possibilities may include heterosexual object choice as a solution to the conflicts of the oedipal and pre-oedipal passages. However, they may also include sadomasochism and other practices formerly dubbed “perversions” as adaptive solutions to disorders of self.
(Weille 2001), for which McDougall (1995) coined the term “neosexualities.”

Revising the Classical Narrative

The oedipal narrative, as classically told, is useful but is, after all, a story—and only one, at that—of how a person becomes heterosexual, not only of how that person becomes sexually and psychologically mature. According to recent postmodernist theories, especially those of Butler (1990), sex and gender contain rather more polyphony. This view, construing sexual desire and gender identity as socially, historically, and culturally variable constructs [Foucault 1976], regards heterosexuality and the gender binary as opposite sides of a coin. Arguing that no object is ever truly given up, and regarding gender as an achievement rather than a given [positions taken alternately by Freud], Butler (2002) put forth the provocative thesis that gender and heterosexuality constitute each other.

This new narrative reveals the multiplicity of desire hiding in any classical oedipal account [e.g., What happens to the girl’s [homosexual] desire for her mother? as Rubin [1975] asked long ago]. Meant to be left behind, homosexuality is in the new account retained as gender. On the journey to heterosexual normality as it is culturally and hence unconsciously inscribed, desire and identification come to exclude one another: the child may not both identify with and desire the same parent. The girl’s identification with mother, for example, requires a repudiation of desire for mother: if she is to be feminine, she will have to desire a man—her father—not a woman. If wanting a girl—that is, being homosexual—puts being a girl into question, then the foreclosure of homosexual desire for girls is foundational to gender. Mutatis mutandis, the same holds for boys, whose gender identity is unfortunately but conventionally founded, as we have seen, on, if not disidentification, then at least repudiation: “If a man becomes heterosexual through the repudiation of the feminine, then where does that repudiation live except in an identification which his heterosexual career seeks to deny; indeed, the desire for the feminine is marked by that repudiation: he wants the woman he would never be; indeed, he wouldn’t be caught dead being her; thus, he wants her” [Butler 2002, p. 7].

Challenging standard linear developmental narratives, this postmodern narrative ironically returns us to classical skepticism about sexual desire’s course: “The synthesis is thus not so satisfactory as the analysis; in other words, from a knowledge of the premises we could not have foretold the nature of the result” [Freud 1920, p. 167]. Consider, for instance, the development of lesbian sexual identity, for which Schuker [1996] suggested we “identify [many] influential nodal points” (p. 496). Although her list built linearly from the biological ground up, we might imagine instead a set of mutually determining possibilities laid out as on a map. These would include early object relations; gender identity’s construction and negotiation; sexual trauma; temperament; desire as attachment and defense; feelings about and representations of procreativity, power, and gender; cultural imagery of sex and gender as transmitted through familial dynamics and fantasy; and identifications with parents, their sexuality, and their gender. Mutatis mutandis, a similar map of sexual development could be drawn for men, and for hetero- and other-sexual people, for perversion as well as procreativity, and so on.

Multiplicities of Desire

It is important to note the contrast with classical binary paradigms [oedipal vs. pre-oedipal, mother vs. father, identification vs. desire, “being vs. loving”]: psychoanalytic theories influenced by the postmodern constructionist turn conceptualize the relations between object love and identification as mutually determining rather than linear, as multifaceted rather than binary, and thus as not merely oppositional but also congruent, interpenetrating, oscillating, and so forth. As we have seen, others (Aron 1995; Bassin 1996; Benjamin 1995) constructed a post-oedipal solution to this problem: the recovery of the gender multiplicity foregone in the oedipal passage. Bassin [1996] imagined that, one’s core gender identity having found psychic coherence, one might then be able to play, to riff on alternate gender identifications much as a jazz musician riffs on fundamental themes. This inventiveness and playfulness rest on a post-oedipal psychic configuration of paradox [Benjamin 1995] wherein opposites are not mutually exclusive and polarities, like masculinity and femininity or homosexual and heterosexual desire, may coexist without requiring resolution.

Sexual Subjectivity

Sexual Self-States

Originally, sex, like any phenomenon [indeed, like any patient], was an object to be studied and known by a scientist’s putatively disinterested mind. Claims to untrammeled objectivity hold no more. Implicated as we are in the subject matter we study, influenced by the people we treat, our definitions, explications, and inter-
pretations of sexuality are informed by our sexual experiences, whether cognitive, affective, personal, familial, or cultural. Our task therefore shifts: If we want to know something of sexuality as an object of study, we need to know something of sexual subjectivity: how is sexuality experienced by patients and even analysts?

If the oedipal narrative historically organizes and creates sex and gender, the new narrative generates the question of sexual self-states. Sexuality itself is no longer taken for granted as a self-evident drive, affect, or set of behaviors. Sexual desire is no longer a unisex model of tension, discharge, relief. Not only must femininity as well as masculinity, homosexuality as well as heterosexuality and bisexuality, be taken into account when it comes to desire. There may be as many sorts of desire as there are individuals who desire [Chodorow 1994], individual sexuality, manifesting as compromise formation [Chodorow 2003], comprises linked, interacting elements that are universally occurring but idiosyncratically combined. Finally, desire itself changes throughout life, to extend a point insisted on by the classical narrative.

The Concept of Desire

Although not so much used by Freud, the concept of desire has gained currency because of the influence of Jacques Lacan. In his view, desire designates a state of longing that receives, at least in Western culture, a primarily sexual expression entailing longing, arousal, and near satisfaction. Yet desire does not mean satisfaction; indeed, it regularly feels like a near miss. Whereas Lacan had a dark view of this as necessary unpleasantness that draws us forward through life, Freud held a view that was more melancholic, characterizing one’s sense of this longing thus: “En attendant toujours quelque chose qui ne venait point [Always waiting for something which never came]” [Freud 1940[1938], p. 300; quoted in Green 1996, p. 872].

Bodymind

Sexual experience shows up in both mind and body. However, this complicated manifestation of affects, impulses, and fantasies is further complicated by others’ desires, as may be seen in new conceptualizations of the body. Traditionally, the body was an object-body made of zones, organized by goals, traversed by a force, and knowable by science. It imprinted psyche, and psyche in turn mapped it. Now, however, the body emerges in subjective, intersubjective (which is also cultural) space, and rather than being divided into parts, it multiplies. The shift from then to now is from the body as object to “embodiment,” which refers to the body as subjectively experienced. Embodiment may be conceptualized as “bodymind” [Wrye 1998]. Bodymind weaves together psyche and soma, private epochs, interpersonal history, and public convention and thereby provides a locus for idiosyncratic experience. Opening the “frontier between the mental and the physical” where Freud [1905, p. 168] situated the instincts, bodymind is neither subject nor object but both: my body, you might put it, is at once “an object for others and a subject for myself” (Merleau-Ponty 1962, p. 167). Bodymind therefore expresses or communicates meaning and an emergent construction in intersubjective, interpersonal, and social life. Finally, key to bodymind is pre-oedipal experience, in which the mother’s caretaking activities create what Anzieu [1989] called the “skin-ego” but that we might dub the “touch-ego” [Dimen 2000, p. 30].

Enigmas of Sexuality

Recent work [e.g., Dimen 1999; Laplanche 1976; Stein 1998; Stoller 1979] has begun to address the dilemmas of sexual experience. Freud, we have seen, found the source of sexual difficulty in the developmental necessity to weld drive, aim, and object into one, a precarious enterprise often likely to fail given the chthonic diffuseness of sexual experience and diversity of aims. Contemporary French psychoanalytic theory, in contrast, delves more deeply into sexual subjectivity. McDougall [1995] located sexuality’s traumatic quality in the necessity of loss: the achievement of identity and maturity means relinquishing the claim to gender “over inclusiveness.” In Laplanche’s [1976] view, sexual desire’s origins render it an “alien internal entity.” For him, as for Kristeva [1983], psychosexual development is strongly marked by the mother, for it is now seen to proceed in relation to her sexuality, which by definition consists in her unconscious.

Sex can then be experienced as puzzling, traumatic, enigmatic. Arising in the early relationship, it is unconsciously transmitted to the infant from the maternal or, as we might now emend it, the parental unconscious. This unavoidable transmission of desire to a being yet incapable of understanding it makes sexuality unconsciously troubling. Stein [1998] limned this excessiveness by recounting how the loss of self that it entails transcends and even contradicts the state of mind, the profane connectedness, required for ordinary life. Making a further distinction, Benjamin [1998] found this excess to result from “failures in affective containment.
[that] may produce sexual tension rather than reflect some interpersonal transmission of unconscious sexual content" [p. 7]. Davies [2001], unearthing yet another intersubjective effect of the unmetabolizable spillover of parent-child intimacy, suggested that the unavoidable absence of parents’ empathy with their children’s sexual feeling inevitably imbues sexuality with a sense of trauma. (Of course, such an absence depends on cultural context: in societies where parents and children share a sleeping space, children’s presence during parental sex may afford mutual sexual empathy. The primal scene’s significance is, in other words, culturally relative, not necessarily traumatic, and even, as Aron [1995] proposed, generative.)

Perhaps, finally, it is this enigmatic dimension that, in the clinical setting, makes sexuality sometimes spill over into a boundary violation. Given how enduring this problem is and given that, according to Glen Gabbard (2008), it is a vulnerability to which all analysts are subject, it is crucial to think about the influence of patients’ and analysts’ desires on each other. Fortunately, this clinical, ethical, and theoretical dilemma is now beginning to receive the scholarly and professional attention it is due, via discussions of erotic countertransference [Davies 1994, 1998; Gabbard 1989; Maroda 1994] and sexual boundary violations (Burka 2008; Celenza 2007; Celenza and Gabbard 2003; Cornell 2009; Dimen 2011; Gabbard 1989; Gabbard and Lester 1995; Makari 2008).

Conclusion: Perversion and Normality

As noted earlier in this chapter, Freud [1905] began his foundational work on sexuality (The Three Essays) with the topic of perversion. So, as a way of illustrating some continuing central dilemmas, let us conclude an admittedly incomplete entry on a rapidly evolving topic with an overview of this highly contestable category of sexuality. Conventionally, sexual perversion is briefly defined as any deviation from coitus with a person of the opposite sex aimed at achieving orgasm through genital penetration [Laplanche and Pontalis 1967/1973]. However, under the bright lights of feminist inquiry, critical object relations theory, and [post-] modern skepticism, the very concept of “perversion,” and its presumed integrity, become suspect, inviting lively debate.

Perversion carries three meanings: that of illness, that of moral sanction, and that of human sexuality itself. Psychoanalysis is, Freud once said, at once a body of knowledge, a theory of human nature, and a method of cure. If, as a method of cure, it diagnoses illness and prescribes treatment, psychosexual theory is critical to the medical function of psychoanalysis. Indeed, the importance of sexual etiology lies precisely in the disciplinary role of psychoanalysis in what Foucault [1976] called a “technology of health and pathology.” If sexual illness causes psychic illness, a standard of sexual health must exist: as we have seen, as soon as heterosexuality and procreation are invoked as the twinned goals of sexual development in a theory that otherwise pronounces on mental health—for example, the achievement of selfhood—they become the criteria for adult normality. By this standard, any deviation from the reproductive heterosexual path indicates the germ of psychic illness.

That calling a perversion an illness has functions over and above medical care is suggested by how well psychoanalysts have ignored disclaimers over the course of the past century. Freud [1905] wrote that perverse practices permit “normal” heterosexual functioning: “neuroses are, so to say, the negative of perversion” [p. 165]. Ninety years later, Kernberg [1995] prescribed that a healthy sexual relationship encompass occasional moments when one uses the other “as a pure sexual object” [p. 58]. Yet the term perversion seems so important that even now it is in the course of being redefined. No longer, Dimen [2001] contended, does it refer to sexuality. Rather, it designates the mutilated capacities to love (Bach 1995; Stoller 1975) and to survive loss and narcissistic injury (Chassegue-Smirgel 1976; Goldberg 1995); the creation of readiness in the psychoanalytic situation (Ogden 1997); or the anal mashing of all distinctions, of the sexes and the generations, as part of an effort to destroy civilization (Chassegue-Smirgel 1976).

The cultural values and social sanctions contained in this effort to rehabilitate a category doomed from its inception are inevitable in a topic as hot as sexuality. It is no longer possible, since the Foucauldian critique, to view psychoanalysis as existing outside its cultural and political milieu [see also Person 2004]. As such, it possesses both facilitating and socially controlling functions and emancipatory and dominating clinical and theoretical practices. Psychoanalysis is implicated in a system of disciplinary power that facilitates healing by naming the illness or helping the patient to name it. The power to name is, however, also the power to blame.
Consider Laplanche and Pontalis’s [1967/1973] caution: “It is difficult to comprehend the idea of perversion otherwise than by reference to a norm” [p. 306]. In other words, perversion and that inadequately specific term normality construct each other. However, normality is not merely a scientific term: the very idea of a norm is always already filled with and prompted by cultural significance and custom. In the discourse of psychosexuality, perversion and heteronormality constitute each other’s limits. Perversion marks the boundary across which you become an outlaw. Normality marks off the territory that, if stayed inside, keeps you safe from shame, disgust, and anxiety.

The same may be said of sexuality altogether. All sexuality may in fact be considered a deviation, a swerving from a path that no longer may be traversed [Laplanche 1976]. If we are correct in thinking that sexuality, like the psyche itself, is simultaneously subjective and intersubjective, intrapsychic and interpersonal, then desire itself is inevitably marked by the losses of the earliest object-relational experience, indeed, by the loss of that state of mind itself. Here we must agree with Lacan’s view of desire as distinguished from need. Need, like hunger, must have one thing and one thing only: food. Desire thrives on substitutes. It may be satisfied or deferred—turned into pleasure or babies or buildings or bombs. It may accept a blowjob or coitus or a beating, a fantasy or a body, a belt or a breast or a picture, a male or a female or a transvestite.

The reconstruction of psychosexual theory challenges other psychoanalytic fundamentals, notably the question of mental health, and hence of treatment and cure. What, after all, is sexual pathology? If all sexualities may claim wholesomeness, if all have a valid psychic place, then all are subject to the same psychic vicissitudes. Here we return full circle to Freud’s clinical observation: sexuality has nothing inherently to do with mental health or mental illness. You may be ill if you are heterosexual or transvestite, and you may be healthy if you are homosexual or bisexual or... whatever.

The difficulty and variousness of perversion, as of sexuality itself, should make us hesitate before we proclaim or adhere to a single explanation for sexuality or a single developmental account. For much of the past century, the pull has been toward the normalizing and one-dimensionalizing pole of psychoanalytic theory: a single narrative of reproductive heterosexual desire as the gold standard by which mental health is measured. Yet even as conformism dominated psychoanalytic thought and clinical practice, an opposing pole existed and is, as we have seen, now receiving its due. Psychosexual theory is a work in process, and its results are not yet in.

KEY POINTS

- Psychoanalytic theories of sexuality and gender are not neutral and objective. They are embedded in history and politics and cannot be understood apart from that context.

- Psychoanalytic feminism conceives of gender as an analytic and social category, not merely a psychological one. Thus, an adequate theory of gender must also incorporate cultural, philosophical, literary/linguistic, and sociopolitical perspectives.

- Freud vacillated between a radical and a heteronormative view of the relationship between gender and sexuality. The conformist Freud opined that gender splitting was necessary for procreative purposes, while the radical Freud maintained that “every individual displays a combination of activity and passivity” and that nothing can inherently distinguish procreative from pleasure oriented sex.

- Freud’s idealization of phallic masculinity as a cultural ideal (e.g., rational, abstract) not only derogated women (emotional, concrete), it also delayed the theorization of masculinity as a uniquely personal psychic formation. Chodorow and Corbett have shown how the defensive construction of masculinity as an ideal constrains men’s psyches to negations such as “not femininity/not mother” and “never loser/only winner.”
Gender and Sexuality

- Attachment-individuation theories of gender emphasize that gender develops in a relational field and can be used as a strategy to establish, maintain, or deny crucial attachments by highlighting the child's likeness or difference from others.

- Gender is built out of multiple identifications and dis-identifications. There is no singular masculinity or femininity, and gender diversity and rudimentary forms of body modification have always existed. The clinical issue is whether the subject experiences herself or himself as personally investing gender with meaning, or whether she or he takes it as concrete fact.

- Although the term sexuality is no less complex than that of gender, the debates about it are much less thickly layered and its intellectual history patchier. Ideas about sexuality possess a reality of their own, constituting a sort of parallel universe that must be parsed so as to set in sharp relief the world it is meant to illuminate.

- In contemporary view, we return to the classical position that the sexual instinct, albeit innate, lacks an inborn aim and object, rendering aim and object as acquired, pleasure as taking many forms, both aims and objects as multiple and fragmented, and erogenous zones and component instincts as participating in a two-person psychology.

- The oedipal narrative can no longer be uncritically accepted as a veridical account or accurate prediction of psyche, culture, or history.

- No single narrative accounts for homosexuality and heterosexuality, and standards of sexual normality are now contingent and emergent.

- The reconstruction of psychosexual theory challenges other psychoanalytic fundamentals, notably the question of mental health, of sanity, and, hence, of treatment and cure.

References

Anzieu D: The Skin Ego. Translated by Turner C. New Haven, CT, Yale University Press, 1989
Bassin D: Beyond the he and the she: toward the reconciliation of the masculine and feminine in the postoedipal female mind. J Am Psychoanal Assoc 44(suppl):157–190, 1996
Bassin D: Working through our predecessors and our own readings, in Female Sexuality. Edited by Bassin D. Northvale, NJ, Jason Aronson, 1999, pp 5–21
Benjamin J: Like Subjects, Love Objects. New Haven, CT, Yale University Press, 1995
Chodorow NJ: Femininities, Masculinities, Sexualities. Lexington, University of Kentucky Press, 1994
Chodorow NJ: The Power of Feelings: Personal Meaning in Psychoanalysis, Gender, and Culture. New Haven, CT, Yale University Press, 1999a
Coates S: Is it time to jettison the concept of developmental lines? Commentary on de Marneffe’s paper. Gender and Psychoanalysis 1:35–55, 1997
Davies JM: Between the disclosure and foreclosure of erotic transference–countertransference: can psychoanalysis find a place for adult sexuality? Psychoanalytic Dialogues 8:747–766, 1998
Davies JM: Erotic overstimulation and the co-construction of sexual meanings in transference and countertransference experience. Psychoanal Q 70:757–788, 2001
Dimen M: Lapsus linguæ, or a slip of the tongue? Contemp Psychoanal 47:35–79, 2011
Gender and Sexuality


Harris A: Gender as contradiction. Psychoanalytic Dialogues 1:197–220, 1991


Harris A: Gender as a soft assembly. Studies in Gender and Sexuality 1:223–251, 2000


Horney K: The flight from womanhood [1926], in Feminine Psychology. Edited by Kelman H. New York, WW Norton, 1967, pp. 54–70


Kernberg O: Love Relations: Pathology and Normality. New Haven, CT, Yale University Press, 1995


Laplanche J: Life and Death in Psychoanalysis. Translated by Mehlman J. Baltimore, MD, Johns Hopkins University Press, 1976


Person E: The Sexual Century. New Haven, CT, Yale University Press, 1999
Stimmel B: The baby with the bathwater. Studies in Gender and Sexuality 1:79–85, 2000
Stimpson C, Person E [eds]: Women: Sex and Sexuality. Chicago, IL, University of Chicago Press, 1980
Young-Bruehl E: Gender and psychoanalysis: an introductory essay. Gender and Psychoanalysis 1:7–19, 1996
SECTION III

Schools of Thought

Section Editor: Adrienne Harris, Ph.D.
Classical Psychoanalysis

Past and Present

Richard M. Gottlieb, M.D.

TODAY IN THE UNITED STATES ALONE there are many psychoanalyses, not just one. Some “schools” are sufficiently important to be represented by separate chapters in this textbook. They share some fundamental ideas and clinical approaches but differ in important ways, sometimes radically so. Only one school has been called “classical,” a term often used with pride by its own members but that can be also used pejoratively by competing schools to cast the so-called classicists as outmoded or superseded. In either case the designation “classical” is a misnomer, as I shall explain.

Although members of psychoanalytic “schools” are never in unanimous agreement on any point of theory or technique, still it is useful to think about them as though ideal types existed. Doing so helps us to understand in greater depth the history and evolution of psychoanalytic thought, what is at stake in current controversies, and the fundamental structure of psychoanalytic thinking and practice. Accordingly, I focus in this chapter on the so-called classical school, the history and evolution of its theories and clinical practices, the ways in which these differ from those of selected other schools, and the common ground they all share.

First a word about the designation “classical” as applied to psychoanalysis. Although often applied to a certain style of psychoanalytic theory and technique, classical is a misnomer. Conjuring as it does associations to fifth-century B.C.E. Greek or Roman civilizations and early dramatists such as Euripides and Sophocles—that is, conjuring a sense of origins—one would think, therefore, that Freud was a classical psychoanalyst. In fact, he was not considered such. Oddly, Freud’s psychoanalytic technique was repudiated time and again as deviant and un-analytic—and some of his clinical behavior as representing defections from “traditional” clinical practice—by some of the most influential writers of the mid-20th-century American ego psychology school [K.R. Eissler, personal communication, 1987; see Beigler 1975; Kanzer 1952; Kris 1951; Lipton 1977; Mahony 1986; Zetzel 1966; Beigler, a self psychologist, wrote in 1975 of Freud’s “non-Freudian” behavior with the Rat Man]. Those ego psychologists, it seems, in-
vented themselves as “classical” or “traditional” even though the tradition would appear to have begun with them. Their seeming purpose was to burnish their own way of doing things with a certain gravitas. Consequently, in psychoanalysis, the term classical usually refers roughly to American ego psychology, a collection of psychoanalytic ideas and techniques emerging in the late 1930s, extending through the 1960s and—with significant accretions and modifications—down to the present day. Although arguably no longer the mainstream of analysis in America (see Smith 2001), the classical style has survived and yields great and continuing influence.

In 2006, Penzer, a then-recent graduate of the New York Psychoanalytic Institute, long considered the headquarters for the classical point of view, wrote about what he learned there:

Most of my teachers and supervisors adhered to what has been characterized as classical psychoanalysis—in its development through ego psychology and, more recently, compromise formation theory—with its relative emphasis on the centrality of childhood instinctual conflicts and their apotheosis in the oedipal period and the attendant compromise formations, adaptations, and organizing unconscious fantasies that characterize subsequent mental life and manifest themselves in the transference. [p. 730]

Although “apotheosis” might be a bit excessive, I develop little in this chapter that disagrees with his brief description.

In 1989 Jacob Arlow, one of its major architects, wrote that the classical point of view takes a) persistent b) intrapsychic conflict, usually c) originating in early childhood, as central to the shaping of d) unsatisfactory compromise formations that are the sources of neurotic suffering.

There are other names for today’s descendants of this tradition: conflict theory, modern ego psychology, modern conflict theory, compromise formation theory, and the Freudian or modern Freudian school. All are used to designate a tradition that transplanted itself to America from its earliest beginnings in central Europe in the mid-1930s. Its foundational works are Anna Freud’s [1936] The Ego and the Mechanisms of Defense and Heinz Hartmann’s [1939] The Ego and the Problem of Adaptation. Both are studies of ego functioning as viewed from within Sigmund Freud’s [1923] second major model of the mind, the “structural hypothesis,” as explicated in The Ego and the Id. The ego, wrote Robert Waelder in a prescient 1936 paper, “is the [mental] representative of the central steering in an organism” [p. 46]. He described the ego’s task as devising and executing ongoing solutions to the continuous problem of balancing the various demands of the mind, demands that were often at odds with one another. Our instinctual endowment [id], conscience and value system [superego], and reality considerations would each pull us in a different direction were it not for Waelder’s ego. It might be fair to say that Waelder’s ego is the chief executive officer of the mind conceived of as a large and complex organization. Rescuing Waelder’s ego concept from relative obscurity in his groundbreaking paper on the masochistic character [Brenner 1959], and in numerous papers and books for more than 50 years thereafter, Charles Brenner put Waelder’s principle of multiple function at the center of his own evolving conflict theory, first as central to the ego’s functioning and later as one of the two primary operating principles of the entire mind as viewed from a psychoanalytic perspective. The other principle he called, echoing Freud, the “pleasure-unpleasure principle,” which dictated that the mind always operated so as to maximize pleasure and minimize unpleasure [Brenner 1982].

In this chapter, then, I examine the origins and evolution of American ego psychology through the time of its predominance during the third quarter of the 20th century down to the present day. I show how a selection from Freud’s ideas were woven into ego psychology and retained (e.g., the structural theory of id, ego, and superego), whereas others proved less useful or incompatible (e.g., the topographic theory of conscious, unconscious, and preconscious). In parallel with these theoretical developments were developments in clinical technique. “Classical” technique reached a crystallization around the mid-20th century into a technique that Freud himself—were he to return for a posthumous visit to America—would not have recognized as “psychoanalysis.” In their turn, neither would the most classical of analysts have recognized Freud’s technique as “analysis.” In fact, in his address to the 1990 graduating class of candidates from the San Francisco Psychoanalytic Institute, Arlow argued that Freud’s application for membership in the American Psychoanalytic Association would have to be rejected had it hinged on the clinical technique reported in his case histories of Dora, the Rat Man, Little Hans, and the Wolf-Man. None of the reports would be acceptable [Arlow 1991].

However, time pressures from within and without the classical school have since brought about far-reaching changes in these clinical techniques, changes related to two advances: 1) the increasing recognition of the importance of pre-oedipal development and 2) the emergent recognition and understanding of the importance of the nontransferential or “real” relationship between analyst and patient, that aspect of the relationship that
was not thought to be a repetition or “new edition” of the analysand’s earliest relationships.

Freud and the Early Ego Psychologists

Theory

So many of Freud’s central concepts and discoveries were continued into the classical tradition that it is impossible to discuss all of them here. We have to satisfy ourselves with brief and summary references to only the most important.

Freud’s central concepts of the importance of sexuality, the role of fantasy, and the compromise structure of neurotic symptoms were well developed by the mid to late 1890s. His idea that neurotic symptoms are compromise formations appeared first in an 1896 paper [Freud 1896]. During this period, too, we find reference to the idea that symptoms are expressions of the sexual life of hysterics. Yet the formalization of these stunning innovations had to wait until the publication of his two fundamental texts of the early 1900s, The Interpretation of Dreams [Freud 1900] and Three Essays on the Theory of Sexuality [Freud 1905], including the later addenda of 1915 and 1920.

The Interpretation of Dreams

Always implicit in The Interpretation of Dreams is the assumption of psychic determinism—that is, that all mental events have preceding causes that can in principle be discovered. Dreams are neither gibberish, nonsense, visitations from the Beyond, nor divinely inspired. Rather, once we learn to decode them, it becomes apparent that they are sense-making reflections of our everyday concerns, often the most urgent of these. The same is true of all mental activity, no matter how nonsensical it may at first strike us. Although it rarely seems necessary to acknowledge this assumption explicitly, it is carried forward through all schools of psychoanalysis. A second, no less important assumption, that of overdetermination, is referred to again and again and cemented in this foundational work. By overdetermination is meant that a mental event, such as a neurotic symptom, dream image, or parapraxis, is always brought about by more than one antecedent mental cause. Hence when analyzed, it will be seen that many streams of mental activity have flowed together in its creation. It might be said that psychic determinism and psychic overdetermination were major discoveries developed in The Interpretation of Dreams.

From The Interpretation of Dreams we also come to understand that a significant portion of meaningful mental life takes place outside of our awareness; that thoughts and feelings can move from consciousness to unconsciousness and back again; that their “acceptability” contributes to the mind’s motivation for barring thoughts from consciousness; and that adult logic and rationality are not the only principles guiding our thinking. This last introduces a cognitive-developmental point of view.

Finally, in Chapter 7 of “the dream book” Freud explicated and diagrammed his division of the mind into regions of conscious and unconscious functioning, perception, memory, and action, creating what was later called the topographic model or topographic theory of the mind [to be contrasted with his later structural model of 1923, discussed later].

Three Essays on the Theory of Sexuality

The Three Essays provides us with the characterization of an instinct—the sexual instinct or libido—as a biological given, a part of our phylogenetic inheritance that during childhood undergoes a genetically preprogrammed developmental unfolding of organizations (e.g., oral or cannibalistic, anal, phallic, genital). One of the major distinguishing features that later emerged between the classical school and the interpersonal or relational school was precisely over this point, Freud’s view of instinctual life. Are human drives inborn, developing more or less autonomously given an “average expectable environment” [Hartmann 1939], or is motivation powered and shaped from the beginning of life by our need for relationships with others? Greenberg and Mitchell [1988], writing from a relational point of view, saw this distinction as the great watershed, separating all “drive/structural” schools of psychoanalysis (of which the classical school is the exemplar) from the “relational/structural” schools. Still others, notably Loewald [1972, for example], tried with some success to define a middle ground in which both instinctual pressure and intimacy with early caretakers played synergistic roles.

Other premises developed in the Three Essays were subject to later revision as well. Kohut, the architect of
self psychology, for example, proposed a third source of psychic energy, narcissism, that underwent regular phasic reorganizations in parallel with libido (and Freud’s later-added aggression).

The Three Essays also argued that the so-called sexual deviations represent arrests or regressions of the inborn developmental program; that the sexual instinct can be analyzed into its source, aim, and object [see also Freud 1915a]; and that each of these can be viewed as developing independently of one another. The aim of “normal” development, Freud argued, is for the final “genital” organization to subsume all the preceding ones, with traces of the earlier history remaining in foreplay and other sensual pleasures [e.g., kissing as a residue of the oral-cannibalistic phase).

How Many Elemental Instincts?

Freud’s 1920 paper Beyond the Pleasure Principle had many aims, chief among them his wish to find a place for aggression as a primary human urge, motivator, or instinct, having earlier thought of it as an aspect of the sexual drive. Sadism is an example. Yet clinical observation [and probably also Freud’s experience of the destruction wrought by World War I] had led him to posit aggression as a second elemental instinct alongside sexuality. This revision, Freud’s dual instinct theory, contrasted with his earlier single instinct theory [libido alone]. The dual instinct theory has remained a cornerstone of the classical point of view.

The Structural Hypothesis and the Centrality of Bodily Experience

It was the group of ideas developed in Freud’s 1923 monograph The Ego and the Id that would become the central pillar of ego psychology and its subsequent development as the classical point of view. Discarding the topographic model’s principle of separating mental phenomena according to whether they were conscious or unconscious, Freud constructed a system of division by functions into id, ego, and superego, a model later termed the structural hypothesis. Because the nature of these “agencies,” familiar to all psychoanalysts, is discussed elsewhere in this textbook. I do not dwell on them here.

In their highly influential “classical” study Psychoanalytic Concepts and the Structural Theory, Arlow and Brenner (1964) argued that because the two models [topographic and structural] were logically incompatible, and because in their view the structural model was superior, the earlier one should be jettisoned. Although not all analysts agree with their argument [e.g., Loewald 1956], it is fair to say that on the whole the classical point of view revolved around Freud’s 1923 model of the mind until 1994, when one of its foremost exponents abandoned it. Proposing then that “the mind be no longer divided into agencies or structures” [p. 486], Charles Brenner [1994] abandoned the structural theory in the course of further defining his own “conflict theory,” the major present-day offshoot of the classical perspective. Brenner emphasized the idea that all mental activity is best viewed psychoanalytically as a compromise formation among the competing forces of drive derivatives, reality concerns, moral interests, and defensive activity acted to maximize pleasure and minimize “unpleasure.”

In The Ego and the Id Freud continued to accord a central role to the individual’s experience of his or her own body. His famous statement that “the ego is first and foremost a bodily ego” [p. 26] is of a piece with the principles laid down in Three Essays. In Three Essays he emphasized that the sexual instinct, an energy derived from bodily experience, has a superordinate organizing effect on mental life. In The Ego and the Id he reemphasized it. For our purposes its importance lies in the fact that a distinguishing hallmark of the classical perspective has been its emphasis on bodily experience, including but not limited to sexuality. Although no school of psychoanalysis ignores the body, none accords to it a more central place in both theory and technique. The relational/interpersonal and self-psychology schools, for example, do not focus on the body to nearly the same extent as does the classical. From the classical point of view then it would be only a slight exaggeration to say that ego psychology was first and foremost a body-based psychology.

Role of Anxiety

Just as Freud had revised his theory of instincts in 1920 and his model of the mind in 1923, so too he revised his theory of the genesis of anxiety and its pivotal role in psychic conflict in his 1926 monograph The Problem of Anxiety [Freud 1926]. Freud’s first theory explaining the genesis of anxiety was that anxiety was the product of the transformation of dammed up sexual energy, in other words, a product of sexual frustration. Although he never fully abandoned this view in 1926 he added a
second, more important, explanation: an individual developed anxiety in response to the perception of a developing danger situation. He called this “signal anxiety,” in response to which the ego mobilized its defensive operations. Here Freud set out his series of the typical danger situations for the developing child: loss of the object, loss of the penis (castration), and loss of the superego’s love (moral or social anxiety, fear of punishment) (Freud 1926). The genesis and role of anxiety in psychic life has long been an arena for disagreement among psychoanalytic schools, although generally speaking most schools adopted Freud’s view of anxiety as a motive for defense. The differences lie in the question of just what is feared and what kind of psychic structure is postulated. Accordingly, Freud’s castration anxiety has been enlarged to include fears of genital mutilation in both sexes as well as fears of bodily injury more generally. Birth anxiety (Rank 1924), death anxiety, fear of the sheer power of the instincts (Anna Freud 1936), annihilation and disintegration anxieties, and fears of the revival or repetition of traumatic states of all kinds, among others, have all been proposed as fundamental sources of anxiety along with Freud’s series. What is also clear is that in practice none of these is ever seen in isolation, but always in some combination with all of the others. An original conception within the classical tradition was offered by Brenner (1975), who added a second group of unpleasurable affect states, depressive affects, that he thought could also set defensive operations into motion.

Evolution of the Classical Perspective

The early ego psychologists were the precursors of the classical perspective. In their writings during the 1930s and 1940s they made selective use of Freud’s assumptions and contentions, drawing liberally on ideas explicated in several major works: The Interpretation of Dreams, Three Essays on the Theory of Sexuality, Beyond the Pleasure Principle, The Ego and the Id, and The Problem of Anxiety. Their focus was on the ego of The Ego and the Id. Anna Freud’s 1936 study of the ego’s defensive apparatus stressed threats to the mind originating primarily from within, from the pressures and demands of the drives. Hartmann’s (1939) view was of the ego as the “organ” of adaptation. His focus was on its inner workings and structure as well as on threats and other tasks set for it from without, the problem of adaptation. Together with Ernst Kris and Rudolph Loewenstein, Hartmann produced a series of theoretical and clinical works that provided the framework of American ego psychology from the 1940s through the 1970s.

Although not yet defining ego psychology as such, some of Freud’s earliest collaborators addressed themselves to certain problems raised by the ego concept. Richard Sterba (1934) developed the idea of a therapeutic split in the ego. Before this idea was developed, it had been impossible to conceive of how an individual could both experience and observe himself, a minimal condition necessary for participation in psychoanalytic treatment. Herman Nunberg (1931) identified a capacity of the ego to integrate diverse but related elements and termed this the ego’s synthetic function, an idea to be later refined by Hartmann as its organizing function and Kris as its integrative function (Kris 1956). Paul Federn (1934) studied the operations and transformations of the ego during psychosis.

While the ego concept was being defined, refined, and elaborated, the important theoretical features that would come to define the classical perspective were: 1) the assumption of an inborn instinctual life that 1a) unfolded in accordance with an inherited program of development; 2) an emphasis on development during the first 5 years of life, especially during the oedipal period, that 2a) stressed the decisive and enduring influence of conflicts involving sexual and aggressive drives; 3) a model of the mind that included ego, id, and superego along with remnants of the earlier topographic model; 4) an emphasis on the centrality of bodily experience; 5) the influential role of fantasy; and 6) an understanding of anxiety as a danger signal generated by the ego that initiates conflict, defense, and compromise formation.

Background: Genealogy of Classical Technique

How did ego psychologists talk with their patients, and how did this differ from the behavior of their predecessors?

Theory and technique have always had a reciprocal relationship in psychoanalysis, each informing the other, which in turn informs the first, and so on. Freud’s earliest formulation of the structure of a neurotic symptom was that an unacceptable impulse or thought threatened to emerge into awareness, was repressed, and in its place a compromise substitute—the symptom—appeared in consciousness. If there were no need for the repression in
the first place, there would be no symptom formed. The aim of analytic therapy, therefore, was to “make the unconscious conscious.” The analyst’s first task was to discern the unconscious forbidden impulse [wish, thought] in the analysand’s free associations by decoding its disguises [condensation, displacement— the work of primary process thinking]. Having figured out the warded-off content, the analyst’s next job was to “interpret” the unconscious forbidden wish to the analysand. The goal of the analyst’s behavior, then, was to interpret the unconscious wish that lay at the root of the patient’s symptom, which would, Freud thought, result in elimination of the need for the symptom. The unacceptable impulse might be accepted or rejected, but this time rejection would be due to conscious judgment rather than repression. In either case, cure was effected as the need for the symptom was eliminated.

Here an example may help. In the famous case of “Dora,” Freud’s [1905 [1901]] patient developed abdominal pain 9 months after she had violently refused her suitor’s sexual advances. Discerning Dora’s unconscious [because it was unacceptable] love for her suitor in her associations, Freud reasoned that she had repressed her wish to become impregnated by him and that her abdominal pain 9 months after represented her disguised fantasy of being delivered of his baby. He told her this (“interpreted”), with the expectation that her abdominal pain would resolve, as it was no longer necessary.

This early approach, evident in all of Freud’s [1905 [1901], 1909a, 1909b, 1918] case histories, was subsequently thought of as “id interpretation,” because the cure consisted of the interpretation of derivatives of repressed, unconscious, instinctually driven wishes. When these wishes were of childhood origin and directed toward the analyst, they constituted aspects of what Freud called “by far the hardest part” of analysis, the transference. The content of transference wishes needed especially to be interpreted because if they were not, these wishes could cause the treatment to come to grief, as happened to Dora’s treatment. Yet they also needed to be interpreted because of the light they could shed on the analysand’s presenting problems. These clinical guidelines were systematically laid out by Freud in a series of papers published between 1911 and 1915, the so-called technical papers [Freud 1911, 1912a, 1912b, 1914, 1915b], and in the Introductory Lectures on Psycho-Analysis of 1916–1917, especially Chapters 27 and 28 [Freud 1916–1917]. It was here that Freud articulated his concept of the transference neurosis, the form—modeled on an inevitably preceding neurosis during childhood—the analysand’s adult neurosis took in relation to the analyst. The transference neurosis concept and its resolution by interpretation were carried forward into the mid-century classical school to become a shibboleth signifying membership in that school. Reed [1987] wrote that “in the 1950s the concept began to be used [by classical psychoanalysts] to designate whether or not the treatment was a psychoanalysis” [p. 467].

Techniques Emerging With Ego Psychology: Ego Analysis and Defense Analysis

As is easy to imagine, emergent theoretical trends of ego psychology positioned the ego as a major focus of interest for clinical psychoanalytic technique. Because the ego’s functioning was partly unconscious, one goal of analytic therapy continued to be making conscious what had been unconscious. Classical analytic treatments became thoroughgoing explorations of analysands’ ego functioning, most prominently defensive activity but also character style, cognitive style, modes of perception, memory functioning, motoric style and activity, and modes of interaction with others.1

Analysis of the ego became in a sense preparatory or preliminary to identification [interpreting] of warded-off instincual derivatives. An axiom of classical technique was that one always analyzed defense before drive [Fenichel 1941]. This was not to say that at first one analyzed the ego exclusively and only after that was done, the id. Rather, it was believed, as Gray [1982] wrote, that “[a]ppropriate defense analysis does gradually strengthen the ego and bring change in the intensity or predominant form of defense” [p. 635]. Following defense interpretations aimed at creating a more tolerant ego, then “reference to the defense, and then to the drive derivative defended against, typically [took] place within a single interpretation” [Gray 1982, paraphrasing Fenichel, p. 635].

The classical technique during this time made use of all the clinical guidelines Freud had set out in his technical papers [frequent sessions, free association, recumbent

---

1 The broad category of “object relations” was considered an ego function, although it would later become the central detailed concern of other, nonclassical schools of psychoanalysis.
position of the analysand, analysis of resistances, analysis of the transference, transference resistances and the transference neurosis, an attitude of abstinence on the part of the analyst, the use of dream interpretation). The major difference was one of emphasis. Whereas Freud and his early followers seemed focused on repressed unconscious drive derivatives and gave little systematic attention to the role of the ego, the later classicists devoted meticulous and detailed attention to ego analysis. Common to both generations of analysts was the near-exclusive emphasis on the Oedipus complex, the configuration that Freud had designated as the “nuclear complex of the neuroses,” by which he meant all neuroses. Therapeutic work on the Oedipus complex always engaged the analysand’s childhood relationships of love, rivalry, and hate with each parent—and the array of anxieties, terrors, and defensive activity around these “primal” urges. This work was thought to be especially productive of therapeutic change when the issues were engaged in their transference manifestations. Strachey [1934] argued that the truly “mutative” interpretations, which he called “the ultimate instrument of psychoanalytic therapy” [p. 142] (interpretations that could bring about therapeutic change), were interpretations of the transference to the analyst. Although Strachey explicitly acknowledged the necessity of frequent use of other kinds of interpretations, the widespread adoption of his misunderstood point of view by classical analysts led at times to treatments in which an analyst’s only comments were directed to transference manifestations.

Yet in their struggle to establish a beachhead beyond their native Chicago, self psychologists who made the claim of “empathy” at the same time seemed to imply that their more classical colleagues lacked empathy. This claim exemplified an unfortunate tendency of emerging schools to criticize what were, for the most part, caricatures of the classical analyst. As Smith [2001], among many others, later observed, “[T]he traditional classical analyst [is seen as a] cold, rigid, authoritarian, pathologically certain analyst who misses the nuances of the patient’s perspective and the interactive dimension of the relationship altogether” [p. 490]. In its own turn classical analysts might mischaracterize the relational/interpersonal schools as advocating a kind of therapeutic anarchy, promoting an “anything goes” technique that “threw away the book.” The classicists might also snicker at the “misguided” Kleinians who believed that a very young infant could possibly have an Oedipus complex. These unkind, misleading, and inaccurate characterizations of theory and practice abounded not only in written work but also at professional conferences and—perhaps most destructive of all—in the classrooms of analytic institutes, risking permanent closure of the minds of students who were all too eager to identify with their teachers.

Bearing in mind that such misrepresentation and caricature leads to no good place, I have in this chapter assiduously attempted to avoid these. Should any creep in outside my awareness, the oversight is mine and mine alone.

Rhetoric of Competition

A word of caution about language is necessary at this point in our discussion of the history of the classical school in America. Especially as psychoanalysis entered the third quarter of the 20th century, the competition for patients, trainees, and favorable public opinion heated up. Innovations in technique and theory vied for recognition. The innovators launched challenges to the hegemony of the ego-psychological tradition. An early challenge came from the self psychology of Heinz Kohut and his followers. These were analysts who had deep roots in the classical tradition but believed that certain patients—those with disorders of the self—required lengthy preliminary phases of analysis guided by a different theory and technique. Self psychology stressed the importance of the analyst’s empathy, especially in the treatment of narcissistic conditions. So far so good.

Growth of the Classical Perspective

Accretion and Assimilation

Beginning around 1970 and continuing to the present day, the classical perspective has been expanding far beyond what it was at the mid-20th century. This expansion has been the result of two trends: 1) accretion from within, and 2) assimilation of findings and frameworks from other schools of psychoanalysis, from its “neighboring disciplines,” and from the cultural and scientific zeitgeist. Before discussing these, I want to offer a note on mid-century classical technique, because it has so often been an object of rhetorically invidious comparisons with other psychoanalytic techniques.

The early classical psychoanalysis was rooted in biology, not social relations. Its engines of motivation
were instincts, not the need for other persons, most notably not mother, and those instincts were sex and aggression. Its central interpretive tenet was concerned overwhelmingly with incest and homicide. Clinically, many classical analysts endorsed Freud’s vision of analyst-as-scientist-surgeon operating upon an objectified analysand, the latter not recognized as an equal partner in the enterprise; the analysand’s thoughts were divulged, but those of the analyst were kept private; the role of mother as nurturer was put in the background, whereas the role of father as punishing castrator was foregrounded; the validity of the patient’s perceptions were to be questioned, whereas those of the doctor were not. When taken to extremes [brought about partially to repudiate Alexander’s [1950] technical recommendation that analysis should provide a “corrective emotional experience” [p. 484]], the classical technique could become a set of clinical procedures rife with “hypertrophied formalism and ritualism” and “unreservedly depriving attitudes,” a technique Leo Stone [1981] dubbed “neoclassical” to distinguish it from classical.

Stone [1981] noted that the “essential and austere features” include the following:

“The analyst maintains “anonymity” [and that] except for certain inevitable activities of his identity and role, the patient is given no information or access to significant information about him. In general, the analyst does not answer questions. He gives no affective response to the patient’s material or evident state of mind, nor opinions, nor direction, not to speak of active interest, advice, or other allied communications. Some of these elements were epitomized in [Freud’s] renowned “surgical” and “mirror” analogies. (p. 99)

These were central features of the “classical”—or more fanatically put, the “orthodox”—or neoclassical technique. Its “essential original purpose was to avoid ‘contamination’ of the transference so that it could emerge in relatively ‘pure culture’” (p. 100).

This was the “neoclassical” or “orthodox” technique sometimes practiced and often caricatured in comparative psychoanalytic polemics. Although Stone himself endorsed some of these techniques as essential to creating the conditions for a psychoanalytic process, he thought that they had been carried to extremes during what he called the “long period of hypertrophied formalism,” a period of several decades that had largely passed by 1981. Along with the dawning of the women’s movement, an increased interest in child psychoanalysis and psychoanalytic infant observational research, the growth of the interpersonal schools of analysis, and the apparently changing nature of patients seeking psychoanalytic treatment, many trends were observable. Attention to so-called pre-oedipal development moved to the fore, bringing serious challenges to Freud’s contention that the Oedipus complex was the nuclear complex of [all] neuroses and foregrounding the formative role of the mother in development. Very early nurturing experiences and their pathologies drew increasing attention as it became clear that pre-oedipal development could be decisive.

This was not a new area of inquiry for classical analysts, but it was a new emphasis. The initial volume of The Psychoanalytic Study of the Child was published in 1945, with classicists such as Hartmann, Kris, and Anna Freud all contributing papers. This volume included the studies of Rene Spitz, best known for his work on “hospitalism” (Spitz 1945, 1946), that underscored the momentous importance of the early emotional environment. Margaret Mahler’s [1952] early studies of childhood psychosis evolved into her later work on separation-individuation and her fruitful collaborations, first with Furer [Mahler and Furer 1960, 1963] and later with Pine and Bergman, on The Psychological Birth of the Human Infant [Mahler et al. 1975]. These developments represented what I earlier termed “accretions from within” the classical perspective. They were studies in infant development—by the direct observation of children—and at the same time they provided suggestive hints that might identify critical junctures at which emotional development could go awry, that is, they inspired in some a search for the beginnings of psychopathologies.

The burgeoning interest in earliest (“pre-oedipal”) childhood had a profound influence on psychoanalytic technique with adults. Stone and Greenacre, both leading thinkers and admired clinicians of the classical school, thought that the fundamentals of the psychoanalytic setup for adults regularly revived the most profound infantile fantasies and yearnings, reflections of the earliest mother-infant experiences. Stone (1981) called this “deprivation-in-intimacy” [p. 98]. Greenacre [1954] wrote that the “matrix” of emotion developing between analyst and analysand “comes largely from the original mother-infant quasi-union of the first months of life” [p. 672]. The classical authors largely rejected the formulations of the British clinicians that imputed oedipal development to the earliest months of life and made inferences about defensive operations during infancy. Yet from abroad the influence of Winnicott [1947] was beginning to be felt. His now-famous dictum, “There is no such thing as a baby” [p. 88], not only stressed the early importance of the mother but also was an early intimation of what would become the growing importance within the evolving classical tradition of two-person, re-
lational, and interpersonal perspectives. These shifting and emergent perspectives encouraged classical analysts to make inferences about their analysands’ very earliest relationships, sometimes to their offering reconstructions of experiences thought to have taken place at the very dawn of an analysand’s life. Others, perhaps the more conservative classicists, while acknowledging that pre-oedipal experiences undeniably took place and influenced the outcomes of development, continued to hold to Freud’s view that the Oedipus complex was the nuclear complex. These theorists and clinicians believed that developments during the oedipal period so vastly and completely organized and reorganized all prior experience that—although influential—the preoedipal period could not be clearly inferred during the analysis of adults once this reorganization had taken place.

From Transference to “Real” Relationship

By the 1950s it had become the belief of many classical analysts that the analysand’s perceptions of the analyst were so powerfully colored by the residues of early experience that most of what the patient said and thought about the analyst could usefully be regarded as transference and, as such, an unrealistic view of him or her. Freud [1912a] had written about what he called the “unobjectionable” positive transference of analytic patients, unobjectionable because it did not interfere with the ongoing psychoanalytic process. Much more than that, it was “the [very] vehicle of success in psychoanalysis” (p. 107), but one need not interpret it because it did not generate a resistance to analysis work.

The idea that nonpsychotic patients might be utterly unable to view their analysts and the analytic enterprise at least at certain times with a degree of objectivity seemed to some untrue. How could treatment proceed if the patient was capable only of an infantile, childish, distorted, or even delusional view of his or her therapist? Some part of the patient must have a mature view of what is going on. Through the years a number of ideas were advanced to meet this obvious clinical observation. Some of the very earliest writers on the ego had recognized the problem. Sterba [1934], following an earlier suggestion of Freud’s, proposed that for treatment to take place there must be a “dissociation” within the ego that can account for the cooperation with the procedure even as resistances were active. Later writers began to speak of a “therapeutic split in the ego” (e.g., Bilbring 1954; Orr and Zetzel 1953). The basic idea—later elaborated by Zetzel (1956) as the “therapeutic alliance,” by Greenson (1965) as the “working alliance,” and yet later by Lipton (1977) as the “personal relationship” between analyst and patient—was that the analysand is capable of forming a partial “realistic” relationship with the analyst for the purposes of sustaining the treatment and that this realistic aspect of the relationship is only minimally affected by the transference and does not require interpretation.

Along with all of this, more recently there has developed a trend toward the reduction in the attribution of authority and privilege to analyst’s point of view compared with that of the patient, a tendency to view analysand and analyst more as equals, collaborators, or partners. One hears frequently today of the “analytic couple” or “pair,” and less frequently of patient and doctor. These changes—and they are no mere changes in vocabulary!—seem the end result of several factors, including the relocation of analysis away from the more hierarchical Germanic Central Europe to the more democratic America; the contemporary revolution in women’s position in American society; the change from the fact that most patients were women and most analysts men, the increasingly influential interpersonal/relational schools of analysis, and the increasing recognition of the intense and continuous emotional participation of the analyst in every treatment from its beginning to its ending. They also derive from, in Renik’s (1993) felicitous phrase, the increasing appreciation of the analyst’s “irreducible subjectivity.” Renik’s insistence, from within the classical tradition [he was editor-in-chief of The Psychoanalytic Quarterly], on a subjectivity the analyst could never shed and never fully grasp (its being unconscious in large measure as well) was not an idea without a history and context. It had been in the zeitgeist for decades, and Renik himself acknowledged his debt to Einsteiian relativity. This is perhaps the most important example of the growth and evolution of the classical perspective by assimilation of the surround and leads naturally to a consideration of the analyst’s countertransference, of two-person psychologies, and of the many and varied [but not well understood] ways in which analyst and patient may influence each other.

Through Scopes
Broad and Narrow

Along with changing views of the therapeutic relationship, there were concomitant changes in analysts’ beliefs
about who can benefit from psychoanalytic therapy. A common criticism of the classical school had been that, in keeping with Freud’s early view, the more disturbed patients could not be helped by psychoanalysis. Freud had divided the “functional” mental disorders into three broad classes: the transference neuroses, the narcissistic neuroses, and the *aktuelle* neuroses (neurasthenia, “anxiety neurosis,” and more tentatively, hypochondria). These last, he thought, were not psychogenically caused but resulted instead from toxic bodily states. He thought they were somatic medical illnesses following the model of thyrotoxicosis. The transference neuroses such as hysterics and obsession depression arose in patients who were capable of forming psychoanalytic transferences during treatment. Because of this capacity they were in principle capable of being helped by analytic treatment. The narcissistic neuroses were an entirely different story, reasoned Freud. Into this category he placed the schizophrenia, paranoia, melancholia, and the “severer neuroses” (Freud 1919). “The transference neuroses are the objects proper of psycho-analytic treatment, while the...narcissistic neuroses...offer fundamental difficulties to therapeutic influence,” he wrote (Freud 1924, p. 203). The problematic psychopathology of the narcissistic disorders was the patient’s incapacity to invest “objects” (mental representations of other persons) with libido. “The subject’s libido is attached to his own ego instead of to an object,” wrote Freud (1925, p. 55). rendering these patients beyond psychoanalytic help.

Freud’s view that these more disturbed patients were not analyzable became the prevailing “mainstream” classical view, and students attending classical psychoanalytic institutes were taught this view. A shift in opinion within the classical school began with Stone’s 1954 paper, and his later work (Stone 1961) stood as an important corrective to the overly averse methods of “neo-classicism.” Moreover, his “widening scope of indications for psychoanalysis” was endorsed enthusiastically by Anna Freud (1954). Stone observed that the “incapacity” of narcissistic patients for investing others with libido was only apparent; he said that they did form transferences, only with more difficulty (more tentatively and with more brittleness) than ordinary neurotics, and they could be successfully psychoanalyzed. From outside the classical mainstream, Heinz Kohut’s studies of narcissistic disorders produced many useful analytic clinical approaches to these patients, approaches that have been adopted by many classicalists despite the fact that his theoretical framework has found less favor. Of special value in the treatment of narcissistic problems were his characterizations of their idealizing and mirror transferences and the appreciation of the analyst’s role as a “selfobject” to the patient. He also emphasized the degree of psychic damage of such patients and the need for attentive patience on the analyst’s part.

Further facilitation of the development and success of the “widening scope” can be found in a line of research into the more severe mental disorders considered to lie at the diagnostic border between neurosis and psychosis. Although certain analytic authors had grappled with the borderline problem early on (e.g., Deutsch 1942), the most influential line of research, treatment development, and theory is generally thought to have begun in the early 1950s. The pioneering work of Hoch and Polatin (1949), Knight (1953), Stone (1954), Frosch (1964), and others, later including Kohut (1966) and Kernberg (1967), and more recently Lyons-Ruth (2006) and the attachment “school” of Fonagy et al. (2003), have all been instrumental in producing—over 40 years—a nuanced and progressively detailed understanding of the structure, early development, and analytic treatment of borderline conditions, narcissistic disorders, and more severe character pathology.

Deutsch (1942) characterized forms of psychopathology that appeared superficially to be psychoneurotic but that under certain stresses could collapse into psychosis. Most famously, she wrote of what she termed the “as if” personality. “Outwardly,” she wrote, “the person seems normal,” yet closer (i.e., psychoanalytic) observation leaves the “inescapable impression that the individual’s whole relationship to life has something about it which is lacking in genuineness and yet outwardly runs along ‘as if’ it were complete” (p. 302).

Hoch and Polatin (1949) at the New York State Psychiatric Institute identified a group of patients who appeared not so much normal as neurotic but who were prone nonetheless to episodic psychotic decompensations. They coined the diagnostic term *pseudoneurotic schizophrenia* for these patients’ condition and thought that their multiplicity of neurotic symptoms (“pan-neurosis”), the pervasiveness of their anxious states (“pan-anxiety”), and the fluidity of their sexuality (“pan-sexuality”) provided diagnostic clues to their underlying predisposition to psychosis.

Robert Knight (1953) differentiated the “borderline” condition as an entity in itself and contributed to its characterization, especially its characteristic constellation of defenses. Frosch (1964) developed the idea that
even when a patient did not show frank symptoms of psychosis, a psychotic core could be inferred from aspects of his or her character structure. He called this the “psychotic character.” From an object-relational perspective, Kernberg’s far-reaching studies have helped to clarify the character pathology, symptoms, and relational disturbances that characterize the borderline conditions. Kernberg believed these patients to be treatable psychoanalytically and advocated a psychoanalytic technique modified to a greater or lesser extent depending upon the particulars of the case. All of these developments have found their way into the classical psychoanalytic perspective.

From a One-Person Toward a Two-Person Psychology

Finally, in my view, the most powerful, comprehensive influence on the classical tradition over the past 40 years has been the gradual movement from viewing the psychoanalytic encounter as a situation in which one person studies and elucidates the psychology of another to an encounter between two persons who profoundly affect each other and together create something new from their encounter. What is interesting about this trend is that it seems today to pervade all schools of psychoanalysis, often under different names and marked by other—in my view—minor variations. Although the major theorists contend that their divergent theories cannot be reconciled with one another, clinicians have been carefully picking and choosing what they find useful in their day-to-day work with patients, regardless of what theory these techniques hail from.

Speaking for incompleteness, Greenberg and Mitchell (1983) argued that “the different models [classical and relational] that characterize psychoanalytic thought…reflect different visions of reality. They cannot be meaningfully combined into a single theory” (p. 19). They added that in clinical practice as well, “a fundamentally different understanding of human development directs the two models toward equally incompatible approaches to the therapeutic action of psychoanalysis” (p. 390). From the classical perspective, Brenner asserted the same conclusion: one must discard one theory or the other, both cannot be true. Yet despite these well-reasoned conclusions, I would say that the mutual influence—and convergence—of the two great schools has to a large extent already begun to take place and is highly likely to continue into the foreseeable future.

How can one explain this? It seems to me that it is a matter ultimately of the primitive state of our knowl-

dge and the difficulty in providing proof of any of our assertions, be they points of theory or clinical technique. Yet it is neither unscientific nor otherwise untenable for analysts to hold in their minds mutually incompatible descriptions and beliefs about some of the phenomena with which we deal. Because human mentation is complex and our concepts are not easily subject to verification, and because analysts have urgent, practical tasks at hand when we act as healers, our clinical theories and practices must, logically speaking, be untidy. The outcome, therefore, of the theoretical collision between the one- and two-person psychologies (or if one prefers, the “drive/structure” and the “relational/structure” models) has been complicated and has left each indelibly affected by the other.

The role of the Freudian “object” is illustrative. If we reach back to Freud’s assertion in the Three Essays on the Theory of Sexuality that the object of the libidinal drive can be conceived of independently of its source and aim, and extend throughout the eras of ego psychology and the “classical” or “neoclassical” developments, mainstream psychoanalysis in America had been a one-person psychology. Hartmann’s (1939) notion of individual development within an “average expectable environment” epitomized the one-person view: ordinarily, development unfolded in an orderly fashion without much regard for the subtle influences of variations in the individual’s interpersonal environment. Although, for example, what a person’s mother was like was hardly disregarded (e.g., if she were depressed, an individual might identify with her), the details of her interactions with that person were not closely studied, nor were their effects much accounted for. As we have discussed, this emphasis also had its corollary in the mainstream views of the clinical analytic technique and its aims: the “objective” analyst interpreted the psychology of the analysand. Accordingly, countertransference—the analyst’s conscious and unconscious emotional reactions to the patient, including the patient’s transference to the analyst—was viewed as peculiar to that analyst and an obstacle interfering with his or her capacity for the “objectivity” required to conduct the analysis. The analyst, when not impaired by countertransference, was the reckoner of the patient’s mind. This was neither a partnership nor a collaboration; analyst and patient were neither a “couple” nor a “pair.”

Reflecting on this remarkable flowering of developments in the study of countertransference, Theodore Jacobs (1999) wrote:

Looking back on the final decades of the twentieth century,…future historians of psychoanalysis may
well designate this period the countertransference years, for in this time few concepts in our field [I would say none!] have gained as much attention, have been as widely explored and written about, and have been the subject of as much controversy as has... countertransference and its role in the analytic process. (p. 575)

Jacobs is describing an alternative perspective for viewing the role of the analyst’s irreducible subjectivity and of the task of understanding its influence on the analytic relationship, including the analysand’s impact on the analyst’s subjectivity, vice versa, and so on. Widely understood today is the fact that the analyst and analysand influence each other, powerfully, continuously, and largely unconsciously. These influences affect everything they do and say (and refrain from doing and saying) to each other.

Beyond the very fertile area of countertransference studies, there has been little other innovation in classical analytic thought over the past 30 years. Two exceptions have been the birth of “neuro-pyschoanalysis” (e.g., Olds 1992; Solms 1995) and the study of the effects of the newer psychotropic medications on analytic work (Busch and Sandberg 2007; Gottlieb 2002, 2004, 2006, 2008).

**Conclusion**

Although it is true that more has been left out of this chapter than it has been possible to include, I hope I have sketched the central currents in the history and evolution of the classical (or traditional or Freudian) school of American psychoanalysis. Its beginnings, like all things psychoanalytic, can be traced to Freud’s work, especially to his concept of compromise formation, elements of his first “topographic” model of the mind, his technical prescriptions of the 1910s, and his reformulations of the 1920s that included the dual instinct theory, the structural model, and his second anxiety theory. Influenced by early contributions of analysts interested in Freud’s newly conceptualized ego (Sterba, Waelde), and a bit later by the major theorists of ego psychology (A. Freud, Hartmann), the school of American ego psychology developed and prospered in the United States and dominated psychoanalysis here beginning in the immediate post–World War II period. Ego psychology’s hegemony began to fade in the 1970s. Following a renewed interest in very early infant and child development from the mid-1940s through the mid-1970s, classical psychoanalysis was theoretically quiet without much intellectual ferment or innovation until the last few decades of the 20th century, beginning first with the renewed study of narcissism (Kohut, Kernberg) and then entering the “countertransference years” (Jacobs). The intense reconsideration of countertransference phenomena evolved easily into a preoccupation with the mutual unconscious influences between patient and analyst, including, most recently, mutual enactments. All of these more recent developments bear the earmarks of the classical school’s increasing appreciation of certain relational/interpersonal and object relations contributions.

From the point of view of clinical technique, it was of interest that what came to be called “classical” (or “neoclassical” [Stone]) technique was not Freud’s technique but a much later one that evolved during the 1940s and 1950s by the American ego psychologists. This technique, centrally concerned with the unimpeded development of the patient’s transference neurosis and interpretation of unconscious conflict (broadly construed as a configuration of drive derivative, anxiety, defense, moral concerns, and realistic considerations), conceived of the analyst as an objective observer of the patient’s mental function, minimally emotionally entangled in the treatment process, as might be a surgeon.

Although there is certainly no unanimity even among self-declared “classical” analysts, a trend is discernable that reflects the convergent evolution of the ego-psychological and relational/interpersonal models of the mind and models of the psychoanalytic treatment process. Moreover, although major theorists from both camps (Greenberg and Mitchell, and Brenner) have cogently argued that the two points of view are incompatible and that analysts need to choose one or the other, what is happening “on the psychoanalytic street” is quite different. Instead of choosing, analysts are selecting from many schools what they find most useful in their clinical work and trying hard to disregard any logical inconsistencies.
KEY POINTS

- Today, the classical point of view in psychoanalysis refers not to that of Freud and his collaborators but to the tenets and practices of American ego psychology beginning in the 1940s and how these evolved down to the present day.

- Classical theory has always relied heavily on Freud’s second model of the mind, called the “structural theory.” The structural theory organized the functions of the mind into three groups—the ego, id, and superego—a division that is still important to most classical analysts today.

- Classical theory relies heavily on the assumption of two classes of inborn instincts: sexual and aggressive.

- Symptoms, character traits, dreams—indeed all mental phenomena—are viewed as compromise products of interacting mental events and forces such as instinctual pressures, defensive activity, moral concerns, pleasurable and unpleasurable affects, and the individual’s relationship to reality.

- The mental agency of most interest to the ego psychologists was, of course, the ego. Its hypothesized functions, such as defense and adaptation to reality, were central objects of study for the mid-20th-century ego psychologists.

- Early on within classical psychoanalysis, a clinical technique developed that had a major focus on the exploration and understanding of the functioning of the analysand’s ego, especially as revealed and expressed in the analysand’s transference to the analyst.

- During the second half of the 20th century, the classical perspective underwent far-reaching changes. Most important, it became more concerned than in the past with the analyst’s experience of the analytic relationship and how this contributed to the analytic process. Classical analysts increasingly spoke and wrote about the transference-countertransference matrix and less about the analysand’s transference as if it unfolded in isolation. Theory too was influenced by this shift in focus so as to emphasize the observation that a child’s early relations with important others shaped his or her view not only of others but of himself or herself as well.

References

Brenner C: Affects and psychic conflict. Psychoanal Q 44:5–28, 1975
Deutsch H: Some forms of emotional disturbance and their relationship to schizophrenia. Psychoanal Q 11:301–321, 1942
Fenichel O: Problems of psychoanalytic technique. Psychoanal Q 7:421–442, 1941
Kris E: Ego psychology and interpretation in psychoanalytic therapy. Psychoanal Q 20:15–30, 1951
Loewald HW: Freud’s conception of the negative therapeutic reaction, with comments on instinct theory. PsychoanaL Study Child 20:235–245, 1972
Mahler MS: On child psychosis and schizophrenia: autistic and symbiotic infantile psychoses. Psychoanal Study Child 7:286–305, 1952
Mahler MS, Furer M: Observations on research regarding the “symbiotic syndrome” of infantile psychosis. Psychoanal Q 29:317–327, 1960
Mahler MS, Furer M: Certain aspects of the separation-individual phase. Psychoanal Q 32:1–14, 1963
Mahony PJ: Freud and the Rat Man. New Haven, CT, Yale University Press, 1986
Smith HF: Obstacles to integration: another look at why we talk past each other. Psychoanal Psychol 18:485–514, 2001
Spitz R: Hospitalism: an inquiry into the genesis of psychiatric conditions in early childhood. Psychoanal Study Child 1:53–74, 1945
Waelder R: The principle of multiple function: observations on over-determination. Psychoanal Q 5:45–62, 1936
Zetzel ER: Current concepts of transfERENCE. Int J Psychoanal 37:369–375, 1956
Object Relations

Paul Williams, Ph.D.

At the Maudsley Hospital, the United Kingdom’s main psychiatry teaching hospital, there arose in the 1970s and 1980s an experimental ward in which patients with psychosis or very severe personality disorder lived for a year or more while receiving intensive psychiatric care, predominantly psychoanalytic therapy, individually and in groups. An account of the clinical work of this unit and its results is provided in Jackson and Williams’s (1994) Unimaginable Storms: A Search for Meaning in Psychosis. On this ward worked a sensitive, middle-aged black nursing assistant who was the lowest-paid staff member after the cleaners. She was more gifted at talking intimately with patients with psychosis than the doctors or nurses. Eventually, the staff campaigned for her to receive an honor from the Queen of England at Buckingham Palace for her services to mental health. This modest woman talked to patients in a personal way that did not evade the anguish and fear underlying their distress, past or present. She had a knack for framing dialogue in terms of relationships—the relationship between the patient and her, other patients, him- or herself, family members, friends, or acquaintances as well as the patients’ environment, hobbies, feelings, and experiences. Everything seemed connected to everything else, without orchestration and with no estrangement of inner from outer. She intuited what psychoanalysts refer to as internal “part-object” relationships: fleeting anxieties, terrors, and longings that overwhelm and distract the mind, often reflecting unsatisfactory childhood relationships. Her conversations were alive to these anxieties and the need to talk about them in the context of an enduring, trustworthy relationship. It was here that I began to grasp why it is not possible to understand any of the most important things in life without talking about them with another person who is receptive and open-minded. The process begins with the earliest dyadic relationships; it is internalized and is subsequently reactivated in the transference and countertransference. It is the condition for entering into social relations and has become the domain of inquiry for object relations theory.

Object relations is a less-than-graceful term that describes ways in which human beings interact interpersonally and intrapsychically (i.e., with their internal objects). The phrase took root in the psychoanalytic lexicon through the distinction it drew between Freud’s emphasis on drives (libidinal and aggressive) that seek an object (i.e., a person or part of a person) and the par-
adigmatic change signified by the emergence of object relations theory in which the primary motivational need in human beings is seen to be the establishment of relationships. From an object relations perspective, we are not so much driven in pursuit of pleasure as in need of relatedness.

In this chapter I provide an overview of contributions to, and developments in, object relations theory. This review is not intended to be comprehensive and cannot do justice to the scope of the contributions cited and, in particular, those it does not cite. The reader is encouraged to consult primary sources. The principal contributors to object relations theory include Abraham, Klein, Fairbairn, Winnicott, Bion, Guntrip, Balint, Kernberg, Greenberg, Mitchell, and Ogden. It has also had a profound influence on the work of Sullivan, Kohut, Bowlby, Sandler, and contemporary analytic thinkers such as Bollas, Parsons, Ferro, Kennedy, Kohon, and Perelberg, among many others.

In the drive/structural model of the psyche, Freud defined the role of the object as anything toward which an infantile drive is directed for satisfaction and satiation. Drive, for Freud, was a somatopsychic phenomenon arising “between” body and mind by virtue of the inherent connection of the two—a biological force that impacted upon and took representational form in the psyche. Object, for Freud, was not a lifeless entity but a live being or person, fantasized or real, toward which instincts/drives sought to attain their aim of gratification. Instinctual aim and instinctual object are categories Freud never relinquished: the former he saw as conditioned by constitutional factors, whereas the latter undergoes influence from childhood developmental experiences. Freud (1905) conceived of the instinctual object from his understanding of the operation of the sexual instincts. He also identified self-preservation instincts that served the body’s vital functions (e.g., the need for nutrition) and proposed a link between sexual and self-preservation instincts and the object through an anachistic dependence of the sexual instincts upon the self-preservation instincts. In other words, the self-preservation instincts show the sexual instincts the path to the object (Laplanche and Pontalis 1974). This can be seen in oral phantasies, for example, in which incorporation of objects other than nutritional ones is frequent.

The terms instinct, object, and object choice also occur repeatedly throughout Freud’s writings. At moments, he does use the term object relationship, although not in a way that reflects the departure from drive theory produced by object relations theory. From the outset, Freud was conscious of the relationship between the subject, the ego, and the object. In “On Narcissism: An Introduction” (Freud 1914), he illustrated how certain individuals take their own ego as their love object, the ego acting as both a functioning agency and an object. In “Mourning and Melancholia” (Freud 1917), he developed this line of thinking by circumscribing the ego’s identification in melancholia with the lost object. The self-reproaches of the melancholic individual derive from reproaches meant for the lost object, which are turned against the subject: “thus the shadow of the object fell upon the ego” (Freud 1917, p. 249). In both of these papers, the object is emphasized over the drive as part of a wider inquiry into the nature of identification.

Freud’s thinking in the area of identification in particular was to greatly influence Melanie Klein. Although the role of social influences in drive theory is evidently de-emphasized in Freud, the evolution of his thinking [leading to the structural model] identified psychological derivatives of object relations (Greenberg and Mitchell 1983). The introduction of processes of identification, of ego and superego structure out of early relationships, of pre-oedipal object ties, and of unfolding modes of relating endows the object with increased significance as a figure in reality and in the formation of the psychic economy. At the same time, Freud maintained that the nature of an object relationship experienced or reported by an individual is contingent upon the active drive. Ties to an object do not exist from birth but are formed as a consequence of personality development. Classical psychoanalytic theory did not develop a concept of internal objects in interplay with current relationships and with each other.

Karl Abraham

Karl Abraham was the first psychoanalyst to place greater importance on the role of the object in libidinal development and in the life of unconscious fantasy. He divided infant development into pre-ambivalent, ambivalent, and post-ambivalent phases, and this conceptualization became the forerunner of Melanie Klein’s and Ronald Fairbairn’s schizoid and depressive levels of early psychological organization. Inherent in Abraham’s conception of different forms of ambivalence toward objects was the notion of a variety of forms of psychological conflict over the experience of self-object differentiation [Ogden, in Grotstein and Rinsley 1994, p. 91]. The oral stage of infant development was divided into two phases: the first 6 months or so were characterized by the pleasure and satisfaction derived from sucking at
the breast. This is the pre-ambivalent phase that reflects how the breast is yet to be experienced as both good (gratifying) and bad (frustrating). The second 6 months, coinciding with the beginning of teething, Abraham referred to as the oral-sadistic or “cannibalistic” phase, echoing the infant’s ambivalence. A wish to bite and devour the frustrating love object (prototypically, the breast) generates fear of destruction of the object and, in turn, fear of destruction by the object.

A clear connection was established by Abraham between orality, love of the object, and destructiveness. Grotstein (1982) summarized the oral-sadistic stage as a point when the object is believed to be identified with feces and is violently expelled only to be reincorporated again orally in phantasy so as to become an internalized object. Abraham made the important constant conjunction between body products, zones, and the phase-appropriate objects, all of which were linked in phantasy and introjected as imagined psychic structures within the self, with significant consequences for the development of the ego.

Melanie Klein

Building on the work of Freud and Abraham, particularly on the influence of objects on the ego, Melanie Klein extended Abraham’s position by arguing that libidinal development cannot be properly realized until hostile, destructive phantasies toward the object have been integrated into it. Klein posited an earlier onset of oedipal fantasies and anxieties than did Freud, locating their inception during the early part of the first year of life, when sadism in phantasy reaches its peak. There was no “pre-ambivalent” stage for Klein. Breastfeeding and weaning, denoting a complex and difficult separation from the mother’s body, were held by Klein to be of critical importance in terms of their impact on phantasy, including oedipal fantasies. For Klein, an object-relating ego exists from birth, and early objects, albeit partial, epitomized by the function of the breast, are experienced either as “good” or “bad” depending upon whether they are viewed as nourishing or as hostile and dangerous (persecutory). The linked activities of projection and introjection of these qualities are viewed by Klein as foundational in the formation of the ego. The infant’s reaction to early experiences is one of introjection of good experiences or expulsion via projection of bad experiences (projection of the mind “iato” the object or part object, temporarily ridding the subject’s mind of unwanted thoughts and feelings). Whereas Freud posited a primary form of narcissism, Klein saw drives as linked to objects from the outset. Klein’s is a drive theory and an object relations theory. Object relatedness exists from birth, and the object is, ab initio, integral to all psychological processes. Whereas Freud viewed independent drives as making their aim the search for an object, Klein argued that it was not possible to distinguish drives from relationships.

Klein was drawn to the role of aggression in early fantasy life. She sought to identify destructive and self-destructive manifestations of aggression in the context of the biologically derived substratum of self-destructive aggressive activity Freud had identified and termed “the death instinct.” For Klein, innate susceptibility to the influence of the death instinct gave rise to destructive impulses arising in fantasies and led to a preoccupation in infantile fantasy life with envy, possession, destruction, and persecution—a paranoid-schizoid stage of development in which attack, retaliation, and destruction infuse psychic reality. Her emphasis on object relatedness from birth, the force of unconscious phantasy, and her discovery of early superego figures deriving from threatening, self-critical fantasies led her to locate the emergence of the superego far closer to birth than the “heir to the Oedipus complex” superego identified by Freud. Klein’s writings on the superego are complex, but one significant observation is that it is formed from the fusion of life and death drives in relation to objects. This is clinically important because in melancholic states the defusion of the death drive may be regarded as making the superego carry the ego to its own destruction in identification with the hated, lost object and in place of mourning [Bronstein 2001]. Klein’s work, and that of post-Kleinian psychoanalysts on the superego, has yielded valuable findings regarding different degrees of superego activity. There remains, however, a need for psychoanalysts to better understand the widespread phenomenon of self-destructiveness in object relations terms that do not rely ultimately on heuristic biological theorizing. Whether or not the death instinct exists, the human personality is capable of regressing to primitive, part-object forms of relating that can generate savage behavior beyond the most stringent of superego sanctions. The psychological processes involved constitute a domain of psychoanalytic, rather than psychiatric, inquiry and are of the utmost importance in developing advanced treatment strategies for the severely disturbed.

The child’s love for the object is expressed, according to Klein, as essential care for the object from the outset, but it is the psychological conflict between love and hate in unconscious phantasy and conscious fantasy, directed
toward the object, that constitutes the dynamic foundations of infantile mental life. The term phantasy [originally used by Freud] was employed to denote the endowment of unconscious fantasies that reflect phylogenetic inheritance and that both accompany and inform conscious fantasies. Phantasy is employed by Klein to denote how the unconscious mind thinks—phantasies are generated endlessly on the basis of biological life and death drives that find mental representation in the unconscious in relation to objects. These are to be distinguished from passing fantasies or fantasized responses to, for example, frustration. Steiner (2003) captures the literal quality of unconscious phantasies:

As for the content of unconscious phantasies, Klein insists on their omnipotent and extremely concrete and realistic quality for the baby; this is also due to their pre-verbal character and to the prevalence, though not absolute dominance, of the primary process at this stage of the baby’s development. According to Klein, the baby really believes it has got hold of the mother’s breast or the father’s penis; it really does believe that, when, in frustration, it attacks the mother’s breast or body, their contents, or the parental intercourse, it has actually destroyed its external or internal objects, and, in consequence of its paranoid anxiety, that it will be subjected to an enormous retaliatory punishment. [p. 38]

In other words, the modus vivendi of unconscious phantasy comprises internal objects acting in relation to the subject and to one another. They have a strong phenomenological aspect to them, as noted earlier, but they also have qualities, intentions, and characteristics that denote an intense phantasy life of their own. Internal objects may change shape or form according to the prevailing unconscious phantasy. An internal object is, essentially, an unconscious phantasy containing a figure that possesses qualities that are malign or benign. Internal objects and unconscious phantasies are, for Klein, in continuous relationship to each other. Paranoid-schizoid infantile mental life utilizes internal part or split objects representing “good” and “bad” aspects of objects and experiences—qualities the infant strives to keep apart to allay persecuting and ultimately psychotic anxieties. Healthy splitting is necessary if good and bad experiences are to be identified for what they are. From 6 months of age or so, an infant who experiences good enough mothering becomes capable of identifying and integrating “good” and “bad” parts of mother and other experiences, laying the foundation for a capacity to view the object as more “whole” and no longer radically split, with this phase of development arrives the experience of depressive anxiety (“the depressive position”—a subjective sense of concern for the fate of the object. Winnicott [1975] described a similar transition from a stage of “pre-ruth” to “ruth,” a development he considered to be the most vital of infantile mental life. In projection of a whole object and the acquisition of a capacity to sustain a relationship with the object under the sway of hostile, reparative, and loving impulses provide the basis for evolving mental health. Libido, for Klein, infuses the reparative activity characteristic of the depressive position phase of development (“essential care for the object from the outset”), with whole-object relating gradually succeeding the more aggressive part-object relating of the paranoid-schizoid position. The maturation of personality centers around the negotiation of love and hate for the object within the tumultuous inner world of unconscious and conscious fantasies, alongside “real” experiences:

Feelings of love and gratitude arise directly and spontaneously in the baby in response to the love and care of his mother. The power of love—which is the manifestation of the forces which tend to preserve life—is there in the baby as well as the destructive impulses, and finds its first fundamental expression in the baby’s attachment to his mother’s breast, which develops into love for her as a person. My psycho-analytic work has convinced me that when in the baby’s mind the conflicts between love and hate arise, and the fears of losing the loved one become active, a very important step is made in development. These feelings of guilt and distress now enter as a new element into the emotion of love. They become an inherent part of love, and influence is profoundly both in quality and quantity. [Klein 1985, p. 311]

A sequence of dreams from the early part of the analysis of a young woman with a borderline personality disorder and a vignette from a later stage of the analysis illustrate how split objects and part objects [paranoid-schizoid functioning] can come to persecute the individual, and how the achievement of more whole-object [depressive position] functioning offers a stable but nonetheless emotionally exposed psychic state requiring psychological work to sustain.

For a number of years this patient, Miss A., was unable to think about her dreams or their symbolic meaning, reporting them graphically as concrete events that threatened her sanity, for example:

“There was a baby bird in a nest with its beak open. It was starvation. Nobody came to feed it. I watch it die. I am crying.”

“A minibus crashes through the front of a food store. There is a huge explosion. My older brother helpfully leads people away. There are many dead pregnant women. I touch the stomach of one but
there is no life. Tins of food are embedded in people’s faces. They are missing arms and legs. The manager says “We carry on, we stay open. I desperately try to stop him but can’t.”

“I am lying on a bed surrounded by cut-up foetuses. I can’t look at them because they are parts of the devil.”

“I am waiting in a doctor’s waiting room. There are other patients waiting. You come out, look around smiling and call me into your consulting room. You take your trousers down and tell me to suck your penis. There is shit on the end, but I have to do it.” [Williams 2010, p. 55]

The dreams evoke many levels of meaning but a compelling characteristic is their fragmented, “part object” quality in which good and bad aspects of objects and of the self are confused. Dire threats issue from projected parts of the individual’s personality [Steiner 2003]. The interplay of unconscious phantasy with internal objects in structuring the patient’s psychic processes is extremely clear, implying a traumatic history. Later in the analysis, when Miss A had done much work on reclaiming many of her projected experiences and could relate to herself and others in a more integrated way, she demonstrated a growing capacity for whole-object (depressive position) relating, as the following vignette illustrates [Williams 2010, p. 65]:

Miss A’s capacity to address loving and hating feelings toward the same person (initially her psychiatrist and then her analyst) indicated a growing tolerance of her losses due to a capacity to begin to be able to mourn:

**Miss A:** I did something stupid yesterday. I went to the hospital where Dr. X [her treating psychiatrist] works and parked my car near to hers. I kept thinking of just sitting next to her. We wouldn’t be saying anything special, just chatting. I wanted to go in but I was afraid she wouldn’t have the time to see me. I know she’s busy. I went home. [Cries]

**Analyst:** Perhaps knowing that she would find it difficult to see you without an appointment spared you from feeling that you were being too demanding.

**Miss A:** I knew I probably couldn’t see her. You see, as a child I was always told to be good, to never ask for anything, never cry. I wanted to sit with her, that’s all. I like her. She’s been good to me. I can’t make demands on anybody. The only thing that ever counted at home was being well behaved. [Angry]

**Analyst:** I think you feel that to be demanding here will disturb me, but I think the truth is that you do feel demanding and angry when I don’t meet your needs.

**Miss A:** Yes I do. You are a rotten analyst, you know. I don’t think you care. You don’t give me enough time. I want more time, I want to read your books, ask you things, but you don’t let me… I’m sorry [cries, pause] …I remember there was a boy in primary school who complained and he got to play in the sandpit. I never said anything. I was good and got nothing. [Angry] My mother was always smiling. Even at the doctor’s once when he found something wrong with her, she just kept on smiling. It’s ridiculous. I do nothing and all I have is the empty. I can’t stand the empty. I miss you so much sometimes. [Cries] I feel so lonely.

From a Kleinian perspective, this vignette denotes greater integration of destructive impulses with more benign impulses and a synthesizing of different aspects of objects by the ego. There is a move from a highly persecuting, harsh superego (in the paranoid-schizoid position) to a capacity to repair damage done to objects in reality and in phantasy (the depressive position), leading to a better capacity to contain anxiety and to relate to external reality as well as a greater freedom in the internal world [Bronstein 2001]. Melanie Klein’s portrayal of the internal world of early object relations cannot be proven conclusively to reflect the realities of infantile mental life. However, it has provided a powerful model for understanding psychic conflict in adolescents and adults through the study of the interaction between internal objects and part objects in unconscious phantasy and its expression in relationships. Post-Kleinian psychoanalysis places particular emphasis on relationships between internal objects and part objects in the unconscious and on a detailed understanding of the content and function of projective and introjective activity in the formation of these internal object relationships that structure the object-relating capacities of the individual [Britton 1998; Joseph 1989; Riesenberg-Malcolm 1999, Steiner 1993].

**W.R.D. Fairbairn**

Ronald Fairbairn was a member of the group of independent psychoanalysts in the British Psychoanalytic Society who worked in relative isolation in Edinburgh, Scotland. In a productive period during the 1940s and 1950s, Fairbairn inaugurated a series of revisions to psychoanalytic theory that gave rise to a truly object relational view of the personality. Fairbairn was the first psychoanalyst to delineate the object-related nature of the self, asserting that primary, nonpathological relationships are essentially interpersonal and not, like their pathological equivalents, internalized [Grotstein and Rinsley 1994]. He helped to establish the psychoanalytic conception of infantile dependence in contrast to primary, autoerotic infantile sexuality, thus formulating
the principles of infantile innocence and entitlement that anticipated the work of Bowlby on attachment. Fairbairn’s conception of endopsychic structure depicted the psyche as a system of egos and internalized objects for which splitting and regression function as defensive operations. Endopsychic structure was, for Fairbairn, the indicator and subsequent cause of pathology. Finally, Fairbairn discovered the existentialist domain of schizoid isolation and withdrawal, which has had important ramifications for the treatment of traumatic, symbiotic, borderline, and narcissistic personality disorders (Grotstein and Rinsley 1994).

Fairbairn’s work followed initially in the wake of Kleinian thinking. Fairbairn himself stated: “The ground has already been prepared for such a development of thought by the work of Melanie Klein, and indeed it is only in the light of her conception of internalized objects that a study of object relationships can be expected to yield any significant results for psychopathology” (Fairbairn 1952, p. 60). Fairbairn went on to develop a powerful critique of Kleinian object relations theory: “Dr. Fairbairn ... notes, for example, that ‘the conception of internalized objects has been developed without any significant modification of a libido theory, with which there is no small reason to think that it is incompatible’” (Bromley 1955, p. 83), and “Mrs. Klein has, of course, come to regard the Oedipus situation as originating at a very much earlier stage than was formerly supposed. Her resolution of the difficulty must accordingly be interpreted as having been achieved at the expense of the ‘phase’ theory” (pp. 92–93). Fairbairn was explicit in his criticisms of libido theory and Freud’s emphasis on psychosexual theory, arguing that they represented a misunderstanding of human motivation. We are not pleasure seeking in the way Freud suggested, nor is libido primarily aimed at pleasure but rather at making relationships with others. The earliest bonds an infant makes determine and shape the emotional life of the person and influence the formation of future relationships. This Fairbairn set out to demonstrate in his publication Psychoanalytic Studies of the Personality (Fairbairn 1952). Bromley (1955) conveyed the scale of Fairbairn’s innovatory conceptual system:

Fairbairn proceeds to take over the task of pushing Kleinian concepts to their logical conclusion, by means of a more wholesale scuttling. Overboard go the concept of the unconscious, infantile sexuality, the theory of instincts, the interpretation of dreams—in fact, the embryo, the dynamic aspects, the structure, and the economics of the mental apparatus. From Freudian theory and from the Kleinian contribution he proceeds to build an original structure by devel-

oping his ideas of object relationship and a theory of preformed, unitary ego. (p. 577)

Fairbairn’s ideas present a very different view of human nature and motivation than those embodied in drive theory. In the latter, human beings acquire relationships secondarily in response to a primary need to reduce tensions generated by biologically determined drives. In Fairbairn’s model, human beings have evolved to seek others from the outset as their primary motivation and activity. Although Klein is often credited with the introduction of object relations theory, it is perhaps historically more accurate to say that the most developed theory of object relations emerged from Fairbairn and his reformulation of Freudian and Kleinian meta-psychology. His work has influenced object relations and relational schools of psychoanalysis but has yet to achieve widespread recognition.

Beginning with the proposition that normal human relationships are fundamentally interpersonal, Fairbairn drew a distinction between “interpersonal relationships” and “object relationships” (Grotstein and Rinsley 1994). The nature of interpersonal relationships and the influence of object relationships remain a preoccupying interest of psychoanalysts in view of the complexity of the interplay between external and psychic reality. A clear example can be seen in Donald Winnicott’s critique of Klein’s derivation of object relations from inherent, constitutional sources such as a priori object images and innate aggression (Greenberg and Mitchell 1983). Although committed to the world of internal objects and the power of phantasy, Winnicott stressed, in contrast to Klein, that object relations are rooted in and constituted by both the mother’s performance of caretaking functions and her character (Greenberg and Mitchell 1983).

Like a number of contemporary British Independents, I have explored this interplay between interpersonal and intrapsychic factors (Williams 2010). Fairbairn takes the matter of interpersonal relationships farther than Winnicott. For Fairbairn, an interpersonal relationship is the product of interaction between two individuals and, being of an essentially nonpathological nature, does not need to be internalized because the relationship itself is inherently satisfying. Satisfaction for human beings, Fairbairn argued, consists in being treated as a person in one’s own right. In contrast, an intolerably ambivalent relationship results in a splitting of one’s attitude about the other person, such that the rejected part of that person is transformed into the status of an internal object. It is the external person who is the disappointing object, and pathological relationships are characterized by object re-
laidness in terms of their need to adapt to or comply with a disappointing real-life situation by internalizing the very badness of the needed [but rejecting] person [Grotstein and Rinsley 1994]. To the extent that natural, satisfying relationships with real people disappoint or fail, there is a need to establish a relationship with an internal object. This is a radical departure from Klein. Internal objects are, for Fairbairn, psychopathological structures, whereas relations with real, external people are satisfying and nonpathological to the extent that they do not give rise to internal objects. Inevitably, every infant experiences frustration and disappointment, and some of these experiences stem from the infant’s having misconstrued the parents’ intentions.

The establishment of internal objects as a result of disappointments is thus a universal psychological activity, albeit varied in scope and intensity. For Fairbairn, internal objects are not merely mental representations of individuals or parts of individuals. They are active psychic structures with a dynamism of their own, and they interact in the unconscious, giving rise to an identifiable system of ego/object relations. The frustrations of postnatal, infantile mental life produce an inevitable splitting of the ego and its objects deriving from experiences of acceptance and rejection of the infant’s love. Both object and ego become split into accepting and rejecting versions, and these are internalized [Figure 12-1]. The schizoid personality is the condition that subsumes this activity of splitting. The schizoid state of withdrawal is the alienating consequence of the splitting of objects and the ego due to disappointment, and to this extent schizoid states of mind affect everyone. The schizoid condition is universal, Fairbairn argued, and it is to be distinguished from the nosological clinical term schizoid personality or schizoid personality disorder, which refers to its severe psychopathological expression.

Freud and Klein emphasized the impact of hostility in melancholic object relationships, but Fairbairn attributed the schizoid state of mind [a withdrawn as opposed to a melancholic personality] to a belief in the infant that it is his or her love that has harmed the object. The infant experiences his or her love as destructive and initiates withdrawal from the object. The development of a sense of self was, for Fairbairn, contingent on the primacy of personal relationships: to the extent that these failed, so the individual’s selfhood was impaired. Fairbairn’s proposal of a universal schizoid position, and the internal object relations drama pertaining to it, derived from his clinical work and, in particular, schizoid tendencies in dreaming, transference splits, withdrawals in analytic treatment, and hysterical conversion symptoms.

![Figure 12-1. Relationships among the psychic structures.](image)

In 1963, Fairbairn published a synopsis of his theoretical model. What follows is a brief resume of the main elements of this synopsis, followed by an illustration of Fairbairn’s model of psychic structure. For Fairbairn, an ego is present from birth, and libido is a function of the ego. There is no death instinct, and aggression is a reaction to frustration or deprivation. There is no such thing as an id. The ego [and therefore libido] is inherently object-seeking. The earliest and original form of anxiety is separation anxiety. Internalization of the object is a defensive measure in so far as the object is unsatisfying and is not just a product of phantasy—it is a distinct psychological process. Two aspects of the internalized object [its exciting and frustrating aspects] are split off from the main core of the object and are repressed by the ego: as a result of this activity, an exciting [libidinal] object and a rejecting [antilibidinal] object are constituted and repressed. The core of the internalized object that is not repressed is the ideal object or ego ideal. As the exciting and rejecting objects are cathexed by the original ego, so these objects carry into repression with them parts of the ego by which they are cathexed, leaving the central core of the ego [which Fairbairn re-
ferred to as the central ego] unrepressed but acting as the agent of repression.

The resulting internal situation is one in which the original ego is split into three egos: a central [conscious] ego attached to the ideal object [ego ideal], a repressed libidinal ego attached to the exciting [libidinal] object, and a repressed antilibidinal ego attached to the rejecting [antilibidinal] object. This internal situation represents a basic schizoid position that is more fundamental than the depressive position described by Melanie Klein. The antilibidinal ego, by virtue of its attachment to the antilibidinal object, adopts an uncompromisingly hostile attitude toward the libidinal ego and has the effect of powerfully reinforcing the repression of the libidinal ego by the central ego. What Freud described as the “super-ego” turns out to be a complex structure comprising the 1) ideal object or ego-ideal, 2) antilibidinal ego, and 3) rejecting [antilibidinal] object (see Figure 12–1).

Fairbairn’s ideas effectively replaced instinct theory and introduced a theory of the personality based firmly in object relations. So radical was Fairbairn’s departure from classical and Kleinian metapsychology that it received a cool and occasionally hostile reception from his colleagues. Its supporters point not only to the theoretical coherence of the model but also to its clinical utility in identifying the unconscious conditions for much of contemporary psychopathology.

Wilfred Bion

Wilfred Bion developed Klein’s object relations conceptions in a variety of ways. His most enduring contribution to object relations thinking, and perhaps to psychoanalysis as a whole, is his theory of containment and his model of container-contained. Riesenber-Malcolm defined Bion’s theory of containment as

the capacity of one individual [or object] to receive in himself projections from another individual, which he then can sense and use as communications [from him, transform them and finally give them back [or convey back] to the subject in modified form. Eventually, this can enable the individual [an infant at first] to sense and tolerate his own feelings and develop a capacity to think. [Riesenber-Malcolm, in Bronstein 2001, p. 166]

This model, in which one object relies on another for the facilitation of a capacity for thinking, was formulated by Bion initially from his work with psychotic patients who struggled to communicate what was thought to be unbearable and incommunicable. Bion found that confused, agonized utterances, often pre-verbal, with which the patient appeared to be able to do nothing required the analyst to experience and think about them sufficiently for something to be said about them to the patient. The patient could then use the analyst’s statements as a stepping stone toward thinking about his or her own experiences.

From such clinical encounters Bion came to understand the nature of a mother’s ability to contain and “hand back” her infant’s core anxieties in ameliorated form through what he termed “maternal reverie.” The transformative element within this reverie he conceived of as “alpha function,” which denotes the mental and psychological work done on raw sensations or “beta elements.” Without this capacity in the mother, the infant is left in an intolerable mental and bodily state in relation to the raw beta elements, able only to respond violently to fear, anxiety, and dread or to resort to action. The expelled sensations undergo deformation and turn into persecuting part objects or bizarre objects that threaten the subject by their return. The individual may, in a further effort to avoid persecution, instigate attacks on links to objects, actual or potential, out of a perverse but not entirely unfounded belief that relations with objects are destructive. Where the mother [or analyst] is able to accept and work on projections felt by the subject to be unbearable, so the mother/analyst becomes a container for the now-contained beta elements. These are handed back, modified and transformed by alpha function, in a way that allows the subject to also acquire the capacity to become a container of the contained [Riesenber-Malcolm, in Bronstein 2001].

In extending Klein’s thinking on projective identification in this object-related way, Bion demonstrated that the need for an object lies at the heart of emotional development. From this, he went on to develop a comprehensive and original definition of the way in which human beings acquire the capacity to think and the psychic apparatus to do so. The scope of Bion’s contribution to psychoanalysis and to understanding the internal object world is difficult to overestimate. He brought to the clinical situation ways of thinking that illuminated primary strivings in the subject to find and communicate with an object from the outset, and these have been taken up widely, including in the treatment of psychotic states.
D. W. Winnicott

Donald Winnicott, like Bion, was influenced early in his career by the work of Klein. Also like Bion, Winnicott took an interest in the impact of the environment [in infancy, the mother] on psychic development, although he developed his theoretical ideas in a different direction. Bion and Winnicott could be said to be important object relations theorists and were prominent representatives of the British Object Relations School. However, both differ from Fairbairn in their use of object relations theory, in that it became for them a platform for developing their respective ideas on how human beings think. Winnicott was interested in how a self (personhood) is created, in the acquisition of a capacity to be alone, and in the ability to play (be creative). Object relations theory was, for Winnicott, a substrate to an interest in how a differentiated, integrated individual emerges from a relational context, beginning with the delicate experience of the newborn infant’s relationship to the mother.

The elusive, subtle qualities associated with this period of life are reflected in Winnicott’s poetic, informal style of writing, which can be evocative, epigrammatic, and deceptively simple. His understanding of the infant-mother relationship differed from those of Bion, Fairbairn, or Klein in that he placed emphasis on a primary state of merger between infant and mother in which the infant is “held” in an “inter-penetrating mix-up” until capable of differentiation (famously, he argued that “there is no such thing as a baby,” referring to an initial “mother-baby unit”). Winnicott’s work as a pediatrician as well as a psychoanalyst convinced him of the crucial importance of “maternal preoccupation” of the newborn infant, the mother’s role in the psychic structuring of the infant personality, and the negative effects of impingement by the environment/mother on the individual’s capacity for object relations formation. Winnicott, in questioning the traditional psychoanalytic view of individuals as unified “persons,” argued that infants are “unintegrated” at the outset, become integrated through the “holding environment” provided by the mother without which self-organization cannot proceed, and are vulnerable to “disintegration” if this holding environment fails.

A counterpoint between dependent contact and progressive differentiation characterizes Winnicott’s depiction of the mother-infant relationship. The initial state of merger is characterized by an illusory state in which the infant “creates” the object. Absolutely dependent, the infant receives the breast but experiences himself or herself as having created it, along with the satisfactions this brings. This omnipotence is a necessary psychological step and the basis for a healthy development of a sense of self. [Kohut was subsequently to argue something similar.] The mother’s maternal preoccupation makes possible a close and accurate sensitivity to her infant’s needs and gestures in that she acts as a mirror providing the infant with a precise reflection of his or her own experiences and gestures, despite their fragmented and formless qualities [Greenberg and Mitchell 1983]. When the mother resonates with the baby’s wants and needs, the latter becomes attuned to his or her own bodily functions and impulses—a basis for the infant’s slowly evolving sense of self. The failure of the mother to actualize the child’s gestures and needs undercuts his or her sense of hallucinatory omnipotence, constricting the child’s belief in his or her own creativity and powers and driving a wedge between the evolution of the psyche and its somatic underpinnings [Greenberg and Mitchell 1983]. It is through the repetition of hallucination of the object, accompanied by the mother’s presentation of herself as the object, that the infant comes to be introduced gradually to the real world, as the mother inevitably fails, little by little, to be able to consistently represent the world according to the infant’s hallucinatory, omnipotent demands. The good-enough mother facilitates the relinquishment of the infant’s hallucinatory omnipotence in a way that permits transition to the real world securely and with curiosity.

Winnicott’s [1953] best-known object relations formulation is his conception of the transitional object. This refers to an intermediate stage of development in which the depth of the dependent, fused relationship between the infant and mother is reflected while at the same time a degree of separation and differentiation is evident through the adoption by the infant of an inanimate object. This seemingly inert object—a comfort blanket, soft toy, or piece of rag—acquires an indispensable dual function as a symbolic representation of the bond between infant and mother while allowing the infant to begin making a transition toward a world of separate individuals and experiences. The transitional state of mind that the transitional object signifies is neither one of hallucinatory omnipotence nor yet one of separateness and independence. At a certain point, when the child has become more immersed in testing the reality of the external world while remaining connected to the internal object representation of the mother [as well as her actual presence], the symbolic power of the transforma-
tional objects fades until eventually it is left in a state of
limbo, its transitional purpose having been served.

Grotstein (1982) noted how transitional phenomena
and the transitional space between mother and infant
were to become important metapsychological landmarks
for the development of playing, phantasying, and think-
ing in Winnicott’s work. When the object world fails the
infant—through a deficit in maternal holding and facilita-
tion or as a consequence of impingement—the conse-
quences for emotional development are grave. If either of
the infant’s states of mind (the need for actualization of
needs and wishes or quiescence) is violated, the integrative
work of self-development is destroyed. At its worst,
impingement and disintegration can produce a feeling of
“falling forever.” The disturbed infant is obliged to com-
ply with the demands of the environment (mother) and
loses touch with internal experiences and spontaneity.
His or her “true self” is split off, and a pathological “false
self” is installed to adapt to the mother’s distorted image
of him or her and to act as caretaker of the true self.
The establishment of personhood is compromised until such
time as the true self is able to resume its development.

Winnicott, of all object relations analysts, placed
most emphasis on the impact of the environment on infantile psychological development (and, by exten-
sion, stressed the importance of the analytic setting and
of “environmental provision” in treatment). His critics
have accused him of promoting regression and under-
representing the power of unconscious phantasy in the
production of psychopathology. Although there may be
some truth in this, Winnicott’s model of self-develop-
ment emerging from a primary, object-relational con-
text has remained highly influential.

American Contributions

Object relations thinking in America cannot be sepa-
rated from the influence of Anna Freud and ego psychol-
ogy—historically the dominant psychoanalytic school
in the United States. Object relations concepts have had
some impact on American psychoanalysis, perhaps
most visibly in the work of psychoanalysts from the
relational school. Greenberg and Mitchell’s (1983)
review of the changes that took place to permit ideas
about the roles of significant other people (object rela-
tions) to impinge on drive-based psychoanalytic psy-
chology takes as its transitional starting point the work
of Heinz Hartmann.

Heinz Hartmann

An unswerving ego psychologist and drive theorist, Hart-
mann attempted to expand drive theory to encompass
the individual’s relationship to the environment, includ-
ing people (Greenberg and Mitchell 1983). He never
modified the core premises of classical drive theory, cre-
ating instead a model of “theoretical accommodation”
that subsumed emerging ideas on motivation and per-
nonal relationships into drive theory, a strategy that was
pursued by Mahler and Jacobson. Hartmann saw the ego
as a product of biology—an organ of adaptation, synthe-
sis, integration, and organization. The infant’s relation-
ship to the mother is a biological one. In addressing social
aspects, Hartmann subordinated human relationships to
the survival conditions that they represent. Caught
between two models, Hartmann never succeeded in
addressing how a self develops in relation to others, how
play and creativity emerge, or how relations with other
people contribute to pathogenic intrapsychic conflicts
(Greenberg and Mitchell 1983).

Margaret Mahler

Margaret Mahler was the most influential follower of
Hartmann’s “accommodation strategy,” which empha-
sized the personal aspects of relations with reality in
terms of the immediate human environment. She iden-
tified a symbiotic relationship between infant and
mother and coined the term separation-individuation
through which the individual acquires a stable identity
within a world of predictable and realistically perceived
others (Greenberg and Mitchell 1983). Mahler opened up
a line of inquiry into relations between the self and its
objects, depicting pre-oedipal life through a sequence of
phases and subphases in a compelling account of the
infant’s struggles not seen since Freud. Her concept of
symbiosis became an established tenet of psychoanalysis.
Her emphasis on object-relational aspects of pre-oedipal
development offered a link between ego psychology and
subsequent theorists like Kohut, Kernberg, George Klein,
and Loewald. Infant research has subsequently not sup-
ported Mahler’s delineation of the autistic and symbiotic
phases of infant development, and this has led to a
decline in interest in her work among American analysts.

Edith Jacobson

Edith Jacobson (1964) extended drive/structural theory
by focusing on the “representational world” of the sub-
Otto Kernberg

Otto Kernberg, in his contribution to psychoanalytic theorizing, began by extending Jacobson’s and Mahler’s work toward a blending of the drive model with the relational model. He was the first American theorist to declare himself a Freudian [retaining the language and thinking of dual instinct theory] while stating explicitly that he drew from the writings of object relations authors [Greenberg and Mitchell 1983]. He characterized his work as “object relations theory” but not in the sense used by Fairbairn. Kernberg employed a more restricted definition of object relations as part of an integrative model that draws on several sources. His focus was on the detailed buildup of internal representations of self and object that begin with the infant-mother relationship and that are colored, critically, by feeling states [derived from the libidinal and aggressive drives]. Kernberg’s is a structural model of personality development and of psychopathology that incorporates many aspects of Kleinian theory on unconscious relations between objects. His object relations thinking is particularly evident in precise diagnostic formulations and treatment strategies for severe borderline and narcissistic disorders.

Stephen Mitchell

Stephen Mitchell, a founder of the relational school, made a far-reaching attempt to synthesize, in object relations terms, the long-standing object relations discrepancy and theoretical conflict between what Grotstein characterized as Klein’s “immoral infant” and Fairbairn’s “helpless infant”:

I believe that the most fundamental psychological principle underlying [Fairbairn’s] conception of psychological growth is the idea that all psychological maturation involves the patient’s genuine acceptance of himself and, by extension, acceptance of others. That acceptance is achieved by means of the work of coming to terms with the full range of aspects of oneself, including one’s disturbing infantile, split-off identifications with one’s unloving, unaccepting mother… the world of thought, feeling and human relatedness that is opened by such self-acceptance is a world in which one feels no compulsion to transform the realities of one’s human relationships into something other than what they are,
i.e., to change oneself or “the object” [who is now a
whole and separate subject] into other people. It is also a
world in which one can learn from one’s experience
with other people because those experiences are no
longer dominated by projections of static internal object
relationships. [Ogden 2010, p. 114]

This is a far cry from the biologically driven infant of
Hartmann, helplessly constrained by limitations on psy-
chological agency. Psychological growth, as defined by
Ogden, involves a form of self-acceptance that can be
achieved only in the context of a real relationship with a
relatively psychologically mature person. A relationship
of this sort [of which the analytic relationship is poten-
tially a cardinal example] is the source of egress from a
solipsistic world of static, internal object relationships.
Self-acceptance is a state of mind that marks the [never
fully achieved] relinquishment of the life-consuming ef-
fort to transform unsatisfactory internal object relation-
ships into satisfactory [i.e., loving and accepting] ones.
With psychological growth, one comes to know at a
depth that one’s early experiences with one’s unloving
and unaccepting mother will never be other than what
they were. It is a waste of life to devote oneself to the ef-
fort to transform oneself [and others] into the person
one wishes one were [or wishes they were]. In order to
take part in experience in a world populated by people
[including oneself] one has not invented, and from
whom one may learn, one must first loosen the uncon-
scious bonds of resentment, addictive love, contempt,
and disillusionment that confine oneself to a life lived
principally in the mind [Ogden 2010]. This idea—that
an alteration in the very nature of the relationship be-
tween the subject and internal objects, and between in-
ternal objects, can provide the conditions in psychic
reality for psychological growth—is present in Fairbairn’s,
Bion’s, Winnicott’s, and, most markedly, Ogden’s work.
Post-Kleinian psychoanalysts also pay attention to the
fate of internal objects and part objects, with a particular
emphasis on the role and impact of unconscious phan-
tasy. The evolution of what might be called internal
“subject-object relations” is a theme that is discernible
in one form or another in much object relations think-
ing and could be said to be a cornerstone of contempo-
rary object relations psychoanalysis.

---

**KEY POINTS**

- **Object relations** describes ways in which human beings interact, interpersonally and
  intrapsychically (i.e., with their internal objects). The process begins with the earliest dy-
  adic relationships, is internalized, is subsequently reactivated in the transference and
  countertransference, is the condition for entering into social relations, and has be-
  come the domain of inquiry for object relations theory in its various forms.

- Object relations theory draws a distinction between Freud’s emphasis on drives (libid-
  inal and aggressive) that seek an object (i.e., a person or part of a person) and a the-
  oretical perspective in which the primary motivational need in human beings is seen
  to be the establishment of relationships. From an object relations perspective, we are
  not so much driven by the pursuit of pleasure as the need for relatedness.

- Karl Abraham was the first psychoanalyst to place specific importance on the role of
  the object in libidinal development and unconscious fantasy. Klein extended Abra-
  ham’s position, identifying an object-relating ego from birth and positing innate sus-
  ceptibility to the influence of the death instinct expressed as unconscious phantasies
  of envy, possession, destruction, and persecution alongside love toward the object
  (internal and external). Klein thus argued for an earlier onset of oedipal fantasies and
  anxieties than Freud suggested.

- Principal contributors to object relations theory include Abraham, Klein, Fairbairn, Win-
  nicott, Bion, Guntrip, Balint, Kernberg, Greenberg, Mitchell, and Ogden. Object rela-
tions theory also has had a profound influence on the work of Sullivan, Kohut, Bowlby, Sandler and contemporary analytic thinkers such as Bollas, Parsons, Ferro, Kennedy, Kohon, Perelberg, and many others.

- A fundamental characteristic of object relationships in severe disturbance is their fragmented, “part object” quality in which good and bad aspects of objects and of the self become confused. Because “whole object” relating is unavailable, complex technical demands are made on the analyst to distinguish psychotic from nonpsychotic thought processes attached to objects that are internal and/or external, projected and/or introjected.

References

Fairbairn WRD: Psycho-Analytic Studies of the Personality. London, Tavistock, 1952
Kohon G: No Lost Certainties to Be Recovered: Sexuality, Creativity, Knowledge. London, Karnac, 1999
Melanie Klein

What is called “Kleinian analysis” is based on the clinical work, phenomenology, and psychoanalytic theories of Melanie Klein. Born in Vienna in 1882, Klein was still working clinically and writing up to the time of her death in London in 1960. Klein was the youngest of four children. When Klein was 5 years old her 9-year-old sister Sidonie died. Klein was 18 when her father died, and her idolized brother Emmanuel died in his mid-20s when Klein was 21 and pregnant with her first child. She abandoned her intention to study medicine by becoming engaged at 19 to Arthur Klein, with whom she had three children, Melitta, Hans, and Eric, but she was unhappily married and eventually divorced in Berlin in 1922. She suffered from depression, and this, together with reading Freud in Budapest, led her into analysis with Sandor Ferenczi in 1914, the year of her mother’s death. She became an associate member of the Hungarian Psychoanalytic Society in 1919, reading a paper titled The Development of a Child [Klein 1921]. She moved from Budapest to Berlin in 1921 and later to London in 1927, where she became the center of representatives of a new school of thought later to be called the “Kleinians.”

Klein’s original contributions can be divided into three periods: 1) the development of her approach to child analysis; 2) the evolution of her concept of the depressive position; and 3) the description of the paranoid-schizoid position, including projective identification.

Beginnings

Kleinian analysis begins in Berlin with the pioneering analytic work that Melanie Klein did there with young children between 1921 and 1926. In other words, the Kleinian modification of adult analysis came from her work with children. After attempting an orthodox analytic approach, Klein developed a method of analyzing children’s play and their enacted imaginary dramas. She treated the children’s play as attempts to express wishes, deal with trauma, and master anxiety. She interpreted it as the equivalent of dreaming, accepting comments and further play as free associations. She also willingly partic-
ipated in enacted stories in which she was assigned fic-
tional identities by the child, sometimes as the child.
Thanks to recent scholarly work in the Klein Ar-
chives in London and some records of the Berlin Clinic
by Claudia Frank, we know that Melanie Klein saw some
22 children between February 1921 and July 1926 in
Berlin. Frank has, from Klein’s clinical notes, diaries,
and clinic records, painstakingly identified which chil-
dren appear under what pseudonyms in Klein’s published
work [Frank 2009 [see Tables 2.1 and 2.2, pp 60–67]].
Initially she saw some children from one to three times
a week, but as time passed she intensified the frequency
of some analyses to six times a week.
Claudia Frank uses the cases to follow the develop-
ment of Klein’s gradual departure from the preexisting
analytic technique and the familiar libidinally based
theories to those for which she became celebrated, in-
cluding aggressive phantasy and a drive for knowledge.
Grete, like other children Klein saw in 1921–1922, was
on the couch in treatment, but by the time Inge was in
analysis with Klein in 1923 the interpretative work
was on her play and her role assignments to Klein and
herself in her imaginative stories.
Klein’s findings supported Freud and Karl Abraham’s
view that adult neurosis is built on childhood anxieties
and depression, but she also came to the conclusion
that childhood neurosis is based on infantile anxieties.
These infantile phantasies she found to be more like
those found in adult psychosis than neurosis, and this
led to the equation of infantile anxiety with psychotic
anxiety. These ideas came into adult analysis in the be-
ief that underlying neurotic anxieties are more primi-
tive psychotic anxieties. These are of two main types as
she described them: one persecutory—that is, a fear of
being annihilated, and the other she called depressive
anxiety, a fear that the primary love object would be dam-
aged irreparably or destroyed.
Her new ideas were summarized by Alix Strachey
after Klein presented them to the Berlin Society in De-
cember 1924. Strachey’s report was sent to her hus-
bond James Strachey in London [Meisel and Kendrick
1986]. It stimulated great interest and was read to the
British Psychoanalytic Society at a scientific meeting
in January 1925. This led to Melanie Klein being in-
vited to London to give a series of lectures.
Strachey’s report described Klein’s play analysis, her
belief in direct interpretation to the child, her new the-
ory of the early Oedipus complex, the importance of the
primal scene in childhood phantasy and pathology, and
her belief in the early development of an archaic super-
ego. Alix Strachey concluded “that the only satisfactory
method of reaching valid conclusions on the subject of
child-analysis—and indeed, of forming an understand-
ing of the mentality of the child in general—was by col-
lecting and reviewing direct data as Frau Klein has long
been doing, rather than relying on deductions from our
existing knowledge of the structure of the adult mind’
[quoted in Meisel and Kendrick 1986, p. 329].
Klein prepared her course of six lectures within 6
months and gave them in London in July 1925 in the
house of Adrian Stephens and his wife, who was also an
analyst. Stephens was the brother of Virginia Woolf, and
like the Strachey, the Stephens were members of the
Bloomsbury group. The lectures were a great success
and paved the way for Melanie Klein’s eventual move to
England a year later. This move was a consequence of
the sudden illness and unexpected death of Karl Abra-
ham, her second analyst and teacher. She was now un-
supported and unprotected in Berlin and exposed to the
hostility her new ideas generated from some colleagues.
She gratefully accepted Ernest Jones’ suggestion that
she emigrate to London, which she did in September
1926.
When Melanie Klein moved to London, she con-
tinued to develop her ideas and was supported by a num-
ber of enthusiastic colleagues such as Joan Rivière and
Susan Isaacs. Her book The Psycho-Analysis of Chil-
dren [Klein 1932], based on her London lectures, was
published in 1932: the lectures emphasized anxiety,
unconscious phantasy, and continuity, which was at the
heart of it—continuity between infancy and childhood,
childhood and adult mental life, psychosis and neuro-
sis, and abnormal and normal mental life. She came to
believe that there was an inborn fear of annihilation in
infancy along with overwhelming love and attachment
to the mother. She explained this by adopting Freud’s
new concept of the death instinct, putting together the
fear of annihilation and the hostility to the external
world as the internal and projected manifestations of this
basic death drive.
There is no logical necessity to explain these two
phenomena in this way, but Klein simply adopted
Freud’s model, which was characteristic of her theoriz-
ing unless she found new phenomena to which she at-
tached particular importance, like the early oedipus
situation. In this she regarded herself as a faithful fol-
lower of Freud and was taken aback at being seen by
some as heretical. From Freud’s account of an internal
world of relationships between the different agencies of
the mind, ego, superego, and id, she developed a theory
of internal objects that were the phantasied personifi-
cations of these agencies.
The principal characters in her first version of the
“internal world” were introjected parents, composing
the superego; they, like parents in the child’s external world, could be the internal sources of comfort and joy, persecution and fear, or guilt and despair. Klein’s concept of the id (das es), however, was different from Freud’s and is much better named simply as the unconscious, a place containing infantile phantasies. Klein’s es (it) is more like the unconscious actually described by Groddeck in Das Buch vom Es, from whom Freud borrowed the term [Groddeck 1928].

What Freud had described as infantile neurosis Klein now saw as the means the individual adopted for working through or defending against infantile “psychotic anxieties.” She came to see infantile anxiety as ubiquitous and the crucial role of the love and understanding of parental care as mitigating primitive anxieties in addition to providing a realization for the internalization of the “good object.” There is an implication of an innate expectation of good and bad objects in her writing that is made explicit later in Bion’s theory of preconceptions.

By 1927, a year after her arrival, Klein was well established in the British Society, supported by Ernest Jones. Along with like-minded colleagues, particularly Joan Rivière, she had become a major influence in child-centered analytic thinking in London. At this point Anna Freud in Vienna published her own approach to child analysis in which she was critical of Klein’s method and dismissive of her ideas. A somewhat heated controversy arose between London and Vienna, and to resolve this, exchange lectures between these two centers were arranged, with Rivière, a favorite former analysand of Sigmund Freud who was a wholehearted supporter of Klein, representing London in Vienna. Sigmund Freud stayed out of the controversy over child analysis, officially leaving it to the future to decide who was right, but he was protective of his daughter from London’s critical comments, which he wrongly attributed to Ernest Jones.

The concepts that were at issue were the existence of infantile fantasy, the early oedipal situation [that is the primal scene] as a forerunner of the classical Oedipus complex, the idea of an early archaic superego, and the emphasis on aggression. The contentious technical issues were about direct interpretation of unconscious fantasy and the existence of transference in child analysis.

This theoretical controversy moved to London in 1938 when the Freud family and the Vienna group arrived as refugees from Nazi rule in Austria, and it was considerably intensified after Sigmund Freud’s death in 1939. By that time Melanie Klein had proposed a new model of infantile development she called the depressive position and found herself accused of heresy by Edward Glover for establishing a non-Freudian metapsychology. This eventually led to a series of scientific meetings called the Controversial Discussions in 1943 and 1944. Klein defended herself by saying that she had only extended and modified Freud’s model, and together with Rivière, Susan Isaacs, and Paula Heimann, she also put forward her new model of the depressive position and the paranoid, manic, and obsessional defenses against it.

These papers were revised and published in Developments in Psychoanalysis [Rivière 1952]. The crisis was ended by an agreement to differ scientifically and to create a system of groups to protect the training. Initially within the British Society there was the “A” group at the Institute of Psychoanalysis and the “B” group under Anna Freud’s organization. This evolved into an integrated training with three groupings: Anna Freud’s B group, Klein’s group, and the middle group; later these names changed to “contemporary Freudian,” Kleinian, and Independent. This grouping has lasted, with diminishing differences between the groups, ever since.

# The Depressive Position and Internal Objects

Initially the depressive position was seen as an inevitable developmental phase of early infancy that was based on the inexorable experiences of object loss and cognitive development. It was described in Klein’s paper “A Contribution to the Psychogenesis of Manic-Depressive States” [Klein 1935] and elaborated further in “Mourning and Its Relation to the Manic-Depressive States” [Klein 1940]. She wrote, “In my view, wherever a state of depression exists, be it in the normal, the neurotic, in manic-depressive or in mixed cases, there is always in it this specific grouping of anxieties, distressed feelings and different varieties of these defences, which I have here described and called the depressive position” [Klein 1935, p. 276]. Later she wrote, “All infant experiences anxieties which are psychotic in content, and that the infantile neurosis is the normal means of dealing with and modifying these anxieties... the infantile depressive position is the central position in the child’s development. In the infantile neurosis the early depressive position finds expression is worked through and gradually overcome” [Klein 1940, p. 347].

In its first formulations, the depressive position was thought to be preceded by a paranoid position in which the fear was of annihilation of the self, and then when the survival of the loved object became the central anxiety, a defensive paranoid position developed in which danger came from a bad object and love and life
came from the good object. This was enhanced by what she called splitting—that is, widening the gap between bad and good objects by demonization and idealization. The hatred of the bad object securely separated from the love of the good object is a comfortable state of mind as compared with the realization that bad and good experiences emanate from the same object, resulting in ambivalence. This realization, however, was inevitable when “part objects” became the “whole object,” the term part applying not only anatomically but experientially. Time-segregated bad experience from one part object became continuous with good experience from another, and the separately hatred and loved object became one object of ambivalence. As Klein used it, the term part object meant pars pro toto, the part treated as the whole unlike a whole composed of parts. In this way an individual person is perceived as the personification of a quality.

The realization of ambivalence, or more precisely the recognition that the loved and hated objects are aspects of a single one, intensifies depressive anxiety and adds guilt to the repertoire of emotional experience. Klein had taken from Ferenczi the concept of the introjection of qualities as the reverse of the projection of impulses, and she added to this Abraham’s concept that the underlying paradigm of internalization is oral incorporation. She further developed this into her notion of an internal world of phantasied objects that through projection and re-introjection constantly interacts with external object relationships. Through this process internal objects can be modified by experience. This produced a rationale for change via the transference in the internal object that forms the core of the super ego.

For Klein this also meant that the death of an external object provokes the fear of the death of its internal counterpart:

It now becomes plain why, at this phase of development, the ego feels itself constantly menaced in its possession of internalized good objects. It is full of anxiety lest such objects should die. Both in children and adults suffering from depression, I have discovered the dread of harbouring dying or dead objects [especially the parents] inside one and an identification of the ego with objects in this condition. [Klein 1935, p. 266]

The “cure of souls” she now envisaged was reparation of the damaged object. This term came naturally from her observation of the play of her child cases who first attacked their toys and subsequently, after some form of guilty acknowledgement, tried to repair them. The acknowledgment of loss and guilt prior to reparation was crucially distinct from omnipotent, magical restoration used to deny loss or guilt. The latter she called manic reparation and was part of the major defense against the depressive position.

The Manic Defense

The manic defense was described by Klein as a major defense against the pains and anxieties of the depressive position. Its relinquishment is one of the tasks of mourning or weaning, real or metaphorical. Elements of the manic defense that Klein described were denial of external and internal reality by the substitution of wish fulfillment and dismissal of the significance of the loved object by self-aggrandizement, triumph, and contempt. Mania was seen as the psychotic version of this state, in which everyday beliefs in the limitations of time and space, cause and effect, and ordinary perception were denied and replaced by wish-fulfilling hallucination and omnipotent beliefs.

The nonpsychotic manic defense, however, was seen to be more widespread and more pervasive, in which a rival belief system was substituted, denying the increasing awareness of limitation, loss, ambivalence, and complexity. The enrichment of the concept of the depressive position was now two-way as its infantile roots were sought and as the subtle manifestations of nonpsychotic manic defense were explored in adult analysis. At the heart of Melanie Klein’s analytic thinking was her conviction that later troubles had infantile precursors:

If the infant at this period of life fails to establish its loved object within—if the introjection of the good object miscarries—then the situation of the loss of the loved object arises already in the same sense as it is found in the adult melancholic. The first and fundamental external loss of a real loved object...will only result in later life in a depressive state if at this early period of development the infant has failed to establish its loved object within its ego. [Klein 1935, p. 287]

The emphasis moved to the enrichment of the internal world through the experience of the loss of the external good object and recovery by the “establishment” or reestablishment of it internally. This process was seen to be prevented by the manic defense by the denial of loss and the repudiation of a need for reparation that resulted in an impoverishment of the internal world and a compulsive need for success in the external world to fortify it. This gave analysis another potential therapeutic rationale: the exposure of the illusions of the manic defense and working through the depressive position.
There were various developments linked to this central complex; notable among them was the evolution of symbolism and its relation to sublimation. Klein emphasized the importance of the displacement of love for the primary object to other people, other things, and cherished ideals as the basis of sublimation, which she saw as achieved by symbolism. Hanna Segal, one of Klein’s most significant analysts, developed this further by differentiating between symbolic equations, in which objects are treated as identical with the primary object, and symbols, in which the symbol is seen alongside the original while deriving significance from its relationship to it. A beloved aunt, for example, is not the original mother but has a special place as the mother’s sister, the motherland is not the body of the primitive mother but can be loved with feelings that borrow their nature from that earlier figure. If, however, the symbol is treated as identical with the mother, trespass, invasion, immigration, and so on can arouse murderous feelings. In Segal’s distinction the symbolic equation is a substitute that denies loss, whereas the symbol is a product of mourning the loss in the depressive position [Segal 1957].

In the light of her new theory of the depressive position, Klein revised her version of the Oedipus complex [Klein 1945]. She had already written more than once on this subject, positing an early Oedipus situation that conflicted with the classical Freudian notion of a pre-oedipal phase of childhood. She had found sexual and aggressive phantasies and feelings in relation to the two parents in the analyses of very young children. Now, in 1945, she linked the onset of the depressive position with the discovery of the parental relationship as a consequence of the realization of the independent existence of the primary love object and the relationship of the primary object to others than the self.

One could say that the child worked through the Oedipus situation by working through the depressive position and through the depressive position by working through the Oedipus situation. It is evident to any analyst working with adult patients that the working through of this psychic situation is a lifelong task that is renewed in all new relationships. For this reason the term position replaced the older term of developmental phase because the depressive position was seen as relevant at all the stages of life.

Like the Oedipus complex, which was seen initially as an explanation of hysteria but later as a stage of development, the depressive position was seen at first as a description of the psychopathology of depression but later as a ubiquitous developmental stage. In both cases the process of working through these inevitable psychological complexes was seen as part of normal development, with psychopathology arising when they were not successfully negotiated. In the case of the depressive position this working through was regarded as a recurrent task in life as new circumstances arose.

From this point two particular directions developed from Klein’s work that were taken up by her followers and encouraged by her. One was infant observation, which she encouraged both as research and as a preliminary to analytic training, this was strongly established in the Tavistock Clinic in conjunction with child psychotherapy training. The other development was the analysis of adult psychotic and borderline patients utilizing both the technical innovations and theoretical advances derived from her child analysis, it was from these the new theories developed.

The Paranoid-Schizoid Position and Projective Identification

The Controversial Discussions were over and Klein was safely re-established in the British Society when the next phase in her theoretical development began with her 1946 paper “Notes on Some Schizoid Mechanisms” [Klein 1946], which was published later in Developments in Psychoanalysis. In this she introduced the paranoid-schizoid position and her new concept of projective identification. By this time a new generation was grouped around her, and it was they who became known as the “Kleinians.” Notable among them were three of her former analysts, Herbert Rosenfeld, Hanna Segal, and Wilfred Bion, who were all involved in the analysis of schizophrenic patients using the concepts and approach Klein had pioneered with children.

Prior to this period (1946), a paranoid position was thought of mainly as a precursor of the depressive position, and using the old model of Abraham, it was thought to be the fixation point to which regression took place in schizophrenia. The word schizoid was added by Klein in acknowledgment of Fairbairn’s description of the earliest phase as the schizoid position. Like Klein he thought the ego began life related to objects and defended itself from bad experience by “splitting.” What became apparent in the Kleinian work was that in psychoses the regression was not to a normal paranoid-schizoid position but to a pathological one. The greater degree of splitting in this pathology resulted in fragmentation that made integration impossible. Rosenfeld (1950) made the point that unless a primary split could be achieved based on actual good and bad ex-
perience, there was no indubitably good object and no manifestly bad one. The attempt at integration in the depressive position therefore resulted not in ambivalent feeling coupled with a greater sense of reality but in a frightening confusion and bottomless uncertainty.

The actual experience of the child was clearly crucial in this situation, but were there also factors in the child that might contribute to this? In her paper “On Envy and Gratitude,” Klein (1957) wrote that hostility toward a caretaking object independent of the self meant that an unambiguously loved good object could not be experienced or internalized in the paranoid-schizoid position. Bion emphasized that the intolerance of frustration meant that potential good objects were rendered bad by any delay.

In addition to confusion between good and bad, confusion between self and object was another potential hazard that arose from projective identification. This concept has acquired a number of subsidiary meanings, for the sake of clarity I summarize them here. One is the projection of aspects of the self that are disowned and attributed to the other; another is the phantasy of entering the object and taking over its identity or attributes. An example of the first would be the person who, while denying his or her own anger, says, “You are very angry. Aren’t you?” A psychotic example of the second would be the claim by a patient that he or she is the return of Napoleon; a nonpsychotic example of the second would be the unconscious assumption by a patient of the analyst’s ideas and mannerisms. Another variant of projective identification is between that which has an effect on the recipient and that which remains only a phantasy. The projective identification that evokes effects in the recipient is obviously of considerable significance for countertransference. It was developed further in particular by Bion in his concept of the container-contained, which now is described.

**Wilfred Bion**

Wilfred Bion was born in 1897 to an English family living in British India. He had a younger sister. At the age of 8, he was sent to England as a boarder, first to a boarding “preparatory” school and then to a “public” (private) school. By the time he left school, World War I (1914–1918) was under way, and he joined the army as a young officer of 19 in 1916. He served as a tank and troop commander in the thick of battles, with their appalling carnage, and was decorated with both the British DSO medal and the French Croix de Guerre for conspicuous bravery. From the army he went to Oxford University to study history; the major influence on him there was his tutor, H.J. Paton, who was noted as an authority on the philosophy of Kant. By 1924 Bion had decided to pursue psychoanalysis and took Ernest Jones’s advice to first qualify in medicine, which he did at University College Hospital London. Here he worked for and was greatly influenced by the famous surgeon Wilfred Trotter. As a young doctor Trotter was one of the first in England to encounter the work of Freud and encouraged his junior Ernest Jones to join him in learning German to study more; they were the only British members of the first Psychoanalytic Conference in Salzburg in 1908. Trotter (1916) wrote one of the first post-Darwinian books on group behavior, Instincts of the Herd in Peace and War, and later was a noted writer on the philosophy of medicine. It is clear from these writings how much he influenced the development of Bion’s ideas. Although he was impressed and sympathetic to early psychoanalysis, Trotter had two criticisms: one, that psychoanalysis was too anthropomorphic, and two, that it unquestioningly accepted a concept of normality that he thought was statistical and usually a rationalization of instinctively based group conformity. Rationalization—that is, the intellectual justification of unconsciously determined ideas—was an original concept of Trotter’s that was borrowed by Jones and subsequently attributed to him in the psychoanalytic literature. Trotter emphasized the inevitable internal resistance to new knowledge because it changed preexisting cohesive beliefs of the group. This theme can be found running through Bion’s ideas on groups, and he returns to it in Attention and Interpretation (Bion 1970) in the last phase of his work.

Bion joined the Tavistock Clinic and began to develop his psychoanalytic career, however, this was interrupted by World War II (1939–1945), in which he worked as a psychiatrist with John Rickman, his former analyst, developing group therapy for psychologically disabled soldiers. On his return to the Tavistock Clinic, Bion continued his pioneering work with groups that became the foundation of the group relations approach that has developed worldwide. He also continued his analytic training at the British Society, with Melanie Klein as his training analyst. He rapidly became a leading member of the so-called Kleinian group and succeeded Melanie Klein as chair of the Klein Trust when she died in 1960. Not long afterward he became president of the British Psychoanalytic Society.

Although he was usually cast in leadership roles and found himself at the heart of the establishment, Bion always saw himself as a maverick and disturber of the
peace. In 1967 he was invited to speak to the Los Angeles and the Southern Californian Psychoanalytic Societies and subsequently encouraged to move to Los Angeles. He did so in 1968 with an initial intention of staying for 3 years. He and his wife ended up living there until 1979, when they returned to live in England. He died shortly afterward.

His unexpected move to the United States in 1968 at the age of 70 caused some consternation among his colleagues and followers in London, where he was a central part of a Kleinian establishment. This has given rise in America to the myth that Bion was an intellectual asylum seeker in California. The truth is more likely that he felt he was producing important new concepts and that although he was being venerated, his new ideas were not being attended to. He describes in his unpublished paper “Catastrophic Change,” read to the British Society in 1966 (Bion 1966), an establishment preventing the disruptive effect of the mystic (or genius) by loading him with such honors that he sinks without trace. This view conforms with his theories of the relation of the container to the contained or the mystic to the group that are described later.

Unsurprisingly perhaps, Bion found things much the same for him in Los Angeles. In September 1971 he wrote in his journal:

“The relationship between myself and my colleagues here in Los Angeles could be accurately described as almost entirely unsuccessful. They are puzzled by, and cannot understand me—but have some respect for what they cannot understand. There is, if I am not mistaken, more fear than understanding or sympathy for my thoughts, personality or ideas. There is no question of the situation—the emotional situation—being any better anywhere else. I could say much the same for England. “The old order changeth, yielding place to new.” (Bion 1992, p. 334)

Although Bion was rigorously skeptical of idealization and group worship, he was never able to escape becoming its object. However, he distinguished between defensive idealization based on denial of denigration and idealization springing from a need for “reverence and awe”—which he used as the title of the paper he gave in Los Angeles in 1967 (Bion 1992).

The development of Bion’s psychoanalyst thinking had a trajectory of its own, as though the new superseded the old, and it is only possible to make them clear by writing it as a narrative. This can be misleading because it needs to be borne in mind that valuable concepts have been deposited at all points along the way, and these have been taken up variously by followers, some of whose efforts have proved particularly fruitful, perhaps others less so. This could be said of Freud and Klein, but it may be especially important to keep in mind with Bion, because the ideas in his last phase have been taken up enthusiastically by some and regarded as a new dispensation in psychoanalysis while being regarded by others as a falling away from his previous skepticism and intellectual rigor.

Basic Assumption and Work Groups

In the 1940s he continued, at the Tavistock Clinic, the work with groups he had begun during the war both for therapeutic purposes and for what were then called “study groups.” He produced a model of life in groups that has been used ever since and that also informed his later formulations about psychoanalytic practice. This model was of the distinction between the work group and what he called a basic assumption group. He did not see these as distinct alternatives, but because the innate basic assumption group to varying extent infiltrated the thinking and activities of the work group, this latter group he made clear “embrace only the mental activity of a particular kind, not the people who indulge in it” (Bion 1961, p. 144). Like the ego, he saw the work group as task oriented and realistic. Bion saw the basic assumption group underlying it as unconsciously dedicated to sustaining the group in a particular mode with an overriding shared belief system. He described three possible basic assumptions that would arise spontaneously when a group assembled, one he called dependent, another pairing, and a third fight/flight. It was always possible that a move could take place within an actual physical group from one basic assumption state of mind to another, as was demonstrable in events designed to observe group processes.

A group in the grip of basic assumption thinking has no relation to time, reality testing, or development. The dependent basic assumption is that the group is met to be sustained, nourished, informed, and protected by a leader. The pairing assumption is messianic. An ultimate solution will be produced by the intercourse of the group, probably exemplified by an emergent leader who will save it from conflict or dissolution. The fight/flight group assumption is that the group has met to fight something or to run away from it. The acceptable leader is one who appears to facilitate flight or aggression, and if he or she makes demands that do not do so, he or she is ignored.
The basic assumption state of mind of a group is what determines how it collectively reacts to events. For example, currently there is debate as to how the people of Iran will react to economic sanctions imposed by the Western governments fearful of their nuclear ambitions. If they are in a dependency assertive mode, they will blame their current leadership for economic hardship; if they are in a pairing assumption, they will see this as confirmation that their love affair with their leadership is about to produce a new world order; if they are in a fight/flight assertive mode, this will increase their belligerent belief that the West is at war with them and that they must prepare to attack or be attacked.

Bion turned from working with groups at the Tavistock Clinic to analytic practice and psychoanalytic theories of individuals. When he reviewed his earlier ideas on groups in 1952, he linked the basic assumption states with the paranoid-schizoid position and the basic assumption group phenomena with projective identification. In the 1960s he was rethinking both individual and group phenomena, particularly in Attention and Interpretation, in the light of his ideas on containment, which are described later.

**Differentiation of the Psychotic From the Nonpsychotic Personality**

During the 1950s Bion was mainly influenced by his growing experience of analyzing psychotic patients. Armed with Klein's description of the paranoid-schizoid position, including projective identification, Bion took as his theoretical starting point Freud's paper on the two principles of mental functioning. Bion suggested that the profound hostility of the psychotic personality to the reality principle and the use of projective identification to eliminate it was at the heart of psychoanalytic work. It is important to realize that he regarded both personalities, psychotic and nonpsychotic, as present in everyone [Bion 1957]. It was therefore essential to talk to psychotic patients in a way that assumed comprehension by the nonpsychotic part of them while taking their psychotic beliefs seriously; otherwise the patient, who had projected the "sane" part of themselves that they wished to be rid of into the analyst, would take their projective phantasy to be realized as a fact.

Bion thought that the apparatus in schizophrenia that linked the patient's ego to externally perceived reality and internally perceived reality, namely thoughts, was under constant attack. Perceptual cognizance as link between self and objects, language as a link between potential ideas and words, memory as a link between present and past—all were likely to be subject to attack.

Bion described three types of link: L (love), H (hate), and K (knowledge). He saw the vicissitudes of L and H as the main area of Klein's investigations and concentrated his attention on K. The wish to know the "truth" inevitably encountered resistance to its potentially unpleasant disclosures in normal/neurotic personalities. However, in the psychotic personality the internal opposition that he called K was more profound because it opposed any incremental knowledge. The source of K he located in an ego-destructive superego that was represented in the Eden myth of the punishment of Adam and Eve for eating fruit from the tree of knowledge, in the Tower of Babel story of the destruction of a unified language as punishment for building toward the sky; in the curse of the Sphinx in the Oedipus myth; and of the tragic outcome of Oedipus's insistence on knowing the truth despite Tiresias's warning.

**Learning From Experience**

To learn from experience, Wilfred Trotter said, is particularly difficult for us as a social species because we are united by our shared belief systems and fear that these may be contradicted. Bion used Trotter's phrase as the title of the book published in 1962 that culminated from this period of inquiry and brought together what many would see as his most original psychoanalytic contributions [Bion 1962]. These were encapsulated in four new concepts: 1) the model of PS ↔ D, 2) the transformation of beta elements into alpha elements, 3) the notion of preconceptions, and 4) the theory of containment.

PS was his nonpathological cognitive version of the paranoid-schizoid position, and D denoted the integration of the depressive position. He represented the disintegrating effect of new experience into part objects as PS and its resolution into a newly formed whole object as D, using the chemical sign for reversible equations to link the two, and the capacity to move from one to the other being essential for mental growth.

Bion's theory of innate preconceptions was like Kant's empty thoughts, what one might call imageless expectations awaiting a meeting with experience to fill them and give them form. This required a tolerance of approximation and a capacity to wait, Bion thus saw the inability to bear frustration as crucial in producing pathology in this
situation. His formulation was that when preconception meets realization, it produces a conception, for example, a breast now signifying the source of satisfaction; in the nonpathological version preconception meets absence (negative realization), which produces a thought, for example, the idea of a breast. In the pathological version it produces a no-thing, a bad object that annihilates the potential space for a good object.

Bion based his system on the notion that thoughts preceded thinking and that thinking was a means of dealing with thoughts, but first he postulated the origin of thoughts from raw experience—that is, the mentalization of somatic and perceptual proto-thoughts. These elements required a process, which he called alpha process, to transform what he called beta elements into alpha elements, the building blocks of thought. Beta elements could only be evacuated by projection into the external world (creating hallucination or animism) or into the body (producing psychosomatic effects) or by physical action. In an analytic session, although communication is possible with alpha elements, only evacuation is possible with beta elements, such as by screaming or hitting.

In Bion’s model the newborn lacks an alpha process and relies on the maternal object to provide it. This is accomplished by the infant’s projection of beta elements being transformed by the mother into a response that gives meaning to the infant’s experience. If, as Bion suggests, the infant’s unmetabolized fear of annihilation is not transformed by the mother’s response into a fear of dying that requires amelioration, what is instead introjected is “nameless dread.” The assumption is that the process is introjected as a result of experience and maturation. This would result in an expectation of understanding, whereas a failure of this relationship would result in an expectation of misunderstanding.

It has been suggested (Britton 1998) that the need for agreement is inversely proportional to the expectation of understanding and that an absolute need for agreement with no expectation of understanding is characteristic of borderline personalities.

Bion’s theory of containment has provided us with another potential therapeutic effect. If the patient’s unmetabolized mental content can be processed and named or the unbounded psychic experiences contained, this in itself is beneficial. This means articulating the analytic situation from the patient’s point of view rather than attempting to explain it or to repudiate it.

The infantile genesis of this concept of a universal relationship Bion called container, signified by-chair, and contained, signified by-sitting, with the relationship represented by-where. For example, a thought may be contained in a containing word or phrase. This may enhance understanding and therefore be symbiotic, or the relationship between thought and word may be a parasitic, destructive one. In a destructive relationship the thoughts as the contained may fragment the word or words, as the container may crush the meaning or life out of the thoughts. Similarly, a powerful new member may fragment the group meant to contain him or her, or a group organization might crush the individuality of its newest arrival. Likewise a newly born child may disrupt a preexisting family or be confined inside an identity formed by their preexisting expectations.

Catastrophic Change and Second Thoughts

Learning From Experience, published in 1962, was the culmination of Bion’s clinical experience and theorizing, largely based on the analysis of psychotic and borderline patients. New ideas, or at least new formulations with a new emphasis, followed it in the 1960s. He was now focusing more on the analyst’s processes of thinking, recording, and reproducing, which perhaps grew out of his increasing experience of analyzing and supervising analysts and candidate analysts. Central to his concerns was the conflict between truth seeking and the preservation of existing knowledge as a source of security, associated with this was the difference between authenticity and acceptability, between functioning as an analyst in a sea of uncertainty and assuming the role of one who knows.

Bion was also trying to find a way of expressing the reality of analysis while profoundly mistrusting how it was reported. This was a very old theme echoing his ironic skepticism about the contrast between the systematic reports of and the actual chaos of battles in World War I. This theme culminated in 1967 with publication of Second Thoughts (Bion 1967), which was a reprinting of his earlier papers with a commentary that threw doubt on his own clinical reports. Bion’s intention was not to eradicate psychoanalytic theorizing but to put it on a firmer footing.

His great interest in modern mathematics as well as his reverence for classical literature and his analytic interest in theology meant that he clothed his ideas in a mixture of the language of all three. He tried to locate the experience and events of analytic sessions, first insisting that the analyst must put away memory and desire. By memory he meant conscious recollection...
taken into the session that would obscure observation and obstruct the spontaneous arousal of associations in the analyst. Desire is always likely to distort discovery. What was controversial for many was his inclusion in the taboo of desire the analyst’s wish or intention to cure. In Bion’s view analysis was meant to explore and expose what was there, and if that produced beneficial effects for the patient, that was well and good. Plainly an approach such as this includes an unstated assumption that the truth is therapeutic.

The Selected Fact

In his search for a model for psychoanalytic intuition, Bion adopted that of Henri Poincaré. Bion (1967) suggested that the organization in the analyst’s mind of thoughts about his or her patient resembles a process described by Poincaré in his Science and Method (1914). This process begins with some particular fact among an accumulation of facts arresting the attention of the scientist in such a way that all the others fall into a pattern or configuration by their relationship to this selected fact. Bion adopted the term selected fact because he believed a similar process takes place in the analyst’s mind, when memory and desire are put aside, the analyst achieves that state of “evenly suspended attention” prescribed by Freud for analytic practice (Freud 1912, p. 111). There is, in the analyst’s thinking, an “evolution,” namely the coming together, by a sudden precipitating intuition, of a mass of apparently unrelated incoherent phenomena which are thereby given coherence and meaning not previously possessed.... This experience resembles the phenomenon of the transformation of the paranoid-schizoid position to the depressive position.... From the material the patient produces, there emerges, like the pattern from a kaleidoscope, a configuration which seems to belong not only to the situation unfolding, but to a number of others not previously seen to be connected and which it has not been designed to connect. [Bion 1967, p. 127]

Two terms, K and O, need some explanation because they increasingly play a part in his later writing and have been given great prominence by some followers. K has already figured as the K link and in philosophical terms is epistemological—it has to do with knowing, the O is philosophically ontological—that is, it has to do with being. Bion came to see psychoanalysis as beneficial in as much as it produced evolution in O, with the acquisition of K being a means toward that end, i.e., transformation in O from K (Bion 1970). This means that knowledge, discovery, enlightenment, or whatever may produce change in O, the being of a person or the identity of a group. This may well be felt as a disaster, what Bion called catastrophic change.

Bion read a paper with that title to the British Society in 1966, by which time he was once more thinking about group phenomena. It was probably influenced by his experience of the conflicting groups of the British Society, which at their worst he described as analytic gang warfare. Central to his paper was his idea of the mystic and the group, he chose the word mystic but he could equally have said genius. This choice has encouraged some to see a way through Bion from psychoanalysis to religion. Bion certainly took religious belief seriously as an inherent characteristic of human beings, but there is no evidence that he embraced any supernatural belief. I think there is unspoken reference in this paper to Freud, Klein, and himself in his formulation that an establishment evolves that seeks to tame the mystic innovator’s wild ideas by institutionalizing them.

His fondness for using terms that echoed mathematics or modern physics was increasingly evident, together with his favorite literary and philosophical references. Borrowing the idea of vertices from physics, he saw the invariants of mental life transformed in their manifest realizations along different vertices—mythic, religious, aesthetic, scientific—or in an individual’s psychology. For example, if we take triangularity as an invariant in human relations, its transformations can be found on different vertices: as the myth of Oedipus, as the Trinity in theology, as the story of Jane Eyre in literature, as a model in psychoanalytic theory or perhaps in neuroscience, and in the transference-countertransference relationship that shapes an individual analysis.

The Post-Kleinians

The description post-Kleinian has been attached to the generation of analysts who were trained by Klein’s followers such as Segal, Joseph, and Rosenfeld and who were profoundly influenced by Bion’s approach to the analytic process. Accordingly they adopted a principle of never moving from theory to practice but from practice to theory. Their approach was developed in postgraduate workshops such as those of Betty Joseph, in which the material presented for discussion was a detailed account of analytic sessions (Hargreaves and Varicheveter 2004). General theory was never discussed in the workshop, and the focus was on the elucidation of the transference and countertransference and on the enactments of patient and analyst. This is exemplified in Michael
Feldman’s (2009) book *Doubt, Conviction and the Analytic Process*. As a consequence, although individual members of that workshop wrote theoretical papers, the papers were phenomenological and not metapsychological. There were shared background theories in these work groups that acted as basic assumptions. These theories included Klein’s paranoid-schizoid, depressive position, and projective identification plus Bion’s theory of containment and his theory of thinking.

The characteristic preoccupation of this group was the conflict of the relationship to reality [both external and internal] with the pleasure principle and its transformation as the morality principle—in effect, the use of association and imagination as truth seeking or truth evading. The notion that the individual seeks refuge from reality in psychic systems that provide gratification at the same time as defense was described by John Steiner as pathological organizations (Steiner 1993). That there is frequently resistance to developmental psychic change is a central tenet of the post-Kleinian school.

The analysis of cognitive development and its pathology is the focus of Britton’s (1998) writings on *Belief and Imagination*. In this the Oedipus situation is seen as providing a prototype for triangularity that enables subjectivity and objectivity to coexist so that one can observe oneself while being oneself (Britton et al. 1989). It was the lack of this triangular space that made the analysis of borderline patients so difficult. A post-depressive position was described of uncertainty and incoherence as part of the lifelong repetition of alternating cycles of integration and de-integration in each new stage of the acquisition of knowledge (Britton 1998). That there is frequently resistance to developmental psychic change is a central tenet of the post-Kleinian school.

