the CANDIDATE
Perspectives from an Evolving Psychoanalytic Community

Becoming

Volume 2

December 2007

www.thecandidatejournal.org

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Rachel L. Blakeman, JD, LCSW, and Hilary R. Hatch, PhD

In January 2007, after two years of culling submissions from around the country, we published Volume 1 of *The Candidate,* titled "Beginnings." We envisioned ourselves as activists, creating a scholarly forum for candidates and analysts to discuss psychoanalytic education. We believed that encouraging candidate involvement in psychoanalytic discourse earlier in their careers would fundamentally alter their training experiences, and thus change elements of the current psychoanalytic culture that stifle creativity in the field. We wondered if individual institutional politics hindered the emergence of progressive ideas about psychoanalytic education, and perhaps also inhibited graduate analysts from engaging in written discourse about their own training or experiences as faculty.

Along with these aspirations came the fears and anxieties that we, as candidates, were not sufficiently innovative or scholarly to engage a sophisticated psychoanalytic readership. Following publication of our inaugural volume, we received congratulatory emails from analysts around the world. This widespread community support was evident at our launch party, attended by the most junior candidates to the most senior analysts, with diverse institute affiliations. Their generosity funded our second volume. The energy and enthusiasm generated by *The Candidate's* launch stand in dramatic contrast to the ongoing concerns about dwindling interest in psychoanalytic training and in psychoanalysis itself. The 2700 individual users who viewed our website are further evidence of the emergent curiosity in the field. For one fleeting moment, we enjoyed our success and imagined the second volume would all but publish itself.

As we began work on Volume 2, entitled "Becoming," we were unprepared for the significant challenges, anxieties, and ambivalence that accompany becoming. The topic for Volume 2 reflects our interest in exploring the process of becoming a psychoanalyst, the progression through training culminating in a new identity, transforming from candidate to psychoanalyst. Simultaneously, at *The Candidate*, we began the transition from "beginning" to "becoming," sustaining and furthering interest in an annual journal. From the journal's inception, we realized that the editorial board would graduate and new candidates would become active journal members. We knew these transitions required the continuous cultivation of new leadership and worried about the long-term survival of the journal. As the founding editors, we were proud of *The Candidate* and anticipated its success well into the future. Like parents, we helped build a strong foundation, but knew that the future of the journal was not ours to decide. After the launch of the first volume, we welcomed many new members onto our editorial board and the group elected two co-editors-elect, Abby Herzig and Sharon Lavon-Krein, who both would collaborate with us in creating Volume 2 and beginning to plan Volume 3. The significant contributions of new members are reflected in this second volume, in the expanded Video section (under the able leadership of David Cole), and the new Culture Desk (innovated by Chap Attwell, Sol Bankier and Leslie Cummins).

On a personal note, during this same time period, we struggled with our own "becoming." We terminated our analyses, with an incredible sense of personal growth,

autonomy and accomplishment, as well as feelings of sadness and loss. We became mothers (Hilary for the first time and Rachel for the second), creating a new bond with each other and a new level of intimacy with our supervisors and instructors, as our personal lives became more a part of our therapeutic relationships. We experienced the inevitable conflicts of redefining our balance of career and family. We "completed" the requirements of training cases and supervisions with a sense of satisfaction, but with some confusion about what it means to feel competent as a psychoanalyst. We wondered how others experienced the unique stage of senior candidacy where one is no longer in class, but not yet graduated. We learned that many colleagues, also ambivalent about graduation, looked to the faculty for feedback and experienced versions of the following – all speaking to the difficulties that are inevitable for both teacher and student in becoming: Some faculty held out an encouraging attitude of "I welcome you as a colleague" (read, "I see you as someone who is now able to be as confused as one needs to be as an analyst without despairing completely"). However, many colleagues were told – as seniors – that they had not quite reached some expected level of competence, which was not – and could not be – articulated in exact terms. Even at our own institute, which we both have found to be quite encouraging of candidates, many candidates have reported hearing variations of "Why the rush to graduate?," as if the truly well-analyzed candidate would be above such mundane personal aspirations! Glick and Cabaniss argue in their paper (this volume) that the ambiguity of progression and graduation requirements leads to unnecessary shame-inducing experiences for candidates.

Our identity as editors of *The Candidate* allowed us a unique perspective on our own experiences in psychoanalytic training. We learned not to accept the logic of "this is how things are done because this is how they have always been done." When candidates experience such ambivalent and varied responses from our educators, we suspect this reflects a larger tension within the field, one that, in this case, manifests itself around the "gatekeeping" points in psychoanalysis: admissions, progression, graduation, certification, and becoming a training analyst. The latter two are hotly debated issues in the field at present. We wonder how these experiences impact us personally, as clinicians, and how they impact the psychoanalytic community. How fortunate we are in the history of psychoanalytic education to be training now, in an era when these discussions abound not only at *The Candidate*, but also in many institutes, national and international professional organizations, and in books reviewed in this volume.

The papers and the panel in this volume reflect the individual's experience of *becoming* a psychoanalyst. Fern Cohen's paper, "A Candidate's Dilemma: To Say or Not to Say, To Do or Not to Do," initially written when Cohen was a candidate and revisited for this publication 10 years later, offers a unique perspective of transitioning from the beginner to the established. Her paper not only explores the interesting dynamics between patient and analyst when, after significant internal deliberations, Cohen offers her patient a blanket, but also demonstrates the complexities created by her having done so as a supervised candidate. In "Oedipal or Preoedipal, Is That the Question? Attempting Integration as a Psychoanalytic Candidate," Michal Talby-Abarbanel discusses splits in psychoanalytic theory and practice as she reconciles two very different training experiences, one in Israel and one in New York. Marianne Goldberger recounts her supervisory experiences with Paul Gray, an esteemed mentor and outstanding teacher and later a close friend and colleague. Each author wrestles with an emerging identity, both derived and distinct from her supervisors and analysts, role models and mentors.

The panel in this volume addresses the topic of "Shame in Psychoanalytic Training." Responding to questions proposed by Sandra Buechler, authors address shame from different perspectives, reflecting on the poignant and painful shame so often associated with "becoming" in the course of psychoanalytic training. In her paper, Buechler writes about the destructive legacy, both personal and institutional, of shame in analytic training. She describes sitting in silence while a fellow candidate is humiliated before the whole class. To quote her:

> Part of the legacy of this experience is the painful feeling that in my silence I collaborated. The feeling that one has collaborated in being shamed oneself, or in allowing another to be shamed, can be especially damaging. The candidate who sits in silence as her work is trashed in class, or in supervision, goes home with the shame of feeling exposed but, perhaps even more painfully, the feeling of having betrayed herself by not standing up for herself. I believe that this can be one of the most damaging shame experiences in training (or elsewhere).

We attribute much of our educational, professional, and personal growth to the collegial environment created by the faculty, authors and advisory board members of *The Candidate*. Our admired teachers, Donald Moss, Stephen Reisner, Joseph Reppen, Arden Rothstein, and Jennifer Stuart, demonstrated through example what could be accomplished in the absence of shame and overly hierarchical learning environments. They not only provided us with an unparalleled learning experience, but also offered their friendship, for which we are extremely grateful. Projects similar to *The Candidate* cannot flourish without a nurturing environment, as was created by our beloved mentors.

Most candidates train with a cohort (often a training class). In the best cases, they receive support from this cohort. *The Candidate* strives to be an institutionalized, inclusive cohort of sorts, welcoming all candidates – present, past and future – to engage, discuss, agree, disagree, and ultimately to foster education, growth and creativity in the field of psychoanalysis. For those of us who believe that one is always a student of psychoanalysis, even though not forever a candidate, we welcome you to this new volume.

A Candidate's Dilemma: To Say or Not to Say, To Do or Not to Do

Fern W. Cohen, PhD

But even while we are talking and meditating about the earth's orbit and the solar system, what we feel and adjust our movements to is the stable earth and the changing day. – George Elliot, *Middlemarch*, p. 504

Above all, technique is pragmatic. We do what we do not because it is elegant, or integrated, or aesthetically pleasing, but because it works. I am suggesting that in actual practice most analysts, under the powerful impulsion to do what will be helpful to their patients, metabolize theories, taking from each what best fits their personality and style. – Sydney Pulver, *JAPA,* 1993, p. 342

Over the long and arduous course of analytic training, a candidate undoubtedly will arrive at a model of a psychoanalytic process that has both theoretical and clinical roots. Still, for each candidate, an evolving sense of competence will entail an ongoing struggle to find, adjust and maintain a balance between those roots and the emergent analyst self. Ideally then, toward the end of training, a candidate has not only recognized that he or she is engaged in a process that cannot be absolutely taught for any individual patient or pairing of analysand and analyst, but also has accepted, if not embraced, a model of psychoanalytic process that is forever about *becoming* and tolerating a tension between the known and the unknown.

This aspect of training seems most elusive, perhaps a worthy trademark of the "impossible" profession we have chosen or which may have chosen us. Despite our best efforts to inform ourselves, in the immediacy of the here and now, we are so often confronted with patients who pressure us to speak when we would be silent, who silence us when we would speak, or impel us to act when we should interpret instead.

Among such moments, I am not referring to situations of crisis or extreme clinical difficulty but to our daily efforts, which we have no time to explore given the issues of magnitude or urgency that usually lead us to discuss or write about our work. Of necessity, in-class reporting or supervisory groups tend to be anecdotal or quickly sketched to illustrate a point, which in turn deprives us of exposure to the depth and breadth of our work – from its lightest to its most profound and deeply moving moments. Even when we do attempt to capture who we are or how we behave with our patients, regardless of those who might look over our shoulders (our analysts, our supervisors, our colleagues, or our ghosts), by focusing on one session or experience, we may unduly overemphasize or distort a figure in the overall landscape created by analyst and analysand, a landscape with its unique shared vocabulary, history, and resonances. This is especially the case when we discuss our mistakes, from which we may learn the most.

Toward the end of my training, it was just such a "mistake" that I decided to write about, often the best way for me to understand and metabolize something out of the ordinary that has occurred (positive or negative). Not long before, I had had my first article accepted by a journal about a different experience with the same patient (Cohen 1992), and I was on a roll. It seemed that I might be able to realize a long-standing wish to capture in writing, and illuminate if

possible, what actually goes on in clinical work – even if a less-than-optimal occurrence is its precipitant. This time, the instance occurred three years into the psychoanalytic treatment of Dr. Z, when I became very conflicted one evening in session, even obsessed, about what to do in response to her frequent complaints that the office was cold – as it was. After considerable internal debate, torment really, I did offer her a blanket, which she accepted with a casual "thanks," then continued to associate as she had been before. I, however, immediately became consumed with disproportionate worry that I had made a "mistake" by acting instead of interpreting. I was concerned (if briefly) that I might have done something to derail what had been until recently an extremely difficult treatment, one dominated by Dr. Z's anger and bitter despair.

Several weeks before the session in question, I had noted to my supervisor that Dr. Z seemed to be settling in with noticeably less rage. Although I still did not know when or what would prompt an explosion, I was noticing a corresponding lessening of the tension and sometimes dread with which I had come to anticipate our sessions. I even was beginning to feel some relief. Not only had Dr. Z's bombardments permeated the treatment, on a global level they had exacerbated my anxiety about whether I could ever help her, which, at that stage of my training, translated to whether I could ever be a "good-enough" analyst – for her or anyone else. Thus, with this seeming benevolent shift, even the fleeting thought that I might have done something detrimental made me anxious that I might be repeating a familiar tendency to subtly spoil or sabotage something at a moment of "success." In my analysis, I was discovering that the "spoiler" was often an action that I consciously intended in a positive way but was instead a subtle bending of the rules, which in turn became a "mistake" that contained the punishment for the perpetrated crime. Was my offering the blanket one of these? This question was among many in the currents that flooded me after my offer of the blanket, causing me considerable distress. Fortunately, I was able to ride them out as Dr. Z continued to warm up the session (puns intended), bringing me along with her.