Part of the agenda of this group has been the reevaluation of established Kleinian concepts, as in the recent collective publications *Envy and Gratitude Revisited* (Roth and Lemma 2008) and *Bion Today* (Mawson 2010).

---

**KEY POINTS**

- Melanie Klein developed a technique of child analysis in which the play of the child was interpreted like dreams and free associations in adult analysis.

- Klein found that underlying childhood neurosis were infantile phantasies that resembled the delusional ideas found in adult psychoses and that the superego as conscience had an archaic, monstrous precursor in infancy.

- The depressive position describes a move from part- to whole-object relations, from the segregation in time and space of good and bad objects to continuity in time, the integration of good and bad, and the development of ambivalence. Continuity also means the experience of absence and loss with consequent depressive anxiety and mourning.

- In the paranoid-schizoid position fragmented experiential objects are organized into good and bad on the basis of good and bad experience prior to integration in the depressive position.

- In phantasies of attributive projective identification, part of the self is relocated in the object; in acquisitive projective identification, the self enters into and claims to be the object, as in some psychoses, or to possess the object’s attributes, as in some neuroses.

- Underlying any assembled work group is an unconscious basic assumption group with a shared phantasy; the less task oriented the work group, the more the basic assumption is likely to take over. Bion described three basic assumption groups: dependency (leader dominated), pairing (messianic hope), and fight/flight (paranoid).
• PSD (terms derived from the paranoid-schizoid and depressive positions) are alternating nonpathological psychic states of un-integration and integration.

• A preconception is an innate imageless expectation that becomes a conception through an encounter with its realization in experience.

• Raw sense-based data, called beta elements, require alpha process to become mentalized alpha elements. Initially in infancy projected beta elements are processed by the mother: failure of this process leaves the individual subject to unmetabolized beta elements and nameless dread.

• The theory of container/contained, ṭ Ṽ, is that from the outset of life ideas and experience need containers that encapsulate and give form to what they contain, as in ideas and language. The relationship of ṭ Ṽ may be symbiotic, destructive, or parasitic.

• The analyst should wait for the intuition that some item in the patient’s discourse will emerge as a central selected fact that will, through its connections, produce a meaningful pattern.

• That there is frequently resistance to developmental psychic change is a central tenet of the post-Kleinian school.

References


Bion WR: Experiences in Groups. London, Tavistock, 1961


Bion WR: Second Thoughts. New York, Jason Aronson, 1967

Bion WR: Attention and Interpretation. London, Tavistock, 1970

Bion WR: Cogitations. London, Karnac, 1992


Groddeck C: The Book of the I. New York, Nervous & Mental Disease Publishing Company, 1928


Material com direitos autorais


Self Psychology

David M. Terman, M.D.

History

The central ideas that constitute what has come to be known as self psychology were first formulated by Heinz Kohut in the 1960s in Chicago. They grew out of his deep immersion in the theory and practice of classical psychoanalysis as it was understood in the United States in the mid-20th century. Indeed, it was he, with Maxwell Gitelson, who insisted on the integrity of the analytic process, especially the intense and long-term immersion in the analysis, that was the crucial element of the therapeutic process. It was this position that put them in opposition to Alexander’s attempts to shorten and manipulate the analytic situation and ultimately became the prevailing norm at the Chicago Institute.

Gitelson’s ideas were influential in two other respects. He had coined the term narcissistic personality disorder to describe a group of patients whose rigid character and maladaptive defensive structure made them difficult to treat but who, he believed, suffered not from weaknesses of the ego but from having to adapt to traumatic environments of childhood [Gitelson 1958]. In a 1962 paper he wrote about the importance of what he called “the diatrophic attitude,” that is, the feeling that the analyst felt what Spitz had called the “diatrophic function”—the healing intention to maintain and support the patient. These attitudes were part and parcel of a normal psychoanalytic approach and were part of an expectable and useful countertransference [Gitelson 1962; Spitz 1956].

The combination, then, of deep immersion in the psychoanalytic process, the possibility of viewing narcissistic personality disorder as an adaptation to traumatic childhood experience, and the possible contribution to psychoanalytic healing from a current attitude of the analyst helped lay the groundwork for Kohut’s approach to and understanding of narcissistic personality disorders. The first statement of the theory that would guide his work was in the 1965 presidential address to the American Psychoanalytic Association. Published in 1966 as “Forms and Transformations of Narcissism” (Kohut 1966), it laid out the idea that narcissism had a separate and independent line of development. Rather than the desired fate of narcissism being its conversion to object libido, it would develop into one’s ambitions and ideals,
and even more significantly could become transformed into some of the most desirable aspects of human character: empathy, creativity, humor, acceptance of transience, and wisdom. In separating the lines of development into narcissism and object libido, Kohut wanted to counter both a cultural and a psychoanalytic prejudice toward self concern and self display. By showing that the most valued traits were derivative of this much-maligned aspect of character, he was inviting a more acceptable position toward the manifestations of narcissistic needs. Much as Freud had done with childhood sexuality, Kohut asked us to try to understand the role that self concern, self display, the need for others to admire us, and so on played in development, psychological structure, and treatment. He further cleared the way for a systematic exploration of what these needs were manifestations of: the self.

The original works in which the basic concepts of self psychology are enumerated are three books by Heinz Kohut that were written in the last decade of his life [the last was published posthumously in 1984]: The Analysis of the Self [Kohut 1971], The Restoration of the Self [Kohut 1977], and How Does Analysis Cure? [Kohut 1984]. The reader will find other papers and letters assembled and edited by Paul Ornstein in The Search for the Self [Kohut 1991]. For a comprehensive biography of Kohut’s life and his ideas, see Charles B. Strozier’s (2001) Heinz Kohut: The Making of a Psychoanalyst.

### The Self

What is the self? Kohut began with Hartmann's definition of the self. Distinguished from the ego (Hartmann 1950), the self was a structure analogous to the object and could be found in any of the parts of the tripartite psyche. Especially in regard to the target of cathexis, the opposite of object cathexis was not the ego, which is a set of functions, but the self, which is the person, the sense of one’s personhood. In further filling out the developmental trajectory of this self, however, Kohut became increasingly concerned with the crucial role of the caretaker in the genesis and existence of the self. One central metaphor is that the self is born in the gleam of the mother’s eye. As he elaborated the role of the caretaker, he further specified that the role is a function in the psyche of the child and that the child experiences these functions as part of its self. Because the person or persons who perform these functions are experienced by the child as part of the self, they are called selfobjects. Thus, in elaborating the essential role of the selfobject in the development and maintenance of the self, he changed the concept of a self. It was no longer a discrete structure contained within a tripartite psyche, it was a system that embodied a relationship. This system, self, is often discussed as “self-selfobject,” and it also has become labeled as the “bipolar self.” Later defined as consisting of the person’s ambitions and goals on the one hand and the idealized pole of ideals on the other, with a “tension arc” of capacities, this “bipolar” structure has most frequently been used as the meaning of self [Kohut 1977].

These definitions of self have often been confusing to the student of self psychology. The most difficult to understand and work with is the system definition of self. However, two properties of self are shared by all of the definitions that describe it. The first is the crucial and central role the “other,” the selfobject, has in the existence of the self, and the second is some enduring structural patterning that has broad and deep organizational and motivational force in the personality. Finally, in subsequent discussion of the development and vicissitudes of the self, it may be helpful to bear in mind that all these phenomena are the inner view of a transaction. That inner view is from the perspective of infant/child/adult whose self is the object of understanding.

Given the importance of the concept of the selfobject in the theory and practice of self psychology, a word needs to be added here to clarify its origins. Some critics have noted its similarity to Donald Winnicott’s ideas of the importance and centrality of maternal care in the development of the infant that were first published a few years earlier [Winnicott 1960]. I think it is accurate to say that Kohut derived his theory of the development of the self and the selfobject quite independently of Winnicott. The question of how much Kohut was aware of or influenced by Winnicott’s work is extensively taken up by Strozier (2001) in his biography of Kohut. I agree with his conclusion that whatever influence there may have been, it was slight. From my own experience in following the development of Kohut’s thinking, I believe that the psychoanalysts who exerted the strongest intellectual influence on him were Maxwell Gitelson, Anna Freud, Heinz Hartmann, August Aichorn, and of course Sigmund Freud. I would add that the systematic elaboration of the development of the self and the selfobject into a developmental and clinical theory has become another paradigm for understanding psychic life.
Development of the Self

The idea that the self must consist of and contain another means that development is now a function of a two-person system. Development does not take place as a sort of embryological unfolding, with all the forces within the embryo forming the structure that will later become the infant. Rather, the forces that mold the developing personality come out of both the child and the caretakers. It is the intersection and interaction between the caretakers and the developing child that create the structure. This constitutes a profound shift in how one understands the vicissitudes of development.

Kohut [1966, 1971, 1977] initially divided the development of the self into two classes of experience: the grandiose self and the idealized parental image. A third category of self—the twinship or alter-ego—phase of self development was first subsumed as a variety of the grandiose self, but Kohut later separated alter-ego as an independent category [Kohut 1984]. The grandiose self and the idealized parental image have been elaborated in the most detail, and their manifestations as coherent transferences have been most clearly articulated.

The grandiose self comes into being and develops by virtue of the responses of the caretaker to the displays of the child—that is, the experience of wonderfulness, specialness, or greatness are a part of phase-appropriate development of the “grandiose” self. They require the affirming participation of the caretaker in order to develop further. These qualities of specialness and of pleasure with oneself, the wish to show oneself, become one’s goals and ambitions. Furthermore, they become the basic sense of self-esteem. In favorable circumstances this sense is positive, but the quality of the sense of self is intrinsically bound up with the experience of the responses of the caretaker. These responses are called mirroring selfobject functions. They are understood and described from the point of view of the child. They are executed by an external other, but they are experienced by the child (or the adult, in later versions of such functions) as part of the self. It should be noted that the existence of a seamless inner experience for the child does not imply that he or she has no sense of the other or that there is a total experience of merger with the external other. Rather, the experience of oneness with the other is only in relation to a crucial function that the “other” must perform in particular times and ways.

One interesting example of the seamless structuring of inner experience is in a series experiment that is part of the work on social referencing reported by Emde and colleagues [Klinnert et al. 1983; Sorce et al. 1985] This group set up a situation in which a toddler approached a false precipice, a visual cliff—an optical illusion. In the experiments, the child was in the room with the mother, and the mother was instructed to either smile and nod approvingly or shake her head and look anxious. If the mother smiled and nodded approvingly, the child crossed the apparent precipice. If the mother shook her head and appeared worried, the child would back away from that precipice. In both instances, the mother was an intrinsic part of the child’s capacity to understand the world. It is safe, it is okay to cross, or it is not okay to cross. That definition of the world was a function for the child.

How much more powerful then is the parent’s or the caretaker’s reaction to the child as such—that is, whether the child is reacted to in a smiling and happy or in an angry and upset way. Those reactions define the essence of the child, and those reactions are part of the function of the development of who the child is, what one’s self is like.

The idealized parent image or the idealizing pole of the self develops out of the experience of merger with the perceived strength and perfection of the powerful caretaker. Certain idealizing functions are dependent on the usual caretaking capacities of the caregiver, and the internalization of those capacities is accomplished via the experiences of optimal frustration in those caregiver qualities. The outcomes of this process are affective regulatory structures that are acquired in the course of early development and the set of ideals and guiding values that occupy an elevated status in the individual’s mind that are acquired later. It is this pole of the self that later in the course of life still requires the involvement in institutions and groups that are beyond the confines of one’s person. They include ethnic and national groups as well as institutions that embody systems of ideals such as religions, ideologies, and philosophies [Kohut 1975, 1976, 1981a, 1981b, Strozier et al. 2010; Terman 1984].

The third area of self development has been described as an “intermediate” area of talents and ambitions that is between the goals and ambitions of the developing grandiose self on the one hand and the ideals and idealizations on the other. In the model of the bipolar self (Kohut 1977), it is a “tension arc” between the poles of ambitions and ideals. The development of the talents and skills required to carry out the program of the self requires the presence of another just like or identical to oneself. The experience of alikeness is also an important component of the experience of being human altogether.

The felicitous outcome of the processes of transformation of the infantile/childhood grandiose self, the suc-
cessful experience of alikeness, and the internalization of the idealized parent is a self that is cohesive, solid, and vigorous, with well-focused ambitions, sets of guiding ideals and values, and the employment of skills and talents to pursue a creative and fulfilling life. However, there are many opportunities for failure and trauma.

Developmental Pathology

Either or both poles of the self may encounter obstacles in their unfolding development. These arise from a problematic fit between the child and the caretaker(s) as one might describe it from an external perspective, or the difficulty in the self-selfobject matrix when viewed from the internal perspective. The result of trauma may include a variety of pathologies. One can divide them into the categories that correspond to the two poles of the self.

Pathology of the grandiose self arises from the difficulty of the caretakers to respond to the child’s needs for confirmation and pleasure in his or her displays or very existence. Depressed, preoccupied, morally offended, impatient caretakers may cause the child to repress or split off these aspects of the self. Children may also experience ordinary situations of inattention as traumatic lack of responsiveness. The inner experience of unresponsiveness, hence, is an outcome of the matrix of the interaction between the child and the caretaker or the self-selfobject unit. The result of the trauma to and derailment of the development of the grandiose self is either its repression or disavowal, or often both. When this occurs, the source of one’s vitality and the drive to achieve is unavailable to the person. Hence, the symptomatology of the repression of the grandiose self is typical of the narcissistic character disorder and includes hypochondria, sensitivity to slights, and lack of vitality. If, as is frequently the case, the grandiosity is both disavowed and repressed, there are arrogant claims for recognition, honor, and special treatment alternating with states of depression and depletion. It requires considerable analytic work to first engage the split-off sector of the grandiose self with the mature but depleted part of the personality and then further work to undo the repression of the source of the vitality, the repressed grandiose self.

Symptoms of a repressed or disavowed grandiose self may also lead to various antisocial and self-destructive behaviors. These are grouped under the label of narcissistic behavior disorder, and they include addictions, perversions, and delinquencies. Here the clinician’s emphasis is on the vertical split and the underlying missing structures of the self (Goldberg 1995). The addictive or delinquent behavior is an attempt to fill in the absent regulatory structure. It is also an attempt to experience the vitality or stave off the fragmentation of the immature self in whatever state it exists.

Pathology from the failures in idealizing pole includes the self-regulatory problems described. Diffuse problems in self-regulation often stem from the inability or unavailability of the maternal selfobject to soothe and regulate the affects, for example, of the infant. The traumatic disappointments deprive the child “of the gradual internalization of early experiences of being optimally soothed or of being aided in going to sleep,” for example [Kohut 1971, p. 46]. Later addiction to drugs may then be an attempt to replace the absent or defective regulatory structure.

More circumscribed defects in the idealizing pole include the inability to find meaning and satisfaction in living up to one’s goals and ideals and/or a ceaseless search for idealizable figures to whom to attach in order to feel a sense of security and wholeness. Inevitably, such figures disappoint the searcher when he or she discovers that the person has defects, is not omnipotent, and so on, and then the search continues for another person or cause that also disappoints. Sometimes this kind of search is sexualized—that is, the missing structure of ideals is substituted with sexual activity with a person who seems to have the qualities one feels is missing and hopes to acquire. This is one basis for some sexual perversions. Other reactions to the disappointments in idealized figures may be regression to more archaic grandiosity; hence, the person may have the hypersensitivity to slights and/or the claims for recognition noted earlier [Kohut 1971, see case of Mr. A].

There can be fixations, regressions, and weaknesses and numerous defensive operations to cope with the functional problems. Although there may well be all the defensive operations that are described in traditional terms in regard to standard neurotic symptoms such as repression and reaction formation, other defenses are more common. These include disavowal, denial, and what has become known as vertical splitting.

In discussing the vicissitudes of the pathology of the self, Kohut described the fate of the unmodified grandiose self as “split” either “horizontally” or “vertically.” This shorthand metaphor referred to the model of the psyche in which repression is usually represented as a horizontal line. That which is split horizontally is repressed. Taking Freud’s [1927] theory of the mechanism of fetishism and applying it to the fate of the unmodified grandiose self, Kohut described the vertical split as that aspect of the self—the grandiose wishes, con-
spicuous displays, and so forth—that is present in the conscious and unconscious mind and yet is disavowed by the mature, reality-based part of the ego (Kohut 1971).

The underlying state of the self may be characterized as prone to fragmentation, enfeebled, stunted, or having a low or negative quality or quantity of self-esteem. The source of such difficulties is disruption of the optimal evolution of the self/object matrix; hence the pathology of the self is often referred to as a “deficit.” Although this is often true, this does not preclude the existence of important and strong conflicts as well.

There are significant conflicts in many areas: a fear of shame in revealing the still unmet needs of the self, the affects that have been generated in the quest for self completion; the rage, in particular, that may attend the frustration of narcissistic needs; and the competing claims of disparate aspects of self with each other. Hence, although the equation of self psychology with a deficit model in contrast with traditional conflict psychology has often been stated, it is not accurate. Furthermore, some self psychologists have held that neurotic conflicts have their base in problems in self development and self differentiation and that the self pathology in such situations is not simply a matter of deficit but a complex structure of self distortion and conflict at many levels (Terman 1990).

The reader should note that the meaning of the term of splitting in self psychology is quite different from its meaning in object relations theories. In the latter, splitting refers to representations of self and object that are invested with instinctual energy and/or affect and are polarized into good and bad. These representations are understood with a developmental model that has been elaborated by those who use object relations theories, and that is very different from the one elaborated by self psychology (Tolpin 1986). Furthermore, splitting in self psychology refers to the self as outlined in this chapter and does not imply polarization of the aspects of the self that separated from each other.

There remains a large theoretical problem in the area of the relation between the processes and mechanisms of self and the operations that have characterized as the functions of the ego. For example, in postulating the mechanism of splitting, Kohut transposed the theory of the defense from Freud’s description of the splitting of the ego in fetishism. Yet the splitting here is in the self, not the ego. One may ask, then, how such functions and operations that were understood to be part of a psychic apparatus can be part of a self that is supraordinate and not simply a content of a tripartite psyche. This requires further work.

Kohut’s 1959 seminal paper, “Introspection, Empathy, and Psychoanalysis,” brought empathy to the center of psychoanalytic attention. Since then, there has been an outpouring of articles and papers in the psychoanalytic literature. The PEP Web site [Psychoanalytic Electronic Publishing; http://www.pep-web.org] lists 162 articles, chapters, and books that contain “empathy” in their titles. All but 9 have been published since Kohut wrote his article, and they have taken up the questions of its definition, its scientific status, its nature, and its effect on technique and others. What had Kohut written that inspired such interest and attention? He defined the essential process and essence of empathy as “vicarious introspection.” To arrive at an accurate understanding of the inner experience of another, one had to refer to some aspect of one’s own inner experience. This definition and description stress the similarity of the inner subjective psychological experience of the two parties. In taking this position, Kohut was further emphasizing the importance of the “subjective” in understanding psychological life, and he was extending Freud’s reclamation of the subjective for scientific scrutiny. Furthermore, Kohut maintained that what one could observe with empathy defined the extent and limit of psychoanalysis. Hence, Kohut was emphasizing the importance of inner experience of the observer in making sense of the observed. He was emphasizing the centrality of subjective resonance in making sense even of the more “objective” data of free associations and dreams.

Basch clarified the process further in his 1983 paper. Adding the more precise findings of affect theory, Basch (1983) stated that one component of the empathic process is the apprehension of the other’s affect state by virtue of the fact that “one’s own affective state duplicates that of the other” (p. 105). However, although empathy contains this important feature for Basch, he added that it involves “complex cognitive processes by which we form certain hypotheses about another person’s inner experience, hypotheses that are then open to further study so that the judgments…can be confirmed or proven false” (p. 110; emphasis added). Basch further cautioned that “empathic perception is never a matter of somehow getting a direct look at what goes on inside another mind; rather, it is considered judgment that there is a correspondence between what we are feeling and what, in the case of the analytic situation, the analysand is experiencing, consciously or unconsciously” (p. 114). In other words it
involves complex cognitive tasks and often prolonged dialogue to establish the correct apprehension of the inner experience of the other—what we call prolonged empathic immersion. Goldberg (2010) recently elaborated on the nature of prolonged empathic immersion, which he sees as unique to the psychoanalytic situation. He contrasts the data and experience of prolonged immersion with the momentary apprehension of another’s inner state. The former consists of many aspects of the total personality and so includes those elements that may be sequestered or layered in defense, contradictory feelings, and attitudes, and most importantly the history of such elements.

The selfobject functions and experiences that have played such a central role in both development and therapy are dependent in part or in entirety on empathy. The caretaker’s capacity to respond in the ways the child requires depends on the caretaker’s understanding of the child’s inner state. The child’s experience of response and connection is crucial for his or her growth.

Some analysts have disputed the nature of empathy, and some have been critical of placing empathy as the defining center of analytic work. Several have concentrated on its origins in early mother-child interactions in which there is an experience of merger (Bue 1981). Hence, empathy was seen as based on illusions and could not be considered as scientific. Shapiro (1981) thought that empathy was a “new organ” but was not scientific (Levy 1985). Empathy was also seen to be instantaneous. Goldberg (1983) countered with the argument that empathy, which relies on introspection, is no less scientific than data derived from extraception (defined as direct, public observation). The data of introspection are, indeed, subject to error, as are the data of extraception. Both require theories to make sense of the data gathered, and both use inference. The important role of empathy in the therapeutic process is discussed later.

When one considers the therapeutic effect of empathy, one then is looking at the object, if you will, of the empathic understanding. We then are in the realm of the experience of being understood. As I have just noted, self psychology has elaborated its centrality in development and therapy, for this is a significant means to establish the experience of the selfobject. Appropriate responsiveness to selfobject needs is often made possible by an empathic grasp of those needs. The experience of being understood occurs after the communication of the empathizer’s understanding. As Basch (1983) pointed out, the process of more accurate understanding depends, in part, on a dialogue between the empathizer and the empathizee. The positive effects of being understood also occur in many daily situations and are an important component of the bonds between people. This experience of being understood evokes feelings of alikeness that have a positive effect on the cohesion and the value of the self. The positive effect of understanding in the clinical situation is even greater, for there the focus of the understanding is to foster both a positive bond and the growth and well-being of the patient.

**Therapeutic Process**

There has been both evolution of and controversy over the precise nature of the therapeutic process. At the time Kohut (1971) first outlined his systematic approach, he described two kinds of transferences: mirroring and idealizing. The third, the alter-ego transference, was initially subsumed as part of the mirror transference but was later deemed a transference in its own right. Each of these corresponded to the developmental process discussed earlier. The mirror transference was, in turn, divided into two types. The most archaic is the merger transference, because it corresponds with the earliest experience of wholeness and oneness with the caretaker. The analysand experiences a kind of contented wholeness, usually consciously oblivious of the analyst. There is hardly any recognition of the analyst as a separate person, and “object elaborations in the associative material are either absent or very scanty and inconspicuous” [Kohut 1971, p. 122]. The mirror transference in its narrowest sense, on the other hand, is the experience of the analyst as the echo and confirmation of the patient’s sense of specialness, greatness, and desirability.

The alter-ego or twinship transference was first considered a slightly more differentiated form of mirror transference, because the analyst is perceived as exactly like the analysand—having the same tastes, values, ideas, and so on. It is with the experience of likeness that the patient may develop his or her talents and skills. Even more importantly, however, the child who is able to feel the alikeness establishes the experience of belonging at a deep and basic level. It may constitute the fundamental humanness of our existence. Although the full implications of these ideas have not been elaborated in the clinical situation, this dimension of selfobject experience has been seen in some identity disturbances in work with the elderly (Wada 2003) and in facets of religious experience (Rector 2000).
The idealizing transference revives the wish for a strong, omnipotent, and/or omniscient parental figure. The analyst is so perceived, and the patient feels secure and calm in the analyst’s presence. Once the transference is established, the therapeutic process often hinges on the absence or the unavailability of analyst—either his or her physical absence on weekends or vacations or the psychological absence in his or her mistakes in understanding the patient’s wishes, needs, or affects. In other words, the lack that is central is the analyst’s empathic failure.

Note that there are several aspects of therapeutic process that are implied or elucidated. First is the engagement of the selfobject need that requires a nontraumatic, receptive, responsive, attuned analyst. An important part of the analyst’s position or response is empathic, because an essential aspect of the analyst’s attitude must be the phase appropriateness of the patient’s need or wish as an essential element of his or her developing self. This is a very important part of the therapeutic process, because the analyst’s empathy is an experience of the selfobject bond for the patient (Goldberg 1978). However, much of the emphasis of the therapeutic change focused on what Kohut termed optimal frustration, which was the principal vehicle of transmuting internalization.

Founded solidly on Freud’s (1917) theory of the work of mourning and melancholia, Kohut transposed this mechanism to the sphere of the self in describing what he had labeled transmuting internalization. Freud had explained the mechanism of mourning as a process in which the libidinal attachment to the lost object (a loved person who had died) was relinquished in a bit-by-bit fashion and then freed to attach to another. Yet in melancholia the libido was invested in the ego, and hence there was an identification with the lost object. “The shadow of the object fell upon the ego” (Freud 1917, p. 249). Freud later generalized this mechanism to suggest that the ego was constructed in this way, as the precipitate of abandoned object cathectes. Loss produced structure.

Kohut then translated this mechanism to apply to the formation of the self and the therapeutic process. The loss of the love of the object for Freud became the disappointment in an idealized quality of the parent for Kohut. A disappointment or disillusionment of the perfection of a specific parental function was the impetus for the child to take over that function for himself or herself. In 1971 Kohut outlined a three-step process that was analogous to that proposed by Freud: 1) receptivity for introjects, 2) the “breaking up” of aspects (psychological functions) of the object via optimal frustration, and 3) the depersonalization of those aspects of the object and their transformation into an integral part of the patient’s psyche. For example, the child might admire a parent’s capacity to work a puzzle or soothe the child, but if the parent fails at various times or is absent when the function is required, the child would then work harder at solving the puzzle alone or soothing himself or herself. In the analytic situation, analogous instances of failure to fulfill the desired function—an absence when the patient felt the need for the analyst, a misunderstanding of the patient’s experience—are the experiences of frustration. The subsequent understanding of the failure—the reestablishment of a bond of empathy—permits the patient to internalize the needed function that was not exercised by the analyst.

In the course of development, these small, everyday “failures” and consequent accretions of capacities—functions and structures—are in contrast to a massive disillusionment with the power and goodness of the parent. Then the entire relationship would have been experienced as worthless, and the opportunity and capacity for the acquisition of specific functions would be lost. Defects in self structure that have been described in this chapter would result.

Kohut reiterated the theory of transmuting internalization as it applied in the analytic situation in his last work and again listed three steps: “1) need-activation and optimal frustration via (2) non-fulfillment of the need and (3) substitution of direct need fulfillment with the establishment of a bond of empathy between self and selfobject” (Kohut 1984, pp. 103–104). Yet even with the emphasis on frustration, Kohut had changed a central aspect of internalization: rather than a self-contained process of depersonalization of an introject (as in the first transposition of the mechanism of internalization), he substituted the establishment of the empathic bond.

The importance of understanding and the experience of being understood was further highlighted by Kohut’s division of the analyst’s activity in the therapeutic process into two steps or phases: understanding and explanation. The first consists of the analyst’s gathering of relevant data about the inner life of the analysand and the communication of that understanding to the patient. This was called an experience-near process—attuned understanding that is relatively theory free. Explanation, on the other hand, is the use of empathically gathered data in “experience-distant dynamic and genetic terms” (Kohut 1984, p. 96). Explanation “not only broadens and deepens the patient’s own empathic-accepting grasp of himself, but strengthens the patient’s trust in the reality and reliability of the empathic bond.
...between himself and his analyst by putting him in touch with the full depth and breadth of the analyst’s understanding of him” [p. 105].

Kohut wavered in his position about the nature of empathy in respect to its observational or therapeutic functions. At first, he was at pains to maintain that empathy is a method of observation only and could be used for good or ill depending on the motivations of the empathizer. He used the example of the terror that Nazis inflicted on the population, which he maintained was effective because they had understanding (empathy) for those they were terrorizing. They knew what would make them terrified and helpless. Basch quite emphatically pointed out that the capacity to accurately assess the inner experience of another may be used for neutral or quite nefarious purposes. For Basch, empathy was an observational tool only. Yet I think it is clear that Kohut’s position had changed a great deal by the end of his life and in his last work, for he acknowledged that empathy, per se, had a therapeutic effect.

Many other self psychologists have taken the position that empathy is both the essential method of understanding and an important aspect of the therapeutic process. Howard Bacal [1985] Morton Shane and Estelle Shane [1996], Marian Tolpin [2002], Robert Stolorow and Frank Lachmann [1980, 1985], and I [Terman 1988], among many others, have all written about the importance of the empathic bond in fostering the repair and growth of the self. Developmentally, the experience of being empathically understood is an essential requirement for the development of the self. The accurate perception of intention, affect, and need, after all, constitutes the positive experience of mirroring. That essential element of self construction and self cohesion becomes enacted and alive in the therapeutic process through the experience of empathy.

Stolorow and Lachmann [1980, 1985] contended that the value of optimal frustrations may have little to do with internalizations but rather with the maintenance of the transference tie itself. Stolorow further argued that the structural accretions that are attributed to the process of transmuting internalization are all dependent on the patient’s experience of the presence of the parental response, not on its withdrawal or absence. He called this response optimal empathy. Similarly, Bacal [1985] wished to replace the concept of optimal frustration with one of optimal responsiveness. He believed that the patient’s need for certain kinds of understanding [or some acts] may be in the service of establishing a selfobject experience necessary for growth. The analyst’s response will be different for each patient; it will be “optimal” because it facilitates resolution and growth, and it will include both interpretation and relationship.

I have also pointed to the inadequacy of the concept of optimal frustration in explaining the fundamental mechanism of structuralization and/or therapeutic change. Stressing first the open-system model of structure formation in which the analyst’s response, like that of the caretaker initially, is an intrinsic part of the structure that is constructed—the selfobject functions—I emphasized that the analyst’s understanding is a crucial part of the new structure:

[T]he analyst…in the transference mobilization of the childhood structures…understands the patient’s experience from the patient’s point of view; he understands within a framework of values that arise from his conception of necessary developmental phases; he understands within the context of the analyst’s usual care and concern for the patient and his wishes to alleviate his suffering and promote his growth; and he understands within the calm, reflective ambience with which all psychological experience is greeted. [Terman 1988, pp. 187–188]

Change is the outcome of several factors: the new experience establishes a greater distinction for the patient between past and present and hence enables the patient both to observe him- or herself and to become open to new possibilities. The successful execution of affect and self-esteem-regulating functions changes existing patterns and allows the development of new ones. The new patterns grow out of the need fulfillment, not its frustration.

For further exploration of the use of self psychology in the analytic process, the reader would be best served by starting with the cases that Kohut cited in The Analysis of the Self and the collection of cases in The Psychology of the Self: A Casebook, edited by Arnold Goldberg [1978].

**Narcissistic Rage**

Kohut introduced the concept of narcissistic rage in 1972 [Kohut 1972]. It is interesting to note that two other psychoanalytic writers also distinguished a different variety of aggression at almost precisely the same time. Erich Fromm [1972] wrote of “malignant aggression,” which he differentiated from what he deemed normal defensive aggression because it was a search for vengeance and is “cruel, lustful and insatiable” [p. 271]. Anthony Storr [1972] also noted that a wish for ven-
ence and cruelty was associated with the experience of helplessness against a superior force. Kohut characterized narcissistic rage phenomenologically as “the need for revenge, for righting a wrong, for undoing a hurt by whatever means, and a deeply anchored, unrelenting pursuit of all these aims which gives no rest to those who have suffered a narcissistic injury” (p. 108). Melville’s Captain Ahab is the classic literary example. Kohut anchored this phenomenon firmly in the vicissitudes of the development and integrity of the self. Its origins lay in the experience of damage to the self, and that damage may occur in any part of the self and at any point in its development. The rage is a function of the need of the self to have a sense of absolute control over the responding selfobject in either a mirroring or an idealizing capacity.

As I noted earlier, part of the nature of the selfobject experience is its seamless oneness. The “other”—in its function for the self—is part of the self. Hence, the relationship to that “other” is like the feeling one has about a part of one’s body. For example, if one’s finger or arm does not function automatically, does not move when one tries to execute a task, there is panic and rage. So it is that sense of lack of absolute control over the selfobject, a control that is essential for the existence and integrity development of the self, that stimulates the rage. It is a kind of catastrophic reaction. Often it is in relation to the grandiose self and the wish to shine or be admired. If, instead of the wished-for approving response, one is met with indifference or even derision or contempt, the reaction then is one of shame and narcissistic rage. If, on the other hand, the injury is to the idealizing needs of the self, the reaction is the same. The unavailability, failure, or disappointment in an idealized figure, for example, may evoke not only disillusionment but also rage.

The context of the narcissistic injury is also important to understand. The state of the self at a particular time may determine the intensity of the requirement for a certain kind of selfobject response. The quality of the response may also determine the degree of injury. Contempt, conspicuous defeat, derision, or self-righteous assertions of superiority may evoke feelings of deep helplessness and shame. These affect the experience of lack of control over a responsive other. This is particularly true in later life; when one has invested one’s idealizing needs beyond oneself and in a group of which one feels part, challenge to that group and/or its ideals may stimulate narcissistic rage in the individual and its equivalent in the group.

Narcissistic rage is a frequent occurrence in the therapeutic process. It may be stimulated by an absence of the analyst (e.g., his or her vacation or weekend) or other empathic failure in which the patient experiences the analyst as not understanding or not functioning for the patient in the way he or she needs. The working through of such episodes of rage in the transference is often difficult for both the patient and analyst and sometimes is a kind of suffering through for both parties. The central focus of the analyst is always on the context of the rage. That means that the analyst must attend to the state of the self and the experience of injury to the self that has generated the rage. When the analyst is able to grasp the reason for the injury (which is always some kind of unavailability or empathic failure of the analyst) from the patient’s perspective, the rage subsides. More important, the empathic connection with the experience of injury repairs and strengthens the underlying vulnerability. Furthermore, connections with past experiences of injury—those that created the vulnerability—may then be possible. This would correspond to the third step of transmuting internalization outlined earlier.

Some critics of self psychology have contended that analysts and therapists who are guided by the theories of self psychology do not deal with the rage or anger of the patient. Clinical experience is quite contrary to that assertion. Narcissistic rage is frequently encountered and engaged in length and depth. There is a difference between the self psychological approach and many others: the rage is not isolated or pathologized. It is always understood in context, and part of that understanding is that the participation of the analyst is always part of the reason for the damage to the self at that analytic/therapeutic moment. For an extensive exploration of this subject, the reader is referred to Frank Lachmann’s (2000) book Transforming Aggression.

**Conclusion**

Self psychology offers an additional paradigm for psychoanalytic work. It systematically includes the experience of transactions with caretakers and others in the development of the structure of the personality. This inclusion of the “other” is via the concept of the self as a structure that consists of more than one person. The “self” requires the presence of various operations of the other, the selfobject, in order to be whole and to grow. The introduction of this other into the matrix of the personality has focused attention on the vicissitudes of the transactions between the child and the caretakers and between the analyst and the patient.
This perspective on development and structure formation combined with the force of the experience of qualities of one’s self—the valuation of self that is self-esteem and its vicissitudes—has alerted both clinician and researcher to the role that the other, the selfobject, plays in the generation of central structures of the personality that have been discussed in this chapter.

Introducing the relationship into the heart of structure formation also shifts the focus both to felicitous exchanges in which the required developmental functions are executed to permit the development of the self and to the mismatches, traumas, and lacks that block or deform the self. As noted, both deficits and conflicts may result from such transactional problems. On the other hand, the adequate or optimal execution of the functions required by the self encompasses a wide range of interchanges from affect regulation to the shaping of the quality of the person to shaping the world. Many of these functions are mediated by the exercise of empathy, which has multiple effects. It permits the appropriate exercise of the required function: one must understand what the need is in order to meet it. Furthermore, the experience of the function fosters the experience of connection, as such. The experience of connection increases the strength of the self and the feeling of humanness.

Focus on the transactions that form and maintain the self—the so-called self-selfobject unit—places our attention on context: that is, the context of self and/or the context of the experience of the interaction between caretaker and child or therapist and patient. It is in the context of the integrity of the self or of the interaction that is perceived as a danger or damage to the self that narcissistic rage arises. The emphasis on placing the rage in context makes its integration and regulation possible. The focus on context also leads to an interesting and nuanced understanding of numerous aspects of psychological pattern and promises to yield greater understanding of enduring pattern, which is structure.

Another consequence of the focus on the contribution of the selfobject has been the growth of theories that emphasize this element even more. Intersubjectivity, arising from self psychology, has shifted the focus from the inner view of transaction (from the point of view of the patient’s subjectivity) to a point somewhere between the patient and the caretaker or therapist (to the intersection of both subjectivities). This has led to yet greater scrutiny of the analyst’s role in the therapeutic process and concept of the co-construction of the analytic experience in which the contribution of the analyst and his or her personality becomes an important determinant of the patient’s experience. Relationalist theories concentrating on the here and now of therapist-patient interaction owe some of their interest in the interaction to self psychology’s systematic exploration of the essential role of the other, the selfobject, in the construction of the patient’s inner world.

There remains much to explore further. As mentioned earlier, the full implications of including the other in both formation and maintenance of psychological structure have yet to be understood. The shifts and comparisons of therapeutic positions also need systematic investigation. As always, psychoanalysis is a work in progress.

---

**KEY POINTS**

- Self psychology developed in the context of classical psychoanalysis. Narcissistic personality disorder as defined by Gitelson was viewed with attention to potential strengths relative to a traumatic history. Investigation of such patients and the reevaluation of the place of normal narcissism in development led to a separation of the narcissistic and object libidinal lines of development. Narcissism was removed from the stigma that both culture and psychoanalytic theory had given it, and the importance of its transformation was shown.

- The self is defined in several ways. There is the self as defined by Hartmann, the self that is a system, and the bipolar self. Two very central ideas are that 1) the self exists only as it encompasses the “other” (the selfobject) who performs essential psychological functions for the self, and 2) the self is divided into two classes of experience and structure: the grandiose self and the idealized parent.
• The grandiose self is created and maintained by the response of the mirroring self-object to the displays of the child and the confirmation of the child’s specialness and loveableness by the caretaker. This structure of experience becomes the goals and ambitions of the mature person and is the source of positive self-regard and zest for the world. The idealizing pole of the self develops out of the experience of merger with the perceived strength, protection, regulation, and security of the powerful caretaker. Optimal frustration is the principal vehicle of transmuting internalization. Out of the experiences of merger in early development come important affective regulatory structures, ideals, guiding values, and the need to be part of larger social institutions derive from later experience of later idealizing experience.

• Difficulties may arise in the developmental trajectory of each pole of the self. Failures of the mirroring self-objects for the grandiose self may result in repression or splitting of the self and create the symptoms of hypochondriasis, lack of zest, and sensitivity to slights typical of narcissistic character disorders. Failures in the idealizing pole of the self may result in diffuse regulatory problems that in turn may lead to narcissistic behavior disorders such as addictions or perversions. All manner of conflict at all developmental levels may ensue, and self pathology in such situations may not simply be a matter of deficit but a complex structure of self distortion and conflict at many levels.

• Empathy is defined by Kohut as “vicarious introspection.” To arrive at an accurate understanding of the inner experience of another, one has to refer to some aspect of one’s own inner experience. Empathy, an essential aspect of both development and treatment, is a process that may or may not be correct, and—in the analytic process—involves a dialogue between the patient and the analyst and prolonged immersion to establish its accuracy.

• Engagement of the narcissistic transferences has been classified into mirroring and idealizing types. Transmuting internalization involves a three-step process, as noted by Kohut: 1) need-activation and optimal frustration via 2) nonfulfillment of the need, and 3) substitution of direct need fulfillment with the establishment of a bond of empathy between self and selfobject.

• Narcissistic rage is described phenomenologically as an unrelenting and boundless need to revenge and right a wrong. Its basis is in damage to the self by the noncompliance of the needed selfobject. Humiliation and conspicuous defeat are important instances of such trauma. Narcissistic rage, understood in the context of an injured self, plays an important role in treatment.

References


Goldberg AI: A note on sustained empathy. Paper presented at a meeting of the Self Psychology Study Group, Chicago, IL, 2010
Kohut H: Thoughts on aggression and narcissistic rage. Psychoanalytic Study Child 27:360–400, 1972
Relational Psychoanalysis

Lewis Aron, Ph.D.
Maria L. Lechich, Ph.D.

The contemporary relational tradition, like all psychoanalytic visions, emerged as a product of its time and place. After the fall in dominance of the classical ego psychology model in the United States, relational psychoanalysis was the first approach to develop in an atmosphere of theoretical pluralism. It is the first, and one of the only, psychoanalytic schools of thought developed not by a single founder but by a large group of contributors. Consequently, the relational paradigm is characterized by an emphasis on pluralism and multiplicity, emphasizing “both/and” rather than “either/or.” Throughout its history, psychoanalysis has tended to be caught in binary oppositions such as conscious/unconscious, intrapsychic/interpersonal, inner world/outer behavior, conflict/deficit, oedipal/pre-oedipal. However, the relational approach emphasizes moving beyond these dichotomies by thinking dialectically, attempting to search for a third term in order to create a space within which the tension of these binaries can be held in anticipation of the continual reversal of figure and ground (i.e., that aspects of the relationship may be in the foreground at some moments but then recede to the background when interpretation is in the forefront). The exploration of meaning in context is emphasized. The analyst and the analytic process are viewed as both fully personal and entirely professional, and the unique individuality of each analytic dyad is highlighted.

The relational tradition does not consist of one single theoretical model or unified set of theoretical principles. Rather, it can be conceived as a “big tent” encompassing multiplicity and diversity; it is a form of self-reflective, critical eclecticism held together by a number of common core concepts and clinical strategies. Although relational psychoanalysis share overlapping concerns, ideas, and approaches, the relational paradigm is not a formally organized school or system of belief. In what follows, we highlight some of these concepts, giving special attention to the contributions of Stephen Mitchell. Although Mitchell was not the sole creator of the relational paradigm, he was its most prolific author, an inspiring teacher and mentor to many of the current generation’s leaders. We believe that highlighting some of his
Development of the Relational Perspective

Jay Greenberg and Stephen Mitchell, who first coined the term *relational*, were both graduates of the William Alanson White Institute, the institutional home of interpersonal psychoanalysis. In many respects, the development of the relational perspective must be understood in the context of its emergence from interpersonal psychoanalysis, which had been marginalized until the decline of ego psychology in the 1970s and 1980s. Its major theoretical founders, Harry Stack Sullivan, Erich Fromm, and Clara Thompson, made important contributions during the 1930s and 1940s, and Clara Thompson loosely assembled their major concepts into a multifaceted tradition. Greenberg and Mitchell believed that interpersonal theorists, in their dialogue, swung way from classical intrapsychic theory, tended to de-emphasize the internal world and internal psychic structures. Relational theory emerged from their efforts to extend interpersonal theory into a new, more diverse and pluralistic psychoanalytic discourse that encouraged comparative and integrative efforts.

Greenberg and Mitchell [1983] originated the term *relational* for these purposes in their groundbreaking *Object Relations in Psychoanalytic Theory*. They conceived of the term as bridging the traditions of interpersonal relations as developed by interpersonal psychoanalysis and of object relations as developed within British object relations theory. The term quickly grew in popularity, and by the late 1980s, the relational model incorporated advances in self psychology and intersubjectivity theory, social constructivism and contemporary hermeneutics, gender and queer theory, poststructuralist feminist theory, the reconceptualization of transference by Merton Gill, and the rediscovery of the legacy of Sandor Ferenczi. Ferenczi, one of Freud’s closest friends and collaborators, is viewed by many as the originator of a relational psychoanalytic sensibility, but his contributions had been suppressed for many years within the psychoanalytic mainstream.

The question of how to distinguish the relational and interpersonal schools of psychoanalysis is not easy to answer because they have had ongoing mutual influence and considerable overlap of interests and many within both groups identify themselves as interpersonal/relational; nevertheless, there are differences in terms of key influences and emphases. Generally speaking, the relational perspective began with and continues to build bridges to other psychoanalytic schools, whereas the interpersonal tradition has drawn particularly from Sullivan and Fromm’s theoretical legacy, focusing intensely on interpersonal and cultural experience and excelling excessive elaboration of the internal world, developmental, or metapsychological presuppositions. The distinctions between relational and interpersonal psychoanalysis are presented here from our particular relational perspective, and of course other authors distinguish them and would narrate their histories somewhat differently.

By 1988, the relational movement secured its first institutional home, within the New York University Postdoctoral Program in Psychotherapy and Psychoanalysis. In 1990, Mitchell established the *Relational Perspectives* book series, which to date has included three volumes of seminal papers by major contributors to the emerging relational perspective. At the same time, Mitchell launched *Psychoanalytic Dialogues: A Journal of Relational Perspectives*, the first psychoanalytic journal devoted to providing a platform for dialogue among a multiplicity of voices. Relational thought has been further disseminated at annual meetings of the Division of Psychoanalysis [39] of the American Psychological Association and the International Association for Relational Psychoanalysis and Psychotherapy (IARPP), founded by Mitchell and his colleagues before his sudden and untimely death in December 2000. The Stephen A. Mitchell Center for Relational Studies was founded in 2007 in New York City, providing continuing professional and public education in relational psychoanalysis.

In the interest of concisely summarizing an enormous body of scholarship, we regret only being able to name and cite a small fraction of the many contributors who have been influential. We recommend the following short selection of essential texts for further reading. There is no substitute for beginning with Greenberg and Mitchell’s [1983] *Object Relations in Psychoanalytic Theory*. Our reference list also includes several other of Mitchell’s books that are invaluable. You can find most of the essential papers in relational psychoanalysis in the edited volumes titled *Relational Psychoanalysis* (Aron and Harris 2005; Mitchell and Aron 1999; Suchet et al. 2007). Two additional volumes of essential papers are now in press and all are included in the *Relational Perspectives Book Series* published by Routledge.
The Relational Matrix and Relational Configurations

In “What’s American About American Psychoanalysis?” Mitchell and Harris [2004] explore the evolution of American psychoanalysis shaped by its rich national context and the ideas of American pragmatism as they relate to social constructivism, hermeneutics, and intersubjectivity. They locate one root of the relational tradition in C.S. Peirce’s [1955] semiotic theory of meaning, which identifies a triadic relation between self, objects, and an interaction between the two. The historical influence of Peirce’s emphasis on the dynamic relationship between self and object may be seen in Mitchell’s [1988] relational-conflict model, which introduced the notion of the “relational matrix” constituted by three dimensions: a self pole, an object pole, and an interactional pole, representing the interactions among one’s self-organization, object ties, and interactional patterns derived from past and present interpersonal experiences. The model is based on the assumption that relational configurations, including unconscious, fantasized, and imaginary relations as well as real or external interpersonal relations, influence our experience of ourselves, our interpersonal perceptions and expectations, and relational strivings [Perlman and Frankel 2009]. Mitchell used the concept of the relational matrix to build a new psychoanalytic framework capable of holding the dialectical tension between the interpersonal and intrapsychic.

Previously, psychoanalytic theorists and schools often focused on one dimension of the relational matrix. For example, Kohut and Winnicott emphasized the self dimension, Klein and Fairbairn emphasized the object dimension, and Sullivan and Bowlby focused on the nature of the patterns of behavioral interactions between self and object. Recognizing the complementarity of these different theorists and identifying their focus on a particular dimension, Mitchell used the concept of the relational matrix to provide a framework with which to integrate relational ideas from these diverse psychoanalytic traditions into a relational theory, demonstrating that these three approaches went hand in hand with a theorist’s preferred understanding of relational motivation. For example, Kohut and Winnicott may both be viewed as similar in that they emphasized the centrality of the self—a cohesive, embodied, personalized sense of self contingent on the facilitating provisions provided in our interpersonal relationships. Winnicott, with his emphasis on “holding,” and Kohut, with his attention to “mirroring,” are shown to attend to the self pole of the relational matrix and are therefore designated as “relational by implication.” In contrast, both Fairbairn and Fromm stressed that we crave relatedness and that it is our longing for intense contact with others that propels us toward them, even when those relationships are painful. Because these theorists tended to focus on the individual’s striving after the object, Mitchell considered them “relational by intent.” Finally, Sullivan and Bowlby, who focused on the behavioral interaction, the space between self and object-roles, emphasized our built-in need for personal relatedness, arguing that we are wired toward human contact from the earliest moments of life. They are deemed “relational by design,” an idea that is especially highlighted in Bowlby’s attachment research [see Mitchell 2000] and modern infancy research [Beebe and Lachmann 2005].

The clinical implications of these approaches are significant. Those analysts who are “relational by intent” tend to focus on the object pole of the relational matrix. These theorists, often drawing on Fairbairn and Fromm, tend to place their emphasis on the qualities of the other, or the object in patients’ lives, their theorizing provides a phenomenological map of patients’ internal world and the character of their object relations. Those who are “relational by implication” are particularly focused on describing the self pole of the matrix and on understanding the nature of the patient’s self representations and self-image—that is, the coherence and continuity of the self. Those who are “relational by design,” such as Sullivan or Bowlby, draw our attention to the behaviors and interpersonal factors that operate between the patient and those with whom they relate and interact.

Mitchell was also affected by the existential-humanistic tradition and included in his schema a place for will and choice (i.e., we are not just determined, but determining). Sometimes he included this in the self pole, and other times he viewed it as an overriding factor in the relational matrix. Hoffman, Slavin, Reis, and other relationalists have emphasized existential themes such as will and willfulness, hope and dread, authenticity and inauthenticity, meaning and mortality, and the self and the illusion of cohesiveness.

To summarize, the concept of the relational matrix provided a critical conceptual grid that linked together the intrapsychic and the interpersonal as well as the self, the other, and their interaction. The relational matrix served as a framework that enabled relational theory to house and balance the issues of self-maintenance, self-regulation, identity, self-esteem, authenticity, and self
coherence as one dimension, issues of the other, internal objects, actual others, personifications, and mutual or field regulation as a second dimension; and interactions, enactment, interpersonal behavior, and the who-did-what-to-whom as a third dimension.

Transference and Countertransference

The traditional psychoanalytic definition of transference as a displacement from an old to a new object implied that the patient's experience of the analyst was a distortion. This left the analyst to judge what was part of the "real" relationship and what was the distorted component or transference. By the late 1970s, Merton Gill had abandoned classical metapsychology and had reformulated his understanding of transference. Gill's work startled the analytic world and had a particular influence in shaping the emergence of relational psychoanalysis. Gill had long been a leader within the psychoanalytic mainstream, but his transformation brought him into connection with interpersonal and relational psychoanalysis. Just as Greenberg and Mitchell (1983) were delineating a relational, as opposed to a drive-structure, approach, Gill (1983) similarly proposed a "person" point of view. For Gill, along with his collaborator Irwin Hoffman, the transference was conceived of no longer as a spontaneous production of the patient's but rather as a joint formation of two participants in the analytic situation. In this view, transference is a construction—the patient's selective way of structuring experience through the lens of his or her stereotyped, constructed patterns of relating.

The traditional notions of anonymity and neutrality were intended to enable the transference, free associations, and other aspects of the patient's psychological life to make their appearance in the analysis without interference. The metaphor of the analyst as a "blank screen" traditionally served as the centerpiece of a model of the analytic situation as antiseptic. In the presence of a neutral and anonymous analyst, the patient's experiences were thought to arise unprompted, unstimulated, and, indeed, largely unaffected by the analyst—a "one-person psychology." The patient's associations were thought to "unfold" and "emerge" from within the individual's mind (Wachtel 1982). Gill stopped thinking of the transference as divorced from the analyst's participation in the analysis, and he no longer distinguished between the realistic and distorted aspects of the patient's experience. Gill and Hoffman's social, dialectical, or critical constructivism was a major breakthrough in reconceptualizing transference and countertransference as co-constructed or co-created in the interaction between the two participants—a "two-person psychology."

In this view, the analyst's countertransference is not necessarily a reaction to the patient's transference but might instead be the catalyst for it. In this social, person-oriented paradigm, the patient brings constitutional and temperamental variables as well as past interpersonal experience to the interaction, but the patient's experiences of the analytic relationship are always intermingled with the analyst's behavior and participation. The transference, therefore, is the patient's unique but plausible way of construing the analytic relationship, including observations, inferences, and speculations about the analyst's experience. The analyst's countertransference is thought to arise in dialectical relation to the patient's transference and so should be devoid of pejorative connotation. Neutrality, anonymity, and detached objectivity are eschewed. "Our countertransference is the air our patients breathe" (Greenberg 2001, p. 363). Ferenczi was the earliest champion of the clinical value of countertransference.

Self-Disclosure

In Ferenczi's view, honest, sincere, and authentic reactions from the analyst toward the patient were significant routes to change. Building on Ferenczi, Aron (1996) argued that the patient's efforts to reach the analyst as a person represent a key dimension of the analytic situation. He suggested that the patient's curiosity about and discovery of the analyst in deeply personal terms is essential to what is curative in the analytic process. The patient's curiosity and probing into the analyst's subjectivity is a way of making a deep connection with the analyst, much like the child who at times is powerfully motivated to know his or her parent as a person.

In adopting a more expressive interactive style than is associated with classical technique, many relational analysts have emphasized the therapeutic value of thoughtful and selective self-disclosure, not as a technical prescription of what is required but as one legitimate option for interpersonal engagement (Wachtel 2008). The analytic frame itself is a social and historical construction (Bass 2007). Many analysts now believe that the therapeutic process can be enhanced by judiciously and skil-
fully bringing the analyst’s associations, feelings, and reactions into the open for analytic dialogue and mutual exploration. Darlene Ehrenberg, for example, has called our attention to the “intimate edge” in the analytic relationship, whereas Joyce Slochower has examined the interaction between interpretation and “holding” [see Aron and Harris 2005]. There is nothing arbitrary or unprincipled about the relational approach, nor is it an abandonment of analytic discipline as critics have claimed; it is a more complex, personalized, and individualized approach to analytic process. Thinking dialectically, for relational analysts, along with the restraint and discipline structured by the analytic frame, the freedom to offer passionate, authentic engagement and immediate emotional honesty, is at the heart of psychoanalytic work.

That a mother and infant exert mutual influence in certain interactions does not imply that they influence each other equally or in identical ways [Beebe et al. 1992]. Relational contributions emphasize various aspects of mutuality in the psychoanalytic situation—the inevitability of a mutual and reciprocal two-way influence between patient and analyst [mutual regulation] as well as of mutual resistances, mutual regressions, mutual enactments, and especially mutual recognition. It should be clear, however, that although mutuality connotes a sharing in common or a sharing between people, it does not imply symmetry or equality [Aron 1996].

Drawing on modern evolutionary theory, Slavin and Krieger [see Aron and Harris 2005] argued that patients observe the ways in which their analysts deal with their own inevitable conflicts as well as conflicts of interest between themselves and their patients. It is the patient’s experience of the analyst’s openness to feedback and change that demonstrates for him or her a genuine process of negotiation and mutuality. Thus, we can expect our patients to reorganize their identities only if we are open to revising our own.

Nonlinear Dynamic Systems Theory

Nonlinear dynamic systems theory has become a source of powerful new metaphors for psychoanalysts across the spectrum of relational theory, providing a shared vocabulary for intersubjectivity theorists such as Robert Stolorow [1997], for relationalists associated with Psychoanalytic Dialogues [e.g., Harris 2005; Seligman 2005, Stern 2010], and developmentalists such as those associated with the Boston Change Process Study Group [2010]. The contribution of Thelen and Smith [1994] has been most directly useful for application by psychoanalysis. Dynamic systems theory is centrally concerned with conceptualizing the process of developmental change within complex systems in which development does not “unfocaled” according to a predetermined, linear plan but rather “solutions emerge from relations, not from design” [Thelen and Smith 1994, p. xii]. Mental activity is viewed as emergent, situated, contextual, and historical, with patterns forming contingently, “softly assembled,” not following a preordained, teleological, or hardwired program. Change is nonlinear and discontinuous, emerging through the system’s self-regulation into quasi-stable “attractor states” that lead behavior into a typical or stable pattern. The pattern can be changed only by an extreme perturbation of the system that disturbs the equilibrium and allows for the emergence of new attractor states.

Utilizing a dynamic-systems framework, “chaos theory,” to understand the therapeutic dyad emphasizes the inherently “sloppy,” improvisational, and co-creative nature of change. Sloppiness brings in the intrinsically indeterminate exchange of meanings between patient and analyst, so that change is viewed as spontaneous, discontinuous, and unpredictable. Linking relational and systems theories, Seligman [2005] wrote, “Analytic therapists tolerate uncertainty, find meaning in apparently disordered communication, and embrace the unexpected twists and turns that emerge from intimate attention to the ordinary complexities of everyday life” [p. 285]. Co-creation emerges unexpectedly out of the chaos or sloppiness, as two minds interact to create something psychologically new in developing dyadic states, “moments of meeting” [p. 285].

In the language of dynamic-systems theory, the repetition compulsion is understood to be a rigidly stuck “attractor state” that requires a significant perturbation in order to disorganize and change, whether verbal, in the form of an interpretation, or implicit, perhaps not even reflected upon. The analyst searches for and highlights what is new and variable, even in behavior that at first appears fixed and repetitive. The analyst cannot follow a preformulated linear plan but must live with “not knowing” and surprise, relying on a good deal of trial and error, ingenuity, and resourcefulness to achieve goals that are themselves contingent and co-created [see, e.g., Orfano 1998].

Some years ago, the terms one- and two-person psychologies were used to differentiate an intrapsychic model that examined the patient’s mind from an interpersonal model that looked at both participants in
teraction. We believe, however, that the language of systems theory provides a better set of terms and metaphors than these ambiguous phrasings. A two-person psychology is a form of systems theory meant to draw attention to the dyadic subsystem rather than define the object of investigation as the autonomous individual. Altman (2009) suggested speaking of a three-person psychology, so as to include third parties such as broad social influences, insurance companies, and other third parties. The intent of a two-person psychology was never to limit what was studied to only two variables or people but to challenge a model of mind as closed and shift to a systems theory that examined the dyadic subsystem, to shift the focus so that the context itself became part of the object of investigation.

**Intersubjectivity**

“Where objects were,” Jessica Benjamin (1990) asserts, “subjects must be” [p. 34]. Her ideas about intersubjectivity offer a critique of traditional psychoanalytic theories of development that portray the mother solely as an object of the baby’s drives and needs [Aron 1996; Benjamin 1990; Safran and Muran 2000]. She views the expanding capacity for mutual recognition and intersubjective relatedness in the baby as an important developmental milestone. As Dorothy Dinnerstein (1976), an early feminist psychologist, wrote, “Every I first emerges in relation to an ‘It’ which is not at all clearly an ‘I.’ The separate ‘Itness of the other person is a discovery, an insight achieved over time” [p. 106].

With origins in the Frankfurt School, Benjamin built on Hegel’s classic philosophical study of the master-slave dialectic and drew on Winnicott’s theory of the development of the self and object relations to develop a unique and comprehensive theory of intersubjectivity. Examining Winnicott’s ideas about object relating and “object usage,” Benjamin argued that in relating to the other as a subjective object (object relating), the baby is able to observe that the object survives destruction, which then enables the child to give up his or her omnipotence; this is necessary for developing a capacity to experience the other as a separate self (object usage). Benjamin emphasized the importance of recognizing that intersubjectivity is variably maintained. She noted that all relationships, including the one that develops between analyst and patient, must tolerate the natural dialectic process between subjects relating to others as objects and relating to them as subjects, between wanting to dominate another and wanting to know that person.

Robert Stolorow first introduced the concept of intersubjectivity to American psychoanalysis and further expanded the idea with his colleagues. Expanding on the self psychology tradition, their use of the term intersubjectivity refers to “any psychological field formed by interacting worlds of experience, at whatever developmental level these worlds may be organized” [Stolorow et al. 1978, p. 3]. Stolorow and his colleagues stressed the bidirectional influence on experience of both conscious and unconscious subjectivities. Whereas Benjamin emphasized mutual recognition in her use of the term intersubjectivity, Stolorow emphasized mutual regulation. The Stolorow group expressed concern that Benjamin advocated the analyst’s focus on the patient’s recognition of the analyst’s subjectivity at the expense of the patient’s own. Benjamin replied that she saw such engagement in reciprocal recognition of the other as growing naturally out of the experience of being recognized by the other, as a crucial component of attachment responses that require mutual regulation and attunement and, therefore, as ultimately a pleasure and not merely a chore.

The Boston Change Process Study Group (2010) brought our attention to the relationship between intersubjectivity and “implicit relational knowing.” Implicit relational knowing refers to pre-reflective processes that contribute to our knowledge about ways of being with others that are not based in language. It is an experience of knowing something interpersonally but not being able to describe how you know it, and often not even knowing that you know it. (Think, for example, of times that you may have looked away from someone else’s eyes so as not to make them uncomfortable, even without recognizing that you were averting your eyes.)

On this level of experience, there is an immediate contact with others through gesture, gaze, tone, and rhythm of voice, movement, and feeling. This level of participation with others is seen as an a priori intersubjective condition for human beings. In this model, subjects are not in need of “discovering” others, because it is assumed that they share affect, intention, and mental states with others from birth and throughout life. Minds are always already in immediate contact with others in a shared intersubjective world [Reis 2010]. James Fosshage (2005) also explored the explicit and implicit domains in psychoanalytic change. Steven Knoblauch (Beebe et al. 2005) developed an approach that expanded analytic attention to the embodied registers of an interaction and to the interactive rhythms and tonalities of affectivity.
Relational psychoanalysis not only has enriched our approach to clinical practice and questions of technique but has also revised our understanding of the therapeutic action of psychoanalysis. In particular, rather than emphasize only the impact of insight resulting from verbal interpretation, the effort is to maintain a dialectical tension between verbal and nonverbal, insight and experience, interpretation and relationship. Fonagy and Target’s conceptualization of mentalization and reflective function has been influential in this regard, and they depicted the development of reflective function as a thoroughly relational process. Mentalization refers to the ability to make use of mental representations of one’s own and other people’s emotional states, and reflective function refers to the operationalization of this concept, but the terms are often used interchangeably [see Fonagy and Target 1998; Coates 1998; Berman 2000]. Berman [in Aron and Harris 2005] has extended relational and intersubjective approaches to clinical supervision and psychoanalytic education.

Multiplicity

Focusing on multiple selves, or multiple self-states, is a way of highlighting that people, their selves, or their characters are variable from one context to another. Psychologists have either tended to emphasize the self or character; or they have emphasized the context (often the social or interpersonal context) as the key variable. In traditional psychoanalysis, an intrapsychic focus has tended to privilege psychic structure—that is, character or the individual person—as the essential factor. By talking about multiple self-states, relational analysts are making the point that psychic structure, the self, varies based on interpersonal context. As Sullivan highlighted, for all we know, there may be as many personalities as there are interpersonal contexts. Individuality is an illusion in the sense that individuality is not impervious to context. This way of thinking is a direct result of emphasizing the social context rather than intrapsychic structure, as though intrapsychic structure could be studied in relative isolation.

The postmodern turn in psychoanalysis, along with influences from the explosion of parent-infant research, neurobiology, cognitive psychology, and a renewed interest in trauma research after the Vietnam War, has contributed to relational theorists' conception of the self not as single and unitary but as organized around shifting configurations of multiple self-states [e.g., Bromberg 1998; Davies 1996; Pizer 1998; Slavin 1996]. From the perspective of ‘multiplicity, the subjective experience of “me-ness” or of being a unitary, cohesive self is an illusion and develops out of our fluid ability to maintain “residence” in one self-state while maintaining awareness of others. Bromberg (1998) referred to this relative capacity as “standing in the spaces” (p. 274), and Pizer (1998) referred to it as “building bridges.” The ability to “feel like one self while being many” (Bromberg 1998, p. 274) is protected through the processes of normal dissociation. Self-states arise from direct conscious and unconscious interpersonal experience and have an ongoing influence on our moment-to-moment subjective experience and identity.

Let us try to describe what is meant by a self-state. According to Davies (1996), self-states emerge around the internalization of the primary organizing relationships in our lives. She used the metaphor of a kaleidoscope to capture the ubiquitous, rapidly shifting nature of self-states that are influenced by internal processes and external experiences. Davies suggested that our self-experience within any given self-state is organized around a whole, part, or imaginary other. Each self-state has five components: a self-representation, an object relationship, an affective component, a physiological or bodily component, and a cognitive level of development attached to that self-state. For Davies, therapeutic action is in the analyst’s willingness and ability to work in the interweaving multiple self-states of the transference and countertransference activated by the clinical exchange. Multiple self-states are often conceived as operating within a dissociative model of mind.

Dissociation

Sullivan (1953) believed that our self-states arise from the internalization of recurring patterns of interactions in our early significant relationships with others and are shaped by our distinctive patterns of avoiding or minimizing threats of anxiety activated by these relationships [Howell 2006]. For Sullivan, anxiety in a child comes about through an empathic linkage with the parent. Thus, anxiety is viewed as contagious. Over time, the child discovers that some behaviors are met with tenderness and parental approval (experienced as “good me” in the child), which enhance the child’s security and sense of interpersonal safety. Other behaviors, meanwhile, generate anxiety and disapproval in the parent (experienced as “bad me” in the child) and so compromise the child’s sense of
safety and security. Both “good me” and “bad me” personifications find their way into the subjective experience of “me-ness.”

Sullivan conceptualizes “not me” as the personification of self that arouses intense anxiety in the mother and thus overwhelms the infant with anxiety. “Not me” is the part of the self “one must not be” and is dissociated to enable us “to avoid assuming a certain kind of identity” associated with such feelings as dread, self-hatred, and shame [Stern 2010, p. 13]. “Not me,” or the state of being that was experienced during the traumatic event that precipitated “not me,” becomes dissociated, remaining completely unintegrated, unsymbolized, and unrecognized subjectively as a version of the self. Sullivan used the term selective inattention to refer to the psychic processes that maintain dissociation, keeping us from knowing certain unaccepted aspects of ourselves that trigger intense anxiety.

Enactment is the “interpersonalization” of dissociation because the enactment is seen as the patient’s last-ditch effort to avoid “not me” by externalizing the part of the self he or she finds hard to bear and attaching it to the analyst [Stern 2010]. Erich Fromm explained that in the classical conceptualization of repression, we are actively trying to avoid what is already there and fully formulated by actively pushing unwanted experience out of our awareness. In contrast, Stern offered the concept of unformulated experience as an alternative notion of defense that is based on our unconscious effort to curtail curiosity in our experience.

Bromberg’s (2006) rich, clinically based perspective depicts a dissociative structure of the mind. In order to preserve the subjective experience of selfhood when faced with trauma, our self-reflective capacities are narrowed, and incompatible self-states are rigidly isolated from each other. What is mutative for Bromberg is the analyst’s readiness and ability to serve as a relational bridge (Howell 2006) between dissociated parts of the self, which facilitates the patient’s gradual ability to restore the links between them. Bromberg emphasized the importance of being attuned to the intense shame that organizes the patient’s dissociated self-states and the inevitability of the analyst enacting the same arousal of shame experienced with an earlier significant other. Like Stern, Bromberg (1998, 2006) saw the ability to hold differing and conflicting narratives of ourselves in mind simultaneously—that is, standing in the spaces between realities without losing any of them—as an important achievement.

Grand (2002) and Davies and Frawley (1994) forged links between relational psychoanalysis and the trauma literature. In their pioneering exploration of adult survi-

ors of childhood trauma and sexual abuse, Davies and Frawley (1994) emphasized the importance of inviting multiple dissociated systems of self-object representations associated with the patient’s traumatic events into the therapeutic relationship as a means of integrating them into subjective experience.

There remains a great deal to be explored and theorized about the nature of dissociation. To the degree that dissociation is used as a defense, how does it relate to the many other defenses that psychoanalysts have studied, including not only repression but also splitting, disavowal, projective identification, and others? Do we use the term dissociation to refer to a symptom, a syndrome, a model of mind, a state of mind, defensive process, or all of these? Does this use of the term lead to the danger that we will explain a dissociative disorder by referring to a dissociative defensive system that is understood as occurring in a dissociative mind? If we are going to avoid the dangers of such circular explanations, then we will need to precisely think through how we use these terms and their relation to related and intertwined conceptualizations.

Although we have summarized many remaining questions, in shifting from drives to relations, there has been much more room for taking into account the impact of actual interpersonal experience without neglecting its psychic elaboration. This led relationalists to early attempts to dialogue with and learn from the trauma literature. Relationists, in turn, have contributed to the trauma literature by elaborating an alternative model of mind featuring multiplicity, dissociation, enactment, unformulated experience, and complex relational configurations.

Enactment

Words and action are dialectically related. Levenson (1983), a leading interpersonalist, exerted an enormous influence on relational theory and was among the first to observe that the language of speech and the language of action are transformations of each other, “harmonic variations on the same theme” (p. 81). Interpretation is a form of participation, and participation is not a “prescription” for a particular way an analyst should participate as much as a “description” of inevitable mutual influence (Greenberg 1981; Mitchell 1997).

The theorization of enactment should be seen as an extension of Sullivan’s participant-observer model. Enactment speaks to the unique way in which the analyst is
affectively pulled into and discovers him- or herself as a participant in the patient’s relational matrix in ways that the analyst had not predicted and might not recognize until later [Bass 2003; Black 2003; Maroda 1998]. Enactment is seen as communication [often a nonverbal one] from the patient about his or her dissociated “not-me” self-states that cannot yet be symbolized; the communication is embedded in the relationship between what is spoken and the subjective experience of the analyst toward him- or herself and the patient [Bromberg 2006]. It is the interpersonalization of dissociation and thus precludes mentalization and reflection [Sienk 2010].

The mutative power of enactment is not only in the insight that follows its exploration but also in the new interpersonal experience it generates in the analytic relationship [Hoffman 1998; Mitchell 1988]. Therapeutic action is believed to be embedded in the ongoing process of disruption and repair [see Beebe and Lachmann 1994] and an openness on the part of the analyst to be engaged not only with the interpretive dimensions of the analytic process but also with the experiential [Wachtel 2008].

Mitchell [1988] addressed the importance of the analyst feeling less shame and guilt about participating in the analytic process in a more personally spontaneous, expressive way. Enactments are viewed as two-person, mutually constructed interactional processes, joint creations of analyst and patient. By conceptualizing enactment as mutual, inevitable, and essential, relational analysts avoid the pejorative connotation and shame associated with the older notion of “acting out.” Mitchell said that if the analyst was not “charmed by the patient’s entreaties, shaped by the patient’s projections, antagonized and frustrated by the patient’s defenses—the treatment is never fully engaged, and a certain depth within the analytic experience is lost” [p. 293]. Ringstrom [2007] explored ways to cultivate “improvisation” via a relational ethic—a “hovering” set of questions about what is going on between the analytic participants, for example, the use of improvisational play, creating mini-psychedramas in which the analyst plays with being “the bad object” as opposed to becoming fixed in that role.

Analytic Third

The “third” is a concept that has become popular across a variety of schools of psychoanalysis. It has been developed and extended by some of the leading theorists of psychoanalysis, including Ogden and Benjamin (see Mitchell and Aron 1999), Green, and a variety of Lacan-influenced writers, but it is often defined ambiguously and inconsistently across schools [see Psychoanalytic Quarterly, Volume 73, Issue 1, 2004, for a survey of the topic of the third]. Thomas Ogden’s “the analytic third” represents one of the richest and most intriguing perspectives on the analytic process, conservative and restrained in clinical approach and yet radically intersubjective and generating a profound form of analytic connectedness [see Mitchell and Aron 1999]. For some theorists, the third refers to something beyond the dyad, a context within which we emerge; for others, the third is an emergent property of dyadic interaction; and yet for others, the third is a dyadic achievement that creates the psychic space necessary for reflexive awareness and mentalization [Gerson 2004].

Jessica Benjamin developed a theory of intersubjectivity and thirdness embedded within her broader contributions to relational theory in which she has elaborated the intersubjective dimension as necessary along with, not as replacing, the realm of the intrapsychic. Hers are among the most generative ideas to emerge within contemporary psychoanalysis, having profound clinical implications [see also Benjamin 1990 and 2004 and see review and extension in Aron 2006].

In Benjamin’s scheme, the third is the way out of complementarity. The structure of complementarity is best thought of as a straight line. You can move only forward or backward along the line, but you cannot step outside of that line because it exists in only two dimensions and there is therefore no lateral space. Much like a seesaw, the dyad is limited to up/down, doer/done to, push me/pull you relations, and the theory elegantly depicts what happens in therapeutic impasses and stalemates.

One significant consequence of being stuck on a straight line in complementary twoness is that the line represents an unconscious symmetry [Benjamin 2004]. Both partners on the seesaw mirror each other inversely; they are flip sides of each other, inhabiting reversible perspectives. This structural arrangement captures the mutual experience of their deep, generally unconscious identification with each other. Although each partner plays out one side, both of them identify with both positions. The sadist identifies with the masochist, and vice versa, even if these identifications are repudiated in consciousness. Thus, when patient and analyst get stuck in complementarity, although each thinks that “you are doing this to me; you are forcing me into this position,” there remains a deep connection between them because they unconsciously recognize that they are locked together in this binary relation, however polarized.
In disclosing aspects of their inner processes, particularly their own inner conflict or self-disagreement, analysts conduct a dialogue with themselves in the presence of their patients, thus introducing a third element into the dyad (Aron 2006). At times these self-disclosures operate as strange attractors, breaking up the single-lined stickiness of the seesaw and introducing a third dimension, thus creating psychic space for reflexive awareness and mentalization. Benjamin (2004) argued that in an impasse that is structured along the lines of complementary twoness, of doer/done to relations, analysts may have to reveal their own vulnerability before expecting this of the patient. It is not simply a matter of going first in the sense of sequence, but rather, it is a matter of the analyst taking responsibility for participating in the push/pull by having said or done something that contributed to it. Benjamin was building on the work of Ghent (2002), one of the founding figures of relational theory, who made the significant distinction between submission and surrender (see Mitchell and Aron 1999). Whereas submission carries the connotation of defeat and is accompanied by resignation, surrender means not subjugation but transcendence and acceptance. Masochism is a perversion or distortion of this longing to surrender, to let go of defensiveness of the wish to be penetrated, for one’s essence to be known and recognized.

Cooper (2010) has used a concept of thirdness that he calls “the pluralistic third” to capture the use of one theory to question another, essentially locating your clinical blind spots by triangulating your use of various theories so that you can overcome your own countertransference to theory. This relates to the all-important recognition that enactment and co-participation are essential and facilitative aspects of the analytic process.

## Gender, Sexuality, Race, Class, and Diversity

Perhaps because the relational tradition emerged in the 1980s, it was the first of the major psychoanalytic approaches to have absorbed many of the insights of feminism, deconstruction, and postmodernism. As the discipline entered the 1990s and the 21st century, it incorporated many of the essential lessons of queer theory and postcolonialist critique. It is also not an accident that it was the first school of psychoanalysis to develop when the field had become increasingly composed of women and in the first years after psychoanalytic openly accepted gay and lesbian analysts. The fact is that psychoanalysis has lost influence, prestige, and status within American culture for many reasons, and it is certainly not an accident that with that loss of power came a new openness to diversity and to what had earlier been relegated to the margins, to dissident and disenfranchised voices. For psychoanalysis to survive, it must open itself to diversity in ways it never has before, and the relational community has taken a lead in this direction.

Postmodernism exposed how our “subject positions” [discourse, points of view] are structured around differences in power and has opened up the fixity of structure, challenging us to find fluidity, movement, and multiplicity. Jessica Benjamin’s intersubjectivity theory [discussed earlier] is a direct outgrowth of her feminism and continues to contribute to feminist theory and practice. Adrienne Harris examined “gender as contradiction,” made up of shifting constructions, sometimes thick and reified and at other times porous and insubstantial. Dímen (2003) used the poststructuralist shift from dualism to multiplicity to investigate the intersection of social theory, psychoanalysis, and feminism in reworking our ideas about gender and sexuality. Virginia Goldner radically critiqued the gender conformity of traditional psychoanalysis, viewing gender as, ironically, a problem and not only a solution. Many relational contributors have been enormously influenced by Judith Butler, and Ken Corbett (2009) has used his work to rework our understanding of masculine development, especially the social and cultural pressures on feminine boys.

In recent decades a new generation of relational writers has challenged psychoanalysis to rethink its embeddedness in structures of racism and classism, with a radical call to bring psychoanalysis beyond private practice settings and into the community. (The following is a small sampling of recent work: the edited volumes by Aron and Harris [2005] and Suchet et al. [2007] contain all of the references cited below, unless otherwise indicated.) Altman [2004], Cushman [1995], Leary [1997], Suchet [2004], and Straker [2004] offered a social, historical, and psychoanalytic analysis of racism, with attention to countertransference and the personal nature of “whiteness.” Drawing from Butler’s work on gender melancholia, Eng and Han [2000], Cheng [2001], and Straker [2004] examined the experience of racial melancholia set in motion through assimilation and the recognition of power and privilege one gains unintentionally from being white. Botiucelli [2007] and Hartman [2007] brought our attention to the ubiquitous nature of class, its integration into the psyche, and its influence on the
analytic relationship. Layton et al. (2006) addressed the unconscious ways in which ideologies related to gender, race, and class infiltrate our clinical work through enactment. Rozmarin (2010) explored the politics of identity and the nature of “otherness,” and Peltz (2005) explored how the process of the manic defense interferes with a sense of social responsibility. Spirituality has been a source of great interest and inspiration for many [see Eigen’s (1981) classic article on faith]. Many other relational writers have begun the psychoanalytic study of race, class, poverty, transsexuality, alternative family structures, immigration, politics, war, and more.

A Clinical Case Vignette

The following is a brief summary, just a small selection from one case [Connie] presented by Stephen Mitchell (2000). We include it to illustrate some of the basic relational concepts discussed in this chapter, because his work brings to clinical life such abstract notions as relationality, mutuality, intersubjectivity, multiplicity, and the relational use of transference and countertransference.

Connie was married and in her mid-40s when she sought treatment with Mitchell. Her previous therapy, which had ended about 10 years earlier, was described as helpful in alleviating her chronic sadness that stemmed from the sudden loss of her mother in a fatal car accident when Connie was 5 years old. Connie returned to treatment because her sadness, connected with the mourning of her mother, never fully lifted. In fact, it worsened when she married in her late 30s and again when she gave birth to her son. At the start of her treatment with Mitchell, her son, who was then 5 years old, was experiencing considerable separation difficulties.

Connie’s other reason for returning to therapy was that she felt she lacked a sense of “self.” In her early work with Mitchell, she realized that when her mother died, she also lost her father, who sent her older brother to a military school and Connie to an orphanage/boarding school far from home. They remained separated for the next 7 years, except on weekends, because her father felt overwhelmed by the prospect of taking care of two young children.

Connie’s attachment to her absent mother became a fundamental element of her identity. In one session, she described her fascination with a book about people who had climbed Mt. Everest. She described her interest in “extreme situations,” which Connie pursued through participation in wilderness travel and long-distance running and swimming. Paradoxically, her immersion in these “unforgiving” experiences generated a sense of calm within her and activated a self-state that felt closest to her sense of who she was. Connie’s self-development had been marked by pain and loss. As a result, pain and exertion became the emotional and physical states that allowed for her self-recognition.

Over time, Mitchell started to think that Connie organized her experience in a way that kept her sadness alive and perpetuated her chronic feeling that something was missing from her life. He tells us that “somehow we, probably because it is one of my favorite subjects, had gotten into speaking about her approach to food and eating” (Mitchell 2000, p. 93). There is something that feels personally spontaneous and playful about the quality of Mitchell’s exchange with Connie. Mitchell considers how the patient’s association relates to his own experience, although he does not tell us if this thought was disclosed to the patient. Although Connie ate very well, she told him that she did allow herself to eat one bag of M&Ms every day. Mitchell was struck with her choice of candy, because he preferred the richer, more self-indulgent Milky Way. This discrepancy in taste between them led to his clinical choice to inquire further, which ultimately served to illuminate a deeper understanding of Connie’s pervasive sadness. Yes, she had tried Milky Ways, but she said they could easily make her feel like she had overdone it. They discovered that Connie chose M&Ms precisely because they were bounded and defined and could be counted, thus she was reassured that she could control herself. In the absence of a maternal figure, Mitchell tells us that it had been up to Connie to monitor her food choices. Without her mother’s watchful eye, Connie had had to restrict exploration of her intentions and desires to become what Winnicott referred to as the “care-taker self.” Rather than the richest dessert, Connie chose a “responsible” dessert. Her sadness was seen, in part, as a consequence of having to narrow her experience and foreclose experience within the borders of what she felt was allowed.

Mitchell found himself wanting to have more frequent sessions with Connie as their work together developed. [Note that Mitchell did not write that he thought the patient required or would benefit from more sessions, rather he shared his own longing with the reader.] However, the control she kept on her feelings and her fears of dependency kept Connie from agreeing to come more often. Soon Mitchell found himself feeling deprived by her refusal, much the way he imagined Connie felt deprived as a child, yearning
for more frequent visits from her father. Around this time, Connie confronted Mitchell on his impersonal manner of greeting her in the waiting room. She complained that his simple “hello” without calling her by name at the beginning and end of each session felt cold and anonymous. Mitchell was open to considering the plausibility of her observation, and he recognized that this was in fact characteristic of his style. He started to call her by name, not because she told him to but because he felt there was a certain truth to what she was saying that he was interested in exploring.

In the process of successfully negotiating their manner of greeting and parting, Mitchell examined issues of distance and intimacy, presence and loss, both between them in the present and shaped by past losses and traumas. Mitchell used his exploration of the interactions and negotiations with Connie to uncover the childhood origins of how she learned to control her desire and manage her experience of pleasure, especially in coping with her mother’s death and father’s absence, as well as how these dynamics are repeated in her marriage. His clinical work is an illustration of how relationalists use here-and-now interpersonal experience to uncover deeply unconscious material as well as to address relational themes between the analyst and patient and the links to childhood and family experience and to current interpersonal scenarios. Connie’s transference was thus not viewed by Mitchell predominantly as a “distortion” but rather as her way of “probing” his subjectivity and thus playfully experimenting with and renegotiating her patterns of relating to herself and to others. Mitchell’s case continues, but here we invite the interested reader to pursue Mitchell and the relational literature directly. As we conclude Mitchell’s case and end this chapter, it seems appropriate to note that recent relational work has examined the ongoing mutuality inherent in negotiating breaks, interruptions, and endings (Salberg 2010).

---

**KEY POINTS**

- The relational paradigm is characterized by a focus on pluralism and multiplicity, emphasizing both/and rather than either/or thinking and moving beyond these dichotomies by thinking dialectically (the “third”).

- Transference and countertransference are mutually co-created formations of two participants in the complex dynamic system constituting the analytic situation. Transference is an intersubjective construction, formed in dialogue with what the analyst does and who the analyst is with the patient.

- Along with the restraint and discipline structured by the analytic frame, the freedom to offer passionate, authentic engagement and immediate emotional honesty is at the heart of psychoanalytic work. The analyst cannot follow a preformulated linear “technical” plan but relies on trial and error, ingenuity, and resourcefulness to achieve goals that are themselves contingent, mutually negotiated, and co-created.

- Enactment speaks to the unique way in which the analyst is affectively engaged and discovers him- or herself as a participant in the relational matrix in ways that the analyst had not predicted. Enactment is a communication and “interpersonalization” of dissociated self-states that cannot yet be symbolized and preclude mentalization.

- Relational theory was influenced by feminism, deconstruction, and postmodernism and later by queer theory and postcolonialist critique. It has brought intersubjectivity to bear on sex, gender, race, class, transsexuality, alternative family structures, immigration, politics, war, and more.
References

Bass A: When the frame doesn’t fit the picture. Psychoanalytic Dialogues 17:1–27, 2007
Beebe B, Lachmann FM: Infant Research and Adult Treatment. New York, Routledge, 2005
Benjamin J: Beyond doer and done to: an intersubjective view of thurdness. Psychoanal Q 73:1–46, 2004
Coates SW: Having a mind of one’s own and holding the other in mind: discussion of “Mentalization and the changing aims of child psychoanalysis” by Peter Fonagy and Mary Target. Psychoanalytic Dialogues 8:115–148, 1998
Cooper SH: A Disturbance in the Field. New York, Routledge, 2010
Corbett K: Boyhoods. New Haven, CT, Yale University Press, 2009
Cushman P: Constructing the Self, Constructing America: A Cultural History of Psychotherapy. Reading, MA, Addison-Wesley, 1995
Davies JM: Linking the pre-analytic with the post-classical: integration, dissociation, and the multiplicity of process. Contemp Psychoanal 32:553–576, 1996
Harris A: Gender as Soft Assembly. Hillsdale, NJ, Analytic Press, 2005
Peirce CS: Philosophical Writings of Peirce. Edited by Buchler J. New York, Dover, 1955
Safran JD, Muran JC: Negotiating the Therapeutic Alliance. New York, Analytic Press, 2000
Jacques Lacan

Jeanne Wolff Bernstein, Ph.D.

Theoretical Origins

Jacques Lacan was one of the most influential psychoanalysts in France. He introduced psychoanalysis to France, a country that had been deeply suspicious of the Germanic roots of psychoanalysis. Had it not been for the particular French character of Lacan, who was a psychiatrist and a close friend to many surrealist painters and writers, as well as an avid reader of literature and philosophy, psychoanalysis may have never entered into the fabric of French culture in such a profound way.

Lacan was born in 1901 and died in Paris in 1981. He was born to a bourgeois Catholic family, one of his siblings even went on to become a priest. He pursued his early studies at the prestigious Collège Stanislas and completed his medical studies in 1931. In 1932, Lacan published his dissertation, Paranoiac Psychosis and Its Relation to the Personality, in which he analyzes the case of a woman, Aimée, who had attempted to kill a famous actress whom she imagined had spread slander about her. The fundamental insights he gained in his studies of Aimée influenced him throughout his life.

What Freud had learned from his early studies on hysteria, Lacan had learned from his work on psychosis, in particular as the director of the St. Anne's Hospital in Paris. Aimée's wish to kill another woman whom she had never met illustrated the unconscious psychic mechanism of merging one's own image with that of an idealized other, whom Aimée then sought to destroy in a wish for self-punishment. Lacan asserted that Aimée demonstrated the whole gamut of paranoiac themes, such as jealousy, persecution, prejudice, grandiosity, dreams of flight, and erotomania, while at the same time maintaining all of her intellectual functioning.

In his thinking about Aimée and the psychoanalytic underpinnings of psychosis, Lacan was profoundly influenced by Freud's (1922) paper "Some Neurotic Mechanisms in Jealousy, Paranoia and Homosexuality," which Lacan translated from German into French. From Freud's text, Lacan took the central idea that a paranoiac knowledge (la connaissance paranoïaque) exists at the core of each subjectivity. For Lacan, psychosis became the central subject on which he elaborated his later fundamental concepts of the imaginary, the mirror stage, the importance of language, and the effect of the signer. His surrealist friends read his article on Aimée with
great interest, and the surrealist painter Salvador Dalí, in particular, agreed with Lacan's theory that a paranoid mechanism exists as a powerful force at the core of each person.

In pursuing his interest in those psychic phenomena that escape consciousness and are driven primarily by unconscious mechanisms, Lacan shared with Freud an early awareness of what divides the mind, and not so much what cures the mind. How Lacan eventually conceptualized the “divided subject” finds its theoretical grounds in Freud’s 1927 paper “Fetishism” in which he wrote about the process of Spaltung (division of the ego). Freud had already written about the divided mind when he analyzed the workings of dreams in the first chapter of The Interpretation of Dreams:

The chief feature of dreams and of insanity lies in their eccentric trains of thought and their weakness of judgement. . . . In dreams the personality may be split—when, for instance, the dreamer’s own knowledge is divided between two persons and when, in the dream, the extraneous ego corrects the actual one. This is precisely on a par with the splitting of the personality that is familiar to us in hallucinatory psychosis; the dreamer too hears his own thoughts pronounced by extraneous voices. [Freud 1900, p. 91]

Thus, in a surprising way, Freud argued early in his work that the ability of the mind to split itself is responsible for the creation of both dreams and psychosis. Throughout his life, Lacan described his own work as simply “a return to Freud,” whose radical discovery of the unconscious as a linguistically formed psychic apparatus was at risk of disappearing from the psychoanalytic landscape under the aegis of ego psychology.

The Ego/Marienbad Congress, 1937

In 1934 Lacan began his psychoanalytic training at the Société Psychanalytique de Paris, where he entered into a training analysis with Rudolf Loewenstein, an influential ego psychologist. (Loewenstein immigrated in 1939 to New York City, where he co-authored a number of articles with Heinz Hartmann and Ernst Kris.) In 1937 Lacan left for the international psychoanalytic congress in Marienbad. Upon arriving at the Marienbad Congress as a young and largely unknown psychoanalyst, he found himself surrounded by a majority of psychoanalysts advocating the positive therapeutic results of a strengthened ego. In contrast to their therapeutic findings, however, Lacan had realized that the I [ego] is formed through an illusionary and projective process that alienates the subject from his or her unconscious desire. Realizing that the ego psychologists, including his own analyst, had largely lost sight of the unconscious and had placed the workings of the ego at the center of their theoretical and clinical works, Lacan embarked upon a criticism of their fundamental ideas. In his paper on “The Mirror-Stage as Formative of the Function of the I as Revealed in Psychoanalytic Experience,” Lacan [1949] wrote:

The mirror stage is a drama whose internal thrust is precipitated from insufficiency to anticipation—and which manufactures for the subject, caught up in the lure of spatial identification, the succession of fantasies that extends from a fragmented body-image to a form of its totality that I shall call orthopedic—and, lastly, to the assumption of the armor of a(n) alienating identity, which will mark with its rigid structure the subject’s entire mental development. [p. 4]

In “The Mirror-Stage,” which he defines as both a particular stage of development and a permanent, as he says, “rigid” structure, Lacan explained how the young child, from age 6 to 18 months, forms an image of his body through a gestalt in the mirror that is far more developed and unified than the child’s actual bodily motor capacity. Citing the early observations by Henri Wallon, a French child psychologist, Lacan described how a young infant, as early as 6 months old, may become captivated by his own mirror image and mistake this image for himself. In contrast to a chimpanzee who shows an indifference to a reflection, the young infant greets the perception of his image with jubilation—or, as Lacan writes, with jouissance—because the infant recognizes in the mirror a body that holds out the illusion of a unity and mastery that he cannot yet experience, because the child has not yet attained control over his own body and is still dependent on an Other for his own survival. The infant sees his own image as a whole, and the synthesis of this whole image evokes a tension between the perceived image and the body, which is still felt to be in pieces (corps morcelé). Lacan (1949) wrote, “[T]he child anticipates at the mental level the conquest of his own body’s functional unity, which is still incomplete at the level of volitional motricity at that point in time” [p. 91].

The mirror in the mirror stage does not simply refer to an actual mirror but also to the visual exchange between the infant and the Other through whose gaze the child identifies with herself. Using the work of Charlotte Buehler, who studied the phenomena of infantile transvestism (i.e., children experiencing the emo-
tional or physical responses of other children, e.g., crying when they see another child being hit], Lacan underscored the fact that an Other is necessary for the constitution of the subject. He theorized that this specular exchange between the infant and the Other was mediated by conscious and unconscious desires of the Other that constitute the infant’s subjectivity. It is through the gaze of the Other that the infant/subject comes into being as an object and is delivered to himself through that Other. Therefore, the mirror image is not reflective of the subject’s identity but is constitutive of the subject’s identity. The infant/subject-to-be wants to become what he perceives in the mirror—an ideal image—yet in introjecting this superior held-out image, he also introjects an alien/other image that can take the form of a persecutory rather than an ideal image. In this see-sawing, projective/introjective process, an internal rivalry is established that leads the subject to want to recapture the original of his mirror image.

With the mirror stage, Lacan not only expanded Freud’s concept of the ideal ego and the ego ideal, but also provided a radically new way of conceptualizing identification as a specular, desiring, and alienating process. By unmasking the ego as an agent of deception and illusory mastery, Lacan paid tribute to Freud’s late realization that the ego is not normal but shares many characteristics with the psychotic one, as Freud described it in his 1937 text *Analysis Terminable and Interminable.*

In order to understand the centrality that desire occupied in the work of Lacan, we need to examine how he arrived at the idea that the truth about one’s desire is the essential goal of the analytic talking cure. Lacan emphasized that the human subject is defined by desire, and yet this desire is decentered, because it is only through and for the Other that the subject comes into being. Because the mother is the first to occupy the position of the Other, it is important to comprehend the function the phallus plays in the mother/infant relationship, how the mother’s *jouissance* enters into the picture, and how the child comes to terms with the lack he discovers in the mother/Other [M/Other] through the formation of the objet a. The Other also stands for the site of speech and language, “an-Other scene,” outside consciousness through which the subject, as Freud (1900) had already shown in his *Interpretation of Dreams,* discovers his desire. Using Freud’s early works on the grammar of the unconscious through a transparent of linguistics, Lacan showed how the intricate network of signifiers and signifieds represented the only means by and through which the subject’s true desire could be heard and articulated.

**Desire**

When the mirror stage comes to an end, inaugurating a permanent imaginary structure through which the subject identifies with the imago of his “counterpart,” it brings into focus that the desire of the subject is mediated through the desire of the Other. What I take to be my desire is really what the other desires me to be. Lacan writes:

> Before language, desire exists solely in the single plane of the imaginary relation of the specular image, projected, alienated in the other. The tension it provokes is then deprived of an outcome. That is to say that it has no other outcome—Hegel teaches us this—than the destruction of the other.... But thank God, the subject inhabits the world of the symbol, that is to say a world of others who speak. That is why his desire is susceptible to the mediation of recognition. Without which every human function would simply exhaust itself in the unspecified wish for the destruction of the other as such. [Lacan 1975, pp. 170–171]

In his conceptualization of desire as a desire for and through the other, Lacan was strongly influenced by his studies of Hegel, which he pursued by attending the lectures of Alexandre Kojève [1947] at the Sorbonne. Through the desire of destroying what one wants, the subject becomes aware of himself-as-other in much the same way that children initially refer to themselves as other, by their name, rather than by “I.” A child will say, “Thomas wants a cookie” instead of “I want a cookie.” Thus, a desiring subject is a literal “him” to himself. As Lacan [1949] says, “[T]he subject identifies, in his feeling of self, with the other’s image and that the other’s image captivates this feeling in him” (p. 147). With the mirror stage, where the formation of the ego (moi) depends on the imago perceived through the Other, a door opens to a theory of desire that understands desire as wanting to be recognized by the Other as Hegel had also theorized in the master-slave dialectic.

In contrast to an intersubjective view of desire that moves back and forth between two imaginary poles, Lacan offered a different perspective on desire. He suggested that the Other is a basic structure to one’s being. Rather than viewing the Other as an external other person whom one internalizes, Lacan argued, influenced by Sartre [1966], that the Other is a basic internal structure through which desire is mediated [see Lacan 1949, p. 98]. He used Freud’s case of Dora to illustrate the difference between the Other as an imaginary object and an internal structure through whom subjective desire is mediated:
By Freud’s own admission, he committed an error with regard to the object of Dora’s desire, in as much as he was too focused on the question about the object, because he does not account for the duplicitous subjective ‘fanciere’ that is implied. He asks himself what Dora desires before he asks himself who desires in Dora. And Freud ends up realizing in this ballet of 4, Dora, her father, Mr. and Mrs. K., that it was really Mrs. K. whom Dora desired, in as much as she is identified in her desire with Mr. K. The question of knowledge is where is the me (ego) of Dora is also resolved since the me (ego) of Dora is Mr. K. In as much as she is Mr. K., all her symptoms take their definitive meaning. (Lacan 1955–1956, p. 197, translation mine)

The case of Dora shows the essential structure of the Other and how the subject constructs desire in the place of the Other. Dora desired as though she were Mr. K., and it was that position that structured her whole neurosis. For Lacan, neurosis is always a question, and in the case of the hysterical person, the basic question is “Am I a man or a woman?”

Desire should be distinguished in Lacan’s work from demand and need and is not to be constructed in relation to an object but rather in relation to a lack (manque). Need is a biological instinct, such as hunger or thirst, that becomes translated into a demand that can be satisfied or frustrated. For Lacan (1958), “[D]esire is neither the appetite for satisfaction nor the demand for love, but the difference that results from the subtraction of the first from the second, the phenomenon of their division (Spaltung)” (p. 287). Desire, unlike demand, can never be satisfied, because in the moment that it becomes satisfied it is transformed into a demand. The concept of lack is essential to Lacan’s overall theory because it is at the center of what is necessary to become a desiring subject. In contrast to Klein or even Winnicott, Lacan viewed lack not as being detrimental to the subject but as being absolutely necessary for the subject to assume his own separate being. It is only through the play of presence and absence that a difference can constitute itself between the M/Other and her child.

Phallus

Lack is more comprehensively translated from the French manque-à-être to the English neologism “want to be” (see Lacan 1977, p. xi). For Lacan, the mother does not just become a mother but also remains a woman, and being a woman raises the question of what she lacks and desires as a woman. As such she perceives her child as the phantastic/impossible object—the imaginary phallus—that could plug up her lack. The imaginary phallus is perceived by the child “as that which she desires beyond the child and the child seeks to identify with this object” (Evans 1996, p. 142). The phallus is an imaginary thing that circulates between mother and child. It is something that can neither be reached nor fulfilled, yet it is crucial in its impossible position between the mother and the child. The mother-infant relationship is never dyadic because it is initially mediated through the imaginary phallus and later mediated through the position of the symbolic father. The high frequency of postpartum depression sheds light on how difficult a period this is for many women. What if the infant does not mesh with the mother’s fantasies and does not patch up her internal lack and void? As much as a baby carries the potential of filling up a mother’s imaginary desire, the baby also carries the potential of tearing her apart. When a mother gives birth, she is both at her most fragile and most omnipotent, because a baby can hold the potential of plugging her up or of failing her. Because the child is at the mercy of the mother’s jouissance, a capricious, passionate, and enigmatic lust, the child is helpless when faced with the mother’s omnipotence. A mother can then long for a fetishistic solution and use her baby to patch up her own internal fragmentation. In order to understand early mother-child dynamics, the question of their relationship to the phallus is of utmost consideration.

The Other

The first Other is the specular M/Other whose “want to be” the child attempts to fulfill and complete. The infant comes into the world as an object of love, hate, desire, or rejection, and its entire being is subjected to the forces of maternal jouissance. It is through the mother’s gaze and enigmatic desires for the child that the child identifies with what the mother desires him to be. This mirroring/imaginary relationship is held at the same time in a symbolic framework represented by the second Other through the symbolic figure of the Father. The paternal role fulfills the function of the third, which separates and divides the child from the mother. It is through the name and the “no” of the symbolic father (nom and no are homonyms in French) that the child is pulled out of the imaginary register and given a separate and distinct place in the symbolic world. For the child to move from one position to the other, from being the object of the mother’s jouissance to accepting the “name of the father,” the child must find a credible and respectable figure in this symbolic function for whom he can give up the satisfaction gained from being
in the dyadic position with the mother. The child must also encounter a figure in the dyadic position who can release the child into the social world. A sacrifice of satisfaction is involved in this transmission from a dyadic to a triadic position. For the child to become a separate, speaking subject, he must recognize that the maternal figure is not entirely invested in him but that the mother’s desire is directed elsewhere. However, when the child does not encounter a credible figure in the position of the third with the name-of-the-father being foreclosed, the child is imprisoned in a universe of maternal jouissance. Without access to the symbolic order, the subject creates psychotic substitutions for the Other in form of hallucinatory or persecutory figures, as Freud’s case of Schreiber illustrates. Castration thus refers to the structural movement when the child realizes the mother’s lack and his own inability to complete her. This lack thrusts the child into the larger social and cultural world. Through the acceptance of the name-of-the-father and the separation from the mother, the child traverses the incestuous laws because he renounces the desire to remain the exclusive object of the mother and subordinates himself to the laws of the symbolic father. The repression of incestuous desire for the mother is inextricably linked with the child’s entrance into language because the child begins to substitute words for this fundamental loss.

The third definition for the Other is that it constitutes the keeper of signifiers. Through his studies about psychosis, Lacan affirmed that the signifier (the sound/image of a word) has no meaning in and of itself and can exist by itself. In its ability to isolate itself out from other signifiers, it determines the signified (the meaning arbitrarily connected to the sound of word/image).

**Structuralism/The Other**

Lacan reread Freud’s work through the lens of structuralism and linguistics and posited that the human subject is constituted not only by drives and unconscious desires but also by structural forces that cannot be grasped on an experiential basis. They are laws that exist beyond the individual’s subjectivity and history that shape the subject’s core. Language, for instance, is a structure not only that we speak; it is a structure by which we are spoken. Language precedes the subject and thus structures the subject in the fundamental way that the subject thinks, feels, acts, and desires. Language is not a tool we use but a structure by which we are shaped in our innermost being. When we learn a language, we also absorb its organization, grammar, culture, and laws. For Lacan and the object relations and relational theorists alike, the Other is primary. However, for Lacan, the idea of the Other goes beyond the actual person of a primary actual or fantasized figure. Instead, Lacan’s idea of an Other exists as a formal structure with its particular laws that traverse the subject and the others upon whom he depends. The Other also constitutes the unconscious that informs our conscious life just as the laws of language inform the way we speak, dream, and create fantasies.

Freud’s early texts on dreams, jokes, and parapraxes created the background for Lacan’s link to structural linguistics. He equated Freud’s theory about condensation and displacement with Roman Jakobson’s concepts of metaphor and metonymy. Instead of viewing the unconscious as either a cauldron of instinctual drives or a hotbed of phantasized object relations, Lacan saw the unconscious as structured like a language that functions according to the same operational modes (i.e., condensation and displacement) as any language. The unconscious finds its roots in the discourse of the first Others, the parents of the child. Before the child is born, it is already symbolized as an entity in their minds, and thus projections, wishes, and desires are already imbued into the child before he is born. The parents’ unconscious and conscious signifiers become the cornerstones of the child’s unconscious.

**Signifier and Signified**

Lacan borrowed from Ferdinand de Saussure the concepts of signifier and signified. Signifier means the sound-image of a word, and signified denotes the meaning we associate with that word. Saussure’s important discovery was that the sound of a word and the meaning connected to it were of an arbitrary nature. In contrast to images, words are there to differentiate between the signs—the combination of signifier/signified. Lacan reversed Saussure’s proposed connection between the signifier and the signified. Saussure’s signified (concept) over the signifier (sound-image) became Lacan’s signifier over the signified. Signifier and signified are separated by a bar, which echoes Freud’s censorship and is referred to by Lacan as the bar of repression (see Figure 16–1).

The reason Lacan made this significant change was because he wanted to underscore that the signifier does not represent the signified and that meanings constantly shift between the various signifiers, a shift that accounts for the successful outcome of a joke or the structure of a dream. We hear the word [signifier] “weight” but can also
phonetically hear the signifier “wait.” In dreams and jokes, words have to be efficient in order to convey a multiplicity of meanings at the same time. In addition, Lacan wanted to demonstrate that the insignificant—the stuff that slides underneath the bar—is what counts, recounts, and speaks. Faithful to Freud’s essential teachings about dreams, Lacan demonstrated how unintended meanings emerge that structure and disrupt the subject’s conscious discourse and reveal unconscious intents. These signifying units are connected to one another in a signifying chain of interconnected links that Lacan [1957] described in the following way: “We can say that it is in the chain of the signifier that the meaning ‘insists’ but that none of its elements ‘consists’ in the signification of which it is at the moment capable. We are forced, then, to accept the notion of an incessant sliding of the signified under the signifier” [p. 153].

Repressed wishes hide and slide between the signifiers and attach themselves to words, which have double meanings so as to sidestep the censor. The signifier then functions as a sort of “double agent” for what cannot be directly expressed in a dream. Given the powerful position of the signifier/signified, Lacan was not defining the ego as the true subject but was identifying the subject of the unconscious as the true subject that is speaking and that needs to be listened to. The child thrown into the world of the language of the Other and at the mercy of the M/Other’s jouissance finds his true desire on “another scene.” That “I is another” is a realization won not only through the mirror stage but also through the displacing and substitutive character of language. Lacan wrote, “Entstellung, translated as ‘dis-

tortion’ or ‘transposition’ is what Freud shows to be the general precondition for the functioning of the dream, and it is what I designated, following Saussure, as the sliding of the signified under the signifier, which is always active in discourse” [1957, p. 160].

A thinking exists about which the subject knows nothing, which articulates itself on another level according to its own internal rules. It emerges where the “I” cannot be found, in the gaps and failed actions that intrude upon the conscious discourse.

Imaginary, Symbolic, Real

Lacan’s three structures—the imaginary, the symbolic, and the real—are not mental forces but dimensions of human experience that structure the intrapsychic life of the subject. In contrast to a developmental perspective, Lacan adopted a structural perspective, situating the subject within these three interrelated registers at the same time [Figure 16-2].

Although the imaginary is primarily a register of images, identifications, fixations, resemblances, and idealizations, it is simultaneously held and structured by the symbolic order, which is the dimension of speech, language, order, law, and culture. The imaginary order primarily functions at the level of sameness and illusion—it informs paranoid knowledge, for instance—whereas the symbolic register operates at the level of difference and separateness, bringing order into a largely confusing realm of mirroring relations. The third order of the real is the realm that resists language, containing the unsymbolizable and unspeakable elements that continuously inform and affect life. The real is outside of language and opposes any kind of symbolization. Lacan described the real as impossible because the real cannot be integrated into the symbolic or the imaginary and yet it surrounds and punctures them at all times. The very entrance into language marks the irrevocable separation from the real. The real continues to exert its influence throughout life because it is the bedrock against which all fantasies and words fail. Lacan asserted that what cannot be symbolized will return from the real, as seen in the case of the psychotic persons whose words are foreclosed from the symbolic order and return to them from the real. A similar phenomenon can be observed in dreams and slips of the tongue, in which a word/signifier suddenly breaks into speech, seemingly coming from nowhere. With the dimension of the real, Lacan offered a distinct way to understand trauma. Trauma breaks into the subject’s psyche, leaving the subject speechless and without any

Objet a

During the years of 1959–1962, a profound change occurred in the work of Lacan during which he altered his thinking from an emphasis on desire toward a focus on jouissance. His critique of the concept of the object in object relations theory led him to a new formulation of the object, which he defines as the objet a. The development of this new concept went through several transformations. Lacan agreed with Freud’s idea that the object is always a lost object (described by Freud [1905] in Three Essays on the Theory of Sexuality) that can only be found through substitutes. At the core of any relationship to an object a permanent lack exists that cannot be repaired. Instead of analyzing good or bad object relationships, Lacan argued that the relationship to the primary loss of the object has to be analyzed. His shift from the object to the lack of the object created a new dimension for the psychoanalytic treatment of neurosis. A hysterical person, for instance, constructs her desire by making the other’s object of desire into the object of her own desire. She wants to be the unique object of the other’s desire and will turn anything into the kind of scenario that makes her the object of the other’s desire. By always searching for ways to become the object of the other’s desire, she does not have to face her own lack. She maintains her own desire as unsatisfied as a means of persistently searching for new ways of becoming the essential object to the Other. In contrast, an obsessional person turns the demand of the Other into the object of his desire. He is terrified of the Other’s desire and transforms it into a demand, which becomes his object. Either he makes the Other wait so that the question for him becomes the object, or he turns the demand into an obligation that he can then fulfill for the Other. Either neurotic construction is thus inscribed around the lack and is unconsciously constructed to avoid it.

In Lacan’s seminar on The Ethics of Psychoanalysis (Lacan 1959–1960), objet a refers to the central lack at the heart of desire and to the central void at the core of the unconscious. Lacan rediscovered Freud’s [1915] concept of “primary repression” by affirming that a hole exists at the center of the unconscious that cannot be filled or put into words. Through the process of primary repression (Ur-verdrängung), primary perceptions are inscribed into the unconscious along different stratifications that form a memory that remains inaccessible to the subject. Unconscious processes are set into motion through primal repression that exerts a constant force on secondary repression from around this void, which Lacan equated with the objet a. Lacan divided the original lost object on account of symbolization into two parts, the one which is lost and the other which is the thing (das Ding) that also represents the forbidden/incestuous mother. In concordance with Freud’s [1895] Nebennenschkomplex (complex of the fellow human being), during which the infant divides the primary object into something familiar and something estranged (which Freud called Das Ding), Lacan wrote,

The Ding is the element that is initially isolated by the subject in his experience of the Nebennensch as being by its very nature alien, Fremde. The complex of the object is in two parts, there is a division, a difference in the approach to judgment... The object will be there when in the end all conditions have been fulfilled—it is of course, clear that what is supposed to be found cannot be found again. It is in its nature that the object as such is lost. It will never be found again. Something is there while one waits for something better, or worse, but which one wants. (Lacan 1959–1960, p. 52)

He continued to explain that the mother-child relationship is not so much based on frustration, dependence, and satisfaction but instead is structured in the unconscious by the relation to the thing, which is the incestuous desire for the mother that can never be satisfied. With the thing (i.e., with the mother qua object of incest) at the center, desire becomes a movement cir-
culating around the forbidden object that it can never reach. With this attraction for the forbidden, an early erotic transgression is inscribed in this circulating drive, and it is here that Lacan mentioned *jouissance* for the first time as the pleasure turning to pain when the limit toward a forbidden object is transgressed. The very thing the subject deeply longs for in his unconscious produces inevitable pain, and it is this pain in pleasure—*jouissance*—into which he is hooked in complex, symptomatic ways.

In the seminar *L'Identification*, Lacan (1960–1961) contrasted the specular image *I(a)* to the petit *objet a*. He returned once again to his early theory of paranoid knowledge and illustrated that the process of identification is illusory, as the schema L illustrates [Figure 16-3].

We identify along the imaginary axis with what we mistake to be the object of the other’s desire. We negotiate the loss from the Other by hanging onto a fragment, a leftover piece that always reminds us of this early separation and in so doing acts as the cause of our desire. The *objet a* becomes increasingly a part of the real and assumes the notion of the unobtainable, which is the cause of desire rather than the object of desire. The *objet a* is now the object that sets desire in motion, acting as the cause behind it. The *objet a* becomes constituted in the primary moment of separation from the mother through which the subject then constitutes itself. Lacan identified four kinds of *objet a*, the gaze, the voice, the feces, and the breast, which serve as memorials of this early loss into symbolization. The *objet a* cannot be found in a relationship; it can only be momentarily apprehended in a gaze, a tone of voice, a smell, or a fleeting sensation, and every subject has a particular *objet a* in correspondence to his separation from the mother. Something reminds the person unconsciously of the separation from the object of incestuous desire and fixes him in that particular constellation. The goal of any analysis is to apprehend the subject’s engagement with the cause of the Other’s desire so that the subject has a more informed sense of what is driving him in this unconscious desire.

In his seminar on anxiety (*L’angoisse*), Lacan (1962–1963) arrived at one more transformation of the *objet a*. In this seminar, he discussed Winnicott’s concept of the transitional object and began to speak about the *objet a* as a “transferrable object” (*un objet cessible*): “The most decisive moment in the anxiety involved, the weaning anxiety, is not so much that the breast is missing on a particular occasion when the subject needs it, but rather that the little child gives up the breast to which he is appended, as a part of himself” [p. 362, translation mine].

![Figure 16-3. Schema L.](image)

Here Lacan argued that the infant gives up a part of itself when it gives up the breast, and in so doing identifies with that lost part of himself. The infant makes the mother’s breast a part of himself and thus experiences the loss of the breast as a loss of self and not of the mother. This “transferable object,” which Lacan equated with Winnicott’s transitional object, led Lacan to the important conclusion that a primordial identification takes place prior to the mirror stage, in which the infant identifies with a lost part of himself. This constitutes a pre-specular identificatory moment for the infant long before he identifies himself with his alienating mirror image and mistakes that mirror image for himself. The infant is thus faced with the object—which he mistakes for himself—in front of it and has to let go of something that he believes to be himself. This profound early, pre-imaginary anguished loss of one part of oneself is at the root of human existence. The *objet a* also gains increasing significance in the clinical realm because it is the analyst who has to situate herself as the semblance of the *objet a*, the cause of the analysand’s desire in the treatment.

In Lacan’s seminar on identification, the *objet a* became more and more clearly defined as the object of the drive that can only be seized in a conjugation of a subjective, active, or self-reflexive form. The concept of the fantasms becomes crucial here because it articulates the relation between the *objet a* and the subject. The fantasms represents the basic unconscious structure through which the subject organizes desire in relation to the *objet a*. For instance, a subject may always want to see/hear, or may always want to be seen/heard, or may always want to see/hear himself as a means of “safeguarding” access to his *jouissance*, which lies beyond his desire. Returning to Freud’s notion that there is no direct relationship between the object and the drive and that the object is merely soldered together with the drive, what installs itself between the drive and the object is a fan-
tasm. The fantasm arrives at some articulation of how the drive engages the object, guaranteeing a constant flow of jouissance. The subject is typically passionately attached and fixated on his fantasm—persevere, abject or depressing, and humiliating as it may be—so as not to lose the fundamental autoerotic source of his jouissance. The task of analysis is to reduce the power the basic fantasm yields over the object of the drive. By trying to drain the jouissance from behind the fantasm, analysis attempts to diminish the force the fantasm occupies over the subject’s life.

**Jouissance**

In order to understand the direction of a Lacanian analysis, it is important to clarify the concept of jouissance and the role it plays in the formation of symptoms. Lacan’s definition of jouissance changed as well over time, both in theory and in clinical practice. Whereas “jubilation” might have sufficed as a translation for the moment the infant recognizes himself in the mirror during the mirror stage, it does no justice to Lacan’s later uses of jouissance. Jouissance has many facets and has emerged as one of the most useful clinical ideas for analytic treatment. It is a legal term, referring to the right “to enjoy the use of a thing” as opposed to possessing it. It is an enjoyment that is pursued for its own sake, having no limit or visible aim attached to it. It is of no serviceable use, yet the human being is so constructed that it cannot do without this useless lust. Lacan linked and contrasted jouissance with desire. Whereas desire implies a lack—one can only desire what one does not have—jouissance implies an excess of gratification, readily turning its pursuit of pleasure into an abyss of tension and pain. It has also been compared to Freud’s concept of the death drive because it seeks gratification for its own sake, disregarding limits and boundaries and compelling the subject to risk everything for an often dangerous pursuit. Jouissance is also central to a revised understanding of symptom formation. Whereas a symptom was initially thought to be a purely linguistic phenomenon, a message that was written into the body, ready to be deciphered by the Other, Freud and Lacan realized that symptoms do not readily dissolve but instead stubbornly refuse to be reached by words. This realization led Lacan to define jouissance as excess pleasure/tension residing at the core of each symptom. The subject is deeply attached to his symptom because the symptom provides an autoerotic, unconscious source of painful pleasure that the subject is loath to sacrifice.

**Jouissance, objet a.** the basic fantasm, and the symptom/sintheme are elements of the real that cannot be grasped in symbolic or tangible terms. Yet the four clinical structures Lacan laid out as hysteria, obsession, perversion, and psychosis can be conceptualized as distinct answers to five fundamental questions that lie at the genesis of each subjectivity:

- What does the Other want from me?
- How can I have or be something to fill up the Other’s lack?
- How can I answer the M/Other’s enigmatic demand?
- What am I? and for whom?
- What is my function in the desire of the Other?

**Clinical Structures**

**Psychosis**

No other clinical structure explains the significance of language and the independence of the signifier over the signified as well as the structure of psychosis. Psychosis represents the laboratory for the splitting of the mind, something Freud had already discovered in his treatise on dreams. Modeling his theory of psychosis on Freud’s analysis of the Schreiber case and on his own clinical studies of psychosis at St. Anne’s Hospital, Lacan showed how the psychotic subject forecloses the name-of-the-father. What the subject finds in place of the name-of-the father is a hole, because he cannot forgo the initial maternal satisfaction and thus remains in the grip of being the unique phallic object to complete the mother’s lack. The function of the symbolic father is to render the child’s identification with the object of the mother’s desire impossible. Yet in the case of the psychotic subject, the father cannot intervene as a third, and the mother and child remain fixated in a folie à deux. What cannot be symbolized remains a hole in the symbolic and reappears in the form of a hallucination or delusion from the order of the real. The psychotic speaks, but his words have no symbolic value. Words cannot represent things; they are things. The psychotic subject feels bombarded and persecuted by words that he hears as special commands directed to him. Unlike the neurotic subject who is the speaker, the psychotic subject is the receiver of messages from the other, he has the certitude that he is the object of the other’s jouissance. When the paternal function fails so dramatically, as in the case of the psychotic...
The perverse structure is most akin to the psychotic one, and perversions often function as the next best defense against psychosis. Similar to the psychotic subject, the perverse subject is also the passive object of the mother’s excessive maternal jouissance. He is the instrument of the Other’s enjoyment and comes close to being the phallic extension and object of the mother. What differentiates the perverse subject from the psychotic subject is that he encounters a figure in the third position but that figure is one to take the law into his own hands. A triadic structure exists, but it is perverted. The law as we know it, is not foreclosed but disavowed. The perverse subject does not obey the regular societal rules but instead invents his own rules by which he faithfully lives. He gets a kick out of challenging societal rules and enjoys transgressing the law as a means of evoking anxiety and trepidation in the Other. He derives much satisfaction from the embarrassment and anguish witnessed in the Other. For the perverse subject, the tables are turned around; the Other now becomes an instrument for pleasure, and he is compelled, without knowing why, to pursue a path of pleasure that extols his mighty stance. Few perverse patients seek analysis, but when they do, Lacan used to say that they do not come to discover knowledge about themselves but instead come to get a rise out of their analyst.

The hysterical person does not identify with her lack but instead points to the lack in the Other. The hysterical individual senses that her mother is incomplete and constructs herself as the one to complete her. She constitutes herself as the one the Other desires, so that her status to be desired rests assured. She looks for a master in the Other over whom she can reign. The hysterical person typically attempts to become what the Other desires her to be as a means of denying her own castration, yet she always encounters dissatisfaction in the end. In her unfulfillment, she keeps her own desire alive.

The analyst has to agree to stand in for the unconscious and make the unconscious present through her absence. The analyst positions herself between the patient’s wishes for idealizations and the objet a, which she is called on to represent on behalf of the patient’s unconscious desire. In not giving into the analysand’s demands for love, knowledge, and advice, the analyst creates a realm within which the patient is led back to the source of his own alienation. Holding on to the position of the cause of desire and not becoming caught in the web of the analysand’s object of desire lead in the transference to something other than an identification with the analyst. Instead of interpreting the object relations within the transference, the Lacanian analyst listens to the analysand’s manifestations of unconscious desire through his slips of the tongue, paraphrases, and bungled actions. Because the subject is divided between knowledge and truth, the analyst formed in a Lacanian tradition turns an ear to the truth of the unconscious desire and away from interpretations inspiring idealizations or identification with the analyst. The invitation to free-associate allows the analysand to speak freely and without any consideration for logic or rationality. It
is through this free use of speech that the analysand articulates signifiers that point and erupt as indicators of his unconscious desire.

Interpretations are therefore not offered to explain or convey meanings but to evoke more speech, opening up further passages to the unconscious. For Lacan, a good interpretation resembles a hybrid between a quotation of the patient’s own words [often in an inverse form] and a metaphor that does not nail down a meaning or inform the analysand of a hidden meaning but opens the patient's discourse to a multiplicity of meanings. Although the analysand invests the analyst with a great deal of knowledge and projects that she is “the subject who is supposed to know,” the analyst in fact knows nothing, and it is this nothingness that is the greatest gift she can give. Akin to Lacan’s definition of love as “giving something you don’t have to somebody you don’t know,” the analyst’s most significant gift is to offer nothingness—a non-narcissistic ego—that in turn elicits speech. By speaking from within the position of the objet a, the analyst stands in the place of the unspeakable, of that which waits to be expressed. The analyst’s desire is thus passionately restricted to discovering on behalf of the patient his unconscious desire and to allow him the space to speak at the rim of the unspeakable and discover the signifiers that have determined his desire.

Transference

In 1964, Lacan defined transference as the attribution of knowledge to a subject: “As soon as the subject who is supposed to know exists, there is transference” (1973, p. 232). The fuel of any transference relationship is the analysand’s investment into the figure of the analyst as the one who knows and who is expected to have some knowledge about the analysand. The trick is to maintain this investment while redirecting the presumed knowledge to the analysand himself. Why? Because it is the analysand who walks into analysis with a knowledge he has repressed and cannot bear to have. The analyst does not inform the analysand, but through investment into the analysand’s unconscious and free association, the analyst creates the space for the analysand to hear himself and to listen to what speaks from inside his repressed unconscious desire. Lacan distinguishes between imaginary and symbolic transference. The imaginary transference is constructed between the analyst’s and analysand’s egos and specular counterparts. Strong emotions of love and hate, idealization and contempt, and futility and strong need typically unfold along this imaginary axis [see schema L, the axis between a and a’ [Figure 16–3]]. The symbolic transference pertains to the repetition of structures and the aspect of history that repeats itself in the life of the analysand and across generations. Through frustrating the analysand’s demands for knowledge and love, a frustration is created that allows for the analysand’s unconscious desire to speak through dreams, enactments, mistakes, and surprises. Lacan cautioned to interpret the transference directly because such explanatory interpretations risk positioning the analyst into yet another idealized figure who knows and understands, thus repeating the cycle of imaginary configurations. Hence it remains crucial during the psychoanalytic cure that the analyst maintain the place of and for the Other so that the analysand can find the place from which his desire was constructed for the Other.

End of Cure

For the subject to speak in his own name, he must have “crossed the plane of identification” and traversed “the fundamental fantasms” in order to reach a change in subjective position toward the Other. Crossing the plane of identification involves the analysand’s profound recognition that his whole subjectivity was constructed through and for an Other. All the imaginary relations formed along the imaginary axis between the me and the idealized ego are put into question and show their fragile face. Because there is no longer a guarantee of those signifiers that define the subject’s being, the analysand is forced to confront both the void of the Other and the void inside of himself. Robbed of all identifications (imaginary and symbolic), the subject comes face to face with his unconscious and the ways he has been led away from his original desire. It is this confrontation with the void, with this kernel of no one holding the strings to his being, that brings the subject to the edge of the real. The analysand has to be brought to this brink of nothingness as a desiring subject to speak his own desire.

The fundamental fantasy is a deeply held unconscious construction that embeds the subject’s solution to the Other’s quest. The fantasms installs itself around the way the infant deals with the loss of the primary object and represents a lasting structure through which the subject defines desire toward the Other. The aim of the drive is to obtain satisfaction not so much through the object but through the fantasms attached to the object. Hence the subject is intensely fixated on the fantasms—perverse, abject or depressing, and humiliating
as it may be—so as not to lose the fundamental source of unconscious pleasure/jouissance that is attached to the object of the drive. The fantasm constitutes the important link between the subject’s drive behind the subject’s desire and functions as the essential protection against the primary loss of the Other. Crossing the fundamental fantasm eventually spells out to the subject how his relations to the Other have been compromised so as not to lose an important source of jouissance through a rigid way of finding unconscious pleasure in suffering or dominating or making himself useless or useful to the Other. It takes years to arrive at such a construction, but when it finally emerges, it always surprises the analysand and analyst alike in the simplicity in which it arrives. “Why am I not the most important object to you?” was one patient’s way to reconstruct his previous idealized and failed relationships. In a constant pursuit of crafting himself as the most necessary and useful person to the Other, he had continuously reconfigured the erotically filled relation to the primary Other through a number of unreachable and rejecting women in his life.

In the end, then, the symptom that may have brought an analysand into an analysis is no longer experienced as a foreign body but as a body that is familiar to the subject, something that he can live with and accept as a reminder of the separation from the Other and as a construction of his own being.

---

**KEY POINTS**

- Lacan understood his own writings as a radical return to Freud, to the discovery of the divided subject who is split by an unconscious desire located in the desire of the Other.

- Instead of privileging the Other as an external figure, Lacan anchored human subjectivity in the basic structures of language, culture, and the unconscious. The subject does not use language to express himself; instead, language precedes the subject and structures him in his innermost thoughts and desires.

- Instead of a developmental schema, Lacan proposed a structural model in which the subject lives within the three interrelated registers of the imaginary, the symbolic, and the real. While the imaginary describes the world of images and illusions, and the symbolic the world of language and laws, it is the realm of the real, of the unsymbolizable and inexpressible dimension that punctures human existence in powerfully invisible ways.

- In the Lacanian clinic, the analyst’s desire is passionately restricted to discovering the analysand’s unconscious desire. Whereas the figure of the analyst is invested with the fantasy of being “the subject who is supposed to know,” she instead assumes the position of the objet a, the cause of desire, which in turn allows the analysand to speak at the edge of the unspeakable and discover the signifiers that have shaped his unconscious desire.

- Jouissance refers to excess unconscious pleasure that is unserviceable but provides an endless source of painful pleasure for any symptom formation. Through the naming of one’s desire and the ensuing realization of one’s lack, jouissance is thought to be diminished in the subject’s speaking body.
References


Infant Research and Adult Psychotherapy

Stephen Seligman, D.M.H.
Alexandra Murray Harrison, M.D.

RECENT TRENDS IN CONTEMPORARY psychoanalytic psychotherapy practice are influenced by clinical and research findings about infancy and early childhood. Current developmental research is consistent with findings in related fields, including neuroscience, psychopharmacology, trauma research, psychoanalysis and affect research, among others. In this chapter we approach the relationships between developmental findings and clinical practice, mindful of the complex relationships between infancy, childhood, and adulthood. First we offer an elaboration of the key postulates, followed by a survey of the contemporary psychodynamic transactional-relational-developmental orientation as supported by the developmental research, including attachment theory. We then discuss the implications for dynamic-psychoanalytic clinical theory and technique.

Core Ideas

In the subsections that follow, we discuss these central ideas from psychoanalytically oriented infancy research: 1) social relationships are the essential source and site of human development and a fundamental impetus to psychotherapeutic change; 2) human relationships are best understood from a transactional viewpoint that stresses the fundamental intertwining of individual persons and specific factors of developmental systems; 3) effective psychosocial development occurs intersubjectively; 4) nonverbal communication is an essential organizer of interpersonal experience and individual personality; 5) attachment theory and research have demonstrated strong correlations between early experience and later personality organization and psychopathology.
Relationships as Fundamental Motivators and Organizers

There is now consensus among development researchers that the relationship between infant and parent is the fundamental unit in which development takes place and that the creation and maintenance of ties to other people are central motivations for infants. Humans are prepared, from birth onward, to communicate so as to promote caregiving and the formation of significant emotional ties (see, e.g., Ekman and Friesen 1969; Stern 1985). Over time, through evolving sequences of signals and responses, infants and caregivers continually influence and regulate each other’s internal states and behaviors. Similar patterns of self-regulation, mutual regulation, and mutual influence apply in later childhood and adulthood, albeit in more sophisticated and complex forms. These early interaction patterns have been shown to exert an influence into adulthood (Jaffe et al. 2001; Main 2000). [For excellent reviews of the developmental research, see Schore 1994; Stern 1985; and Wallin 2007, among others.]

The following example, drawn from ordinary infant-parent interaction, is illustrative:

A 7-month-old and her father, face-to-face, are recorded on a video, such that the infant is shown on the left side of the screen and the father on the right. The father smiles. An instant later, the baby lifts her head, coos, smiles, and fixes her eyes on his face. He responds, “Hi! Hi!” as his brows lift and his eyes brighten. Lucie coos even more brightly and loudly, starting to lift her arms enthusiastically. Dad lifts her into the air, and Lucie laughs and waves her arms in rhythm with the pace at which the father is lifting her upward and forward. Their vocalizing follows a similar rhythm.

The Transactional Perspective: Dynamic Process at the Core of Development

The transactional perspective places relationships at the center of both developmental and clinical theory, proposing that living systems (including human beings) organize themselves in dynamic, nonlinear patterns. For infant-parent systems, such factors include genetics, epigenetics, intrauterine effects, affect, sensorimotor growth and development, temperament, the social surround, parental sensitivity or psychopathology, caregiving, and countless others (Sameroff and Emde 1989; Sander 2008).

Here is a hypothetical but realistic illustration. Consider a mildly depressed single mother with each of two imaginary babies, one of whom is constitutionally persistent. Her depression would likely have a less damaging effect on the persistent infant: The baby who grows up quickly may never evoke the engagement she needs from her mother, whereas the persistent one might eventually succeed. Over a series of transactions, the less persistent infant might withdraw, amplifying the depressed mother’s sense of being rejected, leading to further withdrawal on both sides, and so on. In contrast, the persistent infant might disconfirm the mother’s anticipation of rejection, encouraging her to respond in the future and thus reinforcing the child’s ongoing efforts.

Intersubjectivity as Core Motivator and Organizer

Infant researchers have shown how individual identity and the sense of connection with others are related, apparently paradoxically, individuality depends on being recognized by others who see you as you are. This intersubjective perspective further emphasizes the process of mutual recognition, in which one person understands another while feeling separate, even while the very act of seeing the other as separate affirms their connection. Ideally, even as it is rooted in the individual’s history and personality, an individual’s experience becomes what it is by being shared with someone different who understands him or her. The infant researchers have also shown that the infant’s sense of self occurs much earlier in development than has been imagined, supported by the co-constructed early development processes (Braten 1998; Stern 1985; see also, for example, Erikson 1950; Stolorow et al. 2002, Winnicott 1971).

Another ordinary infant-parent interaction illustrates the co-creation of self-experience:

An 8-month-old baby begins biting her father’s nose, with the intensity of the bite getting greater each time. The father shrieks in a combination of delight and, eventually, pain, and the baby squeals responsively. Sometimes they break into peals of laughter, which the baby interrupts by biting again. After a number of increasingly fierce bites, he animatedly exclaims, “Stop that!” finally restraining her more definitively or trying to distract her when it really starts to hurt. This duo is constructing together an experience that is at the same time a reflection of what each of them brings to it and something new that has never existed before.
An intersubjective perspective focuses on how infant and parent “negotiate” both specific behaviors and how they experience each other. If the father had felt the baby’s biting as hostile aggression, for example, he would have responded to it differently, and her response to him would likely have shown a more restrained pleasure in biting or even anxiety. If the father had lost track of her age-related limitations in affect management and had stimulated her even more, she might have felt overwhelmed and anxious rather than feeling pleasure in her biting activities.

Infant research has focused on these intersubjective processes. Recently, computer-aided time series analysis has been used to observe dyadically coordinated emotion displays, physical gestures, and variation in intensity and timing of individual and interpersonal movements such as pacing, cueing, rhythm, imitation, and attunement, showing how these patterns communicate and mutually construct subjective experience [Tronick 2007]. Also, findings from developmental neuroscience describe how brain architecture and physiology are organized to orient the infant to the interpersonal world from the very beginning of life (see, e.g., Wallin 2007). This includes current research on mirror neurons, which register observed motor activity so as to lead the observer to feel as if he or she were making the motion while knowing that it is being made by another (“embodied simulation”). This microprocess of intersubjectivity provides an inner sense of another person’s experience as something similar to one’s own but occurring to someone else [Gallese 2009; Rizzolatti and Craighero 2004]. At a more abstract level, as one of us [S.S.] has written, “Understanding is not about experience. It is itself an experience, and this experience involves the crucial presence of another person with whom one feels secure, in part by virtue of feeling understood by that person” [Seligman 1999].

**Nonverbal Dimensions of Early Experience**

Nonverbal communication is an essential organizer of experience from infancy through the life span [Damasio 1999; Emde 1988; Trevarthen 2009]. The infant relies on motor activity, affect, and sensation to communicate with and make sense of his or her relationship with the caregiver. In the past, researchers and therapists [e.g., Piaget] have often underestimated or over-simplified these basic dimensions of experience. This misapprehension has also encouraged the view of infancy as a “primitive” stage [Freud 1920; Klein 1946]. In fact, nonverbal systems can be complex and highly organized. Affect, proprioceptive, kinesthetic, somatosensory, and autonomic experiences are integrated into an early sense of self in infancy: The infant communicates to the caregiver by movements of arms, legs, head, and neck, by facial expressions, and by vocalizations through crying, cooing, and babbling. The caregiver responds in corresponding modalities, through body temperature, skin tension, and heart and respiratory rate. Even when the caregiver speaks, it is the nonverbal, aural components of his or her speech—tone, volume, pace, and rhythm—that register for the infant. Edelman and Tononi [2000] referred to the integration of these various elements as primary consciousness; Damasio [1999] titled his relevant book The Feeling of What Happens. Nonverbal interactions organize into different patterns between infant and caregiver, many of which can also be observed in adults. These include, for example, moments of mutual regulation [as with the nose-biting play we described earlier], sequences of call and response, disruption and repair, and many others [Beebe and Lachmann 2002; Stern 1977; Tronick 2007].

Models of nonverbal patternings of behavior and interpersonal experience are increasingly at the core of accounts of personality development and psychopathogenesis. For example, the important concepts of implicit, or procedural, knowledge and memories [Grigsby and Schneider 1991; Kihlstrom 1987] are now being added to the interpersonal-affective domain. Procedural knowledge does not involve reflective awareness but instead has to do with action or affect schemas encoded and recalled in the body and emotions, such as those used in riding a bicycle, driving a car, or reacting to certain interpersonal stimuli in particular ways. The term implicit relational knowing has been coined to capture how nondeclarative interpersonal patterns shape everyday behavior [Lyons-Ruth 1998; Tronick 2007]. Therapists and patients bring to their work a repertoire of nonconscious experiences of being with another person—styles of using the body and gaze, backing off or engaging, showing negative or positive responses, moving forward when sensing permission, and creating coordinated patterns with the patient, all without verbal processing or other conscious reflection.
Specific Contributions
From Attachment Theory
and Research

The terms attachment and attachment theory refer to a specific body of theory and research that began with John Bowlby’s (1969, 1980, 1988) seminal work of the first post–World War II decades. Drawing on primate research and direct observation of young children, he asserted that the child’s tie to its parents or other caregivers is a primary, autonomous system rather than secondary to the drives and phantasies that traditional Freudians had held to be the core motivations. Bowlby went on to reformulate the analytic theories of separation and defense in accord with emerging regulatory systems models, stressing the importance of affects, especially fear. Bowlby also proposed that parental care is a core requirement for species reproduction, embedding social motivation in a broader evolutionary-biological perspective.

Subsequently, Mary Ainsworth (1978) developed the “strange situation,” in which infants were briefly separated from their mothers. Ainsworth validated three specific attachment classifications—secure, insecure/avoidant, and insecure/resistant-ambivalent—and demonstrated that attachment is a cross-cultural phenomenon. Her work led to a worldwide network of academic researchers constituting a formidable subfield of developmental psychology. In the past two decades, this group has shepherded “the move to the level of representation,” the third phase of attachment theory. Following Bowlby’s proposal, they described the “internal working models” of each attachment classification as stable representational structures that regulate the sense of personal security around proximity to familiar people. In a major breakthrough, Main and her colleagues (Main 2000; Main and Solomon 1990; Main et al. 2005) developed the Adult Attachment Interview (AAI), a semistructured interview that classifies adults into groups correlated with the infant categories—secure/autonomous, dismissing, and preoccupied. Here the sense of personal security is strongly correlated with the ability to coherently reflect on one’s own memories and experience rather than the actual historical events. This finding is particularly encouraging for psychoanalytic therapists, whose methods support this capacity. Both retrospective and prospective studies correlating infant and adult attachment classifications provide support for the proposition that early interpersonal experience has enduring effects. Attachment researchers have reliably predicted the sense of security in adulthood, measured on the AAI, from attachment classi-

sification in the second year of life (Main 2000; Main et al. 2005). In addition, AAI classifications of prepubertal mothers predict their toddlers’ attachment classification. Taken together, these findings demonstrate the intergenerational transmission of personal security through parent-infant caregiving (van IJzendoorn 1995).

In addition, current attachment researchers have validated a fourth classification, disorganized/disoriented, applied to infants, children, and adults with attachment organizations primarily characterized by mixtures of incoherence, fear, controlling behaviors, and the like. Disorganized attachment is strongly associated with both early relationship trauma and adult borderline psychopathology (Fonagy and Bateman 2008; Main and Solomon 1990). Findings from research in other areas—the study of long-term effects of early neglect, trauma, and maltreatment on the brain and functional magnetic resonance imaging demonstrating patterns of brain dysfunction in adult disorders (see Hollander and Berlin 2008 for review)—suggest a convergence of attachment research and research in the neurosciences (Perry et al. 1995; Schore 1994; van der Kolk and Fisler 1994).

Contemporary
Psychoanalysis and
Developmental Thinking:
An Overview

Psychoanalytic theories rely on accounts of child development to support their basic assumptions. Analytic theories use their theories of early development, motivation, psychic structure, psychopathology, and clinical technique to express their basic assumptions and buttress their arguments about them. Analytic views of development can be roughly sorted into three groups: those that emphasize drive/instincts, those that emphasize relationships, and those that emphasize mixed models.

The “drive instinct baby” is primitive, motivated to reduce internal tension, and has few if any, interpersonal boundaries. Interest in social relationships is secondary to the primitive motives and is acquired in the course of development. Development is discontinuous, because infancy is so different from psychological maturity. Severe psychopathology is analogous with very early development. These models are based on retrospective inferences from psychoanalyses. Traditional Freudian and Kleinian orientations are prominent examples.
In contrast, the “relational baby” is oriented to the outside world from the beginning, particularly prepared for human interaction; social relations are a primary motive. Although the baby is very dependent, his or her mind is already organized, primed for complexity and integration as it meets a responsive caretaking environment. Despite the infant’s immaturity, early development is regarded as more continuous with later development, because similar processes organize adult personality. Primitive psychopathology is not the same as infancy, because normally developing infants are not disorganized or primitive, just less organized and more dependent. Psychopathology is a variant of development rather than a fixation to an early developmental stage. Direct observation of infants and children is given more weight. Interpersonal psychoanalysis, self psychology, attachment theory, and the ego-developmental side of Hartmann’s [1956] and Erikson’s [1950] ego psychology are all in this camp.

Mixed models preserve both images of the baby to varying degrees and with different integrations. Winnicott’s [1960] developmental scheme is the most subtle and extraordinary of these, capturing the distinctive, bodily based frailty and interdependency of the infant’s world without sacrificing a sense of the baby’s social nature. The ego psychologists who worked within the structural model continued to maintain the image of the baby’s primitivity even as they acknowledged its capacities; Hartmann [1956], Mahler [1972], Kernberg [1991], and Anna Freud [1965] and her followers may be included here.

Infancy Research and the Shift Toward Relational Paradigms

The new perspective on infant development gradually took hold in the 1980s and 1990s. This greatly extended an already influential developmental perspective that had materialized in Anglo-American psychoanalysis. Early on, ego psychology had declared an interest in motives and processes that were autonomous of the drives and called for research on child development; links to child analytic work were quite substantial.

Meanwhile, the extension of psychoanalytic treatment to a broader, “subneurotic” population led analytic therapists to reconceptualize their work in terms of developmental deficits rather than as a matter of drive-defense conflicts alone: technical constraints were modified to permit more interaction and direct emotional contact. This burgeoning interest in pre-oedipal psychopathology brought further attention to early childhood and dislocated the Oedipus complex as the cornerstone of personality organization. This shift eventually contributed to loosening the hold of the psychosexual instinct theory. Other factors also supported this dislocation and include emergent feminism and the beginnings of psychopharmacological, neuroscientific, and infant observation research.

Infant development research thus found a warm welcome in some psychoanalytic quarters, along with significant resistance. Taken along with new clinical problems, these new observations dislocated the instinct model’s assumptions about infancy and, correspondingly, about the bedrock of human psychology and the corresponding theories of early development, psychic structure, psychopathology, and clinical technique. Instead, the dyad, rather than the individual, was the fundamental unit of development, and dyadic structures organized mental life from the start. Consistent with the broader relational paradigm, the fundamental units of psychic structure were organized in two-person systems that could be manifested internally, externally, or in the intersubjective spaces between. A number of the core concepts from the infant research, then, directly paralleled an emerging innovative view of the psychoanalytic situation, one which was not only highlighted in self psychology and relational psychoanalysis but also broadly diffused in the contemporary Freudian schools in the United States.

Implications for Clinical Theory and Technique

The Psychoanalytic Relationship as a Dyadic System

The image of infant–parent as a mutual influence system supports the emerging relational-intersubjective conception of analysis as a two-person process. Thus, the image of the detached, “objective” analyst has been dislocated. Engagement, rather than positivist observation, is placed at the center of therapeutic action. As in
early development, analysis depends on the basic human affinity to be activated and changed in a social system. Interventions are mediated in the interpersonal-inter subjective process. Although the direct effects of “insight” are not dismissed, the effects of varied interactions are now appreciated by analysts.

**Intersubjectivity as an Orienting Principle: Infant/Parent and Analytic Dyads as Bidirectional, Transactional Systems**

For both infancy researchers and relationally oriented analysts, individuals are embedded in the social surround. Early development research supports the view of each psychotherapy as a specific interpersonal system: therapist and patient affect each other verbally and non-verbally in a flux of rapid moment-to-moment interactions as well as in the broad sweeps of the evolving relationship. Similarly, the infant-parent relationship is a bidirectional, mutual-influence system in which neither can be conceptualized without reference to the other: Winnicott’s (1960, p. 586) maxim “There is no infant... without maternal care” has been borne out as an observable fact.

The current interest in the inextricability of transference and countertransference specifically parallels the infancy researchers’ dyadic focus. Just as the infant activates the maternal capacities as he or she is sustained by them, the analytic therapist finds reflections of his or her own personality in the patient’s relational dilemmas. The “transactional systems perspective” [Sameroff and Emde 1989] correlates with this: transference and countertransference with one another and with other factors, rather than in a simple linear manner. Similarly, the transactional-mutual influence model also correlates with a hermeneutic-constructivist epistemology. Analytic knowledge cannot be extricated from the intersubjective field. Interventions change the situation, and the analyst’s own psychology and countertransference are implicated in “technique” [Benjamin 1995; Hoffman 1998].

**Implicit and Nonverbal Dimensions of Clinical Practice and Therapeutic Action: Internal Representations, Affect, and Interaction**

The infant researchers have demonstrated the meaningful, expressive, and influential nonverbal rhythms and choreographies of infant-parent interactions, vividly confirming the intentions of parents and anyone else who takes time to look at babies. This research proves that infants create and experience actual interactions. There are multiple pathways for making sense of oneself and the world—both conscious and not—ranging from basic neuroendocrine processes through sensorimotor feelings, emotions, auditory imagery, verbal communication, and the plethora of social and cultural forms. Psychotherapists are increasingly attentive to nonverbal details of therapeutic interactions, drawing on direct [often videotaped] observations of the infant observers and/or microanalyzing videotaped psychotherapy sessions [Beebe et al. 2005; Harrison 2003, 2005; Harrison and Tronick 2007]. Attention to microprocess shows details less visible in conventional case material, including minute variations in facial displays, bodily postures, tones of voice, and vocal rhythms, revealing fine calibrations of meaning and mutual influence ordinarily invisible to both participants. Infant research descriptors such as “disruption and repair,” “chase and dodge” [Beebe and Lachmann 2002], and “affect attunement” [Stern 1985] also apply to therapeutic dyads. Beebe used videotape of her own face with a remote, traumatized patient to evoke safety and potentiate affective recovery [Beebe et al. 2005]. Harrison (2003; Harrison and Tronick 2007) analyzed videotaped interactions in child cases lasting from split seconds to minutes in order to elucidate the details of transformations in therapeutic process. Applying the intersubjective-interpersonal approach, Seligman (1999, 2008) reformulated processes, such as “projective identification” and “mentalization,” that therapists often discuss in abstract, generalized ways.

The following vignette from the first session with a child on the autistic spectrum is illustrative.
A 4-year-old girl is building a “house for dinosaurs” with blocks. The therapist sits quietly, appreciatively saying, “Mmm.” When part of the building falls, the therapist asks, “Would you like me to pick up the block that fell down?” The girl says yes. Another block falls, and the therapist asks again, “Would you like me to pick that one up?” Again the girl says yes. They are co-creating a rhythmic predictable regulatory pattern signifying safety in the back-and-forth rather than in the words themselves. The girl places the block on the building, pauses, and then comments, with the same intonation as the therapist had previously used, “Mmm.” An instant later [without explicit awareness], the therapist says, “Mmm.” Together they co-created the analyst’s original two-part utterance. A sense of safety and mutual recognition is communicated in vocal and body rhythms and gestures as well as words.

Such nonverbal communication of psychological states is often overlooked in adult psychotherapy. Patient and therapist constantly communicate in facial expressions, physical gestures, vocal rhythms, pauses and silences, and even the rustlings of their clothes or changes of bodily position. A throat clearing, for example, may communicate stress, whereas leaning forward may communicate intensified interest:

A therapist walks into the office with her patient, a divorced middle-aged man. Without his speaking, the therapist detects a change. “Something’s up! Something good,” she remarks. The patient grins. “I’ve met someone,” he says. He tells about a new romance, and the therapist wonders what alerted her to the “something good.” As the patient turns at the session’s end, however, he makes an almost unnoticeable flourish with his head and shoulders. The therapist suddenly remembers that same gesture from the beginning of the session. That subtle movement had communicated his good news.

Such interactions occur outside of explicit awareness and are recognized only in retrospect, if at all:

After sessions with a charming, overly polite, and painfully indecisive young man, a therapist felt vaguely unhappy and irritable and eventually came to feel clumsy and inadequate. Before noticing this, he had formulated the man’s indecision as a perfectionistic reluctance to give up alternate possibilities. However, this reasonable intellectual formulation did not bring him into the patient’s experience. Noticing the patient’s nonverbal gestures, he used his annoyance and sense of inferiority to empathize with the patient.

Generally, therapists are encouraged to follow their own visceral experiences, including minute changes in breathing patterns, vocal cadences, bodily postures, and the like, and musical metaphors are increasingly suggested [see, e.g., Knoblauch 2000].

**Integrating the Perspectives: Attention to the Nonverbal With the Intersubjectivist-Transnational Orientation**

The following examples illustrate how potentials for therapeutic change can be accessed directly through action and emotional interchange, within the constructed therapeutic relationship:

The therapist of a woman in her 50s was struggling with his severely depressed patient. Over weeks of the patient’s puzzling silence, punctuated by ruminative remarks about the failure of earlier treatments, he felt constricted and frustrated, choosing words fitfully. His apparently empathic remarks were met with more pained silence or corrections. Irritated as he was, however, the therapist held back from pointing out the patient’s covert critical attitude. Instead he concentrated on “getting into her skin” through nonverbal means: Trying unobtrusively to assume the patient’s posture and repeat her gestures, he went so far as to time his own respirations to match those of the patient. Unexpectedly becoming immersed in the patient’s hopelessness and enormous fragility, he was more able to get past his annoyance. With this expanded visceral awareness, he made occasional comments about his own feelings of sadness and irritability in response to the patient’s remarks that his statements could sound “like fingernails on a chalkboard.” The patient relaxed and began talking about her deep depression and wish to die, along with her poignant will to stay alive for the sake of her adolescent daughter.

Psychodynamic attention to transference and countertransference is enhanced when the transactional, nonverbal, intersubjective processes are followed carefully:

A young man presented with a pattern of “destroying” relationships with women. Over time, he would become “blank” when he began to feel close to his female therapist. He knew that his alcoholic mother had been sexually provocative with him and speculated that she had been overstimulating when he was a baby, but without emotional effect. As the therapist carefully pointed out how his posture and breathing constricted in these “blank” states, he gradually linked these moments to fear—first with the therapist and later to the past, recalling his mother’s seductiveness. The detached states became less frequent, and the patient’s relationships improved.
The Affirmative Approach to Analytic Interaction and Direct Observation of Actual Interactions in Development

Developmental research supports an affirmative approach to interaction in the analytic setting. Action is not presumed to be regressive or to impede analytic process; interaction is not only inevitable but also potentially progressive: the point is to find the most adaptive way of solving the issues at hand, verbally and nonverbally. This respect for the actual analytic interaction is an aspect of the broader elevation of actual reality in the contemporary paradigms from its secondary position in classical instinct models.

An affirmative approach to analytic interaction is also consistent with an interest in interpretation, fantasy, and genetic reconstruction. Once we assume that interaction and interpretation are not intrinsically opposed, the question of how they affect one another can be assessed in each specific clinical situation. Although action may sometimes obviate understanding, recognition, and self-reflection, there is no convincing reason that this is generally true. In fact, understanding is often established nonverbally. This is apparent in child-parent interactions in which understanding and recognition, including specific interpretations of psychological states, are conveyed in interaction sequences. In a compelling elaboration of this, attachment researchers have shown that secure attachment and the sense of being understood are synergistic (Fonagy 2000; Main 2000; see also Seligman 2000; Slade 2009).

Past and Present in Transaction

Rather than viewing the present as intrinsically less significant than the memorial past, the analyst sees the past-present links as more fluid and dialectical: the past is carried into the present so as to be expressed and transformed at the same time. Such transactions take many forms. These include actual reenactments in current situations along with internal representations of all sorts—images, affects, bodily states, interpersonal expectations, fantasies, dreams, memories, and more. Such representations are neither precise nor veridical but instead reflect subjective experience as it is elaborated in the ongoing transactions through which any given moment in development is taken into the next, both transformed and preserved as time goes forward.

In confidently asserting the connections between childhood and adulthood, this psychoanalytic approach goes further than the developmental researchers themselves do. The academic developmentalists are generally cautious about this, oriented by their careful empiricist constraints. The ambitious linkage of present and past is particular to psychoanalysis, with its single-case orientation, its reliance on clinical inference, and, currently, its affirmative use of such hermeneutic validity criteria as narrative efficacy and goodness of fit. Psychoanalysis established itself by linking childhood and adulthood and remains the most articulate of the human sciences in this regard.

Toward a Polyphonic Model of Therapeutic Action

In the midst of such complexity and openness in clinical theory, case formulation, and practice, various modes of therapeutic action are regarded as involved in bringing about therapeutic outcomes, with their effects regarded as synergistic rather than exclusive. An incomplete but informative list includes insight, interruption of old relational patterns, creation of new conditions of safety against which established expectations can be reviewed, containment and holding, empathy and the working through of disruptions in the therapeutic tie (Beebe and Lachmann 2002; Kohut 1977), enhancement of reflective functioning, interpretation, and such innovative notions as negotiation of paradox (Pizer 1992) and the transformative “now moment” (Stern 2004). There is controversy around the idea that the new developmental orientations call for “reparenting”: the traditional rejection of “corrective emotional experience” has been repudiated, but the analogies between therapist-patient and infant-parent dynamics must be applied with circumspection [see, e.g., Loewald 1960; Mitchell 1988; Seligman 2003].

---

1 Some approaches to infant research have directly shown that the fantasy-oriented concepts can be directly observed to a greater extent than has often been thought. One of us [S.S.] has described interactive dynamics between a father who was abused as a boy and a 3-day-old infant that reflect the father’s patterns of primitive projective identification and can be seen as “structuring” such patterns in the boy’s internal world (Seligman 1999).
Therefore, both action and reflection, past and present, have a transactional relationship in the therapeutic process. Just as the past is always immanent in the present without being reducible to it, analytic interaction inevitably reflects the inner world but is simultaneously a new creation. As with the infant and parent, the resonances of the past in the present may be elaborated in interactions, including quite irrational and fantasmatric representations. With older children and adults, they may also be articulated in explicitly reflective thinking. The analyst’s task is not simply to unearth the past in the present, to undo resistances, or to attain an idealized new experience but to “find a way to be with patients that gives them the greatest opportunity, despite the odds, to make better lives for themselves” [Hoffman 1998, p. xxxi].

An ordinary vignette illustrates this approach:

Ms. A was a sophisticated and thoughtful attorney and single mother who would abruptly end her intimate relationships with men whenever she became close to someone. As her analysis proceeded, she and her analyst were able to understand how this involved a reaction to her childhood experience of erotic intrusion from her brother and uncles while her parents were remote and inattentive. She had little confidence in the transformative effects of any close relationship and was instead overwhelmed with a sense of danger and stimulating, troubling thoughts in romantic relationships and analysis.

A number of helpful sessions took place shortly before the male analyst announced an upcoming summer vacation. Shortly thereafter, Ms. A announced that she would have to stop analysis altogether, beginning with the next week’s sessions. With a tone of dismissive irritation, she said that things were getting too hard and “it wasn’t worth it.”

When she did in fact miss the first meeting of the next week, the analyst was aware that calling to suggest that she come back and talk things through might well be taken as a pressuring invitation to more suffering that might also evoke the past history of intrusive coaxing. However, not calling would be neglectful and dismissive of the close and productive analytic relationship. He did call, and Ms. A agreed to meet, albeit ambivalently. The analyst described the “relational-conflict” dilemma: If Ms. A continued, she would be succumbing to a confinement, but if she left, she would be depriving herself of something that could be very helpful, following the affective-interpersonal assumption that deep relationships could not really make any difference.

Ms. A went on to talk with full emotion about her intense “separation anxiety” and her sense that something quite bad was about to happen. When the analyst added that she must find him dangerous, she said that she in fact knew that he was not going to hurt her. He was moved and a bit relieved of his counter-transference anxiety about pressing her to continue in analysis. However, Ms. A added, this made things even more challenging, because she was finding herself in the grip of anxieties that she knew did not make sense. With this in mind, analyst and patient could now talk about how one in her family had responded to her sense that something was wrong, leaving her feeling abandoned and doubting that her own feelings were valid. She now felt freer to consider that it might turn out different here, and things went forward.

**Trauma and Attention to Actual Experience in Both Present and Past**

Current psychodynamic thinking has reemphasized trauma in its account of the origins of psychopathology. This approach draws on the feminist critique of Freud’s abandonment of the seduction theory and the current awareness, in both academic research and the popular mind, of the profound effects of actual trauma, along with direct clinical experience [e.g., Bromberg 1998; Davies and Frawley 1994; Herman 1992] and the growing interest in trauma in a number of related fields, including psychiatry, developmental neuroscience, and cultural studies. This includes both detailed psychological accounts and a recent array of findings about the direct effects of abuse and neglect on brain development [Perry et al. 1995 and Schore 1994, among others].

This approach also synergizes with the analytic attention to actual experience. Rather than starting with a preconceived set of psychosexual, or even psychosocial, challenges that must be solved to attain adequate development, this perspective looks at the particular experiences that derail development in the problematic childhood realities that lead each patient to the impasses that bring him or her to analysis in the first place. The concept of trauma is also being more broadly applied to an array of psychopathologies. This has led to a more open and case-specific approach to case formulation and technique as well as to clinical narratives in the relational-clinical literature [see Hoffman 1998 and Mitchell 1988 for some striking examples].

The emphasis on “what really happened” correlates with the respectful and affirmative attention to the patient’s subjective experience of events, including of childhood events. Rather than start from the Freudian position that experience is likely to involve significant distortion, the contemporary approach takes subjective experience as legitimate in itself, rather than parsing out the veridical events and the contribution of the irrational unconscious. This basic turn is linked to the conempo-
emporary shift to empathy as the basis for the analyst’s inquiry, as opposed to the effort to approach the analysand’s psychology as a matter of objectively ascertainable facts. Kohut [1977] and especially the intersubjectivist self psychologists have been crucial in this direction (see, e.g., Stolorow et al. 2002).

This approach also supports the recognition of an aspect of posttraumatic pathology that has not received sufficient attention until recently. In addition to the overwhelming nature of the experience itself, trauma often occurs in contexts that preclude awareness of its meanings (e.g., Bromberg 1998; Davies and Frawley 1994). When trauma is administered by someone on whom the child depends, a stance of “not knowing what one knows” (Bowlby 1988) must be maintained in order to keep the crucial relationships intact. In the classic example, the victim of parental abuse will have great difficulties appreciating how awful the beatings or sexual approaches are when they come from the same parent who may be so helpful at other times and is someone on whom the victim depends. When others act as though nothing untoward is going on, the difficulties are further amplified. This, in turn, correlates with dissociation coming to play a key role in the emerging approach to psychopathology and clinical technique, as central as the role of repression in classical theory (e.g., Bromberg 1998; Davies 1996). Rather than conceptualizing dissociation as indicative of more primitive pathology or severe trauma, this approach sees it as a form of defensive organization with varying rigidity and fragmenting effects at various developmental-pathological levels.

From this perspective, analysis is understood as facilitating the restoration and integration of aspects of self-experience that have been fragmented or detached, these often make themselves known in interactions whose meaning is not explicit or is disavowed. Bromberg [1998], for example, has called on analysts to “stand in the spaces” between the dissociated “selves,” bearing them in mind and enduring the anxiety of painful and contradictory experiences. Recent articulations of this perspective formulate the therapeutic effect of the analyst working with the various projections of the analysand in such a way as to support this aim. Davies [2004], for example, has described a case in which she found her

self absorbing and barely tolerating her patient’s projected experience of her as cruel and withholding. Eventually, she and her patient were able to talk about this in an affectively saturated way. The example of Ms. A, described earlier, is also illustrative.²

Clinical Applications of Attachment Theory

Both the attachment categories and the findings of the AAI are currently applied suggestively. Attachment categories can be used as guideposts in therapies with both individuals and couples. Slade [2009] suggested that therapists can use knowledge of attachment categories to help understand how different patients construct their attachment to the therapist, usually in a suggestive rather than definitive way, and advised considering the countertransference in a similar light.

For example, whereas traditional psychodynamic therapists might focus on aggression in a patient’s guarded and restrained presentation after a vacation, one following attachment theory might concentrate on the avoidant patient’s tendency to detach in order to minimize the loss. Similarly, a patient who talked incessantly about the break without real feeling might be understood as protecting his or her sense of security through a preoccupied, ambivalently attached pattern. A securely attached person, on the other hand, might directly express sadness or anger about the interruption. Often such observations correspond with patients’ reports of their relationships to their own parents and also to current attachment figures such as spouses and children.

Intersubjectivity Theory, Mentalization, and the Theory of Other Minds

A further evolution of attachment research has to do with what others have called “theory of mind.” Having a theory of mind allows people to see their own inner experiences and expectancies as different from those of others

²Similarities to other object relations approaches can be noted here. Winnicott’s [1960] notion of the analytic integration of the wounded, walled-off “false self” may be most resonant. Contemporary Kleinians’ conceptualizations of “pathological organizations” suggest a similar perspective because they describe psychic life becoming organized around internal object configurations that take the place of the person’s direct experience of his or her unbearable anxieties and authentic motivations and memories (Rosenfeld 1971). Bion’s [1962] conceptualization of what happens in the absence of the reflective capacity for “thinking” contains many parallels to the notion that trauma precludes awareness of the extraordinary confusion and agony that it creates (Seligman 1999).
and of the objective world in general. In adequate development, the child comes to feel a sense of agency, connection, and autonomy through being recognized as both similar to and different from others who understand his or her inner state while showing that their own reactions are different. When a mother speaks in a sad voice to her crying baby, the correspondence of her negative emotion communicates her recognition of her baby’s feeling, while the linguistic tones and rhythms connote that she is not as sad as the baby is but rather is reflecting the child’s inner feelings. Children whose experience is not responded to in this way may be limited in differentiating between their own feelings and those of others and therefore rely excessively on projections in trying to relate to others. Terms such as mentalization, metacognition, and reflective functioning have been offered to capture this crucial developmental capacity (Fonagy 2000; Main 2000, Seligman 2000), whereas psychoanalysts in the British object relations and American relational traditions have offered similar conceptualizations in terms such as thinking (Bion 1962, 1965) and the intersubjective third (see Benjamin 1995; Ogden 1994).

Some psychodynamic workers consider mentalization as one aspect of a more general approach, whereas others take it as the central point of their clinical and developmental theory (e.g., Fonagy 2000; Jurist et al. 2008). One of us (Seligman 2008) described how a patient entered psychotherapy with a reflexive fearful and angry view of those whose interests and perspectives did not coincide with hers. As she moved from blaming others, she came to see that other people might simply have motives of their own that do not originate with her, declaring that she would serve her best interests not by organizing her relationships around a sense of grievance but by reflecting on her emotional reactions and recognizing other people’s subjective experiences.

Some clinical innovators are proposing novel syntheses of varied clinical techniques. Psychotherapy strategies have been standardized and validated as effective treatments for posttraumatic stress disorders and borderline personality disorders, both of which have been linked to deficits in reflective functioning (see, e.g., Clarkin et al. 1999, Fonagy and Bateman 2008). An array of innovators have proposed syntheses of psychodynamic approaches with infant development information so as to intervene with serious relationship problems in infancy and early childhood (see, e.g., Seligman 1994).

**KEY POINTS**

- Infants and their caregivers are involved in active, co-constructed relationship processes from birth onward. These processes involve mutual influence and mutual regulation of emotion, bodily and mental states, and inter- and intrapersonal meanings.

- Social relationships are central motivators and organizers of human development throughout the life cycle.

- Early caregiving relationships have enduring effects on ongoing patterns of social relationships and self-experience. Traditional as it may be in psychoanalysis, this proposition is increasingly supported by developmental neuroscience, psychopathology, and developmental-social psychology. Attachment theory and research, in particular, have demonstrated the salience and durability of patterns of the pursuit of personal security through attachment to other people, with remarkable correlations between infancy and adulthood and across generations.

- Emotion regulation, intersubjective recognition, and other processes of “meaning making” are core motivations. All of these involve processes that coordinate the caregiving relationships and the infant’s developing self-organization. When early interpersonal care deprives or distorts the baby’s or child’s potential for personal agency, coherence, security, integration, and the like, subsequent psychopathology, especially personality disorder, may be likely.
• Early traumatic experiences are likely to have enduring psychopathogenic effects, often quite serious.

• Observations of the (necessarily) nonverbal patterns of communication and self-organization in infancy have drawn attention to the extent to which similar nonverbal processes, including emotions and bodily experiences, shape interpersonal interactions and senses of self and of others throughout the life span.

• The development of individual persons is best approached as embedded in the various contexts within which it takes place and cannot be understood unless those are taken into account. These include genetic, physiological, familial, cultural, and economic factors as well as (apparently) dyadic caregiving systems such as maternal care. The effects of single factors are best assessed as they are interacting with these various contexts. *Transactional and nonlinear dynamic systems* models are increasingly influential in developmental thinking.

## References

Davies JM: Whose bad objects are we anyway? Repetition and our elusive love affair with evil. Psychoanalytic Dialogues 14:711–732, 2004
Herman JL: Trauma and Recovery. New York, Basic Books, 1992
Trevathan C: The intersubjective psychobiology of human meaning: learning of culture depends on interest for cooperative practical work—and affection for the joyous art of good company. Psychoanalytic Dialogues 19:507–518, 2009


SECTION IV

Treatment and Technique

Section Editor: Steven H. Cooper, Ph.D.
Transference, Countertransference, and the Real Relationship

Adrienne Harris, Ph.D.

In the years since the first edition of this volume, changes in the concepts of transference, countertransference, and the "real relationship" have been sometimes steady and sometimes dramatic. In most analytic schools there is an increased emphasis on intersubjectivity, the inevitable and complex interplay of both partners in the analytic dyad. At the same time, each of the major traditions—Kleinian, object-relational, relational, self-psychological, interpersonal, and Freudian in various forms—continues to parse these interactions with different emphases and clinical implications. There is a worry in some quarters that with the impressive expansion of the concept of countertransference, the golden insights of transference analysis may be diminished. Yet there is no doubt that the analytic relationship in all its intricacies continues to be at the heart of what makes our work psychoanalytic.

In my view, the most dramatic changes are in the arena of the real relationship. Although this term has, historically, been used for the unremarkable, non-transference-driven aspects of the analyst (e.g., his or her role as frame setter), there is now a deepening interest in the personality, character, and unconscious projects of repair and relationship that the analyst brings to the work. Perhaps most dramatically, the expansion of what we think of as the analytic instrument now includes bodily states alongside perceptions, affects, fantasies, and thoughts. Now, once one sees an apparently new trend, it becomes

---

I would like to thank Henry F. Smith, Glen Gabbard, Lewis Aron, and the late Rita Frankiel for careful readings of the earlier version of this chapter and Steven Cooper for help with this version.
possible to see its precursors. The very modern preoccupation with the analyst as body, mind, and history has roots in earlier figures and writers.

“Discovery” and Early Developments

Transference and countertransference are the defining processes of a psychoanalytic treatment. Inevitably, over a century of work, these terms have been subject to wide and quite distinct interpretations and technical uses. Yet amid such differences there is an abiding conviction among psychoanalysts that it is primarily in the crucible of the analytic relationship in which two people talk that change and freedom from illness can occur.

Transference appears in Freud’s essays [Freud 1911, 1912a, 1912b, 1913, 1914, 1915] on technique as a discovery, whereas countertransference discussions function mostly as a cautionary tale. In a number of ways, Freud’s discovery that patients revive and relive the crucial conflicts of their psychic lives in the analytic relationship was remarkable. First, analysis of transference entailed a break with earlier powerful and compelling procedures of suggestion and hypnotic induction, techniques thought to reveal and release hidden sources of pathology and pain. Second, almost immediately Freud made a second discovery, namely, that transference is used by the analysand as resistance to change but that this development could be turned quite uniquely toward psychic growth. It is as though Freud’s intelligence functioned like a heat-seeking probe, burrowing into the most tender and incendiary aspect of the analytic relationship and finding there both trouble and revolution. Third, Freud was aware from the beginning, even if incompletely so, of the dangers, fascination, and traps that hide in transference and countertransference. Freud grounded his theory of therapeutics in the most unstable, enigmatic, transpersonal, potent aspects of the analytic situation and never looked back.

Finally, it seems worth noting that the discovery of transference is a rather astonishing victory over personal narcissism. To come to the conclusion that a person who makes an intense declaration of love to you does not really love you but loves someone else in an act of transference takes considerable self-esteem and reflectivity. To the physician it represents an invaluable explanation and a useful warning against any tendency to countertransference that may be lurking in his or her own mind.

The therapist “must recognize that the patient’s falling in love is induced by the analytic situation and is not to be ascribed to the charms of his or her person. It is always well to be reminded of this” [Freud 1912a, p. 160].

In retrospect, surprising “discoveries” often carry the seeds of many earlier processes and practices. Many have argued that transference is no exception. Mannoni, noting how frequently Freud mentioned hypnosis when trying to account for the mechanisms of transference, noted that transference is what we have left of possession [Mannoni 1980, cited in Borch-Jacobsen 1989, p. 98. In many of the ensuing discussions of transference that I review here, when authors try to account for the mechanics of transference, something like an altered state in the analyst as well as the analysand is often being outlined. There is, it seems, some trance in transference. The remnants of magical elements in analytic experience have also been tied to Freud’s perhaps ambivalent relation to traditions in Jewish thought, particularly its mystical tradition [Bakan 1958].

Freud’s reservations about written communication regarding transference and countertransference may join up with concerns regarding confidentiality and protection of patients as well as concerns of professional matters. Part of the renewed interest in analytic subjectivity and matters of technique and disclosure might be seen as an aspect of the ongoing question of who knows what and what information has what effect, concerns that are both self-serving to the analyst and preserving of the integrity of treatment. This paradox in intentions and access to knowledge is perhaps irresolvable. Its ongoing presence has a history in the earliest work on technique and continues to be powerful. (See Dupont 1988, Falzeder 1997, and Haynal 1997 for extensive discussions on the complex crucible of Freud’s relations with Ferenczi as the site for the development of theories of transference and technique.)

In the early papers on technique, Freud’s injunctions on no note taking, no advice, no intellectualizing, no use of the patient or treatment for scientific enterprise, and no offering of analytic writing to the analysand were all proposed in order to enhance transference and remove the barriers between speaker and listener. “Evenly hovering attention” was, for Freud, a guard against overwork, a way to keep distinct the differing relations with numbers of patients and to create conditions in the analyst for a kind of receptivity. To a modern ear, these accounts describe a lot of the conditions for meditative practices, for the inducing and self-inducing of altered states of consciousness, and for the Eastern practices that attempt to dissolve ego and attachment in order to receive input from another.
Although many of the early generation of analysts thought of their analytic work as a direct application of Freud’s programmatic work on technique, Sandor Ferenczi, always the complex son, both admired the work and pushed the envelope (Aron and Harris 1993; Bonomi 1999). Ferenczi (1909) took up the ideas and proposals from the technical papers and began to worry them into more provocative and potentially powerful forms. He used and discarded procedures that indulged and those that frustrated the patient, guided by his overarching interest in the emotional impact of each person on the other. There are contradictions in Ferenczi’s approach. On the one hand, he widened radically the play and province of transference, as the Kleinians would do after him. Transference phenomena were ubiquitous in the analytic relationship. On the other hand, he held out a separate space for a “real” relationship with the analyst as a “real” person. We shall see how this term real transforms over the century of psychoanalytic theory building. Here the term seems to acknowledge the impact of the analyst’s psyche [hostile and loving] but also, enigmatically, keeps something out of the transference (see Ferenczi 1932).

The status of influence is an aspect of transference and countertransference experiences that exerts a kind of gravitational pull on efforts in the field to sort out what happens, why it happens, and how it helps. The official version is that transference is the revolutionary break from hypnosis. However, we can see a continuing debate over the power of speech’s structural properties (symbolic register, interpretation, reflective functioning) and pragmatic, rhetorical, and object relational properties (cures by love, force of power, erlebnis, corrective emotional experience, or procedural now moments).

The Real Relationship

One quandary that threads through discussions of technique, transference, and countertransference is whether there is, in addition to experiences of transference and countertransference, a “real” relationship. It is as though this term real unsettles the field of inquiry. Do not transference and countertransference subsume all the aspects of the relationship? What surplus meaning or what unmanageable aspects of the analytic experience require this category of the real?

Lipton (1977) made a good case for the importance and presence of such a distinction in Freud’s own thinking, in that he distinguished what Freud actually did from the idealized picture of Freudian technique in the classical tradition. In fact, Lipton argued that a word such as classical already idealizes and perhaps fetishizes technique in a way rather different from Freud’s own way of practicing. There is a fascinating and illuminating perspective on Freud’s technique and the real relationship seen through a recently published collection of the circling correspondence among the symbolist poet Hilda Doolittle [called H.D. (1956)]; Bryher, her lover, who was also an involved member of the psychoanalytic community; and Freud (Friedman 2002). The letters of this fascinating group, written during and after two periods of analysis that H.D. had with Freud in Vienna in 1933 and 1934, give a fascinating view of Freud’s power as a clinician and the tremendous strength of transference phenomena coexisting with many strands of a “real” relationship. There is some considerable confusion of real and analytic ties. There are instances of dual functioning that professionally we would criticize. Bryher and Freud exchanged letters about the financing of various aspects of the psychoanalytic movement during H.D.’s analysis, which was being paid for by Bryher. However, there are, throughout the correspondence, equally compelling signs of the early emergence and continuing potency of transference phenomena and their impact on H.D.’s psyche.

Greenson (1967) wrote the definitive midcentury account of the mix of transference and real relationship. He held a distinction between neurotic and non-neurotic aspects of the analysand’s relationship to the analyst. In this, he contrasted Stone’s ideas involving a variety of relational configurations between analyst and analysand [and something like a working alliance] with what he saw in the Kleinian approach as a relative indifference to such an ego-based alliance. Greenson went on to distinguish and hold separate places for a working alliance and a real relationship. The working alliance encompasses many elements—continuity, commitment, ways of being within the hour, management of time and money—elements that we would think of as aspects of the frame.

Greenson, in discussing the real relationship distinct from matters that deepen or hold the therapeutic alliance, spoke about genuineness [including straight-forward admission of errors] and an orientation to reality as well as an appreciation of the extra-analytic reality of the analysand [e.g., family, frailties, contexts]. He saw the working alliance as a permanent aspect of an analysis and the emergence of the “real relationship” as an aspect of the later stages of analysis. We shall see that in the 1990s, with a great sea change in the understanding and exploration of countertransference, the real rela-
tionship was explored and understood in a somewhat different way. In 2011, terms such as *real relationship* and even, to some extent, *countertransference* seem obsolete in the context of the contemporary focus on enactment, a process in which analyst and analysand join, inevitably engaging in some processes that remain unconscious to all the participants.

**Evolution of Transference and Countertransference Matrices**

**Classical Psychoanalytic Theory: American Ego Psychology**

Over the twentieth century, there was a steady attempt at expanding and deepening the concept of transference within mainstream psychoanalytic circles. Transference phenomena could be seen as a kind of growth industry in psychoanalytic writing, whereas countertransference remained relatively undertheorized until the 1990s.

Orr’s review in the 1950s [Orr 1954] showed the field to be deeply engrossed in the workings of unconscious phenomena. There is disagreement with the interpersonal perspective, the work of Horney in particular, but it is clearly part of the canon. There is scarcely any discussion of countertransference, and what occurs is made a matter of the analyst’s unconscious and is treated as an intrusion in the work of transference analysis.

Transference is useful as a ground for interpretation, not for its relational properties. However, Orr (1954) did note some exceptions to this dominant view. MacAlpine (1950), for example, thought countertransference to be inevitable and to have been disavowed by analysts because of the strains of hypnosis that must be excised from analytic understanding. Fenichel (1940a, 1940b), Orr noted, was another figure with a worrying glance at countertransference. Interestingly, what Fenichel worried about was the analyst’s defenses and anxieties, not the dangers of sexuality. Equally interesting to a modern reader, Orr thought there was really little need to write about or discuss these matters, because the management of countertransference was finally dependent on the honesty, self-reflection, and analytic history of the analyst.

Orr’s treatment of the elements of the real relationship is intriguing. He drew on the Balint’s ideas to consider the ways the material conditions of the analyst’s world impinge on the treatment:

[They impinge] in countless ways—the nature and arrangement of his office, the hardness or softness of his couch, his way of covering or not covering the pillow, the frequency, timing, affective emphasis and even diction of his interpretations and, indeed, his whole way of working, some of which in itself is likely to be a carry-over from the transference to his own training analysis—and it is the sum total of these and other, subtle or not so subtle influences, coloring, if not markedly affecting, the patient’s experience. (Orr 1954, p. 649)

One of the most powerful developments in technique from this focus on ego functioning is the work of Paul Gray (1994). Gray, in his technical recommendations (called initially “close process monitoring” and later “close process attention”) counseled for an approach to transference in which the defensive aspects were the primary sites of work. Gray’s recommendation to attune to the surface in any analytic hour was intended to provide experience-near material for the analysand, an approach designed to augment and expand consciousness and ego function.

I approach the contemporary classical consideration of transference and countertransference through the work of Loewald (1971, 1975, 1986) and Schafer (1997). Loewald appreciated the theatricality of transference—its repeating of a repetition, its mimetic nature—and did this without getting mired in the struggles of whether it was authentic or produced/Performed. Because his way in was through the theory of rhetoric and performance in theater, the question of falseness does not exactly arise. Transference enactments or interactions are artistic forms fueled by primary process, intense affect, and transference phenomena, and their careful handling in analysis took an artist’s hand, not the hand of surgeon or scientist.

One of the striking aspects of a long look back at theoretical and clinical work on transference and countertransference matrices is the distinct but parallel channels through which ideas evolve and flow, often with little crossover. Loewald, for example, in his quite prescient and forward-looking 1986 essay “Transference-Countertransference,” does not reference Racker, yet he develops a very integrated picture of these processes:

I believe it is ill-advised, indeed impossible, to treat transference and countertransference as separate issues. They are the two faces of the same dynamic,
rooted in the inextricable intertwining with others in which individual life originates and remains throughout the life of the individual in numberless elaborations, derivatives, and transformations. One of these transformations shows itself in the encounter of the psychoanalytic situation. (Loewald 1986, p. 276)

Loewald saw analytic empathy—the emotional investment of the analyst and the analyst’s ability to tolerate extremes of feeling—as a central element in the curative potential of psychoanalytic treatment. This is certainly a modern sensibility, but it is also true that contemporary classical analysts have made the paradox and conflictual approaches more center stage. Schafer (1997) pointed out the contradictions in Freud’s own earliest formulations. There is the startling fact of the discovery of transference, the direction to analysts to override their own narcissism and find the prehistory being parachuted into the analytic relationship. Yet in the earliest use of transference, Schafer argued, Freud was mostly interested in a kind of controlling hygiene. Transference effects, muddying and clouding the analytic waters, were to be swept up and away to allow the keen penetration of analytic understanding. Patriarchy and authority in these earliest writings occluded the revolutionary nature of the “discovery” of transference.

Examining the development of Freud’s views of transference, Schafer had an interesting perspective. Like a number of feminist critics, Schafer noted that the suturing of transference to father love, to oedipal ties to the father, constricted Freud’s clinical and theoretical vision. Schafer also differentiated how Freud got tangled up in the distinctions and relations of transference and resistance [a remnant of that patriarchal stance] but on the other hand blazed up interesting conceptual and clinical insights in linking transference and acting out. Perhaps we might see in this light that when Freud put aside his own resistances [his difficulties in taking up the feminine], he found a different access to the complexity of transference—the mother ties, the bisexuality, and the multiplicity of sexual desires.

The current situation within the more classical tradition is one of ongoing debate within and across orientations on the status, function, and limits of countertransference analysis (Gabbard 1995). Jacobs’s (1991) original theoretical work on the uses of the analyst’s countertransference drew from object relations, from contemporary Freudians (Sandler 1976), and from self psychology. With Jacobs, countertransference emerged in more florid and multiply configured forms, as rich in its own way and as problematic as transference. In Jacobs’s work, the analyst’s instrument and the creative use of body, mind, fantasy, and interpersonal experience are all crucial for analytic work (Jacobs 1999, 2001). Now countertransference is not a problem but a solution, a necessary register for the analyst’s work. Built into the suppositions of Jacobs’s use of analytic subjectivity was his assumption of the subtle and pervasive communications—meta, conscious, preconscious, and unconscious—that undergird and network through the experiences of all analytic couples. Meaning-making being so richly co-constructed inevitably requires that the analyst understand and explore very deeply his or her own part in these complex communications.

For Jacobs and Smith, and for the more object-relational analysts such as Ogden (1994, 1995) and Gabbard (1994a, 1994b), even as they differ, the analyst’s subjectivity is crucial for the self-analysis that moves analytic work forward. In many instances more is disclosed to colleagues than to analysands. Countertransference more typically is now thought of as enactment. Analytic subjectivity is seen as inevitable or ubiquitous if not for everyone “irreducible,” a term coined by Renik (1993) to speak to the dense, ever-present potency of the analytic subject in clinical dyads. Enactments and intersubjective rich co-constructions are opportunities for psychic movement, although not unambivalently so. This perspective seems relevant for theorists with one-person and with two-person psychologies.

The Kleinian Tradition

Much of the rich understanding of the power of intersubjective process on analyst, analysand, and treatment is deeply indebted to the evolution in Kleinian thought from Klein through Bion (1959, 1961), Rosenfeld (1987), and Racker (1968) and into the next two generations. The work of Segal (1962, 1967), Joseph (1989), Spillius (1988a, 1988b, 1993), and O’Shaughnessy (1983), divided in its allegiance to Klein and the increasing influence of Bion, was followed by the current theoretical and clinical work by Britton (1989), Steiner (1998), and Feldman (1993). For Bion the maternal countertransference reverence was a crucial analogue to analytic work. The analytic instruments, mind and heart and body, are aspects of a metabolizing function whereby the patient is held, including held in mind. The stirring of fantasy, disruptive affect, and mental states in the analyst was a crucial site of analytic understanding. Analytic instruments are from this perspective porous structures through which archaic fantasy, including destructive and aggressive wishes and fantasies, can come to light and become the occasion for interpretive work.
In this evolution, the more alienated, metapsychological treatment of projection and projective identification morphed into a living, breathing interpersonal process whereby minds, affect states, and bodies are cannibalized, evacuated, altered, and perturbed. The most striking clinical innovations come in the work of Betty Joseph [1989], through which Kleinian and post-Kleinian ideas have become very widely influential. What characterizes this work is a careful and systematic appreciation of the presence of powerful unconscious anxieties expressed in the transference. Steiner [1984] made a good case for the clinical utility of this kind of listening for unconscious phantasy expressed as transference manifestations and subtly pervasive within the analysand’s communications.

The Kleinian tradition’s attunement to countertransference primarily uses its phenomena as a source of clinical data on the patient’s dynamics. In regard to countertransference, the theoretical evolution of the concept of projective identification and Bion’s development of the notions of containment and alpha-function [a mental and psychological capacity in the analyst to metabolize and absorb primary process material and represent it to the analysand] led to a keen appreciation of the infusion of analyst mind and affect and body ego with the analysand’s unconscious and preconscious process. Projective identifications of the analyst remain an undertheorized aspect of Kleinian thought, except in the work of Alvarez [1992], who, in her book Live Company, described clinical work with autistic and borderline children that relied a lot on her countertransference intuitions. She understood these intuitions as projections from patients but also saw them in deeply interactive and intersubjective terms.

Because the Kleinian interests have been addressed to early and profound and normal conditions of fantasized destructiveness and aggression, there is a considerable attunement to negative therapeutic reaction and to the power and unconscious presence of negative transference. The Kleinians are wonderfully astute at letting us think and hold reveries about the hostility in compliance, the subtle undoing and demeaning of the analytic project. It is to such endeavors that they mostly give the term perversion. In Joseph’s hands, perversion—although still tied formally and clinically to sexuality—is most deeply tied to destructiveness. Perversion in the analysand encompasses the myriad strategies, conscious and unconscious, aimed at destroying the object who provides help and helpful experiences as well.

One can see the distinct strategies of an object-relational and Kleinian approach to countertransference and transference phenomena where destructiveness and the determination to spoil a good object dominate the clinical situation. A Winnicottian, specifically someone such as Emmanuel Ghent, would be interested in destructiveness and sadism as a form of finding the other. The Kleinian approach, current and historically, would be more centered on the destructiveness as an often primary phenomenon, saddled, of course, with guilt and persecutory anxiety, but at its basic level it would be about destroying, not finding. Clearly different clinical choices attend these theoretical differences.

One of the more intriguing Kleinian rivers to follow surfaces and flourishes in Argentina in the work of Heinrich Racker. In a review of the Latin American tradition on countertransference phenomena, de Bernardi [2000] located Racker’s influences as more Kleinian than Freudian, drawing deeply on ideas of unconscious fantasy and of the mechanisms of projection and introjection as binding aspects in the analytic situation. Racker himself also looked to Ferenczi and to the particular constellation of object relations writing on transference and countertransference done by Heimann [1982] and Little [1981] and one of the central sources of Ferenczi ideas about the analytic relationship, Michael Balint [1950; Balint and Balint 1939]. Racker has been a profound influence on the interpersonal tradition.

Racker, most interestingly, developed the idea that manic reactions in the analyst can lead to flooding the patient, to impeding analytic progress with too overwhelming a reactivity to the patient’s material. He analyzed the resistance [in the field and in the analyst] as a matter of shame. He concluded his essay on countertransference with the following thoughts: “Freud once said that his pupils had learnt to bear a part of the truth about themselves. The deepening of our knowledge of countertransference accords with this principle. And I believe we should do well if we learnt to bear this truth about each of us being also known by some other people” [Racker 1968, p. 194].

The British Object Relations Tradition

The middle group, or independent tradition, has (sometimes obscure) historical links to Ferenczi via Balint. It is perhaps for this reason the tradition with the deepest appreciation for the curative aspects of regression. Some of this flavor of regression and rebirth lingers in Winnicott’s [1974] and Balint’s [1950] ideas of transference to the point of original breakdown.

Winnicott is a crucial figure in the emergence of ideas about countertransference, particularly in his concepu-
alization of the mutative and necessary role for aggression as an aspect of countertransference. This work cast a long shadow in the independent group, from Margaret Little, who spoke eloquently of the depth of transference forms of hate and blocked vitality, to, in a later generation, Christopher Bollas, who promoted a careful attunement to countertransference as the bearer of disavowed aspects of the analyst. Winnicott’s two papers, “Aggression in Relation to Emotional Development” [Winnicott 1950] and “Hate in the Countertransference” [Winnicott 1947], both identify the inevitability of aggression and hatred in the analyst but also motivate its clinical utility. Hatred is paired with, not opposed to, love and primary maternal preoccupation. Hatred is boundary making, aids in separation, and aids in the ability of the analysand to disentangle fantasy and reality in order to lessen the dangerous experience of omnipotence. In this way the hating aspect of the analyst, including as Winnicott brilliantly suggested the hatred that is in the ending of the hour, is a crucial ingredient in change in the analysand.

I include Paula Heimann [1982] in this grouping, although her initial relationships after her flight from Vienna were with the Kleinian group. She herself dated her beginning independence from Klein and her connection to the worlds of Ferenczi and Balint with her essay “On Countertransference,” written in 1949–1950 [Heimann 1950]. That essay has a quite balanced mix of insistence on the rich play of emotional responsiveness in the analyst and caution as to emotional expression. She seemed to have considered analytic countertransference as a kind of creation of the patient that is useful to the analyst. We might note her nascent ideas that have developed through Bion, Ogden, and others on the use of analytic reverie and the analytic object as a new creation.

In the British middle group tradition, the modern evolution of these ideas has been in the work of Sandler [1976] and Bollas [1979, 1987], whose work is an interesting bridge between Winnicott and Fonagy. Bollas was interested in the use of countertransference reverie as a source of analytic work but was more interested in the mutative effect of nonverbal affect states than interpretation. Analytic work was often for Bollas in the preverbal register, providing a holding function as much as insight. Bollas, for example, had the interesting idea that sometimes interpretation pulls for a certain precocity in the analysand, who is actually not fully available to symbolic process in a deep sense. There is then the danger of intellectualization.

Fonagy’s work on transference and countertransference brings back the tradition of Bowlby on the deep relational patterns in early attachment. These ideas about attachment patterning are joined with a Bion-like attention to the mentalizing function in the analyst’s countertransference. Translated into the language of transference phenomena, change occurs not via transference interpretation but through the analyst’s holding in mind the disavowed process in the patient until the capacity to mentalize is induced in the analysand through the relational transactions [Fonagy 2001, Fonagy and Target 1996, 2000; Fonagy et al. 2003].

**Lacanian Models of Transference**

Having mentioned Lacanian influences on the work in transference developing in Latin America, I want to take up what Lacan and Lacanians have done with these concepts. Lacan [1977], although alienated and repudiated by a considerable portion of mainstream psychoanalysis, had much to offer a consideration of transference and countertransference because he approached the phenomena as discourse, finding in the analytic dyad a particular form of speech through which analytic work actually goes on. Transference can be mutative when it addresses the unconscious carried in discourse. It is part of resistance when the relational experiences are cast in pre-oedipal, imaginary, sensory, or narcissistic elements. Lacan was attempting [or succeeding, depending on your point of view] to mine a paradox. Analytic authority was a dangerous illusion. Speech from that perspective was doomed to founder and leave the analysand untouched and unchanged. However, regression and merger states were equally problematic [either in the transference or in the countertransference].

Authority, or rather authoritative knowledge, Lacan [1977] argued, resides in the unconscious of the analysand, although it is often projected out into the analyst as “the one who knows.” The magisterial qualities of the analyst, so crucial for what Freud was noticing in developing the concept of transference and on which many ideas about transference depend, is for Lacan an illusion, an experience lived out in the register of the imaginary. The analytic task is to be attuned to the signals in the analysand’s speech of the workings of unconscious desires and drives, particularly death drives, and for that reason countertransference is simply another one of the resistances [like the analysand’s focus on pleasure or projections of authority] to be pared away. For Lacan, there is probably no real relationship, just as in the realm of sexuality there is no sexual rapport. The enigmatic and potently controlling aspects of Otherness,
present and interactive between analyst and analysand, make conditions of alienation normative and conditions of attunement and identification merely chimerical.

The Interpersonal Tradition: Fromm, Wolstein, Levenson

From the 1920s on, as one sees in Orr, there was some dialogue between classical and interpersonal analysts. These links had pretty much disappeared by the 1970s. Yet this elision is occurring as an alternative, more interpersonally focused approach to transference initiated by Karen Horney and developed by several generations of interpersonalists, from Sullivan (1953, 1964) through Fromm (1941, 1947), Levenson (1972), Wolstein (1956, 1971), and more recently Stern (1997), Ehrenberg (1992), Blechner (1995), and Hirsch (1987, 1996).

The interpersonal tradition in the United States is more formally inaugurated by Sullivan, with crucial contributions from Thompson, drawing on Fromm and Ferenczi. Mitchell, in exploring the technical questions of analytic authenticity, showed some interesting differences within this tradition. For Mitchell, there was a persistent divide in the analytic writers on transference and countertransference. The break point in the interpersonal tradition comes with Fromm, for whom authenticity in the analytic situation becomes a therapeutic goal in itself. Certainly Ferenczi would be a powerful influence in this way of thinking and working. The transference situation for Fromm seems to be a hotbed of experienced agency, intentionality, and subjectivity coming into awareness. Transference has become part of the inherent conditions of communication: free expression, honesty, sincerity.

In the next generation of interpersonalists I single out Levenson (1972) and Wolstein (1956, 1971), each of whom made unique and different contributions to the understanding of transference. Wolstein is perhaps the purest exemplar of the “radical interpersonalists.” For Wolstein, metapsychology was the inevitable contaminant (Shapiro 2000). This particular interpretation of the interpersonal stance did not so much deny an internal world of objects and identifications as refuse to focus there in the transference. The psychic reality of the patient was paramount, and the analyst’s work was more in the direction of inventorying the patient’s experiences. There is, in the interpersonal tradition, a kind of distaste for regression. For Wolstein, the juice was in the transference as lived scenes. He also pulled for an experience that was not so easy to conceptualize—that is, communication that would go from unconscious to unconscious, an idea from Ferenczi. Levenson also took this radical interpersonal stance, but his clinical and technical interests were in the analyst’s use of countertransference. Levenson viewed the enmeshment of analyst in transference messes as crucial for analytic change. The patient digs a trap. You must fall into it, and in digging your way out, the patient is helped to find a new understanding of the transactions and to find the analyst as a new object. Levenson would seem to be saying here that transference change arises when the analyst is first an old and then creatively and actively a new object.

Contemporary interpersonalists draw on a hermeneutic model of clinical conversations, on truths co-constructed and on a decentering of analytic authority. Identification with the analyst is quite explicitly discouraged. Hirsch, in particular, translated the interpersonal project of shared experience and relational fields into the language of enactments, as the inevitably ongoing process in which the psychic life of the analysand emerges and alters. Blechner (1995) was interested in the patient’s use of fantasies of the analyst’s countertransference (whether the accuracy of these fantasies is acknowledged or not). It is as though, for certain patients, it is important to “borrow” or “inhabit” the analyst’s subjectivity in order to explore something not yet emergent and conscious in the patient’s psyche. Here countertransference is offered as a transitional space for the analysand.

Self Psychology: Idealizing and Mirroring Transference

Kohutian self psychology and its multiple lines of evolution focus on transference, but with a strong emphasis on the beneficial and mutative aspects of positive transference. Transference as a source of conflict is for the most part seen as a countertransference failure. The premium is put on careful, acute, attuned clinical listening and an attempt to mirror as closely as possible the emotional experience of the analysand. Idealization of the analyst, often seen as a sign of covert hostility or a worrying protection of the analyst in Kleinian terms, is in self psychology a key to psychic change.

Fosshage (1994, 1997) spoke of the shifting listening perspectives in the analyst. Self-attunement and attunement to the analysand interweave. For critics of this perspective, the idealization in the analytic relation-
ship could remain too unexamined in a process that requires ongoing attunement by the analyst, with errors and misattunement addressable only by the analyst. This epistemologically complex, somewhat unstable situation has its echoes in the self-psychological work on intersubjectivity. Countertransference remained relatively untheorized until the inauguration of interest in intersubjectivity and co-construction—the work of Stolorow and his colleagues (Stolorow 1997; Stolorow et al. 2001). They held a unique perspective on transference and countertransference, seeing a total situation of co-construction in which unconscious aspects are more elements on a horizon than topographically organized underlying features of mind. This project is frankly and self-consciously anti-Cartesian, focusing on a more deeply phenomenological experience of enmeshed self-other interaction.

The Relational Turn


From Mitchell’s clinical writing there is a powerful sense that countertransference affects are the engines for psychic movement. His vignettes often catch the analytic pair in moments of hopeless despair. Without that “felt” experience of hopelessness, the analyst is not compelled to do the work of understanding and identification. The analytic work is to analyze the process by which such impasses take hold. There are then always two speakers with authority. Impasse, improvisation, and the undoing of knots and paradoxes are at the heart of relational work on transference (Bromberg 1998; Davies 1994, 2001; Pizer 1998).

Aron (1996; Aron and Bushra 1998) developed more theoretical purchases on the questions of mutuality and asymmetry. For example, he described a spectrum of experiences that analysands have of their analysts, moving from opacity to translucency to transparency through disclosure but crucially including experiences in which analysts are more porous to analysands than we like to imagine. He also took pains to describe another spectrum, along the orthogonal dimensions of symmetry on the one hand and intersubjective on the other hand. There can be mutually porous and disclosing relationships, relationships that retain the asymmetry and hierarchy of analytic dyads without refusing some role for analytic subjectivity.

Benjamin’s (1995) template of “doer and done to,” the relations of complementarity in which each person in the dyad is held and traumatized through the historical and frozen object relations of their own history, has had an influence on relational analytic listening. Drawing from Ghent (1990) and originally from Winnicott (1947), Benjamin viewed the outcome of analytic transactions as an experience of individuality that is private and recognizable, appreciated but also inalienable. Ghent’s particular interest lay in the defensive vicissitudes in patients’ object relations in transference, whereby sustained respectful relatedness could be spoiled and defended against by collapses alternatively into either sadistic object probing or masochistic submission.

Bromberg’s clinical choice is most often to stay closely attuned to the surfaces of language and speech practices: the genres, styles, and idiosyncrasies of human performance as the surface registration of internal worlds. These metaphors of “surface” and “inside” do not capture the sense of shifting psychic realities shaping the interpersonal relationship, with each state expressed and elaborated through its own unique experience-near styles of being and talking. Deploying theoretical concepts of dissociation and a strong investment in multiplicity and shifting self-states as inevitable attributes of transference and countertransference, Bromberg drew on his countertransference experiences as a guide to the transforming object relations lived out in the transference.

Davies’s (1994, 2001) use of countertransference disclosure has been controversial but also influential. Her intentional use of disclosures of affect states and sexual fantasy has been undertaken in the hopes of opening and altering unresolved sources of unconscious shame and guilt. Regarding the erotic and sexual aspects of countertransference, Davies’s clinical choices—both to disclose and not to disclose—were guided by an assumption that sexual secrets can be massively dangerous to patients and iatrogenically reproduced in analyses.

Much the same process appears in Gabbard’s (2001) clinical account of work with erotic transference. In a clinical report on erotic transference, words’ potency in writing, in e-mail communications inside and outside the analytic frame, in reading aloud, and in analytic speech was powerfully mobilized in the treatment, and transference and countertransference erotics were both
cultivated and defused. Most interestingly, Gabbard seemed to have transformed a charged, driven, eroticized transference into a form of transference love through which the analysand grew and changed, and he or she did so through open talk.

There are important new relational ideas about transference and countertransference often centering on the analyst's use of his or her mind and on the complex dialogues and reveries in which analytic work is situated (Cooper 2010; Stern 1997, 2010). There is in Antony Bass's (2003, 2007) work a determination to revive and refresh the Ferenczi ideas about mutuality and negotiation (Ferenczi 1932). In the work on improvisation and enactment (Knoblauch 2000; Ringstrom 2007), both transference and countertransference are liberated into complex forms of play and openness. Interpretation, in the usual sense, no longer plays such a mutative role. Rather it is in the actions, the theatricality and scenes of transference and countertransference, that clinical movement occurs.

The Real Relationship Revisited

Now, revisiting the “real relationship” in 2011, it seems increasingly anachronistic. Certainly many analysts count on authenticity and a freshness of method and approach, an openness to full examination of countertransference and analytic character, sometimes disclosed and sometimes not. Interest in shifting self-states and the complexity of enactments puts in question the “real” relationship. Post-Bionian understandings of the power and subtlety of what the frame does and what it carries (Goldberg 2009) embed even the “realities” of time, office space, and money in potent unconscious aspects of the clinical situation, endlessly susceptible to analysis and meaning making.

In the turn to countertransference and in the critiques of neutrality and one-person psychology models, the question of reality has arisen again, although now in a way quite unpredicted by Greenson. With the new interest in countertransference and an opening or ventilating of the intersubjective matrix of the relationship, the question of the analyst’s contribution has taken a new turn. The question of explicit use of countertransference (via disclosure) is perhaps the most hotly debated issue in clinical psychoanalysis at this moment. There are many things to consider. Are all affects, including hatred, sexual interest, erotic excitement, and despair, suitable for disclosure in analyses? Can useful psychoanalytic work be conducted in the wake of these disclosures?

One problem with the distinction of real versus performed or authentic versus managed technique is that the categories leak in both directions. Choice, including silence, at any given clinical moment is not always the enactment of false self, even without the postmodern critique that considers all communications and forms of identity aspects of performance. There must be the potential for variation in style, in character, in modes of relating (Greenberg 1995, 2001; Harris and Gold 2001; Smith 2000, 2003a, 2003b; for an earlier look at these issues, see Scarles 1979). Hoffman (1998) built one of the most systematic arguments for a dialectical relationship between technique and spontaneity.

It is worth noting that the new expansion of thinking about countertransference has been accompanied by a new openness in talking about, addressing, and acting on boundary violations. Spearheaded by Glen Gabbard and others, we now have a discourse about the facts of boundary violations and some of the preconditions (institutional and personal) that can lead to these devastating and destructive misuses of analytic power.

“Rough Magic”

Why does transference work? How does talk “cure”? How do words work their performative magic? I propose some answers, or further questions on this matter, drawn from the psychoanalytic tradition I feel personally closest to the relational perspective. Talk cures because of the excess in words, because of words’ materiality, their archaic residues of love and loss—because the constitutive power of speech always depends on the intense object relations hidden within it (Aron and Bushra 1998). Talk cures through the puzzling interdependence of transference and speech’s effects. Transference is a kind of mimesis that only arises and effects its particular magic because the distinction between word and act, and between self and other, is unstable and dissolving and because this blurring is tied to archaic but potent relational matrices.

Transference is a doseable form of trance that is dependent on the aspects of speech that constitute its connective tissues, not its separating function. The shifts from empty to full speech, from pre to proto to symbolic representation, are part of the curative form endowed by language. I have neglected here that more rational fea-
tture of speech, the way language comes to aid a patient in making a story, taking responsibility for it, and constructing coherence and nuanced distinctions. This obviously is also part of the curative power of language. The reasonableness of words must help and can calm and regulate and structure the speaker and the listener. Yet the power of speech to effect and alter soma and psyche comes not from reason but from its mimetic origins, its tie to an archaic maternal imago and the modes of being and related connected to that imago.

A new focus on countertransference is built on the inevitability of enactment (Ringstrom 2007; Smith 2003a, 2003b). An idea that is both old (Searles, Ferenczi) and new (Ehrenberg, Harris, Davies) is that impasses and disruptions in treatment require shifts in the analyst’s functioning. J.H. Rey (1988) had the beautiful and profound idea that patients come to analysis to cure and repair the damaged internal objects. We would extend that to the project of the analyst as well, and it is in the joint project of mourning and repairing various ghosts that analysis moves.

Conclusion

The heart of what makes psychoanalysis psychoanalysis is the talking cure. Yet transference and countertransference phenomena are unstable conceptions. One of the crucial dimensions of transference and countertransference experiences is power. In many ways, although the focus of interest has shifted much more to the study of countertransference, a crucial debate remains. Does analysis cure by experience or by interpretation? Are analytic cures cures by love or cures by widening the ego? Does psychic change or mutative action come as a by-product of enhanced reflection or from the “now” moments of affective link between analyst and analysand? Can these differences become more interdependent?

Because different theoretical groups often work in isolated, uncomprehending parallel, antagonisms may sometimes hide underlying affinities. Looked at comparatively, one can see some strange bedfellows. Lacanians, interpersonalists, and ego psychologists working with close process recording can all sound rather alike in their distaste for regression. Interest in analytic subjectivity crosses Freudian, relational, and self psychological perspectives, although the use of such subjectivity remains contested, quite differentiated, and controversial. There are links between relational and Kleinian perspectives in regard to the importance of regression in the transference.

One of the most interesting examples of cross-pollinations and hybrid theorizing is in the work of Evelyn Schwaber (1995, 1998), who drew on Kohutian ideas of analytic listening while remaining well rooted in the more classical Freudian canon. Schwaber has been interested in how much the patient’s constructions and communications, including countertransference communications, are shaped by the analyst’s way of listening. Patient resistance, Schwaber suggested, has roots in the resistance and defensiveness of the analyst. It is almost as though the analysand’s constructions function as a kind of subtle supervision to the analyst, guiding shifts and attunements in a listening stance.

Reviewed across a century, the concept of transference still sets off a certain puzzle of love and hate that impels thought and movement. Psychoanalytic work, at its heart, in transference and countertransference is very beautiful, dangerous magic, or “rough magic,” as Prospero called the magic arts and creativity of which he had become so ambivalent. There is an irreducible intimacy and closeness among great power, great transformative energy, and grievous error:

I have bid him d / The noontide sun, called forth the mutinous winds And twixt the green sea and the azure vault set roaring war: to the dread rattling thunder have I given fire, and rifted Jove’s stout oak with his own bolt:... 

graves at my command have waked their sleepers, oped and let them forth by my so potent art. But this rough magic I here abjure.

*The Tempest*, Act 5, Scene 1: 32–55
KEY POINTS

- Transference phenomena are at the heart of the psychoanalytic process and technique, representing a break from earlier forms of psychotherapy and a continuation from early forms of trance induction and hypnosis.

- Countertransference is a concept that evolved dramatically over the twentieth century. Beginning as a hindrance to treatment and a problem to be excised, countertransference is now a fully articulated aspect of the analytic instrument.

- Many analysts, in looking at the real relationship, attend to the analyst’s irreducible subjectivity, the authenticity of the analyst, and the inevitable enactments that arise in the analytic dyad.

- Transference and countertransference have been conceptualized in distinct yet overlapping ways in the work of the classical ego psychologists, Kleinians, Lacanians, object-relational analysts, interpersonalists, self psychologists, and relational psychoanalysts. Each tradition has handled action, affect, impasse, and conflict differently.

- The mechanisms and metapsychology of transference phenomena, including the relative importance of the object ties that are activated in both directions and the place of regression and action, can be viewed from different perspectives.

References

Bass A: When the frame doesn’t fit the picture. Psychoanalytic Dialogues 17:1–27, 2007
Benjamin J: Like Objects, Love Subjects. New Haven, CT, Yale University Press, 1995
Bollas C: The transformational object. Int J Psychoanal 60:97–107, 1979
Fenichel O: Criteria for interpretation. Psychoanal Q 9:576, 1940a
Fenichel O: New ways in psychoanalysis. Psychoanal Q 9:114–121, 1940b
Ferenczi S: The Clinical Diary of Sandor Ferenczi. Edited by Dupont J. Translated by Balint M, Jackson NZ. Cambridge, MA, Harvard University Press, 1932
Fromm E: Escape From Freedom. New York, Avon, 1941
Fromm E: Man for himself. New York, Fawcett, 1947
Rosenfeld H: Impasse and Interpretation. London, Tavistock, 1987
Shapiro S: The unique Benjamin Wolstein as experienced and read. Contemp Psychoanal 36:301–341, 2000
Winnicott DW: The fear of breakdown. Int Rev Psychoanal 1:103–107, 1974
Wolstein B: Countertransference. New York, Grune & Stratton, 1956
Wolstein B: Human Psyche in Psychoanalysis. Springfield, IL, Charles C Thomas, 1971
Theories of Therapeutic Action and Their Clinical Consequences

Jay Greenberg, Ph.D.

In 1931, Edward Glover published his provocatively titled paper “The Therapeutic Effect of Inexact Interpretations.” The paper is remarkable both because Glover identified a crucial, previously unnoticed paradox in traditional psychoanalytic accounts of the mechanism of therapeutic action and because his argument introduced and authorized an illogical resolution of the paradox that has haunted psychoanalysis for decades.

The paradox that Glover noticed hinged on the idea that since its beginnings, psychoanalysis had been claiming to cure neurotic symptoms by interpretation—that is, by making the unconscious conscious. Moreover, since Studies on Hysteria (Breuer and Freud 1893–1895), analysts had insisted that cure was possible only if patients became fully aware of the repressed mental contents that were driving the symptoms. Some improvement might be possible along the way, of course, but stable cure depended on the full and precise identification of the relevant unconscious material. Unlike all other treatment modalities, psychoanalytic cure required only that the patient become aware of what had previously been banished from consciousness. The experience of treatment itself, the bond with the doctor that had always been recognized as a weighty force in nonanalytic approaches, played a facilitative but ultimately reducible role in psychoanalytic cures. This ruled out mechanisms of therapeutic action that might characterize other methods; Glover (1931, p. 397) specifically addressed the impact of suggestion and of relying upon “fresh discoveries [to provide] more convenient or rapid access to affective reactions” (i.e., catharsis).

The other side of the paradox, however, lay in the rapid changes (or, as Glover would have it, advances) in psychoanalytic theorizing in the 36 years between the publication of the Studies on Hysteria and the appearance of his paper. To mention a few: the seduction hypothesis had come and gone, the dual-instinct theory had been introduced and modified, the theory of anxiety
had undergone profound revisions, and the topographic model of the mind had been introduced and superseded by the tripartite structural model. The upshot of these changes, especially relevant for clinical work and for theorizing about therapeutic action, was what Glover characterized as “the discovery of fresh phantasy systems” (Glover 1931, p. 397). In other words, by 1931 analysts knew that they needed to uncover repressed mental contents that their predecessors could not have found, because they were unaware of their existence.

How to account for decades of claimed cures—cures by interpretation—when the analysts claiming those cures did not even know what they were supposed to be looking for? Glover found his solution at the heart of the declared difference between psychoanalysis and other therapies: the effects of suggestion. Cleverly and elaborately applying then-current metapsychological principles, he argued that inexact interpretations (those that were reasonably close to the mark but that did not precisely capture the essence of the repressed fantasies) could have the same effects as suggestions; by serving as displacement objects, they could alleviate anxiety and thus contribute to symptom reduction.

Historically, then, analysts had unwittingly trafficked in suggestion, they had provided therapeutic cure but not analytic cure. The latter depended on complete knowledge of the nature and contents of the unconscious. This, of course, is where Glover’s illogic entered the picture and created a paradox more vexing than the one he had set out to resolve. Because if analytic cure requires that we know the unconscious completely and exactly, then cure is possible only when psychoanalysis has nothing more to learn! That is, analytic discovery and analytic cure are incompatible with each other.

Freud never directly responded to Glover’s argument, despite being its implicit target. Most likely this reflects his relative disinterest in the problem of therapeutic action, especially late in his career. Freud put it quite strikingly in Analysis Terminable and Interminable, suggesting that the problem of “how a cure by analysis comes about” is “a matter which I think has been sufficiently elucidated” (Freud 1937a, p. 221).

Yet despite this dismissiveness, Freud responded to Glover implicitly in the paper titled “Constructions in Analysis” (Freud 1937b). The analyst is bound to make mistakes (e.g., inexact interpretations, inaccurate constructions), he admitted, but if these are relatively rare, no harm will be done other than wasting time. He came closest to addressing Glover directly when he asserted that in the face of the analyst’s error “the patient remains as though he were untouched by what has been said” (p. 261). Not only will there be no analytic move-
Theories of Therapeutic Action and Their Clinical Consequences

analyst’s empathic presence and/or willingness to recognize the analysand, and so on.

However, these relational effects have been specified in the work of different theorists, all attempts elaborate an apparently simple alternative to Freud’s views that was expressed almost as soon as he first proposed them. In *Studies on Hysteria* Freud declared that cure depended on recovering repressed memories of lived experience. These were memories of moments that were traumatic for his patients, although he considered unbearable inner conflict to be traumatic, thus avoiding a dichotomous distinction between intrapsychic and interpersonal experience that plagues us today. In *The Interpretation of Dreams* (Freud 1900), Freud shifted the emphasis, if not the essence, of this formulation, narrowing his vision of unconscious mental contents and insisting that it is invariably forbidden wishes that need to be retrieved. He further, in *Three Essays on the Theory of Sexuality* (Freud 1905), narrowed his ideas about what needed to be uncovered, declaring that interpretation must focus on repressed sexual desires and the fantasies to which they had given rise.

Like so many of Freud’s radical, provocative ideas, his assertion that self-awareness was not only an ethical and aesthetic value but also a cure for disease quickly aroused alternative hypotheses. As early as 1906, in an admiring letter expressing interest in joining the emerging psychoanalytic movement, Jung risked one minor protest: “Your therapy seems to me to depend not merely on the affects released by abreaction but also on certain personal rapport[s]” (McGuire 1974, p. 4). Within 15 years, this small quibble had burgeoned into the Freud-Ferenczi debate, focused on whether interpretation alone was responsible for change or whether the new experience with the analyst was curative in its own right (Ferenczi and Rank 1923). By the time of the Marienbad conference in 1936, there were so many competing viewpoints on the workings of therapeutic action that Glover himself warned against overemphasizing the importance of any one factor in the analytic situation. Referring to interpretation on the one hand and to the analyst’s endurance, his or her humaneness, and even his or her unconscious attitude toward the patient on the other, Glover worried that our theories of therapeutic action are at risk of degenerating into what he criticized as “mere special pleading” (Glover 1937).

Yet despite Glover’s wise if somewhat perplexing warning (perplexing in light of his own special pleading only 6 years earlier), analysts continued to claim that they could isolate and identify the element of the psychoanalytic situation that was responsible for therapeutic change. Twenty-five years after Marienbad, at the 1961 Edinburgh conference on therapeutic action, several of the presenters took the position that interpretation is the only carrier of analytic change and that the analyst must resist the impulse to offer anything else to the analysand. The Kleinian analyst Hanna Segal (1962) expressed this most clearly, arguing that “insight is a precondition of any lasting personality change achieved in analysis... To be of therapeutic value, it must be correct and it must be deep enough.” In a summary review another quarter-century later, Blatt and Behrends (1987) found that “interpretation leading to understanding is assumed by most analysts to be the primary mutative force in psychoanalysis” (p. 279).

The insinence on the primacy or even the exclusivity of interpretation, bound as it is to the avoidance of what Valenstein (1979) called “interpersonally promoted experiential effects” (p. 117), entails a peculiar assumption that has remained central to many approaches to the problem of therapeutic action: it suggests that most of what we know about ordinary human involvements does not apply to the analyst-analysand relationship. Indeed, Freid (1915) wrote that “the course the analyst must pursue... is one for which there is no model in real life” (p. 166; see also King 1962, p. 224). What analysts do with and for patients is unlike what anybody else (e.g., parent, friend, doctor) does. Thus we need not—and cannot—look for the therapeutic action of psychoanalysis in the relational effects that it offers. The analytic relationship is, uniquely, one in which personal influence can be—indeed must be—reduced to a vanishing point if the objectives of the treatment are to be achieved.

Wishful thinking must have shaped this formulation; it reflects Freud’s hope that defining the psychoanalytic relationship as *sui generis*, perhaps even defining the relationship out of the psychoanalytic situation entirely, would concentrate attention on the workings of “correct” and “deep enough” interpretations. The importance of this to Freud and to other analysts (including many contemporary theorists) cannot be overestimated, because it appears to solve two problems simultaneously. First, it establishes the uniqueness of psychoanalysis as a treatment compared with all other therapies that historically trade on relational effects. Second, in a kind of circular reasoning, therapeutic success can be taken as a validation of the findings and the hypotheses of psychoanalytic science, if cure depends on correctness, then cure demonstrates truth.

Predictably, Freud’s vision of the uniqueness of the analyst’s role generated alternatives. Theorists following the lead of Jung and Ferenczi looked at the psycho-
analytic situation and found not only “interpersonally promoted experiential effects” but a relationship that might have analogs in human development. Although initially there was no direct challenge to Freud’s claim that the analytic relationship was unique, the implication of their argument was that his claim grew out of a failure to look in the right direction. If we pay attention, we will see that even analysts who scrupulously followed standard technique were participating with their analysands in ways that not only exerted personal influence but also could be understood as revisiting particular sorts of early experience. Along with the information that their interpretations conveyed, analysts have always been implicitly and perhaps even inadvertently repairing some of the damage that had been done as a result of the analysand’s faulty early object relations. This relationally based reparation could not be avoided even if the analyst wished to do so; it was inherent in the nature of analytic engagement itself.

The first to point out a salient parallel and its healing potential was James Strachey [1934]. Strachey noted that the analyst, in the course of applying standard technique, was behaving like and was bound to be experienced as a gentler, more accepting father than the patient had known in the course of growing up. As a result, the analyst would be taken into the patient’s inner world in ways that are bound to soften a harsh and punitive superego. Although Strachey ultimately emphasized the centrality of what he termed “mutative interpretations,” his ideas about the way in which the analyst will be perceived and introjected imply that psychic structure itself can be modified purely on the basis of the experienced relationship. He thus opened the understanding of therapeutic action to include the direct impact of developmentally based relational effects.

Strachey was writing in a time during which psychoanalytic thinking was still dominated by Freud’s phallocentric emphasis on the role of the oedipal father in child development; thus he stressed the relationship with the analyst as benign father and its implications in terms of superego modification. Some 25 years later, as interest shifted to earlier developmental stages and to the importance of mother-child relations, Hans Loewald proposed a new analogue that highlighted different implications of the analyst-analysand relationship. For Loewald, the analyst behaves like and is experienced as a mother who can hold the tension between her child’s current level of development and his or her potential in the future. Loewald’s (1960) analyst is not simply a more permissive and resilient figure, as Strachey believed, rather, the analyst is “a person who can feel with the patient what the patient experiences and how he experiences it, and who understands it as something more than it has been for the patient” (p. 26). Because the analysis—by virtue of behaving as analysts have always behaved—is this sort of person, the patient will be able to claim his or her potential at a higher or more mature level of organization and integration.

More recently, the strategy of seeking developmental analogies to explain relational contributions to therapeutic action has pushed even further back into the analysand’s past. Daniel Stern and the Process of Change Study Group find their analog in the parent-infant dyad [Stern et al. 1998]. As analyst and analysand work together to give shape to their analytic project, they re-create early connections between the infant and his or her caretaker:

Unlike the largely non-verbal behaviours that make up the background of the parent-infant environment, the verbal content usually occupies the foreground in the consciousness of both partners. In the background, however, the movement is towards intersubjective sharing and understanding. The verbal content should not blind us to the parallel process of moving along towards an implicit intersubjective goal. (Stern et al. 1998, p. 909)

It is this jointly created experience that gives rise to the crucial “something more than interpretation” that lies at the core of therapeutic action [Stern et al. 1998, p. 903].

Note that Stern and his colleagues, like Strachey and Loewald, emphasized that the necessary “something more” happens as an intrinsic aspect of psychoanalytic engagement [although more than the earlier authors they do eventually argue for significant modifications of standard technique]. Similarly, over the years other theorists have suggested ways in which the interpreting analyst provides mutative relational experience in the course of conducting a traditional treatment. To mention a few, consider Winnicott’s vision of the analyst as the resilient target of murderous aggression, Bion’s idea that the analyst is a container of toxic projections, and Weiss and Sampson’s concept of the neutral analyst disconfirming the patient’s archaic pathogenic beliefs. Similarly, many of the concepts most frequently used in the current literature direct our attention to ways in which interpretations (and all other ways in which the analyst intervenes) exert relational effects. Role-responsiveness, enactment, the analyst as self-object, transference as a total situation, and countertransference both as source of information and as a determinant of analytic ambience come to mind in this regard.
Persistence and Impenetrability of the Debate

So for almost a century now, the issue has been joined. Some analysts believe that analytic change, by definition, depends on interpretation alone. Others insist that even the analyst operating in accord with the most narrowly construed version of standard technique inevitably provides a quality of relational experience (in some versions analogous to earlier developmental experience, in others unique and unprecedented) that directly contributes to therapeutic action. There have been many attempts to resolve or at least to influence the debate: large-scale studies have been undertaken, volumes of anecdotal evidence have been offered, elegant arguments have been proposed in support of all positions. Yet we have not moved closer to an answer or even toward any consensus. In fact, it seems increasingly improbable that we will ever reach a satisfying conclusion.

In general, history suggests that there is something about the psychoanalytic process that makes it more likely that we will come up with interesting questions than that we will arrive at convincing answers. In this sense psychoanalysis may be different than other “treatments,” despite having its own claims to therapeutic efficacy. Raising questions about this difference is intriguing, it will open a perspective on our conversations about therapeutic action that is likely to be illuminating.

Consider the problem of what must happen to make it possible for a patient to participate in a treatment as rigorous as psychoanalysis. This is a problem that seems amenable to some resolution, because it is apparently accessible to investigation on the basis of empirical evidence. Virtually all analysts agree that participating in and benefiting from analysis are difficult for patients. The difficulty is imposed by the nature of the analytic project itself: modifying ways of being in and of experiencing the world that have seemed, from the patients’ perspective, effective and even essential for their entire lives. Analysis has always required that patients think the unthinkable and take terrifying risks.

Yet this deceptively simple observation raises a question that touches directly on the problem of therapeutic action: What can the analyst offer to the analysand (beyond what is bound to be a vague and often elusive suggestion that life could be better) that will facilitate the analysand’s ability to participate in—and at times to endure—the treatment? What, in Roy Schafer’s (1983) words, constitutes an optimal “analytic attitude”?

Perhaps surprisingly, there is little consensus about this question; each analytic school of thought (e.g., Kleinian, relational, interpersonal, contemporary conflict theory, Lacanian, self-psychological) comes complete with a prescribed analytic stance that is passionately promoted even if, as Joseph Sandler (1983) has noted, it might be honored in the breach by individual practitioners. Why can’t the disagreement be resolved?

The reason for this lack of resolution may become clear if we consider one facet of the problem that has been widely discussed although never directly debated: is the analysis best facilitated by the analyst’s steady presence—his or her persistent adherence to a way of being with the analysand regardless of pressures in the transference/countertransference and regardless of the feelings that either participant may experience in response to this persistence? Or is some measure of technical flexibility—some adaptation to the character, needs, even wishes of the analysand—crucial?

Even a cursory consideration of this question should reveal that any thoughtful, experienced psychoanalyst is likely to be able to argue either side. Indeed, both sides have been argued vigorously. Sometimes, the arguments focus on specific technical issues: frame flexibility, gratifications, the analyst’s spontaneous affective participation, self-disclosure, and so on; sometimes the issue is taken up in more general terms. A clear example arguing the general point is the comment of Paula Heimann (1962), who during the 1961 Edinburgh Symposium on “The Curative Factors in Psycho-Analysis” noted:

[1] If the analyst’s technique changes decisively in the course of the analysis, I fear that this is bound to introduce an element of inconsistency into the analytic situation which is only too reminiscent of experiences which the patient as a child inevitably had with his parents, and which is not compatible with the atmosphere of steadiness and stability which the analytic situation aims at creating. (p. 229; see also a similar argument in Casement 1982, 1990)

Note that this is couched in terms that suggest a conclusion drawn from Heimann’s experience as an analyst, much like the advice in Freud’s (1911–1915) Papers on Technique, it is apparently rooted in empirical observation, not theory. Yet the observation is hardly universal, unlike Heimann, Daniel Stern et al. (1998) in the Process of Change Study Group saw flexibility as crucial. They stressed the centrality to therapeutic action of
communications that reveal a personal aspect of the self that has been evoked in an affective response to another. In turn, it reveals to the other a personal signature, so as to create a new dyadic state specific to the two participants. . . . It is marked by a sense of departure from the habitual way of proceeding in the therapy. It is a novel happening that the ongoing framework can neither account for nor encompass. It is the opposite of business as usual. (p. 916, italics added)

These two formulations, each putatively reflecting a need of the analysand that can be discerned by an observant analyst, are each intuitively appealing, yet they are irreconcilably at odds with each other. Heimann, and years later Casement [1982, 1990], believed that “steadiness” is reassuring and “inconsistency” terrifying. Stern and his colleagues insisted that “business as usual” is rejecting and stultifying, whereas creating “a new dyadic state” will free the analysand from bondage to familiar yet pathogenic ways of being in relationship. Offering a somewhat different explanation of the importance of a flexible stance, Irwin Hoffman [1994] noted, “When the patient senses that the analyst, in becoming more personally expressive and involved, is departing from an internalized convention of some kind, the patient has reason to feel recognized in a special way” (p. 188).

The question is posed: Do our analysands need steadiness to ease them through the rigors of doing analytic work, or do they need flexibility? To put it another way, is inconsistency or rigidity more frightening?

Put so boldly, the question appears strange. It is difficult to imagine any psychoanalyst, indeed anybody who spends a great deal of time engaged with and thinking about the emotional lives of other people, who could not adduce considerable evidence that both steadiness and flexibility are facilitative and that both inconsistency and rigidity are frightening.

We are left with a strong suspicion that theory is at work, silently influencing the reported observations. Broadly speaking, the observations and their attendant technical recommendations have come (predictably, although not without exceptions) from opposing theoretical traditions: consistency has been promoted by classical Freudians and Kleinians; flexibility by analysts working within the relational, intersubjective, and self-psychological traditions. In addition, the opposing sensibilities developed at different times, both in the history of psychoanalysis and in society at large. This amplifies the role of theory, because the different times contribute to the shaping of observation by imposing different demands and constraints on the observer. At the beginning, Freud (despite the famous leeway he allowed himself) was at particular pains to warn practitioners of his new, dangerously intimate method that they must constantly fight their temptation to succumb to the countertransference. Succumbing could take many forms, Freud knew, of which overt boundary violations were only the most egregious tip of the iceberg. Thus arose the idea—hinted at by Freud and developed more explicitly by many of his followers—that countertransference, especially the sort that goes unnoticed by the analyst, always lurks behind the analyst’s inclination to modify technique.

Prescriptions of technical flexibility are especially appealing today, when authority is so broadly questioned throughout our culture and when, in the eyes of many, technical consistency has hardened into authoritarian rigidity. There is, accordingly, a corrective aspect of these recommendations; they address a pendulum that is thought to have swung too far. Yet these prescriptions also have a long history dating back at least to Ferenczi and reaching a peak of notoriety in Franz Alexander’s suggestion that analysts should provide a “corrective emotional experience” tailored to the developmental history of each analysand [Alexander 1950, 1954]. Recently, reflecting both clinical experience with the more diverse group of patients who are considered “analyzable” and broad social changes in attitudes toward authority, flexibility has become a mainstream technical recommendation. In addition to its prominence in the work of analysts operating within the relational tradition [Hoffman 1998; Mitchell 1997; Pizer 1998], flexibility has echoed through the writings of Kleinians [Steiner 1994], contemporary conflict theorists [Smith 2000, 2001], and self psychologists [Goldberg 1999].

It is tempting, of course, to view change as evidence of progress, as a sign that we are moving toward more effective technique and toward a deeper understanding of therapeutic action. However, despite historical ebbs and flows, there is still no consensus on the issue among contemporary analysts. In any case, to assume that we are simply improving on the work of our predecessors discounts the influence both of our personal theories and of the constraints imposed on psychoanalytic practice and even on analytic thinking by cultural trends. When we fail to distinguish change from progress, we lose touch with insights that may have arisen at a different time and under the sway of different premises.

Consider, as a cautionary tale, a paper by Sander Abend [1979] that stands clearly in opposition to the mainstream of contemporary thinking about flexible technique in particular and to “revisionist” theories of therapeutic action in general. Abend suggested that it is crucial that we explore and understand our analyses’ personal theories of what contributes to and results
from analytic “cure.” His idea was that in many cases these theories reflect wishes to rectify childhood experiences and/or to gratify infantile fantasies.

Abend then boldly and provocatively asserted that analysts who depart from “standard technique” may be giving expression to their own, similar fantasies. Analysts who suggest modifying technique (and Abend’s targets are not marginal characters: they include Winnicott, Nacht, and Gitelson as well as the easily debunked, though also easily misunderstood, Alexander) are inadequately aware of themselves. According to Abend (1979), their “less rational and realistic desires seem to be undetected as they ride along below the surface... attached to the consciously acceptable, readily understandable, appealing ‘legitimate’ needs of the suffering patient” (p. 595; see also his similar argument in Abend 1982).

Abend’s argument, a product of its time and one that his more recent work retracts at least implicitly, falters as a consequence of his failure to recognize that all theories of analytic cure—including, of course, his own—reflect the workings of the theorist’s unconscious fantasies. Certainly holding fast to any received technique as a matter of principle is no less likely to be an expression of such fantasies than is modifying technique. The analyst’s personal motives, unconscious as well as conscious, fantastic as well as realistic, shape every clinical decision and every observation. No prescription can immunize us from expressing our own unconscious wishes in our technical choices.

Yet we have much to learn from Abend’s perspective, despite the logical shortfall that limits its scope and that has kept it far outside the contemporary psychoanalytic mainstream. Today, as discourse about therapeutic action has moved in a very different direction, analysts (mercifully) do not talk about unconscious fantasies of their theoretical opponents. Yet, sadly, they do not talk very much about the analyst’s unconscious at all. Instead, they are likely to discuss technical modifications in terms of patient needs rather than in terms of the analyst’s fantasies (see, e.g., Gabbard and Westen 2003; Hoffman 1998; Pine 2001; Stern et al. 1998; for a very different perspective, see Steiner 1994; for an exception, see Smith 2004).

Clinical practice has benefited significantly from this shift in focus; we have learned that many patients previously considered “unanalyzable” can participate effectively in psychoanalytic treatment if their analysts can find ways of helping them to do so. Technical flexibility not only extends our capacity to work analytically with previously unreachable patients but also, more generally, has taught us a great deal about what different people need to help them use psychological treatment. Even more broadly, it has enhanced our understanding of what it takes for people to live effectively in a world of other people.

Yet we lose something crucial, as Abend reminded us, when we explain our analytic choices exclusively in terms of patient needs. What we lose (and this is not quite Abend’s language) is the idea that as analysts we are personally motivated to do whatever we do, that these motivations may be deeply unconscious, and that accordingly we can easily mislead ourselves when we explain our choices to ourselves or to others.

Returning to the question with which I began this section, we see why it is so difficult to decide whether technical consistency or technical flexibility is more “therapeutic,” even after a century of observational experience. If we reject technical flexibility out of hand, we are unlikely to learn very much about possible ways of helping patients to work that are not included in our received technique. Yet if we embrace flexibility (even if we demand that we reflect on our choices, which is always good advice but which is always subject to self-deception), we are unlikely to look inside ourselves as deeply as we must to discover personal motivations for whatever changes we initiate. It is not enough to advise analysts to keep both possibilities in mind, despite the patent wisdom of the suggestion. Beyond this, examination of and conversations about the implications of various choices are necessary, and this will be best served by the investigations of analysts who are committed to the alternative perspectives and by conversations among them.

Multiple Models, Multiple Unconscious Registers

The difficulty of resolving what appear on the surface to be straightforward questions, the range of observations that suggest contradictory answers, and the dichotomously alternative technical recommendations that follow from them have led many contemporary theorists to the idea of multiple models of therapeutic action. On this view, there is no one way of structuring an analytic relationship that works across the board and no one aspect of the psychoanalytic situation that accounts for therapeutic action in all cases (Gabbard and Westen 2003; Pine 2001). Different analysands require different modes of engagement, a point that has been stressed especially by Pine (2001), and different analysands benefit from different aspects of the analytic experience, as emphasized by Gabbard and Westen (2003).
The introduction of multiple models appears to create an inclusiveness that encompasses and endorses a range of clinical observations. Along with this turn in clinical theory, many analysts have been impressed with ideas they have taken from recent developments in cognitive neuroscience. In light of these developments, theorists suggest, our ideas about therapeutic action no longer have to rest on mere clinical impressions or on more or less broadly drawn developmental analogies. There is a structural basis, even more structural than Freud’s because it is anchored in dazzling new methods and findings from the laboratory, that supports new approaches to the problem of therapeutic action.

The ideas that many have found particularly appealing relate to the hypothesis that the unconscious is not a unitary “place” or structure within the mind that operates in a singular way, as Freud’s topographic model and to a lesser extent the tripartite structural model suggested. There are, according to this hypothesis, any number of unconscious registers in which memories are stored, and they behave quite differently from one another. Traditionally, according to this view, psychoanalysis has dealt with what is now referred to as “declarative” or “autobiographical” memory. Experiences that are capable of verbal expression are stored in the declarative system; these experiences vary in their accessibility to conscious recall and are thus the target of traditional psychoanalytic interpretations. When an interpretation succeeds in “making the unconscious conscious,” whatever change is effected occurs within the declarative register.

Yet the declarative system (which is usually assumed to contain ideas and experiences that have been repressed) constitutes a relatively small proportion of the unconscious mind. More extensive by far is the procedural unconscious, which consists of nonverbal aspects of experience that were never repressed because they were shaped outside of awareness from the beginning and are inaccessible to introspection and thus to interpretation. The representations encoded in procedural memory decisively influence how we behave in the world; skills learned and practiced without conscious reflection, such as riding a bicycle, are examples of the kinds of information involved. These unconscious but never repressed (probably nonverbal) memories were recognized but marginalized by the American ego psychologists. Heinz Hartmann, in particular, wrote about what he called the “pre-conscious automatisms” that make it possible for us to perform any number of routine tasks [Hartmann 1939]. However, these representations [Hartmann did not use this more contemporary word to describe the automatisms] were of interest mainly so far as psychoanalysis aspired to become a “general psychology”; they had little impact either on the dynamics of neurotic psychopathology or on the theory of therapeutic action.

The idea of a procedural unconscious has recently taken center stage in clinical/theoretical discourse. Unconscious representations, many theorists suggest, do much more than make the performance of physical tasks efficient, as Hartmann thought they did. Beyond this, they guide our engagement with the interpersonal world, what we have learned to expect from other people, and how we have learned to behave with them. These representations, often referred to under the broad heading of “implicit relational knowing” [Gabbard and Westen 2003; Lyons-Ruth et al. 1998; Stern et al. 1998], are not, by their nature, conducive to verbal expression; think of how difficult it would be to describe in words what we must do to ride a bicycle. They are, however, subject to modification on the basis of nonverbal, lived experience, especially the sort of experience that patients have in an intense, complex relationship such as the relationship with their analyst. These changes, regardless of how accessible to verbal expression they are, will alter the nature of the analysand’s way of seeing the world and his or her behavioral responses to it.

The hypothesis that different interventions an analyst might make would touch different neural systems is tantalizing, especially because the concepts of declarative and procedural memory seem to map so neatly onto the distinction between interpretive and relational effects. This allows for a new theoretical strategy: the priority of one or another mechanism of therapeutic action can be asserted not simply on the basis of anecdotal clinical experience but also on the basis of changes believed to occur at one or another neural level. Gabbard and Westen [2003], for example, used the distinction between declarative and procedural memory to anchor their idea that we must forgo theories that favor any unitary therapeutic action in favor of those that embrace multiple actions.

For some theorists, the concept of procedural memory decisively redefines the problem of therapeutic action. Perhaps the most radical exponent of this strategy is Peter Fonagy [1999], who claimed that “[m]emories of past experience can no longer be considered relevant to therapeutic action…. Change occurs in implicit memory leading to a change of the procedures the person uses in living with himself and with others” (p. 17). Somewhat less drastically [from a conceptual point of view], Daniel Stern et al. [1998] found that the procedural unconscious provides a structural scaffolding that supports the clinically based idea that “something more” than interpretation is essential to the workings of therapeutic action.
It almost seems that developments in contemporary neuroscience provide the key to solving the dilemma of therapeutic action: perhaps we no longer must tie ourselves to theoretically biased “special pleading.” If there are multiple unconscious registers that are touched by psychoanalytic interventions, we need no longer be bound by our preconceptions. Our observations that different analysands benefit from different events in treatment are grounded; the idea of multiple therapeutic actions [Gabbard and Westen 2003; Pine 2001] is strongly supported.

However, things are not so simple; the different ways in which theorists wield the concept of a procedural unconscious create familiar difficulties. The problem begins with the presumed nature of the procedural unconscious, which is by definition made up of patterns that are nonverbal. Because of this, any attempt to translate these patterns into the language of psychoanalysis or into any other language is bound to involve the biases of the translator; translation is creation, and our theories come into play as soon as we attempt to translate.

Consider where we are left when we decline to translate. Edgar Levenson (2001), who appreciated the importance of implicit changes in patterns of behavior and experience but was unwilling to put words to what he considered an ineffable process, was content to say, “We do not cure; we do our work and cure happens” (p. 241). Ironically distancing himself from the translation project that so many analysts eagerly undertake, Levenson (2001) concluded that “[w]e may spend the next millennium happily figuring out how that might happen” (p. 241). However, few analysts are as comfortable with [or as gleeful about] this kind of uncertainty. If we examine the thinking of those who base their theorizing on the new neuroscientific models, we find that we are left with the familiar conceptual divides.

For example, both Peter Fonagy and Daniel Stern’s group think that therapeutic change involves shifts in “implicit relational knowing.” Yet Fonagy (1999), despite his insistence that recovery of memories plays no part in therapeutic action, described any number of complex interpretations of current relational patterns that he considered central. Consider, for example, the following: “infantile grandiosity defensively activated in the face of maltreatment may generate an image of the self as responsible for neglectful or cruel behavior. Although an illusion of control and predictability may be acquired in this way, the self will also be seen as guilty and deserving of punishment” [Fonagy 1999, p. 17].

Note the number and quality of the words that are being used to capture an experience that has been defined as nonverbal: “grandiosity,” “defensively activated,” “mal-treatment,” “self,” “responsible,” “neglectful,” “cruel,” “control,” “guilty.” Fonagy believed that it is essential that the analysand be helped to translate his or her nonverbal experience into words that are similar to the analyst’s translation. Thus, describing his clinical work with a male analysand, he wrote: “It took some time for me to be able to make him aware of this strategy he had…. He became aware of how he was doing this with his mother, and we finally understood it as a way he had of coping with anyone who he felt was intrusive” [Fonagy 1999, p. 19]. In other words, change in implicit memory depends on interpretation, although the target of the interpretation [Friedman 2001] is contemporary experience and behavior, not history.

Fonagy thus makes very different use of the idea of a procedural unconscious than Stern et al. (1998). For them, change in implicit relational knowing depends on a particular quality of interpersonal experience, one that does not need to be interpreted or otherwise verbalized: “When we speak of an ‘authentic’ meeting, we mean communications that reveal a personal aspect of the self that has been evoked in an affective response to another. In turn, it reveals to the other a personal signature, so as to create a new dyadic state specific to the two participants” [Stern et al. 1998, p. 916]. Unlike Fonagy, with his emphasis on the interpretation of patterns that emerge in the course of analysis, Stern et al. (1998) insist that “[w]hereas interpretation is traditionally viewed as the nodal event acting within and upon the transferential relationship, and changing it by altering the intrapsychic environment, we view ‘moments of meeting’ as the nodal event acting within and upon the ‘shared implicit relationship’ and changing it by altering implicit knowledge that is both intrapsychic and interpersonal” (p. 916).

If Freud and Ferenczi had been focusing their debate on how to facilitate changes in implicit memory, their competing emphases on interpretation and experience would have sounded virtually identical to the differences between Fonagy and the Stern group. Developments in cognitive neuroscience do not and cannot dissolve these fundamental differences in clinical sensibility.

More recently, Gabbard and Westen (2003) suggested that interest in the “interpretation versus relationship” debate has waned, and indeed it seems that there is little more to say about it. Perhaps partially in reaction to this, within the past decade a new vision has emerged that steers a kind of middle road between the two points of view. Briefly stated, advocates of this position hold that neither insight [into fantasies, memories, wishes, impressions, or whatever] nor specific relational experiences [mothering, fathering, mirroring, holding, and so
adequately account for the therapeutic changes that psychoanalysis brings about. Rather, it is argued, therapeutic action depends on facilitating ways of thinking that were previously unavailable to the analysand.

The desired change is characterized differently by different authors, but each points to the goal of developing new capacities (variously termed mentalization, insightfulness, conviction of meaningfulness, experiencing conflict rather than dissociating experience, and so on) in contrast to the traditional view that focused on gaining access to previously unconscious mental contents. Thomas Ogden [2010] recently summarized the change by noting the contemporary analytic focus on “what work we do psychically with our lived experience...[O]ur attention as analytic clinicians and analytic theorists has been increasingly focused on the way a person thinks, as opposed to what he thinks” [p. 318, emphasis original].

This position has become widely popular, although hardly uncontroversial, in recent years. It is endorsed by analysts who identify with a range of different theoretical traditions—North American ego psychology, relational psychoanalysis, Bionian object relations approaches, attachment theory, and interpersonal psychoanalysis, among others. A number of considerations have led to this popularity, all related to broader shifts in the psychoanalytic landscape. First, in an increasingly pluralistic theoretical world, it becomes more difficult even to imagine an interpretation that is, in Glover’s terms, anything but “inexact.” All schools of thought include their own narrative structures and interpretive sets, in the absence of a central authority to adjudicate among them, the idea of “exactness” has long since been stripped of any meaning. Moreover, the increasing acceptance of Sandler’s [1983] idea that even analysts who are members of the same school wield its theories differently drives home awareness of how unlikely it is that any two analysts would arrive at “exactly” the same interpretation.

Beyond this, the pluralistic turn has introduced North American analysts to ideas that originated in Europe—especially in the Lacanian and Bionian traditions—that highlighted the psychodynamic importance of unsymbolized proto-experience buried in the core of many, if not most, analysands’ psychic lives. Like procedural memory, these ideas imply a nonverbal and even nonverbalizable unconscious register different from autobiographical memory, unlike procedural memory, these proto-experiences (of what Lacan characterized as the “real” and Bion termed “O”) originate in trauma and are charged with unbearable affect that makes them impossible to recall in words and therefore inaccessible to traditional interpretation.

The European perspective could not be easily assimilated into the assumptions of ego psychology, which dominated North American psychoanalysis through the 1980s and which assumed the centrality of oedipal dynamics and the recall of repressed verbalizable memories. However, there was receptive soil in the interpersonal tradition, especially in Harry Stack Sullivan’s [1940, 1953] concepts of an uncommunicable prototaxic mode of thinking and the related “not-me” experience formed in response to intolerable anxiety. A central element of what became relational psychoanalysis [Greenberg and Mitchell 1983; Mitchell 1988], Sullivan’s ideas complemented the emphasis on preverbal experience derived from infant observation and attachment theory; together they provided a framework that could accommodate other versions of an unsymbolized unconscious register.

Despite their significant differences, theorists who focus on the dynamic importance of unsymbolized psychic contents share the belief that these early proto-experiences are expressed in action [of one kind or another] rather than in words. Bion’s [1958, 1959] interpersonalization of Melanie Klein’s concept of projective identification captured one aspect of this, as did Edgar Levinson’s [1972] vision of analysts transformed as they inevitably get drawn into their analysands’ inner worlds. The concept of enactment, introduced later [Chused 1991; Jacobs 1986, 1991; McLaughlin 1991], pointed to similar phenomena.

Expression of psychic contents in action rather than in words was what Ogden [2010] had in mind when he referred to the “work that we do psychically with our lived experience” [p. 318]. In this view, therapeutic action depends on facilitating new modes of thought through which this work can be done [for different versions of this from very different theoretical perspectives, see, among others, Bromberg 2006; Busch 2009; Ferro 2006; Fonagy and Target 1996; Stern 2010; Sugarman 2006]. Psychic aliveness and creativity are privileged over discovering hidden truths, the goal is to enable new ways of thinking or even to make thinking possible where previously it was not.

Why Does the Debate Matter?

Throughout this chapter we have seen that what appear to be even the simplest formulations about the meaning or the efficacy of particular psychoanalytic interventions
invite opposing assertions. Attempts to engage the larger questions such as the relative effects of interpretation and relationship become shrouded in the fog of theoretical bias and eventually sound very much like Glover’s “special pleading.” Even the apparent “middle road” of emphasizing the development of new mental capabilities rather than retrieving repressed memories invites the same controversies. Although all of the new approaches implicate new dimensions of the analyst’s participation in the clinical process, their emphases differ in familiar ways. Some stress the importance of what the analyst says [e.g., Busch 2009, Ogden 2010], whereas others address aspects of the analyst’s participation that are not explicitly addressed and perhaps never have to be spoken of [e.g., Gerson 2009, Ghent 1992, Res 2009].

In light of this, is there any value in talking about therapeutic action at all? Are we better served by giving up on the problem, as Freud seemed to in “Constructions in Analysis,” or by declaring it solved, as he did in Analysis Terminable and Interminable? Alternatively, should we dismiss the problem as irrelevant and even inimical to the analytic process, as many French psychoanalysts do [see Laplanche 1992]?

Embracing these conclusions, although tempting after a century of debates that have convinced only the already committed, risks impoverishing psychoanalytic discourse by curtailing detailed investigation of the problems involved. Accordingly, in contrast to the French perspective, I suggest that our concern with the problem remains central not only because our analyses come to us with therapeutic goals in mind but also because studying therapeutic action provides a window into what happens in the course of analysis and what changes as a result of the unique interpersonal encounter that we offer. In contrast to Freud, I believe that nothing about therapeutic action has been or ever can be “sufficiently elucidated.” Despite, or perhaps because of, the chaos that has characterized decades of debate, our conversations about the nature of therapeutic action are not only valuable but essential. We do, however, have to look carefully at what we are hoping to achieve when we take up the problem.

In considering the goal of such questioning, we must rethink why we need to keep talking about therapeutic action. We must also entertain the possibility that we have been misguided in looking to our discussions about it as a way of solving a problem—that is, the problem of which facet of the clinical encounter is responsible for change. Instead, we might imagine that these conversations have been and will continue to be vital because they are likely to create a problem—namely, the problem that no matter what any particular theorist has observed about what has gone on in the course of treatment, there is something else that could be observed but that has been inattentively and that this has consequences that have not been sufficiently noticed.

This approach will work especially well in the pluralistic world of contemporary psychoanalysis when conversations are carried out among analysts who represent different theoretical traditions. Fortunately, the situation today contrasts dramatically with the circumstances that prevailed for many years. During those years, analysts talked almost exclusively to colleagues committed to the same fundamental assumptions that they themselves were, and they typically heard their own observations reiterated. The uncontradicted repetition of anecdotal data can easily be taken as evidence of the truth of the idea that is being promoted, and it is easy to see how analysts’ attention was directed to only those aspects of the workings of treatment that were deemed salient within their own tradition. This overly narrow focus led not only to vehement forms of Glover’s “special pleading” but also to theory-bound, unidimensional descriptions of analytic process. Description, as is well known, rests on the narrator’s underlying assumptions about what matters. In psychoanalysis, the framework that determines what we believe is worth describing is our theory. What is not described cannot be theorized, so our accounts and the conclusions we draw from them tend to be circular [see Greenberg 1981; Pine 2001].

In the first [and probably still the most famous] recorded example of a psychoanalyst choosing not to report some of what happened in an analysis, Freud neglected to describe having fed herring to the Rat Man in his formal account of the case. In his private record, he laconically noted that his patient “was hungry and was fed,” a meal that included the herring, which the Rat Man disliked and left untouched [Freud 1909, pp. 303, 308]. Although in less than a week the patient reported a dramatic anal erotic fantasy involving herring [pp. 307–308], Freud did not mention the meal publicly, nor did he seem—even privately—to have placed much weight on the connection between what he did and the fantasy [see Lipton 1977, 1988, for a full discussion of this event]. This elision of detail is by no means unique to Freud or even to “orthodox Freudians.” Consider Guntrip’s [1975] account of his analysis with Fairbairn. Guntrip stressed the austerity of Fairbairn’s presence and his reliance on formal oedipal interpretations. Yet strikingly, his description of his analytic experience does not include what he considered extra-analytic contact, the time after each session during which he and Fairbairn would drink tea together and talk about psychoanalytic theory and other matters of mutual interest. This
slanting of description does not reflect a failure of narrative skill. Rather, it reflects what is inherent in description itself: completeness and coherence are at odds with each other, and coherence is achieved by the application of prejudices that dictate what needs to be included and what can be omitted.

This is where, perhaps surprisingly, there is a place for a contemporary version of “special pleading” in our new psychoanalytic conversation, assuming that analysts who represent a range of theoretical perspectives will be invited to plead their cases. Pluralistic conversations will always highlight aspects of the psychoanalytic situation that have gone untheorized or even inattented in the work of any given observer. It would be unthinkable in today’s climate that Freud’s account of the Rat Man case could stand without questions being raised about the therapeutic implications of the meal or about the assumption that hungry analysands (or this particular hungry analysand) must be fed. Of course, far more subtle omissions will be noted and highlighted, and new narratives of the familiar event will be erected on the foundation created out of the new observations.

The therapeutic action debate, despite its resistance to resolution, remains an important one. Because it invites observers to speculate not only about what works but also—before that—about what happens in the course of an analysis, the debate provides us with a crucial platform from which to view the various events that, taken together in their intricate interconnections, constitute the psychoanalytic process.

**KEY POINTS**

- Although he rarely spoke directly about the problem of therapeutic action, Freud was clear that psychoanalytic change depended on what he called “making the unconscious conscious.” This led to a privileging of the effect of the analyst’s interpretations over other dimensions of the psychoanalytic situation. Only correct, complete interpretations were considered to have therapeutic effect.

- From early in the history of psychoanalysis, a radically alternative vision emerged. The psychoanalytic situation was seen as a relationship between two participants—seen sometimes as recapitulating earlier relationships, sometimes as unique and sui generis—and the relational experience itself was believed to promote beneficial change. For many years, debates about therapeutic action pivoted on whether it was interpretation leading to insight or qualities of the relationship between analyst and analysand that was the most important factor in therapeutic action.

- For many analysts, recent developments in neuroscience provide a conceptual base for a view of therapeutic action that emphasizes the role of nonverbal events occurring between analyst and analysand. The related concepts of procedural memory and implicit relational knowing suggest that there are multiple unconscious registers and that changes in the nonverbal unconscious can lead directly to change.

- In recent years, analysts working within a range of theoretical traditions have moved away from interest in uncovering repressed mental contents and toward a focus on how people think. A range of terms and concepts have been used to describe this wide-spread, although not universally accepted, shift, which leads to an emphasis on promoting the development of symbolic capacity and the free flow of ideas rather than on discovery of hidden truths.

- While it is unlikely that any unified vision of therapeutic action will ever be widely accepted, the debate continues to be vital, because it highlights events of the psychoanalytic situation that can be marginalized within the framework of any one theory.
References

Casement P: Some pressures on the analyst for physical contact during the re-living of an early trauma. Int Rev Psychoanal 9:279–286, 1982
Casement P: Learning From the Patient. New York, Guilford, 1990
Ferenczi S, Rank O: The Development of Psychoanalysis [1923]. New York, Nervous and Mental Disease Publishing, 1925
Fonagy P: The process of change and the change of process: what can change in a “good analysis”? Keynote address given at the spring meeting, Division 39, American Psychological Association, New York, April 1999
Friedman L: Interpretation. Keynote address [PEP-CD ROM], 2001
Guntrip H: My Experience of analysis with Fairbairn and Winnicott (how complete a result does psycho-analysis achieve?). Int Rev Psychoanal 2:145–156, 1975
Ogden T: On three forms of thinking: magical thinking, dream thinking, and transformative thinking. Psychoanal Q 74:317–347, 2010
Process, Resistance, and Interpretation

Peter Goldberg, Ph.D.

Along with the concept of transference, the three terms under consideration in this chapter have long been essential elements in the clinical language of psychoanalysis. Yet the understanding of these terms—process, resistance, and interpretation—has not remained static: each has followed a particular conceptual trajectory, and the clinical use of these terms has varied and changed over time. For this reason, instead of attempting a fixed definition of the terms, I take a historical and comparative approach, showing the different ways that the three concepts have evolved and are employed in contemporary psychoanalytic approaches.

I outline the meaning of process, which in the early days of psychoanalysis had little theoretical definition but took on greater importance and conceptual meaning as new clinical models emerged to try and explain how the therapeutic cure works. Today the analytic “process” has moved to the center of much theory and research, although the word is still used in a variety of ways. Resistance, by contrast, was from the start a crucial clinical concept in early psychoanalysis and found a special place in the American ego psychological school, however, beginning in the post–World War II period, when psychoanalysis began to adopt what was arguably a new post-Freudian paradigm, the use of the term resistance became less pronounced and in some quarters fell into disuse, replaced by new ways of thinking about why and how patients “resist” the therapeutic process. Just as resistance has mutated in recent decades, so has interpretation changed. From the start, interpretation was almost the sine qua non of the analytic method, and although it largely retains its status as the main instrument in the analyst’s toolbox, its definition and significance have evolved considerably. Sweeping changes in modern psychoanalysis (e.g., the shift from a one-person to a two-person psychology and the proliferation of intersubjective theories of the therapeutic process) have broadened our understanding of the curative factors at work in the clinical situation: it is not interpretation alone that effects therapeutic change but also preverbal communications and unconscious identifications that go on between patient and analyst. These include a host of oft-unspoken transactions that, if they are to be conscripted to the purposes of a thera-
peutic process, rely nevertheless on the analyst's steady intuition and technical skill and the careful preservation of a setting and framework within which the clinical experiment is carried out. As a consequence of these changes, interpretation is often no longer narrowly conceived as a technical tool by which the analyst effects change in the patient but as an ongoing psychical process operating in the analyst's mind as well as a shared intersubjective process of unconscious communication and meaning creation in the clinical field of transference and countertransference.

Idea of Process in Psychoanalysis

Broadly speaking, it is possible to discern two separate but interrelated ways in which process is used in the analytic literature as well as in everyday conversation with colleagues. The first type of reference is to the treatment process, and it conveys the sense of something unfolding over time. It is easy to see that certain things can be realized only as this diachronic dimension unfolds: we speak, for example, of the development of a transference neurosis, of the deepening of the treatment over time, or of the working through of the conflicts. These transformations cannot be achieved in a singular exposure to an experience, no matter how meaningful or enlightening. This sense of a process unfolding over time led to the adoption of conceptions of sequential stages of treatment—roughly speaking, the initial, middle, and termination phases, each with its own distinctive characteristics. For this reason, analysts will talk of the treatment being in its "early stages," "middle stages," and so on.\(^1\)

Yet there is another equally important dimension of the analytic process whose effect lies in the immediate quality of something happening in the here and now of the analytic encounter—the momentary appearance of a connection or new link between different psychical elements, however fleetingly, to form a fresh association in thought and feeling. This synchronic dimension of analytic process does not rely on the steady passage of time for its effect; rather, it has a kind of "timeless" quality, an all-at-onceness that reflects the experience of being in a "free associative" state of mind that allows some nonlinear, nonrational ways of linking up with memories and buried emotional experience. We encounter this, for example, in the sudden revelation of a dream, in the surprising appearance of a symptom or a long-forgotten memory, in a slip of the tongue, or in a novel thought or unexpected feeling. It is in this here-and-now dimension that the immediate "work" of psychoanalysis is effected and that the vitality of the process is established anew in each session.

It was recognized early on, by Freud (1913), that the achievement of significant therapeutic insight depends on the patient's affectively charged experiences of reliving, in the current transference relationship with the analyst, the psychical conflicts that had remained fixed and unknown in the repressed unconscious. The analytic encounter provides a laboratory, then, in which alienated parts of one's psychical life can be rediscovered, new associations can be made, and the flow of communication is increased between different layers of psychical life—unconscious and conscious, latent and manifest, felt and thought, past and present, somatic and mental. Hence the importance in analysis of the synchronous dimension—the immediate, unforeseen convergence of affective experience, novel associations in thought, and transferential contact with the analyst.

That the term process is used indiscriminately in these two different ways (in the diachronic sense of a treatment process and the synchronic sense of an associative process) reflects the fact that both meanings are essential to an understanding of the way analysis works. Each serves to underwrite the possibility of the other: without the opportunity to work things through over time, the experience of new connections and associations in the here and now will remain emotionally indigestible—will disrupt the patient's status quo without providing the possibility of a viable new structure being built over time. Conversely, the unfolding of a process over time is meaningful only to the degree that there exists an emotionally convincing spark of experiential connection to unconscious life going on in the transferential here and now. Without this, the diachronic dimension of the process is rendered sterile; time goes by and nothing happens, and the treatment is thereby stripped of its power to bring about a lived (symbolizing) association between different parts of the self, parts that

---

\(^{1}\) Meltzer (1967), in *The Psychoanalytical Process*, proposed a Klein-Bion model of the analytic process that portrays an unfolding series of stages, each of which represents a further step in dealing with the problem of separation over the course of an analysis.
have remained unlinked or estranged from one another, segregated by defense mechanisms in order to protect the self from psychical pain or trauma.

History of Process: From Background to Forefront of Clinical Theory

In considering the concept of the analytic process, we are confronted with certain peculiarities in the way psychoanalysis emerged as a form of therapy. It began as a method of inquiry into the suffering and possible cure of certain types of psychoneurotic patients, but it quickly developed into a general theory of mental life. By the time of publication of The Interpretation of Dreams (Freud 1900), there already existed a full-fledged theory of mind, whereas conceptual models of the clinical method, by contrast, lagged behind. Even when Freud addressed questions of method more explicitly, in the technical papers of 1912–1913, he did not so much describe the phenomenology of the clinical process per se (i.e., patterns that are observable at the level of the clinical field and interaction) but remained focused on the analyst’s technical approach—his position of observer and interpreter of the patient’s discourse. Only gradually, and over many decades, did the clinical process itself come to the forefront of psychoanalytic writing and research.

There are, undoubtedly, many reasons for this gradual gravitation toward an interest in clinical process. Clinical theories are, of course, constantly being reshaped by the larger societal context and cultural conditions of the times. In its second half-century, in a changing scientific and philosophical world, psychoanalysis began branching into a number of different theoretical schools (e.g., Kleinian, object relational, self psychological, interpersonalist, Lacanian). However, in retrospect we can see that, despite their differences, all of these schools in one way or another reflect the emergence of a new paradigm, a new way of understanding the development of self, of its maladies, and of the environmental and interpersonal conditions under which it flourishes or falters. Along with this came new conceptions of the clinical process.

The proliferation of different clinical approaches and schools of thought led in many places to schisms and to a sectarian atmosphere, but this fraught terrain of competing theories has largely resolved itself into a landscape of unresolved pluralism. Inevitably, this pluralism has diminished the truth claims of any singular theory or technical approach: no school has proved itself superior to all the others. Over the past few decades, there has also occurred a steady waning of interest in metapsychological systems. Indeed, analysts today seem to rely on models of clinical process (which make use of process-oriented concepts such as projective identification, mutual regulation, countertransference enactment, and co-creation of meaning), while viewing metapsychological explanations with skepticism, if not mistrust. The postmodern trend away from authorizing any single, objective explanatory system seems to have touched psychoanalysis as well; certainly, contemporary clinical models make only modest claims to theoretical certainty and technical efficacy, and the existence of alternative explanatory systems and clinical models is now taken for granted. All of this has contributed to the modern tendency toward the study of clinical process.

Another notable development, occurring in conjunction with the move toward studying the process of psychoanalysis, is the almost universal trend away from the earlier focus on the workings of the individual mind and its replacement with the now-ubiquitous two-person models of the clinical encounter—models that see psychological life as taking shape in the interaction of interpenetration of two minds, or, taking this trend further, models that locate the emergence of psychological meaning not in the minds of individuals but in a shared phenomenological field. We have arrived in an era when process data (e.g., patterns of unconscious communication, interaction, and mutual regulation) become ever more prominent in our understanding of what transpires in the clinical situation (Stern et al. 1998; Thomä and Kächele 1987).

Today we can say that, generally speaking, the aims of analysis no longer pertain exclusively—or even primarily—to uncovering the inner conflicts of patients but pertain now to facilitating or fostering patients’ psychical capacities (emotional flexibility, tolerance of a variety of self-states, broadened symbolic capacities, greater mobility in object relationships, and so on). Not

---

2 Metapsychological explanations conceptualize what is going on in the clinical encounter in terms of meta-theories of the way the mind works, the way the child develops, the existence of universal structures such as the Oedipus complex or the death instinct, and so on.
only are we living in an age of conceptual pluralism in psychoanalysis, but our contemporary clinical methods implicitly or explicitly aim to instill a kind of pluralism in the patient’s psychical life—an ability to deal flexibly with the complexity of psychosocial experience.

**Early Implicit Model of Analytic Process: Therapeutic Regression in Response to Technique, Setting, and the Fundamental Rule**

If, in the earlier one-person psychology days of psychoanalysis, the analytic process (or the clinical interaction) had not yet become an explicit focus of theoretical attention, there nevertheless existed an *implicit* model of process. In broad terms, the traditional Freudian view of the psychoanalytic process rested on the assumption that the process would be propelled by the *spontaneous* appearance of unconscious material (in the form of symptoms, associations, parapraxes, transferences, resistances) that arose naturally once the patient was installed in the analytic situation. The assumption here was that the analytic setting (which places constraints on motor discharge along with a permissive attitude to the patient’s thoughts and words), plus the application of a *precise technical* approach by the analyst (neutrality, abstention, unbiased or evenly hovering attention), had the effect of inducing a therapeutic regression in the patient, thus allowing for the emergence of material that effectively conveys something about unconscious wishes and conflicts.

There were, of course, important disclaimers and limitations on the application of the analytic method: an analytic process would not get off the ground if the patient lacked certain capacities (e.g., for self-observation and reality testing and for object relationship and transference formation). Likewise, the analyst should be properly analyzed so as to remove the taint of countertransference pathology interfering with his or her therapeutic capacities.

The well-analyzed analyst and the properly selected patient (i.e., suitable for analysis) made it possible to assume a uniformity in the application of the method—that is, a single technique and frame applied to all patients in analysis. As psychoanalysis forged its institutional and professional identity, this early model became enshrined as the standard method, defined in terms of its external, observable characteristics: a uniform method consisting of the patient being on the couch four times a week and a neutral analyst using interpretation only to analyze transference and resistance. Any modification of the analyst’s technique, ground rules, or treatment framework—what Eissler (1953) referred to as “parameters of treatment”—meant that the treatment could no longer be considered psychoanalysis proper but would have to be considered one or another form of psychotherapy (Wallerstein, this volume). However, as we shall see, despite this institutionalization of a standard, unitary model of the analytic practice, the question of what constitutes the analytic process was by no means settled; on the contrary, it was ever contested within clinical theory and challenged from many quarters as new psychoanalytic models evolved.

**Resistance**

The assumptions of the early model of analytic process—that a natural therapeutic regression will occur, leading to the expression of unconscious wishes and conflicts in the transference—reflected Freud’s initial emphasis on the repression of libidinal wishes and, correspondingly, the orderly lifting of repression in the service of the cure. This implicit model of the analytic process would change, in some respects, as Freud (1923) introduced his revised theory of psychical structure (the new model of id, ego, and superego)—a change that brought resistance to the fore.

The term *resistance* was not, initially, a concept defined by its place in the model of the mind (such as repression, censorship, or primary processes) but was used descriptively to refer to difficulties in the clinical encounter. Freud (1900) gave it the broadest possible descriptive definition when he wrote that “whatever interrupts the progress of analytic work is a resistance” (p. 517). From the start, therefore, resistance was something observed in the context of the treatment relationship. Yet it soon began to take on a more particular conceptual meaning in the context of Freud’s (1900) topographic model of the mind, wherein the ego sets up a barrier of censorship that *resists* the entry back into consciousness of the repressed [prohibited, oedipal] wishes. Resistance now had an intrapsychic as well as interpersonal significance that was clearly tied to the defensive activity of the ego.

The phenomenon of resistance took on additional clinical interest when Freud (1912) began to recognize that transference itself is a form of resistance: whatever other ways the patient may resist, forming transfersances
(unconsciously repeating the past in the present) constitutes “the most powerful resistance to the treatment” (p. 101). This strong connection between transference and resistance has not been consistently maintained in subsequent theoretical models, in which the idea of what to do with the transference has evolved in many different directions (whereas the interest in resistance per se has waned).

From Obstacle to Aid in the Analytic Process

However, beyond Freud’s assertion about transference being a form of resistance, the thing that really brought resistance to the forefront in clinical theory was the recognition that resistance, instead of being the main obstacle to therapeutic progress, was perhaps its greatest aid. Thus, Freud (1917) began to express the view that resistances “should not be one-sidedly condemned. They include so much of the most important material from the patient’s past and bring it back in so convincing a fashion that they become some of the best supports of the analysis if a skilful technique knows how to give them the right turn” (p. 291).

This new appreciation of resistance would find a particularly good fit in the emergent ego psychology school that began to form in the 1920s. Ego psychology built on certain aspects of Freud’s (1923) revised theoretical model of psychic life—the so-called structural model that placed the ego in the center of an unconscious world of conflicting psychic agencies. Analyzing the ego’s strategic defensive efforts [as manifested clinically in the form of resistances] would become the established and accepted mainstream position of American psychoanalysis. This new focus on the ego’s defenses did not entail any obvious change in the classical model of the clinical process: it maintained, as before, the assumption of the analyst as a dispassionate observer, neutral with regard to the sources of the patient’s material (equidistant, in the words of Anna Freud [1936], from the id, ego, and superego and from external reality) and committed to the use of interpretation as the exclusive tool of technique. Unchanged, too, was the assumption of a unitary method, a fixed technique and setting that promote spontaneous regression and the development of a transference neurosis. Yet there was, after all, a shift in emphasis from freeing up the repressed contents to analyzing the ego’s defensive processes. Along with this, new conceptions emerged of a “working alliance” (Bibring 1954; Zetzel 1956)—a way of thinking about collaboration between the patient’s ego and the analyst, premised on a conception of a functional division within the ego into an observing part and an experiencing part (Sterba 1936). This proposal reflected the developing interest within ego psychology in the so-called autonomous (conflict-free) functions of the ego postulated by Hartmann (1951) and in the central role of reality testing in the clinical process.

Ego psychology, then, ascribed a dynamic intrapsychic role to resistance, yet the early connotations of resistance as “opposing analysis” and “resisting the analyst” remained. This may account in part for the decline in its use in many schools of modern psychoanalysis in which intersubjective models of the therapeutic process have made “resistance” seem conceptually unhelpful or distasteful. Schafer (1973a) took this up explicitly, and although he did not reject the use of the term, he did make a plea for a new way of considering how we use it: “While mounting this opposition [i.e., resisting] has its negative aspects, such as defiance, avoidance, dread, disclaimed reductionism in understanding, it also has its affirmative, even constructive aspects, such as protecting relationships, being faithful to ideals, maintaining pride and autonomy and achieving mastery” (p. 283). He also reframed the question of how we perceive the patient’s resistances in light of the participation of the countertransference, suggesting that “unless we also identify the affirmations implied by apparently negative behavior, we are committed to using the idea of resisting pejoratively” (Schafer 1973a, p. 284).

Insofar as the patient’s resistances provide a kind of map of the ego’s defensive strategies, it made sense that the analysis of resistance should become central to the ego psychological approach, as carried forward in the work of generations of American analysts. However, as the decades passed, even in the ranks of ego psychology, much of the elaborate metapsychology of the earlier years was stripped away, and those who continued to work within the strict parameters of a neutral observer approach evolved more disciplined and pared-down methods of clinical observation and intervention. The purest form of this pared-down kind of resistance analysis is perhaps to be found in the “close process monitoring” approach (Busch 1995; Gray 1986). Here the analyst interprets the resistance at the very moment when anxiety disrupts the associative process, thereby illuminating precisely the ego’s defensive activity. Another instance of the pared-down approach in modern ego psychology can be found in the work of Arlow and Brenner (1990) who, for their part, placed ever-greater emphasis on the analysis of compromise formations as the singular modality befitting the psychoanalytic treatment process.
Freud’s Expanded View of Resistance

Having touched on the centrality of resistance analysis in ego psychology, it may be worth going back to Freud’s own formulations regarding resistance. His ideas about resistance kept evolving, especially in the context of his struggle to account for the stubborn persistence of phenomena that obstruct and even undermine the therapeutic process in analysis, such as the repetition compulsion, primary masochism, and the negative therapeutic reaction. These difficulties led Freud [1920] to introduce his controversial hypothesis of a “death instinct,” an inherent organicist force opposed to life and to libidinal satisfactions. Along with this came new ways of thinking about deep-seated resistances to change in psychical life and in analysis, especially in the context of Freud’s [1923] new structural theory of id, ego, and superego, introduced in *The Ego and the Id*. In addition to those already-recognized resistances that originate in the ego [as it opposes awareness of unconscious desires], it was now possible to identify those that originate in the superego. Thus, in the course of meting out punishment for the unconscious sense of guilt, the superego—when fueled by the death instinct—carries out vehement attacks on the self, thus forming a tenacious counterforce to any movement toward health on the part of the ego. This superego-based resistance to change provided an explanation for the phenomenon of negative therapeutic reaction [the tendency for the patient to react against progress in the treatment by an unconscious exacerbation of the symptoms of illness]. Another source of resistance could also be identified as originating in the id itself. Thus, Freud saw in the repetition compulsion the work of an id-based resistance that actually works to obstruct the influence or interests of the ego in psychical life. This kind of resistance, which arises directly from the drive to psychosomatic discharge, may be observed in primary masochism and in certain kinds of somatic fixation, and it can confront the analyst with sometimes dangerous forms of obdurate refusal of symbolic thought processes. By the time of *Analysis Terminable and Interminable* [Freud 1937a], Freud’s discussion of resistance had broadened even further, beyond resistance originating in the ego, id, and superego, to a consideration of resistances arising from traumatic experiences, biological-constitutional factors, and developmental contingencies. He also suggested that there exist resistances to psychoanalysis [i.e., to the idea of the cure through revelation of unconscious life) originating in society itself. Resistance, it seems, was not simply the handmaiden of the ego’s defenses after all.

In Freud’s expanded perspective on resistance, we can see the foreshadowing of far-reaching developments in psychoanalytic clinical thinking. Indeed, the subsequent evolution of clinical theory in all its variety can be viewed from this vantage point as innovative attempts to adapt psychoanalysis to the challenges posed by these varieties of resistance [even though the term resistance had little or no currency in any of the new clinical languages]. These new departures in clinical psychoanalysis [e.g., Kleinian, object relational, Lacanian, self psychological, relational], whose fertile seeds were planted before World War II but grew vigorously after, all address in novel ways the problem of how to treat the patient who, for one reason or another, does not regress in the ordinary way in the analytic setting and requires something more than [or other than] the neutral, abstinent, purely interpretive technique advocated earlier on.

An Early Alternative Conception of Process: Melanie Klein

The most significant divergent model of analytic process in the Freudian era of psychoanalysis was that of Melanie Klein, who shifted clinical attention from resistance to anxiety. Klein offered an alternative vision of the analytic process that, although it first took root on British soil, eventually spread to become the equal of Freudian analysis across most of the analytic world, with the notable exception of the United States. Basing her approach on an assumption of endogenous phantasy populating an inner world of psychical reality, Klein turned the spotlight on the role of early object relations in the development of the self or the ego and on the workings of early defensive operations, more fundamental and consequential than those of repression—namely, the mechanism of splitting, accompanied by projection, denial, omnipotence, and schizoid anxieties of fragmentation [Klein 1946]. By conjuring an internal world of object relationships in which the forces of life are pitted against those of destruction, Klein brought unconscious processes within close reach of the analyst’s thought processes. In addition, by postu-

---

3 This theme is taken up extensively by the French psychosomatic school [De M’Uzan 2003; McDougall 1978].
lating the normative existence of a mode of psychical organization (the paranoid-schizoid position) in which the ego is not whole but in separate parts, Klein brought psychoanalytic technique coherently within reach of the non-neurotic (the more “primitive” and often the more disturbing) regions of psychical life in patient and analyst. Klein’s contribution marked a substantial shift in thinking about process and about resistance. When, later on, Klein (1946) introduced the concept of projective identification (i.e., the unconscious attribution of a part of oneself to another), it opened the door to sweeping changes in the way the analytic process could be thought about, leading, in the hands of Bion (1962), Rosenfeld (1971), Racker (1957), and others, to a growing recognition that the analyst’s constant unconscious reception and processing of projective identifications constitutes a crucial aspect of the therapeutic action of psychoanalysis.

Klein and her followers stayed close to the classical psychoanalytic method, adhering to the abstinent position of observer and to the strict technique of interpreting the transference. Yet their conception of clinical process was nevertheless quite different. The clinical emphasis is not on the resistances but is focused instead on the effects of anxiety. Klein is not referring to the signal anxiety [Freud 1926] that alerts the ego to the presence of danger in the internal world; rather, she viewed anxiety as marking the immediate effect of conflict and danger in the internal world of object relations. The therapeutic technique rests on the analyst’s willingness to notice and address this anxiety, which invariably expresses itself in the transference. Klein’s conception of transference differs significantly from Freud’s: rather than a repetition in the present of a repressed object relation from the past, transference in Klein is the recapitulation in the exterior world of what is going on here and now in the unconscious world of psychical reality. The pressing immediacy of the transferences and anxieties should be sought out and readily interpreted, because failing to do so leaves the patient persecuted by internal dangers, prey to the depredations of further attacks in the internal object world. This forces the patient to resort more drastically to splitting defenses, which threatens the self’s cohesiveness and viability. Because there is constant transference from the internal to the external world, the patient’s perception of the analyst should be constantly clarified and explained in terms of the internal conflicts. This results in a progressively modification of the internal world through introjection of the analyst’s words, perceptions, and thought processes. Gradually, the patient is able to relinquish the defensive use of splitting and projection and to tolerate the various and conflicting aspects of psychical experience (the good and the bad) in a realistic whole—an integration of the self as a whole that Klein (1935) called the depressive position, which entails acceptance of the role of symbols in psychical life [Klein 1930] and the separation of self from other and hence the emotional capacity to recognize and value the other.

Klein’s contribution marked a substantial shift in thinking about the analytic process. The process is not seen as depending on the setting and the neutral presence of the analyst to produce a therapeutic regression, as is the case for Freud and ego psychology; it is assumed that the patient brings the already-regressed state of the illness into the treatment situation from the very start. It is the analyst’s job to seek out the illness by bringing it quickly into focus in the transference setting. The analytic process, in other words, does not arise naturally but is propelled forward by the active use of interpretation. It is the unwavering, thorough exploration of the internal world that gradually leads to the goal of allowing the introjection of “realistic” (whole, good, helpful) objects.

---

**Emergence of a Post-Freudian Paradigm: Widening Scope of Application of Analysis, and Variations in Method**

Klein’s focus on schizoid phenomena [splitting mechanisms and primitive anxiety states], along with Freud’s expanded conception of resistance, was a harbinger of what now seems like a sea change that would sweep over clinical psychoanalysis (albeit implicitly and haphazardly) in the post–World War II period. Although Freud’s original delineation of the clinical framework [i.e., the setting and technique] remained in place (and continued to define the institution of psychoanalysis), the landscape of clinical theory nevertheless began to change so extensively that it seems justified now to speak of a shift to a post-Freudian paradigm. New ideas emerged about the nature and the causes of psychical disease and the curative factors in psychoanalysis. Traditional categories of what the analyst is looking for—that is, the metapsychological lenses through which the analyst identifies patterns of suffering and illness in the patient—broadened considerably, and analysts began to consider factors beyond the genetics and dynamics of
intrapsychic conflict. New scope was given to developmental, environmental, and interpersonal factors because these contribute to psychical development and pathology—how the personality is affected in specific ways by failures of environmental provision [Kohut 1971; Winnicott 1965], trauma [Balint 1968; Fairbairn 1952], and developmental failures [Greenacre 1968; Mahler 1974; Stern et al. 1998].

These changes, which had been foreshadowed in the work of Rank and of Ferenczi (1928), gathered steam in the wake of World War II. Hand in hand with these changes came a gradual but significant breakdown of the doctrine of a single, uniform method applicable to the treatment of all analytic patients and a corresponding gradual broadening of the scope of application of the method [Stone 1954] to a wider array of patients beyond the narrow definition of suitability that had prevailed in the first decades of clinical psychoanalysis. Soon there arose, in many quarters, a new calibration of types of patients, including those with “pre-oedipal” conflicts, primitive defensive structures, perversity and narcissistic organizations, schizoid withdrawal, developmental disorders, structural deficits in the ego, disorders of the self, false self illness, regressive personality disorders, and so on. Clearly, at some point the door opened to the idea that different kinds of patients required variations in what the analyst should do and that despite these variations, the treatment process would still be considered psychoanalysis. Kernberg (1976), for example, while systematically laying out guidelines for the distinction between psychoanalysis, psychoanalytically informed psychotherapy, and supportive therapy, nevertheless expanded the legitimate reach of psychoanalysis to the treatment of borderline illnesses.

If we were to extend the idea of resistance into the contemporary era of clinical theory, we would find that there now exists a rich variety of models describing the obstacles to change in psychical life—models of why and how the patient and/or the analyst might resist change and what it is that they are resisting.4

“Resistance” in the Modern Trauma-Based Models: Kohut and the Relational School

The idea of resistance requires further revision in light of the recent trend toward interpersonalist and trauma-based models in contemporary American psychoanalysis. We can see an illustration of this in Kohut’s (1971) theory of the damaged and vulnerable self and his conception of the analytic process as a recapitulation of empathic failures. Resistances, from this point of view, express a legitimate defense against renewed injury at the hands of the analyst. Powerful resistances (accompanied by grandiosity and attempts at idealization) reflect early failures of empathy and represent the patient’s effort to seek compensation, in the person of the analyst, for defects in the patient’s own self-object (caretaking) environment. This view closely resembles Winnicott’s (1956) opinion that the source of an outbreak of resistance in the patient should be sought in what the analyst has done or failed to do.

It is obvious that this view of the cause of psychical distress and the meaning of resistance differs greatly from that of Freudian and ego-psychoanalytic analysts and implies a very different model of the analytic process. For Kohut (1971), the analytic situation is not a rule-bound “technical” setting in which a therapeutic regression spontaneously occurs but a humanly responsive environment designed expressly to provide auxiliary ego functions that the patient lacks. Technically, this means the provision of mirroring and empathic understanding. The therapeutic process, according to Kohut, follows a course in which the initial presentation of resistances (conceived of as traumatic residues) gives way to the expression of disintegration anxiety

---
4We resist not just so we can defend against prohibited wishes and destructive impulses but also because we fear affective disregulation and loss of mutual regulation [Stern et al. 1998] and because we fear reliving or remembering trauma [Bromberg 1996]. We resist because of envious attacks by our objects [Klein 1975] and claustrophobic entrapment and intrusion by the objects [Meltzer 1993] and because we fear disqualification of the organizational status quo in our internal worlds [Joseph 1989] and loss of omnipotent protection provided by idealized objects [Rosenfeld 1971]. We resist because we dread loss of identity [Erikson 1959], loss of recognition in the eyes of the other [Boris 1994], and because of the threat of being erased by the desire of the other [Lacan 1966; Laplanche 1997]. We cling to sameness and resist change when we feel threatened with the dismantling of the sensory adhesive basis of the self [Meltzer 1975; Tustin 1986] and when confronted with the terror of blankness [Green 1983] or the disruption of the private sense of being [Winnicott 1971]. Each of these reasons to resist in the patient requires of us an innovation in technique, sometimes a modification in the analytic frame, setting, and ground rules. In the face of this formidable array of resistances in the patient, the analyst must also confront his or her own counterresistances [Racker 1957] and counteridentifications [Grinberg 1962].
until the patient becomes capable of an experience of a joyful rebirth of the self. The main curative factor is the patient’s gradual internalization of the analyst’s empathic functions [the “transmuting internalization” of self-object functions].

Like self psychologists, relational analysts assume that the analyst has a hand in all difficulties that arise in the clinical encounter but emphasize the idea of mutuality and the co-creation of meaning in the clinical encounter (Aron 1996; Bass 2007; Stern 2009). Resistance, from this point of view, reflects a [legitimate] fear of retraumatization in the treatment situation (Davies and Frawley 1992) and a dread of experiencing shame in the clinical encounter—the shameful helplessness that invariably occurs when dissociated aspects of the patient’s self-experience [i.e., self-states that were disavowed due to trauma] are reactivated and relived in the transference (Bromberg 1996). The role of the analyst as inadvertent perpetrator of disarray in the patient is kept centrally in mind (Grand 2000) and guides the therapist’s technique. Here, the therapeutic process focuses on the question of building a sense of safety and aiding in the regulation of overwhelming affective states that signal the recrudescence of trauma. Therapeutic change is rooted in the shared perceptions of what is brought to light during these painful reenactments.

In these self-psychological and relational approaches, the analytic setting becomes, above all, a venue for a reparative interpersonal encounter between two people, dependent not on the natural therapeutic regression prompted by the analyst’s neutral technique but on the analyst’s willing engagement in an affectional interaction that will allow the patient to recover parts of self that have been dissociated due to trauma and empathic failure.

The Modern Paradigm Change in the Conception of Process: Winnicott and Bion

Donald Winnicott made a pivotal contribution to psychoanalysis, most obviously in the way he brought the function of the environment into the heart of clinical theory. Using the mother-infant relation as a metaphor and prototype, Winnicott (1965) was able to illuminate a fundamental dimension of what the analyst does, namely, the provision of what he called a holding environment. This entails more than providing safety and reliability; it involves a crucial array of distinctive functions, including recognition [comparable to empathy], tolerance of aggression, imaginative ego support, facilitation of the patient’s associative “play,” and management of the setting. The analytic process, in this view, entails the patient’s gradual internalization, over time, of these “holding” functions [a process that bears obvious comparison with Kohut’s conception of the transmuting internalization of self-object provisions].

Winnicott’s contribution, however, also had a substantial impact on the modern reorientation of analysis away from the study of the ego (in the framework of a one-person psychology) and toward a two-person model focused on the lived experience of the phenomenal self [what Winnicott [1960b] referred to as the “going-on-being” of self]. By conceptualizing the environmental conditions [i.e., the specific facilitating role of the mother] within which a viable experience of self may emerge and be sustained, Winnicott turned a spotlight on the analyst’s facilitating functions [i.e., what the analyst provides in order for a therapeutic process to get underway and endure].

This also opened the door for a reconsideration not only of the analyst’s mental functions in the clinical situation but also of the functions of the analytic setting (Green 1975; Khan 1960; Langs 1979; Milner 1952). No longer viewed merely as a kind of neutral laboratory in which the patient’s regression and symptomatic discourse could be observed and interpreted, the setting was now seen as serving a number of essential and active functions, including those of holding and securing primitive anxieties and fragmenting tendencies [Bleger 1967]. This new emphasis on the role of the setting, in concert with revolutionary new ways of conceiving how countertransference plays an active part in the therapeutic process (Heimann 1950; Money-Kyrle 1956; Racker 1968), produced a new model of the analytic process now anchored in a two-person perspective, one in which the analyst’s mental functions are no longer kept at a distance from the patient’s material.

This shift toward a therapeutics of the experiential self, evident in Winnicott’s work, reflects a certain phenomenological influence in some parts of modern psychoanalysis, but it also reflects a change in broader psychosocial patterns of psychological pain, illness, and cure. The contributions of postwar theorists in Britain, including Winnicott, Bion, Fairbairn, Milner, and Guntrip, did a great deal to reorient therapeutic aims away from psychical conflict based on repressed
desire and toward the treatment of the (fragile, alienated, depleted, lifeless self-in-the-world.

Winnicott’s [1965] notion of a facilitating environment provides a much different picture of the analytic process from Freud’s original description and from that of the ego-psychological approach. Winnicott (1958) highlighted the analyst’s background role, comparable with how the mother facilitates the play of her child while not intruding into the play.\(^5\) Winnicott’s approach does not rely on the analyst’s remaining in a neutral, abstinent position of the observer; the analyst instead takes a more active role in facilitating a space in which the patient can begin to experience an authentic “going-on-being” [Winnicott 1960b], uninterrupted by demands for transferential interactions. To be active in this approach is not necessarily to interpret resistances and transferences; it is something closer to a sense of active engagement on the analyst’s part (just as the caretaking mother is attentive and might be very active without necessarily obstructing or demanding the child’s attention). It may be said that Winnicott’s innovation is, in fact, a study in how the analyst must avoid detachment—must remain active—without being intrusive.

Central to Winnicott’s [1954] reconceptualization of the therapeutic process was a view of regression as potentially curative in its own right—that is, not a temporary tactical regression in the service of the ego, but something like a strategic regression that provides an opportunity to escape the pathological grip of the false-self ego [Winnicott 1960a] and affords the patient a way to reexperience the vitality of the instinctual body and unconscious desire (true-self experience).

Wilfred Bion’s contribution relocates the analytic method in this same post-Freudian terrain, highlighting the role of the object and the environment in the psychological development of the self. By extending Klein’s concept of projective identification, Bion (1962) was able to develop a model of the object’s containing function—a crucial function in which the elements of the patient’s “undigested” [split-off, unmanageable] psychic experience are provided containment [metabolized, transformed, digested] by the mental processes of the analyst, reshaping those contents toward a more thinkable [symbolic] form. Provision of a thinking mind for the processing of unthinkable experiences, which Bion [1962] named alpha function, became the basic model of his extensive revision of the analytic process in terms of a container/contained model.

In light of these theories, the analytic process is recast in quite specific ways. Guided by the new conception of the analyst as a container whose “reverie” states provide a receptacle for the processing of the patient’s split-off states of mind, Bion [1970] recommended that the analyst enter each hour in a state of mind uncrowded, if possible, by memories and desires. In this way, Bion suggested, the analyst makes himself or herself maximally available for the reception of uncontained anxiety and for the perception of the patient’s inchoate, split-up, or not-yet-symbolized psychological material. By temporarily giving up the certainties of what is already known and forgoing the premature use of interpretive connections, the analyst is able to get closer to the patient’s own unformed, uncertain, broken-up states of mind.\(^6\)

In some respects, Bion’s recommendation recapitulates Freud’s own interest in the free-associative method and Freud’s [1912] suggestion that the analyst enter a state of “evenly suspended attention.” However, in Bion’s model the analyst’s mental functioning has taken on a far bigger role, and the role of insight in the cure has been eclipsed by identifications and unconscious communications (holding and containing) that take place between analyst and patient and the function of learning from experience in the analytic setting (i.e., conceiving new thoughts rather than achieving insight). Bion’s approach also brings new attention to the temporal aspect of the analytic hour itself: he counted on certain processes unfolding in the hour, a movement from an unorganized, unformed state of the clinical field to something uniquely organized (in terms of emotion, meaning, and thought) over the course of the hour.

### Interpretation

Interpretation has always been the technique par excellence of psychoanalysis. It lies at the very heart of what clinical analysis was originally conceived to do, namely, to bring to consciousness the latent meaning of the pa-

---

\(^5\)This dimension of the analyst’s function can be distinguished from his or her role as a transference object—the object of libidinal or aggressive cathexis—described by Freud and Klein (a role that requires interpretation on the part of the analyst).

\(^6\)This had the effect of turning the analytic process into a kind of epistemological laboratory in which “knowledge” and belief are encouraged to dissolve so that the elements of unconscious lie can make their appearance in fresh form, to be experienced and noted as new facts in the clinical field that can then be turned into thoughts that will undergo further transformations.
tient’s material. Taking the dream as the prototype [although the same technique would be applied to symp-
toms, parapraxes, transference manifestations, and any aspect of the patient’s discourse and behavior in the
Treatment setting], Freud [1900] showed how the latent content of the dream [its hidden meaning] could be dis-
covered by means of interpreting its manifest content—or more exactly, by interpreting the patient’s associa-
tions to the manifest dream. In The Interpretation of
Dreams [Freud 1900], he illustrated the many different pathways taken by the associations as they submit to
the requirements of psychical censorship and the many strategies of disguise found in this dream work [e.g.,
substitutions, condensations, displacements, plasticity of representation, relation of part to whole]. Armed with
this knowledge of how dreams work, the analyst can then follow the clues offered by the manifest dream
[or symptom, or parapraxis] and travel back along the
associative pathways of the dream work to discover re-
pressed wishes hidden in the unconscious. Following
the clues back and illuminating the hidden regions of
desire and conflict are the work of interpretation.

Yet this was not all one needed to know about inter-
pretation: Freud [1911] also set out to address the
question of how interpretation is technically deployed.
He pointed out that “dream interpretation should not be
pursued in analytic treatment as an art for its own
sake, but that its handling should be subject to those
technical rules that govern the conduct of the treat-
ment as a whole” [Freud 1911, p. 94].

Thus began discussions and debates over the tech-
nique of interpretation that would continue for many
decades. Especially as it developed in America, con-
siderable attention was paid to delineating the proper
technique of analysis. Accordingly, interpretation was
carefully differentiated from other types of verbal inter-
ventions [e.g., suggestion, explanation, persuasion,
manipulation, supportive statements] that, although
unavoidable or even useful at times, should neverthe-
less not be confused with interpretation proper, which
alone defined the therapeutic action of psychoanalysis
[Bibring 1954]. Some writers classified the order in
which different kinds of interpretation [e.g., prepara-
tion, confrontation, and clarification] should be given
[Devereaux 1951], whereas others attempted to iden-
tify the proper sequence in which the patient’s mate-
rial should be interpreted [Loewenstein 1951]. A good
deal of attention also was given to questions about how
to deliver an interpretation—that is, questions of tim-
ing and tact and of the correct depth at which to inter-
pret. An example of divergence of opinions over these
issues may be found in the contrast between, on the one
hand, the ego-psychological dictum [A. Freud 1936]
that one should interpret from the surface to the depths
[i.e., speak in a way that is amenable to the ego] and, on
the other hand, the Kleinian method of directing the
interpretation more directly to the “deeper” level of phan-
tasy to address the source of anxiety directly in the in-
ternal object world.

Whereas Freud originally saw interpretation from a
topographical point of view [i.e., the function of bring-
ing the unconscious to conscious awareness through insight], the function of interpretation had now broad-
ened to include other metapsychological functions: in
ego psychology, it came to serve a mainly dynamic func-
tion—that is, the interpretation aimed to illuminate
the ego’s defenses by exposing the resistances. Here the
ego’s awareness of its own defensive processes, rather
than simply the uncovering of hidden meanings, be-
comes the goal of interpretation [Kris 1951]. Klein’s
approach highlights the economic point of view insofar
as the interpretation is timed and aimed at the point of
maximum buildup and urgency of anxiety. Here the
aim of interpretation is neither mainly to offer insight
by uncovering repressed contents nor to illuminate the
defenses but rather to actually affect the current [eco-
nomic] balance of instinctual tensions and object
relations in the internal world. We can see, then, why for
Klein what mattered most was not tact but the timing
of the interpretation.

The central role in the clinical process of interpre-
tation of the transference was given conceptual heft by
Strachey [1934] in his landmark paper titled “The Na-
ture of the Therapeutic Action of Psycho-Analysis,”
which became a touchstone of clinical theory. Central
to his conception of the analytic process was the idea
that the analyst becomes a superego figure in the pa-
tient’s mind. This unconscious identification of the
analyst with the patient’s superego provides the basis,
Strachey thought, for the specific therapeutic action
of analysis because it allows the analyst to make interpre-
tations in the heat of the transference moment, as it

\[7\] Although Strachey’s work is usually viewed as emphasizing insight through interpretation, it is notable that he offered an incipient object-relational model insofar as it points to a central role for identificatory processes between analyst and patient—the way the analyst becomes identified with [becomes a part of] the patient’s inner psychical reality—and indicates that this is an important aspect of the curative process.
were—to speak as a new version of the superego figure that the patient will gradually perceive as being different, alter all, from the archaic superego figure that had remained fixed in the repressed unconscious. The transference interpretations will be *mutative* (i.e., will effect actual structural change in the patient’s personality) only insofar as they are addressed to something actually felt and immediate in the patient’s experience rather than something removed from the here and now. This immediately felt transference experience must be addressed in specific and concrete terms, not vaguely or abstractly. In addition, Strachey added, the mutative effects are enhanced if interpretations are given in well-graded progressive steps rather than hastily or prematurely. In this regard, he suggested two broad phases: First, the patient becomes aware (or is made aware through interpretation) of the presence of anxiety deriving from a pressing unconscious [libidinal] wish aimed at the analyst. Second, the now-manifest anxiety is addressed from the point of view of the ego to show the difference between the archaic [wished for, infantile] object and the actual current object relation, thus strengthening the ego’s ability to differentiate past from present and fantasy from reality.

The idea of the mutative transference interpretation would endure for generations, adhered to as a mainstay in the theory of technique. However, ensuing discussions of clinical method made it clear that, with regard to questions of the technique of interpretation, many aspects remained debatable. In making an interpretation, for example, how much emphasis should be placed on the genetic aspect of the material (i.e., the historical past)? Is it better to tackle the patient’s current life conflicts first, connecting these to transference responses, and only later link these to the historical conflicts, or should these be linked together all at once in the interpretation? In this regard, Freud [1937b] placed considerable importance on the concept of *constructions* in analysis. Constructions differ from interpretations, per se, insofar as interpretations are aimed at *deconstructing* the patient’s manifest material [differentiating its parts and decoding them for their unconscious significance], whereas constructions involve *reconstructing* the past as a whole by putting the parts back together in a historical version of the infantile neurosis. Hartmann et al. [1946] suggested that reconstruction of the past is the ultimate goal of interpretive work, because interpreting the dynamics of current conflicts in the here and now makes it possible to construct a historical (genetic) understanding of the infantile conflicts in the there and then. Yet the role of constructions in analysis was later explicitly questioned by a new generation of writers who were skeptical about the validity of historical reconstructions (and the heavy hand of metapsychological explanation influencing those constructions) and thought that the analysis is best conceived as a process that operates in the realm of *narrative* constructions rather than historical truths [Klein 1973; Schafer 1973b, Spence 1982]. Emphasis on the here-and-now orientation, so prevalent across a range of contemporary analytic approaches, has had the effect of downplaying the exploration of the past and minimizing the role of constructions in analysis. Kleinian analysts, in particular, see things very much in terms of the current transference situation: genetic links to the past do not have to be explicitly sought out because they are actively alive in their current edition in the here-and-now phantasy structures. This is consistent with the assumption that the analyst should address himself or herself to unconscious phantasies, which structure psychical reality and meaning at all times and are the ever-present source of transference at every moment.

Another perennial question about the technique of interpretation involved the advisability of making extratransference interpretations. The long-standing case against extratransference interpretation—from Strachey [1934] to Gill [1982], among many others—is that if we interpret what is going on “out there” in the patient’s life, it invariably dilutes the quality of experiential connection that can happen only in the immediacy of the transference situation [with its unique power to bring together past and present, affect and idea]. One may also object that, when making an interpretation, we are never speaking simply as objective reporters or observers but as transferential figures [Etchegoyen 1991]. Therefore, making an extratransference interpretation will increase the likelihood of misunderstanding [Money-Kyrle 1968] and confusion: it always leaves open the implicit question, *Who are you as you say this, and why are you saying it?*

On the other hand, an overreliance on transference interpretation may lead to distortions of its own: it may lead to the patient’s “artificially reinforcing the conflict with the analyst so as to not see what is happening to him outside or to avoid taking responsibility for his history” [Etchegoyen 1991, p. 435]. Not only is there reason

---

8Extratransference refers to those interpretations that make no direct reference to the transference but link unconscious conflicts to what is going on currently in relation to others in the patient’s life outside the consultation room.
for concern that incessant transference interpretation will valorize or fetishize the domain of transference, thus undercutting its therapeutic utility, but there are theoretical grounds for questioning the validity of transference interpretation altogether. This is the position taken by Lacan (1966) and his followers, who view the interpretation of transference in every instance as reinforcing its phantasmic presence in psychical life and hence perpetuating an imaginary situation in the analysis. Technically, Lacan suggested that the transference is best dealt with by the refusal of the analyst to interpret it, thus aiding in the patient’s own discovery of the illusory quality of transference through the analyst’s silence on the matter.

Paradigm Shift in the Understanding of Interpretation

Lacan’s radical position on transference interpretation reminds us that the clinical approach to the unconscious, even among those who claim a close allegiance to traditional Freudian analysis, may be approached from widely divergent technical standpoints. It is not simply the case, however, that interpretation is viewed differently according to the predilections of divergent and competing theories. There seems to have been, following World War II, a fundamental underlying change in the way interpretation was treated in the psychoanalytic literature and in practice. I have referred already to a mid-century shift in psychoanalysis, one that in retrospect seems to have inaugurated a new paradigm, albeit in haphazard fashion. This new paradigm can be observed in the rise of the language of self in place of the ego, in the new prominence given to the environment or to the object (or, in France, the “other”) in the formation of the self; and correspondingly, in a new consideration of the role of countertransference as something that could inform analytic technique rather than merely a pitfall to avoid. Along with this, as I have noted, the concept of resistance began to fade, and a two-person view of the clinical situation began to take hold.