It did not take long to recognize that my action was not destructive, as I had feared. Nevertheless, it was an action and as such, a departure from a usual analytic stance. This immediately raised the more-than-likely probability that it was a mistake I surely needed to understand more about. At the same time, as I was writing about the background to set the stage for what actually occurred, I was struck by the extent to which that session seemed to encapsulate my struggles as a candidate to juggle the colliding imperatives of theory and practice. Even more, I was struck by the remarkable degree to which I had identified my work with Dr. Z as the proving ground for whether or not I could become a good-enough analyst, undoubtedly evoked and intensified in the context of her periodic challenges to me that treatment was "bullshit" and I was imposing my "rules" on her.

And so, reassured that Dr. Z's treatment was continuing to unfold as it had before I offered her the blanket, I began to write, with the conscious intention of understanding more about what I perceived at the time to be a mistake. At the same time, I was beginning to recognize that my dilemma in that session with Dr. Z had to do with my efforts and increasing ability to disengage from my authoritarian sense of the analyst as the one who "knew," much of this a residual of the five-times weekly classical psychoanalysis I had undertaken as a college student. It had been extremely beneficial to me, and even changed the direction of my life. Still,

for years after that termination, I little realized that I had come away with an over-idealized version of the/my analyst as the authority. So much so, that when I found myself, in midlife, plunged into analysis again and then analytic training, I was still imbued with the idea that only if and when I mastered "the rules" of those who knew, and shaped myself to their standards, would or could I be a good-enough analyst. Obviously, this was about my transference to authorities and my woeful lack of understanding of analytic process as opposed to rigid technique. Over the long haul of my current analysis and training, I was discovering that I could become someone with her own good-enough style and manner without being compelled to imitate "those who knew."

Yet another factor contributing to my authoritarian perspective of the analyst had to do with timing and evolution, inasmuch as my experiences in psychoanalysis more than 20 years apart coincided with a generational and developmental shift away from the psychoanalysis of the '50s and '60s, when the idea of analyst as a neutral, opaque mirror had been carried to such distorted proportions by some (particularly in America) as to almost obliterate acknowledgment that a two-way, human relationship existed. This was the model with which I had identified and to a large extent, internalized: Not only was the analyst an authority in relation to the analysand, countertransference, initially formulated by Freud and further elaborated by Reich (1951), was still viewed primarily as the analyst's unresolved neurotic conflict.[1] As for dyadic interplay, enactment, or intersubjectivity, in the '50s and '60s the psychodynamic meanings of the words did not exist.

Given the unrealistic, even god-like authority I had granted to the analyst, the potential to contribute beyond thought-out and well-articulated interpretations or to feel any freedom to be myself was particularly daunting to me, an austere perspective that allowed little room for error or anything out of the frame. Consequently, I was pained by mistakes, excruciating evidence of what I did not know. Fortunately, my experiences and analysis had begun to open up alternative possibilities: A lot of what I learned had settled – a sediment from which particles of freedom floated up, now reassuring instead of only humiliating. Indeed, a large measure of the grounding I was beginning to feel as an analyst related to my budding comfort with *not* knowing, as well as some tolerance for "mistakes," which in the past triggered doom and shame. Gradually, I was realizing that one might be and use oneself in a unique, responsive manner within each analytic dyad – the epiphany that I hoped to convey when I began to write about Dr. Z. Revisiting that version and revising it now, more than ten years later, it is clear to me that even then, I no longer really cared whether, or even if, I had made a mistake. Instead, I wanted to write about analytic process and to illustrate one candidate's struggles on the way to becoming her own person, and to reach her ideal of becoming a good-enough analyst.

There had been other landmarks along the way. Long before the session in which my conflict about offering Dr. Z a blanket arose, I had broken with classical technique, at least when it came to the matter of answering questions. (In that tradition, the analyst never answered a question and rarely asked one.) In fact, my answering questions had become a theme very early on in the psychotherapy that Dr. Z had grudgingly undertaken as a last resort because she was in

[1] For a concise yet thorough summary of the evolution of different meanings of countertransference, see Pierre Doucet (1992).

such great distress and acute crisis. At that time, *not* to answer questions would have been inappropriate. When we began, she was struggling on every front – with complex health- and work-related issues that had not only impaired her ability to function, but also left her in a state of despair and anger characterized by extreme distrust and hostility that bordered on the paranoid. All of this had had a direct bearing on the manner and style with which I handled her questions, and we had forged a pattern early on in which I often answered Dr. Z's questions in a matter-of-fact way, which to my surprise, seemed to fuel the treatment along. Dynamically speaking, it seemed that if I gave to Dr. Z, she would give back to me.

For instance, once she caught me off guard when she asked whether the coffee she had seen me carry through the waiting room moments earlier was instant; it smelled "so strong." Surprised by the spontaneity coming from someone who typically waited several minutes before she could overcome her struggle to speak, I told her, while inwardly gulping, that it was not and wondered aloud why she asked. My answer (admittedly a countertransferential surge of self-defense lest anyone would think I would stoop to drinking instant coffee) seemed to facilitate a rare flow of associations from her.

Dr. Z had been raised in an environment of social and emotional parental indifference and ineptness that bordered on disavowal, convincing her that she was destined to remain in the same alienated and incompetent state – whether in her relationships, or in her ability to deal with the practical necessities of life, such as providing sufficient food at mealtimes, buying suitable or attractive clothing, even finding ways to negotiate a city. But despite these mysterious and neglected facets of her childhood and adolescence, she certainly knew how to brew coffee. Describing the supermarket blend she used and her disdain for fancy gourmet blends, along with a detailed outline of the steps, Dr. Z punctuated her instructions about making coffee with a rhetorical query about why her two closest friends, to whom she had given all the identical particulars, still couldn't make good coffee – and by inference, of course, me.

At that time, I had been astounded and bemused at the unusual flow of material. Although Dr. Z had settled somewhat less angrily into treatment, her relation to it and to me continued to be guarded, permeated with both fear and resentment. A large part of the transference alternated between her version of me as her inaccessible, emotionally fragile yet competitive mother, and her grandiose father, who often criticized or humiliated her. This, too, was on my mind as I listened, cognizant of how little Dr. Z ever said directly, either about her relationship to me or any feelings she might have, positive or negative. Whatever associations or references she did make were usually indirect or so metaphorically obscure that an interpretation from me about transference could only seem wild and give her the opportunity to remind me, yet again, that we had no relationship: What made me think that we did, since I never answered her questions or gave her advice? How could we, since I sat behind her, could not see her or she me, and she spoke to the ceiling, while I remained detached and followed my rules? I should add, this was in the context of practical, everyday material that begged for a response. Early on I had commented to Dr. Z that however tempting it might be to give her advice, this was not my role; in the long run, it would be more useful to help her understand herself and thus free her from a past that she angrily feared doomed her to isolation and alienation. By the time of which I write, for all Dr. Z's continued occasional jabs, they no longer had any sting. If anything, there were times when I felt like a parent of the toddler who shakes his head "no" in protest but ends up

going along with his or her parent with equanimity. (I do not mean this at all in a condescending way but to try to capture one aspect of the relationship that had evolved between us.)

As Dr. Z continued to wonder about her friends' perceived inability to master the art of coffee-making, I began to wonder whether she might be offering a similar caretaking gift of instructions to me, while at the same time suggesting that, like them, I was incompetent. Competence was something about which we both thought a great deal, part of the strong empathic identification I had made with her from the start. Not only was she struggling to belong in her field as I was, she, too, worried about failing or not measuring up. These were characteristics we shared in relation to our fathers, whose involvement and commitment to work had left us each, for quite different reasons, feeling excluded, unimportant and highly over-invested in the value of work as a primary source of self-worth. This also made me more vulnerable to the intensity of Dr. Z's attacks.

Although her coffee-making instructions and implied suggestion of my incompetence begged for interpretation, I kept my thoughts to myself yet again, although it seemed that we were getting much closer to a time when I could speak up more. For all her ambivalence, Dr. Z had made a despairing, if angry, commitment to treatment. If it was still stormy and often uncomfortable for us both, she had begun to complain less about talking to the ceiling; and even while she denied that we shared any significant emotional connection, she began to talk more about why it made her so angry each time she lay on the couch. Most important, she noticeably was raging less, crying more, and feeling somewhat better about her life, if not yet, herself.

Thus, by the time of the session I am about to detail, I had begun to consider that perhaps the tidal wave of anger that characterized our first few years was receding, leaving in its wake a chronic low-keyed baseline of depression, sadness, and narcissistic depletion, which had begun to include a regressive pull to sleep so profound that there were times I felt like I was sitting with a sick child. Clearly, the treatment was deepening, underscoring how much we had both grown and changed, undoubtedly contributing to some increased confidence on my part, of which I could not let myself be fully aware at the time. That, coupled with the excitement about how far we had come, undoubtedly prompted me to offer a blanket to Dr. Z.

Here's how it came about.

Returning to my office five minutes prior to her evening hour, I found Dr. Z at the entrance to my office, waiting for me to let her in. She frequently arrived for this session before me and was invariably immersed in a book, seemingly oblivious of anyone or anything. However, once aware of me, she usually tried to hold the heavy street door open as I struggled to get my key in the lock, juggling briefcase with my obligatory cup of coffee. Although I rarely drank it during session, it was a habit I believed I should rid myself of, a corollary of my efforts to be appropriately contained. This had been a significant subtext in my work with Dr. Z, who frequently complained that I was bland and non-responsive, the opposite, in truth, of how I felt myself to be.

On this evening, bundled up with earmuffs and winter attire, Dr. Z greeted me with a cheerful comment that it was cold, followed by a humorous sound to imitate the shivers, a cross

between a Bronx cheer and a *brrrr*. As I let us both into the waiting room, I was struck by the marked contrast between her cheerful street demeanor and her subdued and flat affect once she was on the couch. Not long before, I had commented on this to my supervisor, who asked me if Dr. Z made eye contact, a question which made me realize that she rarely did, despite her cheerful greetings or the up-beat sounding messages she occasionally left on my answering machine.

With a few minutes to spare, I closed the window that I had left open earlier in the day, hoping to cool my invariably overheated office. Typical of the pre-World War II apartment building in which it was situated, my office was always hot, and in the 10 years during which I had occupied it, I had not once turned on the radiators. But now, it was very cold. I had been gone several hours and during my absence, the winter chill had definitely settled in. In fact, as I led Dr. Z into the office and she headed toward the couch, she chanted in a friendly exclamatory voice, tinged with surprise. that it was cold – to which I agreed, with a casual reassurance that it would soon warm up. It always did.

Settling herself on the couch, Dr. Z surprised me by starting right in with a few excited comments about the coming eclipse, which she was surprised to have forgotten. She was reminded by the activities across the street at the Planetarium, which my office faced. Without pause, she reiterated that it was cold and thought that I must have left the window open in order to get rid of the smell of smoke, although it had been a long time, she added, since she had detected any smoke in the office.

Continuing her foray, she then picked up on material from several sessions earlier when she had raised a number of work-related incidents that involved smoking, among which was a battle with Nancy, a secretary who had flouted the "no-smoke" rules of the institution in which Dr. Z worked. She found Nancy's flagrant violation offensive and frightening because she suffered from a chronic lung condition that was aggravated by smoke and because it meant confronting Nancy, known to be provocative and hostile.