These epochal changes were accompanied by far-reaching clinical innovations and thus greatly affected the prevailing attitudes toward interpretation. Sole emphasis on interpretation leading to insight gave way to new models of therapeutic action based on conceptions of environmental provision (Balint 1968; Winnicott 1965) and of the containing function of the analyst (Bion 1970), and on the role of the actual interpersonal relationship in the cure (Greenberg and Mitchell 1983; Kohut 1971; Loewald 1960). Soon it became possible to question the advisability of making interpretations not simply on the basis of timing and tact but on more systematic theoretical grounds. Would interpretations rob patients of the ability to discover their own associative process— their own meaningful relationship to their inner life? In a famous warning against the premature utterance of interpretations, Winnicott (1969) wrote: “If only we can wait, the patient arrives at understanding creatively and with immense joy, and I now enjoy this joy more than I used to enjoy the sense of having been clever. I think I interpret mainly to let the patient know the limits of my understanding” [p. 711].

However, I would like to note, emphatically, that this by no means constituted an abandonment of interpretation— quite the contrary. Rather, it reflected a sea change that was taking place in the implicit understanding of the function of interpretation. Instead of focusing on what interpretation is meant to do (its instrumental, technical function), interpretation began to be viewed more broadly as an implicit, ongoing psychological process, something going on all the time in the mind of the analyst, largely unconsciously. Here Bion’s (1962) theory of the analyst providing containment, and his conception of the analyst’s mind functioning in a way that is analogous to digestion, to metabolization, and to the mother’s reverie (Ogdén 1997), loom very large and have by now had a profound influence on the modern view of analytic process. The actual utterance of an interpretation becomes less important here than the ongoing internal interpretive process of the analyst. From this perspective, interpretation becomes coextensive with the entire ongoing transformative work of the analyst’s mind—the function of receptivity, of a practiced analytic intuition, of countertransference awareness, and of a skeptical use of theory and knowledge when giving shape to the material in the unfolding of the analytic hour. Along these lines,

---

9 This is well illustrated in the so-called Controversial Discussions—the debates over clinical theory that took place in 1940s London between Freudian and Kleinian analysts (King and Steiner 1991).

10 André Green (1975), too, described in detail the ongoing interior work that constitutes the interpretive activity of the analyst, and in this regard he ascribed a special place to the preconscious processes in the analyst’s mental functioning. On the special role of the preconscious, see also the paper by Kris (1950).
Bion (1970) advised that interpretations, when uttered, should as far as possible be unsaturated [should not impose previously established meanings and analytic “knowledge” on the patient’s experience].

However, this ongoing interior interpretive process is not to be found in the analyst’s mental functioning alone: it is equally, and quite logically, a feature of the patient’s mental functioning, as Searles (1975) was able to bring to light in his paper “The Patient as Therapist to His Analyst.” Contemporary theorists have taken this a step further: It is not just that the patient also occupies a position of observer and interpreter of what is going on in the analytic encounter, but there is also something like an interpretive function operating in the analytic process itself. Writing from the innovative perspective of South American psychoanalytic theory, Baranger and Baranger (2008) inaugurated a new way of thinking about psychical phenomena as being founded always within a bi-personal field, a model that Ferro (1999) elaborated on in his theory of psychical objects operating in an always-shared space. Ferro was able to show how psychical life is lived in the form of dreamlike characters that spring to life and exist irreducibly in the clinical field. These characters themselves constitute a kind of ongoing interpretation of the internal lives of both patient and analyst in the here and now of the clinical encounter. This is why Ferro (2009) could assert that the patient’s dream is not so much something to be explicitly interpreted by the analyst but is itself an interpretation of what is “going on” in the analysis and in the patient’s life. Ogden (1994) offered an elegant approach to the function of interpretation within an intersubjective matrix, an approach that carries the echo of Winnicott’s (1971) theory of transitional experience and potential space. He described the function of the inter-subjective third—a conjoint psychical creation that comes into existence purely as an artifact of the intersubjective encounter between patient and analyst. One may say that “interpretations” are rooted in this intersubjective creation—an embodiment in dream-thought of newfound meaning born of the meeting of two minds, which is then available to be absorbed and used in the individual mind of each participant to take home, as it were, from the analytic session.

In the work of both Ferro and Ogden we see the emergence of a new dream work model of analytic process, resting on the idea that the analyst and patient are engaged in a conjoint unconscious process of “dreaming” what is happening in the analytic encounter. Interpretation, in this context, is fully reconceived as a psychical process rather than an instrumental technique. No longer something the analyst does, interpretation is now understood as a process of transformation of meaning taking place in the intersubjective field whereby not-yet-thinkable elements of emotional and psychical experience [proto-communications such as projective identifications, pictographic images, actions, and proto-emotions in the form of affect, sensation, and phantasm] are transformed through the work of symbolization into thinkable qualities of self-experience. This model owes a great deal to Bion’s conception of dream-work alpha (Bion 1992), the function of the mind that constantly works to transform raw experience [sensation, emotion, perception] into elements of psychical experience that can hence be used to elaborate an experience of self.12

These contemporary models of analysis as a kind of dream work harken back, in some ways, to Freud’s (1900) early characterization of a clinical approach that allows the patient to enter a somewhat dreamlike [free-associative] state so as to gain access to qualities of psychical experience that have been made inaccessible due to repression. Yet at the same time, there has been a profound change in how the dream function of the mind is understood and used in object relations theory today. For Freud (1900, 1917), the dream work is primarily a means of refashioning the world of repressed meanings: it rearranges the latent dream elements through secondary revision into a manifest version that is domesticated for the purposes of conscious thought; in so doing, the dream work succeeds in disguising the disturbing truth of unconscious desire. The modern object relations analyst, whether implicitly or explicitly, has a different view of the clinical process, at least in part because the malady itself seems to have changed: the patient no longer has repressed desires but incoherence and fragmenting of self—from a troubling loss of connection to unconscious desire and psychical sources of vitality. The modern patient is persecuted by disarray, meaninglessness, and alienation from others. As a consequence, the dream loses its relevance as a text of repressed desire and oedipal conflict to be deciphered by the analyst-sleuth. Instead, the dream becomes an end in itself. Dream work now literally means bringing lost parts of self to life, a means of giving psychical expression to the

---

11Hoffman (1983) would later restate this theme in terms of a “social constructivist” conception of interpersonalist theory.

12Meltzer (1988), in his book Dream Life, developed these ideas into a new kind of metapsychology that places dream work at the center of mental functioning.
previously inexpressible raw materials of experience, not uncovering something but creating something new. The intersubjective context of dream work allows the mind of another to augment one’s own dreaming capability. After Bion, we do not so much use dreams to do analysis but rather use analysis to help the patient learn how to dream.  

### Beyond Interpretation: Contemporary Trends in Analytic Process

Contemporary psychoanalysis has increasingly turned its attention from the specifics of interpretation to the nonspecific aspects of the analyst’s technique that operate implicitly and systematically as therapeutic factors in the treatment. The work of Thomä and Kächele [1987] in Germany is an example of the growing presence of a strong social science orientation, one that uses a very different theoretical language from that of object relations theorists, Kleinians, and traditional Freudians yet offers a strong endorsement of an intersubjective basis for understanding the analytic process. Influenced by insights and findings gleaned from extraclinical research methods (e.g., Bowlby 1969; Bucci 2001; Main 1993; Schore 1997; Stern 2009), Thomä and Kächele explicitly rejected the model of analysis as a naturally occurring process in which the unconscious reveals itself to a technically proficient analyst-as-observer and insisted instead on a view of the analyst as participant-observer. In this view the analyst is shaping the process through a particula kind of attention that shifts focus according to the heuristic purposes of the analytic interaction. The analyst’s technique is guided by the operational principles of participant observation and hypothesis testing in the clinical encounter.

### Variations on “Intersubjectivity” and on the Role of “Relationship” in the Cure

Today, it is clear that all analysts, whatever their theoretical persuasion, have come to view the analytic process in terms of a two-person model, with the analyst (more or less) as a participant-observer. Consequently, some version of the intersubjective view of the analytic process now exists in all clinical theories and in all corners of the analytic world. Yet despite the ascendancy of the intersubjective paradigm, there exist wide variations in the way the clinical process is understood, and these differences remain both challenging and instructive. There are schools of thought that lie rather obviously on opposite poles, for example, the French Lacanian school on the one hand and the self psychological or relational school on the other. However, it is interesting to see how even seemingly compatible approaches may actually differ in significant ways. There is much overlap, for example, between the British object-relations approach and the homegrown American relational approach, both of which seem to highlight what goes on between analyst and patient. Yet there are significant differences in what is implied by “relationship” in these two schools.

---

13We are able to see, in this dream-work version of analysis, the degree to which the analyst’s mental functioning has come into the center of the clinical procedure.

14Non-interpretive aspects of analytic technique have been conceptualized in a number of ways in modern clinical theory in terms of, for example, a necessary therapeutic symbiosis [Bleger 1967; Searles 1973]; the function of the setting as a “framing structure” [Green 1975]; an “interactive matrix” [Greenberg 1995], background of safety [Sandler 1960], and rhythm of safety [Tustin 1986]; and processes of mutual regulation [Beebe et al. 2003; Seligman 2000; Stern 2009] and attachment (Fonagy and Target 2002).

15This has made redundant the debate over whether analysis works through insight or through the “relationship” (Gabbard and Westen 2003).

16Lacanians view the ego’s “relatedness” with suspicion and consider empathy misleading. Relational analysts and self psychologists, on the other hand, assume that the self is seeking empathic contact but is obstructed by trauma, and hence they find nothing useful about the idea of symbolic castration [as constitutive of the self or subject] that is fundamental to Lacan [1966]. Nevertheless, some theorists have made fruitful efforts to try and combine the insights of these clinical theories that are, on the face of it, quite irreconcilable. See, for example, Krischner’s (2004) book Having a Life.

17Indeed, the ideas of the British theorists (Winnicott, Bion, Fairbairn, and others) are to be found commonly in the contemporary relational and interpersonalist literature in the United States.
and thus some divergence in what constitutes a therapeutic process. In the American schools [interpersonal, self psychological, relational], there is a greater emphasis on the therapist bringing affective interactions and mutually felt experience to light and thus more significance given to exploring enactments in the analytic situation. By contrast, object relations analysts, while observing the interactions and the affective resonances in the clinical encounter, nevertheless do not bring these “relational” elements so much to the forefront. Instead of enactments, object relations analysts emphasize the role of the analyst in providing specific psychical functions [e.g., holding, containing, metabolizing], both through processes of identification with the patient and through management of the setting [which allows the patient to safely regress and the analyst’s own primitive anxieties to be contained]. In this regard, the British, French, and Latin American schools share a similar assumption, namely, that the relationship itself is not curative [it might, in fact, get in the way of the cure]: it is a matter not of repairing the damaged self through relationship to another but of using the analytic setting and the analyst’s mental functions to return the patient to an emotional experience of self.18

It must be said that these broad conceptual distinctions, which are in any case conceptually tenuous, may not show up consistently as differences in practice. How we actually work is not how we think we work [as Canestri [2006] and others are attempting to clarify in their current work on the analyst’s implicit theories], nor is it simply a good thing to be faithful to our theoretical beliefs. Pluralism presents many as-yet-unsolved challenges for psychoanalysis [Bernardi 2002] but may prove to be among its greatest strengths.

---

**KEY POINTS**

- The process of analysis refers both to the unfolding of the treatment over time toward its goal and to the quality of therapeutic engagement in the immediacy of the encounter between patient and analyst.

- The workings of the analytic process have become a focus of considerable attention in contemporary clinical theory and research.

- Resistance is understood as any obstacle that arises in the patient’s mind to the awareness of unconscious wishes and conflicts. Resistances express themselves as resistances to therapeutic insight and to the analyst. However, use of the term has waned in modern psychoanalysis; new perspectives on how the analytic process works have led to a much broader view of the reasons why patients resist therapeutic change.

- Interpretation, while remaining at the heart of clinical analysis, has undergone an evolution in the way it is used and understood. No longer limited to being a technical tool for effecting change in the patient, interpretation is now commonly conceived as part of an intersubjective process of unconscious communication and meaning creation taking place in the clinical field of transference and countertransference.

---

18 Here we can see the effects of culture and history on the development of divergent clinical theories, which always reflect prevailing conceptions of what are the maladies of the self and thus what constitutes the intended process of analysis. The object relations view reflects the influence of phenomenology and the problem of existential alienation on the part of postwar European psychoanalysis—hence the emergence of conceptions of the false self, disintegration anxiety, schizoid withdrawal, and so on. On the other hand, the currency of a pragmatic cure through interpersonal interaction remains indelible in homegrown American psychoanalysis, reflecting the enduring spirit of Sullivan’s interpersonally based psychiatry.
References

Bass A: When the frame doesn’t fit the picture. Psychoanalytic Dialogues 17:1–27, 2007
Farbaim WRD: Psycho-Analytic Studies of the Personality. London, Tavistock, 1952
Hartmann H, Kris E, Loewenstein RM: Comments on the formation of psychic structure. Psychoanal Study Child 2:1–38, 1946
Khan MR: Regression and integration in the analytic setting: a clinical essay on the transference and counter-transference aspects of these phenomena. Int J Psychoanal 41:130–146, 1960
Kris E: Ego psychology and interpretation in psychoanalytic therapy. Psychoanal Q 20:15–30, 1951
Loewenstein R: The problem of interpretation. Psychoanal Q 20:1–14, 1951
Main M: Discourse, prediction, and recent studies in attachment: implications for psychoanalysis. J Am Psychoanal Assoc 41S:205–244, 1993
Racker E: The meanings and uses of countertransference. Psychoanal Q 26:303–357, 1957
Schafer R: A New Language for Psychoanalysis. New Haven, CT, Yale University Press, 1973b
Termination and Reanalysis

Martin S. Bergmann

Sociological and developmental events within the history of psychoanalysis have conspired to give the problems of termination and reanalysis a new urgency. To address the sociological aspect, first we have to face the fact that there is a substantial subgroup within the population that requires continued professional assistance just to keep on functioning. It is no longer rare that one is consulted by a patient who is now middle age or even older and has been in continuous treatment since early adulthood or even childhood. It is even conceivable that in the future mental health practitioners will be trained as auxiliary figures whose job will be to assist those who cannot function on their own. In the language that Kohut has created, these will be professionals willing and able to function as an auxiliary self-object to severely impaired patients. The other group will be trained, as most psychoanalysts are today, to bring the treatment to conclusion, with greater attention to termination than is customary in the current training. Today all analysts have among their patients a mixture of the two groups. The professional training of the future psychoanalyst today is geared toward the second group; if psychoanalysts have to deal with the first group—patients whose treatment is either interminable or very prolonged—their own professional commitment and self-esteem suffer. To put it into technical psychoanalytic language, if the superego of the therapist demands a cure within a number of years and the patient is in need of lifelong assistance, the match will not be a good one. In this contribution I deal primarily with the historical culture of psychoanalysis, but the sociological pressures should always be kept in mind.

In two earlier papers on the subject of termination (Bergmann 1988, 1997), I did not have the courage, as I see it now, to think the matter through to the end. What prevented me from doing so was a sense of guilt toward Freud for understanding the history of psychoanalysis in a way he could not, which, now that I am past my 90th birthday, I feel I can do. This reluctance was not unique to me but characterized a whole generation of orthodox Freudian psychoanalysts. The internal structure of psychoanalysis is such that it does not allow us, Freud's disciples, to go easily beyond what Freud achieved. For me, however, it was a relief to discover that a paradigm on termination does not exist, because now I was free to think about it and even encourage the readers of this pa-
per to reflect on how the decision to end the treatment is arrived at and the nature of the pressure exerted on the two parties to bring termination about.

In my 1988 paper I suggested that optimal termination takes place when the analysand is ready to exchange the by-now obsolete transference love for more gratifying love in real life. However, transference love makes far fewer demands than love in real life because the analyst, unlike the real lover, does not demand gratification of her or his own needs. If transference love is the only love the analysand has experienced, termination will be more difficult.

In 1997 I published a paper under the title "Termination: The Achilles Heel of Psychoanalytic Technique" with the following opening statement: "In retrospect, we should have been more surprised than we were that Freud’s papers on technique never included one on termination. Had we idealized Freud less, we would have realized earlier that psychoanalytic technique lacks anything like a 'royal road' toward termination" (Bergmann 1997, p. 163). Continuing to reflect on this subject, I find that this failure on Freud’s part was not an accident and that we have to face the historical fact that Freud did not develop a consistent technique for bringing psychoanalysis to a satisfactory conclusion. This was indeed an Achilles heel that Freud had difficulty admitting publicly until 1937. Somewhere in the back of our minds, we have known this all the time, but our not facing the problem squarely has handicapped our work.

It turns out that as the analysis is coming to an end, many problems that were not dealt with previously emerge and demand solutions. I list only some of the more urgent ones: Does an analysis have a reliable, clear-cut ending, or could it in principle go on forever, making the end an arbitrary decision by therapist or patient? Is there such a thing as a completely analyzed person? Are we justified in claiming that some people were incompletely analyzed if they ended their analyses prematurely?

In 1937 Freud himself formulated such an ideal situation:

[T]he patient shall no longer be suffering from his symptoms and shall have overcome his anxieties and his inhibitions; and secondly, that the analyst shall judge that so much repressed material has been made conscious, so much that was unintelligible has been explained, and so much internal resistance conquered, that there is no need to fear a repetition of the pathological processes concerned. (p. 219)

I am not sure that Freud realized the complexity of this statement. Whether symptomatic relief has taken place is easy to ascertain, but whether the pathological process will reassert itself in the future is more difficult to predict and is more a reflection of the therapist’s faith rather than a scientific conclusion.

Harold Blum (1989) may well have been the first psychoanalyst to state that psychoanalysis lacks the paradigm for its own termination: "During Freud’s lifetime there was an opening and middle phase of clinical analysis. There was no description of a concluding or terminating phase in an otherwise open-ended, timeless analytic process" (p. 275). Blum further noted: "Termination had not been taught or supervised in analytic training. Prior to 1950 it had been assumed that anyone who could conduct analysis properly could terminate it correctly. A terminated case was not required for institute graduation, nor for certification in the American Psychoanalytic Association" (p. 283).

It is precisely now that psychoanalysis is facing new criticism that we have to examine termination problems with renewed efforts. My first task is to demonstrate that indeed Freud had no technique for termination at his disposal. As the first "witness" I ask my readers to remember the Wolf Man’s difficulties in termination (Freud 1918). In that case history, Freud described "peculiarities of the patient’s mentality which were revealed by the psychoanalytic treatment but not further elucidated and were accordingly not susceptible to direct influence." Among those were "tenacity of fixation," “propensity to ambivalence,” and “contradictory libidinal attachments” capable of functioning side by side. The special difficulties of this case made Freud (1918) resort to a new technical procedure:

I determined—but not until trustworthy signs had led me to judge that the right moment had come—that the treatment must be brought to an end at a particular fixed date, and eventually the patient came to see that I was in earnest. Under the inexorable pressure of this fixed limit his resistance and his fixation to the illness gave way, and now in a disproportionately short time the analysis produced all the material which made it possible to clear up his inhibitions and remove his symptoms. (p. 11)

It has been observed repeatedly that there are patients like the Wolf Man who need the “danger” of the termination to rouse them out of their passivity, but the optimism that Freud experienced when asserting that the Wolf Man was cured did not prove to be correct. With the Wolf Man the concept of “forced termination” became part of the psychoanalytic technique. The use of the term trustworthy signs should make us pause. Instead of instructing us as to when this point is reached in treat-
ment, Freud relied on his own intuition, and as subsequent events showed, he was mistaken in believing that the Wolf Man was close to termination. Because the Wolf Man remained in contact with psychoanalysis for the rest of his life, we know that he was not cured either by Freud or by his subsequent analyses (Gardiner 1971).

In 1926, when Freud reevaluated his anxiety theory, he returned to the Wolf Man and explained his failure to cure him by the instinctual regression of the Wolf Man to the oral stage and hence his fear of being eaten by the seven wolves. Freud also reconstructed that two opposed instinctual impulses—sadistic aggressiveness toward the father and a tender passive love for him—were repressed: thus repression attacked almost all the components of the Oedipus complex and by implication made a satisfactory termination impossible [Freud 1926].

André Green (1980) made us aware of the pivotal role that the Wolf Man played in the history of psychoanalysis. As he put it, “After 1915 the wolf man haunts theory ceaselessly” [p. 231]. Green located the main reason for Freud’s inability to cure the Wolf Man in “the patient’s power of maintaining simultaneously the most various and contradictory libidinal cathexes, all of them capable of functioning side by side” (p. 229).

The Wolf Man was in reanalysis with Ruth Mack Brunswick between October 1926 and February 1927 [Brunswick 1928]. The prewar rich Russian aristocrat was by then a destitute refugee in Vienna. We are told without any comment by the therapist that Freud collected money for his former patient, “who had served the theoretical ends of psychoanalysis so well” [Brunswick 1928, p. 441]. From a humanitarian point of view, this was on Freud’s part an act of generosity, but from a psychoanalytic point of view, it was a disaster because it made this very passive man even more passive and a permanent patient of psychoanalysis. Without a word of criticism of Freud, Brunswick said that the Wolf Man became greedy, wondering every year how large the next year’s gift would be. I myself recall Paul Federn saying that the Wolf Man complained that he could not get anything published under his real name but that everything he wrote was published when he wrote as the Wolf Man. He was discharged as being “well and relatively productive.” During the second treatment he was suffering from a “hypochondriacal idée fixe” that he was victim of a nasal injury. The supposed injury compelled the Wolf Man to stare for long periods into the mirror.

Brunswick attributed the source of the new illness to an unresolved remnant of the transference, but when she described the current illness of the Wolf Man, she left little doubt in the mind of the reader that the Wolf Man was a seriously ill, paranoid man. It is relevant for my discussion of termination that the Wolf Man had developed an ambivalent attitude toward Freud. He blamed Freud for the loss of his fortune and believed that this blame justified Freud’s collecting money for him, but at the same time he claimed to be Freud’s favorite patient. It seems that Brunswick did not analyze the meaning of Freud’s financial subsidy but rigorously attacked the belief that he was Freud’s favorite. She pointed out that he was not the only published case and therefore had no right to be proud. What I believe Brunswick did not realize was that instead of a cure, psychoanalysis had given the Wolf Man a permanent new sense of identity as Freud’s famous patient. Once, detained by Russian authorities in Vienna, he announced, “I am the Wolf Man.” The whole analysis with Freud was transformed into a new myth, resulting in a new identity. Deutsch (1957) reported that something similar happened to Dora, who was proud of having been Freud’s famous case. Brunswick does not explain why she felt compelled to attack the Wolf Man’s feeling that he was a special case. Was it sibling rivalry? In any case the fact that analysis can give a patient a new identity was not subjected to psychoanalytic scrutiny. By reconstructing the past along new lines, every analysis effects the sense of identity of the analysand, but for the Wolf Man the analysis represented a new birth fantasy, forcing us to accept the fact that an analysis can itself be transformed by the irrational forces of the unconscious.

As my next example of Freud’s inability to terminate an analysis, I cite the case of the poet Hilda Doolittle, known as H.D. Precisely because her book Tribute to Freud (H.D. 1956) is so positive in the expression of love toward Freud, it is useful to illustrate that Freud could not bring his analyses to a termination. Fortunately for the history of psychoanalysis, H.D.’s book can be supplemented by a more recently published book edited by Susan and Stanford Friedman (Friedman and Friedman 2002). There we learn that in 1932 Freud was corresponding with Bryher, H.D.’s financial supporter, about the possibility of her “cousin” H.D. entering analysis with Freud. In fact, Bryher and H.D. had been lovers and later were part of a ménage à trois with Bryher’s second husband until the latter abandoned them both to become a homosexual. On November 13, Freud wrote to Bryher the following astonishing letter from which I am quoting in part:

With me things are no longer the way they used to be. I am old, often ill, and only work for 5 hours with students or patients. There isn’t a long waiting list anymore, clients in need of help prefer younger people. But material circumstances force me to keep on earning money. Until recently my fee was $25 per hour,
as a result of the general impoverishment I have low-
cred this to $20 or $15. I donate one of my five hours
free of charge, something with I would like to be able
to do in general anyway. But I can’t do that. Some of
my adult children are out of work and have to be as-
sisted or supported.

If you designate £100 for your cousin’s analysis,
I calculate that this sum won’t last beyond one month,
and I am worried that this time frame and number of
hours will not be sufficient to achieve anything for
her. With such a limitation it seems more ethical not
to begin anything at all. We consider three months
the shortest possible time limit for a trial period.
[Friedman and Friedman 2002, pp. 7–8]

Freud was clearly not concerned with anonymity
toward his future patients. He apologizes for his fees
and describes himself as old and exhausted. In later times
the phrase “trial period” acquired the meaning of a
period in which the analyst determines whether the
patient is analyzable or not, but that is not what Freud
meant. He thought that 3 months was the minimum
time the patient must allot if the patient wished to
benefit from the analysis. As late as 1932 Freud still
believed that 3 months might suffice and only if neces-
sary could the patient return for further analysis.

H.D. [1956] reported the following outburst by Freud
from her analysis:

The Professor himself is uncanonical enough; he is
beating with his hand, with his fist, on the head-piece
of the old-fashioned horseshoe sofa that had heard
more secrets than the confession box of any popular
Roman Catholic father-confessor in his heyday…
Consciously, I was not aware of having said anything
that might account for the Professor’s outburst. And
even as I veered around, facing him, my mind was de-
tached enough to wonder if this was some idea of his
for speeding up the analytic content of redirecting the
flow of associated images. The Professor said, “The
trouble is—I am an old man—you do not think it
worth your while to love me.” (p. 21)

Later on H.D. showed the professor that he was worth
loving by coming to an hour of therapy when the civil
war raging in Vienna made this visit a life-threatening
one. An enactment by the analyst leads to a dangerous
acting out by the patient. In my view, Freud stepped
out of his role as interpreter to act as a rejected lover;
by doing so, he forged with the patient a real bond that
remained unanalyzable, and therefore the analysis
could not be brought to a satisfactory termination.

Every psychoanalytic cure contains a mixture of two
components. The first consists of the insights gained by
the recovery of what was repressed—a new understand-
ing of a more realistic picture of the self and the major
love objects in the patient’s life. The other consists of
what is called the “corrective emotional experience.”

This second type of cure comes about when the ther-
apist behaves in a way different than what the analysands
expected and different from the way the early parental
figures behaved. The more disturbed the patient is, the
more important is the corrective emotional experience.
When the first component predominates, termination
can be reached. If the second predominates, however,
ending treatment is more difficult. To put it in psycho-
analytic language, if the analyst is serving as a trans-
ference figure either as a result of displacement from
parental figures or as a projection of unacceptable
aspects of the self, the end of the analysis can be reached.

However, if the psychoanalyst is serving as a new object
and the treatment is a “corrective emotional experi-
ence,” the therapist becomes a primary object like the
parent, and termination becomes uncertain. If the ana-
lyst as a result of a traumatic past becomes the first re-
liable object the patient ever had, termination is in
danger of becoming another traumatic event. Only a
transference relationship has a termination point; a pri-
mary relationship cannot be terminated.

The patient who preceded H.D. was J.J. van der Leeuw,
a now-forgotten but at the time well-known explorer
and popular writer. H.D. developed the type of fantasies
about him that analysands create in such situations.
When van der Leeuw’s plane crashed in Africa, H.D. re-
turned to Freud and said: “I know there is the great body
of the Psycho-Analytical Association, research workers,
doctors, trained analysts and so on! But Dr van der Leeuw
was different. I know that you have felt this very deeply.
I came back to Vienna to tell you how sorry I am. The
Professor said, ‘You have come to take his place’” (H.D.
1956, p. 6).

It is hard to read this encounter without feeling that
Freud’s sense of timing was not always right. He may
have guessed the patient’s unconscious correctly, but the
interpretation was premature. The patient was away;
the analyst does not know what changes have occurred
in the patient over the months of separation. To say
that she came back to replace the dead rival may have a
kernel of truth but is needlessly wounding. The en-
counter raises the question of what kind of termina-
tion can be expected if the analyst’s interpretations dis-
regard timing and are wounding.

If we examine H.D.’s book carefully, we come to
the conclusion that what H.D. felt for Freud was more
than transference. He is “real” to her, and what she de-
velops toward him is something akin to real love.

In 1977 Samuel Lipton created a minor storm within
psychoanalysis when he published a paper titled “The
The definition reflects Freud’s commitment at that time to ego psychology. The ego should at the end of the analysis be stronger than both the id and the superego, but it is not easy to determine when this optimal strength has been reached, particularly once future internal conflicts are visualized. “The work of analysis proceeds best if the patient’s pathogenic experiences belong to the past, so that his ego can stand at a distance from them. In states of acute crisis analysis is to all intents and purposes unusable” (Freud 1937, p. 232). To this remark of Freud’s we can say that neurosis for which treatment is sought is rarely entirely in the past. Most patients come in acute crisis. “The patients cannot themselves bring all their conflicts into the transference, nor is the analyst able to call out all their possible instinctual conflicts from the transference situation” (p. 233). This passage gave rise to the famous controversy as to whether only transference interpretations are mutative. If Freud was right and only part of the inner conflict is reflected in the transference, what will be the fate of the conflicts that never enter the transference? “The defensive mechanisms directed against former danger recur in the treatment as resistances against recovery. It follows from this that the ego treats recovery itself as a new danger” (Freud 1937, p. 238).

Even though it was not recognized at that time, the publication of Analysis Terminable and Interminable (Freud 1937) was a major event in the history of psychoanalytic technique, because as Shapiro (2003) noted, it marked the end of a cherished illusion of the “complete psychoanalysis.” The logic of that paper demanded a continuous capacity for self-analysis after termination, the periodic return to analysis with the same analyst, or a series of analyses with different psychoanalysts. Fenichel’s (1974) opposition to Freud’s paper is of historical interest because it shows what a blow that paper was to the next generation. The prolonged analysis that followed during what I called the Hartmann era can be read as another response to that paper: a prolonged attempt to demonstrate that a complete analysis is possible.

Freud went on to add “the sense of guilt and need for punishment” is a force “absolutely resolved to hold on to illness and suffering” (Freud 1937, p. 242). Freud coined the interesting term “psychical entrophy.” He then added “masochism” and “the negative therapeutic reaction,” phenomena that are “unmistakable indications of the presence of the instinct of aggression…which we trace back to the original death instinct of living matter” (p. 243). Finally the famous passage: “The ego ceases to support our efforts at uncovering the id; it opposes them, disobeys the fundamental rule of psychoanalysis [free association] and allows no further derivatives of the repressed to emerge” (p. 239). Freud further noted, “We often have the impression that with the wish for a penis and the masculine protest we have penetrated through all the psychological strata and have reached bedrock, and that thus our activities are at an end” (p. 252).

Perhaps the most controversial assertion was Freud’s rejoinder to Ferenczi’s criticism of his incomplete analysis that it is impossible and needlessly painful for the analysand to try to analyze latent conflicts. After 1937 psychoanalysts came close to the position of Goethe’s sorcerer apprentice, who could command a broomstick to fetch water but could not learn how to stop the broom once the work was done.

The death instinct as a concept may well be one of the concepts that Fonagy (2003) called “over specifying the theory.” Overspecifying takes place when psychoanalysts create new concepts to which the psychoanalytic interview can offer no clear answers. It is at these points that dissidence and controversy develop (Bergmann 2004). The introduction of the death instinct had a major impact on the question of termination. Because in the course of treatment the impact of the death instinct can be diminished in favor of the life instinct but never eliminated, it becomes difficult to decide when termination is to be reached. Even after termination, aging, illness, bereavement, and other traumatic events can change the balance of forces once more in favor of the death instinct and its manifestation in depressive illnesses.

Post-Freudian Concepts of Termination

What Freud failed to do other psychoanalysts attempted to do, but because they too shied away from facing the problem, their contribution remained limited. I quote once more from my 1997 paper:

The first psychoanalysts to address difficulties in termination were Ferenczi and Rank (1924). In keeping with Freud’s (1914) idea that during psychoanalysis the infantile neurosis is transformed into a transference neurosis, they advocated that the analyst should set the termination date the moment this transformation occurs. They believed that only then could a repetition of clinging to the early object be avoided. The termination date must be set this early if fixation
on the mother is not to give way to transfERENCE fixa-
tion. They advocated that analysis must end before it
can become a vehicle for the repetition-compulsion.
[Bergmann 1997, p. 164]

The Ferenczi-Rank forced innovation shows how
already in 1924 termination had become a problem.
Ferenczi’s paper of 1927 was the first paper to address
the problem of termination:

The proper ending of an analysis is when neither the
physician nor the patient put an end to it, but when it
dies of exhaustion…. A truly cured patient frees himself
from analysis slowly but surely; so long as he wishes to
come to analysis he should continue to do so…. The pa-
tient finally becomes convinced that he is continuing
analysis only because he is treating it as a new but still
a fantasy source of gratification, which in terms of reality
yields him nothing. (Ferenczi 1927, p. 85)

All subsequent efforts to address the problem of ter-
mination [Firestein 1964; Glover 1955; Waelder 1960]
came to the same conclusion: that there is no royal road
to termination. Glover [1955] devoted two chapters to
the terminal phase, in which he wrote of “transference
weaning and ego readaptation” [p. 139]. Glover took it for
granted that it is the analyst’s task to give the notice of
termination. The analysand will frequently react to the
danger of termination by a return of the symptoms that
have already been overcome, and a new period of work-
ning through will then take place. The termination phase
can take months and even years. Glover was well aware
of the fact that many analyses that are terminated end
because a stalemate has been reached. What Glover
called stalemate I see as a new equilibrium that the two
parties collaborated in establishing, and like other states
of equilibrium, they are apt to last at least until the an-
alyst, perhaps after some consultation, understands the
role she or he played in establishing the equilibrium.
A stalemate analysis is not fundamentally different from
a stalemated marriage or a nonproductive relationship
between parent and offspring. In all such relations un-
conscious destructive needs are met.

Strictly speaking, the question of whether the ther-
apist should be the one to announce that the analysis
has come to an end or if the patient be allowed to termi-
nate whenever he or she is ready, as Ferenczi advi-
cated, is not a problem of technique; it goes to the core
of the value system under which the analysis took place
and how authoritarian it was. If termination gives rise
to an irreconcilable conflict, we may assume that the
analytic process did not take place.

Freud’s dual instinct theory gave rise to the Kleinian
point of view, which assumes that the child comes into
the world in the paranoid position, where destructive
wishes projected on the mother hold sway. Only later, by
the infusion of the mother’s libido, does the child reach
the depressive position where it is willing to make resti-
tution for these aggressive wishes. In the Kleinian model,
treatment takes place between the paranoid and the de-
pressive position, but even if the depressive position is in
the ascendancy, the victory is never certain or permanent,
and termination always to some extent is arbitrary.

We know now that the conclusions reached by Freud
in 1937 were not acceptable to many psychoanalysts.
One of the sharpest criticisms came from Otto Fen-
iche, but the culture of psychoanalysis before World
War II was such that Fenichel’s paper was written only
for the circular letters and not meant to be published.
It was published posthumously in 1974, or as the edi-
tors euphemistically put it, the paper “was recently dis-
covered in Mrs. Frances Déri’s estate.” Fenichel [1974]
criticized Freud’s assumption that the ego is naturally
always hostile to the instincts and instead postulated
that if the ego can control undesirable instincts, it can
guide the person to a realistically possible gratification
of instinctual demands. Against Freud’s claim that it is
neither possible nor desirable to analyze latent con-
licts, Fenichel argued that in the analytic process lat-
tent conflicts are always mobilized and analyzed and
are never completely latent. Here I believe the diffi-
culty was terminological. Fenichel is right: latent con-
licts are continuously brought up in analysis, yet that
does not mean that in the analysis of a single, childless
woman one can analyze a future conflict between moth-
ering and wishes for career advancement. Some latent
problems do emerge in psychoanalytic treatment, but
others do not.

Freud’s death instinct theory was unacceptable not
only to Fenichel [1935] but to a whole generation of
psychoanalysts who believed that war was an aspect of
capitalism and would disappear under socialism. More
could be said about Fenichel’s criticism of Freud’s 1937
paper, but ultimately the greatest difference is Fenichel’s
opposition to Freud’s death instinct theory, a criticism
that most psychoanalysts committed to social revolu-
tion shared. The death instinct, insofar as it became a
belief rather than a mere hypothesis, sets limits on the
possibility of any termination that is not a compromise
formation between the two antagonists: libido and ag-
gression or libido and the death instinct.

After World War II, something fundamental hap-
pened to the culture of psychoanalysis that increased
the lengths of analyses from months to years and from
terminable analyses into interminable ones. During
the same period, under the influence of Loewald in the
United States and Winnicott in England, the aim of analysis slowly changed from relief of painful symptoms and neurotic character traits to resumption of growth and development. Whereas Freud and Abraham recognized only arrest in the development of the sexual drive manifesting itself in fixation on pregenital stages of the libido, Loewald and Winnicott set new goals for psychoanalysis. They saw neurosis as impeding the whole development of the person and psychoanalysis as the technique that enables the former analysand to keep growing after termination.

One of Freud’s important contributions to the understanding of human nature was his realization that reality allows gratification only to a small part of our libidinal and aggressive wishes. Many of these wishes remain ungratified. The transference to the psychoanalyst is the result of the mobilization of many of the wishes left ungratified. What precisely these wishes are becomes the subject matter of the analysis, but if these aroused wishes have no outlet in reality, the termination of treatment reestablishes the preanalytic state of lack of gratification and makes termination difficult. However, as long as the patient can verbalize these wishes within the safe confines of the treatment, some relief is obtained. In opposition to this idea, it may be argued that in the analysis these wishes were experienced and verbalized for the first time and therefore lost the tyrannical power they once had. That may well be so, but the question remains whether they lost most or only some of their power and, if so, whether termination will once more be experienced as an unwelcome and forced weaning process.

Glover (1955) touched on, but did not adequately deal with, the differences between those analysands who end on a positive transference, praise the analyst to their friends, and refer new patients and those who end on a negative transference. The latter are apt to seek a reanalysis because their analysis ended without resolution. If the relationship is strongly negative, an analyst of a different school may be sought. The patient and the new analyst will tend to ascribe the limitations of the analysis to the particular school to which the previous analyst belonged until a new equilibrium in the form of a second stalemate sets in.

The weak point in Glover’s book was his inability to tell the analyst at what point to give the notice of termination and to differentiate between a stalemate of analysis and a genuine termination point. In my own supervisory teaching, I have found that the less experienced therapist reaches the stalemate position much earlier than the experienced therapist and that a major task of the supervisor or control analyst is to point out to the student how to break out of the stalled position. Because of the barrier between unconscious and preconscious and because of the power of the repetition compulsion, all but the few very gifted analysands soon begin to go in circles and repeat rather than discover new data. It is the therapist’s task to break through the repetition and point out derivatives of new unconscious thoughts in the material or even draw attention to the fact that the border between conscious and unconscious has been shut.

Waelder’s (1960) discussion of the completion of analysis is much shorter than Glover’s but contains a similar difficulty. Waelder accepted that a complete analysis in the sense of complete understanding of a person’s psychic life is beyond our capacity to achieve. However, from a therapeutic point of view, an analysis is complete “if the pathological structures have been fully understood both dynamically and structurally… and if the psychopathology has thereby disappeared or has been rendered comfortable” (pp. 242–243). However, like Glover, he added, “[A]n analysis should be terminated when we have reached the point of diminishing returns.” Waelder does not comment on the contradiction between a complete termination and a stalemated one.

Waelder assumed a prolonged postpsychoanalysis truce between superego, ego, and id and the repetition compulsion. The ego, the most mature part of the personality and the agency closest to the reality principle, may well favor such a truce, but will the other agencies abide it? It seems that when discussing termination, many psychoanalysts forget what they know about id, superego, and the repetition compulsion.

Ella Sharpe (1937) ended her book on dream analysis with a chapter titled “Analyzed Persons and Their Dreams.” She delineated an analyzed person “as one in which direct instinct gratification and sublimation is accompanied by zest and a feeling of well being” (p. 192). She noted that in the dreams of analyzed and unanalyzed individuals, the difference is mainly that dreams that used to evoke painful affects can now be dreamed with greater ease. Furthermore, she felt that the need to disguise is not as great and that the capacity of dreams to affect the mood of the next day is less pronounced. These analyzed people also had the capacity to analyze their dreams without resistance. The ego of the analyzed person is capable of accepting the primitive wishes better, and the punishment of the superego is greatly diminished. Sharpe also thought that prolific dreaming indicated faulty working of the psychic apparatus. Repetitive dreams are also not experienced by analyzed people. Absence of dreams indicates that there is something wrong intrapsychically. These ideas were written before the study of rapid eye movements showed that we all dream
around 20%–25% of our sleeping time. Sharpe’s book, in contrast to Freud’s *Analysis Terminable and Interminable* (written in the same year), is an optimistic appraisal of what an analysis can achieve. Her data are impressionistic, and to my knowledge no systematic study has either confirmed or disconfirmed Sharpe’s hypothesis that psychoanalysis does in fact bring alteration in the dreaming process.

**Internalization of the Psychoanalyst**

How is the analyst to be internalized? In his classic paper in 1934, Strachey argued that the analyst becomes internalized as a more rational superego imposed upon or supplementing the harsher superego of the analysand. By contrast, Sterba (1934), in a paper written in the same year, laid more stress on identification with the psychoanalyst and stressed the therapeutic alliance based on the capacity of the patient’s ego for disassociation. In 1936, 3 years after Hitler’s assumed power, an important symposium took place in Marienbad, Czechoslovakia. There, for the first time, ego psychoanalysts, those who absorbed some of the implications of the new view adopted by Freud, faced the older generation that still adhered to the topographic point of view. Now two kinds of analysis were conceivable. The first and more authoritarian aims to replace the excessively condemnatory superego of the analyses with a more reasonable superego of the internalized psychoanalyst. The other view recognized the supposed fact that only changes in the ego structure are enduring and would work toward modifying the ego. Depending on the point of view, different terminations will be reached.

A truly optimistic termination is found in Menninger’s (1958) conclusions, in which a terminating patient is quoted as saying: “I have gotten what I paid for, I can do for myself. I can assume a mature role in preference to one of expectant pleading, I can substitute hoping for despairing, enjoying for expecting, giving for taking. I can endure foregoing what must be foregone and accept and enjoy without guilt such pleasures as are accessible to me” (p. 159). Yet even Menninger does not tell us how often in treatment analysands get to this point and if this state of feeling endures over the years and becomes a permanent acquisition of the analysand: “If, for instance, the patient could be made less frightened of his super-ego or introjected object, he would project less terrifying images on to the outer object and would therefore have less need to feel hostility towards it; the object which he then introjected would in turn be less savage in its pressure upon the id-impulses, which would be able to lose something of their primitive ferocity” (p. 341).

In a revolutionary paper published in 1960 and in subsequent papers in 1962 and 1988, Loewald redirected the thinking on termination by postulating that neurosis blocks further growth and that ego development is resumed as a result of a psychoanalysis (Loewald 1960, 1962, 1988). This idea went well beyond Freud’s expectations. Freud sought resolution of intrapsychic conflict, resulting in a conflict-free life, but Loewald asked for continuous growth. Instead of the analyst as a mirror image reflecting back to the analysand what is being projected on him, Loewald emphasized the analyst as a new object, making a new object relationship possible. The therapist as a mirror leads to a clear termination point when the mirror no longer gives rise to new projections and can be discarded. The analyst is a new object enriching the inner life of the patient; the analysis has no natural ending point. Whether the analyst is seen primarily as a transference object or as a new object, the end of any analysis must contain a sense of loss, and termination should deal with the anticipated mourning. When death takes place, the mourner is left alone to mourn and internalize the loss. In the analytic process, this mourning process takes place as much as possible for both participants before the ending. If the mirror image is the primary model, the ending can be a joyous moment of a growing independent self. If the new object model predominates, then termination is a quasi-mourning process. In my opinion, it follows that our failure to differentiate between the two models has handicapped our capacity to help effectively end an analysis. Reflecting further on this subject leads me to the conclusion that we need to differentiate more sharply between the process of separation-individuation that should take place in normal development and catastrophic separation that occurs when there is real object loss in childhood, such as when a parent is lost to death or separation.

In recent years, in keeping with the Hegelian emphasis on thesis and antithesis, a new attitude toward termination has entered our field. A new term, the “good enough termination,” has become influential. It is taken from Winnicott’s term the “good enough mother.” The aim of the new emphasis is to lower the demands of the superego of the therapist and make it easier for us to accept good enough results even when they fall short of unrealistic professional expectations (Gabbard 2009; Salberg 2010). A similar attempt was made in 1972 by
2. Analyst and analysand believe that self-analysis can now replace the analyst. A well-known quip of Bernfeld is often quoted against this solution: “Question: what is wrong with self-analysis? Answer: countertransference.” Beyond the quip, self-analysis is often useful in solving problems associated with psychopathology of everyday life, such as finding a lost key or remembering a forgotten name, but it is seldom up to the task of solving a serious crisis.

3. The analysand stays in prolonged analysis or in a series of reanalyses. This solution may be the only one available in serious mental pathologies, and it deserves a legitimacy of its own. However, apart from being often unproductive and repetitive, it denies analysands the opportunity to become adults and masters in their own houses.

4. Because we have not found a royal road to termination, every psychoanalytic couple must find their own termination point. The limitations of both the therapist and the patient play a role. It may happen during the termination phase as new insights open new doors; in that situation we need not fear to say that what seemed like termination turned out to be a deepening of the analysis.

There is a time-honored tradition in psychoanalysis that the analysis should be continued to the very last moment, and indeed many authors have shown that very important new psychoanalytically significant material does emerge in the last hour. Nevertheless, in my opinion, it may well be indicated in certain cases to devote the last few hours to the evaluation of the analytic work. When this approach is followed, patients who were lying down during the analysis should be asked to sit up, not necessarily to free-associate but rather to discuss their own understanding of the whole analytic procedure, what has been achieved, and what further work there still is for the analysand to do after the analysis is finished. The analyst should feel free to participate in the discussion. During this time, the two partners are speaking to each other more as equals than they did during the analysis itself.

Reanalysis

A future historian of psychoanalysis may be surprised to discover how many panels of the American Psychoanalytic Association and articles were devoted to the question of reanalysis. Meyer and Debbink [2003] noted that between 1959 and 1994 six panels and many more papers were published on this topic alone. To read this literature in succession is an interesting but also sobering experience. One is struck both by the changing climate in organized psychoanalysis that persisted through the years and by the steady recurrence of the same problems that resist resolution.

I found the first 1959 symposium to be of special interest. One gets the impression that the panel could not cope with the many problems of reanalysis. There was first the lingering and disturbing impact of the two analyses of the Wolf Man. Viennese analysts now in the United States had many memories to tell. Jenny Waelder-Hall stressed that the underlying pathology of the Wolf Man, with his “deeply passive and feminine orientation” and megalomania, was not appreciated at the time. Grete Bibring stressed how Brunswick’s own transference to Freud complicated the picture. By contrast, in another panel on reanalysis, this time chaired by F. McLaughlin [1959] and reported by J. T. McLaughlin and John in 1985, Ruth Eissler stressed Brunswick’s capacity in the reanalysis to penetrate the grandiose fantasies the Wolf Man used against the feelings of his infantile helplessness. The Wolf Man’s legacy to psychoanalysis was the realization that an analysis that fails can nevertheless be powerful enough to serve as the basis for a new psychopathology, which only a reanalysis can discover.

The relationship of the new therapist to an older one poses the danger of an alliance between the patient and analyst against the first analyst, who exists only in the recollections of the patient. This recollection is conducive to a collusion between new analyst and patient. Cases in which an analysis ended successfully and the reanalysis takes place because life has radically changed are the least problematic for the next analyst, whereas the opposite is true if the first analysis failed or ended in a negative transference: it is the most problematic for the second analyst because the first analysis ended traumatically, increasing resistance to the second. One of the surprises to me was the recognition that many former patients return to analysis not because new problems arose but because the superego could not tolerate a significant prize or a major promotion; they represent the type Freud [1916] described as “wrecked by success.” The very fact that analysis enabled the former analysand to succeed beyond expectations may make another analysis necessary.

What is difficult to accept for analysts who were attracted to psychoanalysis precisely because it offered such high hopes is that a perfect solution is beyond our
reach. A good termination is more likely if the analyst does not become emotionally or financially dependent on the patient. Throughout this chapter I have stressed the advantage of the new internalization of the analyst that a good analysis should achieve. This precludes social contacts after the termination. Former patients, such as powerful politicians, can do us psychoanalysts many favors. However, a good analysis does demand that the former analysand remain free from such obligations. In a training analysis, when the former analyst and the former patient continue to meet socially and professionally, such a termination is not possible.

I do not wish to imply that therefore training analyses cannot end well but merely to point out that when social contact replaces analytic contact, the analysand will have the added task of reconciling the image of the analyst that was created during the analysis with the image that will emerge in postanalytic contact. Many analysands are intensely curious what the real analyst is like: her or his political views, how he or she spends vacations, and how well he or she plays tennis. The analytic process demands that imagination and not facts be the center of attention. If the analysis was good enough, the postanalytic experience need not play a significant role, but here too the results are not easily predictable, especially if analyst and former patient do not see eye to eye on important issues. Here it may be useful to anticipate such a possibility during the last phase of analysis and prepare the candidate for postanalytic encounters.

**Conclusion**

A survey of the history of psychoanalysis has shown that a fully satisfactory termination of a psychoanalysis and, by implication also, psychotherapy occurs only rarely. The disappearance of the original symptoms is not a reliable test because symptoms can be exchanged for other symptoms or by character neuroses. Real life offers no paradigm for termination because human relationships usually end in lack of gratification, hostility, or death. Typically the therapist becomes included in the life equilibrium of the patient, and the analysand becomes part of the life equilibrium of the therapist. Such equilibriums resist termination. Most active wishes in psychoanalysis tend to be reaction formations to earlier and deeper passive yearnings. When these are analyzed, these passive wishes are left over. Most psychoanalyses come to an end when a therapeutic standstill is reached. However, the standstill only reflects either the limitation of the therapist or that of the patient. A consultation with a colleague can often reopen the clogged channels. On the other end, we must face the fact that the yearning for an ideal termination as distinguished from the mere “good enough” one is a deeply felt need for therapist and patient. This yearning for a perfect ending, like the yearning for a perfect love relationship or a perfect relationship between parent and child, is a valid human need. The termination phase should allow the analysand the opportunity to verbalize why the conclusion could not be achieved.

**KEY POINTS**

- When Freud wrote his initial papers on technique, termination was not yet considered a special phase of treatment requiring special skills on the part of the therapist. The first contribution to the subject of termination came from Ferenczi in 1927, in which he suggested that patients be allowed to continue with treatment as long as they wish.

- Freud’s forced termination of the Wolf Man and its impact on the history of psychoanalysis are discussed, followed by a discussion of the analysis of the poet H.D. with Freud.

- The impact of the structural phase on Freud’s Analysis ‘Terminable and Interminable’ is considered, including the significance of the “negative therapeutic reaction.”

- In the post-Freudian period, Loewald’s views were considered and the differences between the views that the analyst is primarily a transference object and that the analyst is a new object were addressed, as well as the differences between genuine termina-
Over the subsequent two decades, many psychoanalysts reconsidered the initial resistance to the use of psychotropic medication. In his reconsideration of the psychoanalysis of a patient with masochistic personality who also met diagnostic criteria for dysthymia and panic disorder, Cooper (1985) concluded that “retrospectively, pharmacological assistance earlier might have provided a much clearer focus on her content-related psychodynamic problems and would have made it more difficult for her to use her symptoms masochistically as proof that she was an innocent victim of endless emotional pain” [p. 1399]. Today, many analysts question the theory of etiology based on intrapsychic conflict for many syndromes, including some considered to be paradigmatic of psychoanalytic theory such as obsessional neurosis, and note the lack of therapeutic efficacy of psychoanalysis in these conditions [Esman 1989]. One-dimensional theoretical models, especially when unsupported by empirical evidence, are no longer tenable. Combining multiple modalities of treatment not only is conceptually more sophisticated but also may be therapeutically advantageous.

Unfortunately, the goal of a constructive revaluation of psychoanalytic theories of etiology and therapeutic efficacy in certain conditions has led some clinicians to artificially divide psychopathology into two groups. According to this construct, Axis I disorders are biological—that is, not derived from intrapsychic conflict—and therefore somatic rather than psychological treatments are necessary. In contrast, Axis II disorders are the result of intrapsychic conflict, and the primary modality of treatment should be a psychoanalytic approach [Roos 1995]. If both Axis I and II disorders are present, then medication should be combined with psychoanalysis because “there is an analysis being conducted simultaneously with the management of a medical illness” [Finkel 1986, p. 238]. Although this approach seemingly provides a theoretical tent under which psychoanalysis and medication can be combined, it is problematic for two reasons: 1) there is no empirical or theoretical basis for this division and 2) artificially dividing the etiologies of Axis I and Axis II disorders supports a discredited mind-body dichotomy.

Despite these theoretical debates, clinical pragmatism ultimately led to an appreciation of the therapeutic effects of psychotropic medication and to the relatively widespread use of medication in combination with psychoanalytic treatment. Studies have indicated that approximately 20%–35% of patients in psychoanalysis are also taking psychotropic medication (Caligor et al. 2003, Donovan and Roos 1995; Roos and Stern 1995; Yang et al. 2003). Although psychoanalysis and psychotropic medication are now commonly used concurrently, these two treatments, based on different models of the mind and requiring divergent styles of intervention on the part of the clinician, have not been technically or theoretically integrated. Currently, the critical clinical issue is no longer whether analytic patients should be prescribed psychotropic medication but rather how to combine these treatments most effectively. Specific questions include:

1. How does the analyst decide when to prescribe or to refer the patient for a medication consultation?
2. Can a psychoanalyst practice optimal psychopharmacology in the psychoanalytic situation?
3. What is the impact of psychotropic medication prescription on the analyst, the patient, and the treatment itself?

In this chapter, we consider these questions and review data from the relevant empirical studies.

Empirical Studies: Rates of Combined Treatment With Medication and Psychoanalysis

The rate of psychotropic medication use in the psychoanalytic setting has been documented in a number of studies surveying candidates, graduate analysts, and training analysts. The first systematic assessment of the combination treatment of psychotropic medication and psychoanalysis was a study of control cases in which patients were being treated by candidates at the Center for Psychoanalytic Training and Research at Columbia University. In this study, 89% of candidates returned a survey inquiring about psychotropic medication use. It was reported that 29% (16/56) of patients currently in analysis with the candidates were also being prescribed medication [Roos and Stern 1995]. This practice was not restricted to a few candidates; 46% (11/24) of those returning the survey had at least one patient in analysis who was also on psychotropic medication.

It could be hypothesized that the results of this study might not reflect general practice in psychoanalysis but rather represent a finding in a skewed sample. That is, the rate of medication prescription by a cohort of candidates trained after the use of psychotropic med-
Combining Psychoanalysis and Psychopharmacology: Theory and Technique

ication became standard treatment for mood and psychotic disorder might be significantly greater than the rate from the practice of more senior analysts who had been trained in a previous era. However, a subsequent study of training and supervising analysts at Columbia University produced strikingly similar results (Donovan and Roose 1995). In this study, 76% (34/45) of the training analysts returned the survey. The group had a mean age of 60 ± 8 years—that is, they were considerably older than the candidate cohort in the previous study. The training analyst group reported on 277 patients who had been in analysis within the past 5 years, 18% (51/277) of whom had been prescribed psychotropic medication. Again, this was not a practice restricted to just a few, 62% (21/34) of training analysts reported having had at least one patient on medication. The training and supervising analysts also reported that of the 51 psychoanalytic patients taking medication, 43 had been diagnosed by the treating analyst as having either major depressive disorder or dysthymia. Not surprisingly, antidepressants were the most common class of medication prescribed. The psychoanalysts were also asked to assess the impact of medication on the mood disorder and on the analytic process, and in 84% (36/43) of the cases involving patients with a current mood disorder who were prescribed medication, the psychoanalysts reported that the mood disorder improved and that the analytic process deepened.

More recently, studies at two psychoanalytic institutes (Columbia and Cincinnati) reported the rates of psychotropic medication use in current psychoanalytic cases among graduate analysts (Yang et al. 2003). In the Columbia study, 87 analysts reported on 241 patients in psychoanalysis, 31% (75/241) of whom were being prescribed psychotropic medication. In the Cincinnati study, 23 analysts reported on 69 patients in psychoanalysis, and 36% (25/69) were being prescribed psychotropic medications. In a large survey study, Vaughan et al. (2000) sent surveys about medication prescriptions for psychoanalytic patients to half of the membership of the American Psychoanalytic Association, and 40% responded (i.e., the data are from only 20% of the members). Of the 766 analytic cases reported on, the clinical diagnosis was an Axis I mood disorder in 74% and an anxiety disorder in 60%. In 18% of cases, a psychotropic medication was being prescribed, and the analyst acted as pharmacologist in 55% of those cases. These rates of psychotropic medication prescription, primarily antidepressants, appear appropriate given studies showing that from 30% to 50% of patients currently entering psychoanalysis have an Axis I mood and/or anxiety disorder. For example, in one series (Caligor et al. 2009), 100 consecutive patients applying for psychoanalytic treatment were assessed with structured interviews for DSM-IV-TR Axis I diagnosis and rating scales for mood and anxiety symptom severity. Fifty percent of the patients met criteria for a current mood disorder (major depressive disorder or dysthymic disorder), 74% had a lifetime history of mood disorder, 56% met criteria for a current anxiety disorder (generalized anxiety disorder, social phobia, or panic disorder), and 61% had a lifetime history of anxiety disorder. Forty percent of depressed patients had a Hamilton Rating Scale for Depression (Hamilton 1960) score equal to or greater than 18, which is often the cutoff for entry into antidepressant clinical trials corresponding to symptoms in the moderate range. Five percent of patients had a Hamilton depression score in the severe range of 27 or greater. These studies document that the prescription of psychotropic medication, once considered the quintessential anti-analytic intervention, is now the most accepted and prevalent significant change in the practice of psychoanalysis during the past 30 years.

Decision to Prescribe Medication

The nature of the information necessary for a clinician to make an informed recommendation about medication requires an evaluation approach that may be a significant departure from standard technique for many psychoanalysts. Patients presenting to a psychoanalyst often do so with the intent of entering into a psychodynamic psychotherapy or psychoanalysis. The standard psychoanalytic evaluation focuses on developing a dynamic case formulation and an assessment of whether the patient has qualities, such as psychological mindedness or the capacity to contain intense affect states, considered necessary to engage in a long-term psychodynamic treatment. The initial evaluation is more an assessment of the “suitability” of the patient than a diagnostic evaluation.

There is no consensus among psychoanalysts on either the validity of a phenomenologically based diagnostic system such as DSM-IV (American Psychiatric Association 1994, 2000) or the relevance of psychiatric diagnoses to the recommendation for psychoanalysis. Indeed, some psychoanalysts believe the initial evaluation of a patient is so limited by the patient’s defenses and the absence of a therapeutic alliance that the infor-
must recognize that their traditional technique is inadequate for making an accurate Axis I diagnosis. The goals of the traditional psychoanalytic evaluation and the clinical psychiatric evaluation are different but not necessarily competitive or contradictory. On the contrary, they can be complementary and are certainly both necessary. Thus, from the very first time that a psychoanalyst meets a patient, the analyst must be cognizant of the different models of the mind, theories of illness, and clinical techniques that must be equally applied and respected in order to decide on optimal treatment interventions. The evaluation should reflect this paradigm.

The decision whether to recommend treatment with psychotropic medication for a patient in psychoanalysis should depend on the psychoanalyst’s acquisition and use of appropriate data necessary to make an informed clinical recommendation. However, there are many other factors, beyond the clinical data, that may influence the analyst’s decision. For candidates in psychoanalytic training, these influences may include the pressures of training such as a candidate’s fears that prescription of medication for a control case might jeopardize progression or certification, supervisors who disagree with the use of medication in psychoanalysis, or a supervisor’s interpretation that the candidate’s wish to medicate represents countertransference issues [Abel-Horowitz 1998].

Dr. B, a third-year candidate, had been treating Mr. Y in psychoanalysis for 1 year when Mr. Y began to complain of severe anxiety attacks. The onset of these attacks coincided with Mr. Y’s graduation from law school and his preparation for taking the bar exam. Dr. B explored the meaning of graduation to Mr. Y, whose father was the managing partner in a large law firm, and interpreted Mr. Y’s conflicts about studying law. Despite these interventions, Mr. Y’s anxiety attacks worsened. Mr. Y complained to Dr. B that he was having palpitations that woke him from sleep and said that he feared that he was having a heart attack. Dr. B wondered whether Mr. Y might be suffering from panic disorder but was confused about the extent to which the psychodynamic issues might be producing the anxiety. He was afraid to approach his supervisor with this issue, fearing that his supervisor might think that he was not “thinking like a psychoanalyst” and worrying that treating the patient with medication might jeopardize his “getting credit for the case.”

There are some data that illuminate the influence of the psychoanalytic situation on the candidate’s decision to prescribe medication. A study conducted at Columbia compared candidate training cases in which the patients had applied directly to the Psychoanalytic Clinic for treatment with training cases in which the patients had been converted from psychotherapy to analysis from the candidates’ private practices (Caligor et al. 2003). The patients in the clinic and the converted case patients did not differ significantly in mean age or gender distribution or as to whether the candidate received credit for the case. The rates of Axis I mood or anxiety disorder were comparable in both the clinic and converted cases (53% and 58%, respectively), and 9% of both samples had current substance abuse other than nicotine. However, despite comparable rates of Axis I disorders, there was a striking difference in the rates of antidepressant medication prescription: 56% of the converted case patients versus 6% of the clinic case patients were prescribed medication ($\chi^2 = 21.2$, df = 1, $P < 0.0001$). If one considers medication prescription only in patients with current Axis I mood disorder, then 0% of the clinic case patients versus 81% of the converted case patients with the same diagnosis were prescribed medication ($\chi^2 = 12.2$, df = 1, $P < 0.0001$).

Thus, the same psychoanalytic candidate recommending treatment for diagnostically comparable patients prescribed antidepressant medication for analytic patients being seen in the private practice setting but not for those patients entering psychoanalysis through the psychoanalytic clinic. There are many possible explanations for this finding, including the candidate’s desire to have a “pure” analytic case or the influence of the supervisor, and a better understanding of the results of the study awaits further empirical research. However, at the very least, the results indicate that the setting affected the candidate’s decision to prescribe medication.

The influence of factors other than diagnosis on the analyst’s decision to recommend medication is not restricted to candidates. Graduate analysts wanting to conduct “ideal” or “standard” psychoanalysis may aspire to adhere to an “abstinent model” that would preclude the use of medication [Kelly 1998]. Others have written about concern that the recommendation of medication might affect the patient’s feelings of self-esteem or be a confirmation of the patient’s self-representation as defective [Swoiskin 2001].

**Treatment**

**Recommendation and Informed Consent**

Originally, the process of informed consent was restricted to invasive procedures or participation in re-
The Psychoanalyst as Pharmacologist and Issues of Split Treatment

The treatment combination of psychoanalysis and medication can be delivered in two different ways. In the first, referred to as split treatment, the psychoanalysis and medication treatments are administered by different clinicians. In the second, the psychoanalyst both conducts the analysis and acts as psychopharmacologist.

Split Treatment

Originally, the procedure of split treatment was developed because it was believed that psychoanalysts could not maintain analytic neutrality if they participated in the more active doctor-patient relationship necessary for the effective and safe administration of psychotropic medication. In order to preserve technical neutrality and avoid the development of iatrogenic transference paradigms, the analysis was separated from the medication treatment, often to such a degree that the psychoanalyst and psychopharmacologist did not communicate. Obviously, the relationship among the psychoanalyst, the patient, and the medication provider will differ depending on whether the treatment is split or not. In a split treatment, the effective administration of combined psychoanalysis and psychopharmacological treatments requires the establishment of multiple therapeutic alliances: between the analyst and patient, between the patient and psychopharmacologist, and perhaps most importantly between the psychoanalyst and psychopharmacologist [Kahn 1991; Roose 1990; Vaughan et al. 1997]. This last relationship is often unexplored, is certainly unstudied, and may generate profound theoretical conflicts and professional rivalries that may have a negative impact on the treatment. If a split treatment is failing, attention to the relationship between the psychoanalyst and psychopharmacologist may be the critical intervention [Roose 1990].

Ms. R had been in psychoanalysis with Dr. C for 3 years when she developed symptoms of major depression characterized by anhedonia, depressed mood, and sleep and appetite disturbance. Dr. C, a psychologist, explored Ms. R's symptoms in the context of the transference, which recently had been dominated by Ms. R's rage at the analyst for having taken a 4-week vacation at a time of year that he did not usually go away. Despite his conviction that Ms. R was depressed because of her ambivalently held feelings for him, after a few weeks of hearing Ms. R's symptoms, Dr. C suggested to Ms. R that she have a consultation with a psychopharmacologist. The consultant diagnosed Ms. R with major depression and prescribed an antidepressant. Ms. R was relieved by this and returned to Dr. C further enraged that Dr. C had taken a few weeks to send her for a medication consultation. Dr. C was glad that the patient had received the medication treatment but still had reservations about whether Ms. R's symptoms could have remitted with psychoanalysis alone. Perhaps because of these reservations, Dr. C failed to explore Ms. R's feelings about his inability to prescribe the medication and did not communicate directly with the psychopharmacologist after receiving his consultation note. In the next few weeks, when Ms. R felt depressed, she called Dr. C to see whether her medication should be increased rather than continuing to discuss both aspects of her treatment with Dr. C. Although Dr. C interpreted this split to Ms. R, he did not attempt to discuss this with the consultant. In addition, Dr. C interpreted Ms. R's fantasy that the increase in medication would solve the problems she had with trusting him. Approximately 1 month after Ms. R's depression remitted, she abruptly stopped her analysis, citing Dr. C's lack of conviction about the effectiveness of the medication as her reason for terminating prematurely.

Currently most medically trained psychoanalysts choose not to split treatments. The recent surveys of medication use by graduate psychoanalysts at the Columbia and Cincinnati institutes indicate that most medically trained psychoanalysts prescribe medication for their own patients [Yang et al. 2003]. Possible explanations for this change in practice include the increasing recognition that the transference and countertransference paradigms encountered when the analyst prescribes medication can be interpreted as part of the analysis [Cabaniss 1998; Kelly 1998; Roose 1990] as well as the introduction of antidepressant medications [e.g., selective serotonin reuptake inhibitors (SSRIs)] that appear, perhaps deceptively, to be easier to dose and to be associated with fewer problematic side effects.

Sometimes, however, it may become necessary or prudent for the physician/analyst to suggest that an analysand see a psychopharmacologist for medication. This may occur when the medication management takes up a disproportionate amount of time in the analytic hours or when an increasingly complex medication regimen exceeds the analyst's pharmacological expertise. This situation may have ramifications for both the transference and the countertransference. It may be difficult for the psychiatrist/analyst to acknowledge the need for help in this area. The psychiatrist practicing pharmacol-
ogy with his or her analysands may fear that the patient will no longer see value in the analysis if sent to an outside pharmacologist. When present in the analyst, these fantasies need to be explored in self-analysis or with the help of a supervisor; when present in the patient, the working through of such fantasies is an essential part of the analysis. An analysand may devalue the analyst who feels the need to have a pharmacologist help with the medication; if interpreted, this may become part of the necessary understanding of the analyst’s limitations.

Mr. W, a 60-year-old man with a history of heart disease and major depression, was in his third year of analysis. Mr. W had originally presented to the analyst, Dr. I, in the midst of a major depressive episode. The analyst, who was a psychiatrist, had treated Mr. W with fluoxetine that he had continued to take throughout the analysis. Now Mr. W was having a relapse that was not responding to increasing dosages of fluoxetine. Concomitantly, Mr. W was having more difficulties with his underlying cardiac illness, leading to sporadic arrhythmias. Dr. I tried different augmentation strategies with some success. Mr. W became hopeless, fearing that his cardiologists would not be able to handle his medical condition and that he would have a fatal arrhythmia.

Over the next few weeks, Dr. I became increasingly anxious in sessions with Mr. W. At one point, Mr. W dreamed that he lived in a house with Dr. I and that Dr. I was cooking a meal for him. Dr. I felt unable to listen carefully to the dream and was unable to formulate an interpretation. Usually confident of his formulation of Mr. W’s case, Dr. I now sought supervision with a peer, who suggested that Dr. I might be anxious about prescribing increasingly complex antidepressants in the face of Mr. W’s underlying medical condition. Following this supervision, Dr. I suggested to the patient that the dream of the meal might reflect feelings that the patient had about the medication that the analyst was prescribing for the patient. Mr. W said that he had a wish that Dr. I could prescribe all of his medications, including his cardiac medications. Dr. I linked this wish to the dream and told Mr. W that because of his worsening depression and cardiac condition, he felt that Mr. W should consult a pharmacologist with expertise in treatment of depression and arrhythmia. Initially, Mr. W felt angry at Dr. I, stating that he had sought out an analyst who was also a psychiatrist in order to avoid a split treatment. Over the ensuing weeks, Dr. I interpreted the patient’s feelings of rejection and their relationship to wishes that Mr. W had about feeling perfectly cared for by the analyst.

Eventually, Mr. W agreed to the consultation, and with the new psychopharmacological regimen, his depression gradually lifted. Over the next year, this episode became linked to the patient’s growing understanding of the analyst’s limitations and contributed to his conceptualization of him as a separate, three-dimensional person.

This vignette demonstrates the ways in which the patient’s fantasies about the analyst can become intertwined with the pharmacological management. Attending to the vicissitudes of the pharmacology and the roles that both patient and analyst/pharmacologist play in the pharmacological aspect of the treatment can yield important information about the transference/countertransference paradigms that are dominant in the treatment.

Adding a third person to the analytic setting in which the analyst had conducted the pharmacology may reveal new fantasies and enactments. Patients and analysts may value the “secrecy” of the dyadic relationship; thus the advent of splitting the treatment can bring up interesting fantasies for both patients and analysts. Analysts may have secret fears of being found to be lacking, whereas patients may seek to protect or attack their analysts with the new member of the team. Once an analysand has consulted with the pharmacologist, the patient may cease to talk about mood problems with the analyst. Rather than approach these developments as unwelcome obstacles, they can be seen as opportunities to identify unconscious fantasies in analyst and analysand that might have otherwise remain unexplored.

The Psychoanalyst/ Psychopharmacologist

If a psychoanalyst is also prescribing medication, the preeminent concern has traditionally been whether the role of pharmacologist will interfere with analytic neutrality or the conduct of the analysis. Specific concerns are whether the use of medication and the subsequent reduction in depression and/or anxiety would undermine the patient’s motivation for and commitment to a long-term treatment or whether the quality and quantity of interaction necessary to effectively administer medication would interfere with the development of transference paradigms [Rooze 1990]. As cited previously, the admittedly few systematically collected data available suggest that the use of medication does not endanger the analytic situation; on the contrary, training analysts have reported that the effective use of antidepressant medication resulted in a deepening of the analytic process [Donovan and Rooze 1995]. This is consistent with data that psychological mindedness and depression severity are inversely correlated and that improvement in depression will result in a greater engagement in a psychoanalytic treatment [Vaughan et al. 2000].

However, the impact of assuming the role of psychopharmacologist on the role of the analyst and on the
measure that has been used increasingly in clinical trials of antidepressants. The psychoanalyst who prescribes medication needs to use techniques standard in pharmacological practice in order to evaluate effect of medication.

Although rating scales may represent the gold standard for determining presence or absence of the affective disorders described in DSM-IV-TR, clinicians may be unschooled in their use or think that they are awkward to use in the clinical situation. These clinicians may choose to familiarize themselves with the items on the rating scales so that they can seamlessly incorporate them into their evaluation interviews and extract them, if possible, from the analytic material. Whether or not the scales themselves are used, the important issue is to privilege phenomenological diagnostic considerations in the evaluation of every patient requesting psychopharmacology or psychoanalytic psychotherapy and to rely on phenomenological data when making decisions about medication in the course of treatment.

When Mr. T presented for evaluation with Dr. V, he described a lifelong history of low mood and poor self-esteem that had not interfered with academic or work function but that had markedly impaired his object relationships. Upon further exploration of this and other symptoms, Dr. V suggested to Mr. T that he enter psychoanalysis in order to further understand the roots of his low self-esteem and difficulties in his relationships with others. In psychoanalysis, Mr. T quickly developed a masochistic transference to the analyst, characterized by willingness to make any and all schedule changes and an inability to recognize any angry feelings toward the analyst. Dr. V did not think that he was hearing other symptoms of affective disorder and did not prescribe medication. However, 2 weeks prior to Dr. V’s 4-week August vacation, Mr. T again brought up his low mood, and Dr. V decided to prescribe medication because Mr. T would not be seeing the analyst for 4 weeks.

In this example, the analyst’s decision to use medication was based not on the presence or absence of symptoms that would constitute major depression but on his anxiety that the patient needed “something” in his absence.

The Practice of Psychopharmacology in an Ongoing Analysis

The information needed to evaluate medication effect and decide if treatment changes are needed will not necessarily emerge in the course of free association. Even if psychoanalysts employ both phenomenological and dynamic theoretical approaches to facilitate an informed recommendation about medication, it does not necessarily follow that they will be able to maintain a phenomenological perspective during the course of the analysis and thereby access the information necessary to practice optimal pharmacology. Psychoanalysts look beyond the manifest content of the patient’s verbal associations, affect states, and behaviors. Thus, when a patient reports persistently low mood, anhedonia, hopelessness, worthlessness, and other symptoms of an affective or anxiety disorder, the psychoanalyst is likely to consider this material in the context of the current transference/countertransference paradigm and the unconscious meaning and motivation of the depressive symptoms. For example, the analyst would consider, separate from the therapeutic effect, the meaning and impact that the act of prescribing medication could have in the context of the transference.

The symbolic meanings of medication to the analyst, such as the fantasy of being led by the analyst or the medication being a transitional object, have been extensively discussed in the literature [Adelman 1985; Cabaniss 2001; Gutheil 1982; Hausner 1985; Levy 1977]. Although the analyst must consider the meaning of both the act of taking medication and the act of prescribing, it is critical that this not preclude him or her from overlooking the manifest content. Phenomenological data, not dynamic data, are the determinants of medication management. The analyst must temporarily abandon analytic metapsychology and technique in order to practice psychopharmacology and then return to the analytic position. This transition, which is frequently required, may prove to be disruptive to the analyst, the patient, and the analytic process.

The only study of the practice of psychopharmacology by psychoanalysts during the course of an analysis investigated all training cases begun by candidates at Columbia between September 1992 and September 1995 involving either patients who had a diagnosis of Axis I mood or anxiety disorder at the point of initial evaluation or patients who were prescribed psychotropic medication at some point during the analysis [Gwynn and Roose 2004]. All the material in the charts, including the initial evaluation by the candidate and supervisor and detailed narrative summaries of the treatment written after 3 months and yearly thereafter, was reviewed. All references to diagnosis or to medication were noted, and summaries of the relevant chart material were developed. The cases were separated into three groups: 1) patients who had been taking medication prior to the analysis or patients who started taking med-
ication at the beginning of analysis; 2) patients who began taking medication during the analysis; and 3) patients diagnosed with mood or anxiety disorder who were not taking medication during the analysis. In this study, 52% [40/77] of patients had a current mood or anxiety disorder, and 39% [30/77] of patients were taking medication at some point during analysis. Of the 30 patients taking psychotropic medication during analysis, two charts were unavailable for review. Of the remaining 28 patients, 9 had started taking medication prior to the analysis, with no change during the analysis; 8 patients had been taking medication prior to the analysis, and changes in medication were made during the course of analysis, and 8 patients had been taking medication prior to the analysis, and the medication was discontinued at the start of analysis. In 4 of the last-mentioned cases, there was a significant recrudescence of symptoms, and medication was reinstated. Only 3 patients started taking medication during the analysis.

A review of the charts led to the following conclusions: 1) documentation of medication treatment, including assessment of response and side effects, was inadequate in an overwhelming number of charts and absent in many; 2) in many cases, medication was changed in response to either the patient’s or the analyst’s reaction to an upcoming separation, most notably changes in medication or initiation of medication within 3 weeks of the summer vacations; 3) in a number of cases, there was no evidence in the chart that medication had ever been discussed or that the current treatment had been reviewed by the analyst; and 4) in only a handful of cases did the candidate make medication decisions based on appropriate data and effectively differentiate this information from the analytic process. In contrast to the inadequacy of documentation about medication decisions, the charts included thoughtful documentation of the analytic process, revisions of the initial dynamic formulation, and discussions of transfer and countertransferance paradigms, some related specifically to the medication.

The results of the study suggest that in this cohort of patients, the analysts did not adequately fulfill the role of psychopharmacologist. Why did this occur? One possible explanation is that there is inadequate didactic and supervisory teaching about the way in which the role of psychopharmacologist or the addition of a psychopharmacological consultant may impact all aspects of the psychoanalysis. Given the history of the relationship between psychoanalysis and psychotropic medication, another strong possibility is that in the psychoanalytic setting, the role of psychopharmacologist is considered secondary to that of a psychoanalyst, just as the psychotropic medication is considered adjunctive or secondary to the analytic treatment.

Mr. P had been in analysis with Dr. U, a psychiatrist, for 2 years. Prior to beginning analysis, he was treated by Dr. U for major depression. He had not been depressed before. The depression remitted after 3 months, and when Dr. U suggested psychoanalysis to address Mr. P’s work inhibitions, Mr. P readily agreed. In one session, Mr. P mentioned to Dr. U that he read an article that suggested that people only need to be treated with antidepressants for 6 months to a year following remission of a first episode of major depression. After the session, Dr. U realized that he had consciously forgotten that Mr. P was on medication and resolved to discuss the option of tapering the medication in their next meeting.

The impact on the analyst of assuming the responsibilities of psychopharmacologist in the analytic situation has not been sufficiently appreciated. Further study is needed to determine whether a single practitioner can optimally administer both forms of treatment, and if so, what this practice requires. Inquiry of this nature is likely to suggest that psychoanalytic educators need to provide focused teaching—for both medical and nonmedical analysts—about the use of phenomenological data in assessing affective disorders in their analytic patients and about the particular challenges of being both the analyst and prescriber of medications for the same patient.

This relative inattention to the psychopharmacological treatment conducted during an analysis may have other consequences as well. For example, the large role of nonspecific factors such as placebo effects in psychiatric treatments has been increasingly appreciated in recent years. Placebo effects are particularly important in depressive and anxiety disorders, for which placebo response in clinical trials of antidepressant medications averages 30% (Walsh et al. 2002) and the proportion of medication response attributable to placebo is estimated at 50%–75% (Kirsch and Sapirstein 1998, Kirsch et al. 2008). Placebo effects do not appear to be merely transitory phenomena; one meta-analysis showed that up to 75% of placebo responders stay well during the continuation phase of treatment (Zimmerman et al. 2007). This finding contrasts sharply with depression relapse rates of 40%–60% when acute responders to medication or placebo have their treatment discontinued (Cohen et al. 2006; Keller et al. 1982; Zis and Goodwin 1979). Taken as a whole, these findings suggest that placebo effects ameliorate the pathophysiology and influence the course of major depressive disorder.

Patients’ expectation of therapeutic benefit, which refers to patients’ beliefs about how treatment will affect
them, is the principal mechanism of placebo effects in clinical treatments (Haour 2005; Kirsch 1997; Swartzman and Burkell 1998). Two studies have specifically investigated expectancy in clinical trials for depression and have shown it to predict depression improvement (Krell et al. 2004; Meyer et al. 2002). In the National Institute of Mental Health Treatment of Depression Collaborative Research Program (TDCRP), which enrolled 239 outpatients with major depressive disorder, higher patient expectation of improvement predicted greater likelihood of depression response and lower final depression scores in all four treatment conditions (cognitive-behavioral therapy, interpersonal therapy, imipramine, and placebo plus clinical management) (Meyer et al. 2002, Sotsky et al. 1991). In a single-blind trial of reboxetine for 25 subjects with major depression, subjects with a higher pretreatment expectation of medication effectiveness had a greater likelihood of response: 90% of patients with high expectations of improvement responded compared with 33% of patients with lower expectations ($X^2 = 7.819; P < 0.005$) (Krell et al. 2004).

Psychoanalysts might appreciate the significant impact of patient expectancy on clinical outcome as an exciting possibility, because it speaks to the potential for patients to literally “heal themselves” in facilitating treatment contexts. On the other hand, the traditional psychoanalytic stance of neutrality, abstinence, and anonymity seems unlikely to maximize patient expectancy and may actually function to depress placebo response. Even worse, a theoretical bias against medication on the part of the analyst may result in decreased treatment expectations on the part of the patient that then contribute to medication failures. If psychoanalysts are to effectively prescribe medications, it may be necessary to deliver them with the appropriate therapeutic optimism in order to realize their full potential clinical benefit.

Ms. E had entered analysis with Dr. T in order to discuss her contentious relationship with her husband. Three years into the treatment, Ms. E’s husband died unexpectedly of cardiac arrest. Although she was able to discuss her feelings in session, she developed persistent insomnia and anhedonia and lost 10 pounds. Dr. T analyzed Ms. E’s symptoms as resulting from unresolved feelings about her recently deceased husband. Although this was useful to Ms. E, she asked Dr. T whether he thought that medication could also be helpful for a while. Dr. T reluctantly agreed and prescribed the medication, saying, “It might help your symptoms, but it’s not what’s going to really help you.” Ms. E took the medication but had little faith that it would work. Her symptoms persisted for 6 months, at which point her internist suggested that she consult a psychopharmacologist. He was much more positive about the potential benefit of medication and suggested that she continue it. She remitted within a few weeks.

Providing training to psychoanalysts on how to conduct good pharmacology with their analytic patients is an obvious goal. However, it is equally important to consider and study without bias whether psychoanalysts are in fact able to conduct optimal pharmacology with their psychoanalytic patients, even if they possess outstanding pharmacological skills and knowledge. It is possible that the intense pressures of the psychoanalytic situation and the omnipresent vicissitudes and enactments of the transference and countertransference preclude even the most knowledgeable psychoanalyst/pharmacologist from conducting optimal pharmacology while also analyzing a patient.

Conclusion

Although pharmacology still has little place in the theory of psychoanalysis, studies of clinical practice indicate that between 20% and 36% of patients in psychoanalysis are concomitantly treated with psychotropic medication. The use of medication affects every aspect of the psychoanalysis. The efficacy of these psychotropic medications has been demonstrated in clinical trials based on the phenomenological diagnoses outlined in the DSM series. Therefore, all psychoanalysts must be trained to make Axis I diagnoses, to understand the treatment implications of these diagnoses, and to discuss alternative treatment options with their potential psychoanalytic patients. They must also be able to continue to evaluate symptoms of depression and to make appropriate treatment recommendations in the context of an ongoing psychoanalysis. Most of all, psychoanalysts must be cognizant that we are only beginning to appreciate the many ways in which the prescription of medication impacts the analytic situation and must remain alert to these potential effects, their practice of psychoanalysis and pharmacology.
KEY POINTS

- Data from multiple studies demonstrate that approximately 30% of patients in psychoanalysis are prescribed medication, particularly for affective and anxiety disorders.

- Although many analysts’ predominant concern about combined therapy has been whether medication will interfere with their capacity to analyze, they must also question whether the dual role might compromise their capacity to optimally practice psychopharmacology.

- The proper diagnosis, treatment, and ongoing assessment of affective and anxiety disorders require specific phenomenological data (e.g., DSM criteria, symptom severity measurement on standardized scales) that may not be collected typically in the course of an ongoing psychoanalysis.

- Separation of psychopharmacological treatment and psychoanalysis between two different providers (i.e., split treatment) can be practically useful but may generate professional rivalries, confusion over roles, and conflict between differing treatment models.

References

Cabaniss D: Shifting gears: the challenge to teach students to think psychodynamically and psychopharmacologically at the same time. Psychoanal Inq 18:639–656, 1998
Roose SP: Does anxiety obstruct or motivate treatment? When to talk, when to prescribe and when to do both, in Anxiety: Symptoms and Signals. Edited by Roose SP, Glick RA. Hillsdale, NJ, Analytic Press, 1995, pp 155–169
Zis AP, Goodwin FK: Major affective disorder as a recurrent illness: a critical review. Arch Gen Psychiatry 36:835–839, 1979
Technique in Child Analysis

Judith A. Yanof, M.D.
Alexandra Murray Harrison, M.D.

Analysts who work with children and those who work with adults have the same goals in doing analysis with their patients, and they rely on many of the same general principles. For both, the analytic engagement is about establishing a relationship in which analyst and patient together make meaning of what happens between them, with a particular focus on how it is experienced in the mind of the patient. This unusual engagement involves creating conditions of both safety and freedom for the elaboration and exploration of internal thoughts and external behavior. The nature of this engagement usually has to be affective and experiential to be successful. It involves establishing a clear, bounded, but negotiable “frame” in which imagination is enhanced. The purpose of this venture, of course, is to improve the patient’s quality of life.

For many years child analysts were preoccupied with how much their technique matched or differed from the technique prescribed for adult patients by adult analysts, and for many years adult analysts questioned whether child analysis was “real” analysis. Today this question has receded in importance. Contemporary psychoanalysis is marked by a diversity of perspectives. There is not one psychoanalytic technique but many. This is no less true for child psychoanalysis.

In an article on therapeutic action, Gabbard and Weston (2003) drew attention to three major trends in current psychoanalytic discourse that have influenced technique: 1) an increasing recognition that there are multiple modes of therapeutic action—no longer the polarized, either/or debate between interpretation and relationship, 2) a shift in emphasis from reconstruction to a focus on in-the-moment interactions in the relationship between patient and analyst, and 3) a movement toward flexibility and negotiation in defining the boundaries, frame, and “rules” of the analytic endeavor.

Child analysts found themselves moving in all of these directions before their adult analyst counterparts. Working with children forced them to recognize the limitations of a “standard” adult psychoanalytic technique (Kris 2001). For example, child analysts appreciated and accepted the pivotal place of action long before “enactment” was an everyday concept. From early on they acknowledged that the relationship with the analyst
For children, the fact that play is “pretend” allows them to elaborate wished-for, forbidden, or disavowed aspects of themselves more freely and with less conflict. For example, they are neither the dinosaurs, aliens, or monsters that unleash aggression nor the small, helpless creatures that can be hurt. In play, children can “try on” particular ideas or roles without being permanently committed to them. They can “remember” experience that is too difficult to remember or that has never been laid down in verbal, semantic memory systems [Schacter 1996]. Children can regulate affect incrementally by changing the story or disrupting the play [see Erikson 1940 for further discussion of play disruptions].

Although there is nothing in adult analysis that truly corresponds to engaging in pretend play, the use of free association in the presence of an analyst is probably most closely analogous. Like free association in adult analysis, the use of play provides a structure in which ordinary constraints are let go and there is an attempt to express what cannot be expressed in ordinary discourse. It is the oscillation between intense affective engagement with the analyst (engagement that feels and is emotionally “authentic”) and the simultaneous sense that what is being expressed is “pretend,” “as if,” and can be disavowed (or reflected upon) that is paradoxical. This oscillation characterizes both child and adult analysis. The adult does not consider his or her associations “pretend,” but neither does the adult consider what he or she says to be bound by intent. In adult analysis, this oscillation is also part of the complex state of transference [Modell 1990]. In psychoanalysis, when things are going well, both play and free association create a paradoxical state of being in two realms at once, the real world and the world of the imagination.

A child is not born with the ability to play. Play is built on a series of cognitive maturational developments that are achieved sequentially over the first 3 years of life [Mayes and Cohen 1996]. To play creatively, children have to be nurtured in a context that promotes play. Fonagy et al. [2002] wrote convincingly about the intimate relationship between the caretaker’s early attitude toward the infant as an intentional being, the ability of the dyad to “mark” certain communications as pretend, and the subsequent ability of the child to mentalize—that is, to understand that he or she and others can hold different ideas about external reality. Very young children behave as though their thoughts and others’ thoughts accurately mirror the external world. Fonagy et al. [2002] called this mode of thinking “psychic equivalence mode.” Young children at a certain age come to be able to use another kind of thought in play, “pretend mode.” In play, ideas are represented that the child knows are not accurate representations of the real world—that is, ideas are freed from their real-world referents. Fonagy and colleagues hypothesized that a child’s eventual ability to mentalize and develop a reflective stance is a developmental achievement that is the result of an integration of these dual modes of thought, psychic equivalence mode and pretend mode.

What is significant in this theory for the child analyst’s work is that in play the child is often working with a more flexible mode of thought than might otherwise be available to him or her developmentally. It has been shown in research experiments that children are often able to comprehend complex relationships, such as false belief, in play before they can do so in real life [Fonagy et al. 2002; Perner et al. 1987].

Let us take a clinical example:

Four-year-old Emily enacted the following compelling story. She took two dolls and called one Mother and one Child. In her story Mother was taking Child ice skating. Emily made Child fall down again and again while Mother repeated in a saccharine voice, “Oh, how beautifully you skate, my darling!” completely oblivious to Child’s difficulty maintaining her equilibrium.

This ice skating interaction may or may not have occurred in real life, although the session occurred on a hot summer day. In either case, the play vividly represented Emily’s feelings through the use of a conceptual metaphor. The child’s slipping on ice conveyed Emily’s vulnerable emotional state through a universal and concrete physical experience, falling down. In Emily’s metaphor, Child was off balance. In contrast, well-being is typically conveyed metaphorically in terms of verticality [Lakoff 1987; Lakoff and Johnson 1980, 1999], hence expressions such as “I’m feeling up,” “I’m on a high,” “My heart is sinking.” Beyond the primary conceptual metaphor referring to self-state, however, Emily’s play also used a rich and unique individual metaphor. She communicated something nuanced and very specific about what it was like for her to be with her mother. In this metaphor, she experienced her mother as unable or unwilling to recognize that she needed help and therefore unable to respond to her needs. In her play, the concrete ice skating incident stood for the more general emotional gestalt of the relationship. The play sequence conveyed in a simple way a much more abstract conceptualization—namely, the striking disconnect between two worldviews (mother’s and child’s), the mother’s lack of response to the child’s psychic re-
ality, and the child’s experience of the mother’s supportive words as contextually meaningless because she felt unrecognized.

As a result of Emily’s eloquent communication in her play metaphor, it became immediately apparent that she was also saying something about her current experience with her analyst. This precocious little girl had walked into the office as though she were in total command of the situation, separating easily from her mother, although she hardly knew the analyst. She had seemed quite firmly grounded. However, underneath her self-sufficient veneer was someone smaller and more frightened, someone feeling shaky.

Certainly Emily would not have been able to say in words what she experienced with her mother or what she was feeling with her analyst. As a young child, she did not have conceptual language for these ideas. By playing with the dolls, she was able to convey her experience by acting out the narrative metaphorically with its attendant affective component. However, the act of playing was not simply the communication of a previously developed, unshared thought, although it was probably motivated by Emily’s wish to be known. The frame of pretend play optimized the use of her imaginative and metaphorical capacities and helped her to organize what had been likely inchoate experience. In making meaning through play, Emily had the opportunity to discover something about herself, as an adult patient can discover new meaning in the narrative act of telling his or her story. The analytic encounter, when it works at its best, requires an analyst to be engaged with the child in the process of making new meaning and in recognizing that meaning is being made.

**Working Within the Play**

Although the content of the child’s play may seem to have obvious meaning to the analyst, technically speaking, it is important not to automatically treat this material as though the child were communicating directly about his or her inner thoughts. This ignores the child’s fundamental assumption that play is “pretend.” The preschool child may have no cognitive awareness that play and internal thoughts are connected (Mayes and Cohen 1993), whereas the latency-age child may need to use play defensively without being intruded upon. As in adult analysis, timing is all-important, and analysts must direct their interventions to the child’s cognitive level and state of emotional receptivity.

There are many ways Emily’s material could have been engaged. Suppose the analyst had said to Emily, “You are like the little girl in your play. You feel like you are falling down inside and your mommy doesn’t see how much help you need.” Although this intervention stays close to the child’s metaphor, this translation makes an explicit link between Child doll and the patient. Making play and reality equivalent tends to confuse young children and tends to shut down the play in older children. If the analyst were to disregard defenses and say, “You are angry at your mother because she doesn’t know what you are feeling,” the child might feel frightened and guilty for letting out something that she did not know explicitly or was not yet ready to own.

Thus there is some wisdom in making one’s interventions from inside the play first, a technique a number of child analysts have recommended (Ritvo 1978). Using such a technique and staying at the surface, one might simply say, “Child has a falling-down feeling, and the mommy doesn’t notice.”

What one chooses to say depends on what one feels is most salient in the moment. If the analyst substitutes “grown-up” for “mommy,” saying, “Child has a falling-down feeling, and the grown-ups don’t notice,” this opens up the communication to include the analytic situation. If the analyst discerns that the child is very anxious in the moment and needs active support, he or she might say directly, “Sometimes it is really confusing to be in a new place and not know what is going to happen—like being with me now.”

If the analyst is less concerned about Emily’s anxiety, he or she might pick up Child doll and expand the play elaboration. He or she might give it an emotional dimension, such as irritation, by complaining, “Look, Mommy, I’m falling down!” By accenting irritation, the analyst communicates understanding and gives permission for negative, disavowed feelings to become part of the exchange.

One can listen to play material at many different levels. Emily’s play metaphor was first heard as a communication about her experience, her history, and her view of the relationship with her mother. On another level, the ice skating metaphor was also a communication about how she was experiencing being with the analyst in the moment, in this case a transference. At still another level, Emily’s play sequence could be understood as a metaphor for her internal landscape: the disconnection between the part of herself that is falling down and the part that needs to put on a happy face. Ideally, the analyst wants to hear the child’s material on as many different levels as possible and keep them all open as possibilities for future work. In the child an-
alytic situation, complexity can be enhanced through the use of metaphor and imaginary play.

The Play Process

The child analyst comes to appreciate that children have variable capacities to engage in the play process. Children who can play and feel safe with the analyst readily engage in pretend play that is pleasurable and has a momentum. A child's play involves the creation of new metaphors and associated narratives in the context of a relationship in which both child and analyst have a space to have a voice. Although both recognize that the child's story is salient, it is impossible to differentiate what is strictly the child's story and what emerges as part of the interaction. During play the analyst helps the child to create a meaningful story that would not be created in precisely the same way outside of that relationship [see Lyons-Ruth 2006 for a related discussion].

In playing with a child like Emily who has achieved a robust capacity to play, one can participate in a variety of ways. The analyst can show interest by asking questions about the story. He or she can focus on the feelings of the play by resonating with its affective rhythms or appreciating the dilemmas of its main characters. The analyst can add interesting ideas or insights about the play from a vantage point outside the play or from inside the play via one of the characters, as long as this facilitates rather than disrupts the play process. Eventually one hopes that, at times, analyst and child will be able to reflect on the play process together, although this is not a sine qua non of child analysis.

Although many analysts are uncomfortable about "just playing," participating in the play as a player is an important way of deepening the play process. To do this, one takes as many cues as possible from the child about whom one's character is supposed to be and how this character is supposed to respond. The cues come from the child's direction and from everything that is known about the child—his or her history, family life, areas of interest, and favorite stories—and from the past experience of playing together. Cues also come from the child's immediate affective response to the analyst's contributions. One need not be afraid to introduce something new, particularly when one marks it as "pretend," if one attends to how it is being metabolized by the child. When things are going well, the child's story deepens and becomes more elaborated, and the analyst feels more emotionally involved with the child. There is an exchange of meanings that both learn from.

Take the following example from the play of a 4-year-old child, seen by one of us twice a week. This child had an excellent capacity to engage in the play process.

Randy was consumed with a story that had been read to him about a pirate. He had make a sword out of cardboard, and he carried it around with him to fight off a variety of dangers in his imaginary world. He pretended that it was night and that my couch was his bed. He placed his sword under the couch. Sometimes I was his mother, but usually I was his male sidekick and had to sleep on the floor. My role was to inform him that his sword had been stolen in the middle of the night. We played this game many times in various versions and permutations.

One day when the game seemed to lose its momentum, I added something to the story. As the sidekick, I became more shocked and distressed in my announcement that the sword was, indeed, missing. I exaggerated the pretend. This stirred a more lively engagement in the story, in which Randy told me for the first time that his sister had taken the sword. He then became involved in counterattacks. He yelled at her. He warned her that he would shrink her and put her in the computer mouse! He would gouge out her eyes! However, quite suddenly he became excited and silly, throwing himself off the couch in a dangerous way. Every time he imagined doing something to his sister, he fell off the couch and hurt himself.

I had to move in quickly and use my real voice to reinstate the play frame. I told him that I liked his pirate story but that we had to keep everything in pretend because somebody might really get hurt while we were playing out these big feelings. Only when Randy was back in physical control did I ask, "Who was that boy who just came into the room and was throwing himself away?" tentatively inviting a re-engagement in the play. He told me that the boy was Wild Guy, a wild boy who had no parents and no rules to live by. I showed him how he could pretend to be wild. He shook his head "no" and told me that we had to get rid of the out-of-control Wild Guy for good. I said, "I think Wild Guy is scary because he gets so out of control that he scares himself. But we can't get rid of him until we get to know him and what makes him do the things he does, because everybody has a Wild Guy in them. We need to be able to figure out what he is trying to tell us." Tentatively he took his sword and said, "Follow me then. Stay very close to me. We have to look for him." However, although we tried to find him, Wild Guy had largely disappeared for the rest of the hour.

Several days later, however, the play involved some action figures who were throwing furniture out of the dollhouse and scaring the family. It was the end of the hour, and when I said, "It's time to go," Randy escalated, "I won't and you can't make me! I won't! I won't! And I won't!" Then, with a mixture of fear and delight, he whispered, "Because I am a Wild Guy boy!" and left the session with no further ado.
Children, particularly young children, move in and out of the play frame often with little warning. The process of this play sequence is a good example of this in a typical young child’s play. Randy went from playing pretend pirate, in very good control of his impulses, to throwing himself off the couch dangerously. Here pretend and real suddenly collapsed into each other. Older children with trouble regulating affect also display this lack of regulation during play, and any child in treatment under the pressure of certain affects at times will be unable to maintain the pretend state.

Randy also moved in and out of different characters quite fluidly but quite coherently. This is also indicative of a good play capacity. He went from positions of strength to positions of vulnerability and back again. He was a fearless pirate who had a big sword, a brave hero who saved his mother from intrusion, a small boy who needed to be tucked in, an unsuspecting pirate who was tricked and had his sword stolen, a vengeful boy who gouged out his sister’s eyes, a boy who broke his own sword in a silly frenzy, and Wild Guy who lived without rules and had to be banished. Certainly the content of the play touches on some of the commonplace developmental conflicts of an oedipal-age boy. Is he big or little? Does he have a big sword or a little one? Would his mother love him better if he were big and strong, or does she want him to stay small? If he wants what the big man has, will he have to steal it from him? If he has such big, aggressive wishes, will he expose himself to retaliation and danger? Is he good or is he bad? Is he the hero or the intruder? Will he live by the rules or not?

Randy used play as a way to work out conflicts that he had about growing up, being phallic, being aggressive, being a competitive force, and finding his place in the family. He was using play to communicate his fears about affectively getting out of control, being defiant, and keeping his body intact, while trying on different possible options. The play demonstrated that when he threw away his sword, he felt momentarily protected from the danger of his aggressive conflicts. What the play did not yet reveal was why he felt so anxious.

My own addition to the play was to intensify the affect around the missing sword. In retrospect, I think I was trying to communicate affectively that I understood that whenever we talked about the sword, we were talking about something very significant; we were symbolically representing some kind of calamity. This might be equivalent to commenting to an adult patient that he or she was telling me something terribly sad but had taken all the sadness out of the story in the telling. The child analyst can participate in the play by upregulating or downregulating the affect. My intervention did increase the affect in the room, as well as the story’s elaboration, but perhaps it also overwhelmed Randy’s capacity to stay in pretend mode.

Putting into words what we were trying to do together not only reinforced the analytic “frame” but also gave Randy permission to play with certain dangerous ideas. Telling him that wild was a way of talking to him in a language that he could understand at his stage of development through the use of his own play metaphor. This intervention seemed fruitful when 2 days later he was willing to acknowledge that he, too, was a Wild Guy boy.

**Children Who Cannot Play**

Children between the ages of 3 and 6 years are developmentally at a prime time to enjoy imaginative play. Children in latency, on the other hand, may have begun to put aside playing imaginatively as part of their developmental process. They may think that play is “babyish” and fear its regressive pull. Learning the rules of sports and board games gives latency-age children a sense of mastery in the real world, but in the treatment setting it also can be used as a retreat from the expression of more conflicted, unacceptable feelings and the expression of fantasy. Children in latency may begin treatment by turning to more structured games, but they often learn to have a great investment in imaginative play, particularly if their analyses help them to play. The play of latency-age children allows them to revisit past themes and old ways of thinking in the presence of their more mature social and cognitive functioning. Play in the treatment setting promotes synthesis and integration.

However, a child’s age is not the sole factor in whether he or she will be able to engage in pretend play. There can be many different reasons why a child may have difficulties engaging in a play process (Gilmore 2005). There are children who cannot play imaginatively on a biological basis. These children fall into the spectrum of children with autism and pervasive developmental disorder (Cohen and Volkmar 1997). These children also have disturbances on false belief tests and do not develop a robust theory of mind. Children who have suffered severe or chronic trauma can have significant difficulty playing and often engage in a very repetitive, rigid type of play. Moreover, children cannot play when they do not have a way of coherently organizing their experience, whether due to trauma, constitutional failures in devel-
pretend collapsed. Over time this play became rigid and concrete, losing its metaphorical capacity.

At times the patient’s stereotyped play had a compulsive quality that seemed to be used to defensively manage anxiety that might result if a more open-ended play situation were allowed. At times her control over the analyst seemed gratifying to her. The queen/slave play configuration also represented a transference paradigm that had historical significance in the relationship with her mother. Using this play paradigm, the child turned passive into active and showed the analyst her experience of being powerless. In this case, the play represented defense, enactment, and communication simultaneously. However, this sadomasochistic play constellation, important as it enfolded, was not very useful to the analysis over time because it could not be reflected on, modified, or “played with.” The analyst tried many ways of addressing this impasse both from within the play and by direct interpretation of the enactment. Finally, when the analyst refused to play this game exactly by the patient’s rules, the patient turned her fury on the analyst. The child was then able to talk more fruitfully about her disappointment and anger at the analyst. There are times when there seems no way to work with such rigid play; sometimes time itself is the necessary ingredient.

For children who cannot play, the analyst tries to help them enter a play process. Asking questions about a story may help children to learn what the ingredients of a narrative are. The analyst can provide the structure herself, suggesting, “Let’s write a story about what happened in the waiting room. I’ll draw the picture. What do you want to be doing?” Alternatively, the analyst can make a puppet show for the child, choosing a theme that he or she knows will be appealing and putting it into displaced form. If the child is playing a board game, the analyst can become the voice of one of the pieces, elaborating a story about how it feels to be losing or winning or being trapped. Or the analyst can put on a puppet and do something playful or act vulnerable. The analyst can model a way of being free in using pretend. The analyst, through the voice of a character, can become the voice for aspects the child cannot yet acknowledge.

**Play With Nonimaginative Play**

Older school-age children and adolescents often use structured play such as games, craft projects, or music to communicate about their inner world. One child and her analyst would negotiate the inclusion of the unlucky cards at the beginning of the game to establish the current mood of the child and the child’s tolerance for losing. “Is this a ‘bad guys in’ or bad guys out day?” her analyst would ask her. If it were a “bad guys in” day, they would communicate about the child’s more positive mood and flexible attitude toward competition. If it were a “bad guys out” day, the analyst would explore what was making the child feel like a “loser” at the outset.

Children also communicate in less explicit ways about their fantasies and emotions during nonimaginative play. Cheating in games can express a child’s fantasies about power and aggression in relationships. The manner in which the child cheats—blatantly or cleverly—is significant, both in terms of the child’s cognitive competence and in terms of fantasies about gaining and manipulating power. The child who cheats consistently so that the analyst never wins is “playing out” something quite different about relationships than the child who teases the analyst by sometimes allowing a “fair fight” and then cheating only when the analyst is a step away from success.

Craft projects can be regulating and soothing as well as expressive. One child and analyst crocheted granny squares for an Afghan that the child planned to take home with her at their anticipated termination. Their silent experience of being together as well as their talk about the girl’s life and their relationship was in a sense woven into the squares that made up the “security blanket.” An adolescent boy, previously unable to talk to his analyst, brought in his extensive collection of iTunes music and gave a copy to the analyst. He then played the music piece by piece, explaining his understanding of each song and the appeal each had for him. In doing so, he told the analyst in displacement about his loneliness, his longings, and his anger and disappointment with his parents.

**Interpretation and Insight**

Child analysts differ among themselves about the place of interpretation and insight in the play process. They have different views about 1) what understandings need to be decoded from the play, applied to the real world, and interpreted directly to the child; 2) what understandings need to be verbalized but can be articulated as part of the play displacement; and 3) what understandings can or should go unsaid. Clearly some of this controversy has to do with theoretical disagreements about how psychoanalysis brings about change. When inter-
interpretation was considered to be the primary mutative agent in adult psychoanalysis, there was a tendency to apply the same thinking to child analysis. Thus, there was an expectation that in order to do “real analysis,” the child analyst should decode the conflicts uncovered in the play material and relate them directly to the child’s actual circumstances for acknowledgment. Unfortunately, this often shut down the play process.

Developmental theory tells us that older children have a greater capacity to appreciate that the stories they are playing emerge from their own thoughts and fantasies (Mayes and Cohen 1993). Under favorable environmental circumstances, children gradually achieve a self-reflective capacity by late latency. However, despite the fact that one might expect the capacity to verbalize feelings to increase with age, age is not always an indicator of who will be able to self-reflect. Some children of all ages have difficulty acknowledging their feelings, whereas some very young children can talk about their feelings directly and easily.

As a result of increased data from the neurosciences, we now know that implicit associational memory systems operate and are influenced outside conscious awareness (Gabbard and Westen 2003). Change can occur in different systems (conscious and unconscious), with and without words. Implicit change is possible during play not only because procedural schemas of interacting with another (Stern et al. 1998) can shift but also because conceptual (symbolic) ideas can be “played with” metaphorically during the play process without necessarily being brought to awareness.

Furthermore, conscious change and implicit change are not an either/or matter; they often enhance each other (Gabbard and Westen 2003). For example, we assume that the degree and stability of therapeutic change may be facilitated in children, as in adults, by making them aware of factors initially outside of awareness, such as how they relate to others and how they feel about their experience. Moreover, verbalizing what happens in play is helpful to children because words are powerful tools. By naming things, words give permission for certain ideas and feelings to exist, and they can create a space between thought and action.

For insight to work with children, however, it is important that the analyst put his or her ideas in a language that children can understand. It is helpful to use the child’s own metaphors in interpreting—metaphors that have been developed in the process of playing together. Children are frequently able to understand complicated concepts such as transference or defense (Yanof 1996) if the analyst adapts his or her language to the level of the child’s cognitive and emotional understanding. With children, conscious awareness and self-reflection are more apt to occur toward the end of, and as a result of, the analysis.

Transference in Child Analysis

At first Anna Freud (1927) believed that children did not form transferences because their parents continued to be the primary objects in their lives; children enacted their conflicts with their parents and did not “transfer” them to the person of the analyst. Later (Freud 1965) she reversed this position, agreeing that children did indeed develop transferences during their analytic treatment and that these transferences could be similar, but not equal, to the “transference neurosis” of the adult. The absence or presence of a transference neurosis in child analysis comparable with the adult’s became a subject of scrutiny and controversy for many years (Fraiberg 1951, 1966; Harley 1967; Sandler et al. 1980; Scharfman 1978; Tyson 1978) until the concept “transference neurosis” lost its prominence in adult analysis (Brenner 1982; Smith 2003).

Chused (1988) wrote a seminal paper in 1988, making the point that contemporary child analysts often do not observe as much transference in child analysis because their technique hinders the development of a full-blown transference. Chused found that child analysts often gave up a neutral position and took on the traditional (and more gratifying) role of adult with a child. In this way Chused’s view echoed the earlier position of Melanie Klein (1932, 1955), who believed that children could be analyzed by classical adult technique through the analysis of their play. Klein believed that as long as the child analyst methodically interpreted the child’s negative transference and avoided the role of educator, a transference neurosis would develop very similar in kind to that of an adult (Klein 1932).

Other authors, however, have found that transference is less observable in children because the child analyst is used by children in different ways more of the time—not simply as a transference object but as a new, real, or developmental object or an object of externalization. These uses of the child analyst have been recognized, differentiated from transfer proper, and credited with contributing to the therapeutic action in child analysis (Abrams 1996; Furman 1980; Lilleskov 1971; Sandler et al. 1980; Tyson 1978).
Despite these differences of opinion, work in the transference continues to have a pivotal place in child analysis just as it does in adult analysis. In the broadest sense, transference includes all the child’s feelings and attitudes toward the analyst. In analysis, the repetition of the past always occurs in the context of a new relationship in which there is an attempt to negotiate a different outcome. At the same time, the current analytic situation is always framed by past paradigms. Although theoretically it may be useful to differentiate transferences from other feelings directed toward the analyst, operationally they are inextricably intertwined. This position recognizes the ubiquity of transference (Joseph 1985): whatever the child chooses to play or do with the analyst during the session has relevance to the transference.

Children (especially young children), however, are not readily able to experience the full emotional impact of their transference feelings and simultaneously to recognize their “as if” nature (Yanof 1996). Reconstructions are often not understood by children in the way they are by adults (Yanof 1996). One of our goals with adult patients is for them to achieve an appreciation of the paradoxical nature of the transference. Perceptions of the analyst are simultaneously “real” and “illusory” (Modell 1990; Smith 2003). It is often at the point when this paradox is recognized that the adult patient is able to gain a sense of mastery in separating present from past. Because children have limited understanding of transference conceptually (i.e., its “as if” nature), transference work must be done with children “in the moment.”

Transference in children is most likely played out or enacted. Children rarely talk about how they experience the analyst, rarely report dreams that are explicitly about the analyst, and rarely speculate about the analyst in undisguised fantasy. Nevertheless, transference should be thought of whenever the child expresses direct curiosity about the analyst. Sometimes children ask the analyst questions about his or her age, family configuration, or other patients. It is difficult for a child to understand why a familiar and intimate adult would not answer a simple question. Asking a child to fantasize about an answer withheld is generally misunderstood and counterproductive. It is most fruitful to try to address the reasons behind the child’s curiosity, whether or not a direct answer is provided: “You are wondering what I do with the other children who come to see me and how I feel about them?” “Maybe you are wondering if I am a mother and what kind of mother I would be.”

Play displacement is also a place in which transference can be revealed, as in the example of Emily, who played about falling down on the ice. Although it was not explicit, she was talking about her experience in the moment with her analyst as well as her experience at home. It is useful for the analyst to ask, “Why is the child telling me this story at this time?” The transference may come up in an explicit way through characters that are designated “feelings doctors” or just plain “doctors” who may enter the play to do brain surgery, kidnap children, marry them, or send them to someone else to treat.

When work in the transference is most mutative, as with adults, it is affectively alive in the interaction between the child and the analyst. Often the analytic frame provides intense moments at which it is particularly effective to take up the transference. Entering and leaving the session or separations around vacations are such opportunities. The child may fear coming into the session, refuse to leave, or demand to take home a toy he or she has been playing with. Each of these situations can be used by the analyst to articulate feelings toward the analyst or defenses against allowing such feelings to emerge. When child and analyst are deeply engaged in the play process, affects become more intense, and the transference/countertransference paradigms also become more transparent. As with adults, transference often feels less cohesive and consolidated in the beginning than it does later in the treatment.

The following clinical example (first presented by Yanof 1996) involves a selectively mute boy who was in analysis from ages 4 to 7 years:

At the beginning of treatment, Jeremy played for many hours with action figures in my dollhouse, his back turned toward me, in complete and utter silence. He responded to nothing that I said and nothing that I ventured about the feelings in the room. There was an important turning point in the treatment when I abandoned words altogether and limited myself to making noises that accompanied his action-play as closely as possible. Later, Jeremy began to use words, yet the paradigm of an interrupted dialogue repeated itself again and again in the interaction that we developed.

At first, I thought of Jeremy’s silence as a resistance to treatment, a symptom or obstacle we had to eliminate. Later, I began to understand the silence or the disrupted dialogue as a metaphor and a transference repetition of an earlier way of being with the other. In the beginning, we negotiated our relationship through action: How much silence, excitement, or control would I tolerate before I set limits, disengaged, talked, or stopped talking? As the transference became more consolidated, I began to verbalize what felt affectively alive and available between us. Some-
multiple times a week can be a very effective treatment by itself. As a portal of entry into the family system, changes within the child can often lead to broader changes within the family. Limited contact, however, if it means lack of involvement with parents, carries its own serious risks. It may make parents feel excluded from the child’s treatment, stimulating resistance to support of the analysis. Parents can subtly undermine a treatment by making a child feel guilty for his or her involvement with the analyst or by making the child feel solely responsible for the family’s troubles. Moreover, to the degree that the child’s difficulties inevitably are intertwined with the parents’ issues, the parents may contribute to the child’s troubles without being aware of it, nor are parents always pleased when a child gets better, if getting better means a psychological separation that feels threatening to them [Novick and Novick 2002]. More often than not, parents need the child’s analyst to provide them with ongoing support and containment via a parent treatment in order for them to allow the child enough space to move forward with his or her own analysis.

There are some child analysts who, after evaluating the child, work for a substantial period with the parents in parent guidance before taking the child into psychoanalysis [J.E. Chused, personal communication, 2004; Novick and Novick 2001; Rosenbaum 1994]. This allows parents to see what gains can be made in improving family interactions prior to treating the child. Such an experience often provides parents with conviction about the necessity for the analysis and helps them feel more strongly aligned with the analyst before the treatment begins. Some child analysts, after an initial evaluation, preferentially work via the parents when treating young children (younger than age 5), believing that the input from the environment is always a factor of greater significance for the young child [Furman 1957].

Most analysts treat a child individually from the outset and work with the parents conjointly. The decision to see the child individually from the beginning is often made because 1) the child is suffering significantly, 2) the child’s development is derailed, and the analyst wants to intervene before the child falls further behind; 3) the child’s issues appear to be largely internalized, or 4) the analyst feels there is value in beginning the intervention on both fronts [parent and child] simultaneously. However, child analysis should only be undertaken if parents are likely to support treatment until its completion. Assessing this commitment usually requires a prolonged evaluation.

There are times when children are very young, or when children cannot separate from a parent, when analytic treatment must begin with the child’s parent in the room. In such dyadic beginnings, the parent-child relationship may become the focus of the analyst’s intervention. This can have important reparative effects for the parent-child relationship, particularly if attachment has been compromised, because the disruption in the relationship will be apparent and the affects between parent and child will be available to address. Moreover, the parent can benefit from the analyst’s ability to contain, name, and understand the feelings in the room. The analyst’s interpretations will often be psychologically relevant and useful to both parent and child, even though only one family member may be voicing the conflict or disturbance at a time. Nevertheless, in psychoanalysis, the inner life of the child is the main focus of the eventual work. The child’s inner life is generally not as accessible to the analyst in a treatment in which the parent remains present over time, because the child generally does not have the same freedom to express unconscious thoughts and fantasies when his or her parent is in the room, nor does the child have the same opportunity to become deeply attached to the analyst as a transference figure or developmental object.

As we, the authors, have gotten more experienced, parent work has become a more important part of our treatment recommendation for psychoanalysis and psychotherapy, because we have found that treatment simply goes better when parents are involved. Thinking of parents as important members of the treatment team, as well as patients, is a helpful concept. Treating parents weekly or biweekly with regular appointment times is an important part of our recommendation. Being accessible to parents by phone is also important. When working with older adolescents or young adults, it is more variable how and when we see the parents, but an alliance with the parents of adolescents is certainly indispensable (see Novick and Novick 2005 for a further discussion of parent work with adolescents and young adults).

When things go well, the child’s analysis will be supported by the family, and the family will feel supported by the child’s treatment. At some time during the treatment, however, transference/countertransference issues with one or both parents inevitably heat up, and they must be dealt with flexibly, thoughtfully, and at times innovatively. Interestingly, this is true whether or not parents are in their own individual treatments. In fact, it is often the case that parents in individual treatment may not talk about parenting issues to their own therapists, no matter how much turmoil these issues may be causing at home. Furthermore, although the child analyst is often an object of transference to parents, parents do not often consider themselves to be the child analyst’s “patients.” Therefore, parents do not have the same commitment and motivation to communicate feelings as opposed to enacting them. It stands to reason
Ethics in Psychoanalysis

Ernest Wallwork, Ph.D.

Psychoanalysis has a long history of deep ambivalence about ethics, defined as critical reflection about “right” and “wrong” actions and “good” and “bad” character traits and other states of affairs. Ethics differ from morality in that ethics provides arguments on behalf of basic normative standards and decision-making procedures, whereas morality is a more descriptive concept referring to how people do in fact think and behave within particular cultural contexts.

Many of Freud’s interpreters have concluded that classical psychoanalytic theory makes ethical reflection and discourse pointless, because genuine moral conduct is simply not possible, given what metapsychology holds about determinism, the pleasure principle, and the superego [see Gregory 1975; Hopsers 1950; Wallwork 1991; Yankelovich and Barrett 1970]. Freud’s comments on “the determination of mental life” [Freud 1910, p. 38] appear to undermine both freedom of choice and moral responsibility. The pleasure principle’s governance of the psychic apparatus seems to entail an egoistic hedonism of a sort that precludes genuine concern for others for their own sake. Freud’s explanation of morality in terms of the superego ostensibly embraces an ethical relativism inconsistent with any rational way of adjudicating among rival moral standards, which apparently vary systematically with the vicissitudes of child development, personality type, and sociocultural context [see Hartmann 1960]. The body blow to traditional ethics wrought by the cumulative effect of these and other psychoanalytic doctrines is seen by contemporary cultural critics as partially responsible for the culture of narcissism and privatism that pervades modern Western societies [see Bellah et al. 1985; Lasch 1979; Rieff 1961, 1968; Wallwork 1991]. This is one reason why today many potential patients are so profoundly suspicious of psychoanalysis.

Yet, as I argue in my book Psychoanalysis and Ethics [Wallwork 1991], psychoanalytic practice is constituted by what Freud calls a moral “pact” involving implicit reciprocal duties of both analysand and analyst [Freud 1940[1938], p. 173]. The analysand is expected to speak as truthfully as possible, even about the most shameful matters, and to keep his or her promises, at least minimally, by showing up on time for appointments and paying the bill by the agreed date. The patient must also begin to assume “moral responsibility” for disavowed
motivations, fantasies, and behaviors [Freud 1925]. The analyst, in turn, is guided by such standards as *primum non nocere* ("above all [or first] do no harm"), respect for the patient [Breuer and Freud 1893–1895], truthfulness [Freud 1926], protection of confidentiality [Freud 1913], and the therapeutic goals of relieving suffering and restoring the patient’s autonomy [see Freud 1915a, 1926, 1940[1938]]. These are not trivial moral standards of concern only to a few analysts. They constitute the conditions of the possibility of psychoanalytic treatment.

Serious analytic thinking about the contradiction between the anti-moral implications of classical psychoanalytic theory and the moral aspects of analytic practice has been astonishingly scant [Hartmann 1960, Wallwork 1991]. Why this should be merits study. Answers found in such a study would help explain how the moral aspects of psychoanalysis have been obscured for so long. What is clear is that the failure of Freud’s followers to find an adequate approach to ethics has served as a major impetus for many of those, like Alfred Adler and Erich Fromm, who have broken ranks with the classical tradition, as well as those, such as Erik Erikson, Heinz Kohut, and Irwin Hoffman, who have revised psychoanalysis substantially from within, partly in order to find an ethic in psychoanalysis [see Erikson 1963, 1964; Fromm 1941, 1947, 1956; Hoffman 1998]. The widespread skepticism toward ethics among psychoanalysts has undoubtedly contributed to the sad history of boundary violations by experienced clinicians who have falsely imagined themselves blessedly liberated from morals by a value-free, “amoral” profession.

The first generation of analysts after Freud eschewed ethical reflection, in part because they were convinced that psychoanalysis was, or should aim at being, a value-neutral science, free of the distorting effects of moral values [Hartmann 1960]. Psychoanalysis, it was asserted, describes and explains the facts of mental life and behavior, including moral conduct, without passing judgment on them, whereas ethics belong to another [suspect] discipline about how we “ought” to think and act [see Flugel 1945]. This fact-value dichotomy held sway during the heyday of positivism and its chief ethical corollary, emotivism, which stretched from the 1930s through the 1950s (see Hudson 1970; Stevenson 1944). One result was that moral judgments came to be seen as little more than an unjustifiable expression of an individual’s private affects and biases. In contrast with factual propositions, which were in principle verifiable, it was thought that moral claims could not be empirically or rationally supported. Had not Freud himself declared: “There are no sources of knowledge of the universe other than the intellectual working-over of carefully scrutinized observations—in other words, what we call research—and alongside of it no knowledge derived from revelation, intuition or divination” [Freud 1933[1932], p. 159]? Forgotten, for the time being, was that Freud also often approvingly quoted F.T. Vischer’s statement “What is moral is self-evident.” Not only did Freud require psychoanalysts to honor traditional normative standards, he demanded that the analyst’s “own character must be irreproachable” [Freud 1905, p. 267].

The clinical consequence of the construal of psychoanalysis as a value-free science by Freud’s immediate followers was that the analyst was expected to practice a neutrality, anonymity, and abstinence that mirrored the natural scientist’s detachment from the world of investigation. Leading figures like Ernest Jones and Heinz Hartmann admonished colleagues to keep their “scientific work free from the interference of value judgments” [Hartmann 1960, p. 54]. Freud’s depiction of the analyst as a mirror and surgeon and his “The Question of a Weltanschauung” [Freud 1933[1932]] were [and are] much cited in support of a concept of neutrality requiring freedom from morals, as though Hartmann was right to attribute to Freud Max Weber’s epistemological skepticism about ethics as part of a value-free methodology [Hartmann 1960], even though Freud’s own technical writings make it clear that clinical work must be guided by moral standards [see Breuer and Freud 1893–1895; Freud 1913, 1926, 1940[1938], Wallwork 1991]. The pejorative attitude toward ethics was so prevalent in the 1950s that the single mention of “ethics” by the then-president of the American Psychoanalytic Association, Ives Hendrick, in his 1955 presidential address on professional standards was of the self-serving “basic principle … [that] it is unethical” to teach psychotherapy in any organization not directly affiliated with the association [Hendrick 1955, p. 576].

The primary goal of psychoanalysis as a scientific undertaking became restricted to discovering psychological truths, with the result that other values, such as the therapeutic aims enshrined in the Hippocratic tradition and the patient’s expectations for enhanced freedom of thought and action, were eclipsed—at least as explicit treatment goals [see Grinberg 1988, and Rivière, cited in Phillips 1988]. Freud was again cited, out of context, to the effect that therapeutic goals inevitably interfere with the analyst’s primary aim of interpreting unconscious truths [Freud 1912, 1937]. That Freud scarcely imagined that his warnings against excessive “therapeutic ambition” (furore sanandi) and “passion for curing people” implied goallessness is evident in the following key passage:
The doctor should hold himself in check, and take the patient’s capacities rather than his own desires as guide. Not every neurotic has a high talent for sublimation; one can assume of many of them that they would not have fallen ill at all if they had possessed the art of sublimating their instincts. If we press them unduly towards sublimation and cut them off from the most accessible and convenient instinctual satisfactions, we shall usually make life even harder for them than they feel it in any case. As a doctor, one must above all be tolerant to the weakness of a patient, and must be content if one has won back some degree of capacity for work and enjoyment for a person…. [In] those who have a capacity for sublimation the process usually takes place of itself as soon as their inhibitions have been overcome by analysis. In my opinion, therefore, efforts invariably to make use of the analytic treatment to bring about sublimation of instinct are, though no doubt always laudable, far from being in every case advisable. (Freud 1912, p. 119; italics added)

Freud’s advice about tempering therapeutic ambition is here set in a broader conception of an ethics of practice in which less grandiose ambitions are seen as the best means toward the moral aim of providing optimal patient benefit at the least harm. The analyst’s temporary goallessness is ethically justified, because in the long run it is deemed most likely to benefit the patient by discovering the true meaning of his or her symptoms and helping the patient work through them. “The removal of the symptoms of the illness is not especially aimed at, but is achieved, as it were, as a by-product if the analysis is properly carried through” (Freud 1921). For Freud, truth is a leading goal but never the sole aim of analytic work, because the therapist has a broad set of “duties towards the individual patient” beyond the pursuit of knowledge [Freud 1905[1901], p. 8; see Wallwork 1991].

One problem with the post-Freudian claim that psychoanalysis is singularly focused on pursuing emotional truth, whatever the cost, is that it delegitimizes other ethical questions and concerns—for example, whether unremitting pursuit of the truth with a patient might be a form of coercion, aiming at compliance, rather than authentic analytic exploration. This was one of Kohut’s concerns: “the primacy of the [classical psychoanalytic] value system that it is ‘good’ to know…that it is ‘bad not to know’ may lead to a cognitive penetration that overtaxes the resilience of the analysand (Kohut 1977; Lichtenberg 1983; see also Schafer 1997).

It was commonly believed, and still is in some circles, that taking a value-free stance enables therapists to be nonbiased toward all of the patient’s communications. However, as feminists and cultural historians such as Michel Foucault [1990] have pointed out, the neutral scientific discourse of medicine is no guarantor of the moral innocuousness of theories and practices, especially regarding gender and sexual behavior. To the contrary, claims of scientific objectivity about these topics are apt to be all the more dangerous morally for pretend- ing to be value free (see Wallwork 1995). The psychoanalytic bias against homosexuality for its first eight decades is one example of an injustice perpetuated in the name of presumptions about scientific objectivity. Until recently, these biases could not be subjected to ethical interrogation for their “unfairness” and lack of “respect” for the homosexual patient because they were thought to be based on objective, value-neutral findings.

The narrowing of ethics to the value of scientific truth failed because the suppressed question kept returning: How is the analyst to account for the other values, particularly therapeutic standards, that are part and parcel of the analytic relationship? One popular answer was found in the old adage that “the truth will set you free,” to which it was often added that the truth also, fortunately, tends to reduce suffering and to unlock optimal possible internal conditions for autonomy and happiness. The singular focus on scientific truth was thus quietly expanded to include such central moral goals as increasing the patient’s freedom and autonomy, reducing pain and suffering, and improving the patient’s capacity for experiencing pleasure and happiness. Yet analysts continued to assert that even if these desirable by-products of the search for truth did not occur, a good analysis could occur nonetheless. Some, including Hartmann, also contended that therapeutic values were not really moral values and thus analysis could continue to be construed as truly value free.

One problem with treating therapeutic aims as non-moral health values is that the concept of mental health cannot be separated from moral and ethical considerations. Mental health is neither a statistical norm nor the absence of psychic discomfort. A patient with an “average” state of depression scarcely represents the psychoanalytic idea of the mentally healthy person. A “happy” narcissist is not free of psychopathology because he or she is not experiencing discomfort. Most formulations of mental illness have to do with some failure to understand oneself or to guide one’s own actions, not with departures from a statistical average or pleasurable mental state (see Daly 1991). Diminished or impaired mental functioning not only cannot be measured against a natural norm but also cannot be articulated without the help of implicit moral standards such as authenticity, self-knowledge, and autonomy that together constitute what we mean by agency. When someone’s authentic self-guidance is impaired by irrational underlying motives or inexplicable
behavior to such an extent that the agent is no longer the author of her or his actions, we consider the person mentally ill [see Feinberg 1970].

Hartmann notwithstanding, the presence of moral values in our concepts of mental illness and health, as well as in our beliefs about efficacious technique, does not constitute an undesirable interference with psychoanalysis. Rather, moral evaluations are a necessary condition for having standards of health and illness and therapeutic practices to treat them. Just as there are no facts without theories, there are no mental illnesses and states of well-being without some implicit moral evaluations. Psychoanalysts may not often think consciously about moral evaluations in their daily work, but all aspects of psychoanalysis can be examined for their ethical dimensions [see Schafer 1997]. Moral standards such as truthfulness, confidentiality, beneficence, nonmalice, and promise keeping, as well as the role-specific virtues and treatment goals discussed in this chapter, set the context within which analysis takes place. Many ordinary interpretations presuppose the analysand’s concurrence about the moral harm of, say, projective identification, irrational rage, or self-defeating conduct. Thus, the issue is not whether value freedom is a desirable state of affairs, because it is not possible to attain such a mental condition; the issue is how we think ethically of the standards that we do hold [or should hold] about the work that we do.

Ethical Aspects of Neutrality

Since Hartmann’s era, the concept of neutrality has given rise to considerable controversy about both its meaning and its usefulness. If the term today less often signifies an amoral value-free posture, it continues to be used in writings on technique for a desirable mental state consisting of a combination of benignly attentive and tolerant attitudes and dispositions that are constitutive of analytic listening [see Laplanche and Pontalis 1973; Moore and Fine 1990].

The term neutrality, which Strachey introduced as a translation of Freud’s indifferenz [see Freud 1915a], comes from the Latin neuter, meaning “neither one nor the other.” Unlike “abstinence,” which involves not doing something, such as revealing personal information, neutrality is a state of mind. The term attempts to capture Freud’s recommendation that the analyst listen with “evenly suspended attention” [Freud 1912, p. 111], which Anna Freud characterized in structural terms as taking up a menial position equidistant from the demands of the id, ego, and superego [Freud 1936; Smith 1999, 2003]. To the Freuds, to be neutral in the sense of free-floating attention was not to be value free, because the rationale for this listening mode was that it would benefit the patient by enabling the analyst to hear the full range of meanings in the patient’s communications with minimal distortion and interference from the analyst’s subjective opinions. “We will suspend our judgment and give our impartial attention to everything that is there to observe,” Freud advised in the Little Hans case (cited in Balsam 1997, p. 5). The analyst was cautioned not to lend a special ear to particular parts of the patient’s discourse or “read particular meanings into it, according to…theoretical or moral preconceptions” [Laplanche and Pontalis 1973, p. 271]. The idea was to foster “reversc” in the analyst, enabling him or her to be receptive to what Bollas calls “unthought knowns” and to create a mood essential for the analysand’s freedom to speak without fear of being encroached upon by the analyst’s personal biases, opinions, and judgments [see Bollas 1999].

However, this temporary suspension of the analyst’s narcissistic investem in favored theories, moral judgments about the patient’s conduct, and particular life goals for the patient does not extend to the moral framework that makes analysis possible or to the analyst’s moral character or the long-term moral goals toward which the analysis is directed. For instance, neutral attention does not suspend the principle of respect for the patient as a person or the general obligation to avoid gratuitous harm. Rather than dispensing with moral character, neutrality actually requires it, in that the analyst cultivates the moral attitude of attentive tolerance, even toward the most extraordinarily provocative behavior.

If neutrality is conceived as a technical stance involving evenly suspended attentiveness, it characterizes the way the analyst is present [not absent, as some relational critics contend] in the analytic situation. This way of being present creates an ambiance that fosters both the analysand’s freedom to speak and the analyst’s ability simultaneously to hear the multiple meanings of the patient’s verbal and nonverbal communications, without either party being pressured by the constraints of theories, morals, or goals. This analytic attitude/disposition is in turn warranted by such moral considerations as having respect for the patient and benefiting him or her optimally by facilitating freedom of expression, self-understanding, and autonomy. The patient is respected both as the conscious not-yet-analyzed self-determining subject who chooses to speak at any given moment and as
the more fully self-aware agent he or she might become with the advent of fuller, more authentic, and richer speech [for discussion of these two notions of respect for the analysand, see Blass 2003]. Freud described aspects of neutrality based on respect for the patient’s autonomy this way: “We refused most emphatically to turn a patient who puts himself in our hands in search of help into our private property, to decide his fate for him, to force our own ideals upon him, and with the pride of a Creator to form him in our own image and to see that it is good” [Freud 1919, p. 164].

Acknowledging that neutrality, as a mental state, is supported by moral standards carries with it the implication that the analyst’s evenly suspended attentiveness may be—indeed, should be—modified if the weight of ethical and technical considerations warrants a more engaged style that better facilitates analytic listening [possibly through retrospective interpretation of enactments] as well as a particular patient’s freedom of expression, expanded self-understanding, and autonomy. Neutrality in the sense of benign attentiveness is certainly not incompatible with either personal warmth or empathy. In fact, neutrality is intended to facilitate empathy, so that if it does not, some adjustments in its practice are ethically desirable.

**Freud’s Ethics**

The ethics of clinical practice for psychoanalysis do not stand or fall with what Freud or his disciples thought, but it is instructive to look at the deep ethic that informs classical psychoanalytic theory and practice. This ethic, which I explore at length in *Psychoanalysis and Ethics* [Wallwork 1991], has not been widely appreciated by psychoanalysts, largely because the prevailing value-neutral, “scientistic” [Habermas 1971] bias against ethics has led to the distortion of Freud’s thought on a number of issues central to moral philosophy. However, the deep ethic that informs Freud’s work persists to this day as one of the unacknowledged factors that unite psychoanalysts, despite theoretical and technical differences among contemporary schools.

**Determinism**

One widely shared misperception is the assumption that Freud embraced the hard determinist thesis that the individual could not have acted otherwise. For example, Arlow and Brenner (1964) echoed Ernest Jones (1953) when they wrote, “[Mental processes] follow the same general laws of cause and effect which we customarily assume to operate in the physical world. Psychoanalysis postulates that psychic determinism is as strict as physical determinism” [p. 7].

However, contrary to the suppositions of Jones, Arlow and Brenner, and Yankelovich and Barrett, among others, none of the few brief references to determinism in Freud’s writings actually advocate the metaphysical determinist thesis that all human actions are causally necessitated by antecedent conditions and universal laws [Wallwork 1991]. Freud wrote only about “psychic determinism,” and he was careful to confine the concept to “motives” as “causes” that affect the occurrence of an outcome without actually requiring it. In the main, Freud employed “psychic determinism” to signal that some particular kinds of behavior (e.g., dreams, symptoms, parapraxies, and free associations) do not occur accidentally or fortuitously, as his predecessors had thought, but are traceable to the influence of repressed unconscious motives that function as “causes” in the realm of mental life. Thus, when Freud stated that “psychoanalysts are marked by a particularly strict belief in the determination of mental life,” he went on to explain: “For them there is nothing trivial, nothing arbitrary or haphazard. They expect in every case to find sufficient motives where, as a rule, no such expectation is raised” [Freud 1910, p. 38].

For Freud, “psychic determinism” does not imply an absence of choice so much as the claim that all behavior is motivated and, as such, may fall under conscious voluntary control [Wallwork 1991, 1997]. Choice is made possible in the structural theory by the “I” or the “ego,” which has “voluntary movement at its command” [Freud 1940[1938], p. 145]. Thus, it is not inconsistent with psychic determinism for Freud to claim that the goal of psychoanalysis is to expand the range of “conscious willpower” and “freedom” (*Freiheit*) [Freud 1905, 1915a]. In fact, the ultimate goal of psychoanalysis is “to give the patient’s ego freedom to decide one way or the other” among the motives or reasons for action available to consciousness [Freud 1923, p. 50].

Psychoanalysis is well known for shrinking the domain of moral responsibility by bringing to light new excusing circumstances that explain that an individual acted in a given way in some situation because of unconscious motivations. However, psychoanalysis paradoxically also expands the realm of moral responsibility by encouraging owning one’s own disavowed motivations. The analysand is expected to assume responsibility for not only conscious intentions and conduct, as the
Western ethical tradition advises, but also unconscious motivations. In his remarkable 1925 essay "Moral Responsibility for the Content of Dreams," Freud stated:

I must assume responsibility for both [conscious and unconscious motives]; and if, in defence, I say that what is unknown, unconscious and repressed in me is not my "ego," then I shall not be basing my position upon psycho-analysis, I shall not have accepted its conclusions—and I shall perhaps have to be taught better by the criticisms of my fellow-men, by the disturbances in my actions and the confusion of my feelings. I shall perhaps learn that what I am disavowing not only "is" in me but sometimes "acts" from out of me as well. [p. 133; see my discussion of Freud's views on moral responsibility in Wallwork 1991, pp. 75–100]

Egoistic Hedonism

A second commonplace misreading of Freud that undermines both the possibility of morality and the point of ethical reflection attributes psychological egoistic hedonism to the pleasure principle [see Asch 1952; Fromm 1973; Gregory 1975; Hoffmann 1976; Wallwork 1991]. Certainly, Freud sometimes wrote as though he subscribed to the psychological hedonist thesis that human desire and volition are "always determined by pleasures or pains, actual or prospective" [Sidgwick 1962, p. 40].

Yet the key ethical issue at stake is whether Freud's hedonism always directs the agent egoistically, so that all seemingly disinterested behavior, such as pursuit of the truth, can be reduced ultimately to a desire for pleasure for oneself alone. That Freud tried to stake out a place for nonegoistic motives is obvious. Writing against egoism, he declared that it is both possible and desirable to pursue knowledge, even though it offers "no compensation for...[those] who suffer grievously from life" [Freud 1927, p. 54]. He made a similar point about the possibility of loving others for their own sake ("ihnen zu Liebe") [Freud 1921]. In Freud's early work, disinterested motives are attributed to the reality principle's opposition to unrestrained libidinal pleasure seeking. In 1915, Freud added that nonegoistic motivations are a result of the developmental "transformation of egoistic into altruistic inclinations" [Freud 1915b, pp. 283–284]. There is an enormous difference, Freud argued, between the egoist [or narcissist] who "acts morally" only for egoistic reasons—that is, because "such cultural behaviour is advantageous for his selfish purposes"—and the person who acts morally "because his instinctual inclinations compel him to" [Freud 1915b, p. 284]. The latter individual has undergone "the transformation of instinct [Trie- bumbildung] that differentiates the 'truly civilized' from 'cultural hypocrites'" [p. 283–284]. The civilized moral agent finds "satisfaction" in acting benevolently for another, but the basis of this is no more egoistic than it is in the writings of those many Western moralists since Aristotle who have emphasized the pleasurable aspects of acting morally.

Ethical Relativism

A third common misinterpretation of Freud that affects current attitudes toward ethics derives from the potentially relativistic implications of the concept of the superego [see Wallwork 1991]. If the superego is synonymous with morality, as Freud sometimes indicated [Brenner 1982; Freud 1933/1932; Kafka 1990], and if the superego is nothing more than a set of purely arbitrary standards that the individual has internalized by introjecting the prohibitions and ideals of his or her parents and other authority figures, then nothing can be said in defense of moral standards other than that they are the standards one happens to have. There is no principled basis for choosing one set of ethical norms over another as guides for action—no grounds for reasoning that might persuade in the presence of conflict—other than egoistic strategies for obtaining rewards and avoiding external punishments and internal guilt or shame.

This is not Freud's position, however. Freud resists the pull of ethical relativism by arguing that there are certain reasonable moral guidelines that can be rationally defended [Wallwork 1991]. This side of Freud's work has not been appreciated because it occurs as the subtext of Freud's all-out attack on religion in Future of an Illusion [Freud 1927]. Here, Freud's sub rosa point is that weakening the religious grounds for morality poses dangers to society and requires new rational justifications—the main task of ethics. Against ethical relativism, Freud (1927) declared that the time had come to "put forward rational grounds for the precepts of civilization" (p. 44). The challenge to contemporary analysts is to locate these grounds.

The Deep Ethical Theory Informing the Practice of Psychoanalysis

Although Freud never directly addressed the "rational bases" for morality, much can be deduced about the deep
ethic in his work from what he said about happiness as the goal of life, the primacy of love of and respect for others as natural dispositions, the good of community, and the value of shared rules [see Wallwork 1991]. This deep ethic continues to inform psychoanalysis today.

Freud’s alternative ethic to superego moralism is often missed because it is drowned out by the negativity of his critique of religious and duty-oriented—particularly Kantian—ethics. Readers are unprepared for the Aristotelian form of ethics (oriented toward achieving personal happiness) that informs Freud’s thinking, including his critique of superego moralism. Instead of viewing ethics as seeking an ahistorical, perspectiveless set of universal principles legitimated by reason alone, without reference to local commitments or particular experiences and affects, Freud saw ethics (at least when he was thinking constructively) primarily as dealing with the question of how it is best to live our lives. Here ethical deliberation is not about finding and applying a meta-decision-making procedure, such as Kant’s categorical imperative or Bentham’s utilitarian calculus, to resolve moral dilemmas. Rather, ethics is a matter of negotiating or straddling multiple incommensurate conscious and unconscious responsibilities and values that emerge out of “thick” reasoning, supportive of the most fitting moral judgment for the agent[s] in some specific context.

As for the paramount moral standard, Freud was quite explicit that the good that humans universally seek is “happiness” (eudaimonia in Greek, beatitude in Latin): “[W]hat do men themselves show by their behaviour to be the purpose and intention of their lives...? The answer to this can hardly be in doubt. They strive after happiness; they want to become happy and to remain so” [Freud 1930, p. 76]. In identifying “happiness” as the summum bonum, Freud is in alignment with the mainstream of the Western moral tradition stretching from Aristotle through Augustine, Thomas Aquinas, and J.S. Mill. Like them, Freud does not leave the constituents of the intrinsic good of happiness for an individual to arbitrary personal preference (as it is in current formulations of utilitarianism), nor does he think that subjectively pleasurable mental states alone determine happiness [see Freud 1930]. Happiness for Freud, as for Aristotle, is more a matter of functioning well than feeling good. The mentally healthy person’s happiness consists in the well-being that comes with certain forms of sublimation: loving and being loved, creative work, the pursuit of knowledge, freedom, and aesthetic appreciation. These goods of life that make happiness possible are not instrumental means to functioning well but constituent aspects of happiness. It is by means of love and work (lieben and arbeiten), for example, that we are as happy as human beings are capable of being [Freud 1912, 1930].

Love was privileged by Freud as a constituent of happiness partly because the qualitatively unique “union of mental and bodily satisfaction in the enjoyment of love is one of its [life’s] culminating peaks” [Freud 1915a, p. 169]. Mutual love (“loving and being loved”) is universally recognized as one of the chief means for finding “a positive fulfillment of happiness” [Freud 1930, p. 82]. Freud also accorded love pride of place because it underlies so many other nongoalistic values: love of family, friendship, love of others in a community [which provides Freud’s rationale for acceptance of a community’s rules and regulations], and love of humankind. Indeed, Freud [1930] defined “civilization” as a “process in the service of Eros, whose purpose is to combine single... individuals, and after that... peoples and nations, into one great unity” [p. 122]. By means of libidinal ties to the community, the individual feels concern for the welfare of others and can be motivated to “conform to the standards of morality and refrain from brutal and arbitrary conduct.” [Freud 1915b, p. 280], even when it is “disadvantageous” in terms of the agent’s short-range self-interest. Of course, Freud never forgot that “man’s natural aggressive instinct, the hostility of each against all and of all against each, opposes this programme of civilization” [Freud 1930, p. 122]. With characteristic realism, he cautioned that few get beyond common human unhappiness.

Freud is well known, of course, for his sharp criticism of the love commandment (“Thou shalt love thy neighbor as thyself”) in Civilization and Its Discontents [Freud 1930]. Less widely appreciated is that this critique is directed not only against the excessive demands for self-abnegation and self-sacrifice of the Christian version of the commandment and that Freud actually reinterprets the love commandment along more modest, broadly humanistic lines. “I myself have always advocated the love of mankind,” Freud wrote to Romain Rolland, whose humanism he respected [E.L. Freud 1975, p. 374]. In 1933, 3 years after his harsh criticism in Civilization and Its Discontents, Freud himself explicitly embraced “the love commandment” as the antidote to human aggression:

If willingness to engage in war is an effect of the destructive instinct, the most obvious plan will be to bring Eros, its antagonist, into play against it. Anything that encourages the growth of emotional ties between men must operate against war.... There is no need for psycho-analysis to be ashamed to speak of love in this connection, for religion itself uses the same words: “thou shalt love thy neighbour as thyself.” [Freud 1933, p. 212]
MacIntyre, a practice is “any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity” (MacIntyre 1984, p. 187). Tennis and chess are examples of practices, as is psychoanalysis. To enjoy the goods internal to the practice of tennis, one has to play according to the rules and standards of excellence of the game. Enjoyment of a game of tennis or of a good analytic hour comes not from contingent extrinsic rewards, such as fame or riches, but from actualizing the standards of excellence for that kind of activity. A virtue, according to MacIntyre (1984), is “an acquired human quality the possession and exercise of which tends to enable us to achieve those goods which are internal to practices and the lack of which effectively prevents us from achieving any such goods” (p. 191; italics in the original).

The analytic attitudes and dispositions (virtues) that advance the goods of analysis are taught by the example of training analysts, supervisors, and exemplary clinical accounts of how the analyst comports himself or herself, especially when pressured by the patient to act differently. These attitudes and dispositions enable the analyst to see and act correctly with patients—for example, in tolerating being “used” by the patient, as Winnicott (1982) depicted in his paper “The Use of an Object” (see pp. 86–94). To be virtuous in the context of analyzing is not only to be disposed to act in a certain way when tempted to do otherwise but to do so with the appropriate affects. For example, a good analyst is able to restrain a momentary countertransference desire to retaliate against a provocative patient by tapping stronger professional attitudes that help to contain his or her own and the patient’s destructive affects, without rattling the patient with excessive traces of the analyst’s hostility. If an unintentional enactment occurs, additional traits are called forth from the analyst, such as the courage to probe what has transpired and the honesty to admit one’s own contribution, even when doing so is humiliating, if this facilitates the analytic relationship and work.

Analysts typically rely more on attitudes and traits (i.e., “virtues”) than on professional principles and rules for guidance in ordinary interactions with patients. Freud said as much when he wrote in 1927 that psychoanalytic “tact,” under which he said he subsumed “everything positive that…[the psychoanalyst] should do,” was ultimately more important than rules, which are often too “inelastic” to guide actions well (quoted in Jones 1955, p. 241). Elsewhere, Freud observed that learning analytic technique is like learning to play chess: the rules of the game are less important than the example of master players.

Most of the character traits associated with the analyst’s role are variants on familiar virtues in the Western moral tradition. The analyst is expected to be prudent, patient, honest, kind, curious, discreet, tolerant, spontaneous, humorous, courageous, and wise, to mention only a few of the most obvious traits (see Friedman 1996; Grinberg 1980; Jaffe and Pulver 1978; Schafer 1983). Conversely, narratives of psychoanalytic misconduct depict familiar moral “vices,” such as egotism and hostility, under the rubrics of “narcissism,” “masochism/sadism,” and “sadism” (see Gabbard and Lester 1995). However, the distinctive ways analysts comport themselves are sufficiently unique to require a specialized terminology, such as the one formulated in the following discussion.

What, then, are the virtues of psychoanalysts? The answers vary somewhat among postclassical psychoanalytic schools, but some traits are shared across schools because they are so basic to the analyst’s role. These virtues facilitate an intrapsychic and interpersonal environment conducive to the analytic process. These “process virtues” are very different from the idealized “virtues” of the Western moral tradition and the hypocrical ego ideals that many patients bring to treatment. They foster, rather than oppose, the patient’s self-reflective capacities by making a virtue out of not being virtuous in the conventional senses of denying deplorable motives. In place of moral grandiosity, analysts cultivate the courage to accept narcissistic deflation in the arduous process of pushing the boundaries of self-knowledge while tolerating not knowing what cannot yet be grasped.

Empathic Respect

Empathic respect for the patient as a unique individual—evident from the outset of the relationship in the tone, affect, and rhetorical quality of the psychoanalyst’s verbal and nonverbal responsiveness to the particulars of the patient’s life, difficulties, affects, and choices—is an all-important virtue critical to the success or failure of an analysis. Patients come into analysis suffering from self-punitive mental states. The analyst’s ability to recognize this and empathize with what the patient is feeling, while continuing to respect the person who is always more than a bundle of symptoms or a diagnosis, is essential in order for the therapeutic alliance to take hold. “Respect” insufficiently captures this analytic attitude, however, because respect can be cold and
rower set, and therapeutic aims include not only self-knowledge but also reduced suffering, increased mental freedom, and augmented autonomy. Gabbard [2001] is undoubtedly right that analysts who claim not to be interested in symptomatic changes are disingenuous, because “of course we want to help our patients with distressing symptoms” (p. 294). Yet the debate continues over whether we should focus directly on treatment goals and, if so, how and with what degree of commitment.

Ethical issues arise in connection with treatment goals chiefly in terms of 1) who chooses the goals and 2) on what basis. With regard to the first, the analyst’s role in setting treatment goals was privileged until roughly the middle of the 20th century, when the Hippocratic tradition’s preference for paternalistic decisions informed by the physician’s beliefs about the patient’s best interests (under the moral principle of beneficence) began to give way, following the civil rights and feminist movements, to the moral principle of respect for the individual patient’s autonomy. Owen Renik [2001] put the implications of this ethical shift boldly when he proposed that the patient has “the last word” regarding both “the definition of the goals of a particular analysis, and judgments concerning progress towards those goals” (p. 239). The ethical idea behind Renik’s position is not only that the patient has the right, under the moral principle of autonomy, to make an informed decision about what outcomes to pursue but that he or she alone possesses the comprehensive information about, and full perspective on, his or her own life to decide what goals are worth pursuing at what cost in terms of time, money, and effort. In other words, the patient is better suited than the physician to decide what is or is not compatible with his or her prudential interests.

Although Renik’s position captures respect for the patient as a person in deciding on goals, it needs to be balanced by an understanding of the role of collaboration and negotiation between patient and the analyst in arriving at a mutually agreed-on set of realizable aims for their joint undertaking. Ethically, it seems best to view the goals of an analysis as a joint product, unique to each analytic dyad. The result of respectful negotiation and mutual agreement between the parties at the outset of treatment, goals should be repeatedly renegotiated over the course of the analysis as the relationship between the parties changes. The patient can be expected to alter treatment goals as he or she becomes aware of the role of unrealistic unconscious fantasies in initial expectations and arrives, as the analysis unfolds, at more realistic treatment goals and, in turn, life goals.

Ethical considerations enter latently into most efforts to clarify the proper goals of psychoanalysis. Consider, for example, Ernst Ticho’s (1972) familiar distinction between therapeutic goals and life goals. For Ticho, life goals are the personal goals (e.g., a better job, marriage, artistic creativity) that the patient would seek, were he or she overcome inhibiting intrapsychic obstacles. Treatment goals, on the other hand, concern “removal of obstacles to the patient’s discovery of what his/her potentialities are” (Ticho 1972, p. 315). Unlike the attainment of treatment goals, the realization of life goals depends on favorable conditions beyond the influence of the analysis, such as the reaction of others in the outside world, material resources, or just plain luck. Although some interpreters of Ticho have linked ethics with life goals, therapeutic goals are no less ethical. They differ simply in being the moral goals—such as reduction of suffering and increased freedom of thought—sought in treatment, as contrasted with the prudential and moral aims toward which the patient’s life is directed.

Ticho’s formulation correctly focuses attention on therapeutic goals as the primary moral aims of analysis. Yet it is far too vague about the complex conceptual issue of what it means to be mentally ill and to participate in a “treatment” or “therapy” for it. The conceptual door is thus left wide open by Ticho for analysts of varying schools to smuggle high moral ideals, such as Kohut’s transmutation of narcissism, into analytic treatment as “therapeutic” goals rather than clearly identifying them as “moral” aims. Put in terms derived from various theoretical systems [or lexicons], these allegedly therapeutic goals include the following (see Berman 2001; Kohut 1980):

- Making unconscious affects and fantasies conscious
- Encouraging greater flexibility of thought
- Making the superego less persecutory and more subtle
- Facilitating the transition from the paranoid-schizoid position to the depressive position
- Moderating and modifying perfectionist fantasies
- Expanding freedom to know one’s own mind, including unwelcome as well as welcome and bad as well as good thoughts
- Improving accuracy in testing the validity of external or internal realities
- Helping one to unflinchingly confront the emotional truth of one’s own experience
- Increasing tolerance and curiosity about oneself and others
- Unrolling the life plan or curve of life laid down in each human being’s nuclear self
- Remobilizing deep emotional capacities for genuine empathy and love
- Introjecting the analyst’s analyzing function as a form of self-examination
Some of these goals are clearly therapeutic, but others are moral ideals, particularly those having to do with releasing empathic capacities and living the kind of examined life urged by Western moralists since antiquity (see Wallwork 1999).

Whatever the moral goals of the analytic enterprise, however, they are best kept in the background as distant aims as the analysis proceeds. Gabbard [2001] is rightly concerned that “the analyst who is too concerned with achieving certain goals may paradoxically promote a transference-countertransference enactment in which the patient defeats the analyst’s efforts, thereby winning by losing” [p. 292].

### Moral Decision Making

Moral decision making is a fourth way ethical considerations enter into psychoanalytic practice, around such issues as boundary crossings, self-disclosures, financial relations, breaches of confidentiality, a patient’s threat to seriously harm another, damaging rumors about colleagues, and analyst impairment. These topics raise moral dilemmas requiring unique decisions, because an action must be chosen among alternatives, each of which is supported by good principles and values. For example, a pregnant analyst may feel morally conflicted about disclosing her pregnancy, because she wants, on the one hand, to advance the patient’s self-understanding by waiting for the patient to notice her pregnancy so that they can understand together the meaning of the patient’s denial and, on the other hand, to make sure the patient has sufficient time to process the meaning of the pregnancy before the due date and to make plans for the time they will not be meeting. Ethical conundrums such as this may be complicated by unconscious motivations that may interfere with finding a timely resolution of the dilemma, such as the analyst’s guilt about how she imagines her patient will react to news of the pregnancy. A common feature of unethical conduct by analysts lies with failure to fully understand the potential harm to the patient—in this case, perhaps, the patient’s painful humiliation upon belated discovery of his or her denial, reinforced by feelings of being toyed with and betrayed by the analyst during the long period she chose to keep him or her ignorant.

Sometimes the ethical action is transparently obvious, such as whether to sleep with a lovesick patient. Yet very distinguished analysts have rationalized sexual contact, at odds with clear ethical standards against exploiting the asymmetric power of the transference, with profoundly damaging consequences for patients who trusted themselves to their care. Gabbard and Lester’s [1995] work in their book *Boundaries and Boundary Violations in Psychoanalysis* humanized boundary violators by bringing out some typical vulnerabilities. These include a history of abuse, thin defenses, and narcissistic features such as desperate need for validation from patients, a hunger to be loved and idealized, and a tendency to use others to regulate self-esteem, superego, and ego lacunae [see also Celenza 2007; Wallwork 2009]. Boundary violators demonstrate in the extreme the unconscious dynamics often at work in analysts who prove unable to think clearly about lesser ethical issues.

Sometimes analysts face seemingly irresolvable conundrums. Consider the case of a therapist, such as Amy Morrison, who finds herself confronting the difficult problem of how to handle a diagnosis of cancer with her patients [Morrison 1990]. In addition to the usual difficulties of the psychodynamic work, the gravely ill therapist is torn in different directions by her wish to help her patients, concerns about her own well-being, and the impact of her illness on both of them. She may be committed to being open and telling the truth, but not all patients can handle the truth, or at least not at all of it at once, and there are issues not only of whether but how and when to disclose, and then whether and how to go on together. As Judith Chused (1997) pointed out in a thoughtful review of how Amy Morrison handled her life-threatening illness with her patients, these ethical/technical issues have to be worked through anew with each patient. The sick therapist has the obligation we all have to hear the patient’s reactions verbally and nonverbally, with their multiple conscious and unconscious meanings; to listen to how we receive these messages and how our own subjectivity colors our reactions; and to find a way of using this information in framing fresh interpretations and real choices that will be heard by the particular patient, even as they help the therapist help himself or herself. Here again, the therapist must be honest with himself or herself about “therapeutic ambitions, about those goals which are specific for an individual patient and those that the therapist holds dear and would like to achieve with all patients” [Chused 1997].

Historically, analysts have not shown much interest in the problem of thinking ethically about moral dilemmas. Rather, analysts have tended to assume that colleagues who act unethically need more analysis, and thus additional analytic work or supervision has been considered an apt punishment of and rehabilitation for ethical violators. However, additional analysis does not necessar-
ily help someone who is at sea about how to think about the moral conflicts that create genuine dilemmas.

To think ethically, the moral analyst needs both a stock of traditional rules and their justifying principles, such as those in the American Psychoanalytic Association’s *Principles and Standards* (Dewald et al. 2001), and virtuous attitudes and dispositions, without which there is little motivation to be moral. Yet rules and virtues provide inadequate guidance in the absence of “wise judgment” *[phronēsis*, in Aristotle], which involves the developed capacity to balance conflicting values and responsibilities in relation to the particular facts and dynamics of specific situations. From the perspective of wise judgment, rules and principles set forth a form of boundary ethics that helps identify the moral aspects of a situation. However, because often rules conflict in practice, the “good enough” moral analyst must creatively adapt the meaning of moral standards to the particular circumstances. The boundary metaphor for ethics that has taken root recently in psychoanalysis fails to do justice to wise moral judgment, which is more aptly captured by “playing the game well within the court” [see Wallwork 2003].

The case method supplies a particularly apt pedagogical approach for the development of wise judgment because it engages the reader in actively thinking about typical situations of moral conflict, as contrasted with complying passively with rules. Good cases have no “solutions.” Their value lies in stimulating a type of role-playing that entails struggling with difficult moral problems by interrogating feelings, biases, selective misperceptions, value preferences, and ethical standards before arriving at a creative decision appropriate to unique circumstances. For psychoanalysts, joining with colleagues to grapple with morally difficult cases is particularly relevant, because ethical problems for us are intertwined with technical considerations, which also entail moral issues to the extent that technique aims at optimally benefiting the patient [Wallwork 2003]. Case discussions also prepare analysts to consult colleagues about perplexing moral problems when they arise.

---

**KEY POINTS**

- Psychoanalysis is a moral practice in which normative evaluations are inextricably interwoven with concepts of health, illness, and treatment. Such moral values as truthfulness, respect, empathy, beneficence, nonmaleficence, freedom, and autonomy are part and parcel of the analyst-analysand relationship.

- Freud’s determinist statements notwithstanding, the analysand must take moral responsibility for his or her actions. To be sure, psychoanalysis brings to light new excusing conditions for unethical conduct, but it also, paradoxically, expands normal assumptions about moral responsibility to include owning disavowed and “unthought known” motivations.

- Neutrality in the sense of a technical stance involving evenly suspended attentiveness does not entail freedom from morals but rather a moral stance that fosters the patient’s freedom and autonomy, among other values.

- The deep ethic that informs much of Freud’s work and psychoanalysis after him is a form of neo-Aristotelianism that grounds normative ethics in a conception of happiness as well-being that entails functioning well in a variety of pursuits and enjoyments, such as interpersonal love, creative work, aesthetic appreciation, and the pleasures of communal life.

- For psychoanalysts to make reasonably good moral decisions, a plurality of principles and rules, as well as a variety of role-specific virtues (i.e., dispositional traits cultivated in the practice of psychoanalysis), are required. Indeed, without the analytic virtues formed during training and ongoing practice, the goods internal to psychoanalysis cannot be realized.
• Good moral decision making about the dilemmas that arise in practice typically involves balancing conflicting rules, values, and responsibilities in relationship to the particular facts and dynamics of specific situations. The reasonably good psychoanalyst demonstrates "wise judgment" (phronesis, in Aristotle) in deciding particular moral dilemmas as they arise in treatment.

References


Balsam R: Active neutrality and Loewald’s metaphor of theater. Psychoanal Study Child 52:3–16, 1997


Blass R: On ethical issues at the foundation of the debate over the goals of psychoanalysis. Int J Psychoanal 84:929–944, 2003

Bollas C: The Mystery of Things. New York, Routledge, 1999


Habermas J: Knowledge and Human Interests. Translated by Shapiro J. Boston, MA, Beacon Press, 1971


Kafka E: The uses of moral ideas in the mastery of trauma and in adaptation, and the concept of superego severity. Psychoanal Q 59:249–269, 1990


Lasch C: The Culture of Narcissism. New York, WW Norton, 1979


Stevenson CL: Ethics and Language. New Haven, CT, Yale University Press, 1944
Wallwork E: Psychoanalysis and Ethics. New Haven, CT, Yale University Press, 1991
Wallwork E: Thinking ethically with the new ethics code. The American Psychoanalyst 37:23, 2003
Winnicott D: Playing and Reality. New York, Tavistock, 1982
Psychoanalysis and Psychodynamic Psychotherapy

mously swollen in numbers and enriched in prestige by the refugees from Nazi-occupied Europe and successfully propelled itself into the dominant voice within the country’s medical schools and psychiatric clinical centers (although that development of dynamic psychotherapy has always been intensely contentious in addition to being so substantial and vigorous).

In recounting this development, I focus on the role of the main protagonists in several psychoanalytic panel debates of the early 1950s, brought together in one issue of the Journal of the American Psychoanalytic Association in 1954. However, I first consider the pioneering role of Robert Knight in framing the fundamental conceptions that marked the nature of psychoanalytic psychotherapy as psychoanalytic therapy, which was, as then formulated, nonetheless clearly distinct from psychoanalysis proper.

Knight’s principal concerns as a leader in American psychoanalysis were with its relations with psychiatry. He stated that until the advent of psychoanalysis, “psychiatry still lacked a psychology” (Knight 1945, p. 777), and he devoted himself to what he called “a basic science of dynamic psychology” (Knight 1949, p. 101), “the chief contributions to which have been made by psychoanalysis” (p. 102). Knight formulated his proposed fundamental distinction, within a psychoanalytically informed framework, between what he designated as supportive and expressive psychotherapeutic approaches. “Of the various possible ways of classifying psychotherapeutic attempts...two large groups could be identified—those which aim primarily at support of the patient, with suppression of the symptoms and his erupting psychological material, and those which aim primarily at expression” (Knight 1949, p. 101, italics added). The bias in favor of the expressive approach, as more definitive and therefore more desirable, was at the same time made clear:

Suppressive or supportive psychotherapy...may be indicated...where the clinical evaluation of the patient leads to the conclusion that he is too fragile psychologically to be tampered with, or too inflexible to be capable of real personality alteration, or too defensive to be able to achieve insight....The decision to use suppressive measures is made actually because of contraindications to using exploratory devices. [Knight 1949, pp. 107-108]

In a subsequent paper, Knight [1952] further distinguished the goals of supportive and expressive approaches, and within the latter, of psychoanalysis proper: "By the term ‘primarily supportive’ I mean to imply the intention to support and reconstruct the defense mechanisms and adaptive methods customarily used by this patient before his decompensation and the implementation of this intention by the use of explicit supportive techniques” (p. 118)—and he went on to indicate an array of “supportive techniques,” actually the first such detailed listing in a psychoanalytic article.

Among expressive modes, proper psychoanalysis is clearly the most far-reaching: “Psychoanalysis offers the best method available to achieve the more ambitious goals of fundamental alteration of character structure, with eradication or reduction to a minimum of neurotic mechanisms....Psychoanalysis attempts the ultimate in exploration, with a goal of the maximum in self-knowledge and structural alteration of the personality” (Knight 1952, p. 120). In addition, other expressive psychotherapy is given a distinctively different place. “The greatest field...for exploratory psychotherapy, which does not involve the more ambitious goals of psychoanalysis, lies in those clinical conditions which are expressed as relatively recent decompensations arising out of upsetting life experiences” (p. 120). Thus occurred the first clear emergence of the then-declared distinctions among a spectrum of psychoanalytic therapies from supportive psychotherapy to expressive psychotherapy to psychoanalysis proper.

It is these perspectives presented by Knight in this sequence of papers that framed the panels within American psychoanalysis in the early 1950s, all brought together in the dozen articles in one issue of the Journal of the American Psychoanalytic Association in 1954. Collectively they staked out the dominant conceptions about the nature of psychoanalytic psychotherapy—and the controversies about them—that marked what I call the second era in the relationship of psychotherapy to psychoanalysis, that of established diversity of goal and of technique (the spectrum of therapies) within a unity of theory (psychoanalysis), an era that lasted for approximately another 20 years after its full delineation in these manifestos of 1954.

What, then, are these central conceptions about the nature of psychoanalytic psychotherapy—derived from the theory of psychoanalysis but applied to a broad spectrum of patients not deemed amenable to classical analysis—and the relationship to psychoanalysis proper that were delineated at that time, and what were the controversies generated around these positions? The central confrontation was between two major viewpoints on the most appropriate way to conceptualize this relationship between dynamic psychotherapy and psychoanalysis. Basically, the issue lay between the viewpoint advanced by Alexander and French [1946] and Fromm-Reichmann [1950; also Bullard 1959]...
nority) who saw the historical trend as blurring, if not ultimately altogether obliterating, the technical distinctions between dynamic psychotherapy and psychoanalysis, and the viewpoint espoused by analysts (actually the great majority) of whom Bibring [1954], Gill [1951, 1954], Rangell [1954], and Stone [1951, 1954] served as major spokesmen, who conceived the scientific issue to be the more adequate preservation and clarification of the conceptual and operational distinctions between the two. It was these diametrically opposed viewpoints that were contrapuntally propounded so sharply at the panels published in 1954.

Those who “blurred” the distinction between dynamic psychotherapy and psychoanalysis took two somewhat discrepant positions. The more widespread one, seen by its opponents as the more dangerous in its push for the obliteration of the distinction, was that of Alexander. His call was for the total integration of psychoanalysis into psychiatry: “That psychoanalytic concepts…are necessary for every psychiatrist is by now rather generally accepted….Psychoanalytic theory [has become] the common property of whole psychiatry and through psychosomatic channels of the whole of medicine” [Alexander 1954, p. 724]. With this “unification” of psychoanalysis with psychiatry, “a sharp distinction between psychoanalytic treatment and other methods of psychotherapy which are based on psychoanalytic observations and theory is becoming more and more difficult….In their actual practice…all psychiatrists become more and more similar, even though one may practice pure psychoanalysis and the other psychoanalytically oriented psychotherapy” (p. 725). Indeed, any distinction between psychoanalysis proper and other uncovering or expressive procedures was declared only “quantitative” (p. 729), and in fact, “the only logical solution is to identify as ‘psychoanalytic’ all these related procedures which are essentially based on the same scientific concepts, observations and technical principles” (p. 731, italics added).

In the fullest extension of the Alexander position, “the only realistic distinction…is that between primarily supportive and primarily uncovering methods” [p. 730, italics added], thus collapsing all expressive treatment modes, expressive psychotherapy and psychoanalysis proper, into one category of psychoanalytic psychotherapy. Alexander, like Knight, also adumbrated a list of supportive therapeutic techniques, comprising gratification of dependent needs, emotional abreaction with reduction of psychic stresses, intellectual guidance assisting the patient’s judgments through objective review of stressful pressures, aiding the ego’s neurotic defenses when the patient is unable to deal with the unconscious material, and manipulating the life situation when the patient is unable to cope with life circumstance. On the other side of the dichotomy are all expressive approaches, psychoanalysis included, that were stated by Alexander to vary only in quantitative and not in critical dimensions.

Fromm-Reichmann [1954], somewhat differently than Alexander, took the position that the effort to treat the borderline [and, even more, the overtly psychotic] patient psychoanalytically required not only major modifications of technique [with which, of course, all would agree] but also systematic revision of the theory of “classical psychoanalysis” into the more modern “dynamically oriented psychiatric theory” (p. 713), based on the interpersonal conceptions of Harry Stack Sullivan. This she defended as being a more up-to-date version of psychoanalysis, and she tried to buttress this assertion by calling on Freud’s famous definitional dictum—that every therapy that is based on the concepts of transference and resistance can call itself psychoanalysis.3 Set this way, Fromm-Reichmann’s dynamic psychotherapy could simply be redefined as psychoanalysis, with again, as with Alexander, psychoanalysis and psychoanalytically based psychotherapy becoming indistinguishably close on a merely quantitative continuum. In her case, of course, psychoanalysis was assimilated to the new interpersonal theory of dynamic psychiatry, whereas with Alexander, there was the opposite direction of flow, with psychoanalytic psychotherapy blended almost indistinguishably into psychoanalysis. In both directions, the distinctions were blurred, if not yet entirely obliterated.

Both sets of views, those of Alexander and those of Fromm-Reichmann, did at the time have some wide popular appeal, although they were also the distinct minority perspective within the then reigning ego psychology paradigm in American psychoanalysis. Since then the Alexandrian conceptions have essentially dropped

---

3Freud’s definition was stated in his history of the psychoanalytic movement as follows: “Any line of investigation which recognizes these two facts [transference and resistance] and takes them as the starting point of its work has a right to call itself psychoanalysis, even though it arrives at results other than my own. But anyone who takes up other sides of the problem, while avoiding these two hypotheses, will hardly escape a charge of misappropriation of property by attempted impersonation, if he persists in calling himself a psychoanalyst” (Freud 1914, p. 16).
out of psychoanalytic discourse, although his notion of the “corrective emotional experience” has had some checkered survival in varieties of more active psychotherapeutic approaches and can also be discerned, albeit in transmuted form, in varieties of psychoanalytic emphases on the role of the psychoanalytic relationship as a major component factor—alongside working through and insight—in effecting analytic change. Fromm-Reichmann’s views [rather, her techniques] have survived more directly but essentially within a small coterie of colleagues working in the arena where these notions were born, the [modified] psychoanalytic therapy of the overtly psychotic, usually in institutional settings.

By contrast to these positions, those who sought to “sharpen” the distinctions among the range of psychoanalytically based psychotherapies, including psychoanalysis, aimed in their treatment planning to select the therapeutic modality from this differentiated spectrum that was best fitted to the psychological needs of the individual patients. This was the opposite of the position taken by those who would “blur” these distinctions between the psychoanalytic treatment modalities, in effect collapsing them all to the position that good psychotherapy is all psychoanalysis and then logically pushing the limits of this “analysis” to its utmost extension. This difference can be conceptualized as a concern with the limits to which the applicability of a given treatment method [psychoanalytic therapy] can be pushed to benefit the patient versus choosing the most appropriate treatment method for each individual patient, staying, to be sure, within the range of psychoanalytically grounded therapeutic modes.

The initial problem for those [the great majority] who sought to “sharpen” the distinctions between the various psychoanalytically grounded therapies was definitional. Rangell, at the start of his 1954 publication, pointed to the fact that an evaluation committee set up by the American Psychoanalytic Association in 1947 “was never able to pass the initial and vexatious point of trying to arrive at some modicum of agreement as to exactly what constitutes psychoanalysis, psychoanalytic psychotherapy, and possibly transitional forms” [Rangell 1954, p. 734]. Actually, Gill [1954], Rangell [1954], and Stone [1951, 1954] all sought to begin with a definitional statement for psychoanalysis, which was the parent therapy and the one whose dimensions were most clearly conceptualized and articulated. Gill’s statement came to enjoy the widest currency: “Psychoanalysis is that technique which, employed by a neutral analyst, results in the development of a regressive transference neurosis and the ultimate resolution of this neurosis by techniques of interpretation alone” (p. 775). He went on for several pages to explicate each phrase of this sentence in extended detail.

Clearly, this definition circumscribes psychoanalysis far more precisely than did Freud’s 1914 statement that any therapy that recognizes the two facts of transference and resistance and takes them as the starting point of its work can call itself psychoanalysis. In fact, in contradistinction to Freud’s definition, Gill had even earlier stated that

the designation “psychoanalysis” is reserved for the technique which analyzes transference and resistance. Psychoanalytic therapy is any procedure which recognizes transference and resistance and rationally utilizes this recognition in the therapy, though this may be done in many different ways, and part or all of the transference may not be analyzed. (Gill 1951, p. 62)

It is these “many different ways” in which “part or all of the transference may not be analyzed” that represent the various distinctions made in the psychoanalytic therapies [other than psychoanalysis itself] between the expressive and the supportive modes. In that same paper, Gill put the major demarcation between these expressive and supportive modes as follows: “The gross major decision is whether the defenses of the ego are to be strengthened or broken through as a preliminary toward a reintegration of the ego…. The decision to strengthen the defenses is made in cases in which this is all that is necessary, or in those which is all that is safely possible” [Gill 1951, p. 63]. He added to the sophistication of the conceptualization of supportive techniques through elaborating ways of strengthening defenses: 1) by encouraging ego activities in which defense is combined with adaptive gratifications and the discouragement of maladaptive gratifications, 2) by avoiding unwitting attacks on defenses vital to the patient’s psychic equilibrium, and 3] following from Glover’s (1931) conception of “the therapeutic effect of inexact interpretation,” by fostering of neurotic compromises that allow partial discharge of drive pressures, thereby rendering the work of defense against the remainder easier.

Stone (1951) also essayed to list the principles differently operative in analytic psychotherapy as distinct from psychoanalysis, but he conflated supportive and expressive approaches, just distinguishing these together from psychoanalysis proper. Stone also laid out his listing—the most elaborate to that point—of patients for whom analytic psychotherapy is indicated over psychoanalysis as follows: 1] patients for whom limitations of time or money precluded psychoanalysis; 2] patients who were too ill or who had life situations too unpropi-
tious to be amenable to psychoanalysis; 3) oppositely, patients who had illnesses too slight to warrant psychoanalysis; 4) patients who had acute reactive disorders; 5) patients who were in transitional states, psychic readjustments, or shifts in developmental phase; 6) patients who required preparatory, preanalytic work or, on occasion, follow-up or afterwork; 7) patients who had some more specific indications in certain character and illness patterns; and 8) arguably, patients who had too much secondary gain. Again, this listing of Stone’s did not try to separate out those most appropriately steered to expressive from those most appropriately steered to supportive approaches. It did, however, make clear the basis for Gill’s [1951] statement concerning the indications for psychoanalysis: “Analysis then is clearly the procedure for a middle range in which the ego is sufficiently damaged that extensive repair is necessary, but sufficiently strong to withstand pressure” [pp. 63–64].

From these views, the rest follows naturally. A primarily supportive therapy became the preferred mode for those patients whose failed psychic equilibrium is to be restored by “strengthening the defenses” through the variety of techniques outlined by Knight, Alexander, Gill, and Stone. We would consider these patients “too sick” to be amenable to psychoanalysis. Gill [1954] discussed this category of patients this way: “A major contraindication [to psychoanalysis] is the presence of severe regressive factors or the danger that such may develop. Instances of rather sudden psychosis shortly after beginning psychoanalysis are to be attributed to the regressive pressure of the technique per se on a precariously balanced personality” [p. 780]. A primarily expressive psychotherapy became the preferred mode for those patients with acute reactive disorders or in transitional states [Stone] whose egos are not unduly damaged [Gill] and who can tolerate the effort at “analyzing the defenses” to the extent necessary using the established methods of interpretation and working through leading to the requisite insights and resolutions. These patients we would consider as “too well” for psychoanalysis, in the sense of not requiring or warranting so ambitious and far-reaching a treatment.

This way of conceptualizing the nature of the different therapeutic modes and of their differential indications puts expressive psychotherapy into an intermediate position—certainly in techniques—between supportive therapy on the one hand and psychoanalysis on the other. This conception was most explicitly developed by Gill [1954]: “I have one major point to make. I believe we have failed to carry over into our psychotherapy enough of the nondirective spirit of our analyses” [p. 786]. He continued:

My stress on this point arises from my feeling that discussion of therapeutic results in psychoanalysis and psychotherapy too often views them as polar opposites, with psychoanalysis regarded as producing structural changes, and psychotherapy as unable to produce any significant intrapsychic change, but only altering techniques of adjustment through transference effects or shifts in defensive techniques. [p. 787]

Gill concluded: “I would raise the question . . . as to whether there is not more to be said on results and mechanism in prolonged psychotherapy with more ambitious goals by a relatively inactive therapist and in intensive [he means expressive] psychotherapy” [p. 789]. Expressive psychotherapy was called by Gill an “intermediate type of psychotherapy”:

This is the psychotherapy . . . whose goals are intermediate between rapid symptom resolution [i.e., supportive psychotherapy] and character change [i.e., psychoanalysis], where techniques are in a sense intermediate—for example, relative neutrality and inactivity; transference dealt with, though not a full regressive transference neurosis; interpretation the principal vehicle of therapist behavior—and, I suggest, where results are likewise intermediate. [p. 789]

Going on, he wrote: “I wish not to be misunderstood. I am not suggesting that psychotherapy can do what psychoanalysis can do; but I am suggesting that a description of the results of intensive [again, he means expressive] psychotherapy may be not merely in terms of shifts of defenses but also in terms of other intra-ego alterations” [p. 793].

All of this, of course, adds up to the statement that in contrast with the maximalist goals of psychoanalysis in terms of fundamental conflict resolution and character reorganization, the goals in all other psychotherapies range from the most minimal to the increasingly more ambitious, with no agreement as to how asymptotically close to those of psychoanalysis they can reach in the different kinds of patients treated psychotherapeutically. Gill [1951] put it thus:

In psychotherapy the goal may be anything from as quick relief of a symptom as possible, with the restoration of the previous integrative capacity of the ego, through a whole range of more ambitious goals up to analysis, the most ambitious of all. The choice of therapy may be divided into that which determines the minimum necessary to restore the ego to functioning, and that which strives for the maximum change that is possible. [p. 63]

This relates closely to another issue that was also not really resolved in these debates of the 1950s: the degree
of real distinctness among this array of psychoanalytic therapeutic approaches from supportive psychotherapy, to the “intermediate” expressive psychotherapy, to psychoanalysis. Are these really qualitatively distinct, or are they crystallized nodal points along a continuum—another statement of the “blurring” versus “sharpening” argument at the heart of those debates? Gill, as is clear from my quotations from him, made the sharpest conceptual distinctions. Stone (1951), characteristically, tempered his commitment to this distinction:

One may think of a continuum from the free play of human relationships in which there is no conscious psychotherapeutic intention—but which obviously play an enormously important psychotherapeutic role in the lives of relatively normal people—to the objective and precise relation between the surgeon and his patient, which Freud idealized. The well-defined psychoanalytic technique [psychoanalysis proper] and brief psychotherapy [Stone’s phrase then for his own amalgam of supportive and expressive psychotherapy] are both far from either pole, and yet definitely removed from one another in these opposite directions. [pp. 221–222]

Rangell (1954) perhaps best expressed the degree of consensus achieved within the major position that I have labeled as that of those who sought to “sharpen” these distinctions in his statement:

In this view, the two disciplines [psychoanalysis proper and psychoanalytic psychotherapy], at far ends of a spectrum, are qualitatively different from each other, though there is a borderland of cases between them. An analogous comparison can be made to the fact that conscious is different from unconscious even though there exists a preconscious and different degrees of consciousness. Day is different from night, though there is dusk, and black from white, though there is gray. (p. 737)

Rangell’s own principal contribution to the debate, published in 1954, was his effort to state the major similarities and differences between what he called psychoanalysis and dynamic psychotherapy. He stated each side under two headings. In regard to similarities he stated the evident, that both are psychological treatments influencing other human beings through verbal discourse and are rational therapies built on an “identical body of metapsychology” (Rangell 1954, p. 737). In regard to the differences, he stated these to be in technique and in goals, and these he developed more fully. Regarding technique, Rangell singled out that “the crucial differentiating point relates to the role and position of the therapist” (p. 741). He illustrated with an analogy:

Let us consider that the mental apparatus exerts around it a field of magnetic energy. In psychoanalysis, the therapist takes up his position at the periphery of this magnetic field of his patient, not too far away, so that he is useless and might just as well not be there, nor too close, so that he is within the field interacting with it with his own magnetic field...immune from repulsion or attraction...he sits at the margin, like a referee in a tennis match so that he can say to the patient...In psychotherapy, in contrast, the therapist does not sit consistently in that seat, though he may sit there momentarily. He is, rather, generally in the court with his patient, interacting with him, the two magnetic fields interlocked, with the therapist’s own values, opinions, desires, and needs more or less actively operative. [Rangell 1954, pp. 740–742]

Regarding differences in goals, Rangell again used an analogy, this one borrowed from Gitelson, who compares the therapeutic process to a complicated chemical reaction, which, once set under way, will continue to a state of final dynamic equilibrium. During the state of transition of this chemical reaction, many intermediate reactions will have occurred...At any given point, external interfering agents may be introduced which...can change the endpoint at which equilibrium is attained. The therapeutic process can be looked at from this point of view. Psychoanalysis aims at the establishment of the reaction (transference neurosis) and the maintenance of optimum conditions for its complete resolution. It is not only oriented toward such a final end point, but, in contrast to psychotherapy, is potentially capable of attaining it. Psychotherapy, on the other hand, either from necessity or from choice, introduces the external agent and brings the reaction to an end at any intermediate point of stability. [Rangell 1954, pp. 742–743]

Two other major contributions from the 1954 publications need to be mentioned—Bibring’s delineation of basic therapeutic principles that are intended, through differential selection and combination, to be capable of characterizing all psychoanalytic therapies, from psychoanalysis to supportive psychotherapy, and the Leo Stone–Anna Freud discussion of the problem of the “widening scope” of psychoanalysis. Bibring’s (1954) widely influential article described five distinct “basic therapeutic principles,” each aimed to a particular goal: 1) suggestion, the induction of mental processes in the patient independent of his or her rational or critical thinking; 2) abreaction, or emotional discharge, which with Freud’s abandonment of the traumatic theory of the neuroses, was becoming progressively less salient; 3) manipulation, or redirection of emotional systems existing in the patient in the service of the therapy and/or the exposure of the patient to novel experiences (“learning by experience”); 4) insight through
clarification, enhanced self-awareness, and self-observation in the absence of resistance; and 5) insight through interpretation, processing unconscious material with resistance, and working through. According to Bibring all psychotherapies, even those not psychoanalytically based, could be classified through the differential deployment in their technique of these five central therapeutic principles. Psychoanalysis itself was based just on insight through interpretation as its central guiding mechanism, with the other four used only to further the interpretive effort.

The other equally influential contribution from this same year was the presentation by Stone (1954) of what he called the “widening scope of psychoanalysis”:

One might say that in the last decade or two, at least in the United States, any illness or problem which has a significant emotional component in its etiology has become at least a possible indication for psychoanalysis . . . this generally expanding scope of psychoanalysis . . . hopeless or grave reality situations, lack of talent or ability (usually regarded as ‘inhibition’), lack of an adequate philosophy of life, or almost any chronic physical illness may be brought to psychoanalysis for cure. [p. 568]

Stone was warily receptive of this trend, albeit also skeptical—it is, of course, again the argument over extending the applicability of the true (or best) therapy to the margins of its possible indications versus fitting differentiated therapeutic approaches to the nature and the particular needs of the patient.

Stone’s (1954) own final assessment of this issue was that

the scope of psychoanalytic therapy has widened from the transference psychoneurosis, to include practically all psychogenic nosologic categories. The transference neuroses and character disorders of equivalent degree of psychopathology remain the optimum general indications for the classical method. While the difficulties increase and the expectations of success diminish in a general way as the nosological periphery is approached, there is no absolute barrier. [p. 593]

Anna Freud (1954), in her discussion of Stone’s paper, singled out this issue to indicate that her own predilections ran directly counter to such sentiments:

For years now, our most experienced and finest analysts have concentrated their efforts on opening up new fields for the application of analysis by making the psychotic disorders, the severe depressions, the borderline cases, addictions, perversions, delinquency, etc. amenable to treatment. I have no wish to underestimate the resulting benefits to patients, nor the resulting considerable gains to analysis as a therapy and science. But I regret sometimes that so much interest and effort has been withdrawn from the hysterical, phobic and compulsive disorders, leaving their treatment to the beginners or the less knowledgeable and adventurous analytic practitioners. If all the skills, knowledge and pioneering effort which was spent on widening the scope of application of psychoanalysis had been employed instead on intensifying and improving our technique in the original field, I cannot help but feel that, by now, we would find the treatment of the common neuroses child’s play, instead of struggling with their technical problems as we have continued to do. [p. 610]

This was truly a call for narrowing the scope of indications for psychoanalysis, a position to which Anna Freud steadfastly adhered all her life, and against all the popular and current trends.

I have indicated how particularly American was this burgeoning of dynamic psychotherapy, distinct from but inextricably linked to psychoanalysis, and the principle vehicle of the capture of American psychiatry during that era by the psychoanalytic idea—which is not to say that these conceptions remained limited to the American scene. Comparable ideas soon took root elsewhere, at first mostly in England and in northern and central Europe, but then more widely. In 1969 (a decade and a half after the 1954 publications in America), the International Psychoanalytical Association for the first time devoted a major panel at its congress in Rome titled “The Relationship of Psychoanalysis to Psychotherapy.” In my opening presentation as chairman of that panel (Wallerstein 1969), I began by stating that this marked “the growing concern within the world-wide family of psychoanalytic endeavor with what has seemed for so long primarily a purely American creation, the body of theory and practice of psychoanalytically based or psychodynamic psychotherapy, in all of its complex relationships with its psychoanalytic parentage” (p. 117). I then undertook to set the framework for the 1969 panel “by setting down what I feel to be the major scientific issues within this area of the relationship of psychoanalysis and psychotherapy as a sequence of questions, with a relatively brief statement after each of the major, often dichotomized, positions that have been taken in relation to each of them by typical outstanding proponents of the various viewpoints” (p. 117).

I also indicated the major issues, pro and con, that had fueled the debates on these issues published in 1954, and I ended by listing my questions under nine headings (see final paragraph, Wallerstein 1969, pp. 125–126). What was clear in this final listing was that the issues and controversies that had characterized the panel re-
ports a decade and a half earlier were still very much with us, not appreciably altered, let alone resolved, in the crucible of the accumulated clinical experience and the expanded theoretical knowledge accrued during the intervening time. Nor was this assessment at all modified by the considerations of an international panel from the wider vantage point of the varying experiences of psychoanalysts in the diverse national and regional centers of psychoanalytic activity with all their differing historical developments as well as differing ecological settings.

However, clearly things did not remain at that point. In subsequent years, new diagnostic and therapeutic conceptions were advanced in regard to the categories of borderline patients [Kernberg 1975] and patients with narcissistic character [Kohut 1971, 1977]. These newer considerations added both urgency and cogency to the persisting efforts in psychoanalytic ranks to maintain a firm handle on the distinctiveness of psychoanalysis and of psychoanalytically based psychotherapy, with their differentiated spheres of application to the array of psychopathological formations and the shift in the perceptions of this differential applicability as our clinical experience with these new paradigmatic patients cumulated. This was, of course, even more striking as the more classical symptom pictures around which our original conceptualizations had been elaborated correspondingly dwindled in our consulting rooms.

Clearly, the landscape of psychotherapies required reassessment in the light of these newer developments in theory and these shifts in our patient population. Toward this end the Southern Regional Psychoanalytic Societies sponsored a symposium in Atlanta in 1979 at which three of the central protagonists in the discussions published in 1954, Gill, Rangell, and Stone, were invited to update their views on “Psychoanalysis and Psychotherapy, Similarities and Differences, a 25-Year Perspective.” The three chosen were three who were in essential agreement during the debates of the early 1950s, representative of the then-majority “classical” position that maintained a connectedness along a spectrum of psychotherapies, but with an articulated distinctive crystallization of differentiated psychotherapeutic modalities along that spectrum—from psychoanalysis to supportive psychotherapy—each with specific applicability to a particular reasonably nosologically coherent segment of patients specifically amenable to it.

The selection for the panel in 1979 of three contributors who a quarter-century before had spoken with so united a voice renders all the more impressive the major divergence of views—on precisely the same questions and issues—that marked their discourse in 1979. This divergence reflected substantial shifts in the climate of thinking about psychotherapy and psychoanalysis and their relationship that had not yet come front and center in 1969, just a decade earlier. I dubbed this new configuration the third era in the development of psychoanalytic psychotherapy within psychoanalysis. It was a new era in which what I had called the second era, the one of broad consensus [despite the significant deviations of Alexander and Fromm-Reichmann] that had characterized mainstream psychoanalytic thinking in this area [as represented by Gill and Rangell and Stone and the others I have quoted] and reflected the rise of psychodynamic psychotherapy as a distinctive offshoot of psychoanalysis, gave way to an era of fragmented consensus and enforced new thinking about the nature of the psychoanalytic psychotherapy enterprise and its relationship to its psychoanalytic heritage.

Actually Stone’s views, which were the most subtly nuanced in 1954, were those that survived most unaltered in the retrospective a quarter-century later. Basically, Stone adhered to the distinctions he had earlier advanced of the [quantitatively] greater reality orientation of the psychoanalytic psychotherapist. For example:

The therapist’s activity, instead of taking a reductive direction, slanted toward the genetic-infantile environment, or its currently unconscious representations, tends to preserve the patient’s cathexis of his real and immediate environment—his cathexis of persons, of problems as such, and conflicts as such—and [very importantly] his cathexis of the essential realities of the patient-doctor relationship. [Stone 1982, pp. 86–87]

Stone then added a characteristically subtle new distinction he was drawing between the nature of interpretation in psychotherapy as compared with psychoanalysis:

But instead of orienting itself to facilitating the spontaneously evolving transference neurosis of the basis psychoanalytic situation, [psychotherapy] is usually based on the therapist’s conception of what constitutes the major and currently active conflict or conflicts in the patient’s presenting illness or disturbed adaptation, and the relationship of such conflict or conflicts to his actual objects... Interpreting, moreover, tend to be holistic, integrative... Minimizing the distinctions between defense and impulse, infantile and current, emphasizing large, accessible, and readily intelligible personality dynamisms. [p. 87]

This stance was, of course, quite consistent with the fact that neither in the 1950s nor again in 1979 did Stone clearly try, within the range of psychoanalytic psychotherapies, to demarcate the more interpretive [expres-
sive) from the less interpretive or non-interpretive (supportive) therapy, as had Knight, Gill, and Rangell. Stone's longtime consistency in this regard was expressed in a skeptical discussion in his 1982 paper of Knight's original proposal of the expressive-supportive distinction: "The essential idea [of supportive psychotherapy] is that the therapist aligns himself with the patient's defenses, fostering them rather than seeking to weaken them. While this is conceptually and schematically reasonable, it does not lend itself readily to technical specification; and I would feel some doubt that it can often be achieved in a direct and purposive sense" (Stone 1982, p. 92).

All in all, Stone exhibited a remarkable consistency of viewpoint on the basic elements of psychoanalytic psychotherapy and of psychoanalysis [and of their relationship] over the three-decade span from his first writing on this specific topic in 1951 until this retrospective published in 1982. It is a steadiness of perspective that contrasts sharply with the significantly altering views of the other two protagonists in the 1979 panel discussion.

The individual whose views I felt shifted most radically over this intervening time span (although he did not agree with my appraisal; see my written exchange with Gill in Wallerstein 1991a and Gill 1991) is Merton Gill, who, following upon Knight, was clearest in the early 1950s in his distinct delineations of psychoanalysis, expressive psychotherapy, and supportive psychotherapy, each with distinctive characteristics and different goals and techniques and each indicated for a different segment of the psychopathological spectrum. The very radical shift that I saw in Gill's views followed as a direct consequence of his evolving preoccupation with the overriding primacy of the interpretation of the transference as the criterion of psychoanalysis and of what is psychoanalytic: the earliest possible interpretation of the transference, including the searching out of all possible implicit transference allusions [i.e., making the implicit transferences explicit from the very start of the treatment]; the focus on the here and now as against the genetic thrust (there and then) in the transference interpretation; and the elaboration of all the implications of what Gill called the "two-person" versus the "one-person" view of the two participants' contributions to the transference. It was Gill's (1979, 1982, 1984) position that all this was both implicit and explicit throughout Freud's written corpus but that in practice was often accorded only lip service, both by Freud and by all of us who have come after. Here I only pursue the implications of Gill's evolved views about the transference for his [significantly changed] views on the nature of psychoanalysis and analytic psychotherapy and their relationship. This he made explicit in his contribution to the 1979 Atlanta symposium [published in a somewhat revised version in Gill 1984].

Gill (1984) developed these new views on psychoanalysis and psychotherapy with his customary logical precision. He summarized his earlier 1954 paper in one sentence as follows: "the thrust of my 1954 paper was to insist on the difference [between psychoanalysis and psychotherapy] and at the same time to recognize that the two are on a continuum" (p. 162, italics added). He then reviewed the "intrinsic criteria" by which analysis is usually defined ["the centrality of the analysis of transference, a neutral analyst, the induction of a regressive transference neurosis and the resolution of that neurosis by techniques of interpretation alone" (p. 161)] as well as the usually indicated "extrinsic criteria" ["frequent sessions, the couch, a relatively well integrated patient, that is, one who is considered analyzable, and a fully trained psychoanalyst" (p. 161)]. From there he came to his taking-off point:

[the question of the relationship between psychoanalysis and psychotherapy is even more important in practice today than it was in 1954 because of the practical difficulties in maintaining the ordinarily accepted extrinsic criteria of analysis... the question becomes: How widely can the range of extrinsic criteria be expanded before the analyst must decide for psychotherapy rather than psychoanalysis? (Gill 1984, p. 162)

After reviewing the difficulties that analysts now had in maintaining these usual external criteria of psychoanalysis, Gill (1984) went on to say: "the changes I will propose are more radical than a simple extension of the recommendation I made in 1954 that we carry more of the nondirective spirit of psychoanalysis into our psychotherapies" (p. 163). Rather, "I will argue that with the definition of analytic technique at which I will finally arrive, it should be taught to all psychotherapists and that how well it will be employed will depend on their training and natural talent for the work" (p. 163). In addition:

I mean that analytic technique as I will define it should be applied as much as possible even if the patient comes less frequently than is usual in psychoanalysis, uses the chair rather than the couch, is not necessarily committed to a treatment of relatively long duration, is sicker than the usually considered analyzable patient and even if the therapist is relatively inexperienced. In other words, I will recommend that we sharply narrow the indications for psychoanalytic psychotherapy and primarily practice psychoanalysis as I shall define it instead. (p. 163, italics added)
perspective (called more French). This leads to a dialectical view combining two kinds of listening—with different emphases, of course, depending upon the presenting clinical exigency—deconstructive listening leading to knowledge of the unconscious (more psychoanalytic), and reconstructive listening leading to the application of that knowledge toward helping the patient deal with his or her psychic distress (more psychotherapeutic). Widlocher [2010] then proposed

a training for psychotherapy which after a personal anal... provides experience that would help treat a wide range of clinical cases according to principles which remain psychoanalytic in origin, free association of thinking and insight, but would involve applying great flexibility in the setting and in the content of interpretations [less attention to transference, more interpretations regarding symptoms and material reality, etc.]. (p. 49)

This is all summarized in Widlocher’s final sentence: “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 interpretative experience on the one hand, and the analysis of conflicts and symptoms which make up the quest for cure on the other” [Widlocher 2010, p. 50]. Clearly, this is a conception of a spectrum of therapeutic approaches with relatively pure psychoanalysis and psychoanalytic psychotherapy as crystallized nodal points along that spectrum and with unclear boundaries on that spectrum, meaning the flexible intermingling of “deconstructive” and “reconstructive” (typically psychoanalytic and psychotherapeutic) techniques deployed, dependent on clinical judgment and clinical need. This is all in line with what was articulated by Rangell in 1979 [Rangell 1981] and supported as well by the findings of the Psychotherapy Research Project of The Menninger Foundation [Wallerstein 1986, 1988].

The third presentation in the 2010 collection, that of Kächele, based on a professional lifetime of systematic psychotherapy research devoted to the elucidation of just these issues, can be seen as more akin to Gill’s viewpoint at the 1979 conference [Gill 1984] than either of his fellow presenters, with always, in Kächele’s view, the final decision to rest with the findings of empirical psychotherapy research. Kächele’s decades-long systematic research studies had to this point not led to any clear categorical differences between psychoanalysis and psychoanalytic psychotherapy. He rejected the dichotomous view that psychoanalysis is centrally concerned with psychic truth and psychotherapy with psychic cure, with the techniques of each differentially bent toward those distinctive ends. Rather, he thought “that psychoanalytic practice covers a range of instantiations with no clear default value. Each instantiation may be more or less close to the prototype of analytic work as Ablon and Jones put it” [Kächele 2010, p. 38, italics added]. This leads to the question, which only further research could convincingly answer: “As their prototype construction is based on a selection of analysts working in the frame of North American ego psychology one wonders what about a Kohutian, a Kleinian, or even a Lacanian prototype?” [p. 38].

It is this kind of question and his research-anchored approach that led Kächele [2010] to his overall position: “I maintain that psychoanalytic work as a therapeutic enterprise should be covered by the term ‘psychoanalytic therapy’ including a host of variations in setting and intensity, the boundaries of this inclusive term loosely stretch over numerous variations of psychoanalytic practice” [p. 40]. That this is essentially a nondifferentiating, unifying vision is made more explicit in Kächele’s commentary on the presentations of his two colleagues: “The controversy about distinguishing psychoanalysis and analytic psychotherapy—in my view—should centre around the issue of its usefulness. I would maintain that working with a unified view does more justice to the existing diversity of psychoanalytic treatments, to the diversity of analyses and their patients” [Kächele 2010, p. 56]. Kächele would of course qualify this degree of agreement with Gill’s position of 1979, with the default [his term] assertion that it would of course depend on the findings of formal psychoanalytic research, not yet comprehensive enough or definitive enough.4

This view brings us full circle. From the beginning development of the range of psychoanalytically based psychotherapies out of clinical psychoanalysis and its underlying theory in the 1930s and 1940s and in the effort to adapt the understandings and the technique of psycho-analysis to the wider gamut of patients not originally left

4 Amidst the voluminous array of perspectives on this century-long “debate” within psychoanalytic ranks, a very current article by Cooper [2010], essentially supporting the unifying position of Kächele [and many others], displaces the discussion into a different, albeit related, arena. He starts by defining the analytic method by the intentions of the analyst, to engender the patients’ engagement in the nature of their inner lives, their conflicts, their unconscious, their interactions. It is this that comprises the “unity that can be conducted in many forms” (p. 119). Those different forms are what have been elaborated by others over decades as the distinctions between psychoanalysis and psychodynamic psychotherapy. However, the “focus on the intentions, aims, and actions of the analyst” (p. 116) made it all psychoanalytic therapy.


SECTION V

Research

Section Editor: Linda C. Mayes, M.D.
Research on Outcomes of Psychoanalysis and Psychoanalysis-Derived Psychotherapies

Rolf Sandell, Ph.D.

Researchers have found it difficult to comply entirely with modern methodological standards when studying the outcomes of the very long processes in psychoanalysis. The major shortcomings have been in specifying the treatment given, in specifying its patients, and in controlling for confounding factors, such as selection bias for instance, through randomization. Where short-term psychodynamic psychotherapies are concerned, researchers are becoming more compliant with the standards and have been able to publish empirical support for their positive effects, especially with depressed patients. Moderate-length and long-term psychodynamic psychotherapies are less well supported, but research suggests they may be uniquely effective for patients with complex and long-standing personality-based problems or disorders. Psychoanalysis proper has

This review could not have been completed without having the advantage of a number of previous reviews, all of which are duly referenced in the text. Besides, the author specifically wants to express his gratitude to the following colleagues (in alphabetical order) for their helpful interventions: Peter Fonagy, Andrew Gerber, Dorothea Huber, Horst Kächele, Günther Klug, Paul Knekt, Marianne Leuzinger-Bohleber, and Patrick Luyten.
been tested in various designs, which were typically not well controlled. Studies suggest that psychoanalysis may generate results superior to those of psychodynamic psychotherapy, but to what extent this is due to mere treatment intensity or duration is not clear. Symptoms and focused problems tend to change more than relations and personality-based problems in response to treatment, and the treatment results tend to improve during follow-up. Studies of the effects of psychoanalytically oriented treatments on health care utilization have shown mixed results.

A Methodological Approach

How do we know that an intervention has had an effect? First of all, we would have to establish that the intervention has indeed taken place the way it was supposed to be delivered. Second, we would have to make sure that those who have been subjected to it have indeed improved—and stay improved, or continue to improve, after treatment. The general idea is to compare pretreatment and posttreatment observations. Third, we must ascertain that the improvement is in response to the intervention and not to some other factor(s). One such factor is chance. Our observations may have been influenced by irrelevant coincidences in ourselves, in the person being observed, in the observational instrumentation, or in the environment. This results in random errors, which are essentially controlled by increasing the size of the sample of observations and improving the reliability of the observations by controlling and standardizing the conditions under which they are made. Another type of "other factors" results in systematic errors, leading to unsatisfactory internal validity. This occurs when patients change systematically in response to factors other than the intervention itself, referred to as confounding factors or confounders. One such factor is almost always time—that is, the passing of time—because very often people change across time, and often for the better if they were bad off to begin with. Another factor has to do with matura tion, which of course is especially relevant in the case of interventions with children and adolescents. Still another is events and trends occurring along with the intervention but merely coincidental to it, such as employment rates, crises, judicial changes, and other changes in society. We would also like to know whether improvement is due to specific technical ingredients of the intervention or to nonspecific factors inherent in any intervention, such as hope, attention, and caring. Also, where a formal study is concerned, the mere fact of being subjected to the extra attention and more or less intense formal observations is one more such factor that we would like to exclude as a cause, as would the vested interest of the person or persons who are doing the study. Finally, selection bias is a frequent confounder when patients are assigned to treatments on the basis of clinical assessments or preferences.

Ensuring internal validity calls for various controls, often in the form of one or more groups assigned to contrasting non-intervention conditions. In principle, we have to make the intervention/non-intervention contrast independent of possible confounders by keeping them constant, by matching the contrasting groups on them, or by randomizing the contrast [i.e., assigning patients to intervention or non-intervention on a chance basis]. Obviously, establishing change and assigning it to its proper cause are subject to numerous complicating factors when a formal research study is being conducted, and even more so under natural conditions in the clinic. These complications and the measures taken to counteract them have to be taken into account when one is reviewing research on the outcomes of psychoanalytically informed treatments. The extent to which researchers have been able to control for these and similar complicating factors in outcome studies—or have been unable to control them or are uninterested in controlling them—critically determines whether the findings are convincing in building a case for psychoanalytically informed treatments in the eyes of third-party payers, and many second-party ones, too.

Short-Term Psychoanalytically Informed Therapies

Psychological therapies based on psychoanalytic principles come in many forms—for individuals or groups, couples or families: short-term or long-term; time-limited or not; low-frequency or high-frequency. There is now ample evidence that individual psychoanalytically oriented or psychodynamic short-term therapy will achieve treatment results that are respectable and on a
par with comparable nonpsychoanalytic or nonpsychodynamic therapies. Thus, after an initial, largely negative meta-analysis [Svartheg and Stiles 1993], an increasing number of meta-analyses have yielded considerably more positive results. Crits-Christoph [1992], Anderson and Lambert [1995], Leichsenring et al. [2004], Fonagy et al. (2005), Abbass et al. (2006), Connolly Gibbons et al. (2008), Lewis et al. (2008) and Gerber et al. (2011), among others, have compiled and reviewed primary studies of [mostly] short-term psychodynamic psychotherapies (STPP) with [mostly] adult patients. Abbass et al. (2006) concluded that “STPP shows promise, with modest to moderate, often sustained gains for a variety of patients” [p. 1]. Yet they added, “However, given the limited data and the heterogeneity between the studies, these findings should be interpreted with caution.” In their review, Lewis et al. (2008) concluded that STPP is not superior to other forms of psychotherapy but is certainly not inferior, and perhaps more importantly, they cautioned that “further high-quality studies are required of STPP focused on specific clinical problems” [p. 454].

Besides the scarcity of studies, one problem that has been noted by several reviewers [e.g., Abbass et al. 2006; Connolly Gibbons et al. 2008; Fonagy et al. 2005] is that the psychodynamic therapy being delivered in many studies has been poorly specified and that the therapies delivered in different studies may have been quite different in their methods in terms of supportiveness, focus on transference processes, and so forth. Therefore, positive findings for one version of STPP cannot automatically be taken as support for other versions. At most, the various studies may possibly be interpreted to support some common psychodynamic or psychoanalytic factor or factors, but it is not yet clear which these are.

From a psychiatric perspective, it is also considered a problem that the meta-analyses and most of the primary studies were conducted on patient samples that were diagnostically mixed. That psychiatric diagnoses may be irrelevant in a psychoanalytic perspective, where intrapsychic dynamics are the primary problem, and that comorbidity seems to be the rule in psychiatric samples are weak arguments in any contemporary discussion of what constitutes evidence for effective treatment of psychological disturbances. Thus, many primary studies of psychoanalytically informed therapies are dismissed precisely on the ground that the patient samples are heterogeneous.

Short-Term Psychodynamic Therapy With Diagnostically Specific Samples

Nevertheless, there are some meta-analyses that have focused on specific diagnostic groups of patients, especially depressed patients, in psychoanalytic, mostly short-term, therapies [Cuijpers et al. 2008a; Driessen et al. 2010; Leichsenring 2001]. Cuijpers et al. (2008a) reported that “we found very few indications that several important types of psychological treatment for depression differ significantly from each other [in their efficacy]. No significant difference was found for cognitive-behavior therapy, psychodynamic therapy, behavioral activation treatment, problem-solving therapy, and social skills training” [p. 917]. Comparing STPP and pharmacotherapy for depressed patients, de Maat et al. (2006) summarized findings from 10 studies and concluded that “psychotherapy and pharmacotherapy appear equally efficacious…Both treatments have larger effects in mild than in moderate depression, but similar effects in chronic and nonchronic depression and at follow-up psychotherapy outperforms pharmacotherapy” [p. 566]. Although a recent Finnish study confirmed the comparability between STPP and pharmacotherapy for depressed patients [Salminen et al. 2008], a recent meta-analysis claimed that pharmacological treatments may be superior with dysthymic patients and that SSRIs are slightly more effective with major depression [Cuijpers et al. 2008b]. There should be no doubt by now, however, that STPP has shown evidence of being efficacious in dealing with mild or moderate depressive states.

Given the central adaptive role of anxiety as a signal or message rather than an affliction, according to psychoanalytic theory, there are still relatively few studies of STPP with patients diagnosed with anxiety disorders. In their meta-analysis, Lewis et al. (2008) listed only two controlled studies [and three naturalistic ones], and Leichsenring (2005, Leichsenring and Leibing 2007) found none [but one involving moderate-length psychodynamic therapy with social phobias]. During the last few years, however, a manualized psychoanalytically informed therapy for panic disorder has been introduced by Milrod and tested with positive results [Milrod et al. 2007]. Also, positive results have been reported for STPP with generalized anxiety disor-
Short- and Medium-Term Therapies in Samples of Patients With Personality Disorders

Substance abuse and dependence constitute another group of diagnoses with a body of controlled research to suggest that the psychodynamic approach is a viable one (Cris-Christoph et al. 1999, 2008; Woody et al. 1987, 1995). In the clinical spectrum, one is then entering the band of personality disorders. Certainly, in view of the frequency of comorbidity with personality disorders in samples with Axis I syndromes, we may question which is the more fundamental condition and whether the personality disorder should not be prioritized in treatment. Leichsenring and Leibing (2003) performed a meta-analysis of published studies of psychodynamic and cognitive-behavioral therapies in the treatment of personality disorders. Most of the studies were naturalistic and nonrandomized, and in only 3 of 22 of the studies were direct comparisons made. Leichsenring and Leibing’s conclusion corroborates that of Perry and colleagues’ (1999) earlier meta-analysis of a partially overlapping sample of studies: psychodynamic therapies, like cognitive-behavioral ones, are quite effective for patients with these complex clinical states. An interesting detail in the Perry et al. analysis was that the effects in general were larger when based on judgments of independent observers. Furthermore, Leichsenring and Leibing’s (2003) analysis showed that this difference applied to the psychodynamic studies only and was reversed among the cognitive-behavioral studies. On the basis of these results, the indications for psychodynamic therapy with patients with personality disorders are quite compelling.

Although not included in these meta-analyses, more studies on samples of inpatients or day hospital patients with personality disorders have been reported (Bateman and Fonagy 1999, 2001, 2003; Chiesa and Fonagy 2000, 2003; Chiesa et al. 2004; Dolan et al. 1997; Gabbard et al. 2000). In view of the severity of illness in these patient populations, the treatment results are impressive, but it is not possible to sort out the contributions of the psychotherapy component in these treatment packages.

Particular attention, at least in Europe, has been paid to the development of mentalization-based treatment (MBT; Bateman and Fonagy 2004, 2006). Although derived in part from attachment and cognitive theories, MBT is basically psychodynamic in its approach. There is evidence accumulating for the efficacy of MBT protocols with quite disturbed borderline patients. Especially interesting, Bateman and Fonagy (2008) followed up on a patient sample 5 years after treatment discharge. The outcome parameters were socially obtrusive yet nonreactive criteria like suicide attempts, hospitalization, emergency visits, medication, and employment. On all parameters, the MBT group was still significantly and clearly superior to the comparison group whose members had undergone so-called treatment as usual (TAU). Bateman and Fonagy (2009) recently reported findings from a randomized controlled trial of MBT in comparison with structured clinical management with outpatients with a diagnosis of borderline personality disorder. Whereas there was significant improvement in both the MBT and the clinical management groups, improvement was greater in the MBT group based on both self-reported criteria and more “objective” ones like suicide attempts and hospitalization.

Another explicitly specified, psychoanalytically informed therapy is transference-focused psychotherapy (TFP; Clarkin et al. 1999). TFP has been evaluated in a strictly controlled comparison with dialectical behavior therapy (DBT; Linehan 1993) and psychoanalytically informed supportive therapy (Clarkin et al. 2007; Levy et al. 2006). From a psychoanalytic point of view, it is interesting that, besides matching DBT in terms of level of functioning and reduction of suicidality, TFP was the only condition to increase attachment security and reflective functioning.

After a study by Gielen-Bloo et al. (2006) in the Netherlands, with less positive results, Doering et al. (2010) reported on a German-Austrian study of borderline patients randomly assigned to 1 year of either manualized TFP or nonmanualized psychotherapy delivered by experienced private practitioners in the communities. TFP brought about significantly more positive outcomes in terms of treatment dropout, suicide attempts, and borderline symptoms.
The most direct way to test whether the relatively positive findings on psychoanalytically informed psychotherapies apply to psychoanalysis as well is of course to review comparable research on “psychoanalysis proper”. But what is psychoanalysis? Most conveniently and least controversially, it may be defined on the basis of frame factors (e.g., duration longer than 2 years, session frequency higher than twice a week, use of couch). Because the border between psychoanalysis and psychotherapy is hard to distinguish, the following review will include, besides studies of psychoanalysis, studies of psychoanalytically oriented psychotherapy in which treatment duration exceeded 2 years and 200 sessions.

**Chart Reviews of Psychoanalytic Caseloads**

Although some analysts have demonstrated their courage to follow up their own patients and publish their findings (Coriat 1917; Schielderup 1955), such statistical summaries have been more convincing when the sample of patients has been selected from some independent caseload. In a careful and detailed review, Bachrach and colleagues (1991) summarized studies of such collective caseloads from psychoanalytic institutes in Berlin, London, Chicago, Topeka, Kansas, New York, and Boston. They concluded that patients in psychoanalysis derive therapeutic benefit—if they are suitable for psychoanalysis and their pretreatment level of functioning is high—although this may sound like circular reasoning.

Retrospective review of clinical case records for the purposes of treatment evaluation requires extremely stringent procedures—from the design of the initial records, to the coding and rating of the records, and finally to the analysis of these data—as well as an awareness of the methodological weaknesses that nevertheless remain. Bachrach et al. (1991) found many such weaknesses in the caseload studies. An exemplary chart review study that was more compliant with the stringent requirements outlined above is a review of almost 800 cases in child psychoanalysis or psychotherapy at the Anna Freud Centre in London (Fonagy and Target 1994, 1996; Target and Fonagy 1994a, 1994b). This review was as close to a total nonsampling study as is probably possible. Health-sickness ratings and formal diagnoses showed statistically and clinically significant improvements in about 75% of the cases, provided the treatments had been longer than 6 months. Outcome varied greatly with diagnosis. Children with emotional problems had generally better outcomes than children with disruptive acting-out problems. In general, more success was seen in the psychoanalysis cases than in the psychotherapy ones, and this was especially so in cases of more severe disturbance.

**Retrospective Follow-Up Studies**

True, a chart review study is retrospective in the sense that the reviewers revisit the charts. Yet, they were indeed there as the treatments took place. In contrast, a number of follow-up studies, in the United States (Erle and Goldberg 2003; Freedman et al. 1999; Friedman et
sas. Among the many publications of the project, there are two extensive summaries [Kemberg et al. 1972; Wallerstein 1986, 1989]. Most of the 42 patients included were severely disturbed, with repeated previous treatment failures. The original plan was to compare a group in psychoanalysis and one in psychotherapy. However, the contrast gradually broke down, as several patients were later switched between the two forms. Typically, the psychoanalyses also had to be modified, in the sense that supportive measures became more salient than is assumed with “pure” psychoanalysis. The findings were based on case records, repeated interviews with patients, an extensive test battery, interviews with family members, health-sickness ratings, and a complex procedure of paired comparisons among cases on a host of variables. Global ratings suggested that almost 60% of the patients had moderate or very good improvement, and the psychoanalysis and the psychotherapy cases had about equally successful outcomes. Indeed, Wallerstein [1989] found the supportive ingredients more conducive to change than had been expected. Also unexpectedly, change was not necessarily dependent on the resolution of internal core conflicts.

A most interesting result was brought to light when Blatt [1992] assessed treatment outcomes in the Menninger Project in relation to his distinction between introjective and analectic patients. His categorization was based on the patients’ Rorschach protocols and showed that the analectic patients, preoccupied with interpersonal issues, tends to respond more positively to psychotherapy than to psychoanalysis, whereas the introjective patients, concerned with autonomy and self-definition, did better in psychoanalysis.

A series of studies in Berlin and Heidelberg, Germany, has compared groups of psychoanalytic cases with outpatients and inpatients in psychodynamic psychotherapy [Grande et al. 2006, Rudolf et al. 1994, von Rad et al. 1998]. In general, the results have been quite positive both at termination and at follow-up, and especially so in the psychoanalysis cases. However, in contrast to other studies [de Maat et al. 2009], and in contrast to the psychotherapy group, von Rad and colleagues [1998] found that symptomatic changes in the psychoanalysis group were not maintained at follow-up. Also, a patient satisfaction question at follow-up indicated less positive opinions among the analysands. Possibly, the demands of the psychoanalytic regime fostered higher expectations that could not be fulfilled with many patients. These demands may not be justified by the somewhat better effects on symptoms, unless the treatment will lead to more profound changes beyond symptomatology. Grande and his colleagues therefore developed a scale to assess so-called structural change, the Heidelberg Structural Change Scale [HSCS; Grande et al. 2004] was developed on the assumption that structural change will be reflected in increasing awareness and readiness to cope with, and work through, intrapsychic conflicts. Indeed, Grande et al. [2009] found that the patients’ evaluation of their treatment outcome at follow-up interviews even 3 years after termination was significantly predicted by changes in the HSCS at termination but not by corresponding measures of distress or interpersonal problems.

In another ambitious prospective, naturalistic German study, Brockmann and colleagues (2002, 2006) compared long-term (>3 years) psychoanalytic therapies with long-term (>2 years) behavior therapies, delivered by private practitioners. Although diagnostically equal, the groups differed in several respects: besides being less symptomatic initially, the psychoanalytic group tended to have more education, used less psychotropic medication, and had more often sought treatment on their own initiative. While both groups improved significantly until follow-up (at 3.5 years) in terms of symptom distress, the psychoanalytic group showed superior and continuous change until the final follow-up, after 7 years.

**Longitudinal Studies**

Whereas the traditional assessment design has been used to compare pretreatment, posttreatment, and, sometimes, follow-up measurements, a few studies have adopted designs to estimate continuous change trajectories. In the German TRANS-OP project, Puschner and colleagues (2007) used a clever design to construct average change trajectories in real-time during the first 2 years of treatment. This naturalistic study covered almost 500 cases of psychoanalysis or psychodynamic therapies that had been reimbursed by a private health insurance company. The sample was mixed with respect to diagnoses, with a majority of patients having affective and neurotic disorders. Of note, symptom distress showed an especially sharp decline before the first formally scheduled session. After 2 years, when about two-thirds of the patients had terminated their treatments, the psychoanalysis patients, from a more impaired level of distress, had improved somewhat faster than patients in psychodynamic therapy. Neither of these differences was statistically significant, however.

One design to study very long treatments without taking the time to follow each through from beginning to end in real-time is called the “accelerated longitudinal
design” (Bell 1953; Raudenbusch and Chan 1992). In the Stockholm Outcome of Psychoanalysis and Psychotherapy Project (STOPP, Blomberg et al. 2001; Sandell et al. 2000), a panel of patients in psychoanalysis or psychotherapy, mostly psychodynamic, responded to an extensive questionnaire for 3 consecutive years. The sample was divided into subgroups depending on the position of each patient in terms of time in treatment, thus creating a time scale from 1 year before treatment to 3 years after termination. The psychoanalysis group had a significantly higher rate of positive change on a measure of psychological distress, from an initial level almost identical to that of the psychotherapy group. Especially interesting was that the really significant divergence appeared only after treatment termination. By 3 years after termination, the mean trajectory in the psychoanalysis group had reached close to the mean in a “normal,” nonpatient group. On the other hand, the Social Adjustment Scale, which measures the quality and “quantity” of one’s social relations, showed only modest, equal change in the two groups.

A similar design was used by a group at the Netherlands Psychoanalytic Institute in Amsterdam (Berghout and Zevalkink 2009, Berghout et al., in press; Zevalkink and Berghout 2006). On almost all clinical scales, there was significant improvement from before or early in treatment to termination, but nothing further during follow-up. The Minnesota Multiphasic Personality Inventory, assumed to reflect personality structures, showed similar changes on some, but not all, of its subscales, although these changes were consistently smaller. There were no systematic differences between the two forms of treatment on either type of measure, and rather elaborate attempts to predict individual treatment outcome had failed throughout.

Randomized and “Quasi-Randomized” Studies

Randomized studies of long-term psychotherapies and psychoanalyses are extremely rare. Nevertheless, a classic truly randomized comparison between high- and low-frequency long-term psychoanalytic psychotherapy was reported by Heinicke (1965; Heinicke and Ramsey-Klee 1986). The patient population was fairly specific: children with reading difficulties, 7–10 years of age. Interestingly, in the low-frequency group, the children improved at a faster rate than the children in the high-frequency group during the first year, but during the second year the four-times-a-week group caught up and surpassed the low-frequency group.

This “sleeper effect” was also found in a recent Finnish study (Knekt et al. 2008a, 2008b). In this study, 326 outpatients with predominantly mood or anxiety disorders were randomly assigned to one of three treatment groups: long-term psychodynamic psychotherapy, STPP, and solution-focused therapy, a cognitive-behavioral form. Significant reductions on depression and anxiety symptoms, as well as significantly raised levels of functioning and working ability, were noted during the 3-year follow-up. During the first year of treatment, STPP had a higher change rate than long-term psychodynamic psychotherapy, whereas during the second year of follow-up, no significant differences were found between the short-term and long-term therapies. After 3 years of follow-up, long-term psychodynamic psychotherapy was more effective, with 14%–37% lower scores on the outcome variables. No significant differences were found between the short-term therapies. A fourth, nonrandomized group of patients were offered psychoanalysis based on suitability considerations. Here, too, psychoanalysis patients were slower starters, but after 5 years of follow-up, psychoanalysis was the most effective, after a gradual and steady increase in recovery rates. According to preliminary analyses, about 80% of the patients receiving psychoanalysis recovered from their depressive symptoms, whereas the corresponding proportion for the other groups varied from 48% to 67% (Knekt et al. 2011).

In Munich, Germany, Huber and Klug (2004, Huber et al. 2007) compared psychoanalysis with psychodynamic therapy and behavior therapy in a sample of more than 100 patients diagnosed with unipolar depression. Balancing the requirements for internal and external validity, the authors used a design that included a “randomization board,” which decided, on the basis of an audiotaped intake interview, whether a patient should be randomly assigned or not. As it turned out, the board decided that all patients could be randomly assigned. Although selected on a random basis, the cognitive-behavioral group was included only later, unfortunately, and thus reduced the credibility of the design. Follow-up with an extensive outcome assessment battery showed that the psychoanalysis group was superior to both psychotherapy groups on measures of relapse rate and interpersonal problems. Also, a structural type of measure, the Scales of Psychological Capacities (DeWitt et al. 1991), showed superior improvement for the psychoanalysis group (Huber et al. 2005).

Another interesting design, a so-called preference design (Brewin and Bradley 1989), is currently being used in a treatment study involving patients with chronic depression sponsored by the German Association for
chodynamic therapies (mostly of short or moderate length), rated the studies as of only moderate quality, at
an average, in terms of the description, execution, or justi-
fication of their methods. The main problem, possibly
insurmountable, is the randomization issue. Several
scholars (e.g., de Maat et al. 2007; Leichsenring 2005;
Seligman 1995) have pointed out that randomized con-
trolled studies are not appropriate with long-term treat-
ments for several reasons: practically unfeasible, unethical,
and nongeneralizable. It is probably futile to expect
patients to comply for years with a randomized assign-
ment they do not appreciate, and it is nevertheless mean-
ingless to evaluate a treatment with patients who did not
want it, or for whom it was not suitable in the first place.
Also, what is often not recognized is that randomized
designs fail to control for differences in suitability base
rates in the patient population, with the consequence
that the treatment condition that is the most suitable to
more patients has an undue advantage. One should hope
that the preference design (Brewin and Bradley 1989) or
some similar “suitability design,” where patients are allo-
cated to treatments according to their differential suit-
ability, would gain wider acceptance.

An even more fundamental problem may have to do
with disinterest, unwillingness, fear, and other emo-
tional factors among psychoanalysts to expose their
work to serious testing against some sensible well-being
criterion. It is probably at least one good thing about the
evidence movement, in many respects so dogmatic or
fundamentalistic, that it has raised awareness among
clinicians of the need for such tests.

Study Outcomes and Their Interpretation

The studies there are, again, do show that psychoanalyt-
ically informed therapies are viable alternatives in the
psychological treatment assortment. This is true for
short-term therapies, especially with depressed patients
and probably for patients with more complex anxiety dis-
orders than simple phobias and patients with substance
abuse. Moderate-length psychodynamic therapies have
been shown to be quite effective for patients with com-
plex and chronic psychiatric and personality disorders.

The few convincing studies there are of psychoanal-
ysis proper suggest that psychoanalysis in general is su-
perior to psychodynamic therapy, although exceptions
exist. It is not at all clear which is the critical contrast in
these comparisons, however. To what extent are the dif-
fences due to the initial selection of patients, to dura-
tion, to session frequency, and to factors of technique?
First, several studies have shown that patients clinically
assigned to psychoanalysis are different from patients
assigned to psychotherapy in very many respects (e.g.,
Berghout and Zevalkink 2009; Rudolf et al. 1994;
Weber et al. 1985). To the extent that these assignments
are correlated with true suitability differences, it makes
little sense to compare the treatments as if they were in-
terchangeable. Second, as noted earlier, almost all stud-
ies show that increasing treatment duration, whether in
terms of number of weeks or in terms of months or ses-
sions, does influence outcome in the positive direction.

Third, in-session technique may be different in
psychodynamic psychotherapy compared with psycho-
analysis—and to the extent it is not, it may be non-opti-
mal or even dysfunctional, becoming “as-if analysis,”
applying psychoanalytic technique under nonpsycho-
analytical conditions (Grant and Sandell 2004). On the
basis of an inventory of therapeutic attitudes, Sandell
and colleagues (2004) were able to identify a group of
treatment providers with significant overrepresentation
of persons with psychoanalytical training, also in-
cluding a sizable number of psychodynamic therapists.
Persons in this group devalued support, caring, and
kindness in the therapeutic relation but valued neu-
trality and emphasized the irrationality of man and the
intuitive or artistic component in the therapeutic en-
terprise. This pattern of attitudes was interpreted as
classically, even orthodox, psychoanalytical. Whereas
the outcomes of the psychoanalyses run by the ana-
lysts in this group were quite positive, on average, the
outcomes in psychotherapy provided by therapists, and
some analysts too, were clearly inferior to those run by
therapists with less classical, more eclectic patterns of
attitudes (Grant and Sandell 2004; Sandell et al. 2007).
The conclusion was that the classical psychoanalytic
attitude, while quite prevalent among psychodynamic
therapists and analysts, is generally dysfunctional in
psychotherapy. Further support for this conclusion was
offered in a study in which patients with therapists and
analysts with very long personal or training analyses
were found to do poorly in psychotherapy (Sandell et al.
2006). The finding was interpreted in terms of the mod-
eling function of personal or training analysis. The
longer the therapist’s analysis, the stronger she or he
will identify with the approach of her or his psychoan-
alyist, and the more likely she or he will unwittingly adopt
it working with patients in psychotherapy.


Psychoanalytic Process Research

Stuart Ablon, Ph.D.
Lotte Smith-Hansen, Ph.D.
Raymond A. Levy, Psy.D.

Outcome studies have shown that many types of psychoanalytic and psychodynamic treatments (we use the two terms interchangeably to avoid repetitiveness) are effective in bringing about change not only in symptoms but also in internal psychological abilities such as insight, level of defenses, internalized object relations, affect tolerance, and view of self [Leichsenring 2009]. Complementing outcome studies, process studies have identified some of the techniques and patient-therapist interactions most characteristic of psychodynamic treatments (compared with other types of treatment) and some of the active ingredients and mechanisms of change [Blatt et al. 2010; Smith-Hansen et al. 2011b].

As we review in this chapter, studies show that the therapeutic relationships, as well as specific psychodynamic interventions, are important for change in psychotherapy. Research has even begun to explore how the relationship, treatment techniques, and therapist and patient variables impact each other in complex interactions determining treatment outcomes. As we demonstrate later, psychoanalytic concepts and processes can be operationalized, and several valid and reliable measures have been developed for this purpose, including the Psychotherapy Process Q-Set (PQS, Jones 2000), Comparative Psychotherapy Process Scale (Hilsenroth et al. 2005), and Vanderbilt Psychotherapy Process Scale (Smith et al. 2003). The Analytic Process Scales have also been used to assess psychotherapy process but are less well validated than the other measures at this point [Waldroa et al. 2004; for a review of process measures, see Sieffert et al.]
These measures go beyond simple adherence checklists, demonstrate that brand-name treatments integrate more processes from multiple theoretical orientations than expected, and provide the missing link between treatment modalities and outcomes. Thus, process studies are beginning to show us how psychoanalytic treatments work.

The findings from process studies are beneficial to practicing analysts and therapists in part because they bring greater conceptual clarity via their operational definitions. For example, in order to operationalize and measure psychoanalytic constructs, researchers have to first carefully define and distinguish them from related concepts. We believe that the research findings we review here can inform clinical work partly by guiding practice directly and partly by imparting a scientific attitude, which we believe is useful in clinical work [Jimenez 2007]. At the same time, the findings must be integrated with clinical judgment because the research literature is still in its early stages. Research findings at times confirm and at times contradict clinical wisdom.

Our aim is to review the empirical psychotherapy process literature in order to provide an overview of the major lines of research and of the progression from simpler to more complex investigations [although the scope of this chapter precludes us from citing some of the individual studies comprising the literature]. We review the earlier lines of research as a preamble to the more recent and more sophisticated studies that have more direct implications for the clinical encounter. For example, the early literature mirrors two main areas of investigation, namely research on the therapeutic relationship and research on specific interventions [e.g., interpretations], and only recently have researchers begun to examine the interactions between relational and technical factors and to recognize the importance of processes that transcend the “interpretation versus relationship debate” [Gabbard and Westen 2003].

What Processes Characterize Psychodynamic Treatment?

Process studies show that several factors characterize psychodynamic treatments compared with other treatment orientations. In an important review, Blagys and Hilsenroth (2000, 2002) found that seven specific interventions differentiated psychodynamic and interpersonal therapy from cognitive-behavioral therapies:

1. a focus on affect and the expression of patients’ emotions;
2. an exploration of patients’ attempts to avoid topics or engage in activities that hinder the progress of therapy;
3. the identification of patterns in patients’ actions, thoughts, feelings, experiences, and relationships;
4. an emphasis on past experiences;
5. a focus on patients’ interpersonal experiences;
6. an emphasis on the therapeutic relationship; and
7. an exploration of patients’ wishes, dreams, or fantasies. [Blagys and Hilsenroth 2000, p. 167]

Ablon and Jones (1998) also asked 11 expert psychodynamic clinicians and theoreticians to rate the 100 items on the PQS according to how characteristic each item was of an ideal psychodynamic treatment [see Table 27–1 for the 20 most characteristic items] and found not only that the experts could agree on a common set of items central to analytic process but that this process could be differentiated from other treatments and was positively correlated with outcomes across several treatment studies [Ablon and Jones 1998, 2005]. For example, Ablon and Jones (2005) used the PQS to compare therapy process from three different treatment settings: two psychoanalyses (N = 130 sessions), three long-term analytic therapies (two sessions weekly; N = 229 sessions), and two short-term dynamic therapies (N = 122 sessions). The authors calculated each sample’s correspondence to the experts’ prototype of psychoanalytic process and found that the two psychoanalyses demonstrated a significantly greater correlation with the prototype, whereas the psychoanalytic psychotherapy treatments showed a weaker correlation and the short-term dynamic therapies an even weaker correlation. The differences between each sample were statistically significant, providing the first empirical evidence that psychoanalysis proper fosters more of an analytic process than psychodynamic psychotherapy. This study also highlighted several specific items that differentiated the psychoanalyses from the long-term psychotherapies in surprising ways, providing a potential focus for future research. Adherence to this prototype of psychoanalytic process was found to correlate positively and significantly with outcome in both psychodynamic and cognitive-behavioral therapies [Ablon and Jones 1998, Ablon et al. 2006]. Jones and Pulos (1993) also found that psychodynamic therapists encouraged affective experiencing and expression, in contrast to therapists practicing cognitive-behavioral therapy who encouraged control of negative emotions through use of intellect and reason. Using principal components analysis, they identified a
<table>
<thead>
<tr>
<th>Item description</th>
<th>Factor score</th>
</tr>
</thead>
<tbody>
<tr>
<td>P's dreams or fantasies are discussed.</td>
<td>1.71</td>
</tr>
<tr>
<td>T is neutral.</td>
<td>1.57</td>
</tr>
<tr>
<td>T points out P's use of defensive maneuvers, e.g., undoing, denial.</td>
<td>1.53</td>
</tr>
<tr>
<td>T draws connections between the therapeutic relationship and other relationships.</td>
<td>1.47</td>
</tr>
<tr>
<td>T is sensitive to P's feelings, attuned to P; empathic.</td>
<td>1.46</td>
</tr>
<tr>
<td>T interprets warded-off or unconscious wishes, feelings, or ideas.</td>
<td>1.43</td>
</tr>
<tr>
<td>T conveys a sense of nonjudgmental acceptance.</td>
<td>1.38</td>
</tr>
<tr>
<td>P achieves a new understanding or insight.</td>
<td>1.32</td>
</tr>
<tr>
<td>The therapy relationship is a focus of discussion.</td>
<td>1.28</td>
</tr>
<tr>
<td>T communicates with P in a clear, coherent style.</td>
<td>1.24</td>
</tr>
<tr>
<td>T draws attention to feelings regarded by P as unacceptable (e.g., anger, envy, or excitement).</td>
<td>1.17</td>
</tr>
<tr>
<td>Sexual feelings and experiences are discussed.</td>
<td>1.12</td>
</tr>
<tr>
<td>P's behavior during the hour is reformulated by T in a way not explicitly recognized previously.</td>
<td>1.12</td>
</tr>
<tr>
<td>Self-image is a focus of discussion.</td>
<td>1.11</td>
</tr>
<tr>
<td>Memories or reconstructions of infancy and childhood are topics of discussion.</td>
<td>1.08</td>
</tr>
<tr>
<td>P's feelings or perceptions are linked to situations or behavior of the past.</td>
<td>1.05</td>
</tr>
<tr>
<td>T identifies a recurrent theme in P's experience or conduct.</td>
<td>0.95</td>
</tr>
<tr>
<td>T's remarks are aimed at facilitating P's speech.</td>
<td>0.92</td>
</tr>
<tr>
<td>T comments on changes in P's mood or affect.</td>
<td>0.88</td>
</tr>
<tr>
<td>T focuses on P's feelings of guilt.</td>
<td>0.87</td>
</tr>
</tbody>
</table>

Note. Factor scores derived from expert psychodynamic therapists (N = 11) ratings of the Psychotherapy Process Q-Set. P = patient; T = therapist. Sources. Adapted from Ablon and Jones 1998.

explored to the patient and the impact of any intervention will depend on the moment-to-moment context.

Given the influence that therapists have on the alliance, an important question is whether it is possible to train therapists in specific alliance strategies or, alternatively, if only natural and spontaneous therapist behaviors facilitate the development of a good therapeutic alliance. A related question is whether it is possible to teach empathy, as attempted by some researchers. The link between therapist behaviors and alliance quality has been studied mostly with observational, correlational designs, but a few studies have attempted to improve the therapeutic relationship experimentally and prospectively through specific interventions, such as training and supervision in alliance-fostering strate-
gies, with promising results [Crits-Christoph et al. 2006; Hilsenroth et al. 2002; Smith-Hansen et al. 2011a].

As reviewed by Safran et al. (2009), several studies have examined whether different alliance trajectories over time [e.g., stable vs. linear growth] are related to successful outcome. Some studies suggest that high-low alliance patterns are associated with better outcomes, perhaps reflecting the presence of a difficult yet productive working-through phase in the middle of treatment that manifests as lower alliance ratings. Stiles et al. (2004) found that alliance trajectories with brief, sharp declines and quick rebounds to same or better levels predict better outcome. These findings suggest that ongoing monitoring of the alliance is important and
TABLE 27-2. Psychotherapy Process Q-Set factor items and loadings for Psychodynamic Technique

<table>
<thead>
<tr>
<th>Item description</th>
<th>Factor score</th>
</tr>
</thead>
<tbody>
<tr>
<td>T emphasizes P’s feelings to help him/her experience them more deeply.</td>
<td>0.81</td>
</tr>
<tr>
<td>T is neutral.</td>
<td>0.80</td>
</tr>
<tr>
<td>T interprets warded-off or unconscious wishes, feelings, or ideas.</td>
<td>0.70</td>
</tr>
<tr>
<td>T points out P’s use of defensive maneuvers [e.g., undoing, denial].</td>
<td>0.62</td>
</tr>
<tr>
<td>P’s feelings or perceptions are linked to situations or behavior of the past.</td>
<td>0.61</td>
</tr>
<tr>
<td>T draws attention to feelings regarded by P as unacceptable [e.g., anger, envy, or excitement].</td>
<td>0.58</td>
</tr>
<tr>
<td>Memories or reconstructions of infancy and childhood are topics of discussion.</td>
<td>0.57</td>
</tr>
<tr>
<td>T draws connection between the therapeutic relationship and other relationships.</td>
<td>0.50</td>
</tr>
<tr>
<td>P’s behavior during the hour is reformulated by T in a way not explicitly recognized previously.</td>
<td>0.50</td>
</tr>
<tr>
<td>T identifies a recurrent theme in P’s experience or conduct.</td>
<td>0.50</td>
</tr>
</tbody>
</table>

Note. P = patient; T = therapist.
Source. Adapted from Jones and Pulos 1993.

that therapists should view temporary strains in the alliance as opportunities for deepening the therapeutic work.

In fact, Safran and colleagues (2009) have emphasized the importance of such alliance rupture-repair sequences, which they define as problems in the therapeutic relationship that are repaired through interpersonal exploration between patient and therapist. They argued that working through such problems in the alliance may be a key pantheoretical change mechanism in its own right. Based on this principle, Safran and Muran (2000) developed brief relational therapy (BRT) as a stand-alone treatment modality focused on negotiating the therapeutic alliance. However, they stressed that the principles and strategies can be incorporated into any type of treatment. BRT is based on contemporary relational psychoanalytic theory and on the authors’ own research on alliance ruptures and includes elements from humanistic/experiential traditions and Buddhist mindfulness practice. The treatment emphasizes process over content, and therapeutic change is theorized to arise from the development of improved internal awareness as well as new interpersonal experiences with the therapist. In fact, the main focus in BRT is on exploring ruptures in the therapeutic alliance and using these as opportunities for growth, which is facilitated by the therapist’s use of metacommunication to disembodied from maladaptive interpersonal patterns being enacted with the patient. Safran and colleagues have outlined how patients and therapists typically move through various rupture-repair sequences in cases where the patient is either confronting the therapist or withdrawing from the in-session affect or process. In empirical investigations comparing BRT with cognitive-behavioral therapy and short-term dynamic therapy, BRT produced lower dropout rates for patients with personality disorders (Muran et al. 2005) and for patients at risk of treatment failure with whom it is difficult to establish an alliance (Safran et al. 2005).

The questions for future research on the therapeutic alliance include: How is alliance similar to and different from related constructs such as therapist empathy and patient engagement? What exactly are the respective patient and therapist contributions in contrast to the dyadic, synergistic aspects? What patient and therapist characteristics impacting the alliance are relatively stable? Under what conditions do patients and therapists become locked into negative processes [i.e., when, how and why]? How and why does the alliance fluctuate from moment to moment [depending on factors such as arousal level, observing ego capacity, level of felt safety in the room]? How exactly do alliance rupture-repair sequences help create corrective interpersonal experiences for patients? Finally, does the alliance itself account for part of the variance in outcome, or is it the case that a positive alliance simply allows for or facilitates the use of specific interventions?
### Table 27-3. Therapist Techniques and Attributes Found to Contribute Positively to the Alliance

<table>
<thead>
<tr>
<th>Techniques Positively Related to Alliance</th>
<th>Attributes Positively Related to Alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Supportive</strong></td>
<td></td>
</tr>
<tr>
<td>Support the patient’s struggle</td>
<td>Helpful</td>
</tr>
<tr>
<td>Affirm the patient’s experience</td>
<td>Affirming</td>
</tr>
<tr>
<td>Convey a sense of understanding and connection</td>
<td>Understanding</td>
</tr>
<tr>
<td>Note past therapy success</td>
<td>Accepting</td>
</tr>
<tr>
<td>Foster a collaborative treatment process</td>
<td>Collaborative</td>
</tr>
<tr>
<td>Enhance motivation for change</td>
<td>Enthusiastic</td>
</tr>
<tr>
<td><strong>Exploratory</strong></td>
<td></td>
</tr>
<tr>
<td>Utilize open-ended questions</td>
<td>Open</td>
</tr>
<tr>
<td>Clarify areas of distress or discrepancy</td>
<td>Empathic</td>
</tr>
<tr>
<td>Communicate clearly</td>
<td>Warm</td>
</tr>
<tr>
<td>Foster depth</td>
<td>Friendly</td>
</tr>
<tr>
<td>Provide appropriate, nonhostile confrontation</td>
<td>Egalitarian</td>
</tr>
<tr>
<td>Provide accurate interpretation</td>
<td></td>
</tr>
<tr>
<td><strong>Experiential and Affect Focused</strong></td>
<td></td>
</tr>
<tr>
<td>Attend to patient experience</td>
<td>Honest</td>
</tr>
<tr>
<td>Reflect patient statements and experience</td>
<td>Trustworthy</td>
</tr>
<tr>
<td>Facilitate the expression of affect</td>
<td>Respectful</td>
</tr>
<tr>
<td>Explore different patient emotional states</td>
<td></td>
</tr>
<tr>
<td><strong>Engaged and Active Relationship</strong></td>
<td></td>
</tr>
<tr>
<td>Maintain actively engaged involvement</td>
<td>Interested</td>
</tr>
<tr>
<td>Focus on the here and now of therapy relationship</td>
<td>Alert</td>
</tr>
<tr>
<td>Discuss therapist’s own contribution to process</td>
<td>Flexible</td>
</tr>
<tr>
<td>Provide ongoing feedback to patient</td>
<td>Relaxed</td>
</tr>
<tr>
<td></td>
<td>Confident</td>
</tr>
<tr>
<td></td>
<td>Experienced</td>
</tr>
<tr>
<td></td>
<td>Competent</td>
</tr>
</tbody>
</table>

## Role of Technique in Treatment

Studies examining specific techniques have focused on therapist interventions such as providing interpretations, addressing defenses, working with affect, and other ways of fostering insight and improving emotional and social functioning. Research has examined different types of interpretations, including defense interpretations, transference interpretations, and extratransference interpretations (e.g., parents, significant others), focusing on either the past or the present or linking the two. Many aspects of interpretation have been the subject of empirical inquiry (Crites-Christoph and Connolly Gibbons 2001). Studies have examined both the frequency and the concentration of interpretations (i.e., the number in each session or the ratio of interpretations to other interventions), as well as interpretation...
<table>
<thead>
<tr>
<th>Techniques negatively related to alliance</th>
<th>Attributes negatively related to alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management of the treatment in inflexible manner</td>
<td>Rigid</td>
</tr>
<tr>
<td>Overstructuring of the therapy</td>
<td>Tense</td>
</tr>
<tr>
<td>Failure to structure the therapy</td>
<td>Defensive</td>
</tr>
<tr>
<td>Inappropriate self-disclosure</td>
<td>Self-focused</td>
</tr>
<tr>
<td>Inappropriate use of silence</td>
<td>Explosive</td>
</tr>
<tr>
<td>Unyielding transference interpretations</td>
<td>Distant/detached</td>
</tr>
<tr>
<td>Belittling or hostile communication</td>
<td>Cold</td>
</tr>
<tr>
<td>Superficial interventions</td>
<td>Distracted</td>
</tr>
<tr>
<td></td>
<td>Uncertain</td>
</tr>
<tr>
<td></td>
<td>Critical</td>
</tr>
<tr>
<td></td>
<td>Aloof</td>
</tr>
<tr>
<td></td>
<td>Indifferent</td>
</tr>
</tbody>
</table>

accuracy, depth, conflictuality, and congruence between the therapist’s interpretations and 1) the therapist’s initial formulation of the case, 2) the patient’s formulation of his or her own difficulties, and 3) the patient’s plan to reach desired goals [Norville et al. 1996].

Several studies have examined the predictors of the use of interpretation. Hersoug [2004] and Hersoug et al. [2003] found that therapists provided more interpretations in the middle of treatment compared with the beginning. Furthermore, therapists with good parental care in childhood used fewer interpretations, whereas therapists with more negative introjects and more years of experience used more interpretations. They also found that poor object relations in patients were associated with more interpretations early in treatment and that the combination of more maladaptive defenses and a poor working alliance was associated with use of many interpretations.

Perry et al. [2011] have examined the effect of defense interpretations on in-session defensive functioning. In their latest study they coded therapist interventions with the Psychodynamic Interventions Rating Scale [Cooper et al. 2002] and determined whether each interpretation was below, at, or above the patient’s level of defense in the preceding moments. They found that patients using low-level defenses showed an increase in level of defenses when therapists interpreted at the highest level [i.e., supported the best available defenses, even if not high], whereas for healthier patients, interpretations aimed at the highest defensive level typically resulted in a regression/decrease in defensive functioning [Levy and Abion 2011].

Going one step further, researchers have studied therapist interventions in relation to outcomes such as the therapeutic alliance and symptom improvement. For example, Stigler et al. [2007] found that the sum of accuracy and conflictuality scores was positively associated with the therapeutic alliance. Studies examining the frequency or concentration of interpretation [in proportion to other interventions] have generally found that high frequency is associated with less favorable outcomes, whereas low or moderate frequency may be associated with more favorable outcomes [Hoglund et al. 2008; Johansson et al. 2010].

Studies of interpretation accuracy by Crits-Christoph, Connolly Gibbons, and colleagues have used the Core Conflictual Relationship Theme method to operationalize accuracy as the degree of congruence between an interpretation and the formulation of the patient’s difficulties as rated by independent observers [Crits-Christoph et al. 1988]. As reviewed by Crits-Christoph and Connolly Gibbons (2001), studies have found a connection between interpretation accuracy and positive outcomes.

Reviewing the literature on transference interpretations, Hoglund and Gabbed [2011] concluded that prior to the year 2000, only 10 empirical studies had examined the relationship between the number of transference interpretations in a given session and treatment outcomes. Recent advancements in methodology, how-
ever, have led to exciting new findings with important clinical implications.

The empirical literature has examined two types of effects of transference interpretations: 1) immediate in-session outcomes and 2) long-term treatment outcomes. As reviewed by Högland and Gabbard [2011], studies of in-session effects have shown that transference interpretation is a “high-risk, high-gain” enterprise. Specifically, several studies showed that patients do not always respond positively to transference interpretations but in fact sometimes respond by becoming more defensive, behaving in ways indicative of at least a temporary rupture in the alliance, or otherwise becoming less involved in the treatment process. McCullough et al. [1991] found that transference interpretations resulted in increased defensiveness five times more often than affective deepening.

The study by Piper et al. [1999] provides an illustrative example. In this study, the treatments of 22 patients who dropped out of interpretive therapy were examined in detail and found to be characterized by lower quality of therapist-rated alliance, lower levels of patient exploration, and higher levels of transference work compared with 22 matched control subjects who completed treatment.

Another illustrative study was conducted by Gabbard et al. [1994], who examined upward and downward shifts in collaboration between patient and therapist as an indicator of the therapeutic alliance following transference interpretations. Examining three patients diagnosed with borderline personality disorder in long-term dynamic therapy, the researchers found that the patients responded quite differently to transference interventions. In one patient, only 29% of all upward shifts in collaboration were linked to transference work, whereas the second patient responded positively 63% of the time and the third patient 81% of the time. All in all, transference interpretations were found to have a greater impact than other interventions, both positive and negative, which indeed suggests that transference work is a “high-risk, high-gain” enterprise, at least with patients with borderline disorders.

Although more research is needed to examine immediate in-session effects of transference work, it may be hypothesized that transference work should be attempted only if the patient has a strong capacity for exploration and the therapist has successfully built a solid collaborative alliance with him or her (or only during sessions or moments when these “prerequisites” are met). Alternatively, it may be important for clinicians and researchers alike to assess patient exploration and collaboration as immediate in-session outcomes following transference interpretations, because decreased exploration and collaboration may be indicators of increased defensiveness, signaling that the therapist should move to more supportive techniques for the moment or perhaps engage in more explicit rupture-repair work.

In addition, the study by Gabbard et al. [1994] suggests that therapists need to tailor their interventions carefully based on patient characteristics. Although more research is needed, clinical wisdom and the results from their process study suggest that patients with a history of early trauma and externalizing tendencies may require more support and validation before transference work is attempted, and perhaps more rupture-repair work following transference interpretations, compared with more internalizing patients with less severe trauma.

Studies of the long-term effects of transference work have shown mixed results. As reviewed by Högland and Gabbard [2011], some researchers have found no correlations or weak correlations between transference interpretations and outcomes, whereas others have found positive associations, and some others have found negative associations. A small number of studies have examined for whom transference interpretations are effective. To their surprise, Piper et al. [1999] found negative correlations between the number of transference interpretations per session and outcomes within the subsample of patients with high quality of object relations scores. They also found that some therapists were offering up to 10 transference interpretations per session with negative results. In contrast, the patients receiving less than 2 interpretations per session were more likely to recover. Högland [1993] discovered a negative long-term effect of treating patients with healthy object relations with a high concentration of transference interpretations (an average of 6 per session), despite the hypothesis that the patients were highly “suitable.” Connolly et al. [1999a] found that patients with poor interpersonal functioning improved less even with as little as 2 or fewer transference interpretations per session. Examining patients with low quality of object relations, Ogródniczak et al. [1999] found negative correlations between moderate frequency [2–4 interpretations/session] and alliance and outcome.

Unfortunately, all of these studies have serious methodological limitations, and the findings must be seen as preliminary. The limitations include 1) naturalistic treatments under uncontrolled conditions, 2) treatment durations too short for transference work (in some cases, less than 20 sessions), and 3) instructions for therapists to focus on transference work, resulting in therapists “over-
dosing” the patient. Indeed, we agree with Høglend and Gabbard [2011] that the literature is too slim to offer detailed treatment recommendations except that high-frequency transference interpretations [more than 4 per session] likely result in poor process and outcome, especially in the context of a less than superior therapeutic alliance.

Høglend and colleagues [Høglend et al. 2008, Johanson et al. 2010] conducted a sophisticated experimental study of transference work. The therapists in the study relied on general psychodynamic principles, but the therapists in one group were trained to use transference interpretations at a moderate frequency, such as 1–2 per session. To their surprise, Høglend and his colleagues found that patients with poorer object relations and lower Global Assessment of Functioning Scale scores benefited more from treatment with transference focus than from treatment without. Patients with healthier object relations benefited equally from the two treatments. Another key finding was that the positive long-term outcomes were mediated by clinician-rated measures of insight, defined as both intellectual and emotional understanding of inner conflicts and interpersonal patterns and their developmental origins.

Insight has long occupied a central role in psychoanalysis, but only a few studies have been conducted to examine empirically whether insight-fostering techniques in fact are the active ingredients or mechanisms of successful treatments and whether the patient’s development of insight in fact predicts or mediates improvement. One reason may be that defining insight has not been easy, and indeed studies have used different operational definitions. Most investigations use independent observers to rate patient insight, although the scale by Connolly et al. (1999b) is a self-report measure of patients’ insight into their own unique relationship conflicts and their historical origins. The Achievement of Therapeutic Objectives Scale by McCullough et al. (McCullough L, Larsen AE, Schache E, et al.: “Achievement of Therapeutic Objectives Scale: ATOS Scale,” unpublished manuscript, 2003) is considered a measure of therapy process, although it focuses not on therapist interventions but rather on patient responses to therapeutic interventions or “mini-outcomes” in sessions, including insight. A group of researchers led by Hill et al. [2007] reached a consensus definition of insight, agreeing that it implies “a usually conscious shift that involves a sense of newness and making connections [e.g., figuring out a new connection between past and present events, between the therapist and significant others, between cognition and affect, or between disparate statements” [Kallestad et al. 2010, see also Hill et al. 2007].

The empirical literature on insight is unfortunately scant. The review by Connolly Gibbons et al. [2007] found only eight studies of the association between increased insight and treatment outcome [i.e., studies examining insight as a possible predictor or mediator of improvement]. Four studies found a positive association, whereas the other four studies found no association. These findings must be interpreted with caution, however, given the many methodological flaws of the studies, including 1) inconsistent definitions of insight; 2) lack of specification of presenting problems, diagnoses, and treatment types; 3) lack of investigation regarding whether insight leads to symptom improvement or vice versa; and 4) short duration of treatments with insufficient time for insight to develop [Connolly Gibbons et al. 2007].

We found two more recent studies of higher methodological quality. Connolly Gibbons et al. [2009] examined three possible mechanisms of change in manualized dynamic and cognitive treatments, including improvements in self-understanding, coping skills, and views of self. They found, as hypothesized, that insight increased more in psychodynamic versus cognitive therapy [whereas coping skills and views of self changed equally in the different treatments] and that all three factors were associated with symptom change across the treatments. These results confirmed the findings from prior studies. Contrary to hypotheses, they found that increase in insight was no longer associated with symptom reduction when improvements in coping skills and views of self were included in the same analyses and concluded that “self-understanding of interpersonal patterns is not a significant mechanism of therapeutic action” once the effects of changes in coping skills and views of the self are controlled for (Connolly Gibbons et al. 2009, p. 810). The results must be interpreted with caution, however, because change in insight may be related to change in the other two factors (which may therefore show a higher correlation with outcome), the conceptualizations and measures of insight and coping skills showed some overlap, and the study had methodological limitations.

Kallestad et al. [2010] examined the role of insight in long-term outcomes in short-term dynamic psychotherapy and cognitive therapy. Ratings with the Inventory of Therapeutic Strategies showed that the short-term dynamic psychotherapy therapists focused more on defenses and transference, whereas cognitive therapy therapists focused more on support, homework, and agenda setting. Patient insight as a potential predictor of outcome was rated for sessions 6 and 36 by independent observers using the Achievement of Ther-
apeutic Objectives Scale. The authors found that insight improved significantly in short-term dynamic psychotherapy but not in cognitive therapy. Furthermore, insight measured late in treatment predicted improvements in symptoms and interpersonal problems at 2-year follow-up in short-term dynamic psychotherapy, even when early symptom improvement and prior levels of insight were controlled for, whereas increase in insight did not predict long-term outcomes in cognitive therapy. Of note, patients in the two groups fared equally well in the long run in terms of symptoms and interpersonal functioning, so it may be that insight is a key predictor of change only in dynamic treatment, whereas cognitive therapy works in different ways. Later reports from the study will include process ratings from the PQS, which will shed more light on the active ingredients of both treatments.

In summary, few methodologically sound studies have examined insight as a predictor of improvement or as an active ingredient of change. In reviewing the research on therapeutic action, Gabbard and Westen [2003] discussed the growing skepticism regarding the importance of insight in analytic and dynamic treatments, concluding that insight has been “toppled off its prior pedestal” [p. 823]. We agree with Kallestad et al.’s [2010] more recent assessment, however, that clinicians should not disregard insight as unimportant, because at least a few recent studies of higher quality have shown that insight is important for treatment success.

As noted earlier, another important aspect of psychodynamic treatment in addition to the development of insight is the stance toward affect, and indeed interpretations and other, exploratory techniques often heighten the patient’s anxiety or arousal or seek to deepen affective experience (as opposed to more supportive techniques aimed at calming, containing, or suppressing emotions). Diener and Hilsenroth [2009] provided excellent reviews of the role of emotion in psychodynamic theories of psychopathology and treatment. As they noted, empirical studies show that key processes related to affect are associated with positive outcomes, such as encouraging the patient to experience and express feelings in the session, addressing avoidance of important topics, noting shifts in mood, deepening affective experience, drawing attention to feelings regarded as unacceptable by the patient, and using fewer cognitive words in high-affect session segments.

Several studies have shown that focusing on negative or problematic feelings may be particularly helpful—for example, by addressing the patient’s conflictual anxiety or negative feelings toward the therapist or other people. Ablon et al. [2006] found that the strongest predictor of outcome out of all 100 PQS items was the therapist’s emphasizing patient feelings in order to help him or her experience them more deeply (correlated 0.70 with outcome).

Taking these findings a step further, some studies have shown that therapists may need to attend carefully to the patient’s response following affect-focused interventions. For example, McCullough and Magil [2009] found that helpful techniques included interpretations and clarifications to confront defenses only when these were followed by a deepening expression of underlying emotions in contrast to a defensive response. Furthermore, the utility of focusing on affect may depend on the treatment context, because some studies show that encouraging affective experience in session was beneficial only with higher-functioning patients and those with more coherent and stable concepts of self and others [Horowitz et al. 1984].

Going one step further, important studies have shown that therapists may need to balance a confrontive focus on affect with supportive and empathic interventions. Based on many years of studying the role of affect and confrontation in treatment, McCullough and Magil [2009] argued that “a spoonful of sugar makes the confrontive medicine go down” (pp. 259–260), which is in sharp contrast to many models of short-term psychodynamic treatment that emphasize continued confrontation to break through patient defenses. Summarizing a number of studies, McCullough and Magil concluded that “supportive, empathic and clarifying methods generated more affect than did confrontive interventions” [p. 258] as measured with the Psychotherapy Interaction Coding System. In fact, several studies show that interpretations and other confrontive interventions may raise the patient’s defenses and that clarifications may elicit more affect than interpretations and confrontations.

As we have reviewed, a number of psychodynamic techniques have been subjected to empirical scrutiny. Reviewing the literature on the use of technique in psychotherapy, Barber [2009] concluded that a curvilinear relationship may exist between the use of techniques and outcome, noting that a moderate use of technical interventions implies a certain flexibility and responsiveness on the therapist’s part. He also highlighted a key distinction between adherence (which is the therapist’s use of specific techniques prescribed by a treatment manual or theoretical orientation) and competence (which is the degree of skillfulness, nuance, and responsiveness demonstrated by the therapist in using the techniques) and concluded that competence is more important for outcome than adherence.
Interplay of Techniques and Alliance

As noted, a few studies have examined the association between techniques and alliance, for example, showing that accurate interpretations are associated with a stronger alliance and that high levels of adherence to a particular technique or treatment manual are associated with poor alliance. However, because most of these studies were correlational, we caution researchers and clinicians alike about assuming a causal direction and concluding that therapist interventions unidirectionally influence the relationship, because it is just as likely that relational factors drive what techniques are used in treatment.

As reviewed by Barber [2009], only a few studies have taken the next step and examined whether alliance or techniques are related to outcomes when controlling for the other (e.g., showing that competent use of techniques is associated with symptom improvement over and above both the quality of the alliance and the earlier symptom change). A related question is whether use of technique impacts outcome differentially depending on the quality of the alliance. For example, Barber et al. [2008] found that cocaine users benefited most from a moderate level of adherence to the supportive-expressive therapy manual, rather than low or high levels, and that this was especially true for patients with poor alliance.

Taking an even more sophisticated approach, a handful of studies have examined the interaction of alliance and techniques in predicting treatment outcomes. Reviewing several studies of short-term dynamic psychotherapy, Crits-Christoph and Connolly [1999] concluded that the results were “in the direction of better outcome associated with the use of exploratory interventions in the context of a good alliance, and supportive interventions in the context of lower alliances” (p. 699), although they recommended caution given the methodological limitations of the studies. In a sophisticated study, Schut et al. [2005] found that therapists made more interpretations in the context of negative interpersonal process between therapist and patient (e.g., being hostile, blaming, attacking, sulking, wailing off) and that higher frequency of interpretation was associated with poorer outcome. Of note, even small amounts of negative interpersonal process between patient and therapist immediately before, during, and immediately after the therapist made an interpretation were associated with poorer outcomes.

These studies give only preliminary answers to important clinical questions and raise many questions for future research: In what ways are alliance and use of technique conceptually overlapping constructs? How are patient and therapist pretreatment characteristics associated with the alliance and with therapist use of technique? How does the alliance impact use of techniques, and how does use of techniques impact the alliance, both within the unfolding process of each session and in the long term? What underlying third variables may be impacting both alliance and use of technique? How do therapist and patient influence each other bidirectionally, and how does this affect the alliance and use of techniques? How does alliance change over time within each session and over the course of treatment (e.g., rupture-repair sequences), how does use of technique change within a session and over the course of treatment (e.g., interplay of supportive and expressive techniques), and how are these two processes related to each other? How do alliance and use of technique interact in determining in-session process and long-term outcomes? Finally, what works for whom in terms of interpersonal processes and use of techniques?

Tailoring of Treatment to Patient Characteristics and In-Session Process

Only a few studies have examined the questions of what works for whom and what works for whom in what context, addressing important issues related to tailoring treatment to patients and being optimally responsive during the clinical encounter. Many meta-analyses have concluded that different treatments are equally effective, leading to the famous dodo bird verdict [Wampold 2001]. At the same time, differences in patient response to treatment are commonly observed. A key obstacle to understanding why this occurs (and more generally, how treatment works) is the so-called homogeneity myth, with its implicit assumption that patients are alike for the purposes of psychotherapy. Several investigators have challenged this idea and called for the field to abandon the homogeneity myth by incorporating relevant patient characteristics into research designs and tailoring treatment based on these characteristics [Blatt et al. 2010]. To date, researchers have identified several patient characteristics that predict differential response to different types of treatments for a wide range of disorders.
An emphasis on affect in treatment is generally associated with positive outcomes. Encouraging patients to experience and express feelings in the session, addressing avoidance of important topics, noting shifts in mood, deepening affective experience, drawing attention to feelings regarded by the patient as unacceptable, and using fewer cognitive words in high-affect session segments all correlate with positive outcome.

References

Barber J: Toward a working through of some core conflicts in psychotherapy research. Psychother Res 19:1–12, 2009
A developmental perspective is at the heart of most psychoanalytic approaches. Indeed, the idea that psychopathology has its roots in recapitulated ontogeny is acknowledged by all genuinely psychoanalytic theories to some degree. From a psychoanalytic developmental perspective, disorders of the mind are thus at least in part understood as involving maladaptive residues of childhood experience and developmentally primitive modes of mental functioning (Fonagy et al. 2006).

This developmental perspective also defines the contours of what makes psychoanalytic approaches dynamic approaches. From a psychoanalytic perspective, both normal and disrupted development involve an ongoing series of attempts of the individual, throughout the life span, to find a balance between biological givens on the one hand and demands of the environment on the other. Hence, psychopathology, and normal and disrupted development more generally, are not seen as be-
ing a static end state but as reflecting continuing attempts, however maladaptive, to find a more optimal balance between endowment and experience [Luyten and Blatt 2011]. Development, from this perspective, entails that the individual is continually involved in a striving for allostasis, the achievement of stability through continual change (McEwen 2007). This dynamic equilibrium therefore reflects attempts of the individual to cope with developmental tasks and challenges and/or defend against painful conflictual issues.

Moreover, the psychoanalytic study of development has amply demonstrated that development not only proceeds in a linear fashion but also involves important nonlinear, qualitative shifts [Mayes 2001]. During development, the individual is faced with the task of negotiating important developmental challenges (e.g., separation and individuation, development of gender identity) that often necessitate a dramatic reorganization of psychic structures and mental functioning that cannot be simply explained by a reliance on linear models. Despite the “developmental pull” or “forward-looking aspect” of developmental processes (Emde 2005), both research and clinical practice demonstrate how, in this context, the complex interplay between biological, psychological, and environmental factors may lead to developmental disruptions that result in often rigid templates for representations of self and others in the present, thereby also precluding more adaptive developmental pathways in the future.

The inevitable confrontation with adversity throughout the life cycle (e.g., experiences of loss, failure, aging, death and dying) may furthermore seriously challenge the individual’s apparently stable state of allostasis, leading to a reactivation of hitherto “invisible” vulnerabilities, and render problematic what in the past had not been problematic through the mechanism of deferred action (i.e., that prior events take on a new meaning depending on later experiences).

These long-standing psychoanalytic assumptions concerning continual change against the background of stability are remarkably congruent with life event research that has provided impressive evidence for the role of stress and adversity in the causation of psychopathology across the life span [Gunnar and Quevedo 2007], as well as with simulation studies [Fraley and Robersis 2005] showing how important the stability of the environment is in explaining the stability of psychological features.

From a psychoanalytic perspective, it is therefore hard, if not impossible, to imagine an understanding of both normal and disrupted growth without a developmental perspective regarding ontogeny of mind. This theoretical interest is paralleled by an equally strong interest and focus in psychoanalytic treatments on the relationship between the past, present, and future. Indeed, gaining insight into the past to change how one thinks and feels about oneself and others in the present, offering the possibility for a “new beginning” (Bibring 1952), has been considered to be the hallmark of psychoanalytic treatments. Moreover, even in psychodynamic interventions that have less of a focus on the past, there is always a keen awareness of the importance and role of developmental antecedents of behavior, thoughts, feelings, and attitudes and that in the “here and now,” the “there and then” is always present.

Recent longitudinal, epidemiological birth cohort studies (Hofstra et al. 2002; Kim-Cohen et al. 2003), as well as neurobiological [Gunnar and Quevedo 2007] and genetic [Plomin and Davis 2009; Rutter 2009] studies, have provided dramatic confirmation that psychoanalysts were on the right track when they emphasized the developmental perspective in their understanding both of “normal” development and of the problems they faced with their patients [Luyten et al. 2008]. Indeed, studies suggest that in the vast majority of cases, adult psychopathology is antedated by diagnosable childhood disturbance. For instance, estimates suggest that up to 75% of adults with a mental disorder may have had a diagnosable childhood problem [Kim-Cohen et al. 2003]. Moreover, research in both animals and humans suggests, congruent with basic psychoanalytic assumptions, that early adverse experiences may program the developing stress system and associated neurotransmitter systems, the immune system, and systems involved in pain regulation, resulting in an increased vulnerability for a wide array of both psychiatric and [functional] somatic disorders [Gunnar and Quevedo 2007; Lupien et al. 2009]. Furthermore, there is a growing body of research indicating that the developing stress system is under substantial environmental control, with early as well as later attachment experiences playing a crucial role in this respect [Champagne and Curley 2009; Gunnar and Quevedo 2007; Lupien et al. 2009; Luyten et al., manuscript submitted for publication]. Finally, although still controversial, the growing evidence for so-called gene-environment correlations and interactions [the influence of genes on the exposure to certain environments and vice versa, and the synergistic interaction of genes and environment, respectively], as well as the potential role of epigenetic mechanisms [Champagne and Curley 2009] involved in the intergenerational transmission of psychopathology, has dramatically changed the nature-nurture debate and has rekindled interest in complex interactions among environmental and genetic
plasticity, change, or other critical periods across development.

Psychoanalytic developmental theories typically also have underestimated the enormous complexity of developmental processes by their overemphasis on early experience, although it must be said that several authors attempted to redress this balance. These include the work of Anna Freud (1981), who emphasized the importance of simultaneously considering different developmental lines and their complex interactions; Erik Erikson (1959), who developed an epigenetic theory of human development across the life span; and George Vaillant (1977), who was one of the first psychoanalytic investigators to embark on a series of longitudinal studies of adult development. Yet psychoanalytic theories have often been characterized by an unjustified confidence in tracing specific forms of psychopathology to specific [early] phases, examples are the link sometimes made between borderline personality disorder and the rapprochement subphase of separation and individuation, or between oedipal conflict and obsessional neurosis while neglecting other important factors. Of particular note is the neglect of the often considerable role that genetic factors, as well as chance events and stochastic processes in general, play in explaining developmental trajectories (Fraley and Roberts 2005).

Unconscious Motivation and Intentionality

Psychoanalytic developmental approaches share an emphasis on the importance of unconscious motivation and intentionality, consistent with contemporary theoretical models in neuroscience (Lieberman 2007) and cognitive science (Westen and Gabbard 2002a). This view entails a focus on the dynamics involved in development, because both psychoanalytic and contemporary cognitive science (Rumelhart and McClelland 1986) approaches emphasize the coexistence of processing units from different developmental stages, the ubiquity of conflict between these units, and the desirability of adaptive resolution of these conflicts as part of the developmental process. Attachment researchers, for instance, have provided some of the most dramatic confirmation of the unconscious dynamics associated with representations based on interactions with caregivers, influencing various stages of information processing in an attempt to cope with feelings of attachment distress and anxiety (Mikulincer and Shaver 2007).

Normal and Disrupted Development

Psychoanalytic developmental approaches aim to explain both normal and disrupted development, with a focus on factors explaining developmental disruptions (Fonagy and Target 2003). Quite unsurprisingly, therefore, psychoanalytic developmental researchers have played a key role in developing the field of developmental psychopathology, that is, the study of the development of psychological disorders (Fonagy et al. 2006; A. Freud 1974; [1973]; Lyons-Ruth and Jacobvitz 2008; Mahler et al. 1975). Yet, because many psychoanalytic developmental theories were based on work with patients and often rooted in reconstruction rather than direct observation, there has been a tendency to make unwarranted extrapolations from observations of patients to normal development. Observational studies, as well as studies of normative development, therefore continue to be vital to inform psychoanalytic theories about development and its disruptions (Fonagy and Target 2003).

Person-Centered Perspective

Psychoanalytic approaches typically consider the whole person. Rather than focusing on developmental pathways implicated in a particular disorder, a person-centered perspective focuses on the roles of equifinality and multifinality (Cicchetti and Rogosch 1996) in explaining different pathways of individuals. Equifinality, rather than assuming that there is a single etiological pathway for each mental disorder or developmental outcome, argues that there are many possible pathways toward one specific outcome. Multifinality implies that the same factors may result, depending on other factors, in a variety of outcomes. This view thus involves a shift away from disease- and variable-oriented strategies toward person-oriented research and treatment strategies. This emphasis reflects the strong embedding of psychoanalytic developmental theory in clinical practice, where the focus is always on the person and his or her developmental history rather than solely on one particular symptom, disorder, or developmental outcome (Luyten et al. 2008). On the other hand, this broad focus may have led to overly lengthy treatments that inadequately specify the relationship between particular developmental problems or disorders and technical interventions. Currently, there is a clear movement within psychoanalysis toward more specified and tar-
geted interventions that focus on specific problems and disorders in children and adolescents [Fonagy and Target 2002] and toward research that combines person- and variable- or disorder-centered perspectives.

Complexity of Development

Psychoanalytic approaches emphasize the complexity of development, with much consideration of the importance of nonlinear processes, regression and progression on multiple interrelated developmental lines, and the role of deferred action, a notion referring to the reciprocal relationship between developmental events and circumstances and their later reinvestment with new meaning [e.g., a girl realizing only in adolescence that her father’s behavior toward her as a child was clearly sexual in nature]. Hence, earlier experiences can achieve new meaning and thus influence the course of further development, even long after they have happened. This complex conception of time and causality in psychoanalysis is rarely taken into account in clinical theories or research studies. As noted, much of [early] psychoanalytic developmental theories were too linear and overspecified, linking specific disorders or developmental outcomes to specific developmental events. This only shows how difficult it is to adopt a complex developmental model in research as well as clinical practice and how easy it is to revert to more reductionistic and simplistic ways of thinking about development. Yet psychoanalytic clinicians and researchers are increasingly involved in developing more sophisticated ways of thinking about the complexity of development, following in Freud’s (1920) footsteps when he warned about attempts to predict later development from childhood to later adulthood:

So long as we trace the development from its final outcome backwards, the chain of events appears continuous, and insight which is completely satisfactory or even exhaustive. But if we proceed the reverse way...then we no longer get the impression of an inevitable sequence of events which could not have been otherwise determined. We notice at once that there might have been another result, and that we might have been just as well able to understand and explain the latter. The synthesis is thus not so satisfactory as the analysis, in other words, from a knowledge of the premises we could not have foretold the nature of the result.

...we never know beforehand which of the determining factors will prove the weaker or the stronger. We only say at the end that those which succeeded must have been the stronger. Hence the chain of causation can always be recognized with certainty if we follow the line of analysis, whereas to predict it along the line of synthesis is impossible. [pp. 167–168; italics added]

The Inner World and Its Development

Finally, psychoanalytic approaches are characterized by an unwavering focus on the inner world and its development, starting from the most primitive feelings, thoughts, and fantasies of the infant to more elaborated, differentiated, and integrated representations of self and others or internal working models of adults—their hopes, aspirations, fantasies, dreams, and fears. Whereas early psychoanalytic theorists sometimes attributed improbable cognitive abilities to infants, and often overestimated the importance of intrapsychic factors to the neglect of environmental factors, current models of the mind and its origin are becoming increasingly sophisticated and more in line with empirical findings [Fonagy et al. 2007] and provide both developmental researchers and clinicians with a detailed road map to study subjectivity and its role in both normal and disrupted development.

Historical Overview

Historically, different psychoanalytic developmental models have evolved through attempts to explain why and how individuals deviated from the normal path of development and came to experience major intrapsychic and interpersonal difficulties. The earliest models largely derived from analysts’ clinical experience, with each model focusing on particular developmental issues or phases often determined by each analyst’s specific patients and interests. Indeed, psychoanalytic developmental theories evolved, in part, as a response to the ever-increasing scope of patients seen in analytic treatments [Pine 1990]. The shift from drive-based accounts of development toward more object-relational views, for instance, aside perhaps from cultural factors, was primarily influenced by the increasing number of patients with serious personality pathology seen by analytically trained therapists. As a result, rather than the focus being intrapsychic conflicts around the drive-related wishes typical of neurotic patients, interpersonal problems and problems with regard to representations of self and
others took center stage in treatment and thus in theo-

ry. Although many of the views of these early theorists have in the meantime been shown to be incomplete and faulty in some or many respects, their contributions were without exception truly pioneering, and their often revolutionary insights have paved the way for the next generations.

Freud and Drive Psychology

It is well known that Freud’s earliest theories linked psychopathology to developmental trauma (see Breuer and Freud 1893–1895) but quickly evolved into a more encompassing developmental theory. This theory essentially proposed that psychopathology is related to failures of the child’s mental apparatus to deal satisfactorily with the pressures inherent in a maturationally predetermined sequence of drive states, leading to fixation and subsequent regression to these fixation points later in life when the individual is confronted with exo-
genous adversity, endogenous conflicts, or a combination of both [Freud 1905]. This fundamentally developmental view not only provided clinicians with a reasonably comprehensive and theoretically consistent model of development in relation to psychopathology but also paved the way for subsequent developmental approaches to psychopathology and developmental science more generally.

Importantly, and contrary to what is often assumed, Freud’s model was largely maturational, conceptualizing development as progressing along a series of largely biological preprogrammed stages (e.g., oral, anal, phallic, oedipal), with little room for the role of environmental influences. Yet in his notion of complementary series, Freud proposed a more balanced view of the role of different developmental factors, emphasizing the role of both developmental fixation points (determined by hereditary constitution as well as childhood experience) and later-life experiences [Freud 1916]. Moreover, his emphasis on the role of both infantile sexuality and aggression in childhood transformed our perception of the child and focused our attention on one of the most central developmental tasks—that is, the challenges the child faces in adapting both to the exigencies of the external world, represented first by primary caregivers, and to strong internal pressures. From early on, Freud emphasized the role of internalization in this context—how the child appropriates aspects of the environment, and particularly aspects of significant other, in the process of adaptation, thus forming prototypes and tem-
plates that influence and guide future perceptions, expectations, feelings, and thoughts—a view that clearly foreshadowed later object relations and attachment approaches.

Although Freud’s developmental model has received some empirical support (Westen 1999) and remains influential in clinical psychoanalysis, it has attracted relatively little research attention, most probably because later developmental theories have pointed to important limitations in Freud’s accounts of development. Moreover, particularly within the Lacanian tradition, psychoanalysts have moved away from a developmental view, arguing that developmental science has little relevance to psychoanalysis’s focus on the internal world (Green 2000). Moreover, Jacques Lacan’s contributions have played a major role in focusing the attention on cultural factors, and most notably the role of language, in structuring the psyche (see Chapter 16, this volume).

Ego Psychology

Following Freud’s lead, ego psychology further focused on the child’s adaptive capacities [Hartmann 1939], thereby redressing the balance of Freud’s emphasis on sexual and aggressive drives. Moreover, Heinz Hartmann [1955] pointed to the potential pitfalls of a genetic fallacy, arguing that the factors responsible for the persistence of a particular behavior may differ from the reasons for its original appearance. Anna Freud’s pioneering work in the field of child observation, and in particular her work with children in the so-called war nurseries, led her to emphasize the importance of adaptive and environmental factors. Moreover, she developed a more comprehensive developmental theory, emphasizing the notion of developmental lines and the idea that a balance between different developmental lines and processes was characteristic of normal development, whereas unevenness between developmental lines is characteristic of psychopathology [Freud 1974 (1973)], a notion still central in developmental psychopathology. She was among the first to systematically describe the development of defense mechanisms, and her views not only anticipated future research concerning trauma and characteristics, which later research described as factors involved in resilience [Luthar et al. 2000; Masten 2007], but played an important role in the origin and growth of developmental psychopathology because of her emphasis on the importance of the study of normal developmental lines (such as from normal infantile dependency to autonomy) to inform theory and interventions concerning psychopathology and vice versa.
Erik Erikson (1950), in turn, played an instrumental role in drawing attention to cultural and family factors across the entire life cycle, and his epigenetic theory of human development—and particularly his emphasis on concepts such as identity, intimacy, and generativity—continues to inspire developmental research (Cox et al. 2010; Kroger et al. 2010).

René Spitz (1959), in turn, described major shifts in psychological organization marked by the emergence of new behaviors and new forms of affective expression, which was elaborated in a highly influential series of papers by Robert Emde (1980a, 1980b, 1980c). Spitz (1945, 1965) was also one of the first to attribute primary importance to the mother-infant interaction and to describe the detrimental impact of separation, anticipating major discoveries concerning the importance of early relationships that were to become central in attachment theory (see Chapter 17, this volume).

Both Edith Jacobson (1964) and Hans Loewald (1971, 1973), although situated primarily within the drive and ego tradition, emphasized the importance of relational and intersubjective processes and particularly the importance of internalization as a central process driving development, thereby forcing a synthesis between drive and ego perspectives and the emerging object relational tradition. In the same tradition, Joseph Sandler (1976) extended psychoanalytic developmental theory through his emphasis on the internal world or representational structures, consisting of both reality and distortions of reality, which he saw as the driving force of psychic life. Moreover, he presented a more phenomenological approach focusing on feelings, such as the importance of the feeling of safety in regulating the inner world (Sandler and Sandler 1978).

Margaret Mahler’s separation-individuation theory provided another major influential theoretical developmental framework that pushed psychoanalytic developmental theories in the direction of ever more integrative accounts. Mahler and her collaborators proposed, on the basis of detailed observations and clinical work, that the development of the self and autonomy in childhood involved a series of relatively distinct phases, ranging from a phase of “normal autism” through a “symbiotic phase” to a growing separation and individuation in four subphases (Mahler 1975). Her work subsequently inspired many developmental formulations of psychopathology, most notably of patients with borderline pathology as exemplified by the work of Masterson (1972), Rinsley (1977), and Kernberg (1976). Although subsequent empirical studies questioned the existence of normal autism and a symbiotic phase (Gergely 2000), Mahler’s detailed descriptions of early separation and individuation processes still remain influential.

Object Relations Theory

Whereas traditional psychoanalytic approaches mainly focused on intrapsychic factors and greatly valued autonomy of the individual, object relations theory emphasized interpersonal factors and the key role of relatedness in human development throughout the life cycle. This view is reflected in the central assumptions of object relations theory—1) that relationships are primary, rather than secondary, to drive satisfaction as assumed in traditional drive and ego psychology and 2) that development fundamentally takes place within an interpersonal matrix and interpersonal processes have a key determining influence on development, rather than the view that development reflects a preprogrammed maturation process. As we discuss later, both perspectives would later be integrated by Sidney Blatt (2008) in a dialectic model of the development of autonomy or self-definition and relatedness throughout the life span.

The work of Melanie Klein, Harry Guntrip, and Ronald Fairbairn is generally considered to lie at the basis of object relations theory. Klein’s (1935, 1946, 1952; Klein et al. 1946) integration of a drive psychology with an interpersonal, object relations model of development has remained particularly influential. Klein’s view that individuals permanently alternate between two positions that emerge very early in development—the paranoid-schizoid and depressive—continues to provide clinicians and theoreticians alike with a fruitful heuristic theory. In the paranoid-schizoid position, representations of others and the self are split in idealized and persecutory part objects, whereas in the depressive position, relationships with whole objects dominate, and there is the ability to tolerate ambivalence, which coincides with the capacity for true empathy and concern, feelings of guilt about hostility, and the tendency for repairation. Although these ideas remain clinically useful, several of Klein’s assumptions have not withstood the test of research, particularly her attributing very complex mental abilities to very early stages in life that a child is extremely unlikely to possess.

Partly based on Klein’s views, Wilfred Bion (1957) developed a theory about the development of thinking, emphasizing the need for projective identification throughout the life cycle. Particularly for an infant, the caregiver’s mind functions as a container for these projections, and the ability of the caregiver to metabolize these unmetabolized projections through a state of ma-
Several assessment instruments for measuring self and other representations [Huprich and Greenberg 2003], as well as internal working models of self and others based on attachment theory, have been developed for children, adolescents, and adults and have resulted in an impressive research base concerning the stability of attachment representations across the lifespan [Fralley and Roberts 2005; Sroufe 2005; Waters et al. 2000], their role in explaining vulnerability to psychopathology [Cassidy and Shaver 2008; Fonagy et al. 2008; Gunmar and Quevedo 2007], the intergenerational transmission of psychopathology [Fonagy and Target 2005; Grienberger et al. 2005; Slade et al. 2005], their role in current (romantic) relationships [Mikulincer and Shaver 2007], and their influence on the therapeutic process [Daniel 2006].

Moreover, the confluence of psychoanalytic formulations regarding the importance of mentalizing (i.e., the ability to understand the self and others in terms of mental states) and psychodynamic attachment research within this tradition has specifically contributed to the understanding of the developmental origins and intergenerational transmission as well as treatment of serious disruptions in the development of the self and associated personality pathology [Fonagy and Luyten 2009; Fonagy et al. 2010; Levy et al. 2006; Lyons-Ruth et al. 2007]. It has also led to a growing number of treatments and intervention strategies [Bateman and Fonagy 2010; Twemlow et al. 2005a, 2005b] for other problems and conditions, including early intervention programs for vulnerable mothers [Slade 2006; Suchman et al. 2010].

Self Psychology

Self-psychological perspectives emerged in large part because of a perceived need to provide clinicians with a more phenomenological, experience-near language to describe the development of the self and its disruptions. The work of Heinz Kohut [1971, 1977, 1984; Kohut and Wolf 1978], in particular, largely based on his experiences treating narcissistic patients, emphasized the importance of the “mirroring function” of parents in relation to the need for age-appropriate mirroring of feelings of self-worth, ambition, and grandiosity. According to Kohut, in normal development, such mirroring, in combination with age-appropriate frustrations of narcissistic needs, leads to a relatively stable and essentially positive sense of self and realistic ambitions through a process of what he called transmuting internalizations. Hence, beginning with caregivers, others must serve in part a function as self-objects, and phase-appropriate frustration of the child’s needs for grandiosity and ambition permits a gradual modulation of infantile omnipotence through a transmuting internalization of this mirroring function and the gradual consolidation of the nuclear self [Kohut and Wolf 1978]. Yet when such frustrations happen too early and/or are too intense, problems in self-structure remain and are typically expressed in narcissistic pathology.

Although Kohut’s model also puts too much emphasis on the environment to the neglect of other factors, his focus on the importance of early attachment figures treating the child as a psychological agent with wishes, desires, and ambitions is congruent with research on the importance of parental reflective functioning and attachment research more broadly [Fonagy et al. 2007]. However, with some important exceptions [Banai et al. 2005], the vast potential of self psychology remains largely untapped in research, and the legacy of self psychology currently lies first and foremost in providing a model for the understanding and treatment of narcissistic pathology. Self psychology moreover proposes a close parallel between the development of narcissism and its treatment by suggesting that treatment should lead to a reactivation of narcissistic wishes for idealization and admiration and to the unfolding of various self-object transferences. Because of the analyst’s empathic mirroring attitude, these transferences now, in contrast to what happened early in development, provide a context in which new, more mature, transmuting internalizations may develop, leading to a restoration of the self.

Contemporary Integrative Approaches

This review, however incomplete, illustrates both the rich potential and the increasing integrative trends within psychoanalytic developmental approaches (e.g., Tyson and Tyson 1990). Whereas many early theories were relatively overspecified, more contemporary integrative views, as noted, offer more sophisticated views of development that are also more in line with contemporary developmental psychology and psychopathology research [Fonagy and Target 2003] as well as behavior genetics and neurobiological research [Mayes et al. 2007]. Not surprisingly, this has also led to an increasing number of more focused, developmentally in-
formed interventions, although the evidence base for psychoanalytic treatments for children and adolescents is lagging far behind those for adults and particularly for other treatment approaches more generally [Fonagy et al. 2006].

At least two factors have influenced contemporary integrative trends in our view. First is the growing interest of psychoanalysts in theories outside of psychoanalysis, most notably attachment theory which forced psychoanalytic developmental theories to consider the complex interplay of biological, psychological, and sociological factors in development. Second is the growing influence, both explicitly and implicitly, of empirical research on psychoanalytic theory, which has led to a rather dramatic shift in the nature and scope of psychoanalytic developmental theories.

Daniel Stern’s [1985] work, for example, has been a milestone in carefully distinguishing between theories and research concerned with normative versus disrupted development and developmental theories that were based on prospective observations versus on retrospective reconstructions. His detailed views about how the self develops in the context of interpersonal relationships reflecting increasing levels of self-organization and subjectivity (the emerging self, the core self, the subjective self, and the narrative self), as well as his notion of “schemas-of-a-way-of-being-with,” have set a new standard for psychoanalytic developmental research and theories. Moreover, the clinical usefulness of his views has convinced many within the psychoanalytic community of the potential of research findings to inform clinical practice [Stern et al. 1998]. Furthermore, as we discuss in more detail later, his views have paved the way for a more balanced view of development as proceeding through a dialectic interaction between autonomy and relatedness rather than emphasizing either autonomy (e.g., as in traditional Freudian drive theory) or relatedness (e.g., as in attachment theory) [Blatt 2008].

Because a comprehensive overview of recent psychoanalytic developmental research is far beyond the scope of this chapter [yet see Mayes et al. 2007], we illustrate the scope of current psychoanalytic developmental research using a number of recent research programs inspired by psychoanalytic developmental theory—that is, theory and research concerning 1) autonomy and relatedness and the intergenerational transmission of depression, 2) attachment, mentalization, and origins of the self, and 3) parental preoccupation and the neurocircuitry of parenting.

**Autonomy and Relatedness and the Intergenerational Transmission of Depression**

In a remarkably synthetic effort, Blatt and colleagues (Blatt 2008; Blatt and Shichmann 1983) integrated psychoanalytic developmental approaches that focused either on autonomy and separateness (i.e., traditional drive theory) or on dependency and relatedness (e.g., attachment theory) by arguing that development across the life span proceeds through an hierarchical synergetic dialectic interaction between issues of self-definition and interpersonal relatedness—the development of a realistic, essentially positive, and increasingly integrated sense of self and identity and the development of the capacity to establish increasingly mature, reciprocal, and satisfying interpersonal relationships. An adequate balance between relatedness and self-definition is assumed to contribute to an evolving sense of autonomy and identity that, in turn, facilitates the establishment of stable interpersonal relationships; excessive emphasis on either one of these dimensions to the neglect of—or as a defense against—the other, predisposes individuals to psychopathology. Two clusters of psychopathology are thus distinguished: 1) an *anaclitic* cluster, characterized by high levels of interpersonal dependency, in which conflicts with regard to relationship issues dominate to the neglect of self-definition, and 2) an *introjective* cluster, characterized by high levels of self-critical perfectionism, in which conflicts with regard to self-definition predominate to the neglect of relatedness.

This model not only has generated an unusual amount of research on vulnerability for psychopathology in adults, and depression in particular, but also has inspired much developmental research, including research on the transition to parenthood and the intergenerational transmission of depression [for summaries, see Besser et al. 2008; Blatt 2008; Blatt and Luyten 2009]. Congruent with a combination of person-oriented and variable-oriented perspectives typical of contemporary psychodynamic developmental approaches, rather than focusing on discrete descriptive categories such as postpartum depression alone, these studies have focused on developmental analyses of adaptive and maladaptive outcomes in the transition to parenthood based on a broad model of normal and disrupted development. In keeping with clinical psychoanalytic writings, based on Blatt’s model, the transition into parenthood can be con-
terms of activation at 2–4 weeks that are comparable to those of first-time parents at 3–4 months, a finding that may suggest sensitization of parental attachment circuits by first-time exposure to the responsibility of caring for an infant [Swain 2008; Swain et al. 2007]. Overall, it appears that there may be significant differences between parental responses to infant cues, that experience with infants may consolidate neural circuitry, and that for first-time parents there are key changes in reward-stress circuitry in the first months postpartum. Hence, this emerging body of work clearly suggests that there is converging work from a range of other fields that is relevant to Winnicott’s hypotheses regarding a shift in parental mental state in late pregnancy through the early postpartum months. Future research in this area promises to enrich both psychoanalytic developmental theories and intervention programs [Suchman et al. 2010].

Development and Therapeutic Action

As noted, a developmental focus is also central in psychoanalytic treatments. Indeed, a common feature of all psychodynamic treatments is their focus on how the past influences the present and the future in myriads of multifaceted ways. Moreover, many parallels have been proposed between the therapeutic process itself and normal developmental processes, including the idea that psychoanalytic treatment may involve, in some form or another, a corrective emotional experience [Alexander and French 1946] leading to fundamental changes in personality structure, sometimes defined in terms of a transmuting internalization [Kohut 1977; see also Emde 1988, 2005; Loewald 1960; see also Chapter 14, this volume]. This tendency has been further reinforced by the move away from a one-person to a two-person psychology within psychoanalysis [i.e., from the view that a patient is analyzed by an analyst to a focus on interactive processes between patient and therapist that unfold over time] [Luyten et al. 2011]. Recent theoretical formulations within psychoanalysis seem to emphasize, even more strongly than in the past, the importance of developmental factors and findings for conceptualizing the nature and treatment of psychopathology.

However, this view also entails a number of dangers, particularly when it is based on a naive rather than informed use of developmental theory and developmental metaphors [Mayes and Spence 1994]. It must be clear that the psychoanalytic process involves more than a recapitulation of developmental processes. There is increasing consensus that psychoanalytic treatment, and particularly more intensive forms of psychoanalytic treatment, involve the reactivation of “ways of being with” others in the context of a therapeutic relationship (transference). This does not merely imply a re-experiencing, it also involves and provides the basis for new ways of thinking and reflecting about the self and others (mentalizing), leading to changes in representations of self and others and more adaptive ways of dealing with conflict and the unavoidable calamities of life. Various authors have described these processes, which involve the possibility of a “new beginning” [Balint 1952] in terms of core conflictual relationship themes, self-object dyads linked to specific affects, representations of self and others, internal working models, or interpersonal affective foci rooted in earlier experiences, that are reactivated within the therapeutic relationship and can then be examined, revised, and worked through. Yet again this entails not a mere recapitulation of these self-object dyads, because they are constantly influenced by contemporary factors and most notably by features of the analytic setting and the therapist [Westen and Gabbard 2002b]. Hence, rather than assuming that psychoanalytic treatment, and the transference in particular, is a recapitulation of development, a dialectic view seems more appropriate, with the past influencing in many complex ways and in interaction with contemporary factors experiences of engagement and disengagement, of attachment and separation, of gratifying involvement with others, and of incompatibility with aspects of that involvement in the treatment process [Blatt and Behrends 1987]. From this perspective, the psychoanalytic process involves the reactivation of the normal synergistic developmental process in which interpersonal experiences contribute to revisions in the sense of self that lead to more mature expressions of interpersonal relatedness that in turn contribute to further refinements in the sense of self [Blatt et al. 2010].

This focus on changes in mental representations of self and of others in the treatment process provides an exciting area of overlap and interchange between psychoanalysis and social cognitive neuroscience that seeks to understand the “processes that occur at the interface of self and others” [Lieberman 2007]. Moreover, this view is consistent with a broad developmental perspective as articulated in the so-called developmental origins of health and disease paradigm, which originated in biological science [Gluckman et al. 2009]. This paradigm fun-
• Contemporary psychoanalytic developmental models offer more sophisticated accounts of origins of subjectivity and its disruptions that are also more in line with contemporary developmental psychopathology and neuroscience.

• The analytic process can be conceptualized, in part, as a reactivation of normal developmental processes (i.e., a “new beginning”) through the reactivation of representations of self and others or internal working models that can be examined, revised, and worked through in the context of the therapeutic relationship.

• There is an increasing number of developmentally informed interventions for specific problems based on psychoanalytic developmental formulations.

References


Besser A, Prieb B: The apple does not fall far from the tree: attachment styles and personality vulnerabilities to depression in three generations of women. Pers Soc Psychol Bull 31:1052–1073, 2005


Psychoanalysis and the Neurosciences

David D. Olds, M.D.

This chapter might be more usefully titled “An Interdisciplinary Approach to a Brain-Centered Model of the Mind.” In this discussion I make use of several disciplines in the realm of neurological, psychological, and evolutionary sciences. This multidisciplinary approach can provide us with a broad and hopefully accurate picture of the ways in which the various brain sciences are being integrated to create a comprehensive picture of the workings of the mind, particularly the psychoanalytic mind. I focus on the brain sciences—what we might call the studies of the biological infrastructure of mind—rather than the output disciplines, which would include the arts, culture, and indeed science itself, sometimes called applied psychoanalysis or the psychoanalytic understanding of human culture.

The roots of this integrative set of disciplines go back at least to Greek and Egyptian philosophical and medical theories attempting to relate mind and body. More recent sources emerge from Renaissance and later European philosophers, including Kant and Descartes, and the setting of the controversy between dualism and monism. Within the history of psychoanalysis, the crucial figure is of course Freud, who is well known to have begun his theorizing as a neurologist and to have been ambitious to ground the psychology he was developing on a sound scientific neurological foundation [see Chapter 1, this volume].