Despite Dr. Z's greater professional status and authority in relation to Nancy and most others with whom she came in contact at work, she had difficulty asserting herself because she was convinced that any assertion would be interpreted as a criticism and provoke a retaliatory attack. Over the course of previous sessions, we had explored the considerable anxiety stirred by Dr. Z's wish to be outspoken and direct. At some point, I had commented that she seemed to anticipate that all exchanges could only escalate to confrontation instead of discussion or negotiated truce. Perhaps, I continued, she felt unprotected and helpless in those situations as she had in her family. Her parents could not tolerate any conflict among or between their six children (Dr. Z was the oldest) and they would either dismiss or criticize any complaints as inappropriate or hostile. This was typical of their inability to deal with anything emotionally charged, especially the intense rivalries among their children, desperate to get what little emotional support they could from an environment that was spartan and withholding. As adults, it seemed that Dr. Z bore the brunt of her siblings' resentment and aggression, evidenced by her frequent exclusion from family events. Much of this was in retaliation (I believe) for their resentment toward her as the first child, who seems to have received what little their mother was capable of giving before she became increasingly depressed and withdrawn.

After a fairly long pause, Dr. Z reluctantly admitted that she was relieved and surprised that she had handled the recalcitrant and hostile secretary well. In this instance, her reluctance about telling me something positive also pertained to her ever-present anticipation that I would disparage or fail to appreciate its import to her – as her parents usually had. But, she added, although she remained anxious about a future retaliatory attack, she had not only emerged unscathed, but held her own and was proud of having met the enemy as she had. At the least, she and Nancy seemed to have reached a respectful truce, a reflection, it seemed to me then, of where she was in the treatment with me. Although I was tempted to comment on this, I did not, having learned from painful experience with Dr. Z, that less was definitely more. Also, I did not want to interrupt the flow.

Musing more about smoking and the possible repercussions or harm that might come her way if she continued to confront the considerable number of die-hard smokers at work, Dr. Z described yet another experience of having vanquished a smoker, paused, then switched gears more directly back to smoke and to me:

> I remember that I said something to you a long time ago ... about not liking it in here because there was often the smell of smoke. It seems to me that the disappearance of the smell followed closely on my complaint ... (pause) ... I can imagine that you would not smoke around me ... it takes more than that to get stale cigarettes out of a room.

After a pause, she continued:

> It is cold in here ... (pause) ... perhaps there is some way you have of eliminating smoke ... although I think I'd know if there was smoke in here ... I'm not sure though ... it seems to me that you must have stopped smoking ... it would be an amazing thing if you had stopped smoking.

Dr. Z was right, at least about the smoke. At the time she began treatment, I had several patients who smoked and it had become annoying and increasingly difficult to clear the room. Gradually, with more patients on the couch, and assertion on my part as I became more comfortable with their potential anger, none of my current patients smoked in session.

Nor did I. Although the evidence of smoke early on led Dr. Z to assume that I was a smoker, about that she was almost wrong. Years before I began to work with her, on rare occasions I had smoked, but never inhaled, so for all intents and purposes, I did not consider myself to be a smoker. This was something I shared with my father – who had never smoked, but did occasionally puff on unlit cigarettes, which often led people to assume that he did. Thus, when Dr. Z incorrectly assumed that I smoked, I was amused at the parallel to my father – a link that undoubtedly first brought him into the session as the unwitting source of the blanket I subsequently began to think about offering to Dr. Z – who, meanwhile, continued to associate.

> It would be a pretty amazing thing if you had stopped smoking. I tell my students ... if you stop smoking, it will do more for you than anything that I can teach you. If you stopped smoking and allowing others to smoke in

this room, it would be an enormous thing you did for me and an enormous thing I did for you ... it would be too big to measure ...

Among the few direct remarks Dr. Z made about me over the course of our work were her periodic expressions of concern and annoyance that I did not take sufficient care of myself. She had concluded this because of the frequent number of times I blew my nose during session, particularly in winter, which she incorrectly attributed to a cold. A knowledgeable person about health matters, she seemed completely oblivious to other possibilities, despite the absence of other cold-related symptoms, such as coughing or sneezing. As with her assumption that I smoked, Dr. Z was as convinced about my poor health as she was in denial of any specific transference meaning I periodically offered, such as her anxiety about her elderly parents who now required a considerable amount of care-taking, compounded by memories of her father's hypochondria, which had commanded much of the mother's time and attention. This had left Dr. Z and her siblings feeling that their needs came last, as in actuality, they often did. Again, the matter of a father commanding interest and attention, albeit for different reasons, was something I shared with Dr. Z.

When she first began to complain about my health, my response had been primarily focused on her anxiety that I would not be strong enough to contain her anger, let alone take care of her, a wish Dr. Z had suppressed and dealt with through denial and reaction formation, i.e., taking care of others instead. This was also an extreme defense against her unconscious fears/wishes about hurting me, a dynamic that we had not yet fully explored.

Similarly, still in the background were the consequences for Dr. Z of her mother's depression and the resulting preoedipal issues of poor self-esteem, self-regulation, and the sense of herself as dangerous or damaging – all which contributed to her reluctance bordering-on-refusal to acknowledge even the most sparing interpretation – unless it was patently obvious. As a result, these had been few and far between. As if these constrictions were not enough, Dr. Z was determined to figure things out on her own.

For example, on those occasions when she had figured something out (often months after an interpretation that she had initially protested or denied), if I reflected it back choosing different words or adding something slight, Dr. Z would remain silent. Only recently had she explained that her lack of response at those times pertained to her angry conviction that I was trying to correct her or prove my superiority. In either case, it spoiled the moment for her: If she allowed me to help her, I would take the credit or show off my virtuosity, as her mother often did, or worse, she might become dependent, a fate to be avoided at all costs.

In response to Dr. Z's anger about what I intended as mirroring remarks, I agreed that perhaps there were times when I should have remained silent. But as she became able to articulate her feelings, I could interpret that my remarks, which she heard as the one-upmanship of her mother, might also reflect some satisfaction we could share about her having figured something out. But as I have said, such moments were just beginning to occur, and why I was so taken with the tone and content of the session underway.

... stopping smoking is hard ... I still think about it sometimes ... I

> want to smoke sometimes still although it has been more than five and a half years since I stopped ... my parents house has always been cold in winter ... it was always cold because my father kept the heat so low ... it got cold enough so that even sitting in bed at night, under the covers, it got too cold to read ...

With her angry and tearful comments about how cold her father had kept the house and how painful it had been to be deprived of the profound comfort of reading in bed at night, Dr. Z and I were more than halfway into a session during which I had said little except for my comment that it would soon warm up – about which of course, I was wrong.[2] More important, despite Dr. Z's legitimate remarks about the cold, none seemed to warrant a comment, particularly in view of the remarkable unfolding of material thus far.

Still, I was feeling somewhat nonplussed by the paradoxical nature of the situation. If Dr. Z's complaints about the cold were reality based, they had also given rise to many of her associations and enriched the hour. At the same time, despite the warm outer layer of down jacket and earmuffs she had been wearing when we met outside the office, now she wore only a short skirt, lightweight sweater, and thin stockings, which scarcely seemed to provide any protection. I, in contrast, wore a thick sweater and warm slacks, which reinforced an overall sense of Dr. Z as exposed and vulnerable while I was not. It was this contrast that undoubtedly prompted me to ask at her next mention of the cold, whether she might want to get her coat from the waiting room. However, she declined and continued to associate, this time with an unusually poignant and tearful description of the depriving and punishing cold in her father's house.

It was during this segue that I again thought to ask Dr. Z whether she might want to get her coat, a thought immediately supplanted by the memory of the small woolen blanket in my office closet, along with a few other items that belonged to my father, who had died five years before. An insomniac, he sometimes used the blanket in Chambers when he catnapped, driven by exhaustion to catch up on sleep. For me, it was a comforting transitional link to the legendary father who had been distant because of his dedication to his work, but human enough to nap, no less, with a blanket. So I had kept it, pleased to have it, along with a vague idea that I might use it occasionally between sessions – a fantastic notion, really. There were too many obvious Freudian implications and I was still struggling to free myself from the man held in such esteem by his colleagues and clerks, including one who had remembered him fondly at a memorial service as the man for whom "good was never good enough, better always the goal."

For Dr. Z, however, it was another matter entirely. When I first thought to offer her my father's blanket, I inwardly smiled at what seemed a spontaneous, even playful gesture. Just as quickly, however, my delight turned to concern about something so impulsive and unthought, and I tried to push the idea aside. This was exacerbated by the distrust of the warm and congenial feelings I often felt toward my patients, a counterpoint of the earlier versions of the

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[2] *Why* it never occurred to me to turn on the radiator gets into the obscure domain of unconscious compliance -- although on a manifest level, I do believe it was simply force of habit. In all the years in my office, I never turned the radiators on. In fact, flying in the face of reality, I often tried to turn them more off than they already were in my sometimes desperate efforts to rid the room of heat.

austere analyst that I had over-idealized. Although I certainly knew otherwise by then, old habits die hard. For someone who had been "raised" in the classical model of psychoanalysis and its associated abstinence, it was words and interpretations that "cured," not actions with the analyst, who should remain a mostly silent partner and not a participant in any emotional sense. Even assuming that it was possible to know one way or the other with any certainty whether the offer of a blanket might be a mistake, the internalized still-abstinent analyst inside me, with her absolute standards of right and wrong, was already convinced that it was. Once that kicked in, it kept me from entertaining other possibilities, such as what I might be enacting with Dr. Z (e.g., embodying the depriving parent if I did not act, or acting as the good-enough mother if I did). But what is reason against the forces of our unresolved conflicts and ghosts? In my case, such an action would undoubtedly be an indulgence, perhaps a breaking of a "rule" and, therefore, unworthy of a mature analyst.

These very thoughts must have contributed to the growing pressure to act. Despite her complaints and the fact that it *was* cold (perhaps because of it), Dr. Z had definitely thawed: She was freely associating and the material was deepening, while I was in a state bordering on mild exhilaration. Was this an aberration or a transition from a predominantly dolorous minor key to a relative major key, with potential for light and even joy? It seemed likely that it was the latter, indicative of the shift I had already noted in supervision, hoping it was not wishful thinking on my part. Whatever it was, I stayed my tongue, hesitant to intrude, feeling more relaxed than I had ever been with Dr. Z, who continued to surprise and delight with what seemed a wonderfully ordinary analytic session. Despite the cold, Dr. Z was on a roll and taking me along with her – except, of course, for the growing tension about whether or not to offer her a blanket.

Basking in the unexpected glow halfway through a session that I had despaired would ever occur with her, I became increasingly consumed with the idea of whether or not I should offer my father's blanket to Dr. Z. How could I ignore the cold since she kept legitimately reminding me of it? In my desperation, I even wondered whether my thoughts about an offer might be an attempt on my part to ward off her volcanic anger, but this session clearly was not about that. Besides, her comments were more along the lines of interlocutions, although I knew from painful past experience that this type of seemingly benign comment could be misleading. More significant was my increasing awareness that Dr. Z's complaints about the cold were reality based, unlike so many others that were inextricably bound up in her anger at being in treatment and her anticipation that I might abandon her or fail to protect her as her remote and critical parents had.