After Freud turned to a more phenomenological study of the mind and developed metapsychological theories conceptually isolated from brain science, psychoanalytic theories took on lives of their own. A profession evolved in which the founding fathers and later important theorists became by and large isolated from the experimental scientific world, ultimately generating theories that could stand on their own within the psychoanalytic profession and could support that profession in a position independent from general science and from the prevailing winds of academic psychology.
form, the method the neurologists pursued—called the clinico-anatomical method—related neurological symptoms to dysfunction in specific areas in the brain, such as Broca’s aphasia in the left prefrontal cortex, which leads to the inability to produce language and speech, and Wernicke’s aphasia in the posterior, superior temporal cortex, which causes an inability to receive and understand language. For the early masters, the localization could only be done at autopsy, and this method produced an increasingly accurate map of major brain areas and functions. Karen Kaplan-Solms and Mark Solms (2000) wrote a basic text of neuropsychoanalysis that described cases with neurological lesions in which the authors examined patients using a psychoanalytically oriented interviewing method. These patients showed that their fully realized syndromes included both their neurological deficit—caused by brain damage—and a psychological response to that deficit that could be examined and understood using a psychodynamic approach. By this time neuroimaging techniques had improved so that the brain damage involved in the syndrome could be visualized in living patients. This kind of research has continued and has provided psychodynamically enriched pictures of neurologically impaired patients. This research has also given rise to a cadre of analysts who are taking on the long-term, analytically oriented therapies of neurological patients who in the past would have been of no interest to analytic clinicians. This kind of therapy is in its infancy, but there is a growing interest at some analytic institutes. Research in this area has been done largely by people within the neuropsychoanalytic group. (For examples of the literature in this vein, see Feinberg 2005, 2010, Kaplan-Solms and Solms 2000, Solms 1997b, 2000b, Solms and Saling 1986.)

We might say that while this first path brought psychoanalysis to the neurologists, the second is bringing neurology to the psychoanalysts. This route has been taken by analytically oriented therapists who want general neuroscience information about how the brain and the mind work. They are more interested in how the healthy as well as the neurotic mind operates and how psychoanalytic therapies affect the brain. This trend is more about advancing theory and is devoted to the education of analysts to help them find a neuroscientific foundation for psychoanalytic theory and practice. These analysts make up a large and growing group, and many of the presentations at the international congresses and the local group meetings of the society are of this kind. The research that is valued in this endeavor comes mostly from other fields outside the psychoanalytic establishment, including neuroscience, cognitive psychology, evolutionary psychology, primatology, and anthropology. Papers from neuropsychoanalysts are often reviews of the research in these neighboring disciplines that aim to integrate such work with psychoanalytic concepts (Pally 2000; Panksepp 1998; Peterson 2005; Schore 1994; Shevrin et al. 1996; Solms and Turnbull 2002).

As part of this educational effort, psychoanalytic institutes have created courses that integrate psychoanalysis with neuroscience and other disciplines. At psychoanalytic congresses there are invited speakers from among the neighboring sciences. In addition, the American Psychoanalytic Association, which has had seminars that include neuroscientists, now has an ongoing study group with about 30 members who are devoted to advancing theory, supporting research, and helping institutes with their educational endeavors.

Neuropsychoanalysis has been working in parallel with the branch of philosophy called neurophilosophy by one of its early writers, Patricia Churchland. The philosophers, such as Churchland (1986), Daniel Dennett (1991), and John Searle (2002), themselves dealing with the higher functions of the mind, began to see the need for understanding their biological underpinnings; their effort, like neuropsychoanalysis, is a growing endeavor. In the history of psychoanalysis, we may be approaching the point at which there is a body of brain science that can serve as a theoretical foundation for it and its clinical practice.

Two Approaches to the Integrative Effort

The subject of interdisciplinary brain science is massive, and in a textbook chapter such as this, it can only be sampled. Kandel et al.’s (2000) magisterial textbook itself contains more than 1,300 pages and still leaves much uncovered. I provide two examples of the kind of thinking we might use to help integrate brain sciences with psychoanalysis, attempting to describe some of the things being done of interest to analysts. One example is a discussion of the more general effects of integrative efforts on the practice of the analytic psychotherapies. The other is the project of taking a term central to analytic thinking and discussing it using information from the neighboring disciplines.
As shown by Caspi and Moffitt (2006), the gene may have less of a stranglehold on our destiny than has been assumed through the past century. The authors set out to explore the relationship between genes and environment in the generation of adult pathology. They followed a prospective sample of 1,037 families in Dunedin, New Zealand, evaluating the children in these families every 2 years from birth until age 26. A subgroup of the children carried a gene coding for monoamine oxidase A [MAOA] that was a variant from that of the majority. Of the population under study, some of the children had been seriously physically abused by their parents. Either the gene theory or the environment theory might predict that those children would become violent abusers. However, it turned out that those who had been abused and had the variant MAOA gene were more likely to become sociopathic and violent as adults, whereas those who did not have the genetic variant were not more likely to show such behavioral tendencies. Those with the variant gene who grew up in nonviolent homes were also not more prone to violence. Here we have three sciences collaborating: epidemiologists following a substantial sample of a population and recording who develops what sorts of psychopathology, neuroscientists measuring the levels of certain neurohumors, and geneticists discovering the differences in DNA sequences in the two populations—in this case the groups who are more likely to develop into violent sociopaths and those who are not. Note that this is not direct cause and effect. The children with both the variant gene and the history of abuse do not all become violent, but they are more likely to do so than the nonvariant and nonabused subjects.

In another study of the epidemiology of depression (Caspì et al. 2003), the authors arrived at analogous findings; they showed, in the emergence of depressive disorder, an interaction between a genetic difference in the promoter region of a serotonin transporter gene and stressful life events. Individuals with one form of the gene showed a greater tendency to become depressed after a major life stress than did those with the alternate form of the gene. Thus, the emergence of the depression was more likely when both the gene variance and the stressful event were present. Thus, this study corroborates the contemporary psychoanalytic view that the gene is only partially determinant of the child’s future, the environment plays a crucial role (Hoffer, in press). Even for those who have suffered severe early childhood abuse, these interdisciplinary studies suggest the efficacy of therapeutic work as part of a wider treatment plan. Psychoanalysts once were reluctant to take on patients who had been severely trauma-

tized, but new research drawn largely from the brain sciences now provides some evidence that in many cases psychotherapy can be beneficial.

Conscious and Unconscious Processes

The subject of consciousness has received attention from many philosophers and neuroscientists in recent years. Neuropsychoanalysts such as Solms (1997b) and Pally and Olds (1998) have written reviews using information from several disciplines. In the case of consciousness, we are using input from neuroscience about the “neural correlates of consciousness” (Koch 2004; Tononi 2008), from neuropsychologists and philosophers about the nature and properties of the phenomenon (Damasio 2010; Dennett 1991); from neuroanatomists about locations and interactions of contributing parts of the brain (Horstman et al. 2010), and from evolutionary psychologists about the historical species development of consciousness (Barkow et al. 1992, Evans and Zarate 1999, Ornstein 1991).

Probably of even more interest to analysts is the unconscious and its study, from Freud through the work of current branches of science. Although much remains to be explored about unconscious processes, which by definition are hard to operationalize and measure, a broad range of work has emerged in cognitive neuroscience in recent decades about unconscious mental processes and subliminal perception (Bargh and Chartrand 1999, Berlin 2011; Shevrin et al. 1995).

Research in this realm has evolved into two major streams. The more predominant early work in academic research focused on the massive amount of normal work the brain does outside of awareness, usually called the cognitive unconscious. This work dealt with subliminal stimuli, priming, and other forms of implicit learning and memory. It tended to ignore the emotional aspects of learning and of unconscious defensive process, named by Freud and later psychoanalytic researchers as the dynamic unconscious. This term gave credit to the notion that many things are segregated from consciousness by defensive processes designed to help the individual avoid conscious pain.

Cognitive and Dynamic Unconscious

It is now generally accepted that most of the brain’s work is done outside of conscious awareness. Most of the body’s metabolic and homeostatic control mechanisms are automatic and completely out of aware-
ness. No awareness is required to maintain one’s glucose balance, to maintain one’s posture and walking, or even to construct a spoken sentence. Most of the procedures in our behavioral repertoire are in our procedural memory system. In all of these processes, we are unaware until there is a problem, and then consciousness intervenes.

Most of these processes of everyday life are included in the cognitive unconscious, the sort of unconscious that does not permit our mental housekeeping without much attention from us. Research in this area began with the discovery that certain kinds of stimuli do not reach awareness: stimuli of too-short duration, stimuli of insufficient contrast, or stimuli followed by a stronger stimulus that “masks” the earlier stimuli. In priming experiments, a stimulus word or other symbol is presented to a person so briefly or faintly as to escape awareness. Subsequently it can be shown that the “subliminal” stimulus content influences later thought or behavior. Another way in which stimuli can be rendered subliminal is in the case of cortical deficits. For instance, a patient who has damage to the cortical center of vision in the occipital cortex and who considers himself blind, having no awareness of seeing anything, may be able to walk across a room avoiding obstacles that are in the way. The early research into unconscious processes by cognitive scientists tended to focus on the nonemotional side of brain processes. More recently, psychanalytically oriented affective neuroscientists turned their research attention to the influence of emotion on what would be banned from consciousness, thus differentiating the dynamic unconscious from the previously explored cognitive unconscious. Similar experiments can show how the workings of the dynamic unconscious, in which emotionally charged and subliminally presented words are treated differently from neutral words [Anscombe 1986].

In almost all the experiments of this sort, the mechanism seems to be a dual channel of perception, with one channel being outside of consciousness—because of subliminal presentation, masking, or cortical deficit. An example of the dual channel is a study by Winkelman et al. (2005) that showed that when normal subjects were subliminally exposed to pictures of happy or angry faces, they were unaware of the faces or of any emotional reaction. However, when they were later in the presence of an available beverage, they would drink more of it and even pay more for it if they had been exposed to the happy faces. These examples resemble LeDoux’s (1996) description of the dual channel for danger perception: a person walking in the woods may see a curved stick and react reflexively, jumping away as though it were a snake, only a few seconds later becoming conscious of the perception, the fear, the reaction, and the fact that the stick is or is not a snake. In this case it is hypothesized that there is a short limbic circuit through the thalamus to the amygdala, followed by the longer circuit that includes the visual cortex. There are many examples of this kind of phenomenon in which one unconscious channel carries affective, evaluative information that motivates or modifies our behavior or our subsequent thoughts too quickly or indistinctly for awareness.

In addition to these cognitive mechanisms that render many of our decisions unconsciously motivated, we have defense mechanisms whose purpose and evolutionary value lie in keeping things from our awareness. Repression, for example, is a defense that functions to unconsciously remove painful, anxiety-generating, or even anger-generating thoughts and memories from the conscious mind. The use of the defense is itself unconscious, and it works to also maintain obliviousness to the painful mental content. For Freud and all psychoanalysts, the dynamic or motivated unconscious is the foundation stone of the discipline, probably the most clear-cut defining aspect of psychoanalysis, differentiating it from all other types of psychotherapy. Motivated forgetting, by way of defense mechanisms, becomes part of the behavior, the symptoms, the fantasy life, and the personality structure.

How has research that has elucidated and shown features that may contribute to the brain mechanisms of the dynamic unconscious affected psychoanalysis? One important result has been that the very existence of unconscious processes is beginning to be validated. Much of the history of psychology has involved denials and refutations of these processes. Now that we are engaged in demonstrating their existence, we may be able to continue to develop psychodynamic treatments that acknowledge and make use of the unconscious. Furthermore, insofar as the science that is elucidating unconscious processes is providing valid information, it may help define the population of patients who will do better in a psychodynamic treatment than in other more cognitively or behaviorally oriented therapies.
duce a verb, an action word such as “walk” or “climb,” engages the premotor cortex. In other words, a verbal concept of a motor act includes a premotor activation. In order to perceive an action and to symbolize or speak of an action, we draw on the frontal motor part of the brain. The mental representation of an action is a holistic or integrated concept of a piece of behavior; this may be at the same level of complexity as the concept of an object. One striking finding that was noted early on was this: the mirror neuron activation occurs when the action has a purpose. Simply moving one’s hand with no obvious aim will not give rise to the mirror reaction. Thus the intention of a behavior is quite important and is an essential part of what is perceived as an action.

Another major process that is likely to be biologically closely related to identification is empathy. Recently emerging from this research is the finding that the appreciation of affects functions in a similar way. Imaging studies show that observing another’s emotional state activates the same areas that light up when one has that emotion oneself [Carr et al. 2003; Decety and Chaminade 2003; Gallese et al. 2004; Leslie et al. 2004].

What is striking about these experimental findings is that perception has more to it than iconic representation. Perception is “being there.” Especially with interpersonal perception and recognition, one does not simply see. One becomes and acts. In this model the visible actions and expressions of the other seem to some extent invasive and automatic. One replicates or simulates the external world internally and involuntarily, and only in this way can one understand.

Since the initial research on mirror neurons, these entities have become understood as components in larger systems, sometimes called shared circuits—system that include the original premotor neurons and elements in the parietal and temporal cortices [Hurley 2005; Pally 2010].

The mirror neuron system and the simulation model of perception would be expected to contribute to our thinking about the use of the couch in psychoanalytic therapies. Although the use of the couch has been a defining factor in the history of psychoanalysis, there has been little research to either justify or criticize the practice. A review by Schacter and Kächele (2010) concluded that there is no justification for the reclining position as the default mode in analysis and that there is no research showing that the couch makes any difference in therapeutic outcome. Arguments for the use of the couch have to do with the freeing of free associations and allowing a comfortable, relaxed state in both the analyst and the analyst. Arguments against it usually invoke the need for a more nurturing, interactive relationship, countering the patient’s essential loneliness, as well as the naturalness of the vis-à-vis interaction, which is the mode of most human conversation. The mirror neuron phenomenon could suggest against the couch for some patients because of the vast amount of nonverbal communication and influence derived from the simulationist experience. However, this same model would argue that the couch removes the intrusive mutual control being unconsciously enacted between two people in visual contact and therefore enables free association. If the analyst really wants to encourage free association, this could be a reason for using the couch.

Another argument in this same vein comes from the discussion of subliminal stimuli, which we are constantly exposed to in our normal experience. Many of the flashes of emotion that cross the face of an interlocutor are brief and may not be consciously perceived, but the mirror system apprehends them automatically and unconsciously, and they unwittingly influence the next thoughts to come. On the couch, with the analyst out of visual contact, a patient is relieved of this influence on associations from the analyst’s face.

Study of Other Psychoanalytic Concepts

In summary, we have two ways of assessing the outcomes of the dialogue between neuroscience and psychoanalysis: first, the effects of other sciences on psychoanalysis and its practice; second, the attempt to correlate a complex psychoanalytic concept with data and perspectives from other sciences. In both cases it seems that psychoanalysis, long reluctant to intentionally look outside its boundaries, has absorbed a mass of information from other sciences and clearly stands to gain conceptually in the future. Other psychoanalytic concepts will gain credibility and added heuristic potential by such multifocal viewing, some of which has begun. Interdisciplinary papers have begun to illuminate some major theoretical constructs: consciousness [Berlin 2011; Pally and Olds 1998; Solms 1997a, 2000a], dreams [Solms 1997a, 2000a], and transference [Pincus et al. 2007]. Building on the foundation of this “importing” into psychoanalysis, we analysts can in return make contributions to the general fund of knowledge of brain and mind.
Value of Interdisciplinary Work for Psychoanalysis

To the surprise of almost no one, there has been resistance and hostility toward this powerful advance of the integrative scientific approach. There is a solid history of thoughtful writers who have emphasized the need to maintain a separation between the analytic discourse and other sources of information from biological research, even from the patient’s personal history [Edelson 1984]. Peter Wolff (1996) famously declared, “All that is relevant for psychoanalysis must come from the couch.” These contentions represent a version of a recurrent dispute among psychoanalytic thinkers, earlier described as the debate about whether psychoanalysis is a scientific or a hermeneutic discipline [Rees 2007; Ricoeur 1977].

Another current argument raising skepticism of neuroscientific approaches holds that we are not yet ready to use them to understand psychoanalytic concepts. Much of the information is being gathered by brain imaging techniques, and the correlations between their findings and relevant mental phenomena are loose and may even be misleading [Vivona 2009]. There is some truth in this, and it is a caution against premature explanations.

A still more extreme negative view is the argument that neuropsychoanalysis not only is irrelevant but undermines and damages psychoanalysis. Criticisms from this direction are that 1) neuropsychoanalysis is irrelevant to psychoanalysis; 2) it is nonanalytic because it deals only with the physical brain and not with meaning, and meaning is what analysis is about; and 3) it is dangerous to psychoanalysis because it leads us down the wrong path, a path where only the biological is real and the meaning-making in psychoanalysis is ignored, thus misdirecting and impoverishing psychoanalysis [Blass and Carmeli 2007]. The theoretical stance supporting these arguments is a thoroughgoing dualism. This position sees meanings and neuronal and bodily processes as necessarily separate. Many who hold this view will agree that a brain is required to make meanings but that once made, the meanings float clear of the physical. In this view, two people interacting, including an analytic pair, are using their brains to express meanings—their thoughts, intentions, and emotions. The receiver accepts the verbal and nonverbal information from the other and responds on the same language and nonverbal level with no concern for the brain processes involved. Any conclusions about such brain processes are irrelevant and misleading to psychoanalysis.

There are at least two counterarguments against this position. The first is a factual one: there is a two-way street between meanings and physical phenomena; not only do brain changes alter mental output, but mental changes—as in therapy—also make changes in the brain [Etkin et al. 2005; Gabbard 1998; Kandel 1979; Westen and Gabbard 2002a, 2002b]. For instance, therapy for obsessive-compulsive disorder makes brain changes that correlate with clinical improvement [Baxter et al. 1992]. It is also generally accepted that mood states such as depression and anxiety influence the course of a meaning pattern. For example, with depression one can expect more meanings referring to pessimistic outlook and low self-esteem.

The other counterargument is more philosophically based: the nature of causality when we appeal to neuroscientific explanations. First, there is no real alternative to the idea that all mental activity arises from neural brain activity. However, it is becoming clear that meaning-making itself produces changes in the brain and that there are multiple and complex feedback loops between the brain and its own outputs on many levels. The structure that we must contemplate in order to imagine how the brain functions in a deterministic manner is so complex that it no longer works on linear billiard ball principles. Every mental phenomenon is the result of such complex neuron system activations that in order to impose a rational causal explanation, we need non-linear causality. Nonlinear, or dynamic, systems can describe mechanisms of extreme complexity, which include the brain activities associated with mental phenomena. Such systems are subject to the assumption of psychic determinism—the principle that no psychic events are uncaused—but it is also accepted that because of the complexity of the system, they are not completely predictable. A person’s behavior has a certain consistency, enhanced by character structure and often by pathology such as depression or compulsive disorder, but this is not absolute. The comparison has been made to climate and weather. We can presume that in the United States it will be warmer in July than in February, but because of the huge number of variables in the system, the actual temperature a year from now cannot be accurately predicted [Galatzer-Levy 2002; Harris 2004; Piers 2005].

One aspect of the complexity of the mind-brain system is that one thing can represent another. This is common to all biological systems, and it is the way information is transferred. It also can explain how hierarchical levels exist and interact in all living systems. As we go up the evolutionary and complexity ladder, we have different levels of meaning in informational structures. It is
important to realize that there are meaning systems on every level of the biological hierarchy—at the level of DNA/RNA, protein synthesis, enzyme formation and function, neuron networks, anatomical units in the brain, human action and its semiotic significance, language, and cultural artifacts. In this way of thinking, phenomena at different biological levels transfer information between levels of representation to higher biological and mental strata [Litowitz 1990, Olds 2000].

Dual Substance or Dual Aspect

Viewing the mind-brain as a dynamic nonlinear system with multiple levels of representation provides support for a model of mind known as dual-aspect monism. This philosophical theory claims that there is only one brain and only one kind of material substance, but it can and must be understood from two different “aspects” or points of view. One aspect is the subjective view wherein one becomes aware of what one is thinking, feeling, planning, or intending by introspection, or “looking inside one’s self.” In the context of interpersonal discourse, a person introspects and then tells someone about it. This telling, as in analysis, is received by the other, who may understand it in different ways and even interpret it as to its underlying unconscious motivations and intentions. The analyst’s interpretations will themselves have contexts, such as a particular theoretical model and what is already known about the patient’s family, history, and environment. A second aspect is objective, in which we inspect the brain and its functions from the outside. This can involve observing a person, taking measurements, or using imaging and electrophysiological instruments [Solms and Turnbull 2002]. A dualist would hold that only the introspective approach yields meaning, through expression in language and other nonverbal channels. However, every step of the way we must be aware—now that we have some of the tools so that we can be aware—that there are influences on those meanings from brain changes, including those from the aftermath of trauma and subtle attention or cognitive deficits from mood disorders, as well as from personality or character.

Dual-aspect monism avoids reductionism in the usual sense. It might instead be called a “multi-contextualism” in which we have the freedom to look at many levels. Any human thought, act, or pattern of action exists in such a multileveled context, and understanding often requires the integration of several levels. Awareness of this mode of thinking is less unusual now than in the past.

The psychological sciences have passed through the polarized thinking of strict dualism (meaning and brain function are categorically separate) to simple reductionism (anxiety is nothing but amygdala activation), to behaviorism with its inscrutable black box (all is externally measurable stimulus-response patterns), to cognitivism (cognitive patterns are the main target), to current psychodynamic theory (investigation of the conscious and unconscious mind is the focus). We may now be on the verge of a more heterodox way of thinking—a consilience of points of view within a monistic paradigm.

Consilience

In recent decades we have seen two major forms of consilience [Wilson 1998; Valone 2005], or coming together of disparate disciplines, that are profoundly changing the ways we think about the mind and about psychoanalysis. One form is the awareness of the inseparability of mind and the multileveled brain. Interestingly, as the other sciences revealed much about the multiple levels at which we can understand the brain, psychoanalysis was already going beyond oedipal phenomena and making use of the multiple points of view from many sources, developing several different schools of psychoanalytic thought. Although some feel that this has led to splintering and loss of focus in our profession, it is arguably a healthier and more informed appreciation of the complexity of the human mind. In adopting the multiple psychoanalytic models, we have taken on the task of explaining components of the models—the preoedipal aspects, the attachment issues, the object relations, the mood disorders, the attention deficits, the trauma, the genes, and more. Each of these models and each of their components manifest themselves in complex meaning structures expressed verbally and nonverbally by patients and understood by patients and analysts. They also are understood at several levels of functioning of the brain and body. For instance, if one is considering an attachment model with respect to a person, one may think about and integrate the person’s separation anxiety, the verbal expressions as well as facial and bodily signals, and the measurable physiological aspects, including contributions to serious dysregulation and disease processes [Schore 2001]. Our own psychoanalytic community, with each new generation, becomes more open to such a culture in which meanings and underlying brain processes are integrated (for review, see Stepansky 2009). This first
consilience has helped us to begin integrating the multiple levels at which we can understand an individual human being.

A second consilience may help us understand the relations between human beings. As psychoanalytic theory evolved in the last century, it changed from the so-called one-person model to an appreciation of the dyad. In self psychology and object relations theories, interpersonal sensitivities became increasingly acknowledged, and a more dyadic model for the analytic encounter emerged. In developmental theory, including the infant observation studies of Stern (1985) and Beebe and Lachmann (1994), there was more attention to the self, emerging from the mother-infant interaction over time. The research videos of such interplay valuably explicate Winnicott’s (1947/1964, p. 88) dictum, “There is no such thing as a baby.” The subtle turn taking and attunement bi-play give dramatic evidence of the infant’s developing a self out of the dyadic interaction. This research in turn gave support to the emerging school of relational psychoanalysis, where there is an avowed interaction between analyst and patient that is much more active than in other methods.

While interpersonal and intersubjective models were transforming analytic theories, the brain scientists were explicating different mechanisms for the interactions between subjects, including the mirror neuron results from the neuroscientists, described earlier, that give us a deeper layer supporting this interpersonal, intersubjective trend in understanding the human psyche. With this simulationist model, the dialogue between mother and infant, analyst and analysand, indeed any two people, takes on a nonverbal, mostly unconscious, implicit nature that is involuntary and instantaneous. Thus, the psychoanalytic and the brain sciences are coming together and explicating each other.

Where to From Here?

In his paper revisiting the relationship between psychoanalysis and neural science, Eric Kandel (1999) criticized our field for its lack of empirical research. A decade later, research efforts are beginning to assess the effectiveness of various psychotherapies, including psychoanalysis. This research will take time, and during this time, on a parallel track, we will learn much more about how the brain works. These two sources of information will provide a complex, multilayered understanding of brain functioning. We will have answers to how psychoanalysis works. We may even provide research and theoretical support for one or more of our various models of psychoanalysis and for various technical methods related to different kinds of pathology. The more we know, the more understandable, teachable, and learnable psychoanalysis will become.

KEY POINTS

- We are approaching a time when psychoanalysis and the neural and brain sciences can be mutually collaborative—the two endeavors will communicate and mutually inform each other.

- One approach to understanding the integration of psychoanalysis with the brain sciences is to focus on individual sciences and explore how each one has influenced psychoanalysis as a theory and a practice. The varied sciences of the brain have already had an impact on psychoanalysis and have synergized with evolving changes in the psychotherapies.

- Another fruitful way to organize the integration is to take basic psychoanalytic concepts and explicate each one by drawing together relevant information from other neighboring sciences. An example provided is the concept of identification; others include consciousness, the unconscious, dreams, psychic conflict, defenses, transference, countertransference, attachment, drive, and affect.
Some psychoanalysts view this approaching integration with alarm, feeling the project is reductionistic and substitutes neurons for meanings. This dispute actually helps to illuminate the mind-brain endeavor.

The dualistic tradition can be replaced with a dual-aspect monism in which there is only one substance but it is viewed from different points of view.

Understanding any mental event requires understanding the brain at several different levels and contexts. We replace a "nothing but" kind of reductionism with a multi-causal kind.

We can expect that in the future we will learn more about how the brain and mental systems function. Integrating this knowledge with the results of outcome research in the psychotherapies, now under way, will give us a comprehensive view of the mind and of the ways particular therapies work.

In the next few decades, there will be a running co-evolution between brain sciences and psychoanalysis. The disciplines that will be called psychoanalytic will continue to plumb the depths of mind to uncover unconscious wishes, conflicts, and schemas of repetition. In the dialogue with the sciences, we can hope to understand these phenomena of mind and brain.

References

Damasio A: Self Comes to Mind: Constructing the Conscious Brain. New York, Pantheon, 2010
Edelson M: Hypothesis and Evidence in Psychoanalysis. Chicago, IL, University of Chicago Press, 1984


Harris A: Gender As a Soft Assembly. Hillsdale, NJ, Analytic Press, 2004


Hurley S: The shared circuits model [SCM]: how control, mirroring, and simulation can enable imitation, deliberation, and mindreading. Behav Brain Sci 31:1–58, 2005


Litowitz B: Elements of semiotic theory relevant to psychoanalysis, in Semiotic Perspectives on Clinical Theory and Practice: Medicine, Neuropsychotherapy and Psychoanalysis. Edited by Litowitz BL, Epstein PS. Berlin, Germany, Mouton de Gruyter, 1990


Piers C: The mind's multiplicity and continuity. Psychoanalytic Dialogues 15:229–254, 2005


Scofield WB, Milner B: Loss of recent memory after bilateral hippocampal lesions. J Neurol Neurosurg Psychiatry 20:11–21, 1957


Psychoanalysis and Philosophy

Jonathan Lear, Ph.D.

Psychoanalysis and philosophy share more than an interest in the core concepts of the human condition—freedom, happiness, mental life, desire, they both purport to be strategies for changing one’s life for the better. At least, that’s the way it was at philosophy’s beginning, and it continues on in a Socratic tradition.

“Our conversation concerns no ordinary topic,” Socrates says, “but the way we should live” [Plato, Republic 1, 352d, my translation]. For Socrates, this is the fundamental question for humans: How should one live? It is pressing for each person, Socrates thought; for even if a person has not explicitly reflected much on how she should live, her actions through life inherently reflect a sense of what matters. Human action by its very nature reflects an agent’s sense of what is to be done [Rödl 2007]. In that sense, a person’s life is inevitably an answer to the fundamental question. However, humans are born into a cultural world: they absorb values in childhood with little understanding of what they mean or why they matter. So while they may dedicate their lives to their sense of what matters, their sense of what matters may never rise above the clichés and prejudices of the social environment into which they were born. A worthwhile life for Socrates is a distinctive human life—not merely one that is characteristic of the biological species, but one that lives up to a potential we have as human. That potential is practical self-consciousness: our capacity to take our own legacy into account and shape our lives via a proper understanding of how to live well.

Note that Socrates’ question is not obviously a moral question. It asks, in an open-ended way, What would it be to live well? For Socrates, as for all the ancient Greek philosophers, the key is happiness: What is involved in humans living happy lives? The Greek word for happiness is eudaimonia, which literally means “well off when it comes to daimons, demons, or spirits.” It is a good-spirited life. Less literally, it means having that in virtue of which one’s life is full, rich, meaningful, lacking in nothing significant. It is sometimes translated as “flourishing,” but I have come to think that the connotations of this word bring us too
close to our animal nature to capture the sense of eudaimonia. We can think of lions flourishing, sheep flourishing, and so on, but Aristotle insists it is only humans who can be happy. And he famously comes to identify happiness with contemplative activity: the exercise of the best capacity in us [Nicomachean Ethics X.7, 1177a12–18; cf. 1177b26–1178a8]. For Aristotle, happiness is an integrated life organized in such a way as to enable us to use our highest mental faculties in their most creative and thoughtful ways.

Philosophy in the Socratic tradition is an activity that will help us be able to answer the question of how to live well for ourselves. Philosophy, Socratically understood, is not merely a theoretical inquiry into what is the best life for humans, it is a practical activity whose outcome ought to be the active living of a good life. It is the activity of bringing our psyches (or souls) into the best possible shape so that we are thus able to live well. Socratic philosophy intrinsically and essentially had a therapeutic aim.

If one reads through Plato’s Republic, for example, one will see serious forays into metaphysics, science, literary criticism, mythology, psychology, politics, and aesthetics—but all those inquiries are disciplined by an overriding interest in how to live. The basic inquiry is into the basic psychological structure of a person who is to lead a happy life. And though we shall concentrate on Socrates and Plato, as the inventors of philosophy, it is worth noting that the subsequent philosophical schools—of Aristotle, the Stoics, the Epicureans, and the Skeptics—were all concerned with philosophy as an activity that could change one’s life. Even Aristotle’s most abstract thinking—metaphysics or first philosophy—was meant to help humans better understand their place in the world. And understanding that, Aristotle thought, was part of a process of coming to recognize that one’s life ought to be oriented toward such understanding. So, provided one did it in the right sort of way, doing philosophy about the highest things was itself a changing of one’s life for the better.

Psychoanalysis shares with philosophy the same fundamental question. Though analytic patients may not have thought about it explicitly, they come to analysis with a sense that something is going wrong in their own attempts to live well. They may have no developed sense of what is going wrong or what it would be like to live better. But they have come for treatment, and the treatment is a peculiar form of conversation. It is a conversation that is purportedly about whatever it is that comes into their minds. (Often it is about why that conversation cannot quite occur.) We shall look later at some of the peculiarities of this conversation.

But, for the moment, consider this broad-scale feature: people come to analysis for help; they want help in figuring out how to live better, and analysis purports to be a conversation that can help them in that project. Were he alive today, Socrates would be interested, for this is the project he took to be fundamental.

The Socratic Method

For Socrates, conversation is the key. While each of us is confronted with the question of how to live, none of us can answer it well on our own. This is one manifestation of our finite nature: none of us has God’s vantage point; each of us looks out on the world from a limited perspective that [in significant ways] was not of our choosing. It is all but impossible to gain a reasonable perspective on our perspective entirely on our own. We need this conversation of others to test our perspective; indeed, to find out what it is. But what sort of conversation should it be?

One hallmark of Socratic conversation was a method of cross-examination, or elenchos. Socrates and an interlocutor would start out with one of life’s basic values—say, acting courageously. Courage is called a virtue—an aretē—but another translation is excellence. That is, it is agreed that living courageously would be a fine way to live. But Socrates has this crucial insight: people may agree that living courageously is a fine way to live, but they may nevertheless have no real idea what courage is. As a result, they do not really know what living well is. They are educated into current fashions [in this case, fashions about what is courageous], but no one seems to understand whether the fashions are more than that. So not only do people not know what courage is; they don’t know that they don’t know. As a result, people think they have an answer to the question of how to live—live courageously!—and they use that answer to disguise from themselves that they do not know what the answer is. The purported answer to the question turns out to be a defense against confronting the question with any seriousness.

The Socratic method is designed to undo this defense. Socrates asks his interlocutor to state what courage is. The interlocutor thinks he knows and offers an account, through a series of questions and answers, Socrates elicits a contradiction. Once the interlocutor sees that he is in contradiction, something about his life must change. In the best possible circumstances, he would recognize that he didn’t really know what courage is, and then he could
begin a real inquiry into how it is best to live. Another possibility is that he revises some of his other beliefs in order to hold on to his account of courage. Still another possibility is that he evades the problem in some way or other. But even then, life cannot be the same. The contradiction has been brought to the interlocutor’s attention, even in flight from the problem, the flight itself is a response to it.

As a therapeutic technique, the Socratic method does not rest on a sophisticated account of the psyche (Vlastos 1983, 1991). He seems to assume that if a contradiction is brought to a person’s self-conscious awareness, it will help the person rather than harm him. It is true that, until this moment of self-awareness, the person has been living in contradiction without realizing it. And thus it is at least possible that the person will now go down the path of a more truth-filled life. But what grounds Socrates’ confidence that the interlocutor will not choose a path of even greater falsity?

Note, too, that Socrates assumes that the only impediment to rationality is lack of self-awareness. He famously argues that it is impossible for anyone willingly to do bad. Roughly speaking, he argues that it is built into the concept of action that when one acts, one is aiming at something one takes to be good. Thus, it is only through ignorance that one could aim at something bad. Thus, he takes his therapeutic job to be done when he brings the contradiction to light. In this way, Socrates passes over as impossible a phenomenon that psychoanalysts treat seriously: that humans may be motivated to live in contradiction. Not only do they act against their own sense of what is best for them—which Socrates argues is impossible—but that is why they are doing it. To take a common example, consider cigarette smoking. On the standard model of irrational behavior, there may be people who smoke in spite of the fact that they know it is likely to make them ill in the long run, and they genuinely do not want to get ill. On this model, the pleasures of the moment weigh most heavily with them and cloud their judgment of their long-term goal. But now consider a stranger case: a person smokes not primarily for the physical pleasures but for the excitement of knowing he may be throwing away his own life. We cannot legitimately say that such a person is simply throwing away his own life. It is precisely because his life, his long-term health, genuinely matters to him that risking it is exciting. If his life didn’t matter to him, neither would the risk to it matter, and there would be no excitement. Precisely because it violates his own best judgment of how to live, he is drawn to it. Thus, merely bringing the contradiction to light may be of no help; it may even be counterproductive. We know we are in the realm of the distinctively human when we encounter a phenomenon that is alluring precisely because it appears to be self-destructive, while at the very same time the person also wants health, happiness, and long life.

The problems with the Socratic method are by now well known, but it is worth mentioning the most serious. First, there is little evidence that cross-examination helped the interlocutors. At the end of the so-called Socratic dialogues, the interlocutors are often irritated, frustrated, and anxious to leave. Perhaps it helped Socrates in his own efforts to figure out how to live. Perhaps it has helped generations of readers of Platonic dialogues. But there is a question: whom, if anyone, has the Socratic method benefited? One interpretive route is to take seriously a myth in the Phaedrus in which the movement of a soul toward genuine well-being takes between 3,000 and 10,000 years [Phaedrus 245c–247b; cf. Republic X: 614b–621c]. If that is the length of a truly excellent therapy, then one should not expect to see all that much psychic movement in a single conversation. Perhaps the conversations that superficially look like failures were in fact therapeutic successes, but to see this, one needs to take a longer view of therapy.

Here is a second problem with the Socratic method: although the method revealed the interlocutor as living according to unexamined clichés, the clichés were also the values of the time. Thus, there should be no surprise that the Socratic method provoked anger among some citizens. It would be easy enough to assume that Socrates was challenging the fundamental values of society. The death of Socrates has been much written about, but one way to view it is as a psychotherapeutic catastrophe. Obviously, Western civilization may have benefited from two and a half millennia of pondering the death of Socrates. And we may well suspect that Socrates had that outcome in mind. Perhaps his “patient” was Western civilization. But in the short run at least, a purported mode of therapy is open to criticism if it provokes the patient to act out his murderous wishes—and kill the analyst.

Cooperative Conversation

In the Republic Socrates abandons the method of cross-examination. Indeed, the shortcomings of that method seem to be put on display in Book I. Socrates is questioning a proud and clever narcissist: Thrasyvoulos is a bold rhetorician who likes to win admiration through
are. Each part of the psyche is thus a desiring part, the parts differ according to the type of thing they are after ([Republic IV, 435e–444a]).

A Theory of Neurotic Conflict

Neurotic conflict occurs when none of the psychic parts is successful at organizing and disciplining the others ([Republic IV, 444a; see also Books VIII, IX]). So, for example, the narcissistic component might experience a certain sexual temptation as shameful, but appetitive desire goes for it anyway. The impasse is intrapsychic conflict in which powerful feelings of temptation struggle against feelings of shame, humiliation, and worthlessness. Socrates tells the story of Leontius, who, when he was walking back to town, saw some corpses outside the walls of the city:

He had an appetite to look at them but at the same time he was disgusted and turned away. For a long time he struggled with himself and covered his face, but, finally, overpowered by the appetite, he pushed his eyes wide open and rushed towards the corpses, saying, “Look for yourselves, you evil wretches, take your fill of the beautiful sight!” ([Republic IV, 439e–440a])

A Dynamic Theory of Personality Organization

For instance, we can speak of a narcissistic personality when the narcissistic component of the psyche takes control and imposes some kind of organization over the other parts. In the narcissist, the more appetitive desires for sex are disciplined to an overriding desire for admiration. Now it becomes important to have sexual relations with someone who will contribute to one's glory. And reason is deployed as a primarily calculative faculty: figuring out which are the next good moves if one is to achieve celebrity. Thus, we have the formation of what Plato calls dimocratic man, the lover of honor ([Republic VIII, 549c–550; cf. IX, 580d–581c]).

An Account of the Limits of Psychological Integration

"Republic" is the translation of pòleisthai, which can also mean constitution. The English translation follows earlier Latin translations, titled Res Publica, literally, the public thing. The Latin translators particularly emphasized the political aspects of the text, but I suspect that Constitution is a better title. The book is concerned with the question of constitutionality: What is it to be constituted? What is it to function as a differentiated unity? The inquiry is into the very idea of constitutionality—whether it arises in political entities like the polis or the state, in the human psyche, or in the cosmos. Now, in the specific case of the human psyche, there are definite limits to the possibility of integration.
A prime reason is the presence “probably in everyone” of a particularly unruly type of desire:

The ones that wake up when we are asleep, whenever the rest of the soul—the rational, gentle, and ruling element—slumbers. Then the bestial and savage part, full of food or drink, comes alive, casts off sleep, and seeks to go and gratify its own characteristic instincts. You know it will dare to do anything in such a state, released and freed from all shame and wisdom. In fantasy, it does not shrink from trying to have sex with a mother or with anyone else—man, god or beast. It will commit any foul murder, and there is no food it refuses to eat. In a word, it does not refrain from anything, no matter how foolish or shameful. [Republic IX, 571b–571c, my emphasis]

These are desires that basically can only be dealt with by repression. A few exceptional people may be able to get rid of them, but even in these psychically well-organized people, a few weak, unruly desires may remain. For everyone else, these lawless desires need to be “held in check.” This means that there will always be pressure on any attempt at psychic integration. Note that this account implies the next point.

A Theory of Dreams as Expressions of Unconscious and Illicit Desires

Socrates is also interested in showing how a society’s shared sense of reality can be distorted. He argues that the culture’s most magnificent artifacts—the myths of the gods, Homer’s poems, the tragedies—have hidden messages that have shaped the souls of the citizens in ways they do not understand. As a result, people experience themselves and each other according to preformed images yet take themselves to be experiencing things the way they really are. In his famous allegory of the cave, Socrates is trying to give an account of the effect of our education (or lack of it) on our nature [Republic VII, 514a]. Unbeknown to ourselves, we are actually prisoners in a cave, looking at shadows projected on a wall and mistaking them for reality.

Psychologically speaking, the important point is that the outcome of our education is not primarily a set of beliefs, even a set of false beliefs, about the world. It is rather a worldview: a way of experiencing events and interpreting them so that they all hang together, but in such a way as to be kept imprisoned. And thus Plato gives us the next point.

A Theory of Illusion and the Rudiments of a Theory of Transference

Moreover, there is even an account of a precursor to negative transference. Suppose that someone were able to break out of this illusion. The image is of someone breaking his shackles, ascending out of the cave to see things in the light of the sun, and then returning to the cave to help his fellow prisoners. Here is a man with a true understanding of reality but little therapeutic technique:

If this man went back down into the cave and sat down in the same seat, wouldn’t his eyes be filled with darkness, coming suddenly out of the sun like that… Now, if he had to compete once again with the perpetual prisoners in recognizing the shadows, while his sight was still dim and before his eyes had recovered… wouldn’t he provoke ridicule? Wouldn’t it be said of him that he had returned from his upward journey with his eyes ruined, and that it is not worthwhile even to try to travel upward? And as for anyone who tried to free the prisoners and lead them upward, if they somehow get their hands on him, wouldn’t they kill him? [Republic VII, 516e–517a]

To which Glaucon responds, “They certainly would.”

Implications of the Conversation With Glaucon

There are two important features about this less-than-successful therapeutic encounter. First, the prisoners in the cave have a preformed schema in terms of which they interpret this disruption in their environment. Rather than experience this person as having something new to say, they interpret him in terms of familiar, old categories. Given that, unbeknown to themselves, they live in a cave, dominated by shadows mistaken for reality, they are necessarily unaware of the bases of their judgments. And of course, the structure of judgment provides an outlet for ridicule and aggression: it thereby motivates the prisoners to stay precisely where they are. Thus does this unconsciously motivated structure of judgment hold them captive.

Second, Socrates is trying to explain his own death. On the surface, what could be more puzzling: Socrates,
how this comes about. Of course, the Christian answer is religious: through God’s grace. And since philosophy, at least since the Enlightenment, has been a predominantly secular inquiry, it has by and large ignored medieval and early modern Christian thought. One way to view psychoanalysis is as an attempted secular appropriation of the Christian therapeutic tradition.

It is because modern (secular) philosophy has ignored the question of structural psychic change through conversation that philosophy and psychoanalysis have seemed, at least on the surface, to be such different types of activity. What possible routes can philosophy then take, given that it ignores this question? One way to explore the consequences is according to this dilemma: either philosophy cuts itself off altogether from the Socratic question of how to live, or it continues on with that question but without a concern for dynamic psychological structure. On the first lemma, philosophy becomes an abstract inquiry into the most basic world-structuring concepts, for example, the nature of causation, logic, what it is to be a mental state, meaning, and the conceptual foundations of physics. This would be the pursuit of knowledge for its own sake about the basic structure of mind and world. On the second lemma, philosophy would still purport to give some account of how to live via an inquiry into, say, freedom or happiness. But it would ignore challenges raised by the idea that the human psyche is complex, dynamically structured with significant repressed components. So, for example, approaches to ethics or morality that are influenced either by the British Empiricists or by Kant might assume that an understanding of human psychology is important, but the psychology they would assume would be basically one of beliefs and desires. This is a psychology of propositional attitudes: belief that something is the case, desire that something be acquired, hope or fear that something should come to pass, angry that something has happened. The philosopher Donald Davidson has convincingly shown that a psychology in which mental states are propositional attitudes will inherently tend to show the person to be rational (Davidson 1984). And while one can show how, in such a psychology, motivated irrationality is nevertheless possible, this remains basically a technical exercise (see Davidson 1980, 1982). When it comes to central philosophical questions—say, the nature of freedom—the significance of the dynamic unconscious is by and large ignored.

Does this matter? Obviously, I think the answer is yes: ignoring this phenomenon of dynamic psychological structure has had deleterious consequences for philosophy and for psychoanalysis. In the remainder of this chapter, I give a brief sketch of what some of these consequences are, and then, in a more constructive spirit, I indicate how this gap may be overcome through a joint program of philosophical-psychoanalytic inquiry.

Reflection Function and Psychic Functioning

There is a distinguished philosophical tradition—alive in contemporary philosophy but descended at least from Kant—that locates our freedom in self-conscious awareness. How could this be? In Being and Nothingness, Sartre (1956, pp. 595–615) argues that once one becomes reflectively aware of a given psychological impulse, a choice is, as it were, forced on one. One may ignore the impulse, go along with it, endorse it, acquiesce to it, reject it, and so on, but it is no longer possible for the impulse simply to be a given in one’s psychological life. As Harvard philosopher Richard Moran (2001) puts it,

“When I am reflectively aware of some attitude or impulse of mind, I am thereby made aware that its persistence in me (as a “facticity”) is not a foregone conclusion stemming from the inertia of psychic life, and in particular that its counting as a reason for me in my current thought and action is my affair. [p. 140; cf. pp. 138–151]

It is now in the realm of things I can react to and do something about. Christine Korsgaard, another Harvard philosopher, makes a similar point in her book The Sources of Normativity:

[O]ur capacity to turn our attention on to our own mental activities is also a capacity to distance ourselves from them, and to call them into question. I perceive, and I find myself with a powerful impulse to believe. But I back up and bring that impulse into view and then I have a certain distance. Now the impulse doesn’t dominate me and now I have a problem. Shall I believe? Is this perception really a reason to believe? [Korsgaard 1996, p. 93]

And Thomas Nagel, commenting on Korsgaard, gives this gloss:

[T]he reflective self cannot be a mere bystander because it is not someone else; it is the very person who may have begun with a certain unreflective perception, or desire or intention, but who is now in possession of additional information of a special, self-conscious kind. Whatever the person now concludes, or chooses, or does, even if it is exactly what he was
about to do anyway, will either have or lack the endorsement of the reflective view. Given that the person can either try to resist or not, and that he is now self-conscious, anything he does will imply endorsement, permission, or disapproval from the reflective standpoint. [Nagel 1996, pp. 200–201]

In reflection lies responsibility. If I become aware of some psychological datum—say, a tempting impulse, an occurrent thought about another person, a feeling of shame—there will always be a further question of how I should live with respect to it. Should I give into the impulse? Is my judgment of the other person a prejudice? Is there really anything to be ashamed about? We thus bring the impulse into the domain of rational assessment and thereby manifest our freedom with respect to it.

Obviously, it is tempting to use this conception of our rational freedom to illuminate the therapeutic process. Philosophers tend to think that this is what Freud meant by his claim that in psychoanalysis one "makes the unconscious conscious": one brings a hitherto unconscious wish to conscious awareness, and one thereby gains reflective distance with respect to it. And yet, any analyst who has had a patient with an obsessional neurosis will likely have come across someone for whom reflection is a manifestation of unfreedom. Consider this story of O. To all appearances, O. is a psychologically minded fellow; indeed, he devotes much time to bringing various impulses to conscious awareness and wondering what to do about them. He hopes to be an ideal analysand. He's willing to come in and associate until the cows come home; he'll draw his own connections and even make tentative interpretations. Yet none of it seems to do him much good. He is, as it were, stuck in his analytic activity. But he's a sharp student of philosophy; he just completed an essay on the importance of freedom for having one's "second-order" desires in harmony with one's "first-order" impulses (see Frankfurt 1988). Indeed, that is the project on which he sees himself to have embarked. In name at least, his intellectual inquiry and the larger concerns of his life are of a piece. The problem is, he can't ever quite get around to living.

O.'s problem is that his entire faculty of reflective self-consciousness has been taken over by his obsessional personality. On the one hand, he is active in his thinking, on the other hand, he has no choice but to think. Philosophers have tended to assume that if there is going to be a problem for reflective freedom, it is going to be because either our impulses are too strong or our capacity for reflection is too weak or undeveloped. No doubt this is often the situation, but it need not always be thus. It is possible for some obsessively neurotic persons to experience their impulses as weak but to experience reflective thought as powerful and not entirely in their control (Freud 1909). What are they to do, reflect on that? Obviously, this description covers a wide spectrum of cases. At the extreme, there is compulsive reflection, and the compulsiveness may incline us to conclude that the patient has lost the ability genuinely to reflect. But the more interesting case from a philosophical point of view is less severe. O. is able to reflect all right, it's just that the reflecting seems somehow to have taken the place of living. Instead of reflecting on his life being a piece with living that life, reflecting on his life has become his life. In such a case, thoughtful reflection becomes a form of unfreedom (see Kierkegaard 1846/2009).

Here, then, is an example of a significant philosophical insight—that our rational freedom is manifest in our ability to reflect—that is limited by ignorance of the vicissitudes of dynamic psychological structure. No doubt there is something correct in the idea that in reflection we manifest our freedom, but now we see that it's got to be the right sort of reflection. But what could that mean? It cannot be about the content or about the steps of the reflection itself. It must rather be about how the reflection is woven into overall psychic functioning (Lear 2011). But then how are we to explain the difference between the form of psychic functioning in which reflection is a manifestation of our unfreedom and the form in which it is a manifestation of our freedom? One obvious way would be to give an account of the transition from one condition to the other. Suppose now that the transition could itself be achieved through reflective conversation. This would be the situation in which a certain kind of reflective conversation itself facilitated transformation of overall psychic functioning. This would simultaneously be a movement from unfreedom to freedom. Thus are we brought back to the question that arose with Plato: How might a conversation change the structure of the psyche? This is the question psychoanalysis tries to answer, and we can now see that it is of central philosophical importance.

Conclusion: The Future of Psychoanalytic-Philosophical Investigation

Not only does philosophy suffer when cut off from a psychodynamic understanding of the human psyche, but
psychoanalysis also suffers when it is split off from its philosophical roots. Psychoanalysis is essentially a therapeutic activity: it aims at promoting a certain outcome. But if we lack a clear understanding of what this outcome is, we cannot be confident that our activities are aiming at it [Lear 2009]. But what is psychoanalysis aiming at? Psychic health? Mental freedom? The capacity to love? But what do these concepts mean? Psychoanalysts have shed valuable light on the goals of psychoanalytic treatment, but we have just begun to think about the deeper meanings. Without a clear conception of the goal of psychoanalysis and of how to aim at it, we cannot say with confidence whether we are helping people or harming them. We cannot even say with confidence what we are doing. There is astonishing variation within the mental health community both in goal and in method of treatment. Although some of this reflects honest disagreement, too much of it reflects a lack of thinking through what the ultimate values of a talking cure might be.

I shall conclude this chapter by mentioning a few areas for psychoanalytic-philosophical investigation.

Transference

The phenomenon of transference suggests that there is no straightforward way to initiate and carry on a conversation about how to live. Each interlocutor will typically be assigning peculiar roles to the other that occur within highly structured yet idiosyncratic worlds of meaning, much of which remains unconscious. Thus, the purported inquiry into how to live will be distorted by other issues about which no one is very clear. The conversation might be experienced by one person as the hectoring of a maternal figure, while the other person feels that the conversation keeps him too busy actually to think about how to live. It is not enough to say that the conversation needs to get clear on what the transferences are. We need to understand what this claim could possibly mean: for understanding the transferences as we have just done—as intellectual cognition—is of no help. That too can be more intellectualization, keeping genuine conversation at bay. On the surface, it looks as though there is no place from which genuine conversation can occur. Inside the transference, one is assigned a preordained role; outside the transference, the conversation is too remote to engage the interlocutor. So what would it be like to take up the transference in the right sort of way—that is, a way that facilitates genuine conversation about how to live?

Freud gives us two important hints; both of them are worthy of further reflection and research. First, he suggests that transference is not simply a transfer of emotion from some early figure onto the analyst but should rather be understood as an induction of the analyst into an idiosyncratic world. “We soon perceive,” Freud tells us, “that the transference is itself only a piece of repetition, and that the repetition is a transference of the forgotten past not only onto the doctor but also onto all the other aspects of the current situation” [Freud 1914, p. 151; my emphasis]. It is as though the analyst is being drawn into a large-scale structure. Thus, Freud here revises an earlier view in which transference is seen as a discrete, atomic transfer, a “false connection” as he then put it, or a “mesalliance” [Breuer and Freud 1893–1895, pp. 302–303].

Now to call any act a repetition is to say that something is happening again. And this may be true from the point of view of conscious, reflective evaluation. So, to take a simplified example, “I used to think my mother betrayed me; now I think you have betrayed me.” But that is not the only perspective there is. Freud famously said that the unconscious is timeless [Freud 1915, p. 187]. Part of what he meant is that the unconscious tends to generate almost mythic structures, in which ordinary questions of past, present, and future do not arise. From the point of view of the unconscious, things do not happen again and again; they always already fantastically are, with a peculiar timeless temporality. In this way, an unconscious fantasy can express and thereby maintain a world of betrayal. The disparate events in this person’s life are pulled, as though by an idiosyncratic gravitational force, toward a painful, emotion-filled interpretation in terms of betrayal. The analysand does not understand how active she is in interpreting life’s events as betrayals, but all these repetitions serve to stabilize and unify a world of experience. By way of analogy, think of God creating the world. What from one perspective looks like successive repetitive acts, re-creating the world over and over in every successive moment, from a different perspective looks like a single act of creation that is timelessly held in place. It is as if there were the overarching space within which ordinary temporal events occur.

In the transference, the analyst is drawn into the analysand’s idiosyncratic [and often unconscious] world. [Lear 2005, pp. 117–144; 2003b, pp. 181–211; 1998, pp. 56–79]. This is of profound therapeutic as well as philosophical significance. Philosophically speaking, there has been a long-standing interest—going back to Plato and his allegory of the cave, but also including such recent figures as Hegel, Kierkegaard, Marx, and Nietzsche—in the problem of illusion. The philosophers tended to be concerned with social and cultural institu-
tions that provided a false view of the world but, just as important, were also capable of interpreting everything in their terms. For Kierkegaard, for instance, the illusion was Christendom: the culturally established ways of going on as a Christian in nineteenth-century Europe. These forms of Christian life actually got in the way of being a true Christian, but no one could see this, Kierkegaard thought, because people already took themselves to be Christian. Moreover, the illusion is voracious: it aims to interpret all experience in its terms. So, to keep this example going, even debates about what it is to be Christian tend to get tranquilized and absorbed by Christendom. What Freud showed in his discovery of transference is that something like illusion is operating at the level of the individual, in his idiosyncratic unconscious fantasies. (One should expect these two levels of illusion, the personal and the cultural, to interact in fascinating ways.) If psychoanalytic technique is structured so as to allow a therapeutic way into the heart of an individual’s illusion, this may offer an answer to the philosophical question of how to change or undo illusory structures.

The second hint Freud gives us is that transference in analytic treatment creates an “intermediate region” between neurotic repetition and what he calls “remembering.” The significance of this claim is still not well understood. We have already seen that to understand what Freud means by repetition, we have to give an unusual, distinctively psychoanalytic interpretation of the idea of repetition. We shall have to do something similar with Freud’s conception of remembering. He says:

[The patient does not remember anything of what he has forgotten and repressed but acts it out. He reproduces it not as a memory but as an action; he repeats it, without, of course, knowing that he is repeating it. For instance, the patient does not say that he remembers that he used to be defiant and critical towards his parents’ authority; instead, he behaves in that way to the doctor. . . . Above all the patient will begin his treatment with a repetition of this kind. . . . As long as the patient is in the treatment he cannot escape this compulsion to repeat; and in the end we understand this is his way of remembering. (Freud 1914, p. 150)]

On a familiar reading, Freud here introduces a peculiar clinical entity, acting out. It can then seem as though an unconscious wish or fantasy is, as it were, standing behind this clinical entity, bringing it about as hidden efficient cause. But if you go to Freud’s German and look for the expression that is the “act” in acting out, you will look in vain. What Freud actually says is that the patient doesn’t remember what he has repressed; he acts it [Freud 1914/1946, p. 129]. Freud makes no reference to a peculiar clinical entity; rather, his claim is about the mode in which a fantasy is expressed. This permits a very different interpretation of the phenomenon: not that the fantasy is a hidden cause to a distinct clinical entity (acting out) but that the fantasy is right there in the analysand’s acts. The fantasy is being performed rather than consciously remembered.

Philosophically speaking, this commands our interest because it points to a breakdown in human self-consciousness. For the most part, we can say what we are doing. But here in the transference, this ordinary and pervasive capacity for self-conscious understanding of our doings goes missing. Pursuing this line of thought, I think, lead to a richer understanding of unconscious mental activity than we now possess [Anscome 1963; Gardner 1993]. Psychoanalytically speaking, if the unconscious fantasy is right there in the transference act, it becomes easier to understand how an intervention might be therapeutic. Freud noted:

The unconscious impulses do not want to be remembered in the way the treatment desires them to be, but endeavor to reproduce themselves in accordance with the timelessness of the unconscious and its capacity for hallucination. Just as happens in dreams, the patient regards the products of the awakening of his unconscious impulses as contemporaneous and real; he seeks to put his passions into action without taking any account of the real situation. The doctor tries to compel him to fit these emotional impulses into the nexus of the treatment and of his life-history, to submit them to intellectual consideration and to understand them in the light of their psychical value. This struggle between the doctor and the patient, between intellect and instinctual life, between understanding and seeking to act, is played out almost exclusively in the phenomena of transference. It cannot be disputed that controlling the phenomena of transference presents the psychoanalyst with the greatest difficulties. But it should not be forgotten that it is precisely they that do us the inestimable service of making the patient’s hidden and forgotten impulses immediate and manifest. For when all is said and done, it is impossible to destroy anyone in absentia or in effigie. (Freud 1912, p. 108; my emphasis)

Though Freud does not yet have an adequate psychological theory—his penchant for treating the unconscious wish as antecedent efficient cause gets in the way—his clinical acumen outstrips his theory and gets it right: the unconscious fantasy has to be right there in the transference, for one is certainly not going to alter it in absentia.

This insight opens up a remarkable therapeutic possibility: that a verbal interpretation of a fantasy may at
the same time be a transformation inside the fantasy itself. The fantasy is, as it were, learning to express itself in a spoken language, in this case English. The truth of an interpretation, then, does not consist solely in the accuracy of its content but also in the genuineness with which it expresses the dynamism of the fantasy itself. This is the psychoanalytic meaning of remembering: not simply self-conscious memory of one’s past or a self-conscious narrative about one’s desires, but rather an accurate verbalization of fantasy in which the fantasy is alive and present in the verbalization. Psychoanalysis thus gives us a new sense in which the analysand learns to speak his mind. We see Freud on the edge of this insight in a famous passage in “Remembering, Repeating and Working-Through”:

We render the compulsion [to repeat] harmless, and indeed useful, by giving it the right to assert itself in a definite field. We admit it into the transference as a playground in which it is allowed to expand in almost complete freedom and in which it is expected to display to us everything in the way of pathogenic instincts that is hidden in the patient’s mind. Provided only that the patient shows compliance enough to respect the necessary conditions of the analysis, we regularly succeed in giving all the symptoms of the illness a new transference meaning and in replacing his ordinary neurosis by a “transference neurosis” of which he can be cured by the therapeutic work. The transference thus creates an intermediate region between illness and real life through which the transition from one to the other is made. [Freud 1914, p. 154]

Playgrounds are organized sites of playfulness. Freud’s insight is that we are not discovering hidden contents so much as engaging in an organized play in which fantasy learns to speak itself. This is what making the unconscious conscious consists of: a crucial playful moment in the development of the human capacity for self-consciousness, and thus for freedom.

Psychic Change Through Conversation

Psychoanalysis brings about changes in the structure of a person’s psyche—and it does so through conversation. How can any conversation do this? Psychoanalysis does not change this or that desire or this or that wish or fantasy; it transforms the very way the psyche functions. One typical outcome of a successful analysis is that that person has a less punishing superego. What does this mean? It is not just that the voice of the superego becomes less cruel in what it says but that there are important changes in how the superego speaks to the ego. There is increased communication—harmonious and reciprocal—between superego and ego, so much so that the distinction between these two psychic faculties starts to blur. Psychologically speaking, there is a factual question as to how any conversation could bring this about. Indeed, one is inclined to think that this is the question of the therapeutic action of psychoanalysis. But if so, we need to ask what it is about this psychic change that makes it therapeutic (see Lear 2003b).

Perhaps naively, we may think that the conversation about how to live is valuable because it helps us recognize who we are and what we (and the world we inhabit) are like. On the basis of that increased understanding, we might make better life choices. But psychoanalysis shows us that a conversation about how to live might not just reveal what we are like; it might fundamentally alter it, in which case the conversation is not just an inquiry into how to live but a transformation of the conditions of life itself. Thus, it seems that just as one is getting into a position where one could raise the question of how to live in a genuine way, one has already answered it. On what grounds can one be confident that one has answered it for the better?

Activity and Passivity in the Mind

Psychoanalysis reveals that the mind is a heterogeneous place. Not only does a person have beliefs, desires, hopes, fears, and resentments, but he or she also has wishes and fantasies. These are forms of imaginative activity that operate for the most part unconsciously and according to their own rules. Of course, they often intersect with (and influence) beliefs and desires; they often get expressed in actions. But they are not constrained by the limitations of rationality that apply to the standard model of belief, desire, and action in human life (see Davidson 1980, 1984). Psychoanalysis has been extraordinarily successful in charting the form and efficacy of unconscious fantasies.

But what significance do these fantasies have for human happiness and freedom? Obviously, we know that certain fantasies are painful, inhibiting, crippling. But, philosophically speaking, the question is about the significance of having any kind of fantasy life at all. On the one hand, fantasies are forms of mental activity; on the other, we seem to suffer passively many of their consequences. They bypass our will more or less
Frankfurt H: Freedom of the will and the concept of a person, in The Importance of What We Care About. Cambridge, UK, Cambridge University Press, 1988, pp 80–103
Lear J: Therapeutic Action: An Earnest Plea for Irony. New York, Other Press, 2003b
Plato: Republic. Translated by Reeve CDC. Indianapolis, IN, Hackett, 2004
Wollheim R: On the Emotions. New Haven, CT, Yale University Press, 1999
Psychoanalysis and Anthropology

Waud H. Kracke, Ph.D.

Anthropology and psychoanalysis both depend on listening to the speaking human subject. They listen to hear and reconstruct the other’s inner experience—the analyst to access the mind of a troubled person seeking relief from repressed intrapsychic conflicts, the anthropologist to understand the unconscious cultural assumptions that undergird his or her informant’s beliefs. Both disciplines center on the symbolic world articulated by language and the human world constructed by words and by linguistic structures. Both look for the unarticulated assumptions or fantasies about life and reality that entangle the neurotic subject in difficulties relating to others or embed the cultural subject in the reality shaped by his or her culture (Hallowell 1954).

Cross-Fertilization and Conflict

The two disciplines had their beginnings at the same time: 1886 marked both Franz Boas’s year with the Eskimo that initiated modern fieldwork (Boas 1886, 1887) and Freud’s study of hypnosis with Charcot and the opening of his practice with “hysterics” (Freud 1886a, 1886b, Breuer and Freud 1893–1895). They grew in parallel from the late 19th century through the mid 20th century, with considerable cross-fertilization as well as misunderstandings and conflicts. Psychoanalysis focuses attention inward and looks to “psychic reality” as the prime locus of experience, anthropology gives preference to social causation and to the ideas and values shared by a group, thus turning attention outward. They occasionally talk past each other.

Freud was aware of the pressures of society on the inner world of the individual and the contributions of social pressures to neurosis as well as to “everyday misery.” From his article on “Civilized Sexual Morality and Modern Nervousness” (Freud 1908) to Civilization and Its Discontents (Freud 1930, Ch. 2–3, pp. 74–98), he wrote extensively on the restrictions that society and culture place on the fulfillment of emotional and physical needs and the excessive restraints that lead to emotional disorder.

Freud’s early analytic thinking was much influenced by the anthropological writing of his time. He was intrigued with the unarticulated assumptions that anthro-
Erik Erikson, A.I. Hallowell, and George Devereux

The 1940s, 1950s, and 1960s were a time of flourishing union of psychoanalysis with anthropology. In anthropology, personal biographies of informants starting with early childhood became common [Simmons 1942]. Dreams were a topic of interest [Von Grunebaum and Caillois 1956, Wallace 1958, 1959]. Dorothy Eggan [1949, 1955, 1961] worked extensively with dreams of Hopi informants, analyzing them with an approach based on the analytic methods of Thomas French and Erika Fromm [1964]. Analytic journals published articles on dreams in shamanic healing [Freeman 1967; Toffelmeier and Luomala 1936].

Three important thinkers joined psychoanalysis and anthropology in their theories: Erik Erikson, a child analyst trained by Freud; A.I. Hallowell, an anthropologist; and George Devereux, an anthropologist who became a psychoanalyst.

Erik Erikson’s [1950] *Childhood and Society* was a milestone in psychoanalytic thinking about culture [Kracke 1978]. Collaborating with anthropologists, he made visits to the Sioux and the Yurok to study how their cultural values were transmitted to children in developmental stage-appropriate ways [Erikson 1950]. Later, doing research for his book on Gandhi [Erikson 1969], Erikson spent time in India, where he befriended a young engineer through whom he influenced the renewal of Indian psychoanalysis. Although he spent less time in the field than Röheim, he integrated anthropological perspectives more fully into his analyses of the cultures he wrote about. His extension of Freudian childhood developmental stages through life, in eight stages of ego development, each with its distinctive emotional conflict [Erikson 1950, 1959], brought together psychic maturation with social development; his favorite concept of identity, if a bit vague, linked psychological identifications with social role.

A.I. Hallowell drew on Freud’s concepts to rethink the role of culture in human experience. In his article titled “The Self in Its Behavioral Environment” [Hallowell 1954], Hallowell developed a concept of cultural reality parallel to Freud’s “psychic reality,” showing how culturally given images are interwoven with personal fantasy in constructing each person’s inner world. He used Freud’s [1936] later theory of anxiety to show how anxiety-stimulating cultural beliefs may serve the purpose of social control and how personal trauma can link with cultural belief to form a phobia [Hallowell 1955].

George Devereux used psychoanalytic ideas in his extensive writing on the Mohave [Devereux 1961] and other cultures [Devereux 1978, 1980] and then undertook clinical training as an analyst, publishing his analytic psychotherapy of a Plains Indian [Devereux 1969]. Devereux stressed the complementarity of sociocultural and psychoanalytic analyses [Devereux 1978] and contributed an important discussion of the anthropologist’s [or any social scientist’s] role as a subjective observer of other subjects [Devereux 1967]. A human being studying others has emotional reactions to the humans he or she observes and to the particular behaviors he studies in them. Reactions of which one is not aware may lead to defensive distortions of one’s observations. The only way social scientists can be “objective,” Devereux argued, is to recognize their subjectivity—to be aware of their own countertransference and take account of it in their conclusions. We return to this at the end of this chapter.

Issues Between Psychoanalysis and Anthropology

As the dialogue between psychoanalysis and anthropology has matured and grown more complex, specific areas of exchange have developed, with particular issues. Psychoanalytic concepts have been used to deepen understanding of anthropological questions. Anthropologists have brought perspectives from other cultures, or from a cross-cultural point of view, to clarify issues in psychoanalysis.

Psychoanalytic Concepts Illuminating Cultural Forms

Psychoanalyzing Ritual?

Freud was also interested in the meaning and functions of ritual in society. Much of *Totem and Taboo* is a search for the emotional dynamics underlying ritual behavior. Yet how can one understand ritual psychoanalytically? Although Freud intuitively reaches insightful interpretations of rituals and other social forms, there is no procedure for understanding a ritual form corresponding to an individual’s free associations to get at
how orthodox Jewish mourning prescriptions segment bereavement into periods that correspond to the natural phases of grieving—crisis, grief, and coming to terms with loss: Guilt over ambivalence toward the deceased is symbolically articulated in prayers and ritual injunctions, such as rending of the garments, or that the mourner should comport himself “as if the sword lay between his shoulders,” and then “as if it was standing upright in a corner in front of him” [p. 18]. Mourning prescriptions help the bereaved to deal with the demands of the “work of remembering” [Freud 1917] and to face more difficult emotional issues that might otherwise lead to pathology. Janice Reid’s [1979] article on Yolngu mortuary rites in Northern Australia made a similar case and showed the extreme distress that beset a Yolngu woman working far from her tribe when she missed the death rites first for her husband and then for her father. Piers Vitebsky’s [1993] analysis of Sora “dialogues with the dead” in India, and Herdt’s [1981, p. 222] of Sambo initiation in New Guinea, could also be framed in terms of culturally constituted defense systems.

Other cultural practices and injunctions may serve as culturally constituted defenses. Among the Panantintin of the Amazon Basin, a father mourning his young son who had just died a few months earlier told me a dream in which a neighbor went out to hunt and shot a monkey, which turned out to be the man’s own beloved pet monkey. In association, the bereaved father recalled that shortly after his young son’s birth, he had shot an animal that should not be killed by the parent of a newborn child. When he shot that prohibited animal, it had caused his newborn son’s chest to hurt. Going back to his dream, he recalled that monkeys are among the game animals forbidden for the first month of a child’s life. The taboo on game to be hunted by a newborn’s father became a way of articulating the guilt he felt at his young son’s dying, which emerged in his subsequent dreams [Kracke 1990], a form of culturally constituted defense.

Spiro later reformulated the concept in a broader way, a way that highlights the individual’s use of a cultural form: “Cultural belief systems...are adaptive means for the forging of a symbolic reality that integrates the [often conflicting] demands of man’s inner [fantasy] life and the requirements of his outer (social) life” [Spiro 1997, p. 118, cited in Kracke 1990, p. 243].

Anthropological Contributions to Conceptions in Psychoanalysis

Language Pragmatics: Transference and Indexicality

In a brilliant article on Freud’s Dora case, Vincent Crapanzano [1981] pointed out that transference in the immediacy of its expression in repetition [Freud 1914b], creates a psychic reality within which one lives. In unconsciously imagining one’s boss as one’s [real or imagined] authoritarian father, one re-creates one’s childhood situation in the present. It is like the “indexical” aspect of a speech act that refers directly to its context, such as addressing someone with a familiar form in French or German to establish closeness. Unlike a dream, Crapanzano points out, a transference does not have a set of images one can refer to and talk about; rather, the unconscious fantasy that insists itself into...
one’s immediate sense of the present becomes a repetition [Freud 1914b] of something one experienced in the past. It is not experienced as a memory, or even as an ongoing fantasy, because it is unconscious. The repressed fantasy is not experienced as having any “content” because it is simply experienced as an aspect of immediate reality. Like the pragmatic, or indexical, aspect of language to which Malinowski called attention, the transference also accomplishes something in the situation, although what it accomplishes may not always be desirable.

Claude Lévi-Strauss: An Anthropologist Who Inspired a School of Psychoanalysis

One major anthropologist, though rarely thought of as a “psychoanalytic anthropologist,” has nonetheless integrated many of Freud’s concepts and those of other psychoanalysts deeply into his thought and even contributed to transformations within the psychoanalytic field. Claude Lévi-Strauss’s most significant, and perhaps most consequential, commentary on psychoanalysis is his paper on the psychological working of a Cuna shamanic song, “The Effectiveness of Symbols” [Lévi-Strauss 1949a]. He shows how the text of the chant for a difficult childbirth evokes a cosmic scene in which the shaman leads a spiritual expedition to free the parturient woman’s soul held hostage by the spirit of her womb. The shaman’s song draws the woman into the play, identifying herself with this cosmic landscape and her own birth canal with the path the shaman’s helpers follow in their struggle with the errant womb-spirit. Imagery in the text evokes the widening of the canal, inducing her to relax her uterine muscles and facilitate the delivery.

In his analysis, Lévi-Strauss contrasted the shamanic text with a psychoanalytic treatment: in the shamanic treatment, the shaman speaks; in psychoanalysis, it is the patient. The shaman provides the myth to the woman; in analysis the patient comes with his own myth of how he came to his impasse. In the course of the analysis, Lévi-Strauss suggested, the analysesand constructs from his own memories a new myth, enabling him to rework his experience in a new light.

An innovative French psychoanalyst, intrigued by anthropology, was inspired by Lévi-Strauss’s lecture to write a paper on “the inner truth at the heart of the psychoanalytic experience,” titled “The Neurotic’s Individual Myth” [Lacan 1953]. Jacques Lacan, “the French Freud,” continued to develop a new path in psychoanalysis [see Chapter 16, this volume], a return to Freud, peeling off the trappings of ego psychology. He stressed the importance of language for human beings, pointing out that Freud centered his treatment of hysterical symptoms on putting the repressed into words. Language is what creates the reality we live in as humans, but it fails us by its inability to adequately express our desires and by the judgment language subjects our desires to in naming them—“the trauma of language” (Cantin 2002). His use of linguist Ferdinand de Saussure’s scheme of the linguistic signifier was influenced by Lévi-Strauss. Lacanian psychoanalysis, which has become a major line of psychoanalysis in Latin America competing with the earlier dominant Kleinians (and more recently introduced ego and self psychology), thus has anthropology at its base [Zafiropoulos 2010].

Anthropology and the Psychoanalytic Treatment of Psychosis

Anthropologists with an interest in psychoanalysis, and analysts interested in anthropology, seem to have an affinity for the problematics of psychosis. L. Bryce Boyer, who spent long periods with the Apache and was made an honorary shaman for his work with them, pioneered psychoanalytic treatment of schizophrenia in this country with Peter Giovacchini. In the Maudsley Hospital experiment with a wing for psychoanalytic treatment of psychosis, Paul Williams, then an anthropologist, was a central member of the team. As the observer, he took an analytic position of the listener that anticipated his later shift to the place of the analyst (Molino 2004, pp. 98–115, 192–194).

The most effective psychoanalytic treatment program I have witnessed was initiated in Quebec by an analyst first trained as an anthropologist. Willy Apollon did his Sorbonne doctoral research on vaudou religion with anthropological fieldwork in his native Haiti [Apollon 1976, 1979], while in psychoanalytic training with Lacan in Paris. In Quebec, together with Quebeconic colleagues Danielle Bergeron and Lucie Cantin, and with sociologist Raymond Lemieux, he developed a psychoanalytic treatment plan for schizophrenia [Apollon et al. 2002]. They formed the group GIFRIC and in 1982 opened a treatment center for young adults with psychosis based on this treatment plan, the “388” [described more fully in Kracke and Villel 2004]. Each psychotic patron [maugér] of the 388 has an analysis, in which the treating psychoanalyst listens to the analysand’s delusion with the analyst’s “desire to know,” while insisting
that the analysand speak of childhood memories and of
dreams. The dreams gradually bring another view of the
subject’s reality that ultimately questions the delusion.
Crisis that may arise when the analysand begins to doubt
his or her delusion are managed by case workers [inter-
venants] at the center. An anthropologist is an integral
part of the 388 staff, interviewing the families of each
patron of the center, studying communication patterns
in the families in the light of a study of the structure of
the Québec family by Willy Apollon and Raymond Le-
meux. This has been an extraordinarily successful psy-
chosis treatment program, taking people who have had
multiple hospitalizations to a point where most of those
who have completed treatment have never been rehos-
pitalized. A majority can dispense with their medica-
tions, and many return to gainful employment or con-
tinued education.

Why this attraction of psychoanalytically interested
anthropologists to psychosis? Is it that psychotic delu-
sion poses a challenge to the very concept of culture? Or
is culture like a collective delusion in our unshakeable
conviction in our cultural beliefs [Freud 1927]?

Extension of
Psychoanalytic Theory

Does It Apply Outside of
European Cultures?

A central question that psychoanalysis asks of psycho-
analytic anthropology is: can we discover the uncon-
scious in other cultures? Is there a psychic structure
that is the same in other cultures as in our own, or is
what is repressed radically different from culture to
culture?

Analytic Work With Patients of
Various Cultures

Freud and those of his immediate circle analyzed indi-
viduals from many cultures, European and non-Euro-
pean, including the Japanese Heisaku Kosawa, who
undertook psychoanalytic training and returned to
Japan to practice there. Yet they were aware of the diffi-
culties of trying to understand the inner life of someone
in a very different culture. Freud elaborated on these
obstacles in his analysis of the Wolf Man, an exiled Rus-
sian nobleman, noting that the Wolf Man’s “personal
qualities and a national character foreign to ours made
the task of feeling one’s way into his mind a laborious
one” [Freud 1917, p. 104]. Freud broached the difficul-
ties of understanding dreams in different languages in a
footnote in The Interpretation of Dreams [Freud 1900,
p. 99, n. 1], attributing to Sandor Ferenczi (1950), in his
article on Hungarian dreams, the thought that “every
tongue has its own dream language.” Yet Russia is a cul-
ture within the orbit of European cultures, and so is
Hungary, though its language is not. How successful can
one be in “feeling one’s way into [the] mind” of someone
from a culture radically different from the European
world? Something more is required.

It is inconclusive at best to use the myths and prac-
tices of a society, as Malinowski (1927) tried, in order to
determine what the inner fantasy life of the participants of
the culture must be. The inner fantasies that emerge in
psychoanalysis in our own culture are often directly
counter to the accepted logic of our society and reflect
desires contrary to the public morality. We need data of
the same nature as emerge in an analytic treatment for
other cultures: we need either to extend the practice of
psychoanalysis into regions of language and culture rad-
ically different from ours or to adapt psychoanalytic
methods of observation to cultures where analysis have
not yet established their practice [see Molino 2004].

Each of these two approaches has begun to take
shape: psychoanalytic movements have grown up for
many years in India and Japan and more recently in
China, and a few European analysts have gone to prac-
tice in African villages. Some anthropologists have
experimented with the use of psychoanalytic interviewing
in the non-Western cultures where they have done
their fieldwork. Let us begin with the spread of psycho-
analysis.

Psychoanalysis in
Non-Western Societies

The interviews anthropologists have in the field may
provide a window to the experience of the self in other
societies or to comparative information about certain
psychoanalytic questions, however, they cannot pro-
vide the depth of a psychoanalysis carried to its term.
Anthropologists who have become psychoanalysts, such
as Melford Spiro (2003), have stressed that the depth of
knowledge of a subject’s unconscious gained in an anal-
ysis is unavailable in standard anthropological inter-
viewing. It is only partially available in the attempts we
make at depth interviewing, even with series of inter-
views and dreams.
• Anthropology and linguistics can contribute perspectives on psychoanalytic concepts, such as Capanzano’s comparison of transference with “indexicality” in linguistics.

• One anthropologist, Claude Lévi-Strauss, not only incorporated Freud’s ideas but also inspired Jacques Lacan to integrate linguistics and structuralist strategies in his return to Freud.

• That integration has proved useful in the psychoanalytic treatment of psychotics by a Québec Lacanian group. Their highly successful psychoanalytic treatment center, “the 388,” incorporates anthropological interviewing of the families of the utilizers of the center as part of the treatment program.

• An important question of psychoanalytic anthropology is whether Freud’s and other psychoanalytic theories hold up in non-Western societies. An answer to this question can be found where psychoanalytic movements have grown in developing countries, but it also needs psychoanalytic interviewing in the field to access fantasy life of individuals.

• The forming of psychoanalytic movements in non-Western nations has also contributed to observations about the universality of the human psychic structure postulated by Freud—repression and the unconscious, the mechanism of dream formation, and others. These movements also show differences in emphasis in different cultures, which raises the question whether these tendencies (feminine identification in many Indian men, amae in Japan) may be more frequent than we have assumed among our own patients.

• Some anthropologists deny the possibility of such interviewing by anthropologists under field conditions, but a number of anthropologists have succeeded in carrying out interviews that do access the data of inner unconscious fantasies.

• Anthropologists are interested in the question: how do we learn culture? To answer this question, psychoanalytic self-analysis in the field is helpful. Malinowski’s diary shows him engaged in such self-analysis, recognizing transferences to his subjects.

References

Akhtar S, Tummala-Narra P: Psychoanalysis in India, in Freud Along the Ganges: Psychoanalytic Reflections on the People and Cultures of India. Edited by Akhtar S. New York, Other Press, 2005


Boyer B: The man who turned into a water monster: a psychoanalytic contribution to folklore. Psychoanalytic Study of Society 6:100–133, 1975


Boyer B, Boyer R: Some effects of acculturation on the vicissitudes of aggression among the Apaches of the Mescalero Indian Reservation. Psychoanalytic Study of Society 5:40-77, 1973


Crpanzano V: Tuhami: Portrait of a Moroccan. Chicago, IL, University of Chicago Press, 1980


Devereux G: Basic Problems of Ethnopsychiatry. Chicago, IL, University of Chicago Press, 1980

Doi T: The Anatomy of Dependence. Translated by Bester J. Tokyo, Kodansha, 1973


Durkheim É: Sur le totemisme. Annaées Sociologiques 5:82-121, 1902

Durkheim É: Sur l’organisation matrimoniale des sociétés Australiennes. Annaées sociologiques 8:118-147, 1905


Freeman DMA, Foulks E, Freeman P: Superego development in the Kiowa Apache male. Psychoanalytic Study of Society 7:123-171, 1976a


chetes and the like. It is therefore to psychological and sociological—not technological—explanations that we must mainly look.

What contribution can the theory and practice of psychoanalysis make to thinking about these phenomena of group attachment and antagonism, in both their positive and negative forms? Can psychoanalytic thinking help us to mitigate the destructive effects of antagonism between groups and their members and to strengthen the more positive aspects of group affiliations? These are the questions to be discussed in this chapter.

**Freud and Group Psychology**

The psychoanalytical starting point for the understanding of the mentalities and behaviors of human beings in groups is Freud's [1921] paper “Group Psychology and the Analysis of the Ego.” In this paper Freud drew substantially on the work of Gustav Le Bon, an early theorist of crowd and mass behavior, quoting his descriptions of group behavior as “impulsive, changeable and irritable...and led almost exclusively by the unconscious” (p. 77). Freud described the “profound alteration in mental activity” (p. 88) that takes place through the influence of the group, with emotions intensified and intellectual abilities diminished. He said it is characteristic of groups to divide the emotion of love, which is attached to fellow members of the group, and of hatred, which is directed toward outsiders. He approvingly referred to the ideas of a well-known contemporary, Wilfred Trotter, on the herd instinct, to give a biological grounding to his own psychoanalytical approach. He made use of the concept of identification that he had previously developed in the *Three Essays on the Theory of Sexuality* [Freud 1905] and in “Mourning and Melancholia” [Freud 1917] to explain the relations of group members to each other as depending on their feeling themselves to be equally loved by their leader. The leader comes to embody a group ego-ideal that displaces that of each individual. Freud described the church and the army as two artificial kinds of group, each based on relations with a leader and with fellow members.

Two principal explanations can be given for the negative view that Freud attributed to the influence of groups on behavior. The first explanation is the social context in which Freud was writing and the widespread fear that the precarious liberal values of reason and individual freedom were under threat from two sides: 1) the traditional authoritarianism of the ancient regimes dominated by monarchy, aristocracy, the military, and the church under the Austro-Hungarian variant of which Freud himself lived for nearly all of his life, and 2) the mobilization of “the masses,” as they were named not only by their detractors but also by some of their political advocates. Although Freud was liberal in his political sympathies, he was critical of what he saw as the irrational utopianism of mass movements. The psychoanalytic movement instituted by Freud has had as one of its moving principles the defense of individuality and reason, in this respect being part of the movement that began with the 18th-century Enlightenment [Rustin 2001].

The second explanation of Freud’s negative view of the psychological attributes of groups lies in his understanding of human motivation. Freud’s original psychological model has in common with the utilitarian tradition of moral philosophy the idea that human beings are motivated by the appetite for pleasure and gratification and by the aversion to pain. Like the philosophical founders of this tradition, Freud originally looked for material or biological explanations of these primary motivations. The framing idea, developed in his *Project for a Scientific Psychology* [Freud 1895], was that of a biological system that sought to maintain equilibrium through the release of instinctual tension. The “drives” provided the link between the demands of instinct and the desires for objects as these become formulated in minds.

The problem with this model is explaining how the desires of different individuals can be reconciled with one another in the common space that individuals must share. Freud found a solution by conceiving an internal psychological equivalent to the external process through which a society organizes itself via laws and rules that constrain individuals to respect the interests of others. In Freud’s theory, society has its mental representation in the form of internalized norms that constitute for individuals their conscience or superego. The main function of society in this model, in both its external and internal representations, is to regulate and restrain individuals’ desires for gratification of both the libidinal and destructive kinds.

Insofar as individuals become identified with the groups to which they feel they belong, Freud noted additional difficulties in the process whereby both desires and their regulating principles become changed as a result of group membership. Desires and emotions become amplified by unconscious identification with others, as in the libidinal or aggressive excitement of orgastic
crowds or vindictive mobs. The restraints of conscience are correspondingly weakened, and authority is projected onto an imaginary leader or standard-bearer for the group. The leader, far from restraining the desires of the group, may merely give legitimacy to its dominant structure of feelings. Freud and subsequent psychoanalytic theorists of group behavior recognized that individuals may indeed be chosen by the groups they purport to lead because of their capacity to express and embody group emotions and to remove any unwelcome obstacles that lie in the way of the gratification of desires. Inhibitions to the expression of desires that would in calm circumstances be effective in regulating them can be dissolved in the intensity of group life. They can be displaced or projected outside the group onto others who become defined as competitors or enemies.

Freud’s theory is powerful in its explanation of how individuals could become submerged in group life and how the capacities to reason, discriminate, and inhibit destructive feelings can become lost in such contexts. Adorno (1951) showed in his perceptive essay on fascist propaganda how these ideas could explain the manipulation of group psychology by the Nazis.

Psychoanalytic Thinking About Groups

There is a tradition of psychoanalytic thinking subsequent to Freud’s “Group Psychology and the Analysis of the Ego” (1921) that continues in this same vein of skepticism about group life and its consequences. Wilfred Bion’s (1962) Experiences in Groups characterized three distinct forms of irrational or “basic assumption” group mentality—fight-flight, dependency, and pairing—elaborating Freud’s understanding of the loss of discriminating and reasoning capacity that took place as a consequence of identification with the group. Bion followed Freud in taking the church and the army as exemplary instances of the submergence of the individual in different kinds of group.

Some post-Kleinian psychoanalytic writers have continued to explore the risks of psychic regression inherent in group life. Ronald Britton (2002) described two opposite poles of misidentification of the individual with a collective imaginary in his descriptions of “idolatry” [a fetishism of the image] and “fundamentalism” [a fetishism of the word], extending the analysis of pathological group identifications in ways that capture contrasting kinds of group phenomena. Donald Meltzer’s (1994) writing frequently refers to life within institutions, including psychoanalytic societies, as damaging to creativity and even as inherently pathological.

Within this predominantly negative psychoanalytic perspective on group affiliations, it is hard to find substantial grounds for discriminating between the different kinds of group affiliation represented by families, nations, races, and ethnicities, and by organized systems of religious or political beliefs. It is also tempting to find in all such affiliations large risks of a loss of rationality and individuality, insofar as collectives are deemed to be constituted by irrational and polarizing projections of feelings and beliefs.

Melanie Klein and the Object-Relations Perspective in Psychoanalysis

However, there are also in Freud’s work the seeds of a more discriminating and positive conception of group affiliation. The central idea is that of identification and the object relatedness that emerges from this both in Freud’s and in subsequent psychoanalytic writing. Once it is recognized that a person is to be understood not as a bundle of self-gratifying and tension-reducing desires but as a self constituted by his or her identification with others, a psychoanalytic understanding of the social nature of human beings emerges. Freud’s distinction between desiring to possess an object and desiring to be that object is a crucial one. It was from these elements of Freud’s writing that Melanie Klein developed her theory of object relations.

Klein argued, contrary to Freud’s theory of primary narcissism, that infants are object related from the beginning of their lives, a view later taken up by Winnicott. Klein (1935, 1940, 1946) wrote that the development of the infant personality takes place through processes of projection and introjection. She formulated a contrast between the paranoid-schizoid and depressive positions and the patterns of emotion and thought that characterize them. The paranoid-schizoid position involves a radical splitting between good and bad elements of experience. Klein explained the origins of this structure of
mind in the baby’s experience of good and bad aspects of the mother, or in Klein’s shorthand, the “good and bad breast.” The baby is not at first able to recognize that the good and bad aspects of the object that sustains and cares for it belong to the same object. Only as its mind develops, and it comes to experience both itself and its mother as whole beings, does the infant become able to recognize that the mother who is often a source of pleasure and delight is at other times a cause of discomfort and pain. Klein describes the “depressive position” as the stage at which the infant comes to recognize its own capacity for destructiveness and wishes to make reparation for the injuries it thinks it has done to its object. She referred to these paranoid-schizoid and depressive states as “positions” rather than as stages because she believed that they were configurations of mind that could manifest themselves at any moment of life and not only during the phases of infancy. The capacity for thought, in Klein’s and in Bion’s more developed account, is essentially linked to this process of mental integration. It is only when the loved and hated aspects of the other and the self are understood to belong to the same person that the capacity for symbolization can develop [Segal 1957/1981].

Bion (1984a) developed Klein’s ideas through his concept of the relation of container and contained (or containment) and further contributed to understanding the relations between the individual and the group. Probably drawing in part on the contemporary pioneering work of naturalistic infant observation undertaken by Esther Bick, Bion proposed that the development of psychic integration and the capacity for thought (“the mental apparatus”) depends on the capacities of mother or substitute caregiver to take in the unconscious projections of feelings of the infant and to modulate their intensity and possible toxicity. By maintaining the psychic equilibrium of the infant within this early relationship, mother enables her infant to integrate its feelings and perceptions and to develop the mental resources for understanding both its own mental life and that of other persons.

Bion (1984b) further proposed that in paranoid-schizoid modes of being, it is not only the intentional objects of mental life that are subject to destructive attack. He demonstrated, through his clinical work with exceptionally disintegrated patients, that in extreme conditions mental functioning itself is attacked as a further way of detaching the self from intolerable aspects of its reality.

Another valuable concept for understanding the emotional life of groups is that of projective identification, first discovered by Klein (1946) but further elaborated in post-Kleinian psychoanalytic writing (Spillius 1988). This is the process by which unwanted or unbearable aspects of the self are unconsciously lodged in others. Others’ intentions and states of feeling are as a result misperceived: the objects of projective identification come to be seen as filled, for example, with hate or envy, when these emotions have their true location in the self. Projective identification is thus a transitive phenomenon, liable to affect the objects of identification who may unconsciously find themselves taking on attributes ascribed to them. Introjective identification describes the opposite process. Here the self internalizes attributes belonging to others as a result of their intrusive projections. These concepts have had their primary use in understanding the different kinds of projective and introjective relations between mothers and babies and between analysts and analysands in the therapeutic interactions of the consulting room. However, as I discuss later, they have a wider social application to social relationships as well.

Presupposed in the understanding of these patterns of interaction and identification is the presence of dispositions both to love and to hate in the relationships between human beings. This idea derived from Freud’s distinction between the libidinal and self-preservative instincts and from his later conception of the life and death instincts. Freudian psychoanalysis has a fundamentally dualistic conception of human nature in which love and hate strive for dominance over the personality. Klein in particular held that negative states of mind are innate in human beings. This was her most contested belief, which divided her from other psychoanalysts, including many in the British Independent tradition, such as Donald Winnicott (1960, 1964), who preferred to explain negative and destructive states of mind as the outcome of deficits in the early environment rather than to see them than as inescapable elements of human nature.

I suggest that these concepts together provide psychoanalytic resources with which to understand the emotional life of groups and the collective identifications with entities such as race, ethnicity, and nationality that are the subject of this chapter.

**Identification Through the Life Cycle**

Psychoanalytic theory and practice have primarily concerned themselves with the investigation of the object
relationships established in the earliest years and with their consequences for later mental life. This is because its ideas and techniques have been mainly developed in clinical practice in which primary emotional relationships, including those that find expression in the transference, have been the main focus of attention. This is not only because patients may bring such preoccupations to their analysis as matters of great concern to them but also because psychoanalysts may believe that even if patients do locate their problems in the more “external” spheres of their social lives, workplaces, or even politics, what psychoanalysis can contribute comes mainly from its understanding of the “unconscious” configurations established early in life.

This classical psychoanalytical perspective has not hitherto allowed much scope for the investigation of the ties of identification, attachment, and antagonism that are established in later life. Yet it is surely clear that the processes of identification and introjection do not usually stop at the end of infancy but continue throughout the life cycle even if the experience of early object relations within family contexts has a lasting influence on the personality.

Consider, for example, the significance for individual development of children’s relationships with neighboring families; with teachers, friends, or mentors early in their working lives; or with figures from activities such as sports, culture, politics, or religious practices that young people feel inspired to emulate. Identification and the introjection of valued internal objects are not processes located exclusively in early childhood. It is a mistake to suppose that the world consists for nearly everyone of a “primary” sphere constituted by family, on the one hand, in which nearly all intense emotional commitment is located, and an emotionally diffuse “secondary” field of impersonal relationships on the other.

In a historical perspective, one of the contributions of psychoanalysis has been to give legitimacy to this split between the private sphere, conceived as the sphere of emotional intensity, and the “public” sphere of institutions and markets, deemed to function most efficiently where emotions are excluded. The positive effect of this focus of psychoanalytic attention has been the deep understanding it has given of early mental life and its developmental consequences. However, a negative effect has been a neglect of the intense feelings that can be located in the kinds of activities and relationships that occur later in life. This has led the social and institutional spheres to be seen as external, and even inimical, to the well-being of the “subjective” self. The focus of much “applied” psychoanalytic writing, following Freud, on the pathological and destructive aspects of group life and group experience has given further force to the implicit denigration of the “public” sphere.

This focus on the private sphere has limited the explanatory capacities of psychoanalytic thinking and made it difficult to attend to necessary discriminations between more and less benign kinds of collective identification. There has also been a tendency for psychoanalysts to seek explanations of pathological social phenomena in causes that are essentially “internal” to the individuals involved in them. Such explanations are often inadequate, because many kinds of social oppression, cruelty, and violence are institutional in their origin and cannot be explained as the outcomes of the psychopathologies of individuals. There are causal connections between individual and social pathologies, but they go in both directions. Individuals can bring about harm to their network of social relations, but they may also be damaged psychologically by the effects on them of the social structures in which they are located.

### Sublimation

Freud sought a resolution of the intractable conflicts between instinctual desires and the constraining demands of external reality through his concept of sublimation. Whereas the repression of desires through an overpowerful superego contributes to neurosis and misery, their sublimation through the images and narratives of art and the intellectual constructions of the sciences makes possible alternative satisfactions, taking the form both of symbolic wish fulfillments and of imagined new realities and possibilities. The idea of “sublimation” as enabling individuals to transform their instinctual desires into attachments to shared objects of value points toward forms of identification broader than the fields of the arts and sciences that were given special privilege by Freud.

Psychoanalysts have often been drawn to the arts as the sphere of human activity for which they feel the most admiration and affinity. This may be because psychoanalysis is itself a practice devoted to the understanding of symbolic expression. There have been many significant writings, from Freud’s essay on Leonardo da Vinci [Freud 1910] onward, in which the meanings of works of art have been interpreted from a psychoanalytical perspective. The internalization of “good objects” is important in the development of artists and scientists. However, whereas psychoanalysts from Freud onward have tended to focus on artists’ identifications in their
early lives, it is valuable to consider artists’ identifications with fellow artists and their traditions of work as also formative in their development. The object-relations perspective developed by Klein and many others makes possible a much broader recognition of the significance of such identifications than the concept of sublimation can by itself provide.

The identifications of artists (and scientists) with the achievements of their predecessors and with their forms of practice are exemplary of the kinds of identifications one might wish to see in every sphere, such as in people’s relationships to their work or to their environment. There are traditions of radical social criticism that have explicitly sought to link Freud’s concept of sublimation to the idea of a more liberated and expressive society [Marcuse 1956]. The positive and negative potential of such social identifications is the main subject of this article.

Identification and Group Affiliations

I have so far argued that individual identity is built up through identification with and attachment to other significant persons, in the first instance within the context of a family, and that such identifications often become extended during personal development to encompass attachment to specific places, to a larger network of familiar people, and to objects, activities, and practices. Where such object relations are dominated by the life instinct and feelings of love and attachment, the self becomes enriched through internalization and can contribute in its life-giving activities to the well-being of others. Where object relations and identifications are predominantly paranoid-schizoid, the self is taken over by feelings of hatred and seeks to damage and diminish those it defines as “others.” These are contrasting “structures of feeling” that can pervade an entire social formation.

This leads us to the categories of race, ethnicity, and nationality that are our primary topic, as well as those of religious faith and political allegiance and of membership of classes and status groups, which have been important organizers of belonging and exclusion in feudal, caste, and class-divided societies. These larger group identifications also take both positive and negative forms. On the positive side, they are elaborated in patterns of reciprocal social relationships, symbolic forms, and normative rules that give meaning and complexity to individual lives. These constitute what the sociologist Émile Durkheim called a “moral community.” Insofar as a good society is more than an aggregate of pleasure-seeking individuals, its members’ relationships to their various “good objects” are essential to it. Such object relations include love for others, attachments to place, work, and art, and attachments to memories and traditions. One can think of these object relations as predominantly depressive in nature because they are based on care for the object and a capacity to tolerate its many-faceted reality.

On the negative side, there are identifications based on shared hatred and contempt for those categorized as unacceptably different. In this condition, groups become intolerant of their internal differences, and their cohesion is maintained largely through shared antagonisms. This represents a predominantly paranoid-schizoid state of mind that radically splits the dispositions to love and hate, lodging them in different (or ostensibly different) objects. This mentality is also intolerant of what Freud called the “reality principle” and may attack the activity of thinking itself, including those individuals who are believed to harbor dissenting thoughts and “messengers” who are thought to bring unwelcome news. [Consider Oedipus’s threatening attitude to Tiresias, the soothsayer, in Sophocles’s play! The persecution of religious heresies or political “deviations,” the subjugation of those perceived as inferiors, and the demonization of enemies in rival tribes or nations are examples of the excesses that come from these states of mind. The Nazi system of racial classification and its deployment for purposes of extermination and the Inquisition’s categorizations of unbelievers for purposes of persecution are extreme examples of such perverse misuses of reason in a paranoid-schizoid state of mind.

Every human society is constituted by identifications of both positive and negative kinds. Some measure of preference is normally accorded within families to fellow family members, however these are defined, over persons who are unrelated by birth or marriage. Communities that define themselves as nations routinely claim entitlements to discriminate in favor of their members, and against those of other nations, in such matters as rights of entry or residence and entitlements to material assistance. In the paranoid-schizoid condition of war, the lives and well-being of fellow citizens are routinely assigned far greater value than those of enemies of the nation. Perceptions and beliefs, as well as sympathies, are shaped by these identifications. It is always enemies in war, rather than one’s own side, who
are believed to commit atrocities. The problem is to decide where the lines between inclusion and exclusion should be drawn and to determine how far entitlements should be extended to strangers, such as asylum seekers, refugees, or immigrants to a country.

There are persuasive arguments from evolutionary psychology, and from what one might term “evolutionary psychoanalysis,” for believing that a disposition to both positive and negative identifications with others is genetically innate [Hopkins 2003]. Human beings first evolved living in relatively small hunter-gatherer groups. Although technologies, social organization, and cultures have developed hugely since that era, it seems unlikely that the human biological inheritance has altered very much. What was conducive to survival in early human societies, living in conditions of scarcity, seems likely to have been a strong predisposition to loyalty to one’s own extended family group and a suspicion of outsiders as potential rivals and competitors [Hrdy 1999]. Much larger social identifications, including in recent centuries identification with all of humankind, have of course developed as part of humanity’s cultural and social evolution. One version of humanity’s progress is the advance of more universalistic orientations based on reason and on the weakening of habitual and traditional norms. Yet these more inclusive identifications continue to exist alongside, and to contend with, those of more local and particularistic kinds.

Contrasting traditions of political thought have based themselves on opposed particularistic and universalistic principles. Conservatives have been almost by definition more sympathetic to the value of group ties, including the larger affiliations of, for example, kinship, nationality, and religious belief, than have those at the opposite end of the conservative-liberal spectrum. This perspective has generally accepted hierarchy and inequality as normal and necessary attributes of human societies. Liberal political theory has, by contrast, tended toward universalism, has usually focused on the interests and entitlements of individuals, and has been antipathetic toward particularistic attachments. This tradition has been generally committed to equality between individuals, although usually equality of opportunity rather than of condition. One form of universalism is the utilitarian principle of the “greatest happiness of greatest number,” according to which every human individual counts equally, with no preference given to kin, fellow believers, or co-nationals in the calculation of the morality of actions. Kant’s “categorical imperative” also demands that the morality of actions be judged by universalistic criteria. The morality of an action is defined by whether one could consistently prescribe its equivalent for anyone in a similar position, disallowing any preference for oneself or any other particular individual. The classic proclamations of human rights, from those of the American and French Revolutions to the United Nations Declaration of Human Rights of 1948, gave a political and constitutional form to a universalistic perspective on human entitlements, declaring all men [and later women] to be created equal.

Each of these traditions, in its pure form, has its deficiencies. The limitations of particularisms are almost self-evident. The assertion of allegiance to one’s group, whether it be family, nation, or ethnos, over more equal and universal claims risks becoming a paranoid-schizoid orientation whenever any element of insecurity or anxiety leads to attention being directed toward those deemed to lie outside the group. However, there are inherent problems with universalistic moral systems as well. It is usually through particularistic social ties and identifications that individual lives, and indeed shared lives within associations and networks, are given their most intense and complex meanings.

It is unsatisfactory to suppose that men and women should take no account whatever of their group affiliations in deciding on the desirability or morality of their actions. It is hard to imagine any functioning human society in which no preferences at all are expected to be assigned to those linked to an individual by ties of kinship, friendship, shared culture, or belief. The problem is to decide how the assignment of equal entitlement and respect for all human beings are to be reconciled with the more particular attachments and preferences that are formed within social relationships and communities of value.

The contest between these two orientations is complicated by the reality that the historical advocates of the universalist cause have been not only the movements for democracy and human rights but also the ideology of capitalism, which has proclaimed the sovereignty of the individual in the competitive marketplace as the highest good. This ideology not only neglects the value of social affiliations and memberships but also tends to insist on the priority of the self-interest of the individual over all other claims.

Can psychoanalytic thinking help us to make necessary distinctions between forms of group attachment and identification that are benign in their consequences and those that lead to antagonism, denigration, and oppression?
Psychoanalysis and Group Differences

I propose that it can do so, in two ways. The first of these is in the contribution that a psychoanalytic theory of identification can make to thickening and deepening our understanding of the nature of societies and individual lives within them. The second is in regard to the processes through which societies establish classifications and distinctions between their members (and nonmembers) and the states of mind in which they do this.

However, before considering these questions, it is necessary to state that the universalist principle that all human beings are entitled to respect is one whose justification lies beyond psychoanalysis itself. Insofar as Freud set out to develop a new science of the mind that would be relevant to all of humanity, he was subscribing to an already existent and powerful universalist system of values and was not its discoverer. Freud was criticized for assuming in his theories of the mind greater uniformity among human beings than was anthropologically or historically justified. However, although this may be a limitation of his thought, it only further establishes that he was a universalist and humanist in his fundamental orientation.

The principle of just human consideration is essentially one that recognizes all human beings as sharing the same attributes of value. This act of recognition means that a “depressive” orientation that acknowledges the different attributes of “whole objects” will recognize as whole objects human beings as such as a kind or species. Any kind of denial of recognition to a subcategory or class of human beings becomes ipso facto an enactment of paranoid-schizoid splitting. This is at any rate one way in which one may conceptually integrate a psychoanalytic way of thinking into a respect for universal human rights.

On the question of the psychoanalytic understanding of the well-being of societies and human relations within them, I have set out here the contribution that the theories of object relations and of identification—indeed of sublimation also—can make. According to this perspective, satisfying lives depend on the internalization of good objects and on commitment to them, whether these are relations, for example, with loved persons, vocations, forms of art, physical environments, or traditions or heritages. A life lived for “pleasure” is empty and unsatisfying, except where pleasures are found in relation to objects distinct from the self. When social systems attack such intrinsic relations to internal objects, they damage well-being. There are many ways in which actual social systems do this and come between individuals and associations and their self-fulfillment. The excesses of markets and the impositions of authoritarian bureaucracies are two of these.

This approach is consistent with the approach of contemporary neo-Aristotelian philosophy (MacIntyre 2007; Nussbaum 2009), which takes the conditions of human “flourishing” within the roles and relationships that make this possible as its positive agenda. This approach is in opposition to the theory of pleasure-seeking individualism, which is the implicit foundational justification of societies dominated by acquisition and exchange in markets. The neo-Aristotelian view criticizes individualism as positing an empty subject.

Now to the question of the processes by which societies make discriminations between their members (and nonmembers) in regard to their specific entitlements. Critical is the extent to which discriminations are made in a predominantly paranoid-schizoid or a depressive state of mind. This differentiates between an attitude toward others dominated by hatred and antagonism and one dominated by respect and love. A circumstance that greatly influences the balance between paranoid-schizoid and depressive mentalities, in both individuals and groups, is the level of anxiety, both conscious and unconscious, that prevails. The more anxiety-ridden, the more paranoid-schizoid, or the more persecuted by others people feel themselves to be, the more they will be liable to persecute others. This is why violence, in particular when it is unpredictable and unexpected, has such traumatizing effects on all who experience it and why it is so liable to lead to escalating cycles of retribution.

Insofar as there has been historical development, uneven as it is, toward greater universalism and inclusiveness, it seems likely to be the outcome of a lessening of prevailing levels of anxiety and insecurity for at least some parts of the world’s population. Norbert Elias (1983, 2000) proposed in the 1930s a theory of the civilizing process in which the violent expression and enactment of instinctual impulses, including cruelty and violence, became inhibited and sublimated. Elias described the development of civility and manners as part of this inhibition. He saw modern sports as in some respects the sublimation of drives and emotions that in other circumstances are discharged through war (Elias and Dunning 1986). Elias set Freud’s Civilization and Its Discontents in a sociological and historical perspective. He argued that the distinction between the individual and society was a false one, because the individual and the social were inextricably part of one another. This
is a relational perspective, like the later object relations development of Freud's ideas, although in Elias's case drawing on the group analysis tradition of S.H. Foulkes rather than Klein. Elias showed that the innate conflict between instinctual desire and necessary social constraint was a mutable one, when one investigated it historically.

One can conclude from these arguments that a lower incidence of wars and a worldwide diminution of material scarcity, should these be achieved, might lead to the continued evolution of more civilized and inclusive forms of morality. Yet recent historical experience does not suggest that such a benign evolution can be taken for granted.

However, paranoid-schizoid states of mind are not only the consequence of group anxiety. They are sometimes constitutive of structures of group relations and become the psychological basis of enduring systems of discrimination. The practice of oppression can generate the anxieties and fears that then reinforce it. The social relations of imperialism, in whatever imperial regime, are invariably structured by definitions of superiority (of the dominant group) and inferiority (of the dominated) that may be stable over long periods of time. The social identifications formed in these structures and cultures enforce notions of superiority and inferiority as members of each generation learn who they are and who they can (and cannot) legitimately hope to be. Institutional racism is a similar system of oppression in advanced societies and may be the legacy of imperialist mentalities brought home.

The psychoanalytic theory of projective identification [Sandler 1988] enables one to understand the processes by which such identities are established. Identities are constructed interactively. When dominant groups perceive themselves in idealized terms, subordinate groups are correspondingly defined as lacking the desired qualities of the powerful and as burdened with qualities that the dominant groups wish to get rid of or disown. If individual members of subordinate groups wish to cross over or escape into the ranks of the powerful, they must identify with the dominant and reject the attributes and values of the community they are trying to leave. It is in understanding these transactions between the rulers and the ruled under the social relations of colonialism that Franz Fanon's (1952) contribution to psychosocial understanding was so indispensable. The processes of projective identification are transitive, that is to say, they are a form of psychological action. They explain the mechanisms by which states of mind of superiority and inclusion, and inferiority and exclusion, are reproduced.

A further aspect of the ways in which social discriminations are made in more and less malign ways concerns the potential for reflective thought that a system of social relations encourages or undermines. It is a function of paranoid-schizoid and “borderline” states of mind that they inhibit thinking and instead dispose to the acting out of unconscious desires and unconscious responses to anxiety. The Chilean psychoanalytist Ignacio Matte Blanco (1988) described the unconscious as functioning through a combination of conventional and symmetrical logic, the latter being a mode of thinking in which differences are disregarded. In this state of mind, particulars become dissolved into false equivalences or “classes,” and the capacity to discriminate different aspects of reality becomes lost. “All Jews, blacks, women, gays, refugees... etc. are the same” is the characteristic form these acts of non-thinking take, and “the same” usually means something bad. As I discuss later, discriminations made on grounds of race are the most irrational of these, in part because there are so few empirical facts to justify racial categorization and classification. Psychoanalytic approaches may contribute to a lessening of malign projections because they can encourage the understanding of unconscious anxieties and states of mind.

Nationality, Ethnicity, and Race

There is a final question: Can one discriminate between the distinctions of nationality, ethnicity, and race from the psychoanalytic point of view set out here? Are they similar or different in the nature of the social relations to which they are liable to give rise?

Each of these forms of collective identification—indeed all such identifications—can be organized as structures of largely destructive antagonism and conflict. Yet we can differentiate between them in the degrees to which they may also embody possibilities for positive identification and for the development of objects of attachment. Theorists of nationalism such as Ernest Gellner (1983) have demonstrated that at a certain phase of economic development, nation-states have been the organizers of new kinds of membership and attachment. Although these categorizations were established at the expense of preexisting social ties (located in regional, linguistic, or would-be national communities, for example, whose possibilities for development were thereby suppressed), the new national cultures were of-
ten in some respects productive, for example, of economic development, conceptions of shared rights, and distinctive literatures. The dysfunctions of antagonism between nations and the emergence of more global kinds of human connectedness may now be rendering “nation” a somewhat obsolete signifier of identity, but that does not mean that its historical role has been an entirely negative one.

Ethnicity is a concept defined largely through the idea of shared culture. Culture is a system of meanings and values—the symbolic representation of a form of life—that embodies some dimensions of positive object relations and attachment. There are substantive differences between the cultures of groups and networks with different histories and trajectories, and such differences are sometimes valued as traditions or signifiers of common membership. George Orwell’s characterization of Englishness in his essay *The Lion and the Unicorn* [Orwell 1941] at a crucial point in World War II is an example of such a positive ascription of value, although it had a conflictual purpose of imaginatively constituting a national identity worth fighting for.

Discussions of race in modern society are now sometimes reformulated into the discourse of ethnicity. This probably indicates some progress, because the idea of ethnicity takes account of the cultural construction of group identities, whereas the idea of race does not. Thus although “racial” identities can degenerate into vicious states of projection and splitting, they can also contain more benign elements in which members of a self-defined group are more preoccupied with the cultivation of their own “good objects” than with disparagement or contempt for the “bad objects” perceived in or projected into others. Thus the affirmations and celebrations of minority cultures (e.g., black cultures) have had a positive value, seeking to establish relations to “good objects” (e.g., the rediscovery of lost histories or the recognition of traditions such as those of black American literature or music) that may help to displace the negative or inauthentic internal objects projected into them in racialized societies.

If one takes seriously the idea that ethnicity is defined by cultural practices and by the forms of lived lives rather than by biologically given essences, its difference from the category of race is clear. *Ethnicities* are subject to continuous change and development through experiences of migration and intercultural interaction. Stuart Hall [1992] memorably described ethnicity as a state of hybridity, paradoxically using a metaphor from genetics to describe a cultural process. One conclusion that follows from this conception of ethnicity and its mutability is that migration and intercultural connectedness should be seen as sources of possibility for innovation and creativity and not merely as threats to preexisting ways of life held to embody some unchanging essential good.

Finally, I turn to the concept of race itself. I began an earlier paper [Rustin 1991] by writing, “Race’ is both an empty category and one of the most destructive and powerful forms of categorization” [p. 57]. I pointed out that discriminations of race were peculiarly, even distinctively, lacking any basis in fact or rationality. Sartre [1946], writing about anti-Semitism, observed that the anti-Semite is motivated by what he called a “passion.” We could alternatively say, in psychoanalytic terms, that he or she is dominated by unconscious hatred, split off from all loving or reparative impulses and also from the reality principle. Although some have sought to find justifications for distinctions made on grounds of race (e.g., in theories of biologically given racial differences and inferiorities), these are for the most part rationalizations of positions adopted for reasons of the collective self-interest of the powerful. Insofar as the distinctions of race have any empirical foundation, they are the consequences not of biological inheritance but of social practices most often arising from oppression and discrimination (e.g., the legacy of colonization, slavery, or apartheid). Race is a category essentially constituted by discriminatory action, not the reason or fact that explains it. Race, as Farhad Dalal [2002] has well put it, is a category that is essentially produced by processes of racialization. Psychoanalytically, it is paranoid-schizoid states of mind, and the mechanism of projection identification, that best explain how this process takes place.

All three of these signifiers of difference—nationality, ethnicity, and race—have been important in the making of contemporary identities and ways of life. This is a reality, however, whose significance and consequences these categorizations and differentiations may continue to have. None of these forms of difference and discrimination can be expected summarily to disappear.

It seems likely that the environmental crisis, with its reasonable fear of a growing insufficiency of resources to sustain life, may provide the next great challenge to human civilization. In the context of widespread anxiety, one can anticipate that categorizations of difference of every possible kind might become more antagonistic and destructive. This is a challenge, however, that psychoanalysis may provide some resources for understanding.
KEY POINTS

• In the origins of the psychoanalytic theory of group psychology and group relations as set out in the writings of Freud and Bion, involvement in group psychology is seen as generally undermining individual rationality and identity.

• The development of object relations theory in the work of Klein and Bion, although building on Freud, gives greater recognition to the significance of identification in the formation of identity. Their concepts of projective identification and the relation between container and contained add to the resources for understanding identification.

• Psychoanalysis has principally considered primary identifications established in infancy and early life, for example, in relation to parents of each sex and to siblings. Yet identifications occur throughout the life cycle and provide an essential conceptual link between psychoanalytical thinking and social relations.

• There are two different forms of group identification, those dominated primarily by paranoid-schizoid and by depressive states of mind. Paranoid-schizoid identification is characterized by group self-idealization and the projection of hatred outside the group, whereas depressive identification is more reality based and complex and enables kinds of attachment that generate recognition and concern for others.

• An argument is made for a balance between universalistic and particularistic identifications. Although universalistic and inclusive conceptions of human well-being are a mark of civilization and progress, it is neither possible nor desirable that local and particular group ties disappear.

• It is argued that of all categories of social difference, "race" is the most empty of substance and meaning and is the most subject to becoming the vehicle of irrational, antagonistic, and oppressive group identifications. Furthermore, unconscious anxiety is liable to lead to antagonistic states of mind and the loss of rational capacities in groups. Psychoanalysis provides understanding of these mental processes and their effects, which are especially dangerous in times of crisis.

References

Fanon F: Black Skin, White Masks. New York, Grove Press, 1952


Psychoanalysis and Literature

Madelon Sprengnether, Ph.D.

A single idea of general value dawned on me. I have found, in my own case too, [the phenomenon of] being in love with my mother and jealous of my father, and I now consider it a universal event in early childhood. If this is so, we can understand the gripping power of Oedipus Rex.

Sigmund Freud, Letter to Wilhelm Fliess

IN THE PERIOD OF psychic turmoil after his father’s death in 1896, Freud engaged in an activity of profound self-questioning that led to the establishment of a new discipline that provided him with much-needed resources: a livelihood and professional identity, accompanied by a sense of personal mission or destiny. As a medical scientist trained in the field of neurology, Freud considered his achievement to be scientific, universally applicable, and valid across time. I prefer to call attention to the ways in which it may be viewed as a form of literary endeavor. Such an approach, while limiting some paths of investigation of the relations between psychoanalysis and literature—fields too broad to examine in the totality of their interactions—will, I believe, illuminate one important aspect of their inter-involvement over the course of the 20th century: the construction of personal subjectivity.

Freud’s self-analysis in the aftermath of his father’s death was foundational in the sense that it laid the groundwork for the development of psychoanalysis as a new set of theories and clinical practices, it was also an act of self-creation, hence a form of autobiography. That
Freud drew from literature in his labor of self-construction is so obvious that it hardly seems to merit scrutiny. To Freud’s mind, works such as Hamlet and Oedipus Rex served to confirm the truth of his inner discovery—that every man wants to murder his father and marry his mother. Viewed in this light, literature demonstrates the timeless validity of Freud’s insight. Viewed from another angle, however, a text such as Oedipus Rex may be seen as providing a ready-made framework for Freud’s self-understanding.

We know, for instance, that Freud was long and well acquainted with Sophocles’ play and that it held a special place in his imagination (Rudnytsky 1987). He studied it especially carefully in preparation for his Maturity examination, writing braggishly at the time to his friend Emil Fluss: “The Greek paper, consisting of a thirty-three verse passage from Oedipus Rex, came off better. [I was] the only good. This passage I had also read on my own account, and made no secret of it” (E.L. Freud 1975, p. 4). That Freud was particularly affected by Oedipus’s fate is manifest in a story recounted by his biographer Ernest Jones (1955). On his fiftieth birthday, Jones relates, Freud was presented with a medallion bearing an image of Oedipus confronting the Sphinx along with the inscription “Who divined the famed riddle and was a man most mighty.” On receiving it, Freud “became pale and agitated and in a strangled voice demanded to know who had thought of it. He behaved as if he had encountered a revenant, and so he had” (II, p. 14).

As a young student, Freud then explained, “he used to stroll around the great arcaded court inspecting the busts of former famous professors of the institution. He then had the phantasy, not merely of seeing his own bust there in the future, which would not have been anything remarkable in an ambitious student, but of it actually being inscribed with the identical words he now saw on the medallion” (II, p. 14).

Early in his life, it seems, Freud formed an identification with Oedipus as a powerful and courageous investigator. It should hardly be surprising that he would turn to Oedipus as a model for his pursuit of self-knowledge in the midst of his mental upheaval in the late 1890s. In this sense, Sophocles’ Oedipus Rex helped to shape Freud’s questioning and refashioning of his selfhood—to the point that he became the literary hero he admired.

If I seem to be prioritizing literature over psychoanalysis, I am doing so for a reason. Even considering the possibility that literature illuminates Freud’s self-analysis and the discipline to which it gave rise alters the way we perceive these two great textual traditions. Rather than using one to explain or interpret the other, we may consider the ways in which each engages with and influences the other. Both, after all, participate in culture, deriving from and creatively intervening in the web of material and social relations of what we broadly consider the tradition of Western civilization.

Many have commented on the intensity of Freud’s internal self-questioning in the years immediately preceding and following his father’s death as well as the creativity of its resolution in the form of the key concepts and hermeneutic principles articulated in The Interpretation of Dreams (Freud 1900) and other seminal papers. Few, however, challenge the specific formulation of the Oedipus complex or the solution it provided Freud in the midst of his personal and professional crisis. While recognizing Freud’s labor of mourning, for instance, Mark Edmundson (1990) does not pause to consider why Freud did not locate mourning at the core of his theoretical enterprise. Rather, he emphasized Freud’s process of mourning as one that led to a successful reconceptualization of selfhood—one that served not only to release him from the strictures of Victorian culture but also to inaugurate a new, more flexible and dynamic model of subjectivity, suitable to a new era.

Why Oedipus?

I have argued elsewhere (Sprengnether 1995a, 1995b) that Freud’s heroic self-conception—challenged by his lack of professional success in the early years of his marriage and by the upheaval of his grief—required an ambitious model of subjective development, one that was also consonant with the patriarchal social order and gender biases of his time. Freud’s initial assumption that hysterics were victims of sexual abuse did not satisfy these conditions, because it emphasized the position of helplessness that Freud associated with femininity. Because he understood his own symptoms and those of several siblings to be “hysterical” in nature, he would have had to accuse his own father of abuse. Writing to his friend Wilhelm Fliess, he confessed as much: “unfortunately my own father was one of these perverts and is responsible for the hysteria of my brother [all of whose symptoms are identifications] and those of several younger sisters. The frequency of the circumstance often makes me wonder” (Masson 1985, p. 231).

Freud’s “discovery” that he himself as a child was a budding Oedipus reversed the vector of interpretation of hysteria—from father to son. This reversal deflected
attention from the father’s perverse and oppressive authority to the son’s healthy sexual drive and ambition. In this respect, Freud’s formulation of the Oedipus complex provided him with a form of selfhood that validated the “conquistador” side of his nature, his need for “masculine” adventure and conquest. Sophocles’ play lay at hand, so to speak, for Freud’s use at a time when he was at a loss on all levels—suffering from a host of physical symptoms [headaches, sinusitis, heart arrhythmia, impotence] as well as from self-doubts about his competence as a physician and profound grief over his father’s death. He pulled himself up by his own bootstraps, as it were, in the labor of his self-analysis, convinced that the work he performed on his own psyche was universally applicable.

The autobiographical ground of Freud’s first major theorizations has escaped close scrutiny. Instead, Ernest Jones (1953, 1955, 1957) and Peter Gay (1988), Freud’s primary biographers, took his self-analysis at face value, accepting without question its thoroughness and ultimate truth value. For them, Freud was who he said he was—an everyman whose oedipal subjectivity, like an X-ray image, reveals a universal psychic organization.

The material of Freud’s life, as evidenced by his dreams and other forms of mental activity, served as the basis of his self-analysis and the general principles or theories he constructed about the nature of unconscious life. Freud’s major biographers make use of his theories, in reverse order, to explain his life, as though the two perfectly coincide. Freud himself offered a model for this approach in an essay titled An Autobiographical Study [Freud 1925a], which is autobiographical only to the extent that it features his role in the development of psychoanalysis. Justifying his omission of information that does not directly relate to the history of this discipline, Freud writes, “This Autobiographical Study shows how psycho-analysis came to be the whole content of my life and rightly assumes that no personal experiences of mine are of any interest in comparison to my relations with that science” (p. 71). It is as if Freud wished to erase his personal history in favor of the principles he elaborated from it.

We know that Freud purged his personal papers at least three times in his life, as if solicitous to leave only those records that fit his self-conception. He was particularly anxious that his correspondence with Wilhelm Fliess, obtained by Princess Marie Bonaparte in 1936, be destroyed, writing to her in no uncertain terms, “I want none of them to come to the notice of posterity” (Gay 1988, p. 614). Nor did he wish to see his biography written during his lifetime—actively discouraging his friend Arnold Zweig from this endeavor with the forbidding comment, “Truth is unobtainable, mankind does not deserve it, and in any case is not our Prince Hamlet right when he asks who would escape whipping were he used after his desert?” (E. L. Freud 1975, p. 127).

The Freud who understood himself as Oedipus and Oedipus in turn as a universal model of male subjectivity was, it seems, supremely self-assured and unwavering in his conviction of the rightness of his discoveries. This Freud gave rise to forms of literary interpretation that seemed equally confident of their claims. A generation of literary scholars made use of psychoanalysis—in ways now considered naive and reductive—to resolve the ambiguities of literary authorship and production. They discovered oral, anal, and phallic stages in works of poetry and fiction; demonstrated how an author’s neuroses manifested themselves in his or her writing, and maintained in general that texts could be elucidated by a thorough examination of their unconscious content. This approach not only elicited resistance from the literary community but also seemed self-limiting, because the hunt for hidden sexual symbols and evidence of psychological dysfunction fell short of illuminating literary texts in their full range of construction and meaning.

For the so-called New Criticism, psychological approaches to literature—along with other extratextual forms of interpretation—were anathema. The opposition of this school, which dominated the field of literary study for more than 40 years, contributed to the marginalization of Freudian studies of literature. The inherent restrictions within this field, combined with its dismissal by the dominant mode of literary interpretation in England and America in the middle years of the 20th century, eventually led to its demise.

Psychoanalytic criticism of literature in its earliest stage of development consisted mainly in applying various Freudian concepts to literary texts. This practice accepted Freud’s ideas uncritically, in much the same way that Freud’s biographers accepted his account of his self-analysis—as accurate and complete, to the extent that any analysis may be considered to be. A more interesting Freud, and correspondingly more interesting uses of psychoanalysis in relation to the study of literature, emerges out of a more skeptical stance toward Freud’s self-analysis, including the process of psychoanalysis itself.
Although the early attempts at applying psychoanalytic concepts to literary authors and texts did not gain wide acceptance, Freud’s ideas penetrated deeply into Anglo-American culture. The appearance of James Strachey’s translation of his complete works into English in 1953 greatly assisted this process, as did the publication of Ernest Jones’s three-volume biography, beginning in the same year. The availability of Freud’s work in translation meant that English-speaking readers could encounter his ideas in their highly original means of rhetorical presentation. Some readers, as a result, began to interpret his texts from a literary standpoint, using concepts and techniques of analysis specific to their training.

Steven Marcus [1974], a critic especially adept in the New Critical practice of close reading, treated Freud’s Dora case history as an example of modernist fiction. Marcus examined the means by which Freud constructed this famous narrative, maintaining “that Freud is a great writer and that one of his major case histories is a great work of literature” (p. 57). From this standpoint, Marcus argued that Freud’s text resembles “a modern experimental novel” (p. 64) in its nonlinear structure, use of reconstructed dialogue, and deployment of Freud himself as a character. Marcus referred to the dramatic plots and devices of writers such as Ibsen, Borges, Nabokov, Joyce, Mann, and Proust as offering points of comparison to Freud’s narrative strategies. He emphasized, in particular, the constructed or fictional nature of the case history as a form of writing, dependent as it is on the analyst’s personal recollection and individual choice of structure and presentation.

In addition, Marcus called into question a critical feature of Freud’s interpretation—his presumption that Dora felt Herr K’s erect member when he accosted her at his place of business. Here, he stated, “Freud is as much a novelist as he is an analyst. For the central moment of this central scene is a reconstruction that he formed in [his] own mind” (p. 79). Later, Marcus pressed this point, saying in effect that Freud’s case history constitutes an idiosyncratic form of self-narrative. “As the case history advances,” Marcus maintained, “it becomes increasingly clear that Freud and not Dora has become the central character in the action. . . . We begin to sense that it is his story that is being written and not hers” (p. 85). By the end of his essay, Marcus has deconstructed Freud as analyst and re-created him in the guise of an “unreliable narrator” (p. 80), one who misleads not only the reader but also himself. In his identification with Dora’s father, Marcus maintained, Freud failed to recognize the degree of his personal investment in the correctness of his interpretation. Here, Marcus focused on the blind spot of Freud’s treatment of Dora—not simply his failure at the time to recognize or theorize the phenomenon of transference but more significantly his lack of understanding of his own emotional involvement.

Toward the end of Analysis Terminable and Interminable, Freud [1937] described two major obstacles to successful resolution of analysis in women and in men, each of which corresponds to a “blind spot” or limitation in his own thinking. For women, such resistance arises from envy of the penis or the wish to obtain a male organ—a wish that cannot be gratified. In this sense, women struggle to deny their anatomical deficiency, their given condition of castration. Men also resist castration, in the guise of what Freud terms the “repudiation of femininity” or unwillingness to accept a passive or feminine relation to another man. Neither women nor men, it seems, want to embrace femininity, nor does there appear to be any solution to this problem, because “the biological field” according to Freud, “does in fact play the part of underlying bedrock. The repudiation of femininity can be nothing else than a biological fact, a part of the great riddle of sex” (Freud 1937, p. 252).

Freud’s conviction that femininity signifies castration not only deformed his thinking about female sexuality but also set a limit on his ability to explore the mother-infant relationship and the period of development preceding the oedipal stage. In this sense Freud’s own “repudiation of femininity” prevented him from understanding the complexity of women’s sexuality as well as the role that women play as primary caregivers for both male and female offspring. As a result, female subjectivity received short shrift in Freud’s theoretical endeavor, and maternal subjectivity was effectively absent [Sprengerth 1990].

Freud’s idealization of the mother-son relationship, described in “Femininity” [Freud 1933] as “the most perfect, the most free from ambivalence of all human relationships” (p. 133), made it difficult for him to examine it closely, as did his shadowy concept of the period preceding the onset of the Oedipus complex, which he regarded as analogous to “the Minoan-Mycenaean civilization behind the civilization of Greece” [Freud 1931, p. 226].

What Freud failed to imagine, however, opened possibilities for future theorization—in fields such as object relations theory, which explores the earliest phase of human development as arising from a complex set of interactions between mother (or primary caregiver) and child. The evolution of object relations theory, stemming in part from Anna Freud’s interest in early childhood development, offered new avenues for understanding the emergence of human subjectivity as well.
as more nuanced portrayals of women's roles and sexual orientations. These theoretical interventions, combined with the rapid advance of the women's movement in the latter half of the twentieth century, generated a new set of engagements between psychoanalysis and literature.

Feminists at first seemed to follow the lead of Steven Marcus in closely analyzing Freud's texts for evidence of his unacknowledged biases, especially in regard to his views of femininity and female sexuality [Millett 1971]. Rereadings of the Dora case also abounded—with the seeming intent of liberating Dora from Freud's oppressive interpretation of her desire [Bernheimer and Kahane 1985]. Like Marcus, feminist critics made use of the techniques of literary interpretation developed by the New Critics in conjunction with assumptions derived from psychoanalysis about the workings of the unconscious to critique Freud's own texts. Later, however, they began to explore the advantages of object relations theory in examining literary texts in a variety of new ways—in regard to the representation of women in male-authored literature and the practices of women writers.

The mother-centered basis of object relations theory, which posits an initial phase of mother-infant symbiosis [Mahler 1972] succeeded by a phase of separation and individuation, not only assumes that the formation of identity is a relational process but also emphasizes female priority. Although this redirection of focus from paternal prohibition [the threat of castration] and authority to maternal influence does not in itself offer a theory of maternal subjectivity, it opens a new set of questions about women's relationships with their mothers and with one another. The publication of Nancy Chodorow's [1978] groundbreaking book The Reproduction of Mothering, which made use of object relations theory to demonstrate how women raise their daughters to fulfill their cultural role as mothers, was particularly influential in criticism of women's literature by feminists who saw positive value in women's special affinity for relatedness. From this vantage point, women's social conditioning, as represented in literature, could be seen to give expression to positive qualities of emotional sensitivity and attunement.

Whereas feminist literary critics were disposed to take issue with Freud, they were inclined to embrace the theories of the object relations school, which offered an implicit affirmation of female power along with a revaluation of the so-called feminine virtues of intimacy and social connection. Another outcome of the preoedipal emphasis of this body of psychoanalytic theory was a feminist argument for the primacy [and legitimization] of lesbian over heterosexual orientation in women [Rich 1980]. If a girl's first love object is her mother, why and how should she redirect her desire toward a male figure—whether father or husband? Freud (1925b) himself struggled with this question, resorting finally to the explanation that the girl child becomes disillusioned with, and turns away from, her mother because of her castrated condition. Although object relations theory does not directly challenge Freud's oedipal construct, neither does it represent the mother as castrated. Rather than emphasizing the mother's lack, it portrays her as a source of power and [potential] fulfillment. In Melanie Klein's [1975a, 1975b] highly original and influential formulation of the paranoid-schizoid and depressive positions, the mother's breast effectively displaces the father's phallus as a locus of fantasy and desire. The redirection of attention from paternal to maternal authority in object relations theory's exploration of the preoedipal period served feminist critics' desire to explore women's subjectivity as represented in literature and to envision more flexible narratives for women's desire.

In the meantime, the French psychoanalyst Jacques Lacan [1977], in the guise of a "return to Freud," recast Freud's body of theory in ways that Freud himself would hardly have recognized but that opened new possibilities for literary interpretation and expression. Lacan, steeped in the Symbolist and Dada artistic movements of the early 20th century as well as the linguistic and philosophical theory known as structuralism, produced an original synthesis that made use of psychoanalysis to illuminate the role of language in the construction of the subject. While leaving the oedipal and patriarchal organization of culture intact, he destabilized its internal structure.

Given that language is an arbitrary system of signifiers—by which words are understood in relationship to one another rather than being tied to a fixed set of meanings—Lacan argued for the status of the phallus as the primary, yet also arbitrary, signifier of patriarchal culture. The name (nom) and prohibition (non) of the father combine to effect the separation of the speechless infant from its mother and to introduce the child into the paternally organized structure of language and culture. Prior to its acquisition of language, the child is immersed in the Imaginary, a preoedipal condition of symbiosis with its mother. In order to participate in culture, it must experience a severance of this tie, which Lacan attributes to the intervention of the father's authority in the form of his non or prohibition of incest. It is not his actual penis [or his possession thereof] but rather its symbolic function, hence the term "phallus," that accomplishes this task. For Lacan, it is the acquisi-
locates them on the “wrong” side of the Symbolic Order. Although Cixous affirmed the capacity of men to participate in the fluid physical, mental, and sexual awareness that is a prerequisite for l’écriture féminine, she valorized women’s natural affinity for it. Women’s maternal functions, in particular, provide them with an added resource of experiencing an otherness within that acts like the otherness of the unconscious. “How could the woman,” she maintained, “who has experienced the not-me within me, not have a particular relationship to the written? To writing as giving itself away [cutting itself off] from the source?” [p. 90].

In This Sex Which Is Not One, Irigaray [1985b] elaborated on her ideas regarding sexual difference, arguing not only for women’s multiple sources of pleasure but also for their special relationship, as mothers, to the Imaginary and to forms of writing evolved from that experience. Because women’s sexuality is “not one,” that is to say, dependent on a single sexual organ (the phallus), their pleasures are various and not representable within the phallic economy of the Symbolic Order. Irigaray offered an example—in the form of a lyric prose poem—of what kind of writing may be needed to convey the nature and complexity of women’s eroticism:

Kiss me. Two lips kissing two lips. openness is ours again. Our “world.” And the passage from the inside out, from the outside in, the passage between us is limitless. Without end. No knot or loop, no mouth ever stops our exchanges. Between us the house has no wall, the clearing no enclosure, language no circularity. When you kiss me, the world grows so large that the horizon itself disappears. Are we unsatisfied? Yes, if that means we are never finished. If our pleasure consists in moving, being moved, endlessly. Always in motion: openness is never spent nor sated. [p. 210]

I have quoted this passage at length in order to demonstrate a key element in the theoretical interventions of the French feminists into Lacan’s formulation of the Imaginary. They not only critique his understanding of women’s place in the Symbolic Order but also offer another kind of linguistic practice to demonstrate the disruptive and potentially transformative possibilities of what they term l’écriture féminine, a genre of writing that derives specifically from the Imaginary. In this sense, these women use psychoanalytic theory to generate new forms of literary expression.

One might ask in what sense precisely l’écriture féminine is new, because certain male writers, such as Genet, Kleist, Joyce, and Shakespeare, may be said to have practiced it. Julia Kristeva [1977] offered the most extended exploration/explication of this issue in her concept of the “semitic,” a position in language that situates itself on the borderline between the Imaginary and the Symbolic. Like Cixous and Clément, Kristeva embraced the concept of carnival as a strategy of disruption. Like them as well, she assumed that an effective challenge to the Symbolic Order (given its linguistic construction) entails a specific use of language.

Kristeva theorized a relationship to language that derives from the infant’s connection with its mother, a form of expression that responds to the infant’s as yet disorganized internal state of being and multiple sources of bodily pleasure. “The drives,” she stated, “which are energy charges as well as ‘psychical’ marks, articulate what we call a chora: a non-expansive totality formed by the drives and their stases in a motility that is as full of movement as it is regulated” [Kristeva 1977, p. 93]. Although destined to give way to the law of the father, the chora, as the locus of the proto-linguistic, materially focused semiotic, remains as a memory trace—a resource from which one can draw in the practice of writing. Where Kristeva differed from Cixous, Clément, and Irigaray was in her invention of the psychoanalytic category of the chora, an intermediate phase between the condition of voiceless fusion the infant experiences with its mother and that of full access to language. In this sense, she offered a challenge from within psychoanalytic theory itself to its hierarchical ordering of the pre-epidial and oedipal stages. The writing derived from this recasting of Lacan’s revision of Freud is not so much new in its possible rhetorical forms as it is in terms of its political and psychological agenda.

The concept of l’écriture féminine authorizes existing modes of twentieth-century avant-garde writing (e.g., Genet, Kleist, Joyce, Woolf) while also encouraging feminists to generate new work along similar lines. In this sense, writers such as Cixous, Clément, Irigaray, and Kristeva conceived of literature as performing the work of psychoanalysis—insofar as it derives from the stage of development associated with the pre-epidial chora. Here, the boundary between literature and psychoanalysis (in theory at least) dissolves. It makes sense from this point of view that the feminists who critique Lacan’s construction of the Symbolic Order also practice forms of writing they consider to be revolutionary in literary terms. If the problem, psychoanalytically speaking, resides in a developmental relationship to language, then the solution, quite naturally, flows from certain uses of language as expressed in writing. Literature, instead of validating theory, as in Lacan’s readings of classic texts, constitutes a unique form of psychoanalytic writing.

Together, the object relations theorists, Lacan, and his feminist critics succeeded in deflecting attention from the oedipal to the pre-epidial stage of human development.
while highlighting modernist literature and similar forms of avant-garde writing. This set of changes also blurred the boundary between theoretical and literary practitioners, especially in the field of l’écriture féminine.

Reverie

Because memory and sensations are so uncertain, so biased, we always rely on a certain reality—call it an alternate reality—to prove the reality of events. To what extent facts we recognize as such really are as they seem, and to what extent these are facts merely because we label them as such, is an impossible distinction to draw. Therefore, in order to pin down reality as reality, we need another reality to relativize the first. Yet that other reality requires a third reality to serve as its grounding. An endless chain is created within our consciousness, and it is the very maintenance of this chain that produces the sensation that we are actually here, that we ourselves exist.

Haruki Murakami [1992], South of the Border, West of the Sun

Jacques Derrida, the philosopher of deconstruction, disputed Lacan’s conception of the phallus as privileged signifier in the process of language acquisition and by extension his hierarchical ordering of the relationship between oedipal and pre-oedipal periods. For Derrida, there is no originary state of plenitude or fullness of being (as in mother-infant symbiosis) that must be abandoned for the sake of participation in culture. Rather, we are all born into the condition of lack [the necessary gap between words and meanings] that structures language and signification. In his groundbreaking book Of Grammatology, Derrida [1976] articulated his concept of the supplement, which does not take the place of a supposedly originary condition of oneness, presence, or completion but rather structures our very subjecthood and being. Although this philosophical position regarding language and the chain of signification does not in itself constitute a psychoanalytic argument, it has significant implications for the way that contemporary psychoanalytic theorists conceive of culture and subjectivity. If, for instance, words take their meanings from other words rather than from a transcendental base of signification, then the selfhood that is constructed in language is similarly relational and contextual. In addition, if the infant does not experience a condition of oneness with its mother (as Derrida supposed it does not), then there is no need for the phallus as the signifier of the child’s acquisition of language and hence no necessary link between culture and patriarchy.

In addition to these interventions into psychoanalytic accounts of the origins of individual subjectivity and culture, Derrida practiced a form of writing that crossed boundaries among the several disciplines that he examined. His writing is simultaneously literary and avant-garde within that tradition, philosophic and linguistic in its investigation of language and its role in human development, and psychoanalytic in its interrogation of key Freudian and post-Freudian texts. The range of his work, along with the uniqueness of his style and sensibility, is too complex to represent in a chapter of this scope, yet a sample of his writing may help to illustrate not only the multidisciplinary nature of his thinking but also the way he used language in a self-consciously literary way to convey his meaning(s).

Derrida’s [1977] essay “Fors” provides a useful example of his style of philosophical, psychoanalytic, and literary investigation. This essay begins:

What is a crypt?

What if I were writing on one now? In other words on the title of the book alone, on the outer partition of its very first and entirely obvious readability?

Less still: on the first detachable fragment of a title, on its broken symbol or its truncated column-cryptonomy, still minus a name? What if I vaulted to a stop, immobilizing myself and you, reader, in front of a word or a thing, or rather in front of the place of a word-thing, as Nicolas Abraham and Maria Torok present it for us to decipher: the crypt of cryptonomy?

For I shall not engage myself further.

In place of another here the first word is—crypt.

Then it won’t have been, in principle, the first. It won’t have taken place as such. Its rightful place is the other’s. The crypt keeps an undiscoverable place, with reason.

What is a crypt? [Derrida 1977, p. 65]

Here Derrida announced, “cryptically,” the themes that he wished to pursue in this essay—which is part book review, part philosophical disquisition, and part psychoanalytic interpretation and transformation of Freud’s [1917] essay “Mourning and Melancholia.” He also made clear that the reader of such an essay will need to adjust to his genre of writing, which challenges conventional expectations.

Derrida’s [1977] essay resists categorization, perhaps most closely resembling the form of reverie, because it combines so many strands of thought while eluding disciplinary or generic labels. Beginning as a meditation on The Wolf Man’s Magic Word by Nicolas
Abraham and Maria Torok (1986), it engages Freud’s concept of melancholia as a form of encryption, the incorporation of the lost object [or traumatic memory] in the form of an inaccessible, interior psychic space. Following Abraham and Torok’s method of analyzing the Wolf Man’s language as providing clues to the nature of his encrypted memory, Derrida drew a distinction between the “normal” process of mourning as represented by introjection, which is the internalization of a love object, and incorporation, which not only fails to assimilate the experience or object in question but also seals it off [like a corpse within a crypt] from conscious awareness. “Incorporation,” as Derrida explained,

negotiates clandestinely with a prohibition it neither accepts nor transgresses.… “Secrecy is essential,” whence the crypt, a hidden place, a disguise hiding the traces of the act of disguising, a place of silence. Introjection speaks, “denomination,” is its “privileged” medium. Incorporation keeps still, speaks only to silence or to ward off intruders from its secret place. (Derrida 1977, p. 72)

Only through a painstaking dissection of the complex [and often multilingual] meanings contained in the Wolf Man’s highly idiosyncratic and selective use of language can the trace of such a densely concealed internal object be detected.

Derrida called attention to the necessarily literary form this process assumes in the work of Abraham and Torok, who felt the need to invent a discourse appropriate to their subject. Abraham, according to Derrida, “never ceased to feel the necessity, within the new type of scientific mode of verification required by psychoanalysis, of a mytho-poetic text” (Derrida 1977, p. 87). As a result, “The Verbatim reads like a novel, a poem, a myth, a drama, the whole thing in a plural translation, productive and simultaneous”; such an approach does not derive from “forms or genres which would lend themselves, let themselves be borrowed, to a psycho-analytical exposition,” but rather from the uniqueness of “a procedure which has to invent its own language” [pp. 82–83].

Derrida’s distinct manner of writing—along with his affirmation of the manner of writing of Abraham and Torok—is not simply arbitrary. It is consciously chosen as a way of gesturing at a level of reality/understanding that has no inherent linguistic form or means of expression. Derrida addressed this conundrum in the following passage, directly quoted from Nicolas Abraham’s (1987) The Shell and the Kernel:

It is within this hiatus, within the non-presence of the self to itself, the very condition of reflexivity, that the phenomenologist is standing without knowing it, to scrutinize, from the point of view of this terra incognita, his only visible horizon, that of the inhabited continents. Whereas the domain of psychoanalysis is situated precisely on that “ground of not-thought” of phenomenology. To note this is already to designate, if not to resolve, the following problem: How can we include in a discourse, any discourse that which, being the very condition of discourse, would by its very essence escape discourse. If non-presence, the core and ultimate reason behind all discourse, becomes speech, can it—or should it—make itself heard in and through self-presence? (p. 91)

To restate the question Derrida [through Abraham] proposed: How can the unconscious—by definition inaccessible to verbalization—find a means of expression or words through which to speak? Or how—as Lacan might say—can that which is by its very nature inexpressible find its way into articulation? Both Lacan and Derrida, although opposed in important aspects of their thinking, would agree with the author of The Interpretation of Dreams. The messages delivered by the unconscious are elliptic, encoded, elusive, and never completely brought out of shadow into light.

Whereas Derrida wrote in a way that might be described as reverie in order to approximate the unrepresentable element in human discourse and subjectivity, Thomas Ogden made use of the term reverie to designate the state of mind that fosters symbolic communication between analyst and analysand. Ogden, whose work is grounded in the object relations view of human development as emerging from a matrix of relationship [between infant and mother or other primary caregivers], incorporates the insights of intersubjective theory, which emphasizes the analyst’s subjectivity and, by extension, the role of the countertransference in the analytic encounter, into his concept of the “intersubjective analytic third.”

For Ogden, the engagement between analyst and analysand gives rise to a shared space of subjectivity that is co-created and based in states of mind that are dreamlike in their unconscious burden of meaning. Ogden borrowed from D.W. Winnicott’s (1971a) work in its emphasis on play as a point of entry into the symbol-making function of the unconscious, as well as a means of engaging children in treatment. Winnicott’s (1971b) famous squiggle game in which child and analyst together create an image on paper, leading gradually into a shared fantasy space where analytic interchange can begin to occur, offers a model for Ogden’s understanding of what happens between the adult patient and analyst. Ogden drew, in addition, from the somewhat enigmatic [and hence less accessible] work of W.R. Bion (1962) in
in unconscious experience, we are students of metaphor” [Ogden 2001, p. 41].

Making good on this claim in “The Music of What Happens in Poetry and Psychoanalysis,” Ogden juxtaposed his reading of Robert Frost’s poem “Acquainted With the Night” with his account of a session with a woman from the twelfth year of her analysis. He concluded movingly:

The movement of sound and cadence of loneliness and sadness and possibility in “Acquainted with the Night,” and the movement of feelings of anger, fear, sadness, disappointment, and love in the session with Ms. S. represent efforts to generate experiences in which two people (poet and reader, analyst and analysand) may become more fully capable of living with, of remaining alive to, the full range of complexity of human experience. [Ogden 2001, p. 113]

It is simpler—and altogether more likely and predictable—that we should turn away from “the pain of being humanly alive” and attempt to “kill the pain, and in so doing kill a part of ourselves,” yet poetry and psychoanalysis hold out the hope for other possibilities. “We turn to poetry and to psychoanalysis,” Ogden said, “in part with the hope of reclaiming—or perhaps experiencing for the first time—forms of human aliveness that we have foreclosed for ourselves” [Ogden 2001, p. 113].

**Narrative Subjectivity**

I began this chapter with the suggestion that psychoanalysis might productively be viewed as a (specialized) form of literary activity. From this vantage point, Freud’s labor of self-analysis—the foundation on which psychoanalysis rests—might also be understood as an autobiographical act, issuing in a highly creative set of narratives that have altered the history of Western consciousness. The very personal nature of Freud’s investigation, far from undermining its credibility (as he perhaps feared), is one of its greatest strengths, because he [like the major artists of his era] had the courage to articulate aspects of his internal conflicts that resonated powerfully within late Victorian and early modernist culture. In this respect, he invented a language for—and gave voice to—the turbulent inner life of his time.

Yet, as Freud himself admitted, both self-analysis and analysis are subject to a kind of infinite regress, calling into question the notion of “termination.” Nothing, other than a feeling of intuitive “rightness” and a sense of awakening or expanded participation in life, underpins the accuracy of an interpretation. To make matters more complex, the analyst’s own feelings and unresolved conflicts interfere with the possibility of an unbiased process of observation. Once again, however, such seeming deficits have revealed significant advantages over time. It is Freud’s very blind spots in his self-understanding that have given rise to theoretical innovation. Had he achieved his own wish to establish psychoanalysis on grounds of unchallenged ideas and unchanging principles, he would have laid a dead hand on it. Instead, his successors—including his own daughter, Anna—have felt free to explore areas he was unable to theorize and to develop their own ideas. This activity is vitally evident in the preoedipal field—whether in terms of object relations theory or in the work of Jacques Lacan and his successors.

Interest in the preoedipal period, in turn, has led to a gradual redirection of emphasis within psychoanalytic theory and practice from a model of interpretation that is based on analytic neutrality [now perceived to be an impossible ideal or fiction] to one that attends closely to the moment-by-moment unfolding of the analyst-patient interaction. Within this model, there is a general understanding that the process of analysis involves two vulnerable people, each subject to the vagaries of his or her personal history. Although the analyst is trained to scrutinize his or her own inner life and to attend to that of the analysand, there is no presumption that the analyst always “knows best.” Rather, he or she must be vigilant to countertransference reactions and to make use of them in interpretation. Ogden carried this awareness to a new level of theorization in his concept of the “intersubjective analytic third,” which subsists at an almost inarticulate level of emotional interaction between patient and analyst yet leads (as he believed) to deeper levels of contact and understanding.

Nothing really stays or stands in place. The notion of modernist subjectivity, for instance, has given way to something altogether more fluid and less definable—as best evidenced in the work of Jacques Derrida, the most influential philosopher of language and psychoanalysis of the late 20th century. Although his legacy has yet to be fully assessed, one thing seems clear: the concept of stable subjectivity has been effectively undermined. Not only is there general agreement today among psychoanalytic theorists about the relational and contextual nature of the formation of individual subjectivity but also there is an underlying uneasiness among them about establishing any kind of “original” structure of the ego. Rather, a consensus seems to have gathered around the idea of a fragmentary ego that must form or create itself from a relational and cultural matrix. There are many
advantages to this approach, which allows ethnic, racial, sexual, class, gender, nationality, and political issues into play. If the individual "self" evolves out of such a complex matrix, then all such matters need to be included in psychoanalytic theorizing as well as in the treatment of individual patients.

Such transformations of theory have also led to changes in writing practices, as I have indicated in this chapter. The emphasis within theory on the [mostly nonverbal] preoedipal period has prompted new ways of writing about psychoanalysis—whether in the context of theory or in that of clinical observation. Such practices resemble in many ways the changes in literary culture that have taken place over the course of the 20th century. As Steven Marcus observed, Freud’s manner of writing the Dora case history strongly resembled the rhetorical strategies of the modernist writers of his time. The writings of French feminists who wish to critique the phallocentrism of the writings of Lacan mirror in many ways the writings of the avant-garde writers whom they admire. Derrida himself blurred the boundaries in his writing between the conventional forms of philosophical discourse and literary practice.

Many psychoanalytic theorists admit to the provisional nature of their interpretations as well as the constructed narrative of the patient’s life that emerges from them. The point is not so much whether an interpretation is “correct” in some absolute sense as whether it reduces suffering, enabling the analysand to feel more fully alive and accepting of his or her troubled and troubling past. The question here is not “Which story can lay claim to accuracy?” but rather “Which story can accommodate the widest range of experience and make the most sense?”

Is this not what most readers seek from literature—that is to say, a way of expanding their own limited [conscious and unconscious] base of experience in such a way as to permit a fuller understanding and appreciation of life?

---

**KEY POINTS**

- A useful way to consider the relationship between psychoanalysis and literature over the course of the 20th century is to approach Freud’s psychoanalytic texts as literary productions.

- From this point of view, Freud’s labor of self-analysis may be viewed as an autobiographical act that had significant implications for late Victorian and modernist culture, particularly in relation to the construction of subjectivity.

- At the same time, the blind spots in Freud’s self-analysis opened possibilities for further theorizing, especially in regard to preoedipal development—as evidenced by the school of object relations theory and Lacanian psychoanalysis.

- These elaborations on Freud’s theory have led, in turn, to new forms of psychoanalytic writing that parallel developments in avant-garde and modernist forms of literary practice.

- At present, the boundary between psychoanalytic writing and literary writing is quite permeable, as manifest in the style of such writers as philosopher Jacques Derrida and psychoanalyst Thomas Ogden.

- Symbol and metaphor function as primary vehicles in both literary and psychoanalytic writing, both of which serve to awaken the reader to a fuller awareness of the complexities of human experience.
References

Bakhtin M: Rabelais and His World. Translated by Iswolsky H. Bloomington, University of Indiana Press, 1984
Irigaray L: This Sex Which Is Not One. Translated by Porter C, Burke C. Ithaca, NY, Cornell University Press, 1985
Murakami H: South of the Border, West of the Sun. Tokyo, Kodansha, 1992
Ogden T: Reverie and Interpretation. Northvale, NJ, Jason Aronson, 1997
Ogden T: Conversations at the Frontier of Dreaming. Northvale, NJ, Jason Aronson, 2001
Winnicott DW: Playing and Reality. London, Tavistock, 1971a
in other disciplines toward psychoanalysts who have wandered into the aesthetic domain and toward non-analysts who have attempted to import psychoanalytic theories into the realm of the arts. These boundary issues concern not only territorialism in its most basic form—that is to say, protective defense of and resentment at the invasion of what is perceived to be one’s own rightful space—but also failures on the part of psychoanalytically informed authors to specify the limits of their projects. For reasons such as these, outsiders to psychoanalysis have at times considered analytic forays into their territory as presumptuous, naive, and unilluminating. Correspondingly, practicing psychoanalysts have deemed as superficial and hyperintellectual certain efforts on the part of nonclinical academic authors who draw on psychoanalytic theory mechanically without an experience-near grasp of its richly nuanced emotional implications and unconscious resonances. The danger that always looms is superficiality and premature closure. To illustrate this species of “malpractice,” I have adopted the shortcut strategy in my teaching: I sometimes show examples of psychoanalysis treated formulaically and of art objects reductively beheld. Here is an example: Describing *Sunrise in the Catskills*, a lyrical 19th-century landscape by the American Romantic painter Thomas Cole, an art historian wrote:

The narcissistic assertion of the foreground promontory in its extension into the middleground peak is muted into a more clearly oedipal rivalry between foreground and middleground planes.... The narcissism...has been replaced by an erotic object attachment, an attempt at both identification and rivalry along oedipal lines.... Despite the maternal promises of the distant meadowlands, the deepest affective moments within Cole’s sublime works remain centered around the male-male conflict of the central space. [Wolf 1982, pp. 185, 194, 201]

What could such passages mean? The males in this passage appear to be trees, because no human figures are depicted in the painting at all. Trees, rivers, flatlands, hills, and peaks are all simplistically conflated with human gender and generational conflict, and the notion of narcissism is egregiously misapplied. In short, a theory is mapped onto a painted image, and predictably and absurdly, it mismatches. Reading such phrases, we can see how jargon stupefies and how someone who knows too little about the ideas he or she is using, no matter how smart the person may be, can easily slip into making a travesty not only of those ideas but also of the objects of inquiry and, ultimately, of the entire enterprise. In such cases, a disservice to both disciplines is rendered.

However, when psychoanalytic theory as an approach to the arts is more solidly grounded and combined sensitively with other approaches rather than taken as sovereign, and when it is conjoined with qualitatively fine experiences in the arts themselves, then the interdisciplinary marriage bears fruit and the unique value of psychoanalytic ideas in the realm of the aesthetic is made manifest. One stellar example of such excellence is Leo Steinberg’s (1984) tour de force *The Sexuality of Christ in Renaissance Art and in Modern Oblivion*, in which, without resorting to any jargon whatsoever, Steinberg exploited his deep understanding of psychoanalytic thought to unmask sweeping cultural repressions that have persisted unnoticed, denied, and uninterpreted for centuries.

More contemporarily, Margaret Iversen’s (2008) *Beyond Pleasure* offers a moving, carefully researched discourse on Maya Lin’s minimalist, conceptualist, incredibly moving Vietnam War memorial design in Washington, D.C. Iversen made use of the psychoanalytic notion of the fetish to explore ways in which a public monument can serve to disavow traumatic knowledge and at the same time induce memories of trauma by standing simultaneously for and against loss. Drawing on the work of Julia Kristeva (1992), Iversen invoked the image of a scar that heals yet maintains afterward the path of the gash. She quoted psychoanalyst Octave Mannoni’s (1969) formulation of fetishism: “I know, but all the same...” to develop her depiction of Lin’s work in the context of the fraught political and ideological battles that stormed around it, mirroring the already deep riffs that had fragmented American society in the wake of that wasteful war. Citing Freud’s (1910a) fantasy about the imaginary Londoner who might pause in sorrow before a monument to Queen Eleanor of Castile rather than attend to his present love, she asked whether the purpose (or fate) of such a monument is actually to foster what she calls “the necessary art of forgetting.” Telling her reader the precise moment at which tears filled her eyes when she walked along the wall for the first time, she revealed how Lin’s monument negotiates passages between private grief [the highly polished black granite reflecting each mourner’s face as he or she passes by] and public mourning. With the help of psychoanalysis, she demonstrated how Lin’s stark design acts like a “lightning rod” for emotions that continue to swirl around the Vietnam War—principally, anger and outrage. Such feelings and attitudes, she persuasively argued, are, by virtue of the monument’s design, displaced, so that they are transformed into aesthetic issues and can be read as modernism versus tradition or as abstract
onate in fantasy with many aspects of the works one perceives. One also brings to the aesthetic realm a wealth of learned patterns, conscious and unconscious, of preference and response. Hence, although to separate these contingent categories serves the needs of academic discourse, what actually occurs during creation, criticism, and aesthetic encounters are experiences whose psychic differences consist in emphasis rather than in kind and where each mode is implicit in the others.

A parallel interdependence may be observed among the various aspects of psychoanalytic theory. Thus, early drive theory involves recognition, as yet unformulated, of an agency in conflict with the drives, later to be developed into ego psychology. In ego psychology, there is an implicit awareness of and concern with id analysis—with the drives and their derivatives, the wishes out of which unconscious fantasies are made and against which specific defenses are mobilized. Moreover, the full analysis of each drive includes a concern with its object as well as with its aim, impetus, and source [Pine 1990]. Thus, object relations theory is inextricably tied to the earlier paradigms from which it springs, and relational theory, although it privileges the interpersonal world, cannot do without some notion of an inner psychic life. We would do well, therefore, to regard the analysis of drives, ego psychology, object-relations theory, and relational psychoanalysis not as separate approaches but as parts of a whole with varying stresses or accents. Similarly, art criticism shifts among expressive, objective, and phenomenological modes, all of which exist on a continuum. The approaches of romantic, formalist, response theory as well as ideologically driven and contextual criticism in the arts and literature are mutually interdependent [Abrams 1953]. Furthermore, because of its absorption into our intellectual and cultural milieu, 21st-century psychoanalysis now plays (though not always openly), in concert with them, a unique and salient role.

**Contribution of Freud**

Freud’s love of and interest in art are well documented by his sizable art and antiquities collection (“I have sacrificed a great deal for my collection of Greek, Roman and Egyptian antiquities,” he wrote in 1931, “and actually have read more archaeology than psychology,” letter to Stefan Zweig, September 7, 1931]) as well as by his several papers and books devoted to the subject and by the numerous incidental references to art and literature scattered throughout his oeuvre. Although his perspectives on the arts evolved to some extent during his lifetime, his tastes remained stable, and he never attempted to systematize his cultural forays. His general approach—which sets the stage for what comes later in the psychoanalytic writings of others in this domain after his death—can, however, be characterized. Freud’s major concern, with few exceptions, was with the relation between an artist’s inner life and the artistic product. He saw the cultural object as expressive of, as redolent of, as the result of, internal themes and conflicts. “Art,” he stated, brings about a reconciliation between two principles [pleasure and reality]. An artist is originally a man who turns away from reality because he cannot come to terms with the renunciation of instinctual satisfaction which it [reality] at first demands, and who allows his erotic and ambitious wishes full play in the life of fantasy. He finds the way back to reality, however, from this world of phantasy by making use of special gifts to mould his phantasies into truths of a new kind which are valued by men as precious reflections of reality. [Freud 1911]

Through art, in other words, one actually becomes the king or hero or the chosen beloved of one’s dreams but without expending all the energy necessary to do so in the real world and without being blessed with the necessary good luck. The artist’s success, Freud averred, is predicated on the fact that others share his or her dissatisfaction with this obligation, that is, to replace the pleasure principle with the reality principle. Art offers ersatz gratification; it confers temporary but highly satisfactory wish fulfillments, and these are sanctioned, moreover, by the surrounding culture. This formulation makes perfect sense when we apply it to contemporary 21st-century popular arts, including widely prevalent commercial art, the art of advertising, for example, Hollywood movies, television shows, hard rock, rap, country, and world music as well as thrillers, mysteries, romantic novels, even video games, if we are willing to take them as a species of popular art. In the ersatz gratification realm, moreover, we must not omit the recent phenomenon of Harry Potter. Freud’s explanation, however, works less well for much of the fine art of our day which, whether gallery or electronically based, is often so focused on ideological and political themes that it eschews and even mocks aesthetic gratification as an artistic goal, offering scant pleasure to its beholders. A case in point would be the prominent international Documenta exhibition held every 5 years in Kassel, Germany, or closer to home, the Whitney Biennial in New York City.
Psychoanalysis and the Visual Arts

Freud also emphasized communication. Interestingly, in this he concurs with his older contemporary, Leo Tolstoy [1898]. The value of aesthetic experience, for both thinkers, stems from a process of identification. Here, however, we must be cautious. Freud did not say that the specific latent content of an artist's work must resonate with, be mirrored in, or even be revealed to the viewer. The object of identification that counts, as he saw it, is far subler. It is nothing more or less than the quintessential process of circumventing renunciation: what delights an audience and constitutes the very essence of aesthetic experience is, for Freud, art's successful outwitting of the censor by offering up momentary imaginary gratification of our secret wishes. This is what gives us our deepest pleasure in art. Thus, although instinctual matter lies at the core of all art, it is its elaboration into form by the "special gifts" of the artist that brings about a convergence of reality and pleasure and provides grounds for identification and communication.

Speculatively yet persuasively, Freud [1908] traced a path from children's imaginative play through daydreaming and fantasy to the work of artists. In various writings [Freud 1900, 1905b, 1907, 1910b], he underscored the continuity of art with other modes of mental functioning, such as jokes and dreams. The artist exists on a continuum with others who are not, at least principally, artists: "Might we not say that every child at play behaves like a creative writer, in that he creates a world of his own, or, rather, re-arranges the things of his world in a new way which pleases him?" [Freud 1908, p. 143]. Thus, Freud conjured the image of a child/artist rearranging objects in unique configurations that please him or her and in so doing paved the way for D.W. Winnicott and other more recent writers who have elaborated this derivation of artistic activity from childhood play. (For a discussion and critique of this notion, see Spitz 2011a.)

Freud's image also prefigures subsequent theories concerning the experiences of audiences for works of art. This is because, similarly, when art seems new and compelling, it challenges us implicitly to reorient ourselves. It charges us to reconceive phenomena in novel orderings that disrupt our previously unexamined assumptions and tastes. It confronts us with truths heretofore unacknowledged and with fresh possibilities for the fusion of our inner and outer realities. It puts us, in other words, into the place of a child who is experimenting. It forces us to create our own world—or at least some aspects of it—new.

It is important, then, to resist those who would attack Freud for taking art merely as a way of circumventing prohibition by permitting instinctual gratification in an indirect way, for, as we can see, Freud was well aware and profoundly respectful of the potential of art (as content transformed) to bring us in touch with deep inner truths. Freud was not, furthermore, oblivious to his own rather cursory treatment of artistic form. He apologized for it, saying, in the opening paragraph of his "Moses of Michelangelo": "I may say at once that I am no connoisseur in art, but simply a layman....the subject matter of works of art has a stronger attraction for me than their formal and technical qualities, though to the artist their value lies first; and foremost in these latter. I am unable rightly to appreciate many of the methods used and the effects obtained in art" [Freud 1914, p. 214].

Nonetheless, he speculated on the nature of artistic form by asking us to consider why it is that when ordinary persons tell us their daydreams, we often feel bored or repelled, whereas when the daydreams of artists are transformed into painting or sculpture or any of the other visual arts, we awaken from our lethargy and experience intense delight. He analogized the pleasure of artistic form to sexual foreplay in that it gives pleasure of its own while simultaneously readying us for the even greater pleasure we get from the full liberation of sexual tension. He went on to propose that the artist's work provides a kind of model for us, "enabling us thenceforward to enjoy our own dreams without self reproach or shame" [Freud 1908, p. 153]. Thus, Freud hinted that form and content work hand in hand and that art, at its strongest, may function to liberate audiences by empowering us to dare to enter into more intimate contact with our own internal worlds, unlocking boundaries that formerly seemed fixed. This notion, which attempts to explain how it is that art can have (as we know it does) such dramatic effects on us, constitutes Freud's most telling contribution to the philosophy of art and aesthetics. It is, furthermore, a contribution highly pertinent to much of the art of our own time, which, whether or not it eschews ideology, takes risks, shocks into awareness, and opens both technically and conceptually onto horizons that are hallmarks of this new century.

Today's art brings us sensations of human selves that fluctuate and metamorphose not only geographically (through exile and displacement) but also physically (one thinks of art-related surgeries, as in the disturbing work of the French performance artist Orlan, who has since 1990 undergone a series of plastic surgeries in order to transform herself into new beings modeled on Venus, Diana, and Mona Lisa, thus critiquing the enslavement of women to such ideals of beauty, prosthesses, hormonally and surgically induced gender changes, and cyborgs), while adopting a variety of sequential and simultaneous perspectives. What is intriguing is
that Freud’s own actual tastes in art, although passionate and quite highly developed, were somewhat retrograde. He clung to the plastic arts of antiquity in both near and far Eastern venues and preferred them to the exuberant avant-garde art of his own era—fin de siècle Vienna—that swished about him with a dazzling brilliance but that failed utterly to gain his notice (see Schorske 1980). In doing so, he was following the taste and predilections of a typical assimilated Jew in German culture who had, in his youth, acquired a classical education.

**Contribution of Ego Psychology**

Since Freud, other psychoanalytic authors have dealt with the problems of artistic form and content and made their own significant contributions to our understanding. Notable among them is Ernst Kris, who was an art historian in Vienna at the eminent Kunsthistorisches Museum before becoming a psychoanalyst and who emigrated to New York in advance of the Nazi terrors of World War II. In a classic essay called “Aesthetic Ambiguity,” Kris (1952) tackled the complex relationships that exist between artistic production and aesthetic response. He asked how these two experiences are linked. Picture once more an artist who, during the process of creation, simultaneously plays the role of her own work’s first consumer and critic. Imagine her as a painter standing motionless, brush in hand, contemplating her canvas for long moments in silence. Physically inert, she is hard at work. She is communicating with her painting as its initial beholder. Here we have a condensed image of the problem Kris addresses. “Aesthetic creation,” he stated, “is aimed at an audience” (Kris 1952, p. 254), and he actually defined as aesthetic only those self-expressions that communicate. Yet here again, as with Freud, we must be careful, for Kris does not mean—reductionistically—that the content of a work, separated from its form, communicates. On the contrary, he understood “communication” to involve far more than what he took to be the “prior intent” of the artist, as he put it. Rather, communication consists in “the re-creation by the audience” of the artist’s work. Expressing it this way, he came very close to the notions of two American philosophers who were contemporaries of his, John Dewey (1934) and Susanne Langer (1953), who both likewise taught that works of art are best taken as mutual co-creations. Authentic responses to works of art, according to these thinkers, inevitably also entail contributions of self. What counts as aesthetic experience is a collaborative, interactive adventure. For Kris, as for Dewey and Langer, artists must not be seen as active while audiences remain passive, but rather both parties should be seen as active. In the example of the painter, although standing motionless before her canvas, she must be understood as fully engaged, absorbed, and active, just as she is when she is actually daubing the canvas with her brush or mixing her colors. We can see that these ideas dovetail also with relational psychoanalysis.

The image, furthermore, matches a quintessential psychoanalytic tenet, namely, that the process of a psychoanalytic treatment, the work of therapy, involves a genuine partnership. Yet although both individuals engage, they need not, and indeed cannot, engage in precisely the same way. Kris postulated a similarity between the processes of artist and audience, not an identity. By turning away from the artist’s “prior intent,” inner conflicts, and any preexistent condition that must be unearthed, Kris implied that for communication to occur, what is (or was) emotionally charged for a particular artist at the time of his or her work’s creation need not be so for the audience; thus, information about an artist’s life and purposes may be, simply, irrelevant for our aesthetic experience of any particular work he or she has created. Emphasis shifts, on this model, from the hidden to the manifest. What matters is what we can actually perceive in the work itself and what has been presented to us by that work—how it resonates with whatever we bring to it in the moments of our interaction with it. An example that springs readily to mind is the oeuvre of the Belgian surrealist painter René Magritte (1898–1967), whose images often seem highly charged and whose symbols are fraught with meaning. Viewers who come upon them in reproduction or in a museum are often moved to respond to them emotionally, yet the actual occurrences in Magritte’s own life that caused him to create the pictures may have no manifest connection with the particulars of the viewers’ own lives (see Spitz 1994).

Central to Kris’s approach is the role played by ambiguity. He introduced his notion of the “potential of a symbol,” which is “the obverse side of its overdetermination” (Kris 1952, p. 255). In other words—as psychoanalysis teaches us concerning symbols in general—symbols in works of art arise from a condensation of many psychic (and external) factors, some of which are unconscious—that is, either repressed or otherwise unknown to the artist. A potent symbol, however, is potent
readers, and/or it may push us away. Then it may open its arms again for another embrace. [For an elaboration of this notion and a phenomenological account of aesthetic experience, see Spitz 2011b.] What psychoanalysis offers here, through Margaret Mahler’s previously cited work on separation-individuation, is a developmental model that can help explain the power of such experiences and how they can exert their influence on us long after our childhood years have passed.

Newer Paradigms and Suggestions for Further Reading and Research

Much of the published work in psychoanalysis and the arts relies on Freudian psychoanalysis, and among Freud’s papers there are several others that deserve special mention in this context. “Family Romances” (Freud 1909) offers richly nuanced suggestions with regard to artists’ desires for idealization and devaluation in their imagery; it is a paper whose argument complicates our notions of symbolism by showing how the present and past mutually revise one another in terms of the imagery we simultaneously remember and invent. “Leonardo da Vinci and a Memory of His Childhood” (Freud 1910b) is arguably Freud’s most famous paper on art, and despite its egregious errors and inaccuracies, it continues to enthrall readers and to spawn an entire literature of responses with, no doubt, more to come. “Wild’ Psycho-Analysis” (Freud 1910c) proves a useful paper because it cautions authors lest they jump too quickly to erroneous psychoanalytic conclusions, whereas “Formulations on the Two Principles of Mental Functioning” (Freud 1911) divides the field of response into primary and secondary functioning, pleasure and reality, innovation and repetition, all of which have important roles to play vis-à-vis any serious consideration of aesthetic experience and of formal elements in the arts. “Mourning and Melancholia” (Freud 1917[1915]) and “The Uncanny” (Freud 1919) are brilliant works relevant for the oeuvre of specific artists—those steeped in trauma, tragedy, and mystery, respectively, and “The Note Upon ‘The Mystic Writing Pad’” offers metaphors for creative mental processes and for the artistic structure of various works, as do “Fetishism” (Freud 1927) and “The Splitting of the Ego in the Process of Defense” (Freud 1940). In short, it is not simply the papers Freud wrote ostensibly about the arts that can prove useful to us now but the larger corpus of his work where, sometimes in unexpected nooks, he offered stunning aperçus and struggled to define concepts that can help us grapple with the newly emerging arts of our 21st century.

Beyond Freud, there are of course many forays into this territory. One recent effort deserves special mention because it paradigmatically turns the tables and shows how psychoanalysis and psychiatry are themselves influenced by the visual arts and culture of their time. In Mirrors of Memory, Mary Bergstein (2010) explores some far-reaching effects of European fin de siècle visual culture on Freud’s mind. It illuminates heretofore unexamined ways in which the medium of photography, widely taken to be a transparent, objective way of documenting and gaining access to a previously existing reality, was relied on by many disciplines. In addition to psychiatry and neurology, these include archaeology, Egyptology, ethnology, art connoisseurship, criminology, and travel manuals. As such, photography interperernated the cognitive mentalities of the period and shaped analytic thinking in terms of both content and method. Bergstein’s (2010) thesis is that “published photographs and their art historical texts entered the visual imagination—both individual and collective, both conscious and unconscious—of psychoanalytic modernity” (p. 177) and that “photographs and their internal visual language were at least as effective as written texts in the formation of cultural beliefs” (p. 236). To prove this, she showed how the visual culture that enveloped Freud affected both his personal life and the development of his ideas, realms by no means wholly separable, and she raised broader questions as to the impact of visual culture on the mind per se. Freud, inventor with Breuer of the “talking cure” and author of a corpus of writings that—even minus his letters—comprises 24 volumes of prose, surely counts as a prodigiously verbal man, invested preeminently in the word. With respect to music, a quintessentially nonverbal art, he contributed nothing, and likewise, as we have seen, with respect to visual art, he claimed he had only the slightest ability to perceive its purely aesthetic (nonverbal) qualities. Bergstein, aware of these predilections, showed nevertheless how Freud was influenced in his theorizing, his methodology, and even his intimate imaginative thoughts and emotional like not by his reading alone but by the nonverbal visual culture of his time as she pictured Freud poring for hours over photographs, wrote of his attachment to a particular photograph of his fiancée, the young Martha Bernays, in her absence; noted and discussed the salient framed photographs on display for years in his consulting room; cited his long devoted acquaintance with photographs of cities such as Athens and


Rank O: Art and Artist. New York, Knopf, 1932


Spitz EH: Museums of the Mind: Magritte’s Labyrinth and Other Essays in the Arts. New Haven, CT, Yale University Press, 1994
Spitz EH: Illuminating Childhood: Portraits in Film, Fiction, and Drama. Ann Arbor, University of Michigan Press, 2011a
Spitz EH: Zigzagging with full stops from play to art, in From Diversion to Subversion. Edited by Getzy D. University Park, PA, Penn State University Press, 2011b
Steinberg L: The Sexuality of Christ in Renaissance Art and in Modern Oblivion. Chicago, IL, University of Chicago Press, 1984
Wolf B: Romantic Re-Vision. Chicago, IL, University of Chicago Press, 1982
Psychoanalysis and Film

Andrea Sabbadini, M.A., C.Psychol.

QU’EST-CE QUE LE CINÉMA? This deceptively simple title of a seminal book of essays by the French film critic André Bazin (1967) has become over the years the unanswerable question that has occupied the minds of film scholars, including those with a psychoanalytic orientation.

Originally intended by Freud as a form of therapy for the neuroses, psychoanalysis soon became a more ambitious project: a general psychology for the investigation of mental functioning. This opened up a number of areas for the application of psychoanalytic theories outside its original scope: the extra-clinical utilization of psychoanalytic knowledge or indeed aspects of the psychoanalytic approach in relation to cultural products and events, or to “explanatory, methodological, or technological problems arising in disciplines or human endeavours other than psychoanalysis” (Edelson 1988, p. 157). These areas include, in addition to anthropology, education, and history, the arts, including cinema—a form of representation that seems to entertain an important relationship with our mental activities and emotional experiences. Cinema “is a type of mime of both mind and world….Breaking from the confines of photography and theatre, it is unique in its representation of an abundant world in motion….There is a persistent sense that cinema imitates the movement of the mind, that there is a correspondence (however elusive) to be discovered between psyche and cinema” (Lebeau 2001, p. 3; italics added).

The oft-mentioned historical coincidence of birthdays of cinema and psychoanalysis (the inventors of the new medium of cinema, the brothers Auguste and Louis-Jean Lumière, showed their first short movies in Paris in 1895, the year when the first psychoanalytic book, Breuer and Freud’s (1893–1895) Studies on Hysteria, was published in Vienna) is not coincidental. Both disciplines, however different, can be construed as having developed from the same ambivalent attitude toward the positivistic culture prevalent at the end of the nineteenth century. Psychoanalytic ideas, such as unconscious motivation, the transference, ego defenses, the dream as wish fulfillment, infantile sexuality, and the Oedipus complex, have infiltrated many aspects of Western culture. It should not surprise us therefore that they have also been accepted, however unintentionally, by film—the most popular form of mass entertainment throughout the 20th century and beyond.

Some screenwriters and filmmakers adopt psychoanalytic ideas about human experiences. As Claude Chabrol stated in an interview, explaining why he col-
laboried with a psychoanalyst in the writing of his film *La Cérémonie* [1995], “[i]t’s very hard, when you deal with characters, not to use the Freudian grid, because the Freudian grid is composed of signs that also apply to the cinema” [Feinstein 1996, quoted in Gabbard 2001, p. 1]. Other filmmakers may not be as explicit in acknowledging their debt to psychoanalysis, and yet in their work we can identify its influence on such aspects as characterization, choice of narrative themes, emphasis on psychological motivation, or onicric atmosphere.

At the same time, films have often been understood with reference to psychoanalytic concepts. This has been possible because an important aspect of the “correspondence, however elusive,” between psychoanalysis and cinema concerns the analogies between filmic language and the analytic idiom used to describe unconscious processes. Not only are words such as projection current in the filmic and analytic languages, but there are also certain psychoanalytic concepts, for instance, screen memories and primal scenes, that may be considered as definitions of film. Furthermore, the process of free associations (mostly visual in and verbal in psychoanalysis) has in both idioms the similar purpose of encouraging the exploration of deep emotional meanings and of the often uncertain boundaries between reality and fantasy. In Glen Gabbard’s words, “to a large extent, film speaks the language of the unconscious” [Gabbard 1997, p. 429].

---

**A Psychoanalytic Film Genre?**

Although a “psychoanalytic film genre” as such does not exist, certain films are undoubtedly more suitable than others for a psychoanalytic reading and are in turn more likely to provide analysts with observations and insights potentially useful in their clinical work. These films fall into three broad, and to some extent overlapping, categories.

**Films With Psychologically Credible Characters**

In the first group, we find those works in which screenwriters and filmmakers collaborate in portraying their characters in an explicitly psychological way. The emphasis here is not so much on fast-moving action, dramatic plots, or the display of striking special effects but on a detailed, in-depth study of the inner world and personality of the main characters. In these movies generalizations (of the “goodies vs. baddies” kind) are avoided, and people are represented in their ambivalent or conflictual aspects. Their past is taken into account (either by presenting characters as they grow and evolve over time or by using the filmic technique of editing flashback scenes into the main narrative), and their unconscious motivations are hinted at or even openly explored. Spectators can sympathize with the psychologically justified, if often just subtle, transformations that occur to these characters as a result of the vicissitudes they go through in the course of the movie.

These films’ characters, in other words, emerge from the flat silver screen as truly three-dimensional, allowing the viewers to recognize them as real people and therefore to identify with them in all their often disturbing contradictions rather than idealizing or denigrating them as tends to happen in regard to character representations in less psychologically sophisticated movies.

Comfortably fitting into this group are, to give just one example from the many available to film history, several works from the French Nouvelle Vague of the late 1950s throughout the 1960s, by such auteurs as François Truffaut, Louis Malle, Jacques Rivette, and Eric Rohmer. The statement by Rohmer that his movies deal less with what people do than with what is going on in their minds while they are doing it may equally apply to our therapeutic approach to patients.

---

**Films on Themes Directly Concerning Psychoanalysts**

The second category of films popular among psychoanalytic critics includes those many works that deal with themes also familiar to analytic inquiries, thus covering disparate aspects of the human condition: crises in subjectivity related to developmental stages or to acute existential and moral dilemmas [by such directors, to name just a few from different cinematic traditions, as Ingmar Bergman, Akira Kurosawa, and Krzysztof Kieslowski]; loss and mourning, conflictual or abusive family constellations (Yasujiro Ozu, Luchino Visconti, and Satyajit Ray), sometimes with an emphasis on incestuous themes; different forms of mental pathology, such as depressive and suicidal, neurotic, or narcissistic disturbances [Woody Allen]; sexual perversions and gender confusion [Pedro Almodóvar]; drug addiction and alcoholism, dissociative, paranoid, and psychotic states, and so on. It must be noted here that unfortunately many movies on psychosis, including some of the best [such
as Roman Polanski’s *Repulsion* 1965 and David Cronenberg’s *Spider* 2002, tend to associate madness with murderousness, or even to fall in the horror genre, thus reflecting rather than challenging common stereotypes about mental illness.

Specific psychoanalytic interpretations could throw some new light on certain psychological phenomena represented in films, for instance, Alfred Hitchcock’s *Rebecca* (1940) could be watched from the perspective of the “replacement child” syndrome. Peter Weir’s *The Truman Show* (1998) is enriched by understanding it in the light of the Winnieccottian concept of the “false self,” and Alejandro González Iñárritu’s *Amores Perros* (2000) is an interesting instance of the enactment of “rescue fantasies.”

A cinematic theme particularly important to psychoanalytic investigation is that of scopophilia: when watching films whose characters indulge in voyeuristic activities [prominent among them, Alfred Hitchcock’s *Rear Window* (1954), Michael Powell’s *Peeping Tom* (1960), Michelangelo Antonioni’s *Blow-Up* (1966), or Krzysztof Kieslowski’s *A Short Film About Love* (1988)], viewers are no longer just indulging in watching a movie, with all the wishes, anticipation, pleasure, or disappointments intrinsic to such an activity; what they are watching now are other voyeurs like themselves. In other words, their identifications and visual excitement have as their objects not only the film itself but also the subjects and objects of the voyeuristic activities projected on the screen.

**Films (Mis)Representing the Psychoanalytic Profession**

In the third and last group, I have included those films that attempt to represent the psychoanalytic profession itself: those movies whose main characters are psychoanalysts [e.g., Nanni Moretti’s *The Son’s Room* (*La Stanza del Figlio* 2001)], Freud himself [John Huston’s *Freud: The Secret Passion* (1962)], psychoanalytic patients [Hugh Brody’s *Nineteen Nineteen* (1985)], or both analyst and analysand [Georg Wilhelm Pabst’s *Secrets of a Soul* (*Geheimnisse einer Seele* 1926)]. Not surprisingly, prominent patients involved in scandalous relationships have attracted special attention from filmmakers—at least three of them in Sabina Spielrein’s case [Elisabeth Márton in 2002 *My Name Was Sabina Spielrein*], Roberto Faenza in 2003 *The Soul Keeper*, and David Cronenbour in 2011 *A Dangerous Method*.

The earliest example of something approaching the presence of psychoanalysis in a film can be found in *The Mystery of the Rocks of Kador* (*Le Mystère des Roches de Kador*, Léonce Perret, 1912), in which “a celebrated foreign alienist physician” saves the heroine Suzanne from madness by utilizing the “luminous vibrations of cinematographic images” to induce in her an hypnotic state leading to psychotherapeutic suggestion [see Bergstrom 1999, pp. 15–20].

However, the first major and arguably still most successful filmic representation of psychoanalysis is the feature *Secrets of a Soul* (1926). Aesthetically located somewhere between the claustrophobic expressionistic world of *Kammerspiel* and the emergence of the *Neue Sachlichkeit*, the film was directed by Georg Wilhelm Pabst, with leading German psychoanalysts Karl Abraham and Hanns Sachs as consultants. Aptly described as “a silent film about the talking cure” [Ries 1995], *Secrets of a Soul* was an experimental project intended to introduce the general audience to a psychoanalytical understanding of mental phenomena in a thought-provoking and visually engaging form within the structure, not unknown to Freud’s own case histories, of a detective story. It is a detailed and respectful account of the fictional case of a neurotic chemist [played by Werner Krauss], a man who develops a phobia of knives and becomes pathologically jealous and sexually impotent when he hears that a young cousin of his wife’s is coming to visit them. His not-too-accidental encounter with a psychoanalyst eventually brings about his remarkable recovery.

Having been invited by Abraham to cooperate on this film, Freud replied to him in no uncertain terms: “I do not believe that satisfactory plastic representation of our abstractions is at all possible” [Freud 1925a]. Only a few months earlier, Freud had also declined Samuel Goldwyn’s substantial offer of $100,000 for a script on famous love stories.

Psychoanalysis reached Hollywood in the 1940s with Hitchcock’s *Spellbound* (1945). It tells the story of a beautiful psychoanalyst [Ingrid Bergman] who falls in love with her handsome patient [Gregory Peck] as she tries to rescue him from being unjustly accused of murder by helping him to uncover, through a most unethical mixture of therapeutic interventions and erotic passion, a traumatogenic childhood memory. The original twist in *Spellbound* is that, through the psycho-pathological devices of amnesia and guilt complex, the protagonist’s main accuser is not some police detective, court judge, or other such authority figure but a part of himself—his own harsh superego, which has never forgiven him for the accidental death, many years earlier, of his brother. It is only fair to mention that although this film played a part in popularizing psychoanalysis in the United States in those years, Hitchcock
himself had confessed that his movie was “just another manhunt story wrapped up in pseudo-psychoanalysis” [Truffaut 1984, p. 165].

Freud was reserved about his personal life, skeptical about biographies of any kind, and, as we know, unsympathetic to the medium of cinema. However, he reluctantly agreed to be filmed in 1928 by one of his American patients, Philip R. Lehman, for a documentary that was also to include shots of many other prominent psychoanalysts, its final 50-minute version, titled Sigmund Freud: His Family and Colleagues, 1928–1947, was edited, restored, and completed by Lehman’s daughter Lynne Lehman Weiner and released in 1985 [Marinelli 2004].

The founder of psychoanalysis would have thought of a feature film about himself—such as John Huston’s Freud [1962] [the lurid subtitle The Secret Passion was added later for commercial reasons]—as anathema. However, this movie turned out to be no conventional Hollywood biopic, being concerned not so much with Freud the man but with a subject matter that we know to be fundamentally resistant to representation: the unconscious itself. Making this movie caused drama among Universal Pictures, John Huston, his first screenwriter [no less than Jean-Paul Sartre [1985]], and the film’s eponymous star, a sensitive if also disturbed Montgomery Clift. This film demands its audience to get emotionally as well as intellectually involved in ways that feel almost physically painful. “Both sights and sounds in this film,” wrote Brill [1997], “require constant interpretation, both function more as clues that must be construed than as signposts. Both, as Freud says of dreams, ‘speak in riddles’” [p. 183].

Huston’s film concentrates on the early years of psychoanalysis, from 1885 to Freud’s father’s death in 1886, and the publication at the turn of the twentieth century of The Interpretation of Dreams [Freud 1900]. Crucial to those years are the discovery and then the abandonment [circa 1897] of the so-called seduction theory of psychoneurosis, which provides the theoretical underpinnings to the movie’s narrative. Freud’s patient in the film, Cecily [Susannah York], a composite of the cases of Anna O, Dora, and others, is affected by severe hysterical symptoms, eventually understood by Freud in relation to her childhood oedipal fantasies. In Huston’s film, Freud and Cecily embark on a journey toward self-knowledge. The motifs of eyes, mirrors, and keys (also present in Pabst’s and Hitchcock’s movies referred to earlier) and the insistence on the imagery of light and darkness emphasize the arduous character of such a quest.

A more recent film on psychoanalysis is Hugh Brody’s Nineteen Nineteen [1985]. It is the story about two former patients of Freud’s [played by Paul Scofield and Maria Schell] who meet up in Vienna in the 1970s to reminisce about their lives and their tumultuous analytic experiences [their biographies are based on two of Freud’s celebrated case studies]. The narrative unfolds within a structure of four interrelated levels of discourse. At the first level, we witness the interactions and dialogues between the two characters concerning themselves as they are in the present, in their late 60s, and their relationship. At the second level we are spectators to their recounting of events, impressions, and fantasies about their personal and collective history. Then in flashback we are offered, at the third level of discourse, the reliving of the past, either in color during their troubled adolescence on and off the couch or in archival black-and-white newsreels, family movies, and still photographs. Finally, again in flashback, we have the “material” they present to Freud himself in his Berggasse consulting room. We, the viewers [and they, the patients], never actually see Freud but only hear his reassuring off-screen voice from behind the couch.

It must be noticed here that one of the problems concerning many of the representations of our psychoanalytic profession in film is a certain confusion, especially in the minds of Hollywood filmmakers and their audiences, between psychoanalysis and psychiatry. Such a confusion is, at least in part, justified by the fact that until not long ago all American psychoanalysts also were psychiatrists. It is a small but significant detail that psychiatrists display portraits of Freud on their walls in such important films on mental institutions as Anatole Litvak’s The Snake Pit [1948], Nunally Johnson’s The Three Faces of Eve [1957], and Samuel Fuller’s Shock Corridor [1963], a subclass of both our second and third categories that also includes Miloš Forman’s popular One Flew Over the Cuckoo’s Nest [1975].

1See, for instance, the title of the important book on American cinema Psychiatry and the Cinema [Gabbard and Gabbard 1999]. In their “Preface to the Second Edition” the authors wrote: “Since the appearance of our first edition in 1987, psychiatry has continued to distance itself from psychoanalysis and psychotherapy. Nevertheless, in the cinematic world, the emphasis remains on the talking cure…. Hence, we continue to use the term psychiatry in the broadest possible sense to encompass all mental health professionals, especially those who practice psychotherapy” [pp. xix–xx].
In the majority of the films belonging to this third category, psychoanalysis has been presented in the dramatically effective, but inaccurate, version of the therapist being engaged in the cathartic recovery of repressed memories of traumas for the explanation of current events, with much use of flashbacks as the cinematic device equivalent to memory. This approach has been exploited in, among others, some of Alfred Hitchcock’s movies, such as the already mentioned Spellbound (1945) and Marnie (1964). Spellbound is also an example of the way in which psychoanalysis can be misrepresented in cinema by showing analysts acting out their (countertransference) love for their patients by getting involved in romantic or sexual activities with them. An exception to this can be found in the remarkable television series In Treatment (2010), in which the character of the psychotherapist (played by Gabriel Byrne) is shown as emotionally vulnerable to the seductive temptations of one of his patients but professional enough to resist enacting his erotic feelings for her.2

Another distorted picture of our profession on the screen concerns the suggestion, to comical effect, that analysts are more insane than their patients (Deconstructing Harry, Woody Allen, 1997; Analyze This, Harold Ramis, 1999). Other times analysts are portrayed as naive, unprofessional, greedy, abusive, or even involved in criminal activities.

Movies and dreams seem to share a morphological equivalence insofar as both can be considered to express our latent unconscious wishes through their manifest contents, and both use, for the purpose of circumventing repression, similar mechanisms. These include (in films, especially at the editing stage) condensation, displacement, symbolic representation, secondary revision, and distortions of time and space (Freud 1900).

Eberwein [1984] suggested a similarity between the film screen and the dream screen as places of both fusion and separation. The concept of dream screen was originally developed by Bertram D. Lewin: “I conceived the idea that dreams contained a special structure which I named the dream screen…. I thought of the dream as a picture or a projected set of images, and for the reception of these images I predicated a screen, much like the one we see in the artificial night of a dark motion-picture house before the drama has radiated forth from the window of the projection box” (Lewin 1953, p. 174). More recently, Laun Marcus observed that

Another analyst recently made popular by television is Dr. Jennifer Melfi [played by Lorraine Bracco], the attractive therapist of mobster Tony Soprano in the groundbreaking and hugely successful drama series The Sopranos [David Chase, 1999-2007].

Films and Dreams

A special place in the dialogue between psychoanalysis and cinema concerns dreams. As their interpretation constitutes, according to Freud, the “royal road” to the unconscious, perhaps also the exploration of films may lead us in the same direction. The association between movies and dreams is powerfully established in our culture. I still remember that as children growing up in the 1950s, when reporting our dreams to one another, my friends and I always mentioned whether the dreams were in color or black and white. I suppose that children of the previous generation may have commented on their dreams as being silent or talkies. And contemporary ones may question whether they see their dreams in 3-D. Hollywood, of course, has always been described as a “dream factory.”

The severely neurotic psychopathology of the protagonist of Pabst’s already mentioned Secrets of a Soul, whose clinical case is based on one of Karl Abraham’s own patients, is resolved by a psychoanalyst through the interpretation of a 10-minute-long dream, one of the longest dream sequences in the history of cinema. Its many manifest elements, representing in a condensed and floridly symbolic form the various components of the protagonist’s inner world, are explored one by one by his psychoanalyst, leading back to his patient’s latent, repressed infantile wishes until his symptoms disappear.

Hitchcock’s Spellbound is memorable in particular for Salvador Dali’s surrealist design for the oniric sequence, represented with an architectural sharpness that contrasts with the more traditional blurred images of filmed dreams. [Dali had already collaborated in the making of a psychoanalytically significant film, Luis Buñuel’s early masterpiece Un Chien Andalou [1928].] It
not believe, as we have already pointed out, that psychoanalytic ideas could be represented by cinema, but for the rest of his life, he displayed as little interest in films as he had in some other artistic disciplines such as music. “Filmmaking can be avoided as little as—so it seems—bobbed hair,” Freud wrote in a letter to Sándor Ferenczi on August 14, 1925, “but I myself won’t get mine cut, and don’t intend to be brought into personal connection with any film” (Freud 1925b, p. 222).

Many of Freud’s followers, however, had a different opinion. At first, analysts who found movies worthy of their intellectual inquiries limited themselves to an application to film criticism of the concepts they were familiar with from their clinical work. The first attempt to interpret a film from a psychoanalytic perspective was made as early as 1914 by Otto Rank. In the opening chapter of his psychoanalytic study on the phenomenon of “the double,” Rank commented on the German film The Student of Prag (Der Student von Prag, 1913) directed by Stellan Rye and written by Hanns Heinz Ewers [a follower of E.T.A. Hoffmann’s, “the unrivalled master of the uncanny in literature” (Freud 1919, p. 233)]. Freud himself mentioned this film when he quoted Rank in a footnote to his text on “The Uncanny” (Freud 1919, p. 236, n. 1). In that same essay, Rank stated, in stark contrast with the position adopted by Freud, that “the uniqueness of cinematography in visibly portraying psychological events calls our attention, with exaggerated clarity, to the fact that the interesting and meaningful problems of man’s relation to himself—and the fateful disturbance of this relation—finds here an imaginative representation” (Rank 1914, p. 7).

The publication of Hugo Münsterberg’s 1916 The Film: A Psychological Study, the first book on the parallels between the structure of the conscious mind and the filmic experience, occurred 2 years later, in 1916. It would take several more years for Hanns Sachs, the Berlin analyst who in 1926 was to contribute, as we have seen, to the screenplay of a major movie on psychoanalysis, to write an article on cinema (Sachs 1929). In it, among other observations on the formal aspects of the cinematic medium, Sachs identified interesting parallels between silent movies and Freud’s theory of para-praxis.

It would not be until the early 1960s, however, that psychoanalysis started to enrich film theory by providing original and often controversial interpretations of individual movies. Depending on the particular author’s theoretical orientation, these could include references to castration anxiety [classical Freudian], the symbolic order [Lacanian], sellobjects [Kohutian], the paranoid-schizoid and the depressive position [Kleinian], archetypal structures and the collective unconscious [Jungian], and so on. These scholars focused their attention, sometimes with the help of a detailed textual analysis of film sequences, on narratives and characters or even on the personality or psychopathology of the filmmakers themselves, as revealed by their work.

Gradually, however, their interest in cinema expanded to include an appreciation of its language, its formal structure, and its psychological, social, and more generally cultural functions, whereas the sterile psychohistorical activity of analyzing filmmakers on the basis of their artistic productions was to a large extent given up.

**Lacanian Contributions**

Jacques Lacan’s emphasis on language and its isomorphic relationship to the unconscious produced among some of his followers a number of original contributions to psychoanalytic film studies that, especially in the 1970s and 1980s, dominated the academic field on the pages of the prestigious journals *Cahiers du Cinéma* in France, *Screen* in Britain, and *Camera Obscura* in the United States and through the seminal essays of such authors as Jean-Louis Baudry (1974) and Christian Metz (1974).

Lacanian film scholars tried to understand spectator identification through the lens of Lacan’s theory of the “mirror stage”—that developmental process [an aspect of what he called the imaginary order] occurring in children between 6 and 18 months of age when they misrecognize themselves in the mirror as though their fragmentary body was a whole and thus build their ego on the basis of such an illusion. These film theorists took as their assumption the analogy between these decentered children and film viewers, for the latter would be using the silver screen as though it were a mirror. The spectator would thus acquire a false sense of power, or indeed of omnipotence, through a primary identification with the movie camera while in fact being merely a passive viewer of what unfolds in front of him or her. For Metz, this would account for the popularity of cinema insofar as it constitutes an imperfect reflection of the realities it represents while placing the viewers into a repressed dream state. A reason why, according to some Lacanian theorists, this unconscious scenario occurs is that the spectator can remain unseen, a fact facilitated by the absence (typical of mainstream cinema) of self-reflective references to the filming process itself and to the apparatus (the all-seeing, potent, phallic camera) involved in it. In fact, the omnipotent phantasm collapses as soon as a spectator realizes that what is projected on
the screen is just a constructed product. In this sense classical cinema was considered as an instance of commodity fetishism, hiding the labor that went into its production—a view providing a political dimension to such film studies.

Although cinema (and, as we have noted, psychoanalysis) was born at the end of the 19th century when the Lumière brothers showed their first films in public, the idea of cinema goes back more than two millennia, when Plato (360 b.c.) used the “Simile of the Cave” to describe how chained prisoners, unable to move or turn their heads back, would mistakenly believe that the wooden and stone statues carried in front of a fire behind them, and whose shadows were thus projected on the cave wall facing them, were real people and not simulacra. “And so in every way,” Plato concluded in The Republic, “they would believe that the shadows of the objects we mentioned were the whole truth.” Jean-Louis Baudry, another prominent Lacanian film scholar, also referred to Plato’s myth in developing his own views about what he calls the cinema “apparatus.” Following the publication of his articles “Ideological Effects of the Basic Cinematographic Apparatus” (Baudry 1974) and “The Apparatus: Metapsychological Approaches to the Impression of Reality in Cinema” (Baudry 1975), his apparatus theory became influential within academic film studies throughout the 1970s. This approach emphasized the ideological nature of the mechanics of film representation. In particular, the camera and the editing suite were considered by Baudry and his followers to be key tools in providing ideological points of view to the spectators’ gaze, thus making cinema itself instrumental for the transmission of dominant cultural values.

Among the many important issues raised by Metz (1974) in his oft-quoted essay “The Imaginary Signifier,” I focus here on just one that seems to me particularly suggestive. Referring to the fact that, given the nature of the film medium itself, what we watch in a cinema is even further removed from the object being represented than, say, what we would witness on a theater stage, Metz (1974) conceded that what unfolds on the screen “is real [the cinema is not a phantasy], but the perceived is not really the object, it is its shade, its phantom, its double, its replica in a new kind of mirror” (p. 45). What is peculiar about cinema, he says, is not only that it allows us to perceive our object from a distance (through the senses of sight and hearing) but also that “what remains in that distance is no longer the object itself, it is a delegate” (p. 61). This “delegate” is a prime instance of the Lacanian manque (“lack”): like any other form of desire, its essence depends on being fulfilled, while its existence comes to an end the moment it is. Film is suspended, for Metz, in the imaginary space of this paradox. Indeed, a frequent critique of Lacanian theories of cinema is that they tend to describe the desire in film audiences in negative terms, as originating from an absence of the objects signified on the screen.

Lacanian analyst Jacques-Alain Miller (1966) proposed the term suture to describe the imaginary process whereby the subject is “stitched into” the signifying chain. This concept “found immediate favour amongst film theorists in order to describe the mechanism by which the spectator is positioned as a cinematic subject, [and] takes her or his place in the cinematic discourse” (Cowie 1997, p. 115). Other authors with a Lacanian orientation, such as Stephen Heath (1981), Ann Kaplan (1990), Slavoj Zizek (1992), and Joan Copjec (1994), have studied specific formal aspects of filmmaking (i.e., screenplay, direction, mise en scène, camera work) or of film watching, sometimes in the context of their analogy with conscious, preconscious, and unconscious mental processes or in relation to the categories of the real, imaginary, and symbolic orders. Film editing, in particular, lends itself to be discussed in terms of similar defensive mechanisms as those operating, for instance, in dream work and in symptom formation.

Studies on “Spectatorship”

Under the influence of Lacanian-colored semiotics and feminist theories, a fertile ground of research has also been that of the relationship, under the generic label of “spectatorship,” of cinema with its audience. The term spectatorship refers to the complex of psychological, socioeconomic, and more generally cultural phenomena that affect filmmakers in their construction, and audiences in their reception, of cinematic products as well as the mythologies associated with them.

These studies have covered such varied areas as those concerning regressive elements of film (for some, the dark room of the theater is the symbolic equivalent of the intrauterine experience), voyeuristic aspects (the viewer’s curiosity for the primal scene to be enacted on the screen), or fetishistic components (the mass phenomenon of worshipping celluloid stars).

Psychoanalytically influenced film scholars with a feminist orientation, prominent among them Laura Mulvey (1975, 1989), Teresa de Lauretis (1984), and Mary Ann Doane (1987), have provided original per-
A Winnicottian Approach

Film studies inspired by Donald W. Winnicott’s theories are scant, perhaps at least in part because of his own somewhat unenthusiastic attitude toward cinema. Yet his developmental model of mental processes proves useful for an understanding of the structural and functional characteristics of cinema as well as provides original interpretations of individual movies. Particularly relevant here are his concepts of “mirroring” and “transitional space.”

The process of mirroring (Winnicott’s own adaptation of the Lacanian mirror stage) refers to the intimate exchanges of gazes between mother and baby, facilitating in the latter the gradual establishment of a sense of personal identity. Winnicott (1967) once quoted a patient saying that the painter Francis Bacon liked “to have glass over his pictures because then when people look at the picture what they see is not just a picture; they might in fact see themselves” [p. 117]. This detail seems to confirm the meaning of the screen on which the film gets projected as a distorting mirror surface reflecting what we unconsciously wish to see in it.

As to the transitional space, Winnicott conceptualized it as a sort of playground, “a resting-place for the individual engaged in the perpetual human task of keeping inner and outer reality separate yet inter-related” [Winnicott 1953, p. 230]. Cinema could be seen as an eloquent instance of a playful activity [but, like a child’s play, also an entirely serious one] that takes place in what, to use another spatial metaphor, we could call a “bridge space.” As an extension of the transitional space, the bridge space is also an intangible yet at the same time real territory located on the boundaries between the internal and the external worlds and linking them together. Film opens up such a creatively ambiguous space in the cracks between reality and fantasy, documentary and fictional narrative, historical events and subjective experiences. The bridge space is what connects external reality to its filmed representation and the filmmakers’ imagination to the viewers’ experience.

Toward Interdisciplinary Dialogues

As we have seen, psychoanalytically informed film scholars have been engaged from a variety of theoretical perspectives in important research on the connections between cinema and psychoanalysis. As a result, the discourse on their complex relationship has become progressively broader and deeper, no longer involving exclusively the application of concepts borrowed from analytic theory to film interpretation.

What is particularly encouraging is the emerging extension of our field of inquiry into a more sophisticated process characterized by new interdisciplinary dialogues between the practitioners of cinema and those of psychoanalysis. In other words, psychoanalysts are now showing an interest in what films can offer them, in appreciating them also as valuable contributions to their theoretical knowledge about the human mind and to their clinical work with patients.

In particular, psychoanalysts and other analytically oriented therapists believe that they have much to learn from films, especially from those that focus on characters portrayed in all the complexity of their personalities and emphasize subtleties of psychological and interpersonal experience. What the viewing of such movies can do for analysts is to enrich their knowledge of the human condition, in both its normal and its psychopathological manifestations, reminding them of how unclear the boundaries can be between the two.

In some cases, film scholars, filmmakers, and mental health practitioners cooperate to achieve a deeper understanding of many aspects, both normal and abnormal, of our internal world, subjectivity, sexual identity, social roles, and interpersonal relationships for an enrichment of both disciplines. Numerous specialized publications, dedicated Web sites, and the regular inclusion of film essays in the main psychoanalytic journals, as well as increasingly frequent professional events at which psychoanalysts debate their approach to cinéma with filmmakers and the latter discuss their movies with analysts, attest to the importance of such cross-fertilizing interchanges. Furthermore, the program of most psychoanalytic conferences since the 1990s now includes the screening of films followed by panel discussions with psychoanalysts and filmmakers. International events such as the European Psychoanalytic Film Festival taking place biennially in London constitute meeting points for the practitioners and students of the two disciplines and provide invaluable opportunities for such exchanges.

I now present a couple of personal examples of this fruitful dialogue between cinema and psychoanalysis. The first illustrates how filmmakers, while being sometimes suspicious that psychoanalytic interpretations could impose unintended meanings on their work, can at other times be open to the idea that some of their artistic choices may be motivated by factors outside their consciousness. Histoire d’Eaux (2002) is a short film about the passing of time as a subjective experience, showing that different temporal modalities can easily co-
exist. In the course of the roundtable conversation with its director, Bernardo Bertolucci, I commented that the lyrics of “Un Anno d’Amore”—Mina’s love song playing diegetically from a radio in the background—were consistent with the main message of the film. Although this was quite obviously the case (the song suggested that a boyfriend would understand in a single instant the meaning of a whole year of his girlfriend’s love for him), Bertolucci at first objected, claiming that he had chosen that music simply as a friendly gesture toward Pedro Almodóvar, who had used that same song in one of his movies.

On second thought, however, Bertolucci admitted that it could not have been a coincidence that, of all the songs available to him, he should have ended up picking one that was so relevant to the content of his film. Unconscious reasons for his choice, and for then justifying it to himself and to our audience with a rationalization, must have been at work there, and he was pleased that our discussion had allowed him to learn something about his movie, and potentially about himself too, of which he had been hitherto unaware. Bertolucci’s openness to psychoanalysis is also evident in the following quotation: “Since I started to know analysis I found that I had, in my camera, an additional lens which was... it’s not Kodak, it’s not Zeiss, it’s Freud, it’s a lens which really takes you very close to dreams” (Bertolucci and Sabbadini 2007, p. 384).

My second example illustrates how a film could help us become more conscious of certain aspects of our psychoanalytic work. Michael Radford’s Il Postino (1994) is the fictional narrative about a simple postman who, charged with the daily delivery of mail to the exiled Pablo Neruda, develops a personal relationship with the famous poet while learning from him about verse, metaphors, and rhymes. After watching that film, I realized that there were interesting similarities between their friendship and the analytic relationship itself, that the daily encounters between the village postman and Neruda were comparable with therapeutic sessions and, more specifically, that the feelings that il postino was developing for the poet had strong transferential connotations.

Reflecting on that film, I thus became more vividly aware of the extent to which language—and a sensitivity to the sounds and shades of emotional meanings of words—is crucial to both the poetic and the analytic experience. Furthermore, as Neruda, having then departed from the island, soon forgot about his friend, thus leaving him in a state of bewildered despair, I was reminded of the significance of experiencing the phase of termination within the analytic relationship and of allowing for a proper working through of the mourning process in order to minimize the sense of abandonment, betrayal, and loss in our patients, if not also in ourselves.

Conclusion

As we have seen, the relationship between psychoanalysis and cinema is a complex one. Most studies in this area, whether from psychoanalysts or film scholars, originally focused on the application of certain basic analytic concepts, borrowed from Freudian or other metapsychologies, to the interpretation of the contents of individual movies and to the exploration of such themes as their narrative, characterizations, and oniric quality.

Of course, a psychoanalytic film genre as such does not exist. However, there are certain movies that lend themselves better to a psychoanalytic reading: those portraying characters in a psychologically convincing, three-dimensional way; those dealing with themes of direct interest to analysts; and those representing the analytic profession itself.

In the course of the past half century, this field has gradually expanded to embrace also a variety of other contributions, most notably those influenced by Lacan’s theories. These include studies on the form of cinema [its structure, apparatuses, function, language, and so on] and of its reception and impact on its viewers [spectatorship, point of view]. At the same time, an ongoing dialogue has been evolving between filmmakers and psychoanalysts, thus recognizing the importance of cinema [both as an art form and as a popular medium] for providing psychoanalysis with original insights into human nature—how and why people behave, think, feel, and relate to one another—all invaluable material to theoreticians as well as practitioners of the analytic discipline.

In the past few decades, lines of communication among filmmakers and psychoanalysts (not to mention numerous analytically informed film scholars) have been opened on the pages of books and journals, on Internet Web sites, in academic film studies courses, and at conferences and festivals the world over. The by-now large body of work in this area, promising further fruitful developments in the years to come, is a testament to the dedication of those scholars who, through their knowledge about and love for cinema, psychoanalysis, and their relationship, have believed in the value of interdisciplinary dialogues and cross-fertilization between them.
KEY POINTS

- Psychoanalytic ideas can be applied to cultural phenomena, including cinema—an art form with a special relationship to mental activities and emotional experiences.

- Both psychoanalysis and cinema were “born” in 1895. Freud, however, unlike many of his followers (Rank, Abraham), never showed much interest in films.

- There are important analogies between filmic language and the analytic idiom used to describe unconscious processes.

- Either deliberately or unconsciously, many filmmakers are influenced in their work by psychoanalytic ideas about human experiences.

- Often films are interpreted with reference to psychoanalytic concepts, especially movies 1) that portray psychologically credible, three-dimensional characters; 2) whose themes directly concern psychoanalysts (e.g., different psychopathologies); and 3) that represent the psychoanalytic profession itself.

- There is a close link between movies and dreams (Hollywood as a “dream factory”), because they use similar mechanisms (e.g., condensation).

- Concept of “dream screen” (Lewin) as a special structure on which the dream as a set of images gets projected.

- Different psychoanalytic ideas (from Freud’s Oedipus complex and castration anxiety to Winnicott’s mirroring and transitional space) contribute to our understanding of filmic characterization, narrative themes, interpersonal relationships, and psychological (including unconscious) motivation.

- Many valuable psychoanalytic studies on film structure, function, apparatus, and language are influenced by Lacanian theories (mirror stage, desire, lack) (see Metz, Brody).

- Several important psychoanalytic and feminist studies concern issues of spectatorship (Mulvey), focusing on how filmmakers are affected in their construction (and audiences in their reception) of film.

- Psychoanalytic theories of identification could also be applied to an understanding of the point of view. Where do film spectators place themselves?

- In recent years, there has been a progressive move from the application to film studies of psychoanalytic theories toward cross-fertilizing dialogues between the two disciplines. Not only can filmmaking benefit from analytic ideas, but psychoanalytic clinical practice can also be enriched by the filmmakers’ representation of the human condition.

- There has been a welcome flourishing of specialized publications, Web sites, film essays in psychoanalytic journals, and interdisciplinary events at which psychoanalysts debate their approach to cinema with filmmakers and the filmmakers discuss their movies with analysts.
Doane MA: The Desire to Desire: The Woman’s Film of the 1940s. London, Macmillan, 1987
Münsterberg H: The Film: A Psychological Study (1916). New York, Dover, 1970
Sachs H: Zur psychologie des films. Die Psychoanalytische Bewegung 1:122–126, 1929
Vienna Psycho-Analytical Society, a door opened out of the consulting room and into the artist’s studio. Countless psychoanalysts—as well as many nonclinicians schooled in psychoanalytic theory—followed, proposing that psychoanalytic conceptualizations of mental life could uniquely and profitably illuminate the artist and his or her creative productions. Although Freud pointedly eschewed music in favor of archaeology and the visual and literary arts, another of the Wednesday Society’s founding members was musicologist Max Graf [the father of the boy in Freud’s [1909] Little Hans case]. Graf’s [1911] essay on Wagner and The Flying Dutchman can be designated the first distinctly psychoanalytic inquiry into music and musical creativity.

In the following half century, relatively few psychoanalytic studies of music were produced as compared with works focused on other forms of artistic expression [Noy 1966, 1967, Sterba 1965]. Kris’s [1952] groundbreaking work Psychoanalytic Explorations in Art signaled the emergence of more sophisticated applications of Freudian ideas in the arts and creativity. The second half of the 20th century marked a continued shifting away from the historically dominant “regressive” model that tended to correlate pathology and creativity. Writings from the mid-1950s and beyond, however, moved more toward ego-psychologically oriented formulations, emphasizing conflict-free, adaptive, and less neurotically or psychotically influential factors in relation to the psychic organization of the composer as well as the effects of music on the listener.

This change in the climate of psychoanalytic theorizing, coupled with works about music by authors equally knowledgeable about music and psychoanalysis, gave rise to a new generation of writings in which equal emphasis could be placed on the music itself rather than only on the mind of the composer or listener. This new combined approach allowed the extrapsychological data of the music—i.e., its unique and specific forms of notation, form, grammar, and syntactical structure—to be understood [or at least addressed] both on its own terms and as aural representations of mental functioning.

The relative recent history of this mode of the conjoined study of music and psychoanalysis can be traced to the late Stuart Feder, who until his untimely death in 2005 was its most eminent, prolific, and eloquent spokesman. Other important contributions by authors trained both as psychoanalysts and as musicians include works by Martin Nass, Gilbert Rose, Peter Ostwald, Pinchas Noy, Alexander Stein, and Morton Reiser, among others (see http://www.mindandmusic.org/bibliog.html for a comprehensive, if not exhaustive, roster).


Feder established an original perspective in relating the biographical data of composers’ lives to their creative life in music. He sought to illuminate the overdetermined and multifunctional relationship between the artist’s mental life and the music itself by way of a sophisticated, synthesized understanding of both areas. In this mode of analysis, Feder departed significantly from both earlier psychobiographies of composers and psychoanalytic writings on music. He advanced the premise that, in considering the relationship between music and affect, writings on the aesthetics, history, or philosophy of music have always grappled with the manner in which music reflects, symbolizes, and communicates aspects of inner life.

The study of the relationship between affect and music from this point forward has had far-reaching and reciprocal benefits for psychoanalysts as well as for musicians, musicologists, and others studying or writing about music and musicians. On this view, a musical and psychoanalytically knowledgeable study of the nature of representation in the auditory sphere, that is, of auditory symbolism, together with understanding how affect achieves auditory representation, yields a more expansive conceptualization of the nature of affect in mental life [Feder 1982].

Music is therefore considered not only from aesthetic or philosophical perspectives but also as directly related to the mental processes of the composer: “To study the ‘complete biography’ of an artist such as Mahler,” Feder [1978] wrote, “it would not suffice to use only the usual materials of biography such as personal accounts, letters and the like, and to omit documents which reveal mental content expressed and realized in his own most characteristic manner of conceptualizing, namely, the form of thought known as music” [p. 127].
In light of this background, writings about aspects of music and psychoanalysis can be roughly organized into three general categories: 1) those that deal with the biography of the composer and attempts to understand the composition through his or her life events; 2) those that present psychoanalytic treatment studies of musicians and composers; and 3) those that attempt a metapsychological approach to understanding the psychological meaning of music. The psychoanalytic approach taken within each of these categories has tended to reflect the theoretical focus dominant at the time of writing.

Musicologists, aestheticians, and philosophers have long disagreed about how to conceptualize or articulate music, meaning, and emotional experience. Over time, many formulations have been advanced to explain the interrelation of music and emotional experience. For example, Noy (1993) distilled three primary conceptualizations:

1. The narrative route—Music is itself the site of some immanent, pre-encoded narrative to be transmitted to a listener.
2. The direct route—Music is isomorphically concordant with the listener’s emotions. This was an application of a theory of isomorphism espoused by Susanne Langer (1953), a philosopher whose writings on meaning, logic, art, and symbolism have been influential to musicologists and to psychoanalysts involved in the philosophy of music. She took the view that “the tonal structures we call ‘music’ bear a close logical similarity to the forms of human feelings...music is a tonal analogy of emotive life” (Langer 1953, p. 27). In related but independently conducted research, Pratt (1952) conceived of auditory patterns that find correspondence with organic and visceral patterns in the body, concluding, thus, that music sounds the way emotion feels. This defining view of the so-called isomorphist school suggests that a listener’s emotions are activated directly by the innate content of the message, a concept akin to the Platonic doctrine of anamnesis: the experience of learning as bringing to consciousness what the soul already knows from an earlier existence.
3. The indirect route—The listener’s emotional reactions are the result of defensive ego-reorganizational activity triggered by auditory stimuli, if the music in its progression surprisingly deviates from its expected sequence to present something unexpected, the apparatus of perception will be called into action to edit the musical input to fit the form. Kohut and Levarie (1950), for example, suggested that when listeners are “trapped” in the concert hall and “confronted” with entirely unfamiliar atonal music, they will be “unable to cope” [p. 76] with the unfamiliar sounds and will experience a gradual rise of anxious tension at the strange sounds that they cannot master. Heinz Kohut’s proposition departed from the prevailing views of his time by restoring agency to the listener and wrestling activity from its prior position as the exclusive property of the artistic message. According to Kohut, the listener could no longer be considered simply a passive recipient of a musical communication, the meaning of which was pre-embedded, but rather as an active agent in organizing and attributing, albeit unconsciously, his or her own meaning to such communication. In psychoanalytic terms, the music’s effect on a listening subject derives from the resistance mounted against the spontaneous recuperation of the repressed memory of an archaic relationship with music qua symbolic representation.

The prevailing psychoanalytic view is less preoccupied with provenance. Rather, it attends to the dynamic interplay between what can be roughly distinguished as internal elements [psychological, psychoacoustic, psychosomatic, affective, proprioceptive] and external ones (musical, cultural, environmental, sociohistorical, political-aesthetic). Gilbert Rose (1992) underscored this conceptualization by noting “human emotion cannot exist embedded in the inorganic structure of aesthetic form. The structure can only offer the necessary perceptual conditions for an emotional response to occur” (p. 216).

The interaction between music and a listener (or composer) is thus neither an aesthetic creation in which the wealth of human emotion inheres in toto nor a concordant sounding board that resonates sympathetically with a listener’s internal affective life, but rather an object relation. As such, an encounter with music triggers complex intrapsychic events or responses. The aesthetic/ emotional gestalt experience of music’s effects within us can generally be understood as comprising perceptions, distortions, and condensations of time and memory as well as archaically derivative fantasies, defenses, and modes of internalizing, expressing, and responding to affects, all operating within an abstract primary process mode of registering, construing, constructing, and re-constructing experience (Stein 2004b).

Feder (2004) encapsulates these wide-ranging formulations in his felicitously phrased idea of music as simulacrum—music as an analogue of the totality of mental life:
Among the elements the listener brings to the musical experience is a latent awareness of mental process that is properly called preconscious. It is the conveyor, as it were, of images, ideas, affects, memory, fantasy etc, all of which may participate in the individual musical experience. However, the doings of mind itself are readily perceived with a change of focus: that is, the introspective perception of mental process as opposed to mental content. It is precisely to this that the simulacra of mental life in music addresses itself.... [A] fundamental feature of mentation is encoded in music; indeed, as such, it is a basic aspect of nature and of human nature. This allows for an entrainment on the part of the listener to diverse and at first unfamiliar musical ideas, and may thus provide an added dimension of meaning and appreciation. (p. 20)

One of the chief difficulties in articulating musical experience is the need to bridge the divide between the linguistic realm and a nonverbal, nonlinguistic, and nonobjective one. Clinical psychoanalysis is, after all, the so-called talking cure, and music does not, strictly speaking, talk. When we use words to describe musical processes and sounds, in other words, we are shifting from a basically nondiscursive form to a discursive one (Nass 1989). Scholars of music wrestle with this in identifying the mechanisms of expressive reference and also in determining the locus of expressive meaning in music, what Nelson Goodman (1968) considered “the place to look in music” for properties metaphorically exemplified. In a now-famous letter written on October 15, 1842, to Marc-André Souchay in Berlin, the composer Felix Mendelssohn expressed this same tension, though privileging the transparent meaning of music when compared with words themselves:

There is so much talk about music, and yet so little is said. For my part, I believe that words do not suffice for such a purpose... People often complain that music is too ambiguous; that what they should think when they hear it is so unclear, whereas everyone understands words. With me it is exactly the reverse, and not only with regard to an entire speech, but also with individual words. These, too, seem to me so ambiguous, so vague, so easily misunderstood in comparison to genuine music.... The thoughts which are expressed to me by music that I love are not too indefinite to be put into words, but on the contrary, too definite.... The same words never mean the same things to different people. Only the song can say the same thing, can arouse the same feelings in one person as in another, a feeling which is not expressed, however, by the same words.... Words have many meanings, but music we could both understand correctly. [cited in Newcomb 1984, p. 635 and footnote 58, p. 642]

Words to Music: How Does Psychoanalysis Contribute to Musical Understanding?

There is a plethora of issues involved in bringing psychoanalysis to bear on musical forms. Chief among these is rendering assessments of intention, evidence, and methodology in constructing psychoanalytically informed formulations without a patient and outside the consulting room. On this topic, the literature is ample (see, e.g., Baudry 1984; Esman 1998; Kaplan 1988). Such works are generally understood as examples of “applied psychoanalysis.” Yet thinking of psychoanalytic contributions that may be possible beyond the analyst-analysand dyad as “applied” encourages an analysis of, say, musical forms as simply applying psychoanalytic concepts to better understand the composer’s motivation or interest in writing music. It is one-directional in its method and limiting in the kinds of evidence considered toward understanding music and its effect on the listener. More recent efforts to understand artists and artistic forms psychoanalytically appreciate, instead, the interdisciplinarity of the method: aspiring to use an in-depth understanding of music to illuminate the problem of interpreting meaning and motivation and an in-depth psychology to comprehend and evaluate specific musical forms.

Baudry (1984), for example, considered the gains derived from evaluating a work of art (or the artist who created it) within a psychoanalytic framework of interpretation and meaning. Of the various art forms he discussed, music was not directly addressed. Just the same, one of his methodological categories applies: the reaction of the reader (or here, a listener) to the production of poetic and aesthetic effect. This approach focuses both on the listener who hears the music and on the thematic analysis of the musical score that identifies traces or derivatives of mental contents of the composer. The intention is to interpret the meaning that underlies the text—“a” really means “b,” holding on the same plane both the listener and the production of the musical composition. Thus a range of interpretive possibilities is open, depending on whether one conceptualizes the music as, say, representative of an acoustical mirror or as a container for a listener’s projections.

Analogy, simile, and metaphor in so-called applied psychoanalytic investigations appear unavoidable when comparing what are typically regarded as essentially different modes of expression. In his theorizing about the creative process, Freud (1908) saw dreams and dream states as the artist’s primary muse and here established
the paradigmatic relevant analogy: the poet is like a child at play. In addition, such analogical conventions are subject to the vagaries of interpreting the terminol-
yogy itself. Arnold Schoenberg (1923), for example, dem-
ominad the expression “atonal music,” considering it equiva-
ently meaningless to calling flying “the art of not falling” or swimming “the art of not drowning” (p. 210). According to Schoenberg, all relationships be-
tween and among tones are by definition tonal, pro-
vided that they form a progression that is logical and comprehensible; by extension, an opposite, atonal, can no more exist among tones and tone relationships than can an opposite “aspectral” or “accompanying” ex-
ist among colors and progressions of colors (p. 211). In Schoenberg’s view, then, “atonality” describes a quality of the listener, not a feature of the music itself. Thus, applied psychoanalysis, implying in this case the char-
acterization of the music itself, obscures interest in the
listener and the relationship between the hearer and the
heard.

Nass (1989) observed in his critical review of the lit-
erature on psychoanalysis and the arts that “one of the
most common methodological errors made in applied
psychoanalysis is the evaluation of an aesthetic work on
the basis of its dynamic meaning in the history of the
artist, rather than through criteria that concern them-
selves with the aesthetic value of the work itself” (p.
159). Wary of the trend toward pathologizing art and artists, Nass cautioned that psychoanalysis “should avoid reductionistic moves toward explanations of creative ac-
tivity strictly on the basis of conflict and understandings
of works of art strictly on the basis of a narrow view of
the artist’s motivation” [Nass 1989, p. 160]. The cre-
ative act, in Nass’s view, “serves a variety of intrapsychic
functions as well as interactive ones, and though it may
become involved with conflict it does not strictly arise
from conflicted behavior” (p. 160).

As noted here, the preponderance of “applied” psy-
choanalytic enterprises has historically been produced
by psychoanalysts who, although specialists in under-
standing the doings of the mind and perhaps passionate
about an art form, frequently have no specialized
knowledge of music or art or literature. More often
than not, applied analysis actually implies an imperi-
ous incursion into a foreign discipline, the results of
which hold dubious scholarly merit.

To achieve the aims implicitly established, for in-
stance, by Feder’s writings, interdisciplinary literacy has
become increasingly important. Whether psychoanaly-
sis is used to deepen our understanding of other disci-
plines, such as music, or to sharpen our perception and
description of what is going on within the patient or be-
tween the analyst and analysand, it is not sufficient sim-
ply to rely on metaphors or simile drawn from elsewhere
or to reduce musical expression simply to psychoanaly-
tic categories. Current discussions in psychoanalytic
journals on even such foundational topics as interpreta-
tion, evidence, transference, countertransference, and
diagnosis underscore that the scope of psychoanalysis is
still widening. Utilizing works of literature, film, art,
and music has a long, established history, at this point it
certainly requires no further substantiation or justifica-
tion as a credible primary source for material in the
study of the human mind or in the explication of psy-
choanalytic principles, so long as both disciplines are
handled expertly. The goal is to generate an interdisci-
plinary psychoanalysis, not an “applied” one.

Music as Words:

Pitfalls in Applying Musical Language to Describe the
Psychoanalytic Process

There are certain intrinsic difficulties in “importing”
musical terminology to describe the psychoanalytic sit-
tuation. Tone, rhythm, harmony, and melody, among
others, can often be employed to better describe the
nuances of feeling and experience between analyst and
analysand. However, the use of these terms or others
derived from music—a grammar and vocabulary unique
unto themselves—to characterize psychoanalytic phe-
nomena is fraught with misunderstanding and misin-
terpretation. By employing terminology from music in
the ostensibly service of more clearly explaining a psy-
choanalytic principle or clinical encounter, one has typ-
ically only differently described it.

Music is closely tied with primary process experi-
ence—that is, music can be felt without secondary elab-
oration or executive cognition about its meaning (Stein
1999). Conceptualizing analytic moments in musical
terms, whether intrapsychically or interpersonally, can
therefore be an important point of entry for gaining in-
sight into a patient’s unconscious process, fantasy, and
imaginations underlying or constituting his or her affec-
tive expressions. Yet the pitfalls must be overcome of an
overly reductive categorization of abstract nonverbal ex-
pressions such as timbre, pace, intensity, or semiotic
recognizability; in this case, “music” will otherwise
have merit only as a descriptive analogue. Little is ulti-
mately communicated unless the analyst’s underlying
assumptions about the dynamic interplay of perception
and response, interpretation and meaning, and thought
on the paper, the meanings and communicative possibilities of words, the evocative experience of cradling the violin under the chin or holding the bow in the hand, the feel of the reed in the mouth, the sensual embrace of the cello and the sonorities it produces, or more generally, the rich panoply of feelings and associations aroused by hearing and playing the repertoire composed for any particular instrument).

There is a host of constitutive elements distinct to musicians as a class of professional artists. Musicians (especially classical musicians) typically commence their rigorous preparatory training in childhood. There is consequently a “tremendous, life-long ego investment in and entwinement of identity vis-à-vis the chosen instrument and the many issues affiliated with mastery and performance on it” (Nagel 1988, p. 145). Among the skills and attributes that begin to develop from an early age are “exceptional levels of discipline; a heightened toleration for isolation and waiting deriving from the intensive ngos of daily practice and concertizing; augmented powers of concentration and recall memory; an effective sublimatory capacity to split off from real or imagined feelings of anxiety or threat and to remain at least superficially poised during moments of duress” (Stein 2004b, pp. 761–762).

The musician’s relationship to her or his instrument, then, is a complex psychological, physical, and emotional amalgam. Acquiring technical and interpretive expertise requires sustained and focused effort. This work, called “practice” during rehearsal and “play” during performance, can be conceptualized as a processive forum for mastery—of the musical score, motor coordination, affect regulation [or manipulation], and multiple conscious and unconscious mental tasks [Nagel 1988].

There is a profound, intimately tactile, and eroticized physical relationship to the instrument. The sounds of the instrument, not just the sound of the music, become directly connected for the musician with individual thought, feeling, self-perception, and bodily action. Crucial aspects of subjectivity—the idea of a musical personality as an intrapsychic and intersubjective co-construction, a distinctive personal sonic style, interpretive originality, measurement of self-value, and constituent of self-hood—are thus created and extended outward in the sounds and through the infinitely repeated bodily movements required to successfully produce and consistently reproduce them [Cumming 2000].

These intricately entwined aspects of physicality in the construction and production of sound and musical identity become laced together with other less tangible threads. A complex metaphysical relationship is established with the musical score—a system of written notation having its own structure, grammar, and syntax and entailing its own processes of integration and internalization. This psychophysical incorporation equally encompasses the idiosyncratic (and often vaguely defined) constituents of artistry and interpretation, knowledge of style, music theory and history, and performance practices. It also includes a richly populated internalized object world comprised of teachers, mentors, parents, siblings, idols, rivals, colleagues, composers, and a roster of other real, imagined, prospective, or historical auditors of every quality, any or all of whom can be [or are] critical and condemning, neutral or unresponsive, or laudatory and adulating (Stein 2004b).

Especially because the formative processes of training to become a concert artist typically begin at an early age, there are also numerous developmental and psychosexual factors that underlie the motivation to become a musician and necessarily become integrated (or arrested) aspects of character structure (Stein 2004b). The impulse to perform, although not exclusive to musicians, can be understood, similarly, as an extended transformation of the child’s early experiences vis-à-vis important adults’ responses to narcissistic and exhibitionistic strivings. Performing can be narcissistically and exhibitionistically gratifying or, conversely, psychologically overwhelming or anxiety producing, or some imbalanced combination of these, and can betoken the giving and receiving [or the withholding and frustration] of both pleasure and discomfort. Involving as it does such fantastic quotients of ego and other investments of self, making and performing music is, as Cumming (2000) suggested, “interiority made into sound” [p. 8]. In this, the musical performer is highly vulnerable; the wish [or impulse] to perform may be psychologically separate from the desire to make music.

Performing, as distinct from music making, can be generated by a host of complex, even contradictory, archaic needs, including to be watched [as well as heard] and appreciated—to be recognized as special, masterful, communicative, gifted, emotive, sensitive, or the like. There may equally exist an aggressive or hostile component, perhaps as a consequence of the absence of those positive forms of recognition or as a displacement from another sphere of mental existence, that may be given acceptable discharge in overpowering the instrument, the music, or the audience [any or all of which can serve as a symbolic condensation of the actual psychological object of hostility] through the manipulation of tempo, dynamic force, virtuosity, and omnipotent fantasies of control and/or merger [Nagel 1988].
psychic development and attachment, auditory sensations and stimuli constitute our primary contact experiences (Niederland 1958).

In each person is an archive of phantom echoes, unthought memories of sounds that have colloquial and idiomatic meanings, carry affective over- and undertones, preserve relational moorings and associations, or are reminders or evocations of pastness. We live and relate with ourselves and others today in ways profoundly shaped and reshaped by all that was, especially how it all sounded, and by the experiences and memories that may always defy being spoken of in words but are encoded in sound.

All of this can be understood by reference to Freud's concept of screen memories, although with an emphasis on the auditory realm—that is, condensations of sonic experiences essentially out of readily retrievable memory and associatively tethered to an otherwise seemingly "forgotten" time of life. Even as memories and affiliated feelings may resurface and cohere, words that might be used to contextualize and verbalize them to one’s self or another may be unreachable or even not exist. Why? Because the originating experiences are unrepresented in language; they are only aural memories, residues of sounds and feelings.

Case Study

The foregoing conceptualizations of music, sound, and human experience are profitably engaged in the dyadic clinical encounter in which straightforward language is frequently subordinated to oblique linguistic indicators, silence, wordless metaphors, somaticizations, symptoms, kinetic and sonoric gestures or enactments, or primitive utterances. These present a sound world that is, in its own terms, music. The patient is verbalizing in a language of sounds, some of which may be actual words with recognizable meanings, but regardless, it is communication that can be heard as a form of music—an individual’s unique sonic rendering of interiority being verbalized in a language of sounds (Stein 2007).

Consider as illustration Mr. O, a bilingual man in his late 30s with a mild stutter. At the time he entered treatment his attention was dominantly taken up by distress and misgivings about his relationship with a shrewish, volatile, haranguing girlfriend. Although Mr. O’s stammer was most pronounced when speaking with his parents, it was noticeably reduced when speaking English, his second language, and one in which his parents were barely competent.1 In Mr. O’s treatment, special attention was given to the thoughts, feelings, memories, and fantasies unconsciously operative during (or giving rise to) stuttering episodes.

Mr. O’s mother emerged in his presentation of her as hysterical, pathologically narcissistic, and intermittently psychotic. With her son, she was both voraciously engulping and attacking, neglectful in one moment, brutally aggressive in the next. She was psychologically destructive in her disavowal of his separateness. Their fusion returned his desire to retaliate as an attack on himself. Mr. O’s father cohered as schizoid and sadistic, although warmer and more constant than the mother. He was an idealized but limited father figure, having stayed married to the Mother/Gorgon and only rarely having come to his son’s rescue. In this relational constellation, love, attachment, and self-representation present insoluble conundrums. It is a toxic, no-win environment.

Mr. O talked about the appeal of solitude. Aloneness was freedom and ease. Then, “a large part of what comes out of me is my father,” he said. “A specific rhythm and way I whistle is exactly like my dad.” He recalled a memory from age 5 or 6 years: he was alone in his bed, hearing his father whistling in the house. A flood of memories emerge involving hearing his father humming or whistling. These are quasi-musical enunciations that assured Mr. O of his father’s nearby presence and coniectedness. Mr. O linked these moments to feelings of safety.

In the vast lexicon of human sounds, humming and whistling are nonverbal expressions falling between nonspecific communications and formal musical structures. Any sound (or gesture) without a fixed or consensual definition can have multiple and contradictory symbolic meanings (Ostwald 1973). The phoneme “m” is an easy sound to produce and occurs in virtually all European languages. When occurring as the word “Hm,” it can signify assent, questioning, negation, disapproval, or, as frequently used in psychotherapeutic settings, a soft sonic hand denoting presence, connection, or understanding. Subtle variations involving timing, intonation, and inflection can signify almost any context-specific meaning. Humming can focus one’s concentration or aggressively distract others. It can serve as an audible hesitation while thinking or act as a masking or screening sound, like white noise machines in therapists’ waiting rooms.

Greenson (1954) linked the sound “Mm” to the act of humming and its likely early orally gratifying properties.

---

1 Stuttering is frequently symptomatic of psychosexual developmental conflicts and, as Charlotte Balkányi (1961) suggested, is “the dysfunction of molding affects into words” (p. 108).
Music and Time

Time is one of music’s most significant constitutive elements. As a general proposition, music, unlike the visual, is abstract, intangible, and ethereal, disappearing no sooner than it is created. Technology can defeat the natural decay of sound—consider the development of recording devices that can capture and preserve it—and this can provide a calming semblance of permanence. Yet this does not really reverse its evaporation or resolve the paradox that sound is an integral, essential part of the physical world that nonetheless lacks concreteness or mass. In this, music mirrors many fantasies about life and death, repealing the wishes of psychic reality for immortality or resurrection even while introducing an unavoidable reminder, at once painful and pleasurable, of life’s fragility and impermanence.

French Impressionist composer Claude Debussy defined music as “rhythmicized time.” The preponderance of music in the Western classical canon—tonal music of the European tradition until approximately the introduction of serialism at the turn of the twentieth century—is “discursive,” using Suzanne Langer’s [1957] word, meaning that its formal structure unfolds successively in real time, like a narrative. This forward-moving narrative can spontaneously evoke regressive associative responses that in the mind of the listener can seem to skew, compress, expand, reverse, stop, or defy time. This plasticity of time, trenchantly defined by Rose (1992), “is the experience of the movement of lived time made audible” (p. 156).

A psychoanalytic understanding of time includes such ideas as the timelessness of the unconscious, the linearity and asynchrony of primary process functioning, and the private, personal, and subjective experiential meaning of “psychological time.” Additionally illustrative, for example, are elements of dream work such as condensation, distortion, displacement, and reversal. Also profitably considered at the intersection of aesthetic and psychoanalytic conceptualizations of time’s significance in subjective experience are the Greek concepts *kairos*—denoting the experience of ebb and flow of episodic time along a continuum—and *chronos*—referring to clock time, the measurable time of succession. Rose (2004) formulated music as a “representation of the emotional quality of subjective, lived time made audible—an auditory apparition of felt-time” (p. 156), a statement illustrated via the near-universal appeal of Beethoven’s so-called *Moonlight Sonata* [No. 14, Op. 27, No. 2, C# minor], a programmatic title applied by a poet some 30 years after its composition. Rose argued that

the structure [of the music] is devoid of any referential meaning to things outside itself. It has nothing to do with either moonlight or other scenes from nature, let alone abstract concepts such as courage or longing. Rather, the accumulation of three-note wave after similar wave combines near-constancy with minute differences, and this gradual intensification of focused attentions is associated with mounting feeling. (p. 97)

In its unique capacity to transform—or in any case, alter—our perceptual and sensory experience of time, music can serve a host of complex, multidetermined, or overdetermined intrapsychic functions: it can provoke a heightened anticipation of a future moment, induce or relax states of tension, seem to suspend time’s ineluctable forward movement, or affectively evoke temporarily distant events or reminiscences from the past.

Music listening, a psychological-auditory event, occurs in the present and, like our perceptions of time itself, moves the present toward the future; it can also induce the sense that time is standing still or trigger associative links to earlier times (Stein 2004a). These paradoxical experiences are understood by a consideration of rhythm, particularly the gentle swaying or rocking motions used in calming a distressed infant. Fetal and infant life are dominated by the rhythms of the body—mother’s and child’s alike—and these enterceptive, kinesthetic, and biorhythmic experiences are no doubt vestigially retained and resurrected in later life, perhaps most especially in moments of duress when the mind might regressively dissociate to a primitive developmental state when an abstract sense of time has yet to be consolidated. Cradle-like rocking and other hulking mechanisms associated with early life, as well as such later derivatives as slow, rhythmic counting used to quell anger or fear, are thus often used for self-soothing during traumatic or painful events. Similarly, apprehension of time, both conceptual and sensory, is frequently distorted when there is a traumatic breach of the stimulus barrier. There will often be a discontinuity between the sense of time experienced and time remembered as well as significant alterations to perceptions of duration; spans of time can seem compressed or expanded, accelerated, decelerated, or stopped entirely (Stein 2004a).

Music’s discursive narrativism engenders a sense of time’s passage, of a traveling away from now toward some moment hence. Even a retrograde figure [as in a fugue where a thematic subject is reintroduced in reverse], a sonically deceptive Escher-like contrivance used to convince our ears that the end precedes the begin-
ning, nonetheless engages our perception of an unraveling toward a conclusion, not a regressive implosion backward. Concisely put, in transforming our perceptual and sensory experience of time, music can serve deeply as defensive or coping functions: it can provoke a heightened anticipation of a future moment, induce or relax states of tension, seem to suspend time's ineluctable forward movement, or affectively evoke temporally distant events or reminiscences from the past.

Especially in states of mourning or in the wake of a traumatic disturbance, music can function analogously with the latent wish underlying the dream work, serving as a creative solution to a traumatic reality. This is in keeping with what Loewald (1988) supposed are certain "magical" qualities of art, "connected with the achievement of a reconciliation—with the return, on a higher level of organization, to the early magic of thought, gesture, word, image, emotion, fantasy, as they become united again with what in ordinary nonmagical experience they only reflect, recollect, represent, or symbolize" (pp. 80–81). The mind's ear is a fertile locus of interior listening where mental functioning can be translated into conjured sound having symbolic significance.

### KEY POINTS

- Music and psychoanalysis are connected by three common concerns: the study of meaning, the nature and expression of affects, and forms of communication. Both privilege the auditory channel. The fundamental nexus of music and psychoanalysis is the interpretation of meaning from sound.

- Psychoanalytically oriented writings about music can be roughly organized into three categories: 1) those that deal with the biography of the composer and attempts to understand the composition through his or her life events; 2) those that present psychoanalytic treatment studies or psychobiographies of musicians and composers; and 3) those that attempt a metapsychological approach to understanding the psychological meaning of music. The study of music employing these categories is considered a form of "applied psychoanalysis." A more contemporary approach engages music as interdisciplinary, requiring scholars to be knowledgeable about music and psychoanalysis.

- Various formulations were advanced to explain the interrelation of music and emotional experience. Three primary conceptualizations were distilled: 1) narrative route (music is itself the site of a pre-encoded narrative to be transmitted to a listener); 2) direct route (music is isomorphically concordant with the listener's emotions—music sounds the way emotion feels); and 3) indirect route (the listener's emotional reactions are the result of defensive ego-reorganizational activity triggered by auditory stimuli).

- Contemporary psychoanalytic studies of music emphasize the dynamic interplay between internal psychological, psychoacoustic, psychosomatic, affective, proprioceptive elements and external musical, cultural, environmental, sociohistorical, political-aesthetic ones. The interaction between music and a listener (or composer) is conceptualized as an object relation in which an encounter with music triggers complex intrapsychic events or responses.

- Psychoanalysis offers unique tools and conceptual perspectives for understanding the psychological formation and development of individuals who become musicians.

- The physical organs of audition together with the sound environment of earliest life play profound formative roles in psychological development. The vestigial remnants of
early auditory perceptions, experiences, and impressions assert ongoing influences throughout the life cycle.

- Time is one of the most significant constitutive elements of music and human experience. Music listening is a psychological-auditory event; music can alter our perceptual, sensory, and psychological experience of time. Music can serve a host of complex intrapsychic functions.

References

Goodin T: Point-counterpoint: music associations and the interplay of transference and countertransference in the analysis of a visual artist. Paper presented as a part of the panel on Psychoanalysis and Music at the IPA Conference, Jerusalem, Israel, December 1999
Greenon RR: About the Sound “Mm...”. Psychoanal Q 23:234–239, 1954
Knapp PH: The ear, listening and hearing. J Am Psychoanal Assoc 1:672–689, 1953
Langer S: Problems of Art. New York, Charles Scribner’s Sons, 1953
Abstinence  The technical principle that the analyst must refrain from gratifying the wishes of the patient. By refraining from providing gratification, the analyst encourages these wishes to be put into words by the patient so that they can be analyzed.

Acting out  The expression in action outside of a psychoanalytic session of feelings and thoughts that were aroused within the session. By substituting an action or behavior for self-reflection or words, a person deprives himself or herself of knowledge of an important part of his or her inner experience.

Adaptation  The individual’s capacity to deal with the external environment, either by accommodating to the demands of reality or by actively modifying reality in a personally or socially beneficial way.

Affect  In classical psychoanalysis, emotions, and particularly their physiological manifestations, that are derivative [i.e., transformed] expressions of libidinal and/or aggressive drives. The Ego, as an executive agency, deals with affects, with special importance given to anxiety, which serves as a signal of danger.

Agency  The capacity to recognize conditions and consequences in human interactions and to participate in exchange with others through action. Agency is distinguished from a sense of agency, which develops through repeated acknowledgments of one’s agency by others and by repetition of experiences that confirm one’s capacities to bring about desired results. The term is also used locatively to refer to any of the three major subdivisions of the mind in Freud’s structural theory: id, ego, and superego.

Aggression  Manifest strivings, in thought, action, feeling, or fantasy, to dominate, prevail over, or be destructive to others. The term also refers to the drive that gives rise to such manifestations.

Alexithymia  The inability to know and to describe one’s own feelings. Alexithymia differs from intolerance of feelings and may be seen in patients with disorders on the border between somatic and psychological illness.

Alpha function (Bion)  The process through which the mother recovers the primitive affective experiences


SMALL CAPS type indicates terms defined as main entries elsewhere in this glossary.
treatment, which is often bolstered by a shared unconscious fantasy about their functioning as an analytic couple.

Bipolar self  In self psychology, the two-part structure that is the core of an individual’s personality and sense of self. It consists of the pole of the grandiose self, expressed by ambitions, and the pole of the idealizing parental imago, expressed by ideals and experienced as embodied in the parental object. In the psychoanalytic situation, the grandiose self may be activated and forms the basis of the mirror transference. The idealized parental imago may be activated and forms the basis of an idealizing transference.

Birth trauma  The hypothesized experience of overwhelming anxiety for the newborn as he or she emerges from the womb of the mother. Otto Rank proposed that it was the prototypical experience of anxiety and was responded to with repression. He believed that subsequent developmental crises follow from this traumatic loss of the original experience of union with and likeness to the mother.

Bisexuality  A psychological makeup in which the individual may choose either a man or a woman as a sexual object. Freud believed that bisexuality was universal in the unconscious. On a conscious level, research has demonstrated that most individuals have a primary preference for either a male or a female sexual object, while only a minority of individuals are bisexual.

Body ego  The sense of one’s body in three respects: what the body feels (i.e., external and internal sensory input), what the body does (e.g., internal/external movement), and how the body fits into the external world (i.e., its place, position, and extensions).

Body image  The unconscious mental representation of one’s own body, which may be anatomically incomplete or inaccurate and which may structure some psychological symptoms.

Borderline personality organization  A primitive character structure represented by a fluid and labile sense of identity, a desperate fear of isolation and aloneness, along with chaotic intimate relationships in which the other is both intensely needed and experienced as toxic and rejecting, and the use of archaic defenses of splitting and projective identification. This personality often manifests with eruptive anger in chaotic relationships, yet in nonintimate situations, these individuals often function well.

Castration anxiety  The fear, occurring in both sexes, that the most sexually pleasurable parts of the genital anatomy (i.e., the penis and clitoris), which are most valued because they symbolize gender, may be damaged or lost. This fear is particularly intense in children ages 4–6 but continues unconsciously throughout life in displaced form (e.g., as inordinate anxiety in the face of the feared loss of health, youth, beauty, or wealth).

Cathexis  The investment of attention, interest, or mental energy (either libidinal or aggressive), the quantity and quality of which determine the level of engagement between self and other. In the transference, patients withdraw their cathectic investment from past figures and reinvest in the clinician as a new figure.

Character  The aggregate of relatively enduring and stable personality traits in an individual. Examples of these habitual modes of feeling and thinking are obessionality and hysteric. Character develops over time and is related to infantile solutions to particular conflict. It is slow to change, even with psychoanalytic intervention.

Character disorder  A disturbance in the structure of an individual’s personality in which there are rigidly held patterns of behavior that get the individual in trouble or lead to the defeat of his or her own aims but that cause him or her no subjective distress.

Co-construction  A process that integrates the experiences of two individuals in a dyad. Each individual constructs the experience of “self” and “other”; each one’s experience of “self” is affected by the other’s experience of him or her as “other.” For example, a “co-constructed” narrative of an analysis is created by the back-and-forth interaction between the narrative of the analyst’s experience of self and patient, the patient’s experience of self and analyst, and their wish to have a shared narrative of the shared experience.

Component instincts  The different early forms of the sexual drive directed at specific body areas such as the oral mucosa or genitalia, or associated with specific activities that may be erotically charged. These components frequently occur as complementary pairs, such as scopophilia and exhibitionism or sadism and masochism, and gradually combine to form mature sexuality in the course of psychic development.

Compromise formation  The ego’s solution to a problem presented by the competing demands of id, super ego, the repetition compulsion, and external reality. Every psychic action has multiple functions and can be understood as a compromise formation.
The ego serves to mediate among the demands of the instincts, the external world, and the superego. It perceives the needs and wishes of the individual and the qualities of the environment and integrates these perceptions so as to achieve (through modification of internally arising needs and actions taken on the environment) optimal gratification of internal needs and wishes in such a way as to be acceptable to the external world and superego.

Ego apparatus The psychic structure associated with the execution of all of the functions of the ego (e.g., reality testing, thought processes, defensive functions).

Ego defect A failure or weakness of some ego function or functions that would normally be expected in a healthy individual. Ego functions that are often involved are self-object differentiation, defensive functioning, modulation of drives and affects, and reality testing. Constitutional factors, psychic trauma, and early maternal deprivation may all play a role in the genesis of an ego defect.

Ego-dystonic A term describing thoughts, feelings, personality traits, or behaviors that are experienced by the individual as incompatible with the dominant view of the self. Compare with ego-syntonic.

Ego functions The specific capacities employed by the individual in the assessment of and mediation between the demands of the id, the superego, and external reality. Examples are perception, defensive functioning, impulse control, and reality testing.

Ego ideal A set of standards that reflects an exemplary view of the self. It derives from multiple sources, including idealized images of the parent, qualities perceived as necessary to maintain the love of the parents, and vestiges of infantile fantasies of omnipotence and perfection.

Ego psychology The area of psychoanalytic theory that focuses on the ego as a structure, the operation of its varying functions, and how they serve the aims of the individual's adaptation and negotiation between the demands of internal needs and wishes, constraints of conscience, and exigencies of external reality.

Ego-syntonic A term describing thoughts, feelings, personality traits, or behaviors that are experienced by the individual as compatible with the dominant view of the self. Compare with ego-dystonic.

Emotional refueling (Mahler) The experience of the infant, during the practicing subphase of the separation-individuation process (10–15 months of age), in which he or she is able to restore the elation and confidence of being physically separate from the mother and of exercising developing cognitive and motor skills through momentarily reconnecting with the mother. During this phase, the mother needs to be available so that the child can turn to her periodically for this “refueling.”

Empathy The imagining of another's subjective experience through the use of one's own subjective experience. Empathy has been posited by self psychologists as vicarious introspection and the defining means by which the data of psychoanalysis are gathered.

EmpINESS A painful feeling in which the self is experienced as devoid of contents, thoughts, emotions, or inner images of relationships with others. It may be associated with having feelings of worthlessness and having nothing to give to others.

Enactment The expression, in action, of transference impulses or fantasies and their associated memories as a substitute for experiencing, understanding, or remembering them; alternately, the eruption of unformulated thoughts and feelings from infancy into the analytic setting, where articulation and working through can take place. This often takes the form of a scenario, unconsciously played out through joint participation of patient and analyst. Some measure of enactment is inevitable in all analyses and, if interpreted by the analyst, may be therapeutically useful.

Envy The emotion associated with the idea that someone else has something that one wants. Envy is a form of aggression, since it embodies a wish not only to have what the other person has but to deprive the person of what is valuable and make him or her suffer for having possessed it. Envy is often confused with jealousy, which involves three parties and has the aim of winning the exclusive love of the object over a rival for that love.

Eros A mental energy that binds elements of experience from relationships, gratifications, or desires into larger units or patterns. These coalesce into fantasies tinged with sexual excitement.

Erotogenic masochism As defined by Freud, a propensity to seek physical or mental suffering for the purposes of conscious or unconscious sexual gratification.

Erotogenic zone A body part that serves, when stimulated, as a source of erotic excitation or gratification. Freud postulated a developmental series of such zones: the mouth, the anus, and the phallic/genital organs. Under particular circumstances, however, virtually any organ, mucous membrane, or cutaneous surface might fulfill this function.
Evocative memory  The capacity to retrieve a memory by virtue of conscious will, in the absence of an externally perceived cue. It is distinguished from recognition memory, in which the memory is retrieved in response to an external cue.

Exhibitionism  The pleasure in attracting attention to oneself. It is a normal part of child development and may be integrated into a well-functioning adult personality. The term also refers to the paraphilia of exposing the genitals to strangers as a means of achieving orgasm.

Expressive psychoanalytic psychotherapy  A form of treatment that relies on the basic psychoanalytic concepts of transference, countertransference, and unconscious motivation, even though it may not adhere to some conventions of formal psychoanalysis, such as the use of a couch. It seeks to encourage the expression, understanding, and working-through of thoughts and feelings that may have been previously unavailable to conscious awareness.

Externalization  A mental process that results in the individual’s attributing to the external world internal phenomena or personal agency when engaging in interpersonal interactions.

False self  The self experience that emerges and organizes in response to another’s needs, expectations, and demands (as opposed to the True Self that emerges and organizes in response to one’s own needs, expectations, and demands).

Family romance  A fantasy, common in latency-age children, in which, as a result of disillusionment with their family of origin, children imagine they had parents very different from their own. These fantasy parents are endowed with ideal characteristics that they wish their own parents had, such as royalty, wealth, power, or special kindness.

Fantasy/Phantasy  An unconsciously organized intrapsychic “story” about oneself and others. Fantasies shape perceptions of the external world and determine the nature of interpersonal interactions. Freud believed unconscious fantasies were originally elaborated consciously in words and images and became unconscious through repression. The Kleinians added the concept of very early fantasies, elaborated before the attainment of language and experienced primarily on a somatic level, which they believe are part of a developmental continuum with the higher-level fantasies described by Freud. As a convention, the term phantasy is used to connote this broader Kleinian definition of fantasy life.

Feminine masochism  A term used by Freud to describe one of three forms of masochism in which men or women identify with certain aspects of the role of the woman that are experienced as submissive: being castrated, being penetrated, or giving birth to a baby. This identification is reflected in masochistic submissive behavior or sexual fantasies.

Femininity  See Masculinity/Femininity.

Fetish/Fetishism  A paraphilia (or perversion) in which a body part, inanimate object, or piece of clothing substitutes for the genitals as the aim of the sexual drive.

Fixation  The unchanged, unmodulated persistence of earlier patterns of thought or adaptation into advanced levels of maturing development, when their manifestations may be deemed inappropriate. This developmental stasis is often a consequence of early trauma.

Frame  The rules and regulations of social interaction that produce necessary boundaries to sustain the psychoanalytic situation and permit creative understanding in the psychoanalytic process. These include arrangements between patient and analyst regarding time and frequency of sessions and payment of the fee. For patients whose disorders include difficulty in negotiating boundaries, the analytic frame becomes an important focus of the treatment.

Free association  The principal method of fundamental rule of psychoanalytic treatment, in which the patient says whatever comes to mind, without conscious editing. Implicit in this rule is the understanding that difficulties in doing so will inevitably be encountered. The analyst attempts to assist the patient, through interpretation, to create greater freedom of association.

Fundamental rule  In clinical psychoanalysis, the injunction to the patient at the onset of treatment to report whatever comes to mind, regardless of its seeming lack of relevance or logic, social inappropriateness, or feelings of shame or embarrassment that it might stir.

Gender/Gender identity  A concept comprising two aspects of the experience of the self: core gender identity and gender role identity. Core gender identity refers to the individual’s anatomical self-image, usually as either male or female, rarely as hermaphrodite. Gender role identity is the sense of oneself as being masculine or feminine, in comparison to perceived familial/cultural norms on a continuum.

Genital phase/Genitality  The final phase of psychosexual development as conceived by Freud, and the psychic characteristics of this stage. The genital stage begins at the onset of puberty. The integration of object love with genital sexuality is a primary developmental attainment of this stage.
Negative hallucination  The nonperception of something that is actually present, involving any of the senses. This experience is the inverse of a hallucination, which is the subjective perception of an external phenomenon not in fact present.

Negative therapeutic reaction  The worsening of symptoms in response to the therapist’s effort to foster insight. Many different dynamics may underlie such a response, including guilt over lessened suffering or improved functioning or envy of the analyst’s capacity to help.

Neurasthenia  A state of excessive fatigability, lassitude, irritability, lack of concentration, and hypochondria. In Freud’s early work, he attributed these symptoms to physiological consequences of inadequate sexual satisfaction due to masturbation. Both the term and Freud’s understanding of it are important in the history of psychoanalysis but are not considered clinically relevant in modern psychoanalysis.

Neurosis  A category of symptomatic disturbance arising from intrapsychic conflict (see conflict, intrapsychic) that interferes with normal functioning but that does not interfere with reality testing. Compare with psychosis, in which reality testing is impaired.

Neutrality  The position of nonjudgmental listening adopted by a psychoanalyst toward his or her patient, avoiding suggestion, advice, or choice of sides in the patient’s intrapsychic conflicts (see conflict, intrapsychic). Modern analysts have questioned both the realistic attainability and the clinical value of neutrality as it was originally described by Freud. Today, analysts vary widely as to what they believe constitutes a stance of neutrality.

Neutralized energy  A postulated form of psychic energy that results from a process in which sexual and aggressive elements are integrated, providing impetus for the performance of psychic work not dominated by either libidinal or aggressive feelings.

Normality  As commonly used, psychological health or appropriate behavior. Some psychoanalysts have attempted to posit a relatively normal ego that pursues reasonable pleasures and accomplishments in relationships with others. However, there is no consensus among psychoanalysts as to what constitutes “normality” from a psychoanalytic point of view.

Object  A person who is the focus of one’s wishes and needs. The object may be internal (the individual’s mental image of the object) or external (the actual person external to the subject), part (a body part, function, or gratifying or frustrating aspect of the object) or whole (an image of the entire object that takes into account its multiple attributes).

Object constancy  The integration of originally separate, unconscious mental representations of “good” and “bad” objects into more realistic and stable representations combining the “good” and “bad” qualities.

Object relations  A term that refers both to the actual relationships of subject and object and to the internal fantasy of the nature of the object (the “other”), as well as the nature of the relationship of self and object.

Object relations theory  A theory of psychological structure and development that postulates that the internalized representations of objects, and the fantasies of the relationship of self and object, are determining factors in the development of psychic structure.

Object representation  The individual’s mental image of an object in his or her life. The representation contains aspects of the actual external object but is also colored by the individual’s fantasies about the object.

Obsession  A recurrent thought that intrudes on an individual’s mind and cannot be banished from consciousness by an exercise of will. Obsessions are closely related to compulsions but differ in that obsessions occur within the realm of thought, whereas compulsions impel the individual to action.

Oedipus complex  An aggregate of mental processes that develops from the child’s incestuous wishes toward the parent of the opposite sex. There are associated conflictual feelings toward the parent of the same sex as both a rival for the love of the incestuous object and a loved object himself or herself. This conflict is resolved through an identification with the same-sex parent. [The “negative” Oedipus complex involves an identification with the parent of the opposite sex in order to receive the love of the parent of the same sex.]

Oral-incorporative mode  A mode of relating to an object that is characterized by the prominence of fantasies of eating and swallowing the object and making it part of the individual’s own body, thus abolishing individual characteristics of the object.

Oral-intrusive mode  The earliest of the infantile developmental stages. It provides the prototypes of both love (libido) and hate (aggression), manifesting, respectively, through feeding/taking in and biting/spitting out. The oral-intrusive mode reflects the infant’s aggressive insertion of self into the body of the mother through demand for constant feeding or
through biting. Later expressions of clinging and demandingness may be traced developmentally to oral intrusiveness.

**Orality** All the psychic interests, impulses, character traits, and defense mechanisms that stem from the libidinal and aggressive drives associated with the mouth, particularly during the oral phase of psychosexual development, when these drives and the defenses against them are the dominant organizing forces of mental life. Greed, dependency, demandingness, impatience, and sarcasm are character traits associated with orality.

**Oral phase** The psychosexual phase, consisting of approximately the first 18 months of life, in which sensations of the oral zone and striving attached to these sensations are dominant in the organization of psychic life.

**Oral-retentive mode** A mode of relating to objects that is characterized by the prominence of fantasies of holding on by closing or grasping with the mouth.

**Overdetermination** The concept that all aspects of psychic life, including symptoms, fantasies, dreams, personality traits, and behaviors, are caused by a number of intersecting psychic factors, some of which are unconscious.

**Parameter** A term coined by Eissler to describe deviations from a standard psychoanalytic technique. The term and concept are little used today.

**Paranoia** A condition in which the subject holds to irrational beliefs, often circumscribed to one area of life, generally characterized by both grandiosity and persecutory ideas.

**Paranoid-schizoid position (Klein)** The earliest psychic organization, characterized by a predominance of aggression over libido and by primitive defenses such as splitting and projective identification. Through splitting, the mother is perceived alternately as a good [gratifying] or bad [frustrating] object, and the intense aggression stirred by the bad object is projected, so that it is experienced as persecutory. Remnants of this psychic organization persist throughout life and alternate with the more integrative depressive position.

**Paraphilia** A form of sexual behavior in which the aim of the sexual impulse is diverted from coitus and in which orgasm is obtained through other means or in which other activities are required for adequate sexual functioning. Examples are fetishism, pedophilia, exhibitionism, sexual masochism, and sadism. This term replaces perversion, which many analysts have moved away from as imprecise and implicitly judgmental.

**Parapraxis** Slips of the tongue, errors, bungled actions, and memory lapses that usually surprise the subject. These occurrences, like neurotic symptoms, are compromise formations between forbidden wishes or ideas and defenses against them.

**Part object (Klein)** The individual's experience of the object as only one aspect of the object rather than the entire object in its full complexity. This aspect may be a particular body part (e.g., the breast) or an experience of the object dominated by one affect (e.g., the good or the bad object) or of a function of the object (e.g., feeding, containing). The experience of the object as a part object is a hallmark of the paranoid-schizoid position.

**Pathological grandiose self (Kernberg)** The central mental structure in narcissistic personality disorder, which consists of a condensation of elements of the idealized object, the ideal self, and the real self. Though it may describe similar phenomena to Kohut's grandiose self, it differs in that, according to Kernberg, it is a result of a pathological line of development rather than the persistence of a normal developmental phase.

**Penis envy** The envy of power and strength in others, unconsciously attributed to the other's possession of a bigger or "better" penis. While originally attributed primarily to girls envying the larger, more visible penis of boys, penis envy is considered today by many analysts to be a symbol of the social advantages of males in society.

**Phallic phase** That period of psychosexual development, beginning at about 2 years of age and culminating in the oedipal phase, during which the sensations from the phallus [penis or clitoris], and the wishes and impulses connected with these sensations, are dominant in the organization of psychic life.

**Phallus** A term used literally to refer to the mental representation of the genitalia [the penis or clitoris], and figuratively to refer to personality traits such as pride and assertiveness, as well as a type of character in which such traits are prominent.

**Phantasy** See fantasy/phantasy.

**Phobia** A symptom involving the avoidance of an object or situation that stimulates anxiety. A phobia involves the displacement of a feeling away from its actual object onto one that bears some symbolic connection to it, along with a projection of a forbidden urge onto the phobic object.

**Pleasure principle/unpleasure principle** The basic regulatory aim of all mental activity, according to Freud, in which the individual seeks to maximize pleasure and to avoid unpleasure. Frustration in achiev-
ing immediate gratification leads to recognition of environmental constraints and modifications in the pleasure principle so that immediate pleasure is delayed in the interest of eventual satisfaction and self-preservation. Freud called this developmental achievement the REALITY PRINCIPLE and juxtaposed it with the pleasure principle.

**Practicing subphase** (Mahler) The subphase (10–12 to 16–18 months of age) of the SEPARATION-INDIVIDUATION process that is initiated by the infant’s maturational capacity to create physical distance from mother, beginning with crawling and peaking with running, and is at its height with the achievement of upright locomotion. The subphase is distinguished by elation, as the toddler experiences a “love affair with the world”, and excitement about exploration and his or her own growing EGO capacities; and b) the toddler’s capacity to reassure himself or herself by returning to mother’s physical body if ANXIETY intrudes.

**Preconscious** One of the three components (with CONSCIOUS and UNCONSCIOUS) of the mental apparatus in Freud’s TOPOGRAPHIC THEORY. The preconscious contains word residues that can connect an unconscious or conscious feeling, thought, or image with a linguistic REPRESENTATION. Elements of the preconscious are not conscious but are easily brought into conscious awareness through focusing attention on them.

**Pre-oedipal** A term describing the psychic organization, including DRIVES, DEFENSES, and self representations and OBJECT REPRESENTATIONS, specific to the phases of development before the OEDIPUS COMPLEX. Pre-oedipal organization is associated with more primitive forms of PSYCHOPATHOLOGY, such as narcissistic or borderline personalities, but the persistence of some pre-oedipal features of psychic life is ubiquitous, and these features may become prominent in regressive states even in individuals who are primarily organized around oedipal conflicts.

**Primal scene** The childhood perception of parental sexual intercourse, whether actually observed, actually overheard, or only imagined, and the meaning the child attaches to it.

**Primary gain** A term, in reference to a psychological SYMPTOM, that refers to the psychic gain derived from its function in the resolution of an intrapsychic conflict; [see CONFLICT, INTRAPSYCHIC]. It is distinguished from SECONDARY GAIN, which refers to the gain derived from the symptom’s use in the manipulation of the external world.

**Primary identification** The earliest form of IDENTIFICATION with an OBJECT, which occurs before the infant can distinguish the self from the object. This is different from later forms of identification, in which the growing infant or child distinguishes outside influences as external and then takes them in.

**Primary process** A primitive form of thought described by Freud, closely linked with the PLEASURE PRINCIPLE. It seeks immediate discharge of impulses through HALLUCINATORY WISH FULFILLMENT and makes use of the mechanisms of DISPLACEMENT and CONDENSATION in its REPRESENTATIONS of satisfactions. Developmentally it gives way to the SECONDARY PROCESS, which is associated with the REALITY PRINCIPLE and obeys higher-level rules of logic. In Freud’s original TOPOGRAPHIC THEORY, the primary process was believed to be the form of thinking that governed all the activities of the UNCONSCIOUS. Later, in the structural model, Freud understood that many mechanisms governed by the SECONDARY PROCESS can also occur at an unconscious level.

**Procedural memory** A form of memory for motor patterns, habits, and skills. Procedural memory is nonverbal and unconscious. A skill such as skiing or surgery is learned with conscious input, but many of the components of the skill are neither conscious nor verbally expressible. The concept has been applied by some contemporary analysts to understand some aspects of TRANSFERENCE, which can be conceptualized as habitual modes of object relatedness learned as procedures in the first few years of life.

**Prohibition** A mechanism of the SUPEREGO whereby impulses, wishes, or thoughts are deemed unacceptable and blocked from entering consciousness or from being acted on.

**Projection** The DEFENSE mechanism in which an individual attributes his or her unacceptable thought, feeling, or attribute, such as an aggressive or sexual impulse, to another person.

**Projective identification** The DEFENSE mechanism, originally described by Klein, through which an intolerable aspect of the individual’s mental life is projected into another person, accompanied by the FANTASY that this projected element controls the other person from within. In an INTERPERSONAL context, the target of projective identifications may have powerful feelings stirred in him or her, as if he or she is actually taken over by the projected element. Bion added that in addition to functioning as a mechanism of defense, projective identification also functions as a primitive form of communication and can ultimately be a vehicle for emotional growth in the mother-infant interaction.

**Psyche** The realm of the mind, as distinguished from the realm of the body, or soma.
Psychic determinism The hypothesis that mental events are not random and that behavior can be understood to be determined by unconscious as well as conscious influences.

Psychic reality Reality as it is constructed in the mind of an individual at a particular moment. The components of this subjective "reality" are perceptions, memories, wishes, and fears. It is distinguished from objective or historical reality.

Psychoanalysis According to Freud, a theory of mind, an investigative method, and a form of treatment for mental disorders. As a method of treatment, it involves multiple sessions per week for several years. Psychoanalysis utilizes free association, observations about unconscious mental functioning, and the examination of transference and countertransference as major means by which to understand and therapeutically influence the patient.

Psychoanalytic boundaries A set of conditions that composes the frame, including setting, time limit, confidentiality, payment of a fee, avoidance of dual relationships, and abstinence regarding sexual or physical contact. These conditions facilitate the emergence of the transference while also protecting both the patient and the analyst from potential exploitation.

Psychoanalytic method The technique of classical psychoanalysis involving multiple sessions per week with the patient lying on a couch out of view of the analyst and endeavoring to say everything that comes to mind. The analyst uses the patient's associations and the information derived from transference and countertransference to enhance the patient's self-understanding.

Psychoanalytic process The experience within a patient who is responding to the psychoanalytic method. Analysis of resistance leads the patient to master unpleasurable feelings, particularly with respect to the analyst; this leads to the emergence of previously unconscious thoughts and feelings with a new set of resistances, which are, in turn, interpreted. At the same time, unfolding feelings within the analyst help him or her to better understand the patient's emotions and defenses and facilitate his or her capacity to interpret.

Psychoanalytic situation The totality of the conditions—practical, psychological, and interpersonal—that are present when patient and analyst come together for the purposes of psychoanalyzing the patient. It may be seen as having three components: the patient who brings a disposition to use a relationship with an analyst to transform aspects of his or her emotional life; the analyst who listens with the aim of understanding the patient's unconscious, and the setting, which includes practical arrangements such as time and fee, and agreed-on methods and procedures such as the injunction to free-associate.

Psychodynamics The organized constellation of unconscious wishes and defenses against those wishes that underlie a piece of human behavior. Implicit in psychoanalytic theory is the idea that all human behaviors and mental events have psychodynamic underpinnings.

Psychopathology Psychological states or structures, transitory or enduring, that cause active psychological pain to the individual, get in the way of the individual's optimal functioning, or lead to patterns of action in the external world that can be seen by the external observer to inevitably lead to harmful consequences.

Psychosexual phases A series of sequential, overlapping stages in the developing infant and child—oral, anal, phallic, and genital—each representing predominant sensual investment in different bodily zones (e.g., sucking, biting, or mouthing in the oral phase; expelling or retaining feces in the anal phase; and manipulating the genitals in the phallic phase). Fixation at one of these stages may color adult personality development and character type.

Psychosis A category of mental disorders typified by a loss of reality testing, as opposed to neurosis or character pathology, in which reality remains intact. Phenomenologically, psychotic disorders may include delusions, idiosyncratic thinking, hallucinations, abnormal affective states, and bizarre behaviors.

Psychosomatic A term referring to physical symptoms or diseases in whose expression psychological factors play an important role. The sufferer may or may not be aware of this connection. These symptoms and diseases are associated with actual physiological derangements; they are not imaginary or fictitious.

Rapprochement subphase (Mahler) The subphase of the separation-individuation process following the practicing subphase. It extends from about 16 to 25 months of age. The infant has mastered upright locomotion and now becomes more aware of physical separateness from the mother. The need to share every experience with mother is heightened as the infant's exuberance wanes with the recognition that she is not participating in his or her "delusion of parental omnipotence." During this subphase, the toddler is in a crisis of ambivalence, seeking to coerce the mother and yet also escape her orbit.
Rationalization  A defense mechanism in which apparently sensible explanations are used to justify something unconsciously considered unacceptable.

Reaction formation  A defense mechanism in which one convinces oneself that one feels exactly the opposite way from how one does feel. The most common form of reaction formation involves substituting exaggerated feelings of love for hate.

Reality  Psychoanalysis has distinguished between “outer” or “objective” reality and “inner” or “psychic” reality. The former consists of consensually validated judgments of the nature of the external world. The latter, subjective, unique, and idiosyncratic to the individual, is determined by unconscious wishes, perceptions, memory traces, and fantasies about early experiences and object relations. In life, the two are in constant dialectic interaction; psychic reality may distort external perceptions and judgments, while too great a focus on external reality may constrict the imagination.

Reality principle  A basic organizing principle of the mind that developmentally succeeds the pleasure principle in response to both growing cognitive capacities and experiences of frustration. The individual no longer seeks immediate satisfaction of needs and discharge of impulses but interposes an assessment of the environment and actions directed toward the environment with the aim of effectively maximizing pleasure and minimizing unpleasure within the confines of the external reality of the situation.

Reality testing  The process of distinguishing between inner thoughts and feelings and outer perceptions, or between the subjective and objective elements in the judgment of external reality.

Reconstruction  In clinical psychoanalysis, the process of elucidation and recollection of repressed experiences. Though once considered a central mechanism of the therapeutic effect of analysis, analysts have come to see its role as less important and have increasingly understood that it is psychic reality, rather than objective reality, that is retrieved in reconstruction.

Regression  A change in psychological phenomena in a direction that is the reverse of its usual, progressive direction. Freud distinguished three forms of regression, which are conceptually related:

  - Topographic  A reversion to earlier types of energetic discharge (e.g., pleasure principle)
  - Formal  A reversion to earlier forms of representation (e.g., from verbal expression to image or action)
  - Temporal  A reversion to modes of psychological functioning typical of earlier developmental stages (e.g., primary process)

Regression in the service of the ego  A form of regression that, though it may be originally instituted for defensive purposes, leads to a return to a more innovative and adaptive mental function and organization.

Reparation (Klein)  The idea that the guilt experienced by the individual for his or her aggressive wishes toward his or her object may be ameliorated through efforts to repair the fantasied damage done by the aggressive impulses. It is associated with the attainment of the depressive position.

Repetition compulsion  A tendency to repeat patterns of behavior or to re-create situations that may be painful or self-destructive, considered by some analysts to be a major motivational factor in pathology.

Repression  The expulsion of unacceptable psychic content from consciousness. The psychic content is seemingly forgotten via a motivated unconscious action but is potentially retrievable for conscious consideration.

Resistance  Unconsciously mobilized defenses that arise in the course of psychoanalytic treatment. While such defenses may or may not be adaptive in everyday life, in psychoanalytic treatment they constitute an obstruction to the patient’s and analyst’s joint effort to uncover the patient’s unconscious wishes and fantasies. For many analysts, the analysis of these resistances constitutes a major part of a psychoanalytic treatment.

Return of the repressed  The reemergence into consciousness or preconsciousness of previously repressed ideas and affects. This may occur under circumstances of stress, leading to manifest anxiety, deregulation of affect, or emergence of intensification of symptoms. In the context of psychoanalytic therapy, however, the return of the repressed may signal that the ego may now be strong enough to resolve previously overwhelming, and therefore repressed, conflicts.

Reverie  A term used by Bion to refer to the mental state of a mother with her infant. It is a state in which she is filled with what she imagines to be her child’s inner life, in the past, the present, and the future. This state, according to Bion, is the mother’s tool for receiving and understanding the affectionate communications from her infant; in so doing, she is able to contain and modify her infant’s intense affective life so that he can manage intense emotional states more capably. Some analysts use this model in analytic work as a way of thinking about how the analyst helps the patient deal with affective states that are difficult to manage.

Ritual  A sequence of connected behaviors enacted in a specific context. Rituals have meanings that are
both conscious and unconscious. A ritual can be either a normal form of expression or a symptom. When used as a symptom, a ritual is constructed so that it contains a compromise between unacceptable wishes and defenses against those wishes.

Role responsiveness A term used by Sandler to refer to a countertransference response in the analyst in which he or she feels impelled to behave in a way so as to play out a role that the patient unconsciously has assigned to him or her.

Rorschach The “ink blot” test in which, by scoring the subject’s responses to a set of 10 ambiguous forms on cards, inferences can be made about mental functioning and diagnosis, including psychological defenses and major conflicts.

Sadism The seeking of pleasure in the act of fantasy of inflicting pain or humiliation on another. It also refers to a paraphilia (perversion) in which conscious sexual excitement is found in inflicting pain or humiliation.

Schizoid A term used in different contexts with various meanings. Bleuler described some nonpsychotic personality types as schizoid because, as with schizophrenia, they showed a divorce between the mind’s emotional and intellectual functions. More recently, the term schizoid character has come to encompass a broader group of individuals and connotes an individual who is withdrawn, derives a majority of gratification from a vivid fantasy life, and may be suspicious of others while overestimating himself or herself. Fairbairn, in his clinical descriptions of schizoid dynamics, referred to this broader group. Melanie Klein described schizoid defenses, particular to the paranoid-schizoid position, which include splitting, projective identification, and introjection.

Scopophilia The sexual pleasure derived from looking, often at another person’s body or sexual organs. It is linked with its complementary component instinct, exhibitionism, and clinically the two often occur together in the same individual.

Screen memory A memory that is remembered with particular emotional intensity, often containing some prominent visual detail. Though such memories have a very real quality, their details are often inconsistent with the chronology of the memory. The elements of these memories are often symbols associatively linked to repressed aspects of the historical event to which the memories allude. In this way, they may function in a similar way to dreams.

Secondary gain The gratification from a symptom that derives from the use of that symptom to manipulate others or to obtain concrete benefit in the external world. It is distinguished from the primary gain of the symptom, which is the solution of intrapsychic conflict. See conflict, intrapsychic.

Secondary process A type of thinking characterized by rationality, order, and logic. It arises during development in accordance with the reality principle, which aims to replace hallucinatory wish fulfillment with adaptations to reality. It is distinguished from primary process, a more primitive mode of mental activity associated with the pleasure principle. Ordinarily both processes contribute to mental life, although in different proportions at different times.

Secondary revision (or elaboration) The part of the dream work that reorganizes and links together the elements of the dream into a relatively coherent narrative.

Seduction theory An early hypothesis by Freud that the trauma of childhood sexual seduction by adults was the cause of hysterical symptoms. He later abandoned this theory as he came to realize that many of the accounts of seductions were fantasized rather than real and to understand the importance of repressed fantasies in the genesis of neurosis. He never explicitly took the position that all such memories were fantasies, and certainly modern psychoanalysts recognize lasting psychological damage that can arise from childhood sexual abuse.

Self A psychic structure consisting of the individual’s subjective sense of “I,” an agency of the mind that is a center of initiative in relation to the external world, and the total individual (including both mind and body). Kohut emphasized the sense of continuity over time and cohesiveness in space as important aspects of the self; in self psychology, the self refers both to experience-near subjective aspects of the individual’s mental life and to an abstract concept of a mental structure whose vicissitudes are a central focus of clinical attention.

Self-actualization A course of action that results in the positive potentialities and special abilities of the individual finding expression in the external world and the pleasurable subjective experience of the individual when he or she is able to successfully pursue such a course of action.

Self-cohesion The subjective experience of the self as whole, well-functioning, relatively internally consistent, relatively enduring over time, and not subject to serious disruption as a result of disappointments in the self or others.

Selobject (Kohut) In self psychology, the individual’s experience of another person as functioning as
tives for which treatment was undertaken have been substantially achieved. From that point onward until the appointed final day, there is enhanced focus on the imminent separation of patient and analyst, leading to reverberations in emotion and fantasy that revisit the important themes that emerged in the analysis. The prospect of termination may stir symptomatic recurrences that are usually brief.

**Therapeutic alliance** The sense of constructive collaboration between the patient and the analyst as they work together on the patient’s problems. Some research suggests that this element is a predictor of successful treatment. Some differentiate between a transference, which tends to be irrational, and the therapeutic alliance, which is said to be more real. Others believe that this state is just an aspect of a positive transference.

**Topographic theory** An early effort by Freud to classify mental functioning and contents in terms of their relationship to consciousness. A mental event, such as a wish, idea, or feeling, is termed unconscious when it exists outside of conscious awareness and cannot be made conscious via focal attention and termed preconscious when such attention leads to conscious awareness. The structural theory, which divides the mind into id, ego, and super ego, expanded on rather than replaced the topographic theory.

**Training analysis** The personal analysis that is required of prospective analysts. The training analysis is intended to help prospective analysts become aware of their own psychological processes and to master unconscious conflicts that would otherwise lead to interference with participation as an analyst in the analytic treatment of patients.

**Transference** In clinical psychoanalysis, the patient’s emotional experience of and fantasies about the analyst, which, though they may be based in part on actual perceptions of the analyst, recapitulate experiences with and fantasies about important objects in the patient’s childhood.

**Transference neurosis** In clinical psychoanalysis, the analysand’s reexperiencing of his or her characteristic psychic conflicts and modes of defense, finding their expression in fantasies about the analyst. These fantasies recapitulate experiences with and fantasies about important objects in the patient’s childhood.

**Transitional object** An inanimate object (e.g., a blanket, teddy bear, clown) discovered in the environment by the child and invested with powers under the child’s omnipotent control. For the child, the object exists in a third space, which incorporates both reality and fantasy.

**Transitional phenomenon** A developmental process of separating “me” from “not-me” that creates a link between the child’s creativity and external reality, facilitated through the use of the transitional object. The process is the precursor to the capacities for play, creativity, and cultural experiences throughout life.

**Transmuting internalization (Kohut)** In self psychology, the process of internal structure building through the internalization of selfobject functions originally provided by the object. Kohut believed this occurred as a result of nontraumatic empathic failures on the part of the selfobject. The internalization of the analyst’s or parent’s mirroring function enables the patient to regulate affective experience and to more effectively manage disappointment and rage.

**Trauma** An experience in which external events overwhelm the capacity of the ego to process and manage them, evoking intense feelings of helplessness. The meaning of the event, not its reality characteristics, defines it as traumatic.

**True self** An experience of the self that emerges in response to one’s own needs and wishes (as opposed to the false self experience, which emerges in response to another’s needs, expectations, and demands).

**Turning against the self** A defense in which an aggressive impulse is redirected from another to the self. It is commonly found in masochistic individuals.

**Twinship transference** In self psychology, a slightly more differentiated form of mirror transference, in which the analyst is perceived as exactly like the patient, with the same values, tastes, and ideas.

**Uncanny** A term describing the quality of an experience of a mysterious or magical type, not able to be explained scientifically but for which Freud believed a psychoanalytic explanation was possible. Premonitions and states of déjà vu are common examples.

**Unconscious** A term that refers to mental contents that are beyond the reach of conscious thinking and are manifest through their derivatives in compromise formations. For Freud, dreams and parapraxes provided evidence of the existence of the unconscious and its impact on mental life. He distinguished between the dynamic unconscious, meaning the sum of all repressed mental contents, and the system unconscious, which is the seat of the drives, is governed by the pleasure principle, and operates according to the logic of primary process thinking. In his later writings, the term was used in a primarily

 neutrality concept.
descriptive way: most DEFENSES and SUPEREGO conflicts, for example, operate on an unconscious level but are not necessarily part of either the system Unconscious or the dynamic unconscious. In contemporary PSYCHOANALYSIS, nonverbal ENACTMENTS in the analytic setting are viewed as another manifestation of unconscious themes.

Unconscious fantasy A NARRATIVE about the SELF in relation to others that is either consciously elaborated and then repressed or elaborated outside of conscious awareness. Unconscious fantasies represent compromises between DRIVES or wishes and the DEFENSES against them, and they are constituted as well by the individual’s perception of himself or herself in relation to others. The fantasies form a template for behavior in the real world. When these fantasies are brought to consciousness through analysis, their power as motivators of maladaptive behavior is lessened.

Undoing A DEFENSE mechanism in which unacceptable unconscious wishes, feelings, and impulses are disguised by substituting behavior that appears to be their opposite.

Vertical split A process by which conscious but unwanted qualities of SELF are warded off, as by an impenetrable wall, and separated from conscious desirable self elements. Contrasted in self psychology to HORIZONTAL SPLIT, the DEFENSES associated with vertical split are DISSOCIATION and DISAVOWAL.

Whole object (Klein) The experience of the OBJECT as one object comprising both good and bad characteristics, toward whom both love and hatred may be felt. It is characteristic of the DEPRESSIVE POSITION.

Working alliance The spoken or unspoken agreement between patient and analyst to work toward understanding and recovery. It is differentiated from the THERAPEUTIC ALLIANCE in that the working alliance implies an understanding of how the work of analysis proceeds, as well as the patient’s voluntary adherence to his or her role as analysand and to the rules, conventions, and methods of the analysis.

Working-through A phase of clinical PSYCHOANALYSIS during which the dynamics of conflict are repeatedly revisited in experiences of the present, the past, and the TRANSFERENCE. It aims at transforming intellectual understanding into emotional knowledge; unconscious conflicts are resolved or replaced by more adaptive compromises, leading to an increase in adaptive functioning and a decrease in SYMPTOMS.
Index

Page numbers in boldface type refer to tables or figures. Those followed by “n” refer to footnotes.