What is most striking to me now is the degree to which Dr. Z seemed comfortable ignoring the cold at the same time that she kept reminding us both of it. That, of course, was the repetition of her past that I did not recognize, grappling as I was in the moment with conflicts of my own. In either case, if Dr. Z was ignoring her discomfort, I increasingly could not.[3] Thinking that she had probably incorporated this facet of her parental neglect, I began to wonder if she wanted me to act on her behalf, much as a good-enough mother might and as her mother clearly had not. Musing on how often I had felt pressured to speak or to act by Dr. Z, again came the thought of offering her the small blanket, and again, I tried to push it aside.

[3] In those days, theoretically aware of projective identification, I was still far from recognizing it in the moment.

Soon, the possibility turned into a contrapuntal force: Should I say or not say or do or not do? The speck that had appeared on my mental horizon was becoming an obsessive distraction that was making it hard for me to listen and spoiling my pleasure in the session as well.

With the illumination of hindsight, it seems to me that my obsession with whether or not I was making a mistake by offering a blanket was a replay of the familiar conflict stemming from my awe of authorities/my father, for whom adherence to the rule of reason and standards of excellence always had left me feeling uncertain of my abilities – despite whatever accomplishments I might have made. Too often, I still could not imagine finding my own way outside of, or perhaps at times, counter to what I had been taught. As Dr. Z's analyst, that translated to an internal "rule" that I should work through words or silence, and not through action or acting out. Or to put my dilemma about the blanket in most personal terms, I had been transported back to the universe of my childhood where the authorities were the ones who knew, while I was the impotent child who could not measure up unless I followed their rules. Instead of feeling free to consider possibilities or alternatives, or to recognize that my wish to act might be something that Dr. Z was inducing in me, I was trapped, unable to knowingly bend the frame as I had learned it, to experiment or perhaps, to play a variation on a theme. My spontaneous gesture had plunged me into a cauldron of conflicting permutations and combinations subsumed in my familiar anxiety about measuring up and my longing to be a competent analyst who cured through talk and interpretation, not through action and acting out. In the tortured five minutes that followed, the pressure to act became a raging debate about the sins of commission or omission, during which I struggled to regain the comfortable space within the wonderfully ordinary analytic session that for so long had eluded Dr. Z and me.

To complicate matters, as the analyst of this narcissistically vulnerable patient, I did see myself as providing a "holding" environment as Winnicott (1958) formulated and also as a new object as other analysts, such as Bach (1994), Grunes (1984), and Loewald (1960), suggest. Nevertheless, their formulations about holding were terms to encapsulate ongoing processes that would facilitate internal development and were not intended as suggestions to be acted on in a literal way. Now they, of course, had taken my father's place, and as more competent and experienced analysts, I was certain that offering a blanket to a patient was something they would not do.

That the subject of my dilemma was my habit-bound father's blanket made me even more wary. I had spent much of my life trying to come out from under the weight of his legendary excellence, and to have him intrude on a session in any form, even in the shape of a blanket, was extremely annoying to me. Whatever amusement I might have felt was obscured by the thought that I might be about to make a mistake, and I became increasingly transfixed. Reason might have ridiculed my dilemma, but in the intensity of the moment, I was unable to tease apart Dr. Z's multilayered dynamics from my own: my chronic anxiety about saying too little or too much, my wish to be humane yet technically correct, an increased tolerance for the tension between the known and the unknown, a diminished sense of original sin about making mistakes, all encapsulated within the rubric of my desire to be a competent and effective analyst. Equally important was my awareness, if not yet comfortable conviction, that there are moments in the here and now, in the transference-countertransference dynamics of the lengthy journey between analyst and analysand, that may transcend one's most informed understanding of what is

appropriate or correct.

Casting about to find some justification either to say or to stay my words, I immediately rejected the possibility of discussing my dilemma in supervision, which reinforced my sense that I must be digging myself into a hole, not climbing out as I so desperately wished to do. This alone should have signaled to me that the conflict was more about me than about Dr. Z, since it was my supervisor who had encouraged me to be flexible and answer questions, and more importantly, to recognize that it might be a long time before she and I could do any in-depth work: The goal in the first few years was for the treatment to survive.

As for those who might wonder whether I thought about discussing the matter with my analyst, that, too, was beyond the pale at that time. From the start of my analysis, he had taken my father's place as an over-idealized object, and to discuss my work with him at all was borderline excruciating to me. He was a *real* analyst, the best, while I was an imitator and flawed.

Even Freud, the father of psychoanalysis, did not help. In the midst of my self-reproach that offering a blanket would be proof of my imperfections as an analyst, I flashed to his response to his hungry patient the Rat Man, to whom he offered food. But that was out of session and Freud has been much criticized on that score. Besides, while Freud's mistakes made him more endearing and human to me, I certainly did not feel that way about my own.

Which brings me to Patrick Casement (1982), whose article, "Some Pressure on the Analyst for Physical Contact During the Re-Living of an Early Trauma," my supervisor suggested I read after I described my experience with Dr. Z. (It did not take long for me to recover my sanity and discuss the matter with him.) As the title of the article suggests, Casement describes a situation with his patient, Mrs. B, who, in the midst of an intense regression, put enormous pressure on him to hold her hand; if he would not, she threatened to terminate. (Mrs. B had been severely burned as a child and was exploring the impact of a subsequent surgery to repair her scar, during which her mother fainted; that is, instead of holding her child's hand throughout the surgery as she had promised, the mother "disappeared," contributing to Mrs. B's anxiety and rage about abandonment.) After considerable struggle and much reflection about both transference and countertransference, Casement decided that it would not be therapeutically appropriate to hold her hand, telling Mrs. B that the offer "might have appeared to provide a way of getting through the experience she was so terrified of," but that he "now realized that it would instead have become a side-stepping of that experience as it had been rather than a living through it" (p. 281). Casement then describes the aftermath of his refusal: Despite the fact that it induced threats of termination and a near breakdown on the part of Mrs. B, he continued to maintain the abstinent stance and ultimately, they saw it through together, making it clear how crucial the refusal to hold Mrs. B's hand was. It culminated for her in a significant and key piece of analytic work.

Most illuminating for me, however, was Casement's description of how he reached his decision. In the process, he references Bion's concept of "a projective-identificatory rejecting object" in relation to his patient, and Racker's concept of "indirect countertransference," which pertained to the pull he was feeling to go along with Mrs. B's request, "… my response to the

patient was being influenced by some degree of persecutory superego being projected by me on to my professional colleagues" (p. 283). That is, in the face of Mrs. B's threats to terminate if he would not hold her hand, Casement recognized a strong countertransferential pull to go along with her since he was about to present the case to his colleagues. Obviously, he resisted the pull. Suffice it to say that Casement clearly wrestled with himself in regard to both transference and countertransference dynamics to arrive at a decision about what would be best for his patient, and then integrated it as a good-enough analyst should, with what seems a positive outcome for her.

On my first reading, I was blown away by Casement – by his in-depth evocation of a treatment and seeming integration of the clinical and theoretical, which led him, in the best interest of the patient, not to hold her hand. Not only was I affected by the power of the treatment as he described it, but my immediate conclusion (not surprising to those who have followed me thus far) was that Casement did not act because he was a "real analyst," while I, a struggling candidate, clearly was not.

Then calmer (internal) voices prevailed. For one thing, his patient's pressure for Casement to hold her hand occurred in the context of deep treatment, at a time when she was in a state of regression in regard to a childhood trauma, with an intense and acknowledged transference that was very much the subject of their work. Indeed, the situation seems almost the polar opposite of where Dr. Z was with me. Not only did she seem oblivious to what was going on in me, she had not actually asked anything of me except to complain of the cold, although in the light of hindsight, she undoubtedly was inducing something in me.[4] Then, too, my dilemma about the blanket occurred over the course of one session, while the exchanges between Casement and his patient continued over several weeks and included analysis of dreams, exploration of both transference and countertransference dynamics. and perhaps most important – working through – which especially included her/their recognition that Casement could contain her dread – all of which seems very dissimilar to the forces that culminated in my decision to act.

However much the situation may have been caused by Dr. Z's inducing my action (whether to replay or repair a parental failure, or an example of a projective identification at play), my distress seems much more self-induced – by my conflicts with authority, my anxieties about myself as a budding analyst, and my tendencies to revert to what seemed the reasonable and surface instead of remaining more within symbolic, interpretive mode. Moreover, considering the "dance" in which Dr. Z and I were then engaged, and characteristic of where she and I were at that time, it seems most fitting that the way out of my dilemma finally came from Dr. Z.

By that time, five minutes had elapsed and I was feeling helplessly stuck in some netherworld characterized by the now ridiculous lengths to which my seemingly benign caretaking thought had taken me. Trailing on the memory of Freud's mistake, wishing I could care less about the enormity of something that I knew would probably not matter one way or the

[4] I realize, of course, that unconsciously she must have, and that perhaps she even enjoyed my distress – which reminds me that the same supervisor once said to me that when I was more comfortable with my own aggression, the work with Dr. Z would go much better, as indeed it did.

other, Dr. Z had continued to muse, seemingly unaware, as far as I could tell, of my dilemma.[5] Following her angry remarks about the cold in her father's house, her associations had taken another turn, back to the eclipse, then to the events in the afternoon that had preceded her appointment with me. "I did a bizarre thing," she said in an annoyed tone:

> I wanted to go downtown to do some errands ... and the afternoon disappeared while I tied up loose ends at work ... I left too late to go downtown but realized it only after I had gotten there. I had to turn around right away to come back up for this appointment ... I didn't have a chance to do anything I wanted to do. It was very unpleasant [she exclaimed in an angry voice accompanied by a bitter laugh]. I got to feeling lost and asked a lady on the bus going uptown if she knew where we were ... she was pretty far off.

Now Dr. Z became angry and tearful again:

> I have trouble enjoying things ... it is really awful ... I want [she cried with despair] to be able to live in the immediacy of the moment!

With this, my dilemma vanished. Jettisoning my debate, I joined Dr. Z in the spirit of her wish to live in the immediacy of the moment and asked her if she would like a small blanket to cover herself because the office had not warmed up. And as calmly and quietly as I had asked, she had answered, "Yes."

Retrieving the blanket while Dr. Z continued to lie on the couch, seemingly quite comfortable with waiting, I felt somewhat awkward about the mechanics. After all, I had never offered a blanket to a patient before and there were no precedents or rules to guide me other than a nostalgic surge of maternal instinct that would have had me happily tuck her in – but, of course, I did not. Instead, I handed her the blanket (a transitional object perhaps), she thanked me, and casually covered her legs.

Now came material that had never come up before: "I first began to smoke when I was fifteen and a half." This related to Dr. Z's painful adolescence, during which she had spent a year abroad in a cold and unfamiliar country. There, feeling alone, shy, and awkward, she described beginning to smoke as an attempt to make friends and relate to her new classmates. Frequent moves during her childhood and adolescence had been the norm for her, and over the course of our work, we had established the extent to which it had contributed to her sense of awkwardness and isolation, the perpetual new kid on the block, something she now struggled with at work.

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[5] Being somewhat more attuned now to projective identification, I think it more likely that I would have recognized the extent to which Dr. Z was putting me into the role that she had suffered so often as a child or adolescent, while she became the parental figure ignoring my (the child's) distress.

Listening to this new material, I settled back again, and found myself immersed in Dr. Z's moving description of having chain-smoked through an agonizing dinner with friends and her now ex-husband after he had just informed her that he was leaving her. She cried as she described the agony of feeling "like an animal in a trap trying to bite its leg off ... I must have smoked an entire package of cigarettes at least." Gradually, her crying subsided and she was silent for the remaining few minutes of the session. With my usual comment that we would continue next session, Dr. Z got up from the couch, folded the blanket before handing it to me, then turned to retrieve her briefcase and purse from a nearby chair, and left with a "Thank you," something she had never said before.

During the next several days, relieved that the sky had not fallen, I continued to mull over the session, flashing back to some thoughts I had entertained but rejected as rationalizations to justify offering the blanket to Dr. Z. These had both theoretical and personal implications. Now when I contemplated the degree to which Dr. Z had ignored her discomfort in the context of maternal deprivation, I was able to consider that a question about covering herself might in and of itself have offered a counter-experience to her past and to the depriving mother who might not have noticed Dr. Z's discomfort, a role in which she bitterly kept me. However, because of the unpredictable rage that had so permeated our first few years, I was still feeling self-protective, more focused on warding off her anger and, therefore, concerned that to offer the blanket might be an attempt to do just that. In other words, I had not kept up with Dr. Z. I had also forgotten the extent to which, in the early days of our work, Dr. Z kept accusing me of being rule-round and following a set of arbitrary rules that had nothing to do with her or me.

For all her unwilling suspension of disbelief, more and more Dr. Z seemed to be playing by the "rules" of the game, and the treatment was unfolding with an intensification of deeply buried memories and affects. Now, perhaps, I wanted to prove to her that I was not as rule-bound as she decreed. Perhaps I, too, had a wish to rebel against the rigid rules that Dr. Z kept imputing to me (and, of course, those authorities who preceded her). On some level, perhaps I agreed with Dr. Z.

It seems obvious to me now that Dr. Z's accusations about my being rule-bound conflated with my own conflicts with authorities and their rules, and when the thought arose, I became confused about whether the offer of a blanket would be a mistake or "wrong" instead of recognizing that it might be an opportunity to act as her analyst who did not, as she kept accusing me, always stick to the rules. Even more, over the course of revising this article for publication, it occurs to me that not only had I missed an opportunity to comfortably "break the rules," perhaps I had also missed an opportunity to be playful, better yet, to act and throw caution to the winds. But in those days, I was far from that.

While I had recognized the transferential nature of so many of Dr. Z's complaints and the bitter, depriving maternal role she kept me in, what I did not recognize during the session, caught in my own conflicts as I was, was that her neglect of herself when she was cold was a repetition of her past, where not to notice or to be ignored might be as significant as the injustices she complained about. Instead, my initial amusement at what seemed a playful, caretaking gesture morphed into the ghost of my father (the blanket) and my immediate concern that not only might

I be breaking a "rule," but that this was an action unworthy of a mature analyst. This, too, was very much in the context of my own development, where only recently had I begun to be freed up to find my own way without feeling submissive or rebellious and not about whether or not I might have broken a rule.

For what is "becoming" about but our efforts to cope, to master, and to integrate who we are with what is possible and the kinds of negotiations and compromises that are at the heart of any endeavor where two people have agreed, more or less, for better or for worse, to abide by the rules of the game? If Dr. Z could meet me halfway, why should I not do the same for her and offer her something to keep her warm, since she had not yet learned to do that for herself, and at another time, wonder why she did not take care of herself? But however clear in the light of hindsight, it is also obvious to me now that I welcomed an opportunity (however unconsciously induced) to prove to Dr. Z that I was not mean and withholding like her mother, or as rule-bound as she insisted that I was -- a countertransference enactment for sure.

Perhaps that is also why it did not occur to me to point out Dr. Z's obvious neglect of herself or why I had not reflected how struck I was with the degree to which she neglected herself and tolerated the cold. Obviously there is no simple answer except to comment that there remain multiple perspectives and multiple meanings – all which remain at the heart of our work. At the very least and very most, in the intersection of sets in which Dr. Z and I were meeting, it seems that we each were yielding something of ourselves to the other and, in the process, were enlarging the space in which we could work and grow. It is in this spirit that I offer up my dilemma about whether or not to ask Dr. Z if she would like a blanket and hope that it provides an opportunity for further inquiry and openness among us all.

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A Memoir of Supervision

Marianne Goldberger, MD

Early in my training, I could not have imagined writing about my collegial friendship with my former supervisor, Dr. Paul Gray – in fact, I could not have imagined calling him "Paul." However, Paul, the kind of educator who opened minds, demonstrated that "nothing is unimaginable." One time I'll never forget, after we already knew each other well, I started a sentence during a supervisory hour, "I can't imagine why...." He interrupted me and quietly asked, "How come there is anything you can't imagine?"

Paul Gray will of course be remembered as a pioneer; his ideas, published in a series of seminal journal articles over the past forty years, collected in his 1994 book titled *The Ego and Analysis of Defense,* have had a profound effect on the psychoanalytic community. In fact, in 1973, his first paper was so revolutionary that the *Journal of the American Psychoanalytic Association* accepted it with the caveat that the paper be accompanied by an editorial stating that his paper did not reflect the views of the journal. Paul declined such a stipulation and fortunately the journal printed the article without disavowing its contents.

Beyond his written contributions, Paul was a generous, creative and gifted teacher. The fact is that his writing fails to convey the richness of his teaching. From Paul, I learned not only how to make an analytic treatment a truly collaborative enterprise, but also to emulate his extraordinarily open educational style.

As a first-year candidate, I'd encountered Paul in a course, and he spoke so slowly and ponderously that I often could hardly listen to him. I knew he was a popular supervisor but I assumed other students chose him because he was gentle and not judgmental. So it happened that he was my fourth and last supervisor, and this supervisory experience turned out to be entirely different from my first three. He stimulated our minds by making us read. He held a weekly study group on technique, where we first went over, sometimes word by word, Freud's technical papers, Strachey's 1934 paper, Fenichel's monograph, Anna Freud's monograph, Sterba's papers, and Loewald's paper on therapeutic action. Paul was always making us think about therapeutic action. With regard to Fenichel, it was exactly his layered view of defenses that Paul wanted us to appreciate, that is, "In a certain sense it can be said that all defense is 'relative defense': relative to one layer it is defense, and at the same time, relative to another it is that which is warded off" (Fenichel, p. 62).

As much as he valued certain traditional points of view, Paul also got very excited by new and original ways of thinking. We *had* to struggle through Roy Schafer's book on internalization (1968). Heinz Kohut's first book (1971) came out soon after my graduation, and Paul made all of us read it. He immediately recognized the importance of Kohut's contribution; at that time, many other senior mainstream analysts were scoffing at Kohut, but Paul encouraged us to take what was new and integrate it with the old and still useful. Also, we had to read Larry Friedman's papers as they were published (e.g., Friedman 1969; Friedman 1976) (the other senior analysts were not aware of Friedman's important contributions yet). Paul's excitement about ideas and about expanding his own knowledge was contagious. He was not authoritarian;

on the contrary, he was open to any and all questions. He was always willing to explain his thinking, patiently expanding on how he'd arrived at his approach.

Paul opened a whole new way of listening and thinking about analytic data for me, one that allowed me to provide patients with a vivid demonstration of their defenses in action. I'd come to a supervisory session, armed with reams of process notes and sometimes we'd spend the entire hour on the first ten minutes of one patient hour. He repeatedly refocused my attention back to what was going on inside the analytic hour. Sometimes, he pointed out my increased affective interest in behaviors occurring outside the analytic situation and the ways that this distracted me from the task of analyzing. When my thoughts strayed to what felt to me like a crucial dilemma in the patient's life, he'd remind me of my job description: "You've been hired to help the patient understand how his mind works, not how to run his life." It took years before I fully experienced the deeply liberating effect of this view of the work. Paul taught me not only about the analysis of defenses, but also (if possible, and if the patient was ready for it) about the nature of the danger the patient experiences from drive derivatives. In this way, the patient and I realized why a defense felt necessary at a particular moment. Since all this happens in the context of transference, there is the potential for the analyst to comment on the transference. I say "potential" advisedly because Paul emphasized the importance of staying close to what was accessible to the patient; he didn't just say timing was important, he explained how it was important.

As I write about my experiences with Paul over many years of close process supervision, I will focus on the specific details of what I learned and what I find useful in my own supervision of young colleagues. In his papers, Paul wrote about certain principles analysts should be aware of, but he didn't always clarify in detail what he meant. For example, in his paper entitled "A Guide to Analysis of the Ego in Conflict," he states, "The degree to which analysts succeed in …[phase one], depends on their sensitivity to patients' receptivity at the moment of interpretive intervention, with a view toward engaging patients' capacity to observe with rational attention" (Gray [1994] 2005, p. 178). He goes on, "Clearly, in addition to attentive listening, the analyst's language and conceptual skills are crucial to this effort." Then, he added the need for the analyst to develop a sense of the patient's available knowledge, as well as what is bearable to this particular individual. Most therapists and analysts agree with these generalizations, but exactly how they are practiced is an entirely different question.

Paul made me aware that during an analytic hour a patient may be in an altered state of being – self-immersed with different perceptions from usual – so that whenever the analyst speaks, he is interrupting that state. (Paul was, of course, aware of Lewin's original view of this aspect of the analytic situation as analogous to a dreamer who is awakened by the analyst's voice). The impact of the interruption of course varies from patient to patient, but it's always there and, with each interpretation, the analyst risks asking the patient to take on "too much." By too much, he meant too many different things, too much complexity, too much or incorrect affect. Once an exchange has been initiated, the amount under discussion can be increased. We all know that in analysis we ask a patient to keep going back and forth between self-immersion and listening to the analyst. Paul was acutely aware that patients have to lift themselves out of the state of self-immersion in order to respond to an intervention. In the immersed state, patients are often less cognitively tuned in than in an ordinary social situation and, therefore, must adjust

their focus to hear and comprehend. Whatever we ask of patients' minds at such times, they may have to gather all their mental forces in order to respond, and subsequently it may be harder to move back into the associative mode. In my six years of training, Paul was the only analyst to point this out to me. So, close process attention includes an ongoing awareness of and respect for the subtleties of the back-and-forth nature of the analytic situation.

For example, when an analyst refers to something that happened several days or a week before, the patient has to raise his/her consciousness to retrieve that memory in order to join the analyst at the time where the intervention is located. When the immersion is deep, such a retrieval may be difficult and even jolting. Paul didn't say that one should never make such a comment, but he thought we should be aware of the task we impose on a patient, as compared with a comment referring to something happening within the current hour.

A more striking example comes from an analytic case of mine that Paul supervised. Almost every time I spoke, this patient would say, "What?;" apparently he hadn't heard what I'd said. Early in the treatment, I had to repeat myself several times before he understood. Paul suggested I continue to repeat when necessary, and in time we'd understand what this was about. This patient's mother, by his description, had been extremely stimulating both physically and verbally. During his childhood through adolescence, his mother habitually invited him to nap with her. After some months, Paul wondered whether the sound of a woman's voice in the analytic situation was so startling to him that he had to get used to that intrusion, as if it were an assault, before he could start listening. Paul suggested that whenever I spoke, I should begin with a prelude of "filler" words before the meaningful content, giving my patient a chance to get used to the presence of my voice. He demonstrated, "Well…um...I just had a thought... um … what I thought I wanted to say…" and only then make my observation. Of course, his suggestion made a big difference; the patient started to understand me the first time around. Gradually, after a couple of years, the filler became less necessary, and we started to understand the ways he'd learned to protect himself against the feelings aroused inside him from his mother's way of interacting.

Awareness of a patient's state during an analytic hour is crucial in determining what a patient can process, and Paul suggested that this awareness should influence every one of the analyst's communications, even factual information such as schedule changes. He pointed out that at the end of a session, a patient often cannot absorb the facts of what the analyst is saying. He suggested that one prepare the patient to hear something by saying, "Before we stop today, I just want to tell you…." In this way, the patient has time to come out of the immersion without unnecessary strain.

Paul demonstrated how he himself would communicate something. Whenever I said I wanted to convey something to my patient, but couldn't think of a way to do it, he'd try out different interventions, verbalizing them and then rejecting each one until he formulated a way that he found satisfactory. When I was concerned about being heard as critical, I'd tell Paul, "I can never tell my patient this," and he'd muse, "Well, let's see…." He might try as many as five or more different ways to communicate in what sounded to me as less critical ways. I don't exaggerate when I say that there was almost nothing that Paul couldn't figure out an analytic way

of saying. His guiding principles were not to increase the patient's defenses and to use the patient's own material so that he would recognize it as his own (right out of Fenichel!).

Paul chose words carefully, and he explained his reasons for that care. He said it was important for each analyst to develop a vocabulary of words and expressions without even the subtlest pejorative overtones. When I mentioned this at a discussion group on the topic of supervision, attended by training analysts, one person said that choice of words couldn't matter that much and discouraged conveying its importance to candidates for fear that they would feel stilted. As opposed to putting the onus on the candidate, in training to learn how to become the best possible analyst, if a patient felt criticized, well, that was something to be analyzed (grist for the mill). Paul, of course, knew that, but he thought one could actively develop a more neutral repertoire, to avoid feeling constricted, by having those expressions readily available, the more the better, becoming at ease with such a way of speaking. He also knew that every person has particular words that touch a nerve, and it was important for an analyst to know what they were for each individual. He was sensitive to what might be jarring to a patient, not because he feared the patient's anger at being jarred, but on the contrary, if we're insensitive to a patient's vulnerabilities, we stimulate defenses rather than analyzing them.

Another example of Paul introducing me to a new way of thinking was his view on dealing with lateness. He said there is no need to bring up lateness, per se, unless a patient chooses to bring it up. Since we know that in some way the lateness is a manifestation of conflict over coming to the hour, then we can wait until something is revealed within the hour that reflects what the issue might be on that particular day. It's preferable to wait until that conflict arises in a different, additional context than the act of being late, since the analyst's interpreting the lateness is invariably heard as superego-tinged. I've confirmed the correctness of this through my own experiences over the years, having tried interpreting the lateness in various ways in line with other supervisors' and colleagues' viewpoints and practices. I had supervisors who said, "You have to bring up the lateness." Paul said that if you believe in conflict theory, the point at which you bring up the conflict is elective. You don't have to bring it up in an interpretation that the patient will most likely defend against as an accusation. It's there: It was there on the way to the hour and it is still present during the session. Following this approach, I've found that most patients bring it up themselves. When they do, they demonstrate their readiness for and provide the opportunity for a piece of superego analysis.

Here's an example: A patient – late for an analytic hour – starts talking about the analyst having looked annoyed when he came in. He's almost never late and he goes on to describe the events that led to today's lateness. He doesn't think there was any "unconscious" motive making him late, but he speculates about some possibilities. Then, his thoughts reflect on the real adversities encountered en route today, emphasizing that they made him late despite the ample time he'd given himself. The analyst comments that he sounds as if he's defending himself against an unspoken accusation. The patient agrees, and again mentions the annoyed expression he saw on the analyst's face. The analyst wonders if perhaps he has some ideas about what might be annoying about lateness. After protesting that he "knows" this is probably not true, the patient speculates that since the analyst is almost always on time, punctuality must be important to her and, therefore, if he is late, she might think he doesn't take his analysis seriously enough. He says, "It's not so much that you dislike being kept waiting; it's the implied insult that's irritating,

that it'll seem as if I don't think you're important enough." Here's a made-to-order re-externalization of authority, where the rule "to respect elders" is experienced as emanating from the analyst.

After I graduated, I began to discuss all my cases with Paul, as necessary. I had one patient who was chronically late and habitually missed some appointments. My previous supervisor had often questioned the patient's motivation for analysis and had emphasized the resistance aspect of this behavior. As usual, Paul focused more closely on the details of this patient, inquiring "How late was she?" and "How often did she miss?" I told him she was usually about 10 minutes late, sometimes more, and missed about one hour out of five per week. He said, "Well, if you think of it in terms of conflict, she's mostly there, so you can see that her ambivalence weighs more strongly *for* the treatment than against it." This attitude was amazingly refreshing and gave me a different feeling about the case. Paul really practiced what he preached. The point was that an analyst's job was not to teach a patient to behave well, or how to be a proper analytic case, but rather to understand his mind and in so doing, the resulting behavior.

If the analyst was late by more than a few minutes, Paul had a unique attitude that informs us about the creation of a collaborative atmosphere. In such a circumstance, he suggested not an apology, but asking if the patient was able to make up the time that day or whether it would be more convenient to do it on another day. The respect for a patient's time is obvious. Paul's practices were always informed by his utmost respect for patients and the hard work they commit to in an analysis. Similarly, if a patient requested a change of appointment time and one was not available, rather than just say it was not possible, he suggested adding, "If something changes in my schedule, would you like to be called about such a change?" He urged analysts to maintain technical transparency, encouraging the patient's understanding of the purpose of the analyst's interventions. For example, a transparent technique includes educating a patient about why fantasies the patient has about the analyst are useful for the work or why the analyst responds to questions in a particular manner.

With regard to issues about setting the fee, he thought it important to consider what each member of the pair could tolerate. For instance, if an analyst was considering significantly lowering the fee, the amount depended on what an analyst was willing to do without resentment or strain in reality, with the fee still being meaningful to the patient. He was particularly helpful in dealing with difficulties around setting a new fee, as for example, after the analyst proposes an increase, and the patient doesn't bring up the subject at all. If there is no new fee agreement on the first of the month, he suggested giving the bill as usual with the dates on it, but no dollar amount, saying, "I was not able to put the amount on the bill, since our discussion about the fee is still ongoing." This approach demonstrates that the fee agreement depends on a genuine two-way discussion, and that the analyst is willing to wait for an agreement to evolve. This approach has been helpful to me and to many of my supervisees over the years. Candidates are surprised by this entirely new attitude and amazed at how it furthers the analysis.

The kind of close process awareness that Paul showed me creates an atmosphere of safety for both analyst and analysand, supervisor and supervisee. When colleagues describe the Gray approach as sterile and dry, they don't realize the collaborative and safe atmosphere he created by

his steady, interested listening, always attentive, always respectful of every detail of a patient's feelings and thoughts. It's an atmosphere in which a patient can feel increasingly able to unearth the most savage impulses that his superego tries to keep buried. Paul was acutely aware of the myriad subtle ways that an individual could feel startled, assaulted or criticized. Some therapists disagree with such carefulness, saying that it's just a way of avoiding patients' anger, or relates to the analyst's own need to be "perfect." On the contrary, Paul was very invested in helping patients become increasingly tolerant of expressing aggressive impulses in the hour. He thought, like Fenichel, that acting in ways to make patients angry wasn't the optimal way of analyzing inhibitions involving aggression. Central to his way of working was the goal of helping patients dare to express more and more their strongly felt emotions and wishes. But he balanced this goal with his deep respect of patients' autonomy, letting patients set the pace of how much affect they could tolerate. I realized Paul's wealth of experience as the object of patients' aggression, as he said to me more than once when I thought I'd had a big dose of aggression, "You haven't seen anything yet." Paul emphasized the analysis of aggression, or rather, the *fear* of aggression, which was how he'd put it. He thought the fear of libidinal impulses was less problematic in our current culture, and the more crucial issue was the *frustration* of libidinal drives, which then led to fear of "frustration aggression." With regard to erotic impulses, he was particularly interested in the defenses against integrating (bringing together) the caretaking part of sexuality with the sensual part.

Paul had an approach to enactments that followed directly from his "inside" focus. Most of you are familiar with his listening to the context in which thoughts about particular actions occurred. What had just preceded those thoughts? One notable intervention about such contemplated actions was to address the urgency that often accompanies them. He'd say things like, "I get a sense of urgency in what you're saying; can you say more about that urgent feeling?" Mentioning urgency in this way recognizes patients' feelings and does not belittle them – it's clear that you want to know more about that feeling in detail, not just get rid of it.

Closely related to the "urgency" situation are his suggestions for dealing with patients who are in a quandary about decisions and who have a tendency to press the analyst for suggestions. Paul said to invite the patient to imagine the analyst suggesting each alternative. The emphasis was on describing all hypothetical ideas and the analyst not being hesitant to play a role in that fantasy. I should be willing to take whatever the patient imagined as far as it would go, as for example, "And can you describe your experience were I to say, 'Yes, take that first choice that you described…'" and then soon thereafter to add, "…and if I say, pick the second of your alternatives, how would that feel?"

This way of helping patients use their imagination in problem solving also opens the door to an increased facilitation of transference fantasies. For example, when a patient says, "You're not gonna like this" or "You're gonna disagree with this," Paul would suggest, "Can you say more about that picture of me feeling that way?" Patients' initial responses to such an intervention often are that they "don't know," they "can't think of anything." This wouldn't stop Paul; he'd say, "Well, let's say what kind of person am I when I view you (or what you say) that way?" He emphasized that we have to be willing to be seen as *any* kind of person the patient pictures. This approach is especially useful when the patient imagines us as being critical.

Sometimes a patient says, for example, "Well, you *did* sound critical when we were talking about this yesterday." And here's one of the *most* important things I learned from Paul. I call it "*Take it on*!" Those were actually his words when a patient described something I had done. I've never heard any other analyst talk this way. When a patient says, "You had an edge in your voice yesterday and that was hurtful to me," Paul suggested to say, "*When* I had that edge in my voice…or *when* I was hurtful to you...." And you do that regardless of how you remember what went on, because that's what happened to the patient in *his* experience of you, and you go on from there. You have to "take on" what the patient perceived of you. "When I did such-and-such…." Don't waffle and say it was *just* the patient's perception. That's defending yourself and arguing about the "reality." You need to respect the patient's reality. (My other supervisors – and many colleagues – demonstrated a different viewpoint, saying, "When you *thought* you heard an edge…or it *seemed* to you that I sounded critical…I wonder what made you hear it that way.") My experience has been that when you "take it on," most often patients are then spontaneously willing to look at their own contribution to what happened. This reminds me of Paul's saying, which has always stuck with me: He said, "You have to let a patient chew on you!"

This is a good moment to talk about Paul's attitude about countertransference. He's been accused of leaning toward a "one-person" conceptualization of the analytic situation. But his conceptualization of the analytic process always refers to a person speaking in the presence of the analyst; a two-person situation was in his mind, even if it wasn't directly addressed. Countertransference is hardly dealt with in his book. It's briefly mentioned in his 1973 paper, where he wrote, "The use of countertransference as an avenue of observation of the patient's productions is a controversial subject, often discussed with considerable ambiguity, and is...of an order of study different from that of this paper" (p. 6). From my supervisory experience with Paul, I gleaned that he thought countertransference reactions were important information about oneself, but of questionable use as information about the patient. These reactions certainly needed to be examined in ongoing self-analysis, but their value as data about the patient was limited. In contrast to many modern analysts, Paul was very doubtful that an analyst's countertransference was reliable evidence about the patient. To be directly useful, clinical data had to be observable in the moment by both participants in the analytic enterprise. Over the years, I've kept struggling with this controversy about the usefulness of countertransference. As a general rule, I lean toward Paul's view, at times to counterbalance the tendency in our current analytic culture to use countertransference without skepticism. Paul often referred to Fenichel's famous advice about interpretation – an interpretation is at the right level if the preconscious derivative can be recognized as such by the patient merely by turning his attention to it. As Roy Schafer wrote on the dust jacket of the first edition of Paul's book, Paul maximizes the "...patient's experiencing the flow of moments in the here-and-now clinical setting and relationship. This he does by steadily using and developing the patient's own powers of self-observation." And I'd like to add, steadily using and developing the patient's freedom to observe the analyst. That includes the analyst "taking on" the patient's observation, as I described before.

The most important and original part of Paul's contributions is the analysis of the superego. Analysts who continue to use structural concepts all agree that analysis of the superego is important, but almost no one writes about how to do it. In the process of superego analysis, Paul emphasized the re-externalization of authorities, a concept that in practice is hard

to grasp. The difficulty has to do with seeing in each moment the way the perception of an external authority – often the analyst – is used as an inhibitor, unconsciously helping the ego attempt to protect itself from danger in the analytic situation. Paul stressed that every time a transference takes place, the ego immediately works to preserve what feels like a condition of safety. Of course, the sense of danger is a fantasy, a transference distortion and exactly what transference is about. The danger is genuinely felt as external, and Paul's way of working with it in the clinical moment was unique.

I remember one time Paul demonstrated the phenomenon in supervision. The patient we were discussing had an early morning appointment for some time, and one day began haltingly expressing the idea that he liked having this particular time to come here. I commented on his hesitant manner. Soon thereafter, he had a fleeting thought about my husband, the existence of whom he assumed. His thoughts then went in a different direction. Paul interrupted and asked whether I had noticed at what moment he had brought my husband into the room. Other supervisors might have noted the same phenomenon, but they would have emphasized the repetition of an Oedipal dynamic, that is, the patient had created a triangular situation. Paul would not deny the Oedipal, but Paul's focus was on the patient's anxiety that led him to bring in an external inhibitor in order to deal with his discomfort. Just to make the distinction clear: Was it the association to my husband that made the patient anxious, or was he anxious about expressing out loud that he liked his morning visit with me and he then "reached" for the existence of my husband to inhibit any further thoughts about being alone with me.

Everyone knows the importance of putting something into words, verbalized in the presence of one's analyst. Said out loud, "This is what I feel toward you," leads to the sense of danger (a fantasy danger). Paul's emphasis on superego analysis led him to suggest particular kinds of interventions at such times. We know that Anna Freud introduced the emphasis on "transference of defense" seventy years ago, but it continues to be conceptually difficult. Colleagues often groan when I mention that phrase. Only through Paul's instruction did I get it. It's harder to work with transference of defense than with the transference of drive. Our patients are often quick to mention the impulse about which they were uneasy rather than look at the defense, trying to be "good" and say everything obediently, but this is usually an intellectual pursuit, not affectively experienced. Such obedience manifests the human tendency to look for external authority rather than more rigorous pursuit of autonomous functioning. As Sam Ritvo wrote in his introduction to Paul's book, "Patients are reluctant to analyze that aspect of transference because it is so effective in protecting the ego from risky revelations. The patient feels safer against the dangers of instinctual drives if he views the analyst as inhibiting, as were the parents of childhood."

To illustrate the usefulness of this approach to superego analysis, I'll focus on the analysis of a 50-year-old man in a related field, who came to see me for depression that had not remitted despite medication. He'd had two previous analytic treatments in another city, both with analysts whom I respect. He was a very intelligent, likeable, decent person who spoke in a bland monotone most of the time. When I began to make observations to him about signs of his defenses at work, he would, almost reflexively, mention the impulse he thought I had in mind. For example, he'd describe something his wife had done that irritated him, and soon thereafter say something about her good qualities. When I pointed this out, without emotion, he'd say,

"You mean I'm really angry at her." I'd say, "Well, I was noticing that after you expressed criticism, it seemed as if you had to have some antidote for that, and maybe you can say more about that." He said, "I don't like sounding so critical and you'll think that I'm being too hard on her." I said, "How would we know what's 'too hard'?" This last kind of intervention would leave him quiet and thoughtful. "I never thought of that." His strong investment in always being nice gradually became clearer; he was unaware of his strong conviction that he'd no longer be a really good person if his criticism had any "bite" in it.

Another of this patient's characteristic was that he'd break off a train of thought if he ever started to stumble or be halting over his words. I wondered what kind of discomfort he might experience if he continued talking at such times. Initially he'd shrug that off with an "I don't know." When this kind of moment kept repeating itself, I said it seemed as if he might feel it hazardous if he continued when his voice sounded like that. He laughed when I used the word "hazardous" – I was making so much of it! His laughter sounded as if he preferred that it be quite unimportant. I realized this was a very sensitive area, and was more careful and subtle in my comments about his manner of speaking at those times. As it turned out, he never could tolerate being unable to control his voice. I wondered what rule he might be obeying. Initially drawing a blank, he was later able to say, "You're not supposed to be too emotional, to show that you're unhappy." In time, it became clearer that to get "choked up" was something only children did, and he was definitely not supposed to act childish. Here's the most important part: He'd never before put these "rules" into words and hadn't been aware that he operated under their strict aegis. In fact, he volunteered more than once that in his previous analyses these aspects of himself had never been discussed.

Another example of the burdensome rules under which this patient lived was the heavy guilt he continued to experience since his late teen years when he'd been on a group Outward Bound trip out West. During a sudden hailstorm, a member of the group had fallen down a ravine when his horse stumbled. The group leader organized a rescue mission and my patient had never stopped reproaching himself over not having been the rescuer. In fact, intellectually he knew he hadn't had the opportunity to be the rescuer, but the self-reproaches continued. The guilt surrounding this event came up numerous times in the analysis, as it also had in his previous treatments. What came out first was his self-accusation for being a coward; he remembered that in his heart he'd been fearful and would not have wanted to go on the rescue even if he'd been asked. So, clearly one self-exhortation was that he should not be afraid. But his deep inhibition about asserting himself took a great deal longer to emerge. If he actively put himself forward in any situation, he feared he would be seen as too aggressive. (Here we see an example of the "layering of defenses," emphasized by Paul as so important to learn from Fenichel.) Inevitably, this inhibition showed itself in the analytic situation as well, often manifested as a deep reluctance to challenge or correct something I'd said. If he did that, he believed I would no longer like him, or that he'd make me feel sad. He was strongly influenced by the idea that silence was the safer and, therefore, better policy. I cannot give the myriad repeated examples that emerged in our work together, but by the time the treatment ended, his profound guilt had lifted. The analysis had undermined the harsh and immobilizing power of his conscience (often experienced as coming from me) that had been a subtle but ever-present voice. I believe that my having learned to work with the transference of defense was most helpful with this patient.

Paul Gray's approach gets repeatedly criticized in particular ways: His kind of analysis is too intellectual, sterile, and obsessional; it has sometimes been called superficial analysis because he deals with preconscious but not unconscious material; some critics say that his emphasis on self-observation makes it too educational. However, in clinical practice, his consistent observation of conflicts and their defensive solutions as they occur in the material and calling attention to these phenomena at the very moment they arise in the analytic hour provides the most convincing and affective demonstration of them for the patient. The access to affect is increased, not decreased. He used to say, "Using one's intelligence isn't the same as intellectualizing as defense." What many people didn't realize from Paul's conservative exterior was that he was really a revolutionary in disguise. He was ready to dispense with the concept of the superego as a separate agency many years ago, and to view it instead as a hierarchical ego function. It was the freedom rider in him that made him so aware of the analyst's former predilection for an authoritarian stance and the use of influence (including Freud's own reluctance to fully analyze the superego).

Paul's innovative attitude was at work in the changes he brought about in the institute. Every really progressive reform was initiated by him, and usually first encountered significant opposition before he eventually persuaded most of his colleagues. He was the first person to stress developing younger faculty by having an assistant instructor in every course (and this was before many other institutes had begun doing this). He opposed instructors "ownership" of courses for years and years, insisting faculty be rotated to allow for fresh approaches and perspectives. He made several proposals for tactful, respectful ways to deal with aging and impaired training analysts, most of which are finally in place.

I want to end by saying that Paul Gray gave me much more than these many detailed ways of working in analysis. He introduced me to a completely different feeling about my work, which has stayed with me. He is always there in the landscape of my mind, available as a partner to discuss solutions to problems. I know I have shared his commitment to mentoring candidates and passed on his ways to the candidates I have taught over the years.

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Oedipal or Preoedipal, Is That the Question? Attempting Integration as a Psychoanalytic Candidate

Michal Talby-Abarbanel, MA

As an advanced candidate whose training has taken place in two different institutes, in two different countries, each with a very different psychoanalytic climate - in Israel (a neo-Kleinian and Winnicottian program) and in New York (a contemporary Freudian institute) – the author reflects on her personal attempts at integrating those two competing approaches, and incorporating both into her own developing identity as an analyst. In the author's view, the two "schools" of analytic thought reflect a conceptual schism in the field, which has historically manifested itself in pendulum-like swings in psychoanalytic theorizing. At one extreme, theory has overly focused on oedipal (incestuous) issues; at the other extreme, on pre-oedipal (merger-differentiation) issues. Based on Loewald's seminal paper, "The Waning of the Oedipus Complex," the author reflects on a possible developmental explanation for this tendency to split – the difficult developmental juncture that involves integrating the sanctity and innocence of the union with the early mother with the "evil" oedipal incestuous and murderous wishes that violate this sacred bond. It seems that the schism in psychoanalytic theory reflects this difficulty to contain both constellations together and the need to always highlight one of the positions while devaluing the other. The author contends that her struggle to integrate the two perspectives has enriched her clinical work.

As an advanced candidate, undergoing my own personal analysis and at the same time taking classes and conducting my first control analysis, I feel challenged to integrate the varied influences to which I am exposed. As candidates, we absorb our own analysts' ways of relating in the psychoanalytic setting. We get to know different psychoanalytic theoretical models and are in meaningful mutative relationships with supervisors and instructors, each with their own personality and unique theory of mind (Grossman 1995). I often feel puzzled and confused: What to take in and what to renounce? How do I incorporate all this into my own personality in order to form a cohesive and authentic professional identity as an analyst?

My personal history as a candidate contributes to my bewilderment, since my psychoanalytic education has taken place in two different institutes, in two different countries, each with a very different psychoanalytic climate. Three years ago, I "packed up my psychoanalytic assets," those gained as a clinical psychologist and in my training in a three-year psychoanalytic psychotherapy program at the Centre for Psychoanalytically Oriented Psychotherapy Studies (HALFABA) in Israel, and relocated to the States. There I started my training as a candidate in adult psychoanalysis at the Institute for Psychoanalytic Training and Research (IPTAR) in New York. The program in Israel highlighted the neo-Kleinian, Winnicottian and Kohutian models, whereas IPTAR is a contemporary Freudian institute. The curricula of the two programs, the way the courses were taught, and the general atmosphere in supervisions and seminars were different, and the therapeutic action of psychoanalysis was understood differently. I sometimes feel as if I am containing within myself many internalized models, which I am continuously exploring and interpreting. Sometimes these models seem conflicting and difficult to reconcile, but at other times I can see how they are complementary and mutually enriching. At times I feel as if I have to take sides, to choose one and renounce the other, but occasionally I have gotten glimpses of a more integrated picture starting to form within me.

This paper describes my struggle to integrate those two competing approaches. This challenging process has drawn my attention to a conceptual bifurcation I discern in our field, where each model or group of models is built around different points of emphasis, highlighting some aspects and neglecting others. For example, as Rangell (1982) puts it, in some models the external environment is highlighted at the expense of the internal, or object relations rather than drives, pre-genital determinants are pointed to exclusively, without the role played by the oedipal, the "here and now" is sought instead of reconstruction – or vice versa.

I am aware that my perception, like anyone else's, is multi-determined, representing my own compromise formations, so there is probably both a kernel of truth and an element of fantasy and personal meaning to the schism I experience. In writing this paper, I have found that, troubling as it can be, the perception of a schism in the field has made for a productive, dynamic tension in my development as an analyst. Reflecting on the differences between the two competing models in which I was trained and struggling to integrate them is a mutative process for me. It has helped me improve my capacity for managing multiple viewpoints, to overcome the human, natural inclination of adhering to a single perspective (Pray 2002). I hope that elements of my experience may generalize to other candidate analysts who are struggling with similar dilemmas.

I gradually have been developing a more discernible way of thinking and improving my ability to criticize each of these approaches, and at the same time, to see both as valuable and mutually enriching and to incorporate them into my own personality in my own original way. Ogden beautifully described this process of forming personal identity in his interpretation of Loewald's Oedipus complex (Ogden 2006). Ogden suggests that there is always a kind of tension "between one's indebtedness to one's forebears and one's wish to free oneself from them in the process of becoming a person in one's own terms" (p. 654). In this process of forming one's own identity, there is always a tension between influence and originality (Ogden 2006).

In this paper, I explore and define the differences between the two competing psychoanalytic schools of thought, as I see them, and suggest a possible developmental explanation for the tendency to split. As in a good analysis, a deeper understanding of the reasons for the split may lead to a better ability to contain the conflicting parts.

Sensing the Differences

I felt the integration challenge from the moment I was interviewed at one of the Freudian psychoanalytic institutes in New York. I told the interviewer that my personal treatment in Israel was a kind of corrective emotional experience for me. The interviewer smiled at me and commented with a delicate sense of humor: "Be careful! Here, that phrase may get you into trouble." I left his office feeling somewhat perplexed. I was sure that my Winnicottian instructors from Israel would not have raised an eyebrow hearing my comment.

On other occasions, like during case presentations or clinical seminars, I could sense the differences between the two approaches. Many times the presentations reflected the tendency to interpret a case as predominantly oedipal or predominantly pre-oedipal according to the theoretical orientation of the analyst. Sometimes different analysts viewed the same material in

very different ways. For example, my own inclination to see clinical material through the prism of the early mother-infant models in which I was trained in Israel, made me view a woman I treated, who expressed merger wishes and fears of engulfment, as preoedipally fixated. When I presented her in one of my classes, I was surprised to hear my instructor's interpretation of the case. He thought that the merger issues were a major defense against oedipal strivings and saw the patient as neurotic. I found something unnerving about this experience. His interpretation, which had never occurred to me, was as plausible as my own.

As I listened to these cases and the interesting debates that followed them, I sometimes had a kind of kaleidoscopic experience as my view of the patients switched between the two perspectives. Is it an oedipal phenomenon or a preoedipal one? What is the right way to see it? Is it possible to integrate the two approaches at all? Do we have to see it as an either-or situation? Or maybe we can see it as a multilayered phenomenon, reflecting both kinds of dilemmas at the same time?

I especially felt the tension between the two schools of thought (the early infant-mother program in Israel and the more oedipally-oriented model at IPTAR) in the first two years of my training at IPTAR. These first two years focused mainly on the Freudian structural model and its evolution, developments in ego psychology, modern conflict theory, and the contributions of contemporary Freudians. The focus on a relatively pure Freudian model – to which later contributions from contemporary psychoanalytic developments were added – sharpened the contrast between my two training experiences.

During that period, I often reflected on the competing models. Before exploring and conceptualizing the differences, I would like to give you some sense of my experience being trained in two different models by sharing several vignettes from supervisions and clinical seminars at HALFABA and at IPTAR. To protect patients' confidentiality, potentially identifying details have been disguised or omitted. When a vignette describes another therapist, a supervisor or an instructor, I have obtained the clinician's permission for this use of the material.

Neo-Kleinian Supervision at HALFABA

Vignette 1

The patient, Ms. A, was a woman in her forties who habitually formed codependent kinds of relationships where she felt like a "prisoner" and complained about not being able to set boundaries or think about herself.

In treatment, she became aware of a similar quality in her relationship with her mother. She felt that her mother wished to "create A in her own image." She remembered that during her adolescence she and her mother wore the same clothes, which sometimes made it difficult to distinguish them from one another. From very early on, Ms. A felt that her mother would fall apart whenever Ms. A shared her problems with her. If Ms. A was sad, her mother would cry, and if she was anxious, her mother would panic. In order to protect her mother, Ms. A learned to

hold her feelings back and developed a pattern of being the strong one who took care of everyone in the family. Ms. A's mother died of a heart attack when Ms. A was 17.

In sessions, Ms. A watched my every move, detecting the slightest change in my mood. She asked how I was feeling at the beginning of every session. She spoke in a calm and controlled voice, which made me feel as if she were the therapist and I, the vulnerable patient. Work with her was challenging and I felt as if she got under my skin.

As Ms. A gave up her role as caretaker in the therapy, she experienced more overt pain and distress in sessions, and the symbiotic connection she had with her mother then emerged. In one of the sessions, the flavor of the relationship between her and her mother was recreated with me in a striking way. She brought up a business trip she was taking that was anxiety provoking for her. She was afraid to separate from her husband for a whole month because "they could not survive without each other." She started to talk about a lecture she was going to give at a conference, which also stimulated a lot of anxiety.

As Ms. A was talking, I felt an unexplained, intense anxiety, unfamiliar from my work with other patients. I reflected on my own feelings and reveries, which were about feeling transparent, fearing that my anxiety would be exposed, which would leave me feeling embarrassed and humiliated in her presence. To my surprise, Ms. A started to talk about a very similar experience of her own. She said, "I am afraid they will see my anxiety. I have to hide it. I have to look calm and confident. Everything depends on that. They need to see me as professional and competent. I once gave a lecture and my legs were shaking. It was so embarrassing and humiliating. It shouldn't happen again. I am not used to showing my weaknesses. It was so dangerous to show any sign of anxiety to my mother…she would immediately fall apart."

I suggested that Ms. A might have been afraid to express her anxiety with me as well, to show it to me, because she might have feared that I would "fall apart" like her mother and we would feel helpless together. My interpretation freed her up to share her distress and pain. She began to cry as she recalled the last moments with her mother, when her mother was dying. Ms. A felt that there was not enough time before their separation, when her mother's death was approaching. I had the sense that the pressure of time upon her forced separation from her mother was reenacted in our session, since these important memories emerged in the last moments of our session before a four-week break from treatment. Ms. A's pressured speech, as well as her charged emotions in that dense moment, a minute before our four-week break, led me to experience the end of that session as a violent and premature interruption.

In the supervision, we treated my feelings and fantasies not as a subjective, personal countertransference but as an "objective" one, representing the core aspects of the patient's internalized object relationships. We understood my reaction as a projective identification: the patient projecting onto me her vulnerable anxious self, which she could not own and contain. In this supervision, the countertransference was always at the center of the treatment. The presumption was that every reaction of mine and even the parallel process in the supervision reflected aspects of the patient's object relationships.

The transference was seen as a projection or projective-identification and not as a displacement from a prior object relationship. We examined the transference as a "total situation" (Joseph 1985) and tried to discern a general process that was transpiring between us in each session. Even when she talked about other objects, we tried to understand what she was communicating to me in an indirect way about our relationship. For example, the main theme in the session I described was Ms. A's anxiety about the approaching separation from the treatment. Through a process of projective identification, Ms. A recreated with me the shared helplessness and the resulting shame that she experienced with her mother. It was again difficult to discern who was feeling what.

The underlying supposition in this supervision was that it was the early infant-mother relationship that was reenacted non-verbally in the room between us and that events that the patient described from later stages of her life also reflected the atmosphere of that early bond.

The Influence of the Kleinian Model on the Learning Environment

Reflecting on my two training programs, I could see how the theoretical assumptions influenced the learning environment and the general atmosphere in classes and seminars. The atmosphere at HALFABA encouraged discussion of one's own internal processes. The fact that these reactions were viewed as an important source of data about the patient's world helped the students feel comfortable bringing up these experiences in supervisions and clinical seminars. Thus, in clinical seminars, the therapist and the group members shared their own emotional reactions readily, which in turn made discussions rich and creative. It was a great relief for me when I realized that even the most negative feelings I had about patients, or my most bizarre fantasies that were stirred up while treating them, often had meaning in the process and could be spoken of in supervision.

However, I did wonder if this approach, at times, could be biasing the data with our own idiosyncratic material, as the subjective elaborations on the material could sometimes be quite speculative and obscure. I also thought that sometimes this attitude might allow us to avoid taking responsibility for our personal countertransferences, since it was easier and tempting to hide subjective reactions behind theoretical formulations about "objective" countertransference that reflects the patient's pathology.

On occasion, I felt that the boundaries in the Israeli program were not clear enough – between patient and therapist, between the different diagnostic categories and the mode of therapy deemed necessary for each, between supervision and personal treatment, etc. At these moments, I missed a more structured and differentiated way of thinking and working.

Contemporary Freudian Supervision

When reflecting on my Freudian supervisions, I realized that it was difficult to find a vignette to exemplify the Freudian model, because the various supervisions I have encountered in New York differ in many ways from each other. This diversity is part of the contemporary Freudian model, which is very heterogeneous in and of itself. In some of the supervisions or seminars, namely the more classical ones, it was easier to discern and define how they differed

from the HALFABA supervisions but in others, which were more object-relations oriented, the differences were more subtle and complex.

The following vignette is from a clinical seminar given by a more classical Freudian analyst, which was very different from the seminars I encountered in Israel.

Vignette 2

In this seminar, we analyzed verbatim process from the sessions of a male patient who was in a once-a-week therapy. The patient, Mr. B, a man in his late twenties, was raised in a strict and depriving environment by a passive and depressed mother and a very harsh and controlling father.

The seminar's main focus was on the verbal channel. We dealt with the verbal material in a careful and responsible way, in an attempt to understand the nuances of Mr. B's experience with his objects and with the therapist. We traced and explored how the material unfolded and how the transference developed from session to session. We were able to discern sequences in which the patient was expressing his thoughts and feelings more freely, which in turn raised some resistances and complex defenses that were analyzed.

The therapist was advised to always stay very close to the patient's experience, to try not to go beyond his defenses, and to refrain from giving premature transference interpretations so that the transference could unfold in a natural way and get more intense, without the therapist directing it by imposing his own agenda. The notion was that only when the feelings of the patient have intensified enough, and regression has occurred, can the patient see them as transference. In one of the sessions, when the patient talked about a friend of his with whom he was disappointed, I had a sense from the material that he was also conveying a similar indirect message about his relationship with the therapist. When I shared this association with the group, the instructor said we did not have enough evidence for this hypothesis. This was a very different attitude from the one I encountered at HALFABA, where transference interpretations were made from the first moment of the treatment and were readily inferred, even assumed, from the material even when the patient talked about his other objects.

During the IPTAR seminar, the countertransference of the analyst was not addressed, except on the one occasion when it was seen to interfere with the therapeutic process. This conspicuous event occurred after the therapist offered analysis to the patient. The patient refused, the therapist tried to persuade the patient to enter analysis, and a kind of power struggle developed around this issue. On this occasion, the instructor gave the therapist some advice about the desired analytic stance, but we did not explore the details of the therapist's countertransference and the way it may have been influenced by the patient's world, for example, by his internal object relationship with his controlling father. It seemed there was an unspoken message that unless the countertransference is very conspicuous, the place for its analysis is in the candidate's training analysis because it is seen mainly as a subjective experience that the therapist has to analyze. In no way do I intend this to represent the general attitude of the instructor; perhaps this class was meant to highlight