“A Contribution to the Psychogenesis of Manic-Depressive States” [Klein], 187

A Dangerous Method, 530

A Short Film About Love, 530

AAI (Adult Attachment Interview), 242, 248

Abandonment, childhood history of, 118

Abend, Sander, 274–275

Abdon, Stuart, 405–420

Abraham, Karl, 11, 12–13, 14, 15, 58, 121, 189, 312, 425, 539

concept of ambivalence toward objects, 172–173

death of, 186

letter on countertransference, 80, 81, 83, 86, 89

Abraham, Nicolas, 515–516

Abreaction, 53, 62, 120

Abstinence, 14, 28, 350, 352, 567

Achievement of Therapeutic Objectives Scale (ATOS), 413–414

Acting in, 68

Acting out, 68, 471, 474, 567

Adaptation, 14, 22, 96, 180, 567

Adler, Alfred, 11, 12, 15, 25, 350

Adorno, T., 497

Adrian, E. D., 41

Adult Attachment Interview [AAI], 242, 248

“Aesthetic Ambiguity” [Kris], 528

Affec(s), 567

affect research and psychopharmacology, 448

dammed-up abreaction of, 53, 62, 120

dissociation due to, 53

isolation of, 123

motives and, 43

outcome related to emphasis on, 414, 420

Affective disorders, 448

Affective Neuroscience (Panksepp), 448

Agency, 59, 567

Aggression, 162, 567

Freud’s concept of, 13, 15, 22, 45, 58, 122, 158

Fromm’s concept of, 206

Klein’s theory of, 24, 173

Storr’s concept of, 206–207

Agnosis culture [West Africa], 479

Aichhorn, August, 200

Ainsworth, Mary, 242

Aiase complex [Japan], 486

Albers, Josef, 530

Alexander, Franz, 15, 162, 199, 274, 369, 370–371

Alexithymia, 567

Allen, Woody, 538, 541

Allostasis, 424, 437

Almodóvar, Pedro, 538

Alpha function (Bion), 109, 193, 195, 260, 292, 296, 567–568

Alter-ego phase of self development, 201

Alter-ego transference. See Twinship transference

Altmann, N., 216, 220

Alvarez, A., 260

Ambivalence, 172–173, 188, 568

American Institute of Psychoanalysis, 22

American Medical Association, 324

American Psychiatric Association, 144

American Psychoanalytic Association, 14, 21, 23, 25, 28, 82, 156, 199, 314, 324, 350, 371, 447

Interdisciplinary Colloquium #1, 479

Principles and Standards, 356–357, 363

American Psychological Association, Division of Psychoanalysis, 212

Amnesia, infantile, 10, 575

Amores Perros, 530

An Autobiographical Study (S. Freud), 509

Analexie object, 416, 432, 568

Anal phase of development, 58, 121, 157, 568

Analogy, 58, 143, 568

Analysis of the Self, The (Kohut), 200, 206

Analysis Terminable and Interminable (S. Freud), 227, 270, 279, 288, 308, 311, 315, 510, 511

Analytic attitude, 273

Analytic dyad, 31–32, 243–244

Analytic field, 88–89

intersubjectivity and, 110

resistance from perspective of, 93, 102, 103

Analytic Process Scales, 405

Analytic third, 23, 110, 219–220, 222, 296, 516, 518

Analytical psychology (Jung), 12

Analyzability, 164, 286, 367, 568

Analyze This, 541

Anamnesis, 553

Anatomy of Dependence, The (Doi), 486

Andreas-Salomé, Lou, 14

Anhedonia, 568

Anna Freud Centre, 390

Anna O. (Bertha Pappenheim) case, 7–8, 32, 54

Annihilation anxiety, 159

Anonymity, 214, 350, 568

Anscombe, G. E. M., 49

Anthropology and psychoanalysis, 477–490

anthropological contributions to psychoanalytic concepts, 483–485

Lévi-Strauss, 484
Anthropology and psychoanalysis (continued)
anthropological contributions to psychoanalytic concepts (continued)
psychoanalytic treatment of psychosis, 484–485
transference and indexicality, 483–484
application outside of European cultures, 485–487
analytic work with patients of various cultures, 485
in non-Western societies, 479, 485–487, 490
cross-fertilization and conflict between, 477–480
Erikson, Hallowell, and Devereux, 480
Freud, 477–478
Malinowski, 478, 479
key points related to, 489–490
psychoanalysis of fieldwork, 489
psychoanalytic concepts
illuminating cultural forms, 480–483
culturally constituted defense mechanisms, 482–483
personal symbol and work of culture, 483
psychoanalyzing ritual, 480–481
Turner and interpretation of ritual symbols, 481–482
psychoanalytic interviewing in fieldwork situations, 487–488
Antidepressants, 327
Anti-Semitism, 4–5, 7, 11
Antonioni, Michelangelo, 530
Anxiety
annihilation, 159
birth, 159
castration, 11, 28, 94, 124, 136, 137, 159, 229, 511, 512, 569
childhood, Sullivan’s concept of, 217–218
conceptualizations in contemporary psychoanalysis, 123–124
cultural beliefs and, 480
death, 159
definition of, 568
developmental chronology of, 123
relation to gender identity and gender role identity, 124
disintegration, 47, 159
about establishment of analytic process, 97–98
Freud’s theory of, 10, 13, 82, 122, 123, 158–159, 164, 166
Klein’s theory of, 123, 186, 187, 288, 289
primitivism, 123
separation, 140, 584
signal, 159, 288, 584
stranger, 584
superego, 29, 95
Anxiety disorders, 448
outcomes research in, 287
Anzieu, Didier, 146, 559
Apache culture, 479, 484
Aphasia, 446, 447
Apollon, Willy, 484, 485
Applied analysis [applied psychoanalysis], 445, 554–555, 568
Aquinas, Thomas, 355
Argentine Psychoanalytic Association, 84
Aristotle, 354, 355, 363, 462, 530
Arlow, Jacob, 136, 158, 287, 353
Aron, Lewis, 141, 211–222, 263
Arts and psychoanalysis, 499
film, 537–548
literature, 507–519
music, 551–564
visual arts, 523–533
Arunta culture (Australia), 479
“As-if” personality, 164
ATOS [Achievement of Therapeutic Objectives Scale], 413–414
Attachment
avoidant pattern of, 48
definition of, 568
mentalization and, 434
vs. sexual novelty, 47
Attachment theory, 30, 242, 420–431, 568
of Amsworth, 242
of Bowlby, 59, 120, 242, 434
clinical applications of, 248
defenses and, 123
on development of defenses, 96
of gender, 139–140
Attention, 44
Attention and Interpretation [Bion], 190
Atwood, G., 106
Auden, W.H., 16
Auditory symbolism, 552
Augustine, 355
Austin, J., 479
Autistic phase of development (Mahler), 429, 568
Autonomous ego function, 43, 568
Autonomy, 118, 568
primary vs. secondary, 60
relatedness and, 432–434
Axelrod, Sidney, 479
Bacal, Howard, 206
Bachrach, H.L., 390, 395
Bakhtin, M., 513
Balint, Alice, 82
Balint, Michael, 81, 82, 260, 486
Balkányi, Charlotte, 560n
Baranger, Maleleine and Willy, 88–89, 110, 286
Barber, J., 414, 415, 416
Barrett, W., 353
Basch, M.F., 42, 203
Bass, Anthony, 264
Bassin, D., 141, 145
Bastion, 110, 568–569
Baudry, Francis, 542, 554
Baudry, Jean-Louis, 543, 544
Bazin, André, 537
Beebe, B., 244
Beethoven, Ludwig van, 562
Behavior[s]
eggo-dystonic, 42, 572
ego-syntonic, 42, 572
learning of, 451
motivated, 39–40 (See also Motivation nonvolitional, 42
peremptory and driven, 41–42
Behaviorism, 446
Behrends, R., 271
Being and Nothingness [Sartre], 468
Belief and Imagination [Britton], 195
Benjamin, Jessica, 263, 430
intersubjectivity theory of, 110–111, 140, 216, 219–220
theory of gender and sexuality, 134, 135, 138, 140, 141, 142n., 146–147
Bentham, Jeremy, 355
Bergeron, Danielle, 484
Berghout, C.C., 394
Bergman, Ingmar, 538, 542
Bergmann, A., 162
Bergmann, Martin S., 303–316
“Termination: The Achilles Heel of Psychoanalytic Technique,” 304, 308–309
Bergstein, Mary, 532–533
Berlin Clinic, 156
Berlin Psychoanalytic Polyclinic, 81
Berlin Society, 186
Berman, E., 217
Bernheim, Hippolyte, 6, 7, 8
Bernstein, D., 137
Bernstein, Jeanne Wolff, 225–236
Bertolucci, Bernardo, 547
Besser, A., 433
Beta elements [Bion], 109, 193, 196
Beutler, L.E., 416, 417
Beyond Pleasure [Iverson], 524
Beyond the Pleasure Principle [Freud], 13, 158, 159
Bibring, Edward, 61, 470, 373–374
Bibring, Grete, 314
Bick, Esther, 498
Binswanger, Ludwig, 11, 12, 81
Bion, Wilfred, 23, 24, 24n, 26, 79, 189, 190–194, 248n, 272
concept of alpha function and beta elements, 109, 192, 196, 260, 292, 296
concept of catastrophic change, 180, 194
concept of projective identification, 70, 178, 278, 292, 429–430
communicative aspects, 85, 86
concept of reverie, 85, 86, 89, 292, 295, 517
differentiation of psychotic from nonpsychotic personality, 192
dream theory of, 82
early life of, 191
influence on Ogden and Ferro, 72–74
intersubjectivity and, 109
key points related to, 195–196
model for psychoanalytic intuition, 194, 196
model of PS ↔ D, 192
object relations theory of, 178, 429–430, 498
publications and writings of
Attention and Interpretation, 190
“Catastrophic Change,” 190
Experiences in Groups, 497
Learning From Experience, 192, 193
Second Thoughts, 193
theory of container/contained, 178, 191, 193, 196, 260, 292, 295, 498
theory of groups, 88, 190, 497
basic assumption and work groups, 191–192, 195
theory of preconceptions, 187, 192–193, 196
view of interpretation, 295–296
view of psychoanalytic process, 292, 346
view of transference, 69–74, 259
Bion Today [Mawson], 195
Bi-personal field, 296
Bipolar sell, 25, 201, 569
Bird, Brian, 68
Birth anxiety, 150
Birth cohort studies, 424
Birth trauma, 12, 15, 569
Bisexuality, 9, 141, 144, 569
Black, Max, 48
Blagys, M.D., 406
Blanco, Ignacio Matte, 503
Blass, Rachel, 379
Blatt, S.J., 271, 392, 416, 432, 433–434
Blechner, M., 262
Bleuler, Eugene, 12
Bloomsbury group, 186
Blow-Up, 539
Bluestone, H., 319
Blum, Harold, 304
Boas, Franz, 477
Body ego, 569
Body image, 569
Bodymind, 146
Boesky, Dale, 88
Bollas, Christopher, 144, 261, 352
Borderline personality disorder, 412, 426
Borderline personality organization, 96, 118, 164, 569
Borgogno, E., 107
Borromean knot, 231
Bose, Girandrasekhar, 486
Boston Change Process Study Group, 215, 216
Botticelli, S., 220
Boundaries
psychoanalytic, 362, 581
sexual, 147
Boundaries and Boundary Violations in Psychoanalysis [Gabbard and Lester], 462
Bowlby, John, 49, 213, 425
attachment theory of, 59, 120, 242, 434
Boyer, L., Bryce, 479, 484
Brain imaging, 447
Brain sciences. See Neurosciences and psychoanalysis
Brenner, Charles, 29, 30, 31, 156, 158, 159, 165, 287, 313, 353, 360
Breton, Franz, 5
Breuer, Josef, 4, 5, 7–8, 9, 40, 53, 54, 58, 367
case of Anna O., 7–8, 32, 54
Breyer, F., 394
Brief relational therapy (BRT), 409
Brill, A.A., 11, 14, 540
British Object Relations School, 179
British Psychoanalytical Society, 13, 175, 186, 187, 189, 190
Britton, Ronald, 185–196, 259, 497
Broca’s aphasia, 447
Brockmann, J., 492
Brody, Hugh, 539, 540
Bromberg, Philip, 123, 217, 263, 430
theory of trauma and dissociation, 113–114, 218, 248
Bromley, A., 176
Brown, Lawrence J., 79–90
BRT [brief relational therapy], 409
Brücke, Ernst, 5
Brühm, Carl, 4
Brunswick, Ruth Mack, 305, 314
Buchler, Charlotte, 226
Bullard, D.M., 369
Busch, Fred, 379
Butler, Judith, 145, 220
Byrne, R.W., 451
Cabaniss, Deborah L., 319–331
Cahiers du Cinéma, 543
Camera Obscura, 543
Cantin, Lucie, 484
Caper, Robert, 28
Case discussions, 363
Casement, P., 274
Caspi, A., 448–449
Castration anxiety, 11, 28, 94, 124, 136, 137, 159, 279, 511, 512, 569
“Catastrophic Change” [Bion], 190
Catharsis, 8, 120
Cathexis, 20, 27, 60, 200, 292n, 569
Chabrol, Claude, 537–538
Chaos theory, 215
Character, 59, 121–122
definition of, 569
Freud’s theory of development of, 121–122, 125
vs. neurosis, 121
psychotic, 165
Character (continued)
relation to other aspects of childhood, 125–126
role of superego in shaping of, 122
“Character and Anal Erotism,” 121
Character disorder, 569
Character resistance, 95, 103
Charcot, Jean-Martin, 6, 7, 8, 477
Charles Ives: “My Father’s Song”: A Psychoanalytic Biography, 452
Chart review studies of psychoanalysis, 390
Cheng A., 220
Child analysis, 14–15, 20, 333–346
A. Freud’s approach to, 187, 341, 343, 344, 428
analyst–analysand relationship in, 333–334
chart review study of outcome of, 390
comparative with adult analysis, 334
course of developmental help in, 343
defenses and, 95
Ferro’s approach to, 346
Fonagy’s approach to, 335, 344
interparation and insight in, 340–341
Klein’s approach to, 185–187, 195, 341
other theoretical models of, 346
play in, 334–340
children who cannot play, 338–340
defensive functions of, 339–340
with latency-age child, 336, 338
nonimaginative, 340
process of, 337–338
role of, 334–336
working through, 336–337
transference in, 68, 70, 341–343
work with parents, 334, 344–346
Childhood and Society (Erikson), 480
Childhood experiences and adult world, 117–129, 424. See also
Developmental influences; Infant research and adult psychotherapy
contemporary theoretical developments, 125–128
character and its relation to other aspects of childhood, 125–126
construction, reconstruction, and co-construction, 126–128
hermeneutic tradition and memory, 128
importance of early objects and mental representation, 126
early psychoanalytic theory of, 119–122
conceptualizations of memory, 120–121
developmental progression and characterology, 121–122
Freud’s theory of pathogenesis, 119–120
seduction theory, 120
emergence of structural theory of, 122–125
chronology in theories of anxiety and defenses, 96, 123–124
developmental anxieties, gender identity, and gender role
identity, 123–124
Oedipus complex and adult personality, 124–125
role of superego, 122
etiological importance of, 117–118
key points related to, 129
pre-oedipal experiences, 29–30, 31, 60, 67, 118
traumatic experiences, 118
“Chimney sweep,” 7, 54
China, psychoanalysis in, 486–487
Chodorow, Nancy, 134, 138, 140, 141, 144, 146, 512
Christianity, 467–468, 471
Chrzansowski, Gerard, 108
Churchland, Patricia, 447
Chused, Judith, 341, 362
Cincinnati Psychoanalytic Institute, 321, 325
Cinema. See Film and psychoanalysis
Civilization and Its Discontents
[S. Freud], 355, 477, 502
“Civilized Sexual Morality and Modern Nervousness” [S. Freud], 477
Cixous, Hélène, 513–514
Class/classism, 220–221
Classical conditioning, 451
Clément, Catherine, 513–514
“Clinical facts,” 28–31, 82
Clinical Global Impression—Improvement scale, 327
Clinical reporting, 26–27
Clinico-anatomical method, 447
Coates, S., 140, 140n, 144
Cocaine use, 416
Co-construction, 127, 128–129, 208, 569
Cognition, influence of drive organization on, 44–45
Cognitive psychology, 451
Cognitive unconscious, 449–450
Cole, Thomas, 524
Colombo, Daria, 3–16
Columbia Psychoanalytic Institute, 22, 331, 325, 328
Columbia University Center for Psychoanalytic Training and Research, 320–321
Communication. See also Language
nonverbal dimensions of early experience, 241
projective identification as, 85
through play, 334–336
Comparative Psychotherapy Process Scale, 405
Component instincts, 143, 569
Compromise formation, 87, 144, 146, 156, 158, 166, 167, 287, 569
Compulsion, 570
repetition, 13, 61–62, 63, 125, 288, 582
Comte, Auguste, 5
Condensation, 10, 56, 58, 160, 570
Conditioning, 451
Confidentiality, 557
Conflict, intrapsychic, 570
Axis I and Axis II disorders and, 320
classical view of, 156
Freud’s concept of, 8, 13, 29
Conflict resolution, 60, 61
Conflict theory (Brenner), 156, 158
Conflict-free sphere, 22
Confounders in outcome studies, 386
Connolly, M.B., 413, 415
Connolly Gibbons, M.B., 411, 413
Conscious, 59, 570
Freud’s concept of, 10, 156
neuroscience and, 449
Consciousness, 107
primary, 241
Constancy principle, 20, 55
Construction, 126, 570
differentiation from interpretation, 294
narrative, 294
“Constructions in Analysis” [S. Freud], 126–127, 128, 270, 279
Consumer Reports Study, 391, 395
Container/contained (Bion), 178, 191, 193, 196, 260, 292, 295, 498, 570
Controversial Discussions, 187, 189, 295n
Conversations at the Frontier of Dreaming [Ogden], 517–518
Conversion, 54–55, 570
Cooper, A., 12, 75, 330
Cooper, S., 220, 380n
Copjec, Joan, 544
Coral Gardens and Their Magic [Malinowski], 479
Corbett, Ken, 143, 220
Core Confictual Relationship Theme method, 411
Core gender identity, 124, 139, 145, 573
Cost-utility analysis, 394
Counterresistance, 81, 290
Countertransference, 75, 30–31, 82, 79–90, 162, 171
Abraham’s letter to Freud about, 80, 81, 85, 86, 89
as “an instrument of the analysis” (1940–1960), 82–85, 90
Balint and Balint, 82
Bion and communicative aspects of projective identification, 85, 86
Freiss, 82–83
Kleinian school and projective identification, 83–85, 90, 190, 259–260
analysand’s adaptation to, 82
analyst’s self-analysis of, 87, 79–80, 81, 90
analytic field, intersubjectivity, and new theory of dreaming (1990–present), 88–89, 90
Ferro, 88, 89
counterresistance and, 80
definition of, 85, 87, 82, 86, 570
Devereux’s view of, 480
discovery and early developments related to, 256–257
Freud, 80, 67, 79, 81–82, 90, 256, 274
go psychology and, 258–259
erotic, 147
further elaborations of, 86–88
Boesky, 88
Bollas, 261
concept of two-person psychology, 87
focus on enactments, 87–88, 218–219, 222, 258, 265
Fonagy, 261
Isakower, 86
Jacobs, 87–88, 90
Kernberg’s “totalistic” approach, 86–87
Reik, 86
Ross and Rapp, 86
Sandler, 87, 90, 261
Grinberg’s concept of projective counteridentification, 84–85
Heimann’s view of, 83–84, 86, 261
in interpersonal tradition, 262
Jacoby’s view of, 165–166, 259
key points related to, 266
Lacan’s view of, 234–235, 261–262
Loewald’s view of, 89
Money-Kryle’s view of, 84
Ogden’s view of, 73, 89, 90, 259, 516
Racker’s view of, 84, 100, 260
“real” relationship and, 255, 257–258, 264
relational view of, 214, 222, 263–264
reporting of, 27, 30
as resistance, 100–102
reverie and, 85
self psychology and, 262, 263
transactional perspective of, 244
Winnicott’s view of, 85, 260–261
Countertransference neurosis, 84
Courage, 462
Crapanzano, Vincent, 483, 488
Critique of Judgment, The [Kant], 529
Crisis-Christoph, P., 411, 415
Cronenberg, David, 539
Cultural reality, 480
“Culturalists,” 23
Culture(s), 118, See also Anthropology and psychoanalysis
analytic work and, 485–487
China, 486–487
India, 486
Japan, 486
culturally constituted defense mechanisms, 482–483
how one learns about, 489
nationalism, race, ethnicity and, 503–504
personal symbol and work of, 483
psychoanalytic interviewing in fieldwork situations, 487–488
race, ethnicity, and nationality, 495–505
Röheim’s studies of, 479
superego development and, 122
Curiosity
benign and tolerant, of analyst, 359
of patient about analyst, 214
Cushman, P., 220
Dalal, Farhad, 504
Dali, Salvador, 226, 541–542
Damasio, A., 241, 446, 448
Danger situations [Freud], 42, 94, 159
Darwin, Charles, 10, 478, 489
Das es, 41–42, 187, See also Id
Datong, Huo, 486, 487
Davidson, Donald, 468
Davies, J. M., 147, 217, 218, 248, 263
Davis, M., 43
Day residue, 56, 570
Daydreaming, 61, 62
DBT [dialectical behavior therapy], 388
de Beauvoir, Simone, 134
de Lauretis, Teresa, 544
De Maat, S., 390, 395–396
de Saussure, Ferdinand, 229
Death anxiety, 159
Death instinct, 13, 24n, 60, 61, 173, 186, 288, 308, 309, 570
Debinkin, N.L., 314
Dебуссье, Claude, 542
Declarative memory, 127, 276, 451, 570
Deconstructing Harry, 541
Defense(s), 93–103, 122, 450
See also specific defense mechanisms
A. Freud’s theory of, 94–96, 103, 123, 159, 428
The Ego and the Mechanisms of Defence, 14, 156
analysis of, 160
association with psychosexual stages, 123
attachment theory and, 26
axes of defensive function, 96–97
classification of, 95
categorizations in
contemporary psychoanalysis, 96–97, 123–124
culturally constituted, 482–483
definition of, 93, 103, 570
developmental chronology of, 95, 118, 123–124
early prestige and development of, 96
functions of, 96, 450
individual’s repertoire of, 95
Kernberg’s concept of, 96, 123, 125–126
Defense(s) (continued)
Kleinian view of, 95, 103
manic, 95, 96n
motivation and, 42
oedipal/post-oedipal, 123
personality disorders and, 96, 103, 118
against pleasures of anal phase, 121
pre-oedipal, 123
primitive-mature continuum of, 96, 118, 126
resistance and, 93, 97–103
S. Freud’s concept of, 9, 13, 53–55, 93–94
Defense hysteria, 40
Deferred action, 61, 121, 570
DeManeufa, D., 139
Demonization, 188
Denial, 95, 96, 570
of affect, 123
of internal and external reality, 123, 188
Denneit, Daniel, 447
Depersonalization, 571
Depression, 448, 571
genealogy of, 449
intergenerational transmission of, 433
outcomes research in, 287, 391
pharmacotherapy combined with psychoanalysis in, 321–323, 387
postpartum, 433
Depressive group identification, 502, 515
Depressive position [Klein], 95–96, 125, 174–175, 187–188, 195, 309, 429, 497–498, 571
Derealization, 571
Derivatives, 58, 59, 571
Derrida, Jacques, 515–516, 518, 519
Descartes, René, 445
Desire, 40, 146. See also Motivation conflict between love and, 47
Lacan’s concept of, 227–228
Deutscher, Hélene, 15, 164
Development of a Child. The (Klein), 185
Developmental arrest, 58, 571
Developmental formulations, 437
Developmental help, 343
Developmental influences, 56, 61, 63, 423–425
child analysis and, 333–346
childhood experiences and adult world, 117–129
chronology of defenses, 95, 118, 123–124
concept of dynamic equilibrium, 424
contemporary psychoanalysis and developmental thinking, 242–243
defenses and, 95, 118
infant research and adult psychotherapy, 239–250
nonlinear, 424
pre-oedipal, 29–30, 31, 60, 67, 118, 156, 162–163, 180, 243
stages of psychosexual development, 58, 120–122, 157, 581
stress and adversity in causation of psychopathology, 424
transference and, 67–68
universal hierarchical transformations, 118
Developmental research, 423–438
basic assumptions of psychoanalytic developmental approach, 425–427
complexity of development, 427
formative role of early life experiences, 425–426
inner world and its development, 427
normal and disrupted development, 424, 426
person-centered perspective, 426–427
unconscious motivation and intentionality, 426
contemporary integrative approaches to, 431–436
attachment, mentalization, and origins of self, 434
autonomy and relatedness and intergenerational transmission of depression, 432–434
parental preoccupation and neurotic curiosity of parenting, 434–436
developmental and therapeutic action, 436–437
historical overview of, 427–431
ego psychology, 428–429
Freud and drive psychology, 428
object relations theory, 429–431, 511–512
self psychology, 431
key points related to, 437–438
Developments in Psychoanalysis
(Rivière), 187, 189
Devereux, George, 480, 489
DeWaal, Frans, 452
Dewey, John, 528
DeWitt, K. N., 417
Diabetes mellitus, 395
“Diachrony in Psychoanalysis” [Green], 312
Dialectical behavior therapy (DBT), 388
Dialectical constructivism [Hoffman], 112–113
“Diatriptic attitude,” 199
Diener, M. J., 414
Differential subphase of development [Mahler], 571
Dimen, M., 133–148, 220
Dinnerstein, Dorothy, 134, 216
Disavowal, 571
Disintegration anxiety, 47, 150
Displacement, 10, 66, 61, 160, 571
Dissociation, 53, 62, 96, 123–124, 128, 248, 571
Bromberg’s theory of trauma and, 113–114, 218
conceptualization of, 218
intersubjectivity and, 113–114
relational psychoanalysis and, 217–218
Doran, Mary Ann, 544
Doi, Takao, 486
Doolittle, Hilda [H.D.] case [Freud], 257, 305–306
Dora case [Freud], 160, 227–228, 483, 511, 512
Doubt, Conviction and the Analytic Process [Feldman], 194
Dream(s)
absence of, 310
Bion’s theory of dreaming, 89, 90
countertransference, 89
counterfilms and, 541–542
Freud’s studies of, 3, 9–10, 20, 56–57, 121, 296, 554–555
The Interpretation of Dreams, 3, 10, 12, 157, 159, 226, 227, 271, 285, 293, 481, 485, 508, 516, 525, 540
inclusion of day residue in, 56
interpretation of, 3, 10, 13, 56–57, 293, 296
in fieldwork situations, 488
of “Irma’s injection,” 2
Klein’s studies of, 174–175
Index

latent dream thoughts, 10, 56, 57, 293, 296
manifest, 10, 56, 296
posttraumatic, 61
repetitive, 310
rituals and, 481–482
self-state, 584
Sharpe’s studies of psychoanalysis effects on, 310–311
as source of childhood memories, 121
time in Plato’s Republic, 465
Dream Life [Meltzer], 296n
Dream screen, 541, 548
Dream work, 10, 56–58, 63, 293, 296, 571
censorship and, 56
condensation, 10, 56, 58
displacement, 10, 56
as model of psychoanalytic process, 296–297
secondary revision, 10, 56
visual representation, 56
Drive, Ego, Object, and Self [Pinel], 45
Drives, 13, 24, 40–41, 56, 576
aggression, 13, 15, 22, 45, 58
aim of, 58, 142
arousal vs. gratification of, 44
arts and, 525, 526
definition of, 142, 571
derivatives of, 58, 59
Hartmann’s theory of, 180
influence of drive organization on cognition, 44–45
Klein’s object relations theory and, 173
object of, 58, 142, 172, 173
perception and, 45
pressure for discharge of, 58
repetition compulsion and, 61–62
sexual, 10–11, 12, 15, 22, 45, 58, 142–143, 576 [See also Libido theory]
source of, 58
unconscious motivation and, 40–41, 58–59
DSM
homosexuality in, 144
psychotropic medications
combined with psychoanalysis based on diagnostic system of, 320, 321–323
rating scales for affective disorders in, 327–328
Dual instinct theory, 13, 15, 22, 45, 49, 158, 166, 167, 269, 571
Dual-aspect monism, 455, 457
Dührsen, A., 394
Duration of psychoanalysis interminable or very prolonged, 303, 309–310
outcomes and, 395
Durkheim, Emile, 480, 500
Dynamic equilibrium, 424
Dynamic systems theory, nonlinear, 215–216
Dynamic unconscious, 127, 449–450, 525, 571
Dynamic viewpoint, 118
Eagle, Morris N., 39–50
Early life experiences, formative role of, 424, 425–426
Eating disorders, 394–395
Eberwein, R., 541
Edelman, G., 241
Edinburgh Symposium on “The Curative Factors in Psycho-Analysis,” 271, 273
Edmundson, Mark, 508
Effeminacy, 138
Egan, Dorothy, 480, 488
Ego, 13, 59, 122, 156–167, 158
adaptive functions of, 22, 180
autonomous function of, 43, 568
defenses of, 93–97, 122 [See also Defense(s)]
relative to stage of ego development, 95
definition of, 571–572
evolution of concept of, 159
Fairbairn’s concept of, 177–178
Freud’s structural theory and, 13, 59, 82, 122–125, 156, 158, 167, 270, 287, 288, 585
Hartmann’s concept of, 159
Klein’s concept of formation of, 173
Lacan’s concept of, 226–227
as love object, 172
regression in the service of the, 582
relationship with id, 49
relationship with superego, 122
resistances originating in, 288
skin, 559
Sterba’s concept of therapeutic split in, 159, 163
synthetic function of, 159
unconscious, 82
Waelder’s concept of, 156
work, 82, 83
Ego analysis, 14, 160–161, 167
Ego and the Id, The [S. Freud], 13, 156, 158, 159, 288
Ego and the Mechanisms of Defence, The [A. Freud], 14, 156
Ego and the Problem of Adaptation, The [Hartmann], 156
Ego apparatus, 572
Ego defect, 522
Ego functions, 522
adaptive, 22, 180
autonomous, 43, 568
Ego ideal, 59, 178, 530, 572
Ego psychology, 13, 22, 23, 24, 43, 155–167, 572
competition with other schools of psychoanalysis, 161
developmental theory of, 428–429
evolution of classical perspective, 159–161
in evolution of classical perspective, 159–161
fall in dominance of, 211
Freud and, 14–15, 82, 156–159
elemental instincts, 158
role of anxiety, 158–159
structural hypothesis and centrality of bodily experience, 158
theory, 157–158
genealogy of classical technique, 159–160
growth of classical perspective, 161–166
acculturation and assimilation, 161–163
one-person and two-person
pyschoanalytic cultures, 165–166
from transference to “real”
relationship, 163
widening scope of psychoanalytic indications, 163–165
interpretation in, 293
key points related to, 167
object relations and, 180
techniques of, 160–161, 166
theory of motivational systems, 45
transference and, 67–69, 258–259
view of oedipal dynamics, 125
view of resistance, 287
visual arts and, 525, 526, 528–530
Ego-dystonic (thoughts, feelings, traits, behaviors), 42, 49, 572
Ego-instincts, 58
Egoistic hedonism, 254. See also Pleasure principle
Ego-syntonic (thoughts, feelings, traits, behaviors), 42, 49, 572
Ehrenberg, Darlene, 215
Eugen, M., 221
Eissler, K., 286, 307
Eissler, Ruth, 314
Eitington, Max, 11, 81
Ekman, P., 448
Electroconvulsive therapy, 368n
Elementary Forms of the Religious Life
(Durkheim), 478
Elias, Norbert, 502–503
Elisabeth von R. case (Freud), 8
Elise, D., 137
Emde, Robert, 406, 429
Emotional honesty of analyst, 359
boundaries and, 362
Emotional refteling (Mahler), 572
Empathic respect, 358–359
Empathy, 106, 161, 203–206, 248, 250, 297n
confrontation and, 414
definition of, 203, 209, 572
identification and, 453
optimal, 206
prolonged empathic immersion, 204
in self psychology, 203–204, 205, 206, 208
failure of, 205
vs. sympathy, 359
Teaching of, 408
Empiness, 572
Enactment, 87–88, 218–219, 222, 258, 265, 278, 298, 333, 525, 572
Endopsychic structure [Fairbairn], 176, 177, 177
Eng. D.L., 220
Enlighenment, 5
Environmental insults, 120
Environment–gene interactions, 424–425, 449
Envy, 572
pens, 11, 136, 137, 511, 572
womb, 486
Envy and Gratitude Revisited
[Roth and Lema\text{\textenquote{\textmd{\textendquote}}}\textmd{\textendquote}], 125
Epigenetics, 424, 448–449
Equifinality, 426
Erikson, Erik, 243, 350, 426, 429, 479, 480, 486
Eros, 572
Erotopgenic masochism, 572
Erotopgenic zones, 58, 120, 121, 143, 572
Essays on Ego Psychology [Hartmann], 14
Ethics, 349–364
definition of, 349
ethical relativism, 349, 354
ethical theory informing practice of
psychoanalysis, 354–356
of Freud, 349, 350, 353–356
determinism, 353–354
egoistic hedonism, 354
ethical relativism, 354
vs. goal of pursuing emotional
truth, 350–351
key points related to, 363–364
moral decision making, 355
362–364
vs. morality, 349
of neutrality, 352–353
in psychoanalytic practice today, 356–362
goals, 360–362
principles, rules, and guidelines, 356–357
virtues, 357–360
value-free bias against, 349–351
Ethics of Psychoanalysis, The [Lacan], 231
Ethnicity, 503–504
Ethnomographers, 478–479
Evocative memory, 573
Evolutionary psychoanalysis, 501
Executions of May Third [Goya], 529
Executive functions, 13
Exhibitionism, 124, 573
Existential-humanistic tradition, 213
Experiences in Groups [Bion], 497
Expressive psychoanalytic
psychotherapy, 369, 370, 372–373, 573
Externalization, 523
Extratransference interpretation, 294, 294n
Faenza, Roberto, 529
Fairbairn, W. Ronald D., 24, 45, 172, 213
concept of corporeal erogeneity, 143
concept of defenses, 123
concept of infantile dependence, 175–176
concept of libido, 58–59, 142
176–178
concept of schizoid condition, 17, 59, 108, 176, 178
concept of endopsychic
structure, 176, 177, 177
Guntrip’s analysis with, 279–280
intersubjectivity and, 108–109
object relations theory of, 108, 142, 143, 175–178, 177, 429
Psychoanalytic Studies of the
Personality, 176
Falkenström, F., 397
False self, 248n, 202, 573
Family romance, 573
Fantasy(ies), 472–473, 573
Freud’s concept of, 9, 29, 120, 157
infantile, 162
projective identification and, 20
unconscious, 62, 63, 587
verbal interpretation of, 471–472
Fast, L., 140–141
Fate-neuroses, 61
Fechner, Gustav, 7, 10
Feder, S., 552, 553, 554, 555
Federn, Paul, 11
Feeling of What Happens, The
[Damasio], 241
Feldman, M., 194, 250
Feminine masochism, 572
Femininity, 134, 135, 576
“excessive,” in boys and girls, 140
Lacan’s concept of, 513
Oedipus complex and Freudian
concept of, 136–137, 511, 513
phase of “proo-femininity,” 139
primary, 137
repudiation of, 511.
“Femininity” (S. Freud), 511
Feminism, psychoanalytic, 133, 134, 141, 212, 513, 514
Feminist critique of classical
psychosexual theory, 143–144
Feminist literary criticism, 511–515, 519
Feminist movement, 32, 124
Fenichel, O., 160, 308
Ferenczi, Sandor, 11, 12, 14, 31, 75, 81, 82, 106, 214, 260, 271, 290, 308, 312, 485, 543
concept of termination, 309
intersubjectivity and, 107
relational psychoanalysis and, 212
view of transference, 257, 263
Ferro, Antonino, 72–74, 89, 90, 296, 346
Fetish (letishim), 225, 573
“Fetishism” (S. Freud), 225, 532
Feuerbach, Ludwig, 5
Fichte, Johann, 7
Field theory, 84, 88–89
Film, The: A Psychological Study, 543
Film and psychoanalysis, 537–548.
See also specific film titles
“psychoanalytic film genre,” 538–542
films and dreams, 541–542
films on themes directly concerning psychoanalysis, 538–539
films (mis)representing the psychoanalytic profession, 539–541
films with psychologically credible characters, 538
psychoanalytic film studies, 542–547
early days, 542–543
key points related to, 548
Lacanian contributions, 543–544
reflections on point of view, 545
studies on “spectatorship,” 544–545
toward interdisciplinary dialogues, 546–547
Winnicottian approach, 546
Fixation, 121, 125, 573
Flew, A., 42
Flies, Robert, 82
Flies, Wilhelm, 9, 507, 508, 509, 510
Fluss, Emil, 508
Flying Dutchman, The, 552
Fonagy, Peter, 123, 144, 361, 276, 277, 308, 423–438
approach to child analysis, 335, 344
theory of attachment and mentalization, 111–112, 217, 434
Forman, Milos, 540
“Forms and Transformations of Narcissism” [Kohut], 199
“Formulations on Two Principles of Mental Functioning” [S. Freud], 532
“Fors” [Derrida], 515–516
Fortes, Meyer, 479
Fosshage, James, 216, 262–263
Foucault, Michel, 351
Fraiberg, S. H., 430
Frame, 473
Frank, Claudia, 186
Frawley, M. G., 218
Frazer, J. G., 56
Free association method, 8, 10, 11, 23, 54, 58, 67, 81, 160, 214, 573
in dream interpretation, 56, 57
in film, 538
Freedman, N., 395
Freeman, Danny, 479
French, T., 369, 480, 488
Freud, Anna, 10, 13, 14, 15, 23, 24a, 162, 164, 200, 425, 426, 511, 518, 525
approach to child analysis, 187, 341, 343, 344, 428
developmental model of, 428
The Ego and the Mechanisms of Defence, 14, 156
on neutrality of analyst, 352
object relations and, 180
theory of character development, 125
theory of defenses, 94–96, 103, 123, 150, 428
view of transference, 68
on widening scope of psychoanalysis, 373, 374
Freud, Sigmund, 3–16, 79, 200, 425
American lecture of, 3–4, 12
on analyst–analysand relationship, 162
analytic technique of, 8, 155, 156, 160–161, 256, 257
anthropology and, 477–478
anti-Semitism and, 4–5, 7, 11
case histories of, 156, 160
Dora, 160, 227–228, 483, 511, 512
Elisabeth von R., 8
Hilda Doolittle [H.D.], 257, 305–306
Little Hans, 20, 353–488, 553
Rat Man, 279, 280, 307, 481
Wolf Man, 304–305, 313, 314, 315, 485
cathartic technique of, 8
challenges to psychoanalytic principles of, 20–21
on civilization, 355
classical psychoanalysis and, 156–159, 166
classification of functional mental disorders, 164
concept of aggression, 13, 15, 22, 45, 58, 122, 158
concept of childhood sexuality and neurosis, 4, 8, 9–10
concept of danger situations, 42, 94, 159
concept of death instinct, 13, 288, 308, 309
concept of defense, 9, 13, 53–55, 93–94
repression, 10, 13, 20, 40, 53–54, 94, 159–160
concept of femininity, 136–137, 511, 513
concept of hysteria and hypnosis, 5–8, 9, 40, 53, 54–55, 120, 477, 508
concept of instinctual object, 172, 173
concept of memory, 44, 120–121, 126–127
concept of object relationship, 172
can of psychic determinism, 8, 11, 349, 353–354
concept of resistance, 8, 11, 55, 94, 97, 103, 286–288
concept of the divided mind, 226
can of therapeutic action, 270–271, 280
can of unconscious, 3, 10, 53–62, 114
on conflict between love and desire, 47
constancy principle of, 20, 55
death of, 16, 187
definition of psychoanalysis, 370n, 371
developmental theory of, 427, 428
on difference between psychoanalysis and other psychotherapies, 368
dream studies of, 8, 9–10, 20, 56–57, 554–555
dual instinct theory of, 13, 15, 22, 45, 49, 158, 166, 571
early history and intellectual roots of, 4–5
ego psychology and, 14–15, 82, 156–159
eomics of, 349, 350, 353–356
film and, 542–543, 548
focus on childhood as source of adult psychopathology, 119–122
foundations of psychoanalysis, 7–9, 367
free association method of, 8, 10, 54, 67
on goal of psychoanalysis, 353
on group psychology, 496–497
on happiness, 355
in his community, 11–12
Freud, Sigmund (continued)  
insistence on link between  
narrative and metapsychology,  
19–20, 42, 53, 117  
interdisciplinary studies of, 448  
“Just-So Story,” 478  
key points related to, 16  
lack of technique for termination,  
304–308, 315, 518  
libido theory of, 10–11, 142,  
157–158  
on love, 355–356  
on mourning, 60  
as neuroscientist, 445, 446  
on neutrality of analysis, 352, 353  
patient criteria for psychoanalysis,  
164, 367–368  
phases of psychosexual  
development, 58, 120, 428,  
581  
anal phase, 58, 568  
developmental arrest at, 58  
genital phase, 58, 572  
lasting imprint on adult,  
121–122  
oral phase, 58, 579  
phallic phase, 58, 579  
pleasure principle of, 10, 14, 43,  
57–58, 61, 63, 449, 354,  
579–580  
pressure technique of,  
A  
on primary and secondary  
processes, 10, 57–58, 63  
publications and writings of  
An Autobiographical Study, 509  
Analysis Terminable and  
Interminable, 227, 270,  
279, 288, 308, 311, 315,  
510, 511  
On Aphasias: A Critical Study, 7,  
446  
Beyond the Pleasure Principle,  
13, 158, 159  
“Character and Anal Erotism,”  
121  
Civilization and Its Discontents,  
355, 477–502  
“Civilized Sexual Morality and  
Modern Nervousness,”  
477  
“Constructions in Analysis,”  
126–127, 128, 270, 279  
The Ego and the Id, 13, 156,  
158, 159, 288  
“Femininity,” 511  
“Fetishism,” 225, 532  
“Formulations on Two  
Principles of Mental  
Functioning,” 532  
Future of an Illusion, 354  
“Group Psychology and the  
Analysis of the Ego,” 496,  
497  
On the History of the Psycho- 
analytic Movement, 4, 12,  
30, 510  
Imago, 478  
Inhibitions, Symptoms and  
Anxiety, 14  
The Interpretation of Dreams, 3,  
10, 13, 157, 159, 226, 227,  
271, 285, 294, 481, 485,  
508, 516, 535, 540  
Introductory Lectures on  
Psycho-Analysis, 160  
Jokes and Their Relation to the  
Unconscious, 479  
“Leonardo da Vinci and a  
Memory of His Childhood,” 532  
Moses and Monotheism, 128  
“Moses of Michelangelo,” 527  
Mourning and Melancholia,  
177, 205, 496, 515, 542  
“New Introductory Lectures,” 307  
“On Narcissism: An  
Introduction,” 172, 478  
“On Psychotherapy,” 367  
Papers on Technique, 273  
The Problem of Anxiety, 158,  
159  
Project for a Scientific  
Psychology, 19, 446, 496  
The Psychopathology of  
Everyday Life, 10  
“Remembering, Repeating and  
Working-Through,” 472  
“Some Neurotic Mechanisms in  
Jealousy, Paranoia and  
Homosexuality,” 225  
Studies on Hysteria, 4, 20, 40,  
53, 54–55, 120, 269, 271,  
510, 525  
technical papers, 160  
“The Horror of Incest,” 479  
“The Neuro-Psychooses of  
Defence,” 94  
“The Note Upon ‘The Mystic  
Writing Pad,’” 532  
“The Question of a  
Weltanschauung,” 350  
“The Question of Lay Analysis,”  
14  
“The Splitting of the Ego in the  
Process of Defense,” 532  
“The Uncanny,” 532, 543  
Three Essays on the Theory of  
Sexuality, 10, 121, 135,  
142, 144, 147, 157–158,  
159, 165, 231, 271, 496  
Totem and Taboo, 478,  
480–481, 489  
“Wild’ Psycho-Analysis,” 532  
purging of personal papers by, 500  
reality principle of, 10, 57–58, 63,  
500, 582  
on relationship between id and ego,  
49  
on religion, 354, 355  
on rituals, 480–481  
seduction theory of, 8, 9, 15, 120,  
247, 583  
self-analysis of, 9–10, 121,  
507–508, 509, 510, 518, 519  
“selfish gene” hypothesis of, 49  
structural theory of, 13, 59, 82, 94,  
122–125, 156, 158, 167, 287,  
288, 585  
studies of literature, 507–509  
on tempering of therapeutic  
ambition, 350–351  
thoretical shifts during later years,  
15–16  
theory of anxiety, 10, 13, 82, 122,  
123, 158–159, 164, 166  
castration anxiety, 11, 28, 94,  
124, 136, 137, 159, 229,  
511, 517, 569  
theory of character development,  
121–122, 125  
theory of gender and sexuality, 135,  
136, 139, 142, 144, 147  
theory of motivation, 11, 43, 49,  
56, 58  
theory of Oedipus complex, 9,  
136–137, 161, 162, 507–509,  
511  
topographic theory of, 10–11, 59,  
82, 156, 157, 166, 286, 307,  
525, 586  
on the “uncanny,” 532, 542, 543  
on valid sources of analytic data,  
21, 28, 29  
view of countertransference, 30,  
67, 79, 81–82, 90, 256, 274  
view of interpretation, 293, 294  
view of perceptual system, 43–44  

Copyrighted material
Index

view of psychoanalytic process, 284, 286
view of sexual perversion, 144, 147
view of transference, 6, 9, 11, 14, 29, 55, 65, 66–67, 76, 94, 121, 160, 163, 256, 308, 470–472
visual arts and, 524, 525, 526–528, 532
Freud: The Secret Passion, 539, 540
Friedman, L., 47
Friedman, Raymond, 111
Friedman, Susan and Stanford, 305
Fromm, Erich, 21, 22, 206, 212, 213, 218, 262, 350
Fromm, Erika, 480, 488
Fromm-Reichmann, Frieda, 22, 28, 369, 370–371
Frosch, J., 164–165
Frost, Robert, 518
Frustration tolerance, 57
Fuller, Samuel, 540
Fundamental rule, 573
Funeral rituals, 482–483
Furer, M., 162
Future of an Illusion [S. Freud], 354
Gabbard, Glen O., 30, 147, 259, 263–264
Boundaries and Boundary Violations in Psychoanalysis, 362
on psychoanalysis and film, 538, 540n, 542
studies of transference interpretations and treatment outcomes, 411, 412, 413
view of therapeutic action, 275, 276, 277, 333, 414
GAD [generalized anxiety disorder], 387–388
Gagnon, J., 140
Gain
primary, 580
secondary, 94, 583
Gallese, Vittorio, 106
Gedo, John, 22n
Gellner, Ernest, 503
Gender, 134–141
attachment-individuation theories of, 139–140
core gender, 139
gender as symbolic resource and relational strategy, 139–140
binary, 134, 136, 141
child’s age at self-designation of, 139
femininity and masculinity, 137–139
evolution of theories of, 139
phallic masculinity/personal maleness, 137–138
primary femininity, 137
trans and gender variance, 138–139
Freud’s concept of sexuality and, 135, 136
homosexuality as, 145
key points related to, 148
Oedipus complex and, 136–137
postmodern theories of, 135, 220
psychical, 136
psychoanalytic feminism, 134
relational psychoanalysis and, 220, 231
“theoretical” and “psychological,” 134
toward a centered paradigm of, 140–141
gender as personal idiom, 141
gender “over-inclusiveness,” 140–141
Gender identity, 134–141, 145, 573
developmental anxieties and, 124
Gender role identity, 124, 145, 573
developmental anxieties and, 124
Gender splitting, 135
Gene-environment interactions, 424–425, 449
Generalized anxiety disorder (GAD), 387–388
“Generally biological” theory [Hartmann], 22
Genealogical fallacy, 118
Genetic studies, 424, 448–449
Genetic viewpoint, 61, 117–118
Genital phase of development, 58, 157, 158, 522
Genitality, 572
Genocide, 495
German Association for Psychoanalytic Therapies, 393–394
German Psychoanalytical Association, 391
Ghent, Emmanuel, 220, 260, 263
Gill, Merton, 22, 23, 26, 112, 294, 370
definition of psychoanalysis, 271
on distinction between psychoanalysis and psychotherapy, 271, 372–373, 375, 376–378, 380
on indications/contraindications to psychoanalysis, 272
Metapsychology Is Not Psychology, 41
view of transference, 98, 212, 214, 376
Gillin, F.J., 478
Gilmore, Karen, 117–129
Giovacchini, Peter, 484
Gitelson, Maxwell, 199, 200, 298, 873
Global Assessment of Functioning Scale, 413
Glover, Edward, 81, 187, 279, 368
concept of termination, 309, 310, 313
concept of therapeutic action, 269–270, 371, 368, 371
“The Therapeutic Effect of Inexact Interpretations,” 269, 368
view of psychotherapy other than psychoanalysis, 368
Goals, therapeutic, 285–286, 310, 350–351, 353, 470
ethics and, 360–362
vs. life goals, 312, 361
Goethe, 4
Goethe Prize, 16
Goldberg, Arnold, 22n, 204, 206
Goldberg, Peter, 283–298
Goldberg, Steven H., 65–76
Golden Bough, The [Frazer], 56
Goldner, Virginia, 133–148, 220
Goldwyn, Samuel, 539
Good enough mother, 311, 559, 574
Goodman, Nelson, 554
Gottlieb, Richard M., 155–167
Gottman, J.M., 417
Goya, Francisco, 529
Graf, Max, 552
Grand, S., 218
Grande, T., 392
Grandiose self, 201, 208–209, 574
horizontal or vertical split of, 202–203
pathological, 202, 579
Gratification, 57
defenses and, 96
Gravidia [Jensen], 533
Gray, P., 160
Gray, Paul, 258
Gray, Peter, 509
Green, André, 295n, 305, 312
Greenacre, Phyllis, 162, 530, 531

Copyrighted material
intersubjective attitude of, 109–110
Object Relations in Psychoanalytic Theory, 24, 212
relational model of, 212
Greenzon, R., 24n, 163, 257, 560–561
Grinberg, Leon, 84–85
Groddeck, G., 187
Grolnick, Simon, 479
Grotstein, James, 30, 173, 181, 359
Group identification, 495–505
of artists, 499–500
attachments and antagonisms in, 495
Bion’s theory of, 88, 190, 497
attachment and work groups, 191–192, 195
group affiliations and, 500–501
key points related to, 505
national, ethnic, and racial, 500, 503–504, 505
object relations perspective on, 497–498, 502–503, 505
depressive position, 502
paranoid-schizoid position, 502–503, 505
particularistic, 501, 505
pathological, 497
psychoanalysis and group differences, 502–503
psychoanalytic thinking about, 497
classical, ethnic, and national, 503–504
through the life cycle, 498–499
universalistic, 501, 505
Group psychology, 496–497, 505, 574
“Group Psychology and the Analysis of the Ego” (S. Freud), 496, 497
Guernica [Picasso], 529
Guilt, 133, 574
Guntrip, Harry, 229, 429
Gustav Mahler: A Life in Crisis (Feder), 552
Hall, G. Stanley, 2
Hall, Stuart, 504
Hallowell, A.L., 480
Hallucination, negative, 578
Hallucinatory wish fulfillment, 188, 574
Hamilton Rating Scale for Depression, 281, 231
Han, S., 220
Happiness
Freud’s view of, 355
philosophical view of, 461–462, 474
Harris, Adrienne, 135, 140, 141, 220, 255–266
Harrison, Alexandra Murray, 239–250, 333–346
Hartman, S., 220
Hartmann, Heinz, 14, 21–22, 23, 27, 162, 165, 200, 226, 243, 276, 350, 428, 525
core concept of ego, 152, 180
concept of individual development within an “average expectable environment,” 165
“generally biological” theory of, 22
model of theoretical accommodation, 180
object relations and, 180
publications of
The Ego and the Problem of Adaptation, 156
Essays on Ego Psychology, 14
“specifically human” theory of, 22, 27
view of interpretation, 294
Hate, 60
Having a Life [Kirschnr], 297n
H.I.D. case [Freud], 257, 305–306
Health and health care consumption, effects of psychoanalysis on, 394–395
Heath, Stephen, 544
Hedonism, egoistic, 354. See also Pleasure principle
Heidegger Structural Change Scale [HSCS], 392
Heimann, Paula, 187, 273, 274
view of countertransference, 83–84, 86, 260
Heinicke, C. M., 393, 395
Heinz Kohut: The Making of a Psychoanalyst (Srozier), 200
Helmholtz school of psychology, 5
Hendrick, Ives, 350
Herd instinct, 190, 496
Herdt, Gilbert, 483, 487
Here-and-now interactions, 118, 126, 129
transference interpretation in, 74
Hermaphroditism, 134
Hermeneutics, 15, 20, 118, 262, 454, 551, 574
memory and, 128
relational psychoanalysis and, 212, 213
Hersoug, A.G., 411
Heterosexuality, 143, 144
Freud’s concept of, 135
“normality” of, 144, 145
Oedipus complex and, 136
Hill, C.E., 413
Hilsenroth, M.J., 406, 414
Hippocratic tradition, 350, 361
Hirsch, L., 262
Histoire d’Eaux, 546–547
History of psychoanalysis
in North America after Freud, 19–33
challenges to Freud’s conceptualizations, 19–21
key points related to, 33
nature of the discipline, 21–27
new vantage points, new theories, 27–32
Sigmund Freud and his circle, 3–16
eyear in history and intellectual roots, 4–5
eye psychology, 14–15
first topographic model, 9–11
foundations of psychoanalysis, 7–9
Freud in his community, 11–12
key points related to, 16
later years, 15–16
theoretical developments and establishment of a movement, 12–14
understanding hysteria, 5–7, 2, 40, 53, 54–55, 120, 164, 477, 508
Hitchcock, Alfred, 539–540, 541
Hoch, P.H., 164
Hoffman, Irwin, 112–113, 214, 264, 274, 296n, 450, 430
Hegel, P., 411, 412, 413
Holding environment [Winnicott], 391, 344
Holt, Robert, 22, 128
Homeostasis, 574
Homosexuality, 143, 144
in DSM, 144
etiology of, 118, 119
lesbianism, 143, 144, 512
Hope and Dread in Psychoanalysis (Mitchell), 263
Hopi culture, 488
Horizontal split, 202, 574
Horney, Karen, 15, 21, 22, 137, 261, 486
“Horror of Incest, The” [S. Freud], 479
How Does Analysis Cure? [Kohut], 200
Howard, K.L., 395
Index

HSCS (Heidelberg Structural Change Scale), 492
Huber, D., 393
Humanism, 355, 446
Humility, 359
Humming, 560–561
Hungarian Psychoanalytic Society, 185
Hunting rituals, 482
Huston, John, 530, 540
Hypnoid state, 9, 53, 62
Hypnosis (hypnotic suggestion), 574
Charcot's studies of hysteria and, 6, 477
Freud's use of, 7–8, 67
Hypochondriasis, 164, 574
Hysteria, 5–7, 574
Case of Anna O., 7–8, 32, 54
Charcot's studies of hypnosis and, 6, 477
defense, 40
degeneration theory of, 6–7
Freud's concept of, 6–8, 9, 40, 53, 164, 508
Janet's theory of, 6
Lacan's concept of, 234
motivational account of, 40
Hysterical paralysis, 6
IARPP (International Association for Relational Psychoanalysis and Psychotherapy), 112
Id, 13, 41, 43, 59, 156, 158, 574
defense and, 94
Freud's structural theory and, 13, 59, 82, 122–125, 156, 158, 167, 270, 287, 288, 585
Klein's concept of, 187
relationship with ego, 49
resistances originating in, 288
Id interpretation, 160
Idealization, 123, 188, 191, 574
Idealized parent image (Kohut), 201
Idealizing transference, 164, 204, 209, 262, 574, 584
Identification, 59, 60, 172
complementary, 84, 100
cordant, 84, 100
definition of, 574
empathy and, 453
with groups (See Group identification)
primary, 580
projective (See Projective identification)
understanding in light of information from other sciences, 446, 451–453
animal behavior research, 451–452
cognitive psychology and study of memory systems, 451
methods of learning procedures, 451
neuroscience and mirror neuron, 452–453
Identity, 574
core gender, 124, 139, 145, 573
gender role, 124, 139, 573
sexual, 584
Identity diffusion, 574–575
"Ideological Effects of the Basic Cinematographic Apparatus" (Baudry), 544
Illusion, 466, 470–471
Imaginary, 575
Lacan's structure of, 230
"Imaginary Signifier, The," 544
Imago (S. Freud), 478
Imipramine, 330
Imitation, 59, 60, 451–452
Implicit memory, 127, 241, 276, 277, 451, 575, 580
Implicit model of psychoanalytic process, 286
Implicit relational knowing, 216, 241, 276, 277
Impulsivity, 61
In Treatment, 541
Ináritu, Alejandro González, 539
Incest taboo, 136, 478
Incestuous wishes, 47
Incorporation, 59, 60, 575
Indexicality and transference, 483–484, 490
India, psychoanalysis in, 480, 483, 486
Individual psychology (Adler), 12
Individuation phase of development, 575. See also Separation-individuation
Induction phase of psychoanalysis, 575
Infant research and adult psychotherapy, 239–250.
See also Childhood experiences and adult world. Mother–child interactions
clinical implications of, 243–249
affirmative approach to analytic interaction, 246
applications of attachment theory, 248
attention to nonverbal with intersubjectivist-transactional orientation, 245
internal representations, affect, and interaction, 244–245
intersubjectivity as orienting principle, 244
intersubjectivity theory, mentalization, and theory of other minds, 248–249
past and present in transaction, 246
psychoanalytic relationship as dyadic system, 243–244
toward a polyphonic model of therapeutic action, 246–247
trauma and attention to actual experience in present and past, 247–248
contemporary psychoanalysis and developmental thinking, 242–243
core ideas of, 239–242
contributions from attachment theory and research, 242
intersubjectivity, 240–241
nonverbal dimensions of early experience, 241
relationships as fundamental motivators and organizers, 240
transactional perspective, 240
key points related to, 249–250
shift toward relational paradigms, 243
Infantile amnesia, 10, 575
Infantile fantasy, 162
Infantile neurosis, 124, 187, 575
Infantile sexuality, 4, 8–11, 20, 120, 143, 575
Infantile transvestism, 226–227
Inferiority complex, 12
Influence and Autonomy in Psychoanalysis (Mitchell), 263
Informed consent, 357
for pharmacotherapy, 323–324
Inhibition, 122, 125, 575
Inhibitions, Symptoms and Anxiety (S. Freud), 14
Inner world and its development, 427
Insight, 575
  in child analysis, 340–341
Instinct(s), 575. See also Drives
in classical psychoanalysis, 157–158, 162
  component, 143, 569
  death, 13, 24n, 60, 61, 173, 186
  286, 308, 309, 570
Freud's dual instinct theory, 13, 15
  22, 45, 49, 158, 166, 167, 269
  571
  herd, 190, 496
  libido, drive and, 10–11, 12, 15, 22
  45, 58, 142–143, 157–158,
  172, 576
  motivation and, 40–41, 58–59
  self-preservative, 172
Instincts of the Herd in Peace and War
  (Trotter), 190
Instinctual aim, 172, 575
Instinctual object, 172, 575
Instruction for learning, 451
Insulin coma, 568n
Intellectualization, 61, 575
Intention, 40, 426. See also
  Motivation
Internal objects, 174–175, 177, 188
  576
Internal validity of outcome studies, 386
Internalization, 55, 59–60, 63, 188
  429, 575
  mourning and, 59, 60
  of psychoanalyst, 311–313
  transmuting, 265, 299, 391, 431
  436, 586
Internized object relations, 575
International Association for
  Relational Psychoanalysis and
  Psychotherapy (IARPP), 212
International Congress of
  Psychoanalysis, 12
International Journal of
  Psychoanalysis, 27, 30, 379, 542
International Neuropsychoanalysis
  Society, 446
International Psychoanalytical
  Association, 12, 14, 274
International Review of
  Psychoanalysis, The, 552
Interpersonal interactions, 576
Interpersonal theory, 212
  differentiation from relational
  psychoanalysis, 212
  of Sullivan, 21, 24, 20, 96, 120
  262
  of transference and
  countertransference, 262
  Interpretation, 11, 160, 283, 292–297,
  298, 576
  analyst's ongoing interior process
  of, 295–296, 295n
  as basis of therapeutic action,
  269–271, 283–284, 295
  411–414
  Bion's view of, 295–296
  in child analysis, 340–341
  debates over technique of,
  293–294
  delivery of, 293
  differentiation from constructions,
  294
  of dreams, 3, 10, 13, 56–57, 293
  296
  in ego psychology, 293
  emphasis on historical past vs.
  here-and-now, 294
  extratransference, 294, 294n
  Ferro's view of, 296
  Freud's view of, 293, 294
  function of, 295
  Hartmann's view of, 294
  id, 150
  inexact, 269–270, 368
  Kleinian view of, 293, 294
  mutative, 68, 272, 294, 577
  Ogden's view of, 296
  paradigm shift in understanding of,
  295–297, 295n
  sequence of, 293
  studies of accuracy of, 411
  timing of, 293
  of transference, 66–67, 74–75, 160
  293–294, 293n
  Lacan's view of, 295
  overreliance on, 294–295
  treatment outcomes and,
  411–414, 419
Interpretation of Dreams, The
  (S. Freud), 3, 10, 13, 157, 159
  226, 227, 271, 285, 293, 481
  485, 508, 516, 525, 540
Intersubjective third, 296, 518
Intersubjectivity [intersubjective], 23
  89, 105–114, 118, 255
  analytic process and, 283, 297–298
  concept of gender, 140
  contemporary versions of, 109–113
  Barangers, 110
  Benjamin, 110–111, 140, 216
  219–220
  Fonagy and Target, 111–112
Greenberg and Mitchell, 109–110
Hoffman, 112–113
Natterson and Friedman, 111
Ogden, 73, 110, 516
as core motivator and organizer,
  240–241
  definition of, 576
  dissociation and, 113–114
  early precursors of, 107–109
  Fairbairn, 108–109
  Ferenczi, 107
  Klein and Bion, 109
  Kohut, 109
  Sullivan, 108
  Winnicott, 109, 216
implicit relational knowing and,
  216, 241, 276, 377
  infant development evidence for,
  106
  mentalization and, 249
  neuroscience evidence for, 106
  oedipal dynamics and, 125
  as orienting principle, 244
  relational psychoanalysis and, 212
  216–217
  roots of term in psychoanalysis,
  106–107
  Stolorow's concept of, 106–107,
  216
Interventions, 576
  interplay of techniques and
  alliance, 415
  psychodynamic, 406–407, 408, 409
  tailoring to patient characteristics,
  412, 415–418
Intrapsychic conflict. See Conflict,
  intrapsychic
Intrapsychic processes, 576
Introductory Lectures on Psycho-
  Analysis (S. Freud), 160
Introduction, 59, 60, 61, 85, 90, 95
  576
Introspection, 576
"Introspection, Empathy, and
  Psychoanalysis" (Kohut), 203
Irigaray, Luce, 137, 513, 514
Isaacs, Susan, 156, 187
Isakovoy, Otto, 56
Isolation, 55, 61, 95, 123, 576
Iverson, Margaret, 524–525
Ives, Charles, 552
Jackson, M., 171
Jacobs, Theodore, 83, 87–88, 90
  165–166, 259
Index

Jacobson, Edith, 23, 180–181, 429
Jahrbuch für Psychoanalytische und
Psychopathologische
Forschungen, 12
Jakobson, Roman, 222
Janet, Pierre, 6, 7, 8, 40, 54
Japan, psychoanalysis in, 485, 486
Japanese Psychoanalytic Society, 486
Jealousy, 576
Jensen, Wilhelm, 533
Jewish mourning rituals, 483
Johansson, P., 416
John, M., 414
Johnson, M., 334
Johnson, Nunannly, 540
Jokes and Their Relation to the
Unconscious (S. Freud), 479
Jones, E.E., 406, 416, 417–418
Jones, Ernest, 11, 12–13, 14, 137,
187, 190, 307, 350, 353
debate with Malinowski, 479
as Freud’s biographer, 508, 509
Jones, Maxwell, 368n
Jorowitz, E., 394
Joseph, Betty, 70–71, 84, 194, 259,
260
Jouissance (Lacan), 226, 227, 228, 229,
230, 232, 235, 234, 236, 513
Journal of the American
Psychoanalytic Association, 23,
24, 25, 87, 369
Jung, Carl G., 11, 12, 15, 25, 271
“Just-So Story” (S. Freud), 478
Kächele, Horst, 297, 379, 380, 453
Kahan, Max, 11
Kakar, Sudhir, 486
Kallestad, H., 413
Kandel, Eric, 446, 447, 456
Kant, Immanuel, 7, 190, 192, 355,
445, 468, 501, 529
Kaplan, Ann, 544
Kaplan-Solins, Karen, 447
Kapp, F.T., 86
Katzenstein, T., 418
Kazdin, A.E., 418
Keller, W., 394
Kernberg, Otto, 23, 111, 164, 290
concept of defenses and levels of
functioning, 96, 123, 125–126
on countertransference, 80
developmental model of, 430
object relations and, 181, 430
on sexuality, 143, 147
“totalistic” approach to
countertransference, 86–87
Kessler, S., 136n
Kestenberg, J., 112
Kierkegaard, S., 421
Kieslowski, Krzysztof, 538, 539
Kim, P., 435
Kirshner, L.A., 297n
Klein, George, 23, 23, 26, 46, 128
Klein, Melanie, 13, 14–15, 23, 24, 26,
31, 172, 185–190, 213, 425, 525
approach to child analysis,
135–136, 137, 142
A. Freud’s dispute with, 137
concept of defense, 95–96, 103
concept of depressive position,
95–96, 127, 129, 175,
187–188, 195, 309, 429,
497–498, 571
manic defense against, 188–189
concept of id, 137
concept of internal objects, 174,
175, 188
concept of paranoid-schizoid
position, 95, 96, 125, 173,
174, 175, 189–190, 195, 282,
309, 429, 497–498
concept of projective identification,
60, 70, 83, 95, 123, 189–190,
195, 289
countertransference and, 83, 90
intersubjectivity and, 100
transference and, 69–70, 259
concept of splitting, 138, 189–190,
288–289
concept of superego, 122, 123
concept of unconscious phantasy,
60, 61, 95, 174–175, 573
early life of, 185
key points related to, 195–196
in London, 186
object relations theory of, 24n,
60–61, 122, 173–175,
186–187, 429, 497–498
(See also Object relations theory)
Fairbairn’s critique of, 176
participation in Controversial
Discussions, 187, 189
publications of
“A Contribution to the
Psychogenesis of Manic-
Depressive States,” 187
The Development of a Child,
185
“Notes on Some Schizoid
Mechanisms,” 189
“At Envy and Gratitude,” 190
The Psycho-Analysis of
Children, 186
theory of anxiety, 123, 136, 187,
288, 289
theory of ego formation, 172
theory of Oedipus complex, 173,
176, 186, 189
view of interpretation, 293, 294
view of psychoanalytic process,
288–289
Klein Trust, 190
Kluckhohn, Clyde, 479, 487
Klug, G., 393
Knight, Robert, 164, 362, 376, 378
Knolblauch, Steven, 216
Kohut, Heinz, 23–24, 26, 47, 62, 106,
213, 350
analyses of Mr. Z., 109
concept of borderline conditions,
164, 165
concept of defenses, 123
concept of development of the self,
201–202
developmental pathology,
202–203
concept of optimal frustration, 201,
205, 206, 209
concept of resistance and
psychoanalytic process,
290–291
concept of the self, 200
concept of transmuting
internalization, 205, 209, 291,
431, 436, 586
focus on empathy, 203–204
intellectual influences on, 200
intersubjectivity and, 109
on listening to music, 553
on oedipal dynamics, 125
publications of
The Analysis of the Self, 200, 206
“Forms and Transformations of
Narcissism,” 199
How Does Analysis Cure?, 200
“Introspection, Empathy, and
Psychoanalysis,” 203
The Restoration of the Self, 200
The Search for the Self, 200
on pursuit of emotional truth, 351
studies of narcissism, 157–158,
164, 199–200, 431
narcissistic rage, 206–207, 209
theory of self psychology, 23, 24,
25, 38n, 120, 158, 161,
199–209, 431 (See also
Self psychology)
Kohut, Heinz (continued)
therapeutic process of, 204–206
view of transference, 204–206, 262
Koëve, Alexandre, 227
Kordy, H., 394, 395
Korsgaard, Christine, 468
Kosawa, Hirosato, 485, 486
Kracke, Waud H., 477–490
Kraepelin, Emil, 368n
Kraft, S., 394
Kriegman, Daniel, 215
Kris, Anton O., 53–63
Kris, Ernst, 27n, 68, 159, 162, 226, 295n, 307
visual arts and, 525, 528–530
Kris, Ernest, 27n, 68, 159, 162, 226, 295n, 307
visual arts and, 525, 528–530
Kris, Ernst, 27n, 68, 159, 162, 226
visual arts and, 525, 528–530
Kristeva, Julia, 146, 513, 514, 524
Kroese, Alfred, 478
Kurosawa, Akira, 538

La Cérémonie, 538
La Meninas (Velásquez), 529
anthropology and, 428
case of Aimée, 225
clinical structures of, 233–234
hysteria, 234
obsession, 234
perversion, 234
psychosis, 225, 233–234
concept of divided subject, 226
concept of mirror stage, 226–227, 513, 543
concept of Symbolic Order, 513–514
French feminist critique of, 513–515, 519
eyear life of, 225
language
Derrida’s theory of, 515
Kristeva’s theory of, 514
Lacan and structural linguistics, 229, 512–513
of magical spells, 478, 479
musical, 555–556
pragmatics, 479, 483–484
of sounds, 560–562
Wolf Man’s use of, 516
Language of Psycho-Analytic, The [Laplanche and Pontalis], 134
Laplanche, J., 142, 146, 148
Largactil, 368n
Latency, 576
Latent content, 10, 293, 296, 576
Lay analysts, 14, 21, 21n
Layton, L., 221
Lazar, A., 394
Le Bon, Gustav, 496
Learn Jonathan, 461–474
Learning disabilities, 118

Learning From Experience [Bion], 192, 193
Learning theory, 451
Leary, K., 220
Lechich, Maria L., 211–222
LeDoux, J., 448, 450
Leibing, E., 388
Leichsenring, F., 388, 389
Lemieux, Raymond, 485
“Leonardo da Vinci and a Memory of His Childhood” [S. Freud], 532
Lesbianism, 144, 145
Lester, E.P., 362
Leuzzi-Bohleber, M., 391, 394
Levarie, S., 553
Levenson, Edgar, 218, 262, 277, 278
Lévi-Strauss, Claude, 478, 484
Levy, Raymond A., 405–420
Levy, S., 204
Lewin, Kurt, 84, 88
Lewis, Bertram D., 541
Libido, 10, 142, 576
drive, instincts and, 10–11, 12, 15, 22, 45, 58, 142–143, 157–158, 576
Fairbairn’s concept of, 58–59, 142, 176–178
drive, instincts and, 10–11, 12, 15, 22, 45, 58, 142–143, 157–158, 576
Fairbairn’s concept of, 58–59, 142, 176–178
female, 13
drive, instincts and, 10–11, 12, 15, 22, 45, 58, 142–143, 157–158, 576
Fairbairn’s concept of, 58–59, 142, 176–178
female, 13
object-relational model of, 142
sluggishness of, 94
Libido theory, 10–11, 12, 15, 22, 45, 576
Lichtenberg, J., 29, 45–46
L’Identification [Lacan], 232
Liebault, Ambrose Auguste, 6
Life event research, 424, 425–426
Life experiences, early, 424, 425–426
Life goals, 312, 361
Lin, Maya, 524
Lipton, S., 163, 257, 306–307
Listening With the Third Ear: The Inner Experiences of a Psychoanalyst [Reik], 86
Literature and psychoanalysis, 507–519
Freud and, 507–509
Analysis Terminable and Interminable, 510
Oedipus Rex, 508–509
key points related to, 519
narrative subjectivity, 518–519
psychoanalytic writing as literature/literature as psychoanalytic writing, 510–515
reverie, 515–518
Lithium, 368n
<table>
<thead>
<tr>
<th>Word</th>
<th>Page(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little Hans case (Freud)</td>
<td>20, 253, 488, 553</td>
</tr>
<tr>
<td>Livjak, Anatole</td>
<td>540</td>
</tr>
<tr>
<td>Live Company (Alvarez)</td>
<td>260</td>
</tr>
<tr>
<td>Lobotomy, 368n</td>
<td></td>
</tr>
<tr>
<td>Loewald, Hans</td>
<td>31, 67, 157, 273, 429, 563</td>
</tr>
<tr>
<td>view of termination, 309–310, 311</td>
<td></td>
</tr>
<tr>
<td>view of transference, 68–69, 258–259</td>
<td></td>
</tr>
<tr>
<td>Loewenstein, Rudolph, 22n</td>
<td>28, 159, 276</td>
</tr>
<tr>
<td>London Psycho-Analytical Society</td>
<td>12–13</td>
</tr>
<tr>
<td>Longitudinal studies of psychoanalysis, 392–393</td>
<td></td>
</tr>
<tr>
<td>Los Angeles Psychoanalytic Society, 191</td>
<td></td>
</tr>
<tr>
<td>Love, 355</td>
<td></td>
</tr>
<tr>
<td>amae [Japan], 486</td>
<td></td>
</tr>
<tr>
<td>conflict between desire and, 47</td>
<td></td>
</tr>
<tr>
<td>ego as object of, 172</td>
<td></td>
</tr>
<tr>
<td>Luborsky, L., 391</td>
<td></td>
</tr>
<tr>
<td>Lumière, Auguste and Louis-Jean, 537</td>
<td></td>
</tr>
<tr>
<td>Luria, A. R., 446</td>
<td></td>
</tr>
<tr>
<td>Luyten, Patrick, 418, 419, 423–438</td>
<td></td>
</tr>
<tr>
<td>MacAlpine, 1, 258</td>
<td></td>
</tr>
<tr>
<td>MacIntyre, Alasdair, 357–358</td>
<td></td>
</tr>
<tr>
<td>Magical spells</td>
<td></td>
</tr>
<tr>
<td>Freud’s view of, 478, 481</td>
<td></td>
</tr>
<tr>
<td>Malinowski’s language of, 478, 479</td>
<td></td>
</tr>
<tr>
<td>Magil, M., 414</td>
<td></td>
</tr>
<tr>
<td>Magritte, René, 528</td>
<td></td>
</tr>
<tr>
<td>Mahler, Gustav, 552</td>
<td></td>
</tr>
<tr>
<td>Mahler, Margaret, 120, 162, 425, 429, 525</td>
<td></td>
</tr>
<tr>
<td>concept of symbiosis, 180, 429, 512, 515, 525</td>
<td></td>
</tr>
<tr>
<td>object relations and, 180</td>
<td></td>
</tr>
<tr>
<td>observations of mother–child interactions, 29–31</td>
<td></td>
</tr>
<tr>
<td>theory of separation-individuation, 47, 130, 162, 180, 312, 429, 532, 584</td>
<td></td>
</tr>
<tr>
<td>Main, M., 242</td>
<td></td>
</tr>
<tr>
<td>Malik, M.L., 417</td>
<td></td>
</tr>
<tr>
<td>Malinowski, Bronislaw, 478, 479, 485, 489</td>
<td></td>
</tr>
<tr>
<td>Malle, Louis, 538</td>
<td></td>
</tr>
<tr>
<td>Manic defense, 25, 96n, 188–189</td>
<td></td>
</tr>
<tr>
<td>Manic reparation [Klein], 188</td>
<td></td>
</tr>
<tr>
<td>Manifest content, 10, 296, 576</td>
<td></td>
</tr>
<tr>
<td>Mannoni, Octave, 256, 524</td>
<td></td>
</tr>
<tr>
<td>MAOA [monoamine oxidase A] gene, 449</td>
<td></td>
</tr>
<tr>
<td>Marcus, Laura, 541</td>
<td></td>
</tr>
<tr>
<td>Marcus, Steven, 511, 512, 519</td>
<td></td>
</tr>
<tr>
<td>Marienbad Congress, 276, 277, 311</td>
<td></td>
</tr>
<tr>
<td>Marnie, 541</td>
<td></td>
</tr>
<tr>
<td>Márton, Elisabeth, 539</td>
<td></td>
</tr>
<tr>
<td>Masculinity, 134, 135, 576</td>
<td></td>
</tr>
<tr>
<td>Oedipus complex and, 136–137</td>
<td></td>
</tr>
<tr>
<td>passive and active, 143–144</td>
<td></td>
</tr>
<tr>
<td>phallic, 137–138</td>
<td></td>
</tr>
<tr>
<td>Masochism, 143, 144, 220, 308, 576–577</td>
<td></td>
</tr>
<tr>
<td>erotogenic, 572</td>
<td></td>
</tr>
<tr>
<td>feminine, 573</td>
<td></td>
</tr>
<tr>
<td>moral, 577</td>
<td></td>
</tr>
<tr>
<td>Waelder’s concept of, 156</td>
<td></td>
</tr>
<tr>
<td>Maudsley Hospital, 171</td>
<td></td>
</tr>
<tr>
<td>May, R., 141</td>
<td></td>
</tr>
<tr>
<td>Mayes, Linda C., 423–438</td>
<td></td>
</tr>
<tr>
<td>MBT [mentalandization-based treatment], 388</td>
<td></td>
</tr>
<tr>
<td>McCullough, L., 412, 413, 414</td>
<td></td>
</tr>
<tr>
<td>McDougall, J., 145, 146</td>
<td></td>
</tr>
<tr>
<td>McEwen, B.S., 437</td>
<td></td>
</tr>
<tr>
<td>McKay, N., 39, 47</td>
<td></td>
</tr>
<tr>
<td>McLaughlin, E., 414</td>
<td></td>
</tr>
<tr>
<td>McLaughlin, J., 214, 430</td>
<td></td>
</tr>
<tr>
<td>Medications. See Psychopharmacology combined with psychoanalysis</td>
<td></td>
</tr>
<tr>
<td>Melancholia, 13, 164, 577</td>
<td></td>
</tr>
<tr>
<td>Mourning and Melancholia, 172, 205, 496, 515, 532</td>
<td></td>
</tr>
<tr>
<td>racial, 220</td>
<td></td>
</tr>
<tr>
<td>Melden, A.L., 49</td>
<td></td>
</tr>
<tr>
<td>Meltzer, D., 284n, 296n, 497</td>
<td></td>
</tr>
<tr>
<td>Memory/memories</td>
<td></td>
</tr>
<tr>
<td>cognitive psychology and, 451</td>
<td></td>
</tr>
<tr>
<td>construction, reconstruction, and co-construction of, 126–129 declarative (episodic), 127, 276, 451, 570</td>
<td></td>
</tr>
<tr>
<td>deferred action of, 61, 121</td>
<td></td>
</tr>
<tr>
<td>dreams as source of, 121</td>
<td></td>
</tr>
<tr>
<td>early development of, 61</td>
<td></td>
</tr>
<tr>
<td>evocative, 573</td>
<td></td>
</tr>
<tr>
<td>false, 127</td>
<td></td>
</tr>
<tr>
<td>vs. fantasy, 9</td>
<td></td>
</tr>
<tr>
<td>Freud’s concept of, 44, 120–121</td>
<td></td>
</tr>
<tr>
<td>126–127</td>
<td></td>
</tr>
<tr>
<td>hermeneutics and, 128</td>
<td></td>
</tr>
<tr>
<td>hysteria and, 120</td>
<td></td>
</tr>
<tr>
<td>motivation and, 44</td>
<td></td>
</tr>
<tr>
<td>“pre-narrational,” 128</td>
<td></td>
</tr>
<tr>
<td>procedural (implicit), 127, 241, 276, 277, 451, 575, 580</td>
<td></td>
</tr>
<tr>
<td>identification and, 451</td>
<td></td>
</tr>
<tr>
<td>methods of learning procedures, 451</td>
<td></td>
</tr>
<tr>
<td>recovery of, 120, 126</td>
<td></td>
</tr>
<tr>
<td>repressed, 61</td>
<td></td>
</tr>
<tr>
<td>reworking of early memories, 44</td>
<td></td>
</tr>
<tr>
<td>screen, 550, 583</td>
<td></td>
</tr>
<tr>
<td>semantic, 451</td>
<td></td>
</tr>
<tr>
<td>somatic expression of, 54</td>
<td></td>
</tr>
<tr>
<td>transference and, 67</td>
<td></td>
</tr>
<tr>
<td>unconscious, conscious</td>
<td></td>
</tr>
<tr>
<td>recollection of, 54</td>
<td></td>
</tr>
<tr>
<td>Mendelsohn, Felix, 554</td>
<td></td>
</tr>
<tr>
<td>Menninger, K.A., 311</td>
<td></td>
</tr>
<tr>
<td>Menninger Foundation’s Psychotherapy Research Project, 378, 380, 391–392</td>
<td></td>
</tr>
<tr>
<td>Mental representations, 126, 127, 217, 452–453</td>
<td></td>
</tr>
<tr>
<td>Mentalization, 118, 248–249, 577</td>
<td></td>
</tr>
<tr>
<td>Fonagy’s theory of, 111–112, 217, 335, 434</td>
<td></td>
</tr>
<tr>
<td>intersubjectivity and, 111–112, 217</td>
<td></td>
</tr>
<tr>
<td>neurocircuitry of, 434</td>
<td></td>
</tr>
<tr>
<td>reflective function and, 217, 249</td>
<td></td>
</tr>
<tr>
<td>Mentalization-based treatment (MBT), 388</td>
<td></td>
</tr>
<tr>
<td>Merger transference, 204</td>
<td></td>
</tr>
<tr>
<td>Metacognition, 249</td>
<td></td>
</tr>
<tr>
<td>Metapsychology, 21–22, 59, 117, 349, 373, 577</td>
<td></td>
</tr>
<tr>
<td>dissents from, 22, 23, 24, 26, 32, 33, 40, 128, 285, 285n</td>
<td></td>
</tr>
<tr>
<td>genetic view of, 61, 117–118</td>
<td></td>
</tr>
<tr>
<td>Metapsychology Is Not Psychology (Gill), 41</td>
<td></td>
</tr>
<tr>
<td>“Metapsychology of the Analyis, The” (Fliess), 82</td>
<td></td>
</tr>
<tr>
<td>Metz, Christian, 543, 544</td>
<td></td>
</tr>
<tr>
<td>Meyer, Adol, 368</td>
<td></td>
</tr>
<tr>
<td>Meyer, J.K., 314</td>
<td></td>
</tr>
<tr>
<td>Meynert, Theodor, 5</td>
<td></td>
</tr>
<tr>
<td>Michelangelo, 527, 583</td>
<td></td>
</tr>
<tr>
<td>Midphase of psychoanalysis, 577</td>
<td></td>
</tr>
<tr>
<td>Mill, L.S., 355</td>
<td></td>
</tr>
<tr>
<td>Miller, Jacques-Alain, 544</td>
<td></td>
</tr>
<tr>
<td>Milner, Marion, 525</td>
<td></td>
</tr>
<tr>
<td>Minnesota Multiphasic Personality Inventory, 393</td>
<td></td>
</tr>
<tr>
<td>Mirror neurons, 106, 452–453</td>
<td></td>
</tr>
<tr>
<td>Mirror stage (Lacan), 226–227, 513, 543</td>
<td></td>
</tr>
<tr>
<td>Mirror transference, 164, 204, 209, 262, 527–584</td>
<td></td>
</tr>
<tr>
<td>Mirroring self-object, 201</td>
<td></td>
</tr>
<tr>
<td>Mirrors of Memory [Bergstein], 532</td>
<td></td>
</tr>
</tbody>
</table>
“Mirror-Stage as Formative of the Function of the I as Revealed in Psychoanalytic Experience, The” [Lacan], 226
Misogyny, 134
Mitchell, Stephen, 24, 25, 26, 157, 165, 180, 211–222, 430
concepts of relational matrix and relational configurations, 213–214
death of, 212
intersubjective attitude of, 109–110
object relations and, 181
publications of
Hope and Dread in Psychoanalysis, 263
Influence and Autonomy in Psychoanalysis, 263
Object Relations in Psychoanalytic Theory, 24, 212
Psychoanalytic Dialogues: A Journal of Relational Perspectives, 212
relational model of, 211–212
Relational Perspectives Book Series, 212
“‘What’s American About American Psychoanalysis?’”, 213
theory of relational psychoanalysis, 211–222 [See also Relational psychoanalysis]
clinical case vignette of, 221–222
view of transference and countertransference, 262, 263

Mnemonic symbol, 120
Modell, A.H., 46, 87
Moffitt, T., 448–449
Mohave culture, 480
Molina, Anthony, 483
Mondalization, 487
Mondrian, Piet, 530
Money, John, 134, 139
Money-Kyrle, Roger, 84, 88
Monoamine oxidase A [MAOA] gene, 449
Moonlight Sonata, 562
Moral decision making, 355, 362–364
Moral masochism, 577
Moral philosophy, naturalistic, 473–474
Moral transgressions, 122
Morality, 195, 349–354. See also Ethics
universalistic, 501
Moran, Richard, 468
Moretti, Nanni, 539
Morgenenthaler, Fritz, 479
Morrison, Amy, 362
Moses [Michelangelo], 533
Moses and Monotheism (S. Freud), 128
“Moses of Michelangelo” [S. Freud], 522
Mothering, 162. See also Parents/parenting
Chodorow’s theory of, 512
female analysts’ appreciation of developmental impact of, 32
good enough, 311, 559, 574
object relations theory of, 512
production of gender patterns by, 134
Stern’s “motherhood constellation,” 433
Mother–child interactions, 456. See also Infant research and adult psychotherapy
analyst–analyasand relationship and, 162–163, 244
Benjamin’s concept of, 216
as bidirectional, transactional system, 244
Bion’s concept of, 109, 178
Derrida’s concept of, 515
development of defenses and, 96
Freud’s exploration of, 511
Lacan’s mirror stage, 226–229, 513, 543
Mahler’s observation of, 29–31
maternal self-critical perfectionism and, 433
object relations theory of, 60–61, 511, 512
postpartum depression and, 433
Stern’s studies of, 106
symbiotic, 180, 429, 512, 515
525, 559, 585
Winnicott’s theory of, 69, 111, 162, 179–180, 291, 430, 456, 513, 559
Motivation, 39–50
cognitive processes and, 43–45
drive organization and cognition, 44–45
memory, 44
perception, 43–44
conflicts between motivational systems, 47
defense and, 42
definition of, 40, 577
energizing function of, 40
Freud’s theory of, 11, 43, 49, 56
key points related to, 50
limitations of motivational explanation, 48–49
moral, 354, 356
motivated behavior, 39–40
motivational explanations and agent’s point of view, 41
motivational explanations in contemporary psychoanalytic theories, 47–48
motives and affects, 43
motives and needs, 42–43
Nietzschean form of skepticism about, 49
nongeometric, 354
peremptory and driven behavior, 41–42
psychic determinism and, 353–354
psychoanalytic motivational explanation as extension of ordinary discourse, 40–41
psychoanalytic theories and identification of primary motivational systems, 45–47
relation to neural activity, 41
unconscious
instinctual drives and, 40–41, 58–59
intentionality and, 426
Motivational determinism, 39
Motor cortex, 452
Mourning, 59–60, 205, 508, 577
culturally defined rituals of, 482–483
Mourning and Melancholia (S. Freud), 172, 205, 496, 515, 532
Movies. See Film and psychoanalysis
Muensterberger, Warner, 479
Muenz, L.R., 416
Müller, Johann, 7
Multideterminism, 577
Multifinality, 426
Multiple function, principle of, 577
Muliplicity, 217, 222
Mulvey, Laura, 544, 548
Münsterberg, Hugo, 543
Murakami, Haruki, 515
Music and psychoanalysis, 551–564
study of, 560–562
categories of psychoanalytically oriented writings about music, 553, 563
common concerns of, 551
definition of music, 556
Index

definition of musician, 556–557
history and conceptual overview of, 551–554
how psychoanalysis contributes to musical understanding, 554–555
key points related to, 563–564
music and time, 562–563, 564
music of sounds, 558–559
pitfalls in applying musical language to describe the psychoanalytic process, 555–556
sounds as contact experiences, 559–560
Mutative interpretation, 68, 272, 294, 577
My Name Was Sabina Spielrein, 539
Mystery of the Rocks of Kador, The (Le Mystère des Roches de Kador), 539

Nagel, Thomas, 468
Nancy school, 9
Narcissism, 15, 23, 59, 161, 166, 577
analyzability and, 164
healthy, 125
Kohut’s studies of, 157–158, 164, 199–200, 431
narcissistic rage, 206–207, 209
“On Narcissism: An Introduction” (S. Freud), 173, 478
Narcissistic behavior disorder, 202
Narcissistic personality disorder, 199, 202, 208, 465
Narrative subjectivity, 518–519
Narratives, 20, 23, 26, 577
historical vs. narrative truth, 128
jointly constructed, 89
Nass, Martin, 552, 555
National Institute of Mental Health, Treatment of Depression Collaborative Research Program, 330
Nationalism, 500, 503–504
Natterson, Joseph, 111
“Nature of the Therapeutic Action of Psycho-Analysis, The” (Strachey), 293
Navaho witchcraft, 479, 487
Ndembu culture (Zambia), 481
Needs and motives, 42–43
Negation, 577
Negative capability, 74
Negative hallucination, 578
Negative therapeutic reaction, 288, 308, 578
Neglect, childhood history of, 118
“Neosexualities,” 145
Netherlands Psychoanalytic Institute, 393, 394
Neurasthenia, 8, 164, 578
Neurobiology, 424, 452–453
Neuroimaging, 447
Neurophilosophy, 447
“Neuro-Psychose of Defence, The” (S. Freud), 94
Neurosciences and psychoanalysis, 445–457
consilience of, 455–456
effects of interdisciplinary studies on psychoanalytic practice, 448–450
affect research and psychopharmacology, 448
affective and dynamic unconscious, 449–450
conscious and unconscious process, 449
epigenetics and nature-nurture issue, 448–449
future of, 456
International Neuropsychoanalysis Society, 446
key points related to, 456–457
neurophilosophy and, 447
origins of, 445
progress of neuropsychoanalysis, 166, 446–447
separation of, 445–446
study of other psychoanalytic concepts, 453
two approaches to integration of, 446, 447, 456
understanding identification in light of information from other sciences, 451–453
cognitive psychology and study of memory systems, 451
Neurosis(es)

anxiety, 164
vs. character, 121
as compromise formations, 156, 157
countertransference, 84
definition of, 578
dream interpretation in treatment of, 10
fate, 61
Freud’s theory of sexual cleancets in etiology of, 4, 6–10, 56, 120
infantile, 124, 187, 575
motivational account of, 40
narcissistic, 164
obsessional, 55, 58, 61, 120, 164, 481
Rank’s theory of, 12
theory in Plato’s Republic, 465
transference, 68, 75, 160, 164, 441, 467, 586
Neurotic level of functioning, 96
“Neurotic’s Individual Myth, The” [Lacan], 484
Neutrality, 28, 31, 214, 350, 578
ethics of, 352–353, 363
Neutralized energy, 22, 578
New Criticism, 509, 511, 512
“New Introductory Lectures” (S. Freud), 307
“New psychology,” 6
New York Psychoanalytic Institute, 23, 29, 86, 156, 164
Newly Born Woman, The [Clément and Cixous], 513
Nietzsche, Friedrich, 3, 41, 49, 474
Nineteen Nineteen, 532, 540
Nonlinear dynamic systems theory, 215–216
Nonverbal dimensions of early experience, 241
Normality, 578
Normand, W., 319
“Notes on Some Schizoid Mechanisms” [Klein], 189
Nouvelle Vague, 538
Noy, Pinchas, 552, 553
Nunberg, Herman, 159
Obyesekere, Ganathan, 483, 488, 489
Object(s)

definition of, 578
drive(s), 58, 142, 172, 173
importance of early mental representation and, 126
instinctual, 172, 575
individual, 174–175, 177, 188, 576
internalizing qualities of, 59–60

Copyrighted material
Object(s) (continued)
of libido’dive, 165
loss of, 94, 96
part, 60, 125, 171, 173–175, 183, 188, 579
ritual, 481–482
split, 174
transitional, 179, 530–531, 586
whole, 174, 183, 587
Object choice, 172
Object constancy, 578
Object relations, 160n, 171–183
definition of, 171, 182, 578
internalized, 575
psychological derivatives of, 172
relational psychoanalysis and, 212
self-destructiveness and, 173
Object Relations in Psychoanalytic Theory (Greenberg and Mitchell), 24, 212
Object relations theory, 24, 25, 31, 171–183, 429–431, 578
of Abraham, 172–173, 182
American contributions to, 180–182
Hartmann, 180
Jacobson, 180–181, 429
Kernberg, 181, 430
Mahler, 180, 429
Mitchell, 181
Ogden, 181–182
of Bion, 178, 429–430, 498
central assumptions of, 429
developmental perspective of, 429–431, 511–512
of Fairbairn, 108, 142, 143
175–178, 177
vs. Freud’s emphasis on drives that seek an object, 172, 173, 182
do gender, 134, 139, 140
key points related to, 182–183
of Klein, 24n, 60–61, 172
173–175, 186–187, 429, 497–498
of libido, drives, and instincts, 142, 143
of motivational systems, 45
of oedipal dynamics, 125
in Plato’s Republic, 465
principal contributors to, 172
in understanding group
identification, 497–498, 502–503, 505
visual arts and, 525, 526, 530–532
of Winnicott, 173, 179–180, 216, 430
Object relationship (Freud), 172
Object representation, 578
Observational methods, 32
Mahler’s studies of mother-child dyads, 29–31
Obsession, 42, 578
Freud’s comparison between religious rites and, 481
Lacan’s concept of 234
Obsessional neurosis, 55, 61, 120, 481
Obsessive-compulsive disorder, 454
Oedipal/post-oedipal defenses, 123
Oedipus complex, 15, 20, 28–29, 31, 118, 124, 143
adult personality and, 124–125
Britton’s concept of, 195
in current psychoanalytic thinking, 125, 145
definition of, 578
feminist critiques of, 136–137
Freud’s concept of, 9, 136–137, 161, 162, 507–509, 511
ideological gender and, 136
Klein’s theory of, 173, 176, 186, 189
self psychology and, 123
termination of analysis and, 307
Oedipus Rex, 507–509
O’Grammatology (Derrida), 515
Ogden, Thomas, 72–74, 89, 90, 278, 516
concept of analytic third, 73, 110, 219, 516
intersubjective attitude of, 73, 110, 516
object relations and, 181–182, 430
publications of Conversations at the Frontier of Dreaming, 517–518
Reverie and Interpretation, 517
view of countertransference, 73, 89, 90, 259, 516
view of interpretation, 296
view of reverie, 516–518

Ogrodniczuk, J.S., 412
Oils, David D., 445–457
Omnipotence, 123
of thought, 481

On Aphasia: A Critical Study [S. Freud], 2, 446
“On Envy and Gratitude” [Klein], 190
“On Narcissism: An Introduction” [S. Freud], 172, 478
“On Psychotherapy” [S. Freud], 367

On the History of the Psycho-analytic Movement [S. Freud], 4, 12, 20, 510

One Flew Over the Cuckoo’s Nest, 540

One-person psychology, 27, 87, 165, 216, 376
resistance from perspective of, 23, 97–99, 103

Oneness of analyst, 359
Operant conditioning, 451
Optimal frustration, 201, 205, 206, 209
Optimal responsiveness, 206

Oral character, 122
Oral phase of development, 58, 121, 157, 158, 172–173, 579
Oral-incorporative mode, 578
Oral-intrusive mode, 578–579
Orality, 143, 173, 579
Oral-retentive mode, 579
Oral-sadistic phase of development [Abraham], 173

O’Shaughnessy, E., 259

Ostwald, Peter, 452
Outcomes research, 385–398, 405

effects of therapeutic relationship, 407–409, 410, 411
interpretation of, 396
key points related to, 398
limitations and problems of, 395–396
methodology of, 386
confounders, 386
internal validity, 386
for moderate-length psychotherapies, 389
for psychoanalysis and long-term psychoanalytically oriented psychotherapy, 389–395
chart review studies, 390
general issues, 389–390
longitudinal studies, 392–393
meta-analyses, 390
randomized and “quasi-randomized” studies, 393–394
real-time pre-post studies, 391–392
retrospective follow-up studies, 390–391
studies of effects on physical health and health care consumption, 394–395
studies on time factors, 395
and psychoanalysis as “a method,” 397–398
for short- and medium-term
treatments in patients with
personality disorders, 388–389
for short-term psychoanalytically
informed therapies, 386–387
for short-term psychodynamic
therapy with diagnostically
specific samples, 387–388
valued and responsive outcome
criteria, 397
variation in outcomes among cases, 397
Overdetermination, 157, 360, 528, 579
Ovesey, L., 139, 140
Ozu, Yasujirō, 538
Pabst, Georg Wilhelm, 539, 541
Pally, R., 449
Panic disorder, 388
Panksepp, Jaak, 446, 448
Papers on Technique | S. Freud, 273
Parameter, 579
Paranoia, 120, 164, 579
Paranoiac Psychosis and Its Relation to
the Personality | (Lacan), 225
Paranoid-schizoid group identification,
502–503, 505
Paranoid-schizoid position | (Klein), 95, 96,
125, 173, 174, 175, 189–190,
195, 289, 309, 429, 497–498,
579
Paraphilias, 579
Parapraxis, 579
Parents/parenting. See also Mother–
child interactions
child analysis and work with, 334,
344–346
maladaptive relationships as
product of early parental
communications and
interactions with, 42, 48
parental preoccupation and
neurocircuitry of, 434–436
parent/child dyadic
psychotherapies, 346
studies on transition to
parenthood, 432–433
Parin, Paul, 479
Parintintin Indians | (Brazil), 483,
487–488
Part object | (Klein), 60, 125, 171,
173–175, 188, 579
Pathological grandiose self | (Kernberg),
202, 579
“Patient as Therapist to His Analyst,
The” | (Searles), 286
Paton, H. L., 190
Paul, Robert, 478, 487
Pavlovian conditioning, 451
Peeping Tom, 539
Peirce, C. S., 213
Pelz, R., 221
Penis envy, 11, 136, 137, 511, 579
Penzer, R., 156
Perception
drives and, 45
mirror neurons and, 452–453
motivation and, 43–44
Perceptual salience, 44–45
Perret, Léonce, 539
Perry, J. C., 388, 411
Person, E. S., 138, 140, 141
Personal maleness, 137–138
Personal symbol, 483
Personality
anaclitic, 416, 432
“as-if,” 164
borderline personality organization,
96, 118, 164, 569
introjective, 416, 432
Oedipus complex and, 124–125
Psychoanalytic Studies of the
Personality | (Fairbairn), 176
psychotic vs. nonpsychotic | (Bion),
192
theory of organization in Plato’s
Republic, 465
Personality disorders
brief relational therapy in, 409
defenses and, 96, 103, 118
Kernberg’s studies of, 125–126
mentalization-based treatment for,
388
narcissistic, 199, 202, 208
outcomes of short- and medium-
term therapies in, 388–389
supportive-expressive
psychotherapy for, 389
transference-focused psychotherapy
for, 388
Person-centered perspective,
426–427
Perversion
Green’s concept of, 312
Kleinian concept of, 260
Lacan’s concept of, 234
sexual, 144, 147–148
Phallic masculinity, 137–138
Phallic phase of development, 58, 121,
124, 157, 579
Phallus, 579
Lacan’s concept of, 228, 512–513,
515
Phantasy | (Klein), 60, 61, 95, 174–175,
288, 573. See also Fantasy
infantile, 118, 186, 187
oral, 172
Phillips, R. E., 556
Philosophy, 461–474
abandonment of therapeutic ideal, 467
contributions to dynamic
psychological thinking, 464–466
account of limits of
psychological integration, 465–466
dynamic theory of personality
organization, 465
dynamic theory of psychic
structure, 464–465
dynamic theory of typical
pathologies of personality
organization, 465
object relations theory of transmission
of pathology, 465
type of dreams as expressions of
unconscious and illicit
wishes, 466
type of illusion and rudiments
of theory of transference, 466
type of neurotic conflict, 465
type of psychic formation, 464
cooperative conversation, 463–464
fundamental question of, 462
future of psychoanalytic-
philosophical investigation, 469–474
activity and passivity of the
mind, 472–473
idosyncrasy of meaning, 473
naturalistic moral philosophy, 473–474
nature of human happiness and
freedom, 474
psychic change through
conversation, 472
transference, 470–472
implications of conversation with
Glaucous, 466–467
key points related to, 474
psychic change and, 467–468
reflection function and psychic
functioning, 468–469
Socratic method, 462–463
Phobia, 42, 49, 579
Picasso, Pablo, 529
Pine, Fred, 26, 41, 45, 161, 275
Piper, W.E., 412, 416
Pizer, S.A., 217, 263
Plato, 462, 463-467, 469, 473, 544.
See also Republic [Plato]

Pre-oedipal defenses, 123
Pre-oedipal development, 29–30, 31, 60, 62, 118, 156, 162–163, 180, 243
Pre-oedipal organization, 580
Pre-post studies of psychoanalysis, 391–392
Pressure technique [Freud], 8
Priel, B., 433
“Primal horde,” 478, 489
Primal scene, 580
Primary gain, 580
Primary identification, 580
Primary process thinking, 10, 57–58, 63, 160, 529, 580
pleasure principle and, 57
Principles and Standards of the American Psychoanalytic Association, 356–357, 363
Problem of Anxiety, The [S. Freud], 158, 159
Procedural (implicit) memory, 127, 241, 276, 277, 451, 575, 580
Procedural unconscious, 276, 277
Process of Change Study Group, 222, 273
Prohibition, 580
Project for a Scientific Psychology [S. Freud], 19, 446, 496
Project TR-EAT, 395
Projection, 28, 55, 61, 95, 123, 580
Projective counteridentification, 84–85
Projective identification, 23, 55, 96
Projective's metabolization of, 70
Bion's concept of, 70, 178, 278, 297, 429–430
communicative aspects, 85, 86
countertransference induced by, 83–84, 90, 190, 260
definition of, 580
countertransference, 70–71
intersubjectivity and, 109
Joseph's concept of, 70–71
Klein's concept of, 60, 70, 83, 95, 123, 189–190, 195, 289
in understanding groups, 498, 503
violent, 84, 85
Proust, Marcel, 65, 67
Psych, 464–465, 580
Psychiatry and the Cinema [Gabbard and Gabbard], 540
Psyche, 464–465, 580
Psychic apparatus, 56
Psychic change
philosophy and, 467–468
through conversation, 472
Psychic determinism, 9, 11, 39, 56, 57, 119, 157
definition of, 581
ethics and, 349, 353–354, 363
Psychic energy, 22, 41
neutralized, 578
Psychic equivalence mode of thinking [Fonagy], 335
Psychic helplessness, 94
“Psychic presence” [Weiss], 312
Psychic reality, 41, 62, 483, 581
“Psychical entropy,” 308
Psychoanalysis
anthropology and, 477–490
applied, 445, 554–555, 568
binary oppositions in, 211
boundaries in, 362
of children, 14–15, 20, 333–346
See also Child analysis
classical, 155–167
[See also Ego psychology]
accretion and assimilation of, 161–163
definition of, 156
evolution of, 159–161
Freud and early ego psychologists, 156–159, 166
genealogy of, 159–160
growth of, 161–166
key points related to, 167
rhetoric of competition, 161
theoretical features of, 159
clinical reporting of, 26–27
competition between schools of, 161
as “corrective emotional experience,” 306
cost-utility analysis of, 394
definition of, 370n, 371, 390, 581
de-medicalization of, 32n
duration of, 395
interminable or very prolonged, 403, 309–310
ego psychology and, 14–15, 155–167
ethics in, 349–364
evolutionary, 501
film and, 537–548
foundations of, 7–9
“four psychologies” approach to, 26
Freud's technique of, 167
history of
in North America after Freud, 19–33
S. Freud and his circle, 3–16
indeterminacy of observation and
inference in, 54
induction phase of, 575
interpretation in, 292–297
intersubjectivity in, 105–114
literature and, 507–519
midphase of, 577
moral aspects of, 349–350
music and, 551–564
nature of discipline of, 21–27
neurosciences and, 445–457
in non-Western societies, 485–487
one-person and two-person
psychologies and, 27, 87, 128,
165–166
philosophy and, 461–474
pluralistic, 25–26, 32, 32n, 33,
122, 211, 212, 222, 278, 286,
379
problem of hypotheses in, 54
psychoanalytic psychotherapy and,
367–381
psychopharmacology combined
with, 166, 319–331, 448
reanalysis, 203, 314–315
relational, 24–25, 26, 30, 59,
96, 109, 161, 166, 181, 211–222
relationship with psychiatry in
America, 368–369
research on outcomes of, 385–398
(See also Outcomes research)
schools of, 167
session frequency for, 395
as “talking cure,” 2, 32, 54,
264–265
termination of, 303–316, 585–586
resistance to, 92, 101–102
theoretical developments and
establishment of a movement,
12–14
therapeutic action of, 54, 264–265,
269–280
toward a polyphonic model of
therapeutic action of, 246–247
transference in, 65–76, 255–266
value-free methodology of,
349–351
visual arts and, 523–533
widening scope of indications for,
164–165
working-through phase of, 62, 587
resistance to, 99

Psychoanalysis and Ethics [Wallwork],
349, 353
Psychoanalysis and the Social
Sciences, 479
Psycho-Analysis of Children, The
[Klein], 186
Psychoanalyst
abstinence of, 14, 28, 350, 352,
567
adherence of, 414
anonymity of, 214, 350, 568
attributes that contribute positively
or negatively to alliance,
407–408, 410, 411
capacity for trial identification,
82–83
changing concept of role of,
31–32
of children, 333–346
competence of, 414
countertransference reactions of,
27, 30–31, 62, 65, 67, 69,
79–90, 570
“diatropic attitude” of, 199
empathy of, 106, 161, 203–206,
248, 259, 297n, 414
female, 82
Freud’s caution to temper
therapeutic ambition of,
350–351
internalization of, 311–313
“irreducible subjectivity” of, 88
Lacan’s view of position of,
234–235, 236, 487
lay (nonphysician), 14, 21, 21n
neutrality of, 28, 31, 214, 350, 578
ethics of, 352–353, 363
ongoing interpersonal interpretive
process of, 295–296, 295n
patient’s curiosity about, 214
“psychic presence” of, 312
psychoanalytical
psychopharmacologist,
326–328
vs. split treatment, 325–326, 331
relationship of new therapist to
previous one, 314
reporting behavior and experiences of,
27, 30
self-analysis of, 67, 79–80, 81, 90,
510
self-disclosure by, 75, 214–215
stance of transformational
receptiveness, 89
supervision of, 20, 28, 510
technical consistency vs. flexibility of,
273–275, 333
training analysis of, 15, 81, 314,
586
truthfulness of, 359, 362
virtues of, 357–360
benign and tolerant curiosity, 359
definition of, 358
emotional honesty, 359
empathic respect, 358–359
guidance provided by, 358
openness and humility, 359
restraint or self-control,
359–360
role specificity of, 359
teaching of, 358, 359
Winnicott’s view of role of, 292
work ego of, 82, 83
Psychoanalyst—analysando intersections/
relationship, 90, 156–157,
407–409
affirmative approach to, 246
analyst attributes that contribute
positively or negatively to,
407–408, 410, 411
analytic dyad, 31–32, 243–244
analytic field, 89–90, 110
resistance from perspective of,
93, 102, 103
analytic third, 73, 110, 219–220,
222, 296, 516, 518
asymmetry vs. symmetry of, 75
for child analysis, 333–334
classical view of, 162
countertransference and, 79–90,
165–166, 167, 255–266
enactments and, 87–88, 218–219,
222, 258, 265, 278, 298, 572
evolution of classical perspective of,
163
Ferro’s concept of analytic couple’s
fertility, 89
future research on, 408–409
interplay of techniques and, 415
intersubjective model of, 105–114,
255
moral standards for, 349–350
mother–child relationship and,
162–163
mutuality in, 215
in one-person and two-person
psychologies, 27, 32, 165–166
resistance from perspective of,
93, 97–102, 103
ongoing monitoring of, 408–409
Psychoanalytic–analysand interactions/relationship (continued)
psychoanalytic process and, 405, 407–409
“real” relationship, 163, 255, 257–258, 264–266
realistic, 163
in relational psychoanalysis, 211
repairing ruptures in, 409
as shared unconscious phantasy, 88–89
therapeutic action and, 270–272, 280, 283–284
therapeutic symbiosis, 297
trajectory over time, 408
transference and, 65–76, 163, 167, 255–266
working alliance, 257
Psychoanalytic boundaries, 362, 581
Psychoanalytic Concepts and Structural Theory (Arlow), 158
Psychoanalytic data, 21, 28–31, 32
Psychoanalytic Dialogues: A Journal of Relational Perspectives, 212, 215
Psychoanalytic Explorations in Art (Kris), 552
Psychoanalytic Explorations in Music (Feder), 552
Psychoanalytic method, 16, 28, 581
shifts in, 28–32
technical consistency vs. flexibility in, 273–275, 333
Psychoanalytic process, 31–32, 54, 162, 283–298
Bion’s view of, 292
contemporary trends in, 297
definition of, 284, 298, 581
dream work model of, 296
Freud’s view of, 284, 286
history of, 285–286
eyearly implicit model, 286
idea of, 284–285
interpretation and, 292–297, 298
intersubjective theories of, 105–114, 283, 297
key points related to, 298
Klein’s concept of, 288–289
Kohut’s view of, 290–291
measures of, 405–406
modern paradigm change in conception of, 291–292
non-interpretative aspects of, 297
perspectives as tools in, 102–103
post-Freudian paradigm of, 289–290
relational view of, 291, 297–298
resistance to, 97–103, 283, 286–288, 298
synchonic dimension of, 284
therapeutic action of, 54, 264–265, 269–280
Thomà and Kächele’s view of, 297
transference and, 65–76, 255–266
in two-person psychology, 283, 285, 291, 297
unfolding of, 284, 284n, 298
variations on intersubjectivity and on role of relationship in the cure, 297–298, 298n
Winnicott’s view of, 291–292, 295
Psychoanalytic process research, 405–420
future avenues for, 418–419
interplay of techniques and alliance, 415
key points related to, 419–420
measures used in, 405–406
processes that characterize psychodynamic treatment, 406–407, 408, 409
role of technique in treatment, 410–414
tailoring treatment to patient characteristics and in-session process, 415–418
aspects of treatment to be tailored for optimum effectiveness, 416–417
role of single-case studies in tailoring treatments, 417–418
therapeutic relationship, 407–409, 410, 411
Psychoanalytic (psychodynamic) psychotherapy, 367–381
blurring of distinction between psychoanalysis and, 369–371
Alexander, 370–371, 379
Fromm-Reichmann, 370–371, 379
central conceptions about nature of, 369–370
characteristic interventions of, 406–407, 408, 409
contemporary perspectives on psychoanalysis and, 379–381
Blass, 379
Busch, 379
Cooper, 380n
Kächele, 380
Wallerstein, 381
Widlocher, 379–380
development of, 369
expressive, 369, 370, 372–373, 573
key points related to, 381
research on outcomes of, 385–389
(See also Outcomes research)
sharpening of distinction between psychoanalysis and, 371–375
1979 symposium on, 375–379
A. Freud, 374
Bibring, 373–374
Rangell, 371, 373, 375, 378–379, 380
reassessment in light of newer theories, 375
Stone, 371–372, 374, 375–376
supportive, 369, 370, 372–373, 585
Psychoanalytic Quarterly, 24, 163, 219, 360
Psychoanalytic situation, 54, 581
Psychoanalytic Studies of the Personality (Fairbairn), 176
Psychoanalytic Study of Society, The, 479
Psychoanalytic Study of the Child, The, 162
Psychoanalytical Process, The
(Meltzer), 284n
Psychobiology, 358, 368n
Psychodynamic Interventions Rating Scale, 411
Psychodynamic psychotherapy, 367–381. See also Psychoanalytic (psychodynamic) psychotherapy
Psychodynamics, 581
Psychological Birth of the Human Infant, The (Mahler), 162
Psychologie nouvelle, 6
Psychology of the Self: A Casebook
(Goldberg), 206
Psychoneuroses, 2
Psychopathology, 581
Psychopathology of Everyday Life, The
(S. Freud), 10
Psychopharmacology combined with psychoanalysis, 166, 319–331, 320, 448
appreciation of therapeutic effects of, 320
decision to prescribe medication, 321–323
in depression, 321–323, 387
DSM diagnosis and, 320
321–323
Index

empirical studies of rates of, 320–321, 331
initial resistance to, 319–320
key points related to, 331
patient expectancy and clinical outcome of, 330
practice in ongoing analysis, 328–330
psychoanalyst/
psychopharmacologist, 326–328
recommendation and informed consent for, 332–324
split treatment, 325–326, 331
Psychosexual development
biphasic, 143
component instincts of, 143, 158
developmental arrest of, 58
lasting imprint on adult, 121–122
normal, aim of, 158
phases of, 58, 120, 428, 581
anal, 58, 157, 568
defenses associated with, 123
genital, 58, 157, 572
oral, 58, 157, 579
phallic, 58, 157, 579
Psychosis, 45, 44, 164–165
anthropology and psychoanalytic treatment of, 484–485
Bion’s differentiation of psychotic from nonpsychotic personality, 192
in childhood, 162
definition of, 581
etiolog of, 118
Lacan’s concept of, 225, 233–234
Maudsley Hospital treatment of, 171
primary process thinking and, 58
Psychoanalytic symptoms and diseases, 118, 581
Psychotherapy Process Q-Set [PQS], 405, 406–407, 408, 409, 414, 416, 417
Psychotherapy Research Project [Menninger Foundation], 378, 380, 391–392
Psychosexual character, 165
“Psychic core,” 312
Psychotic level of functioning, 96
Puberty, 143
Puberty rituals, 481–482
Pulos, S. M., 406, 417
Pulvermuller, F., 452
Puschner, B., 392, 394
“Quasi-randomized” studies of psychoanalysis, 393–394
Quer theory, 135
Que ch’est que le Cinémat’, 537
Quick Inventory of Depressive Symptoms, 327
Race/racism, 220–221, 503–504, 505
institutional, 503
Racial melancholia, 220
Racker, Heinrich, 84, 87, 100, 259, 260, 359
Radcliffe-Brown, A. R., 479
Radford, Michael, 547
Rado, Sandor, 15, 22
Ramanujam, B. K., 486
Ramis, Harold, 541
Randomized studies of psychoanalysis, 393–394, 396
Rangell, Leo, 28, 29, 370, 371, 373
on distinction between psychoanalysis and psychotherapy, 370, 371, 373, 375, 378–379, 480
Rank, Otto, 11, 12, 15, 31, 290, 353, 543
Rapprochement subphase of development [Mahler], 426, 581
Rat Man case [Friedrich], 279, 280, 307, 481
Rationalization, 190, 582
Ray, Satsayt, 583
Reaction formation, 95, 121, 123, 582
Read, Kenneth, 488
“Real” relationship, 163, 255, 257–258, 264, 366
Reality
definition of, 582
internal and external, denial of, 123, 188
psychic, 581
Reality principle, 10, 57–58, 63, 500, 582
Reality testing, 582
failure of, 96
Real-time pre-post studies of psychoanalysis, 391–392
Reanalysis, 303, 314–315
Reconstruction Window, 539
Reason, 40, See also Motivation
Rebecca, 539
Reboxetine, 330
Reconstruction, 126–127, 294, 582
in child analysis, 342
Reed, C. S., 160
Reflective function, 217, 249
psychic functioning and, 468–469
Regression, 95, 121, 123, 582
formal, 582
in the service of the ego, 582
temporal, 582
topographic, 582
Winnicott’s concept of, 292
Reich, Wilhelm, 95, 103
Reik, Theodor, 81, 86, 481
Reizenberg-Malcolm, R., 178
Reiser, Morton, 532
Reitzel, Rudolf, 11
Relational ethic, 219
Relational matrix [Mitchell], 213
Relational Perspectives Book Series
Mitchell, 212
Relational psychoanalysis, 24–25, 26, 30, 59, 96, 109, 161, 166, 181, 211–222
analytic third in, 219–220, 223
of children, 346
clinical case vignette of, 221–222
countertransference in, 214, 222
development of, 213
differentiation from interpersonal psychoanalysis, 212
dissociation and, 217–218
encounter in, 218–219, 222
gender, sexuality, race, class, diversity and, 220–221
intersubjectivity and, 216–217
key points related to, 223
multiplicity and, 217
nonlinear dynamic systems theory and, 215–216
relational matrix and relational configurations, 213–214
self-disclosure by analyst in, 214–215
view of analytic process, 291, 297–298
view of oedipal dynamics, 125
view of resistance and psychoanalytic process, 291
view of transference, 214, 222, 263–264
visual arts and, 525, 530–532
Relational Psychoanalysis Book Series, 212
“Relational-by-intent” analysts, 213
Relativism, 128
Religion
Christianity and psychic change, 467–468
Freud’s comparison between obsessive acts and religious rites, 481
Freud’s criticism of, 354, 355
Spiro’s concept of, 482
“Remembering, Repeating and Working-Through” [S. Freud], 472
Renik, Owen, 88, 89, 163, 259, 361, 430
Reparation [Klein], 95, 582
Repetition compulsion, 13, 61–62, 63, 125, 288, 582
Repression, 95, 96, 120, 123, 582
Freud’s concept of, 10, 13, 20, 40, 53–54, 94, 159–160
Lacan’s concept of, 281
return of the repressed, 582
Reproduction of Mothering, The [Chodorow], 512
Republic [Plato], 462, 463–467, 469, 473, 544
abandonment of therapeutic ideal, 467
contributions to dynamic psychological thinking, 464–466
account of limits of psychological integration, 465–466
dynamic theory of personality organization, 465
dynamic theory of psychic structure, 464–465
dynamic theory of typical pathologies of personality organization, 465
object relations theory of transmission of pathology, 465
theory of dreams as expressions of unconscious and illicit desires, 466
theory of illusion and rudiments of theory of transference, 466
theory of neurotic conflict, 465
theory of psychic formation, 464
cooperative conversation, 463–464
implications of conversation with Glauccon, 466–467
Repulsion, 539
Research
developmental, 423–438
infant research and adult psychotherapy, 239–250
life event, 424
outcomes, 385–398
psychoanalytic process, 405–420
Resistance, 97–103, 283, 286–288, 298
analysis of, 97, 287–288
close process monitoring” approach to, 287
concept in contemporary psychoanalysis, 97–103
definition of, 93, 103, 582
ego psychological view of, 287
Freud’s concept of, 8, 11, 55, 94, 97, 103, 286–288
Kohut’s view of, 290–291
in modern trauma-based models, 290–291
multiple theoretical models of, 290, 290n
from obstacle to aid in analytic process, 287
from perspective of analytic field, 93, 102, 103
from perspective of one-person psychology, 94, 97–99, 103
resistance to awareness and resolution of transference, 94, 98–99
resistance to establishment of analytic process, 97–98
resistance to working-through and termination, 99
from perspective of two-person psychology, 94, 99–102, 103
entrenched resistance, 100–101
resistance to termination, 101–102
transitory resistance, 100
relational view of, 291
self psychological view of, 291
sources of, 94
transference as, 286–287
Respect, 352, 502
empathic, 358–359
Restoration of the Self, The [Kohut], 200
Retrospective follow-up studies of psychoanalysis, 390–391
Return of the repressed, 582
Reverie, 352, 515–518, 582
Bion’s concept of, 85, 86, 89, 292, 295, 517
Ogden’s view of, 516–518
Reverie and Interpretation [Ogden], 517
 Reversal, 95, 123
Ribot, Théodule, 6
Rickman, John, 27, 87, 190
Ringstrom, P, 219
Rituals, 582–583
funeral, 482–483
hunting, 482
interpretation of, 481–482, 489
psychoanalytic interpretation of, 480–481
puberty, 481–482
Rivera, Wiliam, 478–479, 489
Rivette, Jacques, 538
Riviére, Joan, 186, 187, 545
Rizzolatti, G., 452
Röheim, Géza, 479, 489
Rohmer, Eric, 538
Role responsiveness, 87, 583
Rolland, Romain, 455
Romanticism, 5, 6
Roose, Steven P., 319–331
Rorschach test, 583
Rose, Gilbert, 552, 553, 562
Rosenfeld, H., 189, 194, 259
Ross, J., 106, 138
Ross, W.D., 86
Roudinesco, É., 489
Rozmarin, E., 221
Rubenstein, B., 49
Russon, A.E., 451
Rustin, Martin, 495–505
Rutherford, Bret R., 319–331
Rye, Stellan, 543
Sabbadini, Andrea, 537–548
Sachs, Hanns, 539, 543
Sadism, 143, 144, 158, 583
Safran, J., 407, 408–409
Salpêtrière School [Paris], 6
Sambian initiation rites [New Guinea], 483
San Francisco Psychoanalytic Institute, 156
Sandell, Rolf, 385–398
Sandler, Anne-Marie, 127
Sandler, Joseph, 25, 87, 90, 96, 127, 261, 278, 429
Sartre, Jean-Paul, 468, 504, 540
Scales of Psychological Capacities, 293
Schacter, J., 453
Schafer, Roy, 22, 23, 24, 26, 83, 128, 144, 259, 273, 287
Schelling, Friedrich, 7
Schizoid, 583
Fairbairn’s concept of schizoid condition, 59, 108, 176, 177, 178, 189
Klein’s concept of paranoid-schizoid position, 95, 96, 125, 173, 174, 175, 189–190, 195, 289, 497–498, 579
<table>
<thead>
<tr>
<th>Page</th>
<th>Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>615</td>
<td>Index</td>
</tr>
<tr>
<td></td>
<td>Schizophrenia, 164, 189.</td>
</tr>
<tr>
<td></td>
<td>Bion's differentiation of psychotic from nonpsychotic personality, 192.</td>
</tr>
<tr>
<td></td>
<td>pseudoneurotic, 164.</td>
</tr>
<tr>
<td></td>
<td>Schoenberg, Arnold, 555.</td>
</tr>
<tr>
<td></td>
<td>Schopenhauer, Arthur, 3, 7.</td>
</tr>
<tr>
<td></td>
<td>Schuker, E., 145.</td>
</tr>
<tr>
<td></td>
<td>Schwaber, Evelyn, 265.</td>
</tr>
<tr>
<td></td>
<td>Science and Method [Poincaré], 194.</td>
</tr>
<tr>
<td></td>
<td>Scopophilia, 583.</td>
</tr>
<tr>
<td></td>
<td>Screen, 543.</td>
</tr>
<tr>
<td></td>
<td>Screen memory, 560, 583.</td>
</tr>
<tr>
<td></td>
<td>Search for the Self, The [Kohut], 200.</td>
</tr>
<tr>
<td></td>
<td>Searle, John, 447.</td>
</tr>
<tr>
<td></td>
<td>Searles, H., 69, 296.</td>
</tr>
<tr>
<td></td>
<td>Second Sex, The [de Beauvoir], 134.</td>
</tr>
<tr>
<td></td>
<td>Second Thoughts [Bion], 193.</td>
</tr>
<tr>
<td></td>
<td>Secondary gain, 94, 583.</td>
</tr>
<tr>
<td></td>
<td>Secondary process thinking, 10, 57–58, 63, 583.</td>
</tr>
<tr>
<td></td>
<td>reality principle ard, 57, 58.</td>
</tr>
<tr>
<td></td>
<td>Secondary revision [elaboration], 10, 56, 583.</td>
</tr>
<tr>
<td></td>
<td>Secrets of a Soul, 539, 541.</td>
</tr>
<tr>
<td></td>
<td>Seduction theory, 8, 9, 15, 120, 247, 269, 583.</td>
</tr>
<tr>
<td></td>
<td>Segal, Hanna, 189, 194, 259, 271, 525.</td>
</tr>
<tr>
<td></td>
<td>Selective inattention [Sullivan], 218.</td>
</tr>
<tr>
<td></td>
<td>Selective serotonin reuptake inhibitors [SSRIs], 327.</td>
</tr>
<tr>
<td></td>
<td>Self, 22, 107.</td>
</tr>
<tr>
<td></td>
<td>bipolar, 26, 201, 569.</td>
</tr>
<tr>
<td></td>
<td>core, 432.</td>
</tr>
<tr>
<td></td>
<td>definitions of, 200, 208, 583.</td>
</tr>
<tr>
<td></td>
<td>development of, 201–202 pathological, 202–203, 209.</td>
</tr>
<tr>
<td></td>
<td>Stern's work on, 432.</td>
</tr>
<tr>
<td></td>
<td>emerging, 432.</td>
</tr>
<tr>
<td></td>
<td>false, 248n, 292, 573.</td>
</tr>
<tr>
<td></td>
<td>“going-on-being” of, 291.</td>
</tr>
<tr>
<td></td>
<td>grandiose, 201, 208–209, 574.</td>
</tr>
<tr>
<td></td>
<td>pathological, 202, 579.</td>
</tr>
<tr>
<td></td>
<td>idealizing pole of, 201, 208–209.</td>
</tr>
<tr>
<td></td>
<td>pathology from failures of, 202.</td>
</tr>
<tr>
<td></td>
<td>Kohut's concept of, 200.</td>
</tr>
<tr>
<td></td>
<td>narrative, 432.</td>
</tr>
<tr>
<td></td>
<td>prereflective, 107.</td>
</tr>
<tr>
<td></td>
<td>relational theorists' concept of, 217.</td>
</tr>
<tr>
<td></td>
<td>rise of language of, 295.</td>
</tr>
<tr>
<td></td>
<td>social, 166.</td>
</tr>
<tr>
<td></td>
<td>subjective, 432.</td>
</tr>
<tr>
<td></td>
<td>true, 292, 586.</td>
</tr>
<tr>
<td></td>
<td>turning against, 95, 123, 586.</td>
</tr>
<tr>
<td></td>
<td>Self and the Object World, The [Jacobson], 181.</td>
</tr>
<tr>
<td></td>
<td>Self psychology [Kohut], 22, 24, 25, 28n, 40, 170, 158, 161, 199–209, 584.</td>
</tr>
<tr>
<td></td>
<td>concept of development of self, 201–202.</td>
</tr>
<tr>
<td></td>
<td>developmental pathology, 202–203.</td>
</tr>
<tr>
<td></td>
<td>concept of self, 200.</td>
</tr>
<tr>
<td></td>
<td>concept of splitting in, 202–203, 209.</td>
</tr>
<tr>
<td></td>
<td>developmental perspective of, 431.</td>
</tr>
<tr>
<td></td>
<td>empathy in, 203–204, 205, 206, 208.</td>
</tr>
<tr>
<td></td>
<td>history of, 199–200.</td>
</tr>
<tr>
<td></td>
<td>key points related to, 208–209 motivational systems and, 45, 46, 47–48.</td>
</tr>
<tr>
<td></td>
<td>relational psychoanalysis and, 212.</td>
</tr>
<tr>
<td></td>
<td>therapeutic process of, 204–206 view of defenses, 96.</td>
</tr>
<tr>
<td></td>
<td>view of oedipal dynamics, 125.</td>
</tr>
<tr>
<td></td>
<td>view of resistance and psychoanalytic process, 290–291.</td>
</tr>
<tr>
<td></td>
<td>view of transference and countertransference, 204–206, 262–263.</td>
</tr>
<tr>
<td></td>
<td>Self representation, 584.</td>
</tr>
<tr>
<td></td>
<td>Self-actualization, 48, 360, 583.</td>
</tr>
<tr>
<td></td>
<td>Self-analysis, 67, 79–80, 81, 90, 510.</td>
</tr>
<tr>
<td></td>
<td>Self-cohesion, 583.</td>
</tr>
<tr>
<td></td>
<td>threats to, 125.</td>
</tr>
<tr>
<td></td>
<td>Self-consciousness, 7.</td>
</tr>
<tr>
<td></td>
<td>Self-control of analyst, 359–360.</td>
</tr>
<tr>
<td></td>
<td>Self-disclosure by analyst, 75, 214–215.</td>
</tr>
<tr>
<td></td>
<td>Self-esteem, 201, 208.</td>
</tr>
<tr>
<td></td>
<td>“Selfish gene” hypothesis [Freud], 49.</td>
</tr>
<tr>
<td></td>
<td>Selfobject [Kohut], 200–201, 208, 431, 583–584.</td>
</tr>
<tr>
<td></td>
<td>auxiliary, mental health professionals as, 303.</td>
</tr>
<tr>
<td></td>
<td>empathy and, 204.</td>
</tr>
<tr>
<td></td>
<td>idealizing, 201.</td>
</tr>
<tr>
<td></td>
<td>mirroring, 201, 209.</td>
</tr>
<tr>
<td></td>
<td>Selfobject transference [Kohut], 584.</td>
</tr>
<tr>
<td></td>
<td>Self-state dream, 584.</td>
</tr>
<tr>
<td></td>
<td>Self-states</td>
</tr>
<tr>
<td></td>
<td>Davies' concept of, 217.</td>
</tr>
<tr>
<td></td>
<td>dissociated, 218.</td>
</tr>
<tr>
<td></td>
<td>multiple, 217.</td>
</tr>
<tr>
<td></td>
<td>sexual, 145–146.</td>
</tr>
<tr>
<td></td>
<td>Seligman, C.G., 478.</td>
</tr>
<tr>
<td></td>
<td>Semantic memory, 451.</td>
</tr>
<tr>
<td></td>
<td>Semiotic theory of meaning [Peirce], 213.</td>
</tr>
<tr>
<td></td>
<td>SEP [supportive-expressive psychotherapy], 389.</td>
</tr>
<tr>
<td></td>
<td>Separation anxiety, 140, 584.</td>
</tr>
<tr>
<td></td>
<td>Separation-individuation [Mahler], 47, 120, 162, 180, 412, 429, 512, 584.</td>
</tr>
<tr>
<td></td>
<td>differentiation subphase of, 571.</td>
</tr>
<tr>
<td></td>
<td>Lacanian view of, 312.</td>
</tr>
<tr>
<td></td>
<td>practicing subphase of, 580.</td>
</tr>
<tr>
<td></td>
<td>rapprochement subphase of, 426, 581.</td>
</tr>
<tr>
<td></td>
<td>termination of analysis and, 312, 313.</td>
</tr>
<tr>
<td></td>
<td>Session frequency, 395.</td>
</tr>
<tr>
<td></td>
<td>Sexual abuse, childhood history of, 118.</td>
</tr>
<tr>
<td></td>
<td>Sexual boundary violations, 147.</td>
</tr>
<tr>
<td></td>
<td>Sexual identity, 584.</td>
</tr>
<tr>
<td></td>
<td>Sexual orientation, 143.</td>
</tr>
<tr>
<td></td>
<td>Sexual perversion, 144, 147–148.</td>
</tr>
<tr>
<td></td>
<td>Sexuality, 142–148.</td>
</tr>
<tr>
<td></td>
<td>conflict between love and desire, 47.</td>
</tr>
<tr>
<td></td>
<td>etiological influences on, 112.</td>
</tr>
<tr>
<td></td>
<td>in films, 545.</td>
</tr>
<tr>
<td></td>
<td>Freud's theory of sexual elements in etiology of neurosis, 4, 6–10, 56.</td>
</tr>
<tr>
<td></td>
<td>gender and, 134–141.</td>
</tr>
<tr>
<td></td>
<td>infantile, 4, 8–11, 20, 120, 143, 575.</td>
</tr>
<tr>
<td></td>
<td>key points related to, 148–149.</td>
</tr>
<tr>
<td></td>
<td>libido, drive, and instincts, 10–11, 12, 15, 22, 45, 58, 142–143, 157–158, 576.</td>
</tr>
<tr>
<td></td>
<td>motivational explanations and, 44–47, 56.</td>
</tr>
<tr>
<td></td>
<td>new narrative of, 144–145.</td>
</tr>
<tr>
<td></td>
<td>multiplicities of desire, 145.</td>
</tr>
<tr>
<td></td>
<td>revising classical narrative, 145.</td>
</tr>
<tr>
<td></td>
<td>sexual idiom, 144–145.</td>
</tr>
<tr>
<td></td>
<td>perversion and normality, 147–148.</td>
</tr>
<tr>
<td></td>
<td>phases of psychosexual development, 58, 581.</td>
</tr>
<tr>
<td></td>
<td>anal phase of, 58, 568.</td>
</tr>
<tr>
<td></td>
<td>developmental arrest at, 58.</td>
</tr>
<tr>
<td></td>
<td>genital phase of, 58, 572.</td>
</tr>
</tbody>
</table>
Social Adjustment Scale, 203
Social constructivism, 212, 296n
Social phobia, 382
Social referencing, 201
Société Psychoanalytique de Paris, 226
Socrates, 461–467, 473. See also Republic (Plato)
Socratic method, 462–463
Solms, Mark, 43, 446, 447, 449
Somatic compliance, 584
Somatization, 584
“Some Neurotic Mechanisms in Jealousy, Paranoia, and Homosexuality” (S. Freud), 225
Son’s Room, The (La Stanza del Figlio), 539
Sophocles, 508
Sopranos, The, 541n
Souchay, Marc-André, 554
Soul Keeper, The, 539
Sounds as contact experiences, 559–560
humming, 560–561
music of, 558–559
singing, 561
whistling, 561
Sources of Normativity (Korsgaard), 468
Southern California Psychoanalytic Society, 191
Southern Regional Psychoanalytic Societies 1979 symposium, 375–378
“Specifically human” theory (Hartmann), 22, 27
Spectatorship, 544–545, 548
Speculum of the Other Woman (Irigaray), 513
Spellbound, 539, 541–542
Spence, Donald, 128
Spencer, B., 478
Spezzano, Charles, 105–113
Spider, 539
Spielrein, Sabina, 539
Spillius, E.B., 259, 346
Spirituality, 221
Spiro, Melford, 482–483, 485, 488, 489
Spitz, Ellen Handler, 523–533
Spitz, René, 162, 195, 425, 429
Split horizontal, 202–203, 574
vertical, 202–203, 587
Split treatment, 325–326, 331
Splitting, 60, 95, 96, 123, 430
Klein’s concept of, 188, 189–190, 288–289
definition of, 584
gender polarity and, 134, 140
Kernberg’s view of, 125–126
in self psychology, 202–203, 209
“Splitting of the Ego in the Process of Defense, The” (S. Freud), 532
Sprengnether, Madelon, 507–519
Sri Lankan mystics, 483
SSRIs (selective serotonin reuptake inhibitors), 327
Stein, Alexander, 551–564, 552
Stein, Martin, 86
Stein, R., 146
Steinberg, Leo, 524
Steiner, J., 174, 195, 250, 260
Stekel, Wilhelm, 11
Stephen A. Mitchell Center for Relational Studies, 212
Stephens, Adrian, 186
Sterba, Richard, 159, 163, 311
Stern, Daniel, 106, 272, 273–274, 276, 277, 432, 433
Stern, Donnel B., 114, 218
Stigler, M., 411
Stimulus barrier, 584
Stockholm Outcome of Psychoanalysis and Psychotherapy Project [STOPPPP], 393, 395, 397
Stoller, Mark, 487
Stoller, Robert, 134, 138, 139
Stolorow, Robert, 106–107, 206, 215, 263
Stone, Leo, 162, 164
on distinction between psychoanalysis and psychotherapy, 370, 371–372, 373, 374, 375–376
STOPPPP (Stockholm Outcome of Psychoanalysis and Psychotherapy Project), 393, 395, 397
Storr, Anthony, 206–207
Strachey, Alix, 186
Strachey, James, 31, 41, 68, 161, 186, 272, 311, 352, 511
view of interpretation, 293–294, 293n
Straker, G., 220
“Strange situation,” 242
Stranger anxiety, 584
Stress response, 424
Strozier, Charles B., 200

Sexuality (continued)
phases of psychosexual development (continued)
oral phase of, 58, 579
phallic phase of, 58, 579
relational psychoanalysis and, 220
relationship between drives and perception, 44, 45
sadomasochistic, 58
sex revived, 142
sexual subjectivity, 145–147
bodymind, 146
concept of desire, 146
enigmas of sexuality, 146–147
sexual self-states, 145–146
single narrative of, 143–144
feminist critique of, 143–144
heterosexuality and homosexuality, 144
sexuality, illness, and normality, 144
Three Essays on the Theory of Sexuality, 10, 121, 135, 142, 144, 147, 157–158, 159, 165, 231, 271, 496
transsexuality, 138
Sexuality of Christ in Renaissance Art and in Modern Oblivion, The (Steinberg), 524
Shamanic healing, 480, 484
Shame. 584
Shame and Necessity (Williams), 473
Shane, Morton and Estelle, 206
Shapiro, David, 360
Shapiro, T., 204, 208
Sharpe, Ella, 310–311
Sherwood, M., 307
Shock Corridor, 540
Sifónco, P.E., 417
Sigmund Freud: His Family and Colleagues, 1928–1947, 540
Signal anxiety, 159, 282, 584
Signer and signified (Lacan), 227, 229–230, 230
Simmel, Georg, 495
Simmons, Leo, 488
Singing, 561
Sioux culture, 479, 480
Skin ego, 559
Slavin, M.O., 215
“Sleeper effect,” 393
Slochower, Joyce, 215
Smith, H., 161, 259
Smith, L., 215
Smith-Hansen, Lotte, 405–420
Snake Pit, The, 540
Splitting, 60, 95, 96, 123, 430
Klein’s concept of, 188, 189–190, 288–289
definition of, 584
gender polarity and, 134, 140
Kernberg’s view of, 125–126
in self psychology, 202–203, 209
“Splitting of the Ego in the Process of Defense, The” (S. Freud), 532
Sprengnether, Madelon, 507–519
Sri Lankan mystics, 483
SSRIs (selective serotonin reuptake inhibitors), 327
Stein, Alexander, 551–564, 552
Stein, Martin, 86
Stein, R., 146
Steinberg, Leo, 524
Steiner, J., 174, 195, 250, 260
Stekel, Wilhelm, 11
Stephen A. Mitchell Center for Relational Studies, 212
Stephens, Adrian, 186
Sterba, Richard, 159, 163, 311
Stern, Daniel, 106, 272, 273–274, 276, 277, 432, 433
Stern, Donnel B., 114, 218
Stigler, M., 411
Stimulus barrier, 584
Stockholm Outcome of Psychoanalysis and Psychotherapy Project [STOPPPP], 393, 395, 397
Stoller, Mark, 487
Stoller, Robert, 134, 138, 139
Stolorow, Robert, 106–107, 206, 215, 263
Stone, Leo, 162, 164
on distinction between psychoanalysis and psychotherapy, 370, 371–372, 373, 374, 375–376
STOPPPP (Stockholm Outcome of Psychoanalysis and Psychotherapy Project), 393, 395, 397
Storr, Anthony, 206–207
Strachey, Alix, 186
Strachey, James, 31, 41, 68, 161, 186, 272, 311, 352, 511
view of interpretation, 293–294, 293n
Straker, G., 220
“Strange situation,” 242
Stranger anxiety, 584
Stress response, 424
Strozier, Charles B., 200
Index

Structural change, 585. See also Psychic change

Structural theory, 13, 59, 82, 122–125, 156, 158, 167, 270, 287, 288, 585

chronology in theories of anxiety and defenses, 123–124 defenses and, 94, 95
ego psychology and, 158
Psychoanalytic Concepts and Structural Theory [Arlow], 158
role of superego, 122
Structure, 585
Student of Prague, The [Der Student von Pragl, 543


Stuttering, 560, 560n, 562

Subjectivity, 5, 6, 7, 165–166. See also Intersubjectivity (intersubjective) narrative, 518–519

sexual, 145–147

Sublimation, 95, 121, 123, 189, 482, 499–500, 585

Submission, 220

Suchet, M., 220

Suggestion

therapeutic action and, 270
view of psychotherapy other than psychoanalysis as, 368

Sullivan, Harry Stack, 21, 22, 24, 27, 30, 96, 106, 120, 212, 213, 278, 430

concept of defenses, 123
concepts of “good me,” “bad me,” and “not me” self-states, 217–218, 278
intersubjective theory of, 21, 24, 30, 96, 120, 262
intersubjectivity and, 108
theory of childhood anxiety, 217
Sunrise in the Catskills [Cole], 524

Superego, 13, 59, 156, 158, 585
cultural influences on, 122
defense and, 94
development of, 132
castration anxiety and, 124
Freud's structural theory and, 13, 59, 82, 122–125, 156, 158, 167, 270, 287, 288, 585
Klein's concept of, 122, 173
morality, 354, 355
resistances originating in, 288
role of, 122
susceptibility to corruption of, 122

Superego anxiety, 94, 95
Supportive psychoanalytic psychotherapy, 369, 370, 372–373, 585
Supportive-expressive psychotherapy [SEP], 389

Suppression, 585

Surrender, 220

Symbiosis, therapeutic, 297n
Symbiotic phase [Mahler], 180, 429, 512, 515, 515, 559, 585
Symbol[s], 189, 585
auditory symbolism, 552
mnemonic, 120
personal, 483
ritual, interpretation of, 481–482
Symbolic equation, 189, 585
Symbolization, 189, 585
Sympathy, 359
Symptom[s], 585
defense and formation of, 53–54, 159–160

Systematic Treatment Selection Therapy Process Rating Scale, 417

TADS [Tavistock Adult Depression Study], 394
Tailoring treatment to patient characteristics, 415–418
aspects to be tailored for optimum effectiveness, 416–417
role of single-case studies in, 417–418

Taketomo, Yasuhike, 486
Talavera, Don, 488
“Talking cure,” 7, 32, 54, 264–265, 554
Target, Mary, 111–112, 217, 344, 423–438
Tausk, Victor, 11
Tavistock Adult Depression Study [TADS], 394
Tavistock Clinic, 189, 190, 191, 192
TDCRP [Treatment of Depression Collaborative Research Program], 330
Temporal cortex, 452
Terman, David M., 199–209
“Termination: The Achilles Heel of Psychoanalytic Technique” [Bergmann], 304, 308–309
Termination of psychoanalysis, 303–316
analyst continuing to function as psychopharmacologist after, 327

Bergmann's concept of, 304, 308–309, 312
evaluation of analytic work before, 314
forced, 304, 312, 315
Freud's lack of technique for, 304–308, 315, 518
giving notice of, 309, 310
Glover's view of, 309, 310, 313
good enough, 311
how decision is reached regarding, 304
interminable or prolonged, 314
internalization of psychoanalyst and, 311–313
key points related to, 315–316
Kleinian view of, 309
life equilibrium and, 313
Loewald's view of, 309–310, 311, 315
phase of, 313–314, 585–586
possible conclusions of, 313–314
post-Freudian concepts of, 308–311
preclusion of social contacts after, 315
premature, 313
reanalysis and, 303, 314–315
resistance to, 99, 101–102
separation-individuation and, 312, 313, 316
topographic theory and, 307–308
Waelder's view of, 310

TFP [transference-focused psychotherapy], 388, 390
“The Note Upon 'The Mystic Writing Pad’” [S. Freud], 532
The Shell and the Kernel
(N. Abraham), 516
Thehan, E., 215

Theory of mind, 248–249
Therapeutic action, 54, 264–265, 269–280
analyst-answends interactions and, 270–272, 280, 283–284
development and, 436–437
Edinburgh Symposium on, 271

environmental provision and, 295
Foragy's view of, 276, 277
Freud's view of, 270–271, 280
Gabbard and Westen's view of, 275, 276, 277, 333, 414
Glover's view of, 269–270, 271
Therapeutic action (continued)
key points related to, 280
Loewald’s view of, 222
multiple models and multiple
unconscious registers of,
275–278, 333
Ogden’s view of, 278
patient’s analytic attitude and, 273
persistence and impenetrability of
debate on, 273–275
significance of debate about,
278–280
Stern’s view of, 272, 273–274, 276, 277
Strachey’s view of, 272
suggestion and, 270
technical consistency vs. flexibility
and, 273–275, 333
variations on intersubjectivity and
on role of relationship in the
cure, 297–298
Therapeutic alliance, 163, 257,
407–409, 586. See also
Psychoanalytic–analysand
interactions/relationship
analyst attributes that contribute
positively or negatively to,
407–408, 410, 411
future research on, 405
interplay of techniques and, 415
ongoing monitoring of, 408–409
repairing ruptures in, 409
training in strategies for fostering
of, 408
trajectory over time, 408
Therapeutic community, 368n
“Therapeutic Effect of Inexact
Interpretations, The” [Glover],
269, 368
Therapeutic goals, 285–286, 310,
350–351, 353, 470
ethics and, 360–362
vs. life goals, 312, 361
Therapeutic reaction, negative, 288,
308, 578
Therapeutic symbiosis, 297n
This Sex Which Is Not One [Irigaray],
514
Thomà, II, 297
Thompson, Clara, 21, 22, 30, 212
Thorazine, 368n
“388” [Québec], 484–485, 490
Three Essays on the Theory of
Sexuality [S. Freud], 10, 121, 135,
142, 144, 147, 157–158, 159,
165, 231, 271, 496
Three Faces of Eve, The, 540
Ticho, Ernst, 312, 461.
Time
duration of psychoanalysis, 303,
309–310
outcomes and, 395
music and, 562–563, 564
psychoanalyst–analysand
relationship over, 408
psychoanalytic understanding of,
562
Time-series analysis, 417–418
Tolpin, Marjan, 206
Tolstoy, Leo, 527
Tomkins, S.S., 43
Tononi, G., 241
Topographic theory, 10–11, 59, 82,
156, 157, 166, 270, 286, 307,
525, 586
Torok, Maria, 516
Tutem and Taboo [S. Freud], 478,
480–481, 489
Training analysis, 15, 81, 314, 586
Transcational perspective, 240, 244
Transference, 61, 62, 65–76, 171,
255–266
Bion, the interpersonal field, and
qualities of thinking, 71–74
Ogden and Ferro, 72–74
in British object relations tradition,
260–261
in child analysis, 68, 70, 341–343
current controversies related to,
74–75
asymmetry vs. symmetry, 75
centrality of transference
interpretation, 75
interpretation in the here and
now, 74
definition of, 66, 214, 586
discovery and early developments
related to, 256–257
Frenenzi, 257
Freud, 6, 9, 11, 14, 29, 55, 65,
66–67, 76, 94, 121, 160,
163, 256, 305, 470–472
ego psychology and, 67–69,
258–259
Loewald, 68–69, 258–259
Schafer, 259
Gill’s view of, 98, 212, 214, 376
idealizing, 164, 204, 205, 209, 262,
574, 584
illusion and, 470–471
indexicality and, 483–484, 490
in interpersonal tradition, 262
interpretation of, 66–67, 74–75,
160, 256, 293–294, 293n
mutative, 58, 222, 294, 577
overreliance on, 294–295
treatment outcomes and,
411–414, 419
key points related to, 276, 266
in Kleinian tradition, 69–71,
259–260
Joseph, 70–71, 260
Klein and Bion, 69–70, 259
Lacanian models of, 234–235,
261–262
merger, 204
mirroring, 164, 204, 209, 262,
577, 584
negative, 67
positive, 67, 71
“unobjectionable,” 163
preverbal and primitive, 67, 71
psychoanalytic–philosophical
investigation of, 470–472
“real” relationship and, 163, 255,
257–258, 264, 266
relational view of, 214, 222,
263–264
repetition in, 67, 470, 483–484
reporting of, 22
resistance to awareness and
resolution of, 94, 98–99, 256
as “rough magic,” 264–265
rudimentary theory in Plato’s
Republic, 466
self psychology and, 262–263
Kohut, 204–206, 262
selfobject, 584
total situation of, 70–71
transcational perspective of, 244
twinship (alter-ego), 204, 584,
586
Transference neurosis, 68, 75, 160,
164, 341, 367, 586
Transference-focused psychotherapy
(TFP), 388, 390
Transformational receptiveness, 89
Transforming Aggression [Lachmann],
241
Transgendered persons, 138–139
Transitional object, 179, 530–531,
586
Transitional phenomenon, 69,
179–180, 586
Transmuting internalization [Kohut],
205, 209, 291, 431, 436, 586
TRANS-OP project, 392, 394
Transsexuality, 138–139
Index

Trauma, 586
and attention to actual experience in present and past, 247–248
birth, 12, 15, 569
childhood, 118
carcinoid and urge to repeat, 125
dissociation and, 62, 248
Bromberg’s theory of, 113–114, 218, 248
hypnotic state induced by, 53
Treatment of Depression
Collaborative Research Program [TDCR], 330
Trial identification, 82–83
Triangulation, 29, 34, 195
Trotter, Wilfred, 190, 498
True self, 297, 586
Tuffaut, François, 538
Truman Show, The, 539
Truth, historical vs. narrative, 128
Truthfulness of analyst, 359
Boundaries and, 362
Tuhama (Carpanzano), 488
Turner, Victor, 481–482, 489
Turning against the self, 95, 123, 586
Twinges of reaction, 201
Twins, 584, 585
Twinship phase of self development, 201
Twinship transference, 204, 584, 586
Two-person psychology, 27, 87, 128, 165–166, 214, 215–216, 376
psychoanalytic process in, 283, 285, 291, 297
resistance from perspective of, 93, 99–102, 103
systems theory and, 216
Tyson, P., 513

“Uncanny, The” [S. Freud], 532, 543
Uncanny experience, 532, 542, 543, 586
Unconscious, 586–587

cognitive, 449–450

dynamic, 127, 449–450, 525, 571
Freud’s concept of, 2, 10, 53–62, 114, 156, 157
multiple registers of, 276
neuroscience and, 449–450
past and present, 127
procedural, 276, 277
Uncannny conflict, 53–54
Unconscious, 62, 63, 587
Unconscious processes, 53–63
dissociation, 62
dream interpretation, 3, 9–10, 20, 56–57
ego and superego, 59
further developmental considerations, 61
internalization and mourning, 59–61
key points related to, 63
motivation and instinctual drives, 40–41, 58–59
primary and secondary processes, pleasure principle, and reality principle, 57–58, 63
psychic reality and unconscious fantasy, 62
repetition compulsion, 61–62
studies on hysteria and neuropsychoses of defense, 53–55
Undone, 93, 587
Unimaginable Storms: A Search for Meaning in Psychosis [Jackson and Williams], 171
Unpleasure principle, 156, 158, 579–580
“Use of an Object, The” [Winnicott], 358
Utilitarianism, 355, 501
Vaillant, George, 226
Valenstein, A., 271
van der Leeuw, J.J., 306
van Eyck, Jan, 529
Vanderbilt Psychotherapy Process Scale, 405
Velásquez, Diego, 529
Vertical split, 202, 582
Vienna Psychoanalytic Society, 11, 12, 552
Vietnam War memorial, 524
Virtues of analyst, 357–360
benign and tolerant curiosity, 359
definition of, 358
emotional honesty, 359
empathic respect, 358–359
guidance provided by, 358
openness and humility, 359
restraint or self-control, 359–360
role specificity of, 359
teaching of, 358, 359
Vischer, F.T., 356
Visconti, Luchino, 538
Visual arts and psychoanalysis, 523–533
boundary issues and, 523–524
contribution of ego psychology, 525, 526, 528–530
contribution of Freud, 524–525, 526–528, 532
contribution of object relations theory and relational psychoanalysis, 525, 526, 530–532
key points related to, 533
newer paradigms and suggestions for further research, 532–533
three-plus part paradigm, 525–526
Visual cortex, 452
Vitebsky, Piers, 483
von Rad, M., 392
Wadler, Robert, 156, 310
Wadler-Hall, Jenny, 314
Wagner, Roy, 489
Wallerstein, Robert S., 367–381, 392, 417
Wallon, Henri, 226
Wallwork, Ernest, 349–364
Weber, Max, 350
Wednesday Psychological Society, 11, 551–552
Weinshel, E., 397
Weir, Peter, 539
Weiss, Edoardo, 11, 12, 312
Wernicke’s aphasia, 447
Westen, D., 118, 275, 276, 277, 333, 414
“What’s American About American Psychoanalysis?” [Mitchell and Harris], 213
Whistling, 561
White, Mary, 30
Whole object (Klein), 174, 183, 587
Widlocher, Daniel, 379–380
“‘Wild’ Psycho-Analysis” (S. Freud), 532
Wild Strawberries, 542
William Alanson White Institute, 22, 212
Williams, Bernard, 473
Williams, Paul, 171, 484
Winkelman, P., 450
Winnicott, Donald W., 24, 26, 31, 69, 72, 106, 162, 174, 200, 213, 263, 272, 310, 498, 525
concept of defenses, 123
concept of false self, 248n
concept of holding environment, 291, 344
concept of intermediate space, 531
concept of play, 516, 527, 531
concept of regression, 292
concept of resistance, 290

 matéria مادة بموجب حقوق النشر
Winnicott, Donald W. (continued)
concept of transitional objects, 179, 530–531
film studies inspired by theories of, 546
intersubjectivity and, 109
object relations theory of, 176, 179–180, 216
theory of mother–infant
interaction, 69, 111, 162, 179–180, 243, 244, 291, 430, 456, 513, 559
theory of transitional experience
and potential space, 296
view of analyst’s role, 292
view of countertransference, 85, 260–261
view of psychoanalytic process, 291–292, 295
visual arts and, 530–531
Wish fulfillment, 188
dreams as, 10
hallucinatory, 188, 574
Wishes, 40. See also Motivation
ungratified, 310
Wittgenstein, Ludwig, 42
Wolf Man case (Freud), 304–305, 313, 314, 315, 485
Wolf Man’s Magic World. The
(Abraham and Torok), 515–516
Wolf, Peter, 454
Wollheim, Richard, 474
Wolstein, B., 262
“Womb envy” [Horney], 486
Work ego, 82, 83
Working alliance, 67, 257, 287, 587. See also Psychoanalyst–
analysand interactions/relationship
Working-through, 62, 408, 587
resistance to, 99
Yankelovich, D., 353
Yanof, Judith A., 333–346
Yolngu mortuary rites, 483
Yurok culture, 479, 480
Zetzel, E. R., 163, 307
Zizek, Slavoj, 544
Zweig, Arnold, 509
Zweig, Stefan, 526
The second edition of this renowned textbook makes it even more secure in its place as the outstanding overview of American psychoanalysis. Each chapter is written by an expert in its area, and Gabbard, Litowitz, and Williams have done a remarkable job in ensuring the combination of comprehensiveness, depth of understanding, and readability. The book is more than a textbook. It is the single most complete and authoritative presentation of psychodynamics and psychoanalysis available. Everyone should have it on hand."

Sydney E. Pulver, M.D., Training and Supervising Analyst, Psychodynamic Center of Philadelphia, Philadelphia, Pennsylvania

"Philosopher of science Ludwik Fleck classified the transmission of scientific knowledge into four types: journal science (shared by a professional group); handbook science (technical guides for carrying out practical procedures); popular science (for the general public); and textbook science (repositories of established current knowledge, used to teach and transmit that knowledge). Traditionally, textbooks have played a lesser role in psychoanalytic training as transmitters or encoders of the field's received wisdom than they have in other clinical fields. However, this volume will be an exception. The breadth of its subject matter and the diversity of backgrounds of its contributors not only captures but significantly expands the body of accepted psychoanalytic knowledge. It is not a volume to be kept on the shelf but deserves a place chairside for every psychoanalytic clinician, researcher, and contributor. Congratulations to the editors for their achievement."

Arnold Richards, M.D., Training and Supervising Analyst, New York Psychoanalytic Institute

"It is quite possible that if given a choice of only one volume with which to spend a summer on a deserted island, this would be the one I'd choose. The breadth of this compilation is tantamount to a summary text covering four years of analytic training seminars. It explores psychoanalysis' roots, the history of its core concepts, both "old" and "new", its emergent multiple schools of thought demonstrating their influence on both theory and technique, and finally the extraordinary importance of psychoanalysis to research, philosophy, gender studies, infant development and attachment theory, and the arts. This book brings the psychoanalytic reader, whether neophyte or ancient traveler, up to date with many of the canon's greatest ideas. In so doing, it is an indispensable teaching tool. Bravo Gabbard, Litowitz, and Williams!"

Philip A. Ringstrom, Ph.D., Psy.D., Training and Supervising Analyst, Institute for Contemporary Psychoanalysis, Los Angeles, California

The only comprehensive textbook of psychoanalysis available in the United States, the Textbook of Psychoanalysis was written with both the beginning student in the mental health care professions and the practicing analyst in mind. In a single volume, the editors have compiled contributions that cover the history of psychoanalysis, the major theoretical models, and all facets of treatment and technique. This pluralistic approach is consistent with the conceptual and clinical diversity of contemporary American psychoanalysis, the focus of this newly revised work. The book also reflects the exponential increase in research activity within psychoanalysis, and the section on research is both up to date and substantive. Also current and extensive is the coverage of the interface between psychoanalysis and other disciplines, such as neuroscience. This interdisciplinary emphasis is one of the many strengths of this new edition. The editors have created a format that logically and painlessly educates and engages. No other volume offers the range of topics, the depth of coverage, or the accessible writing style of this groundbreaking text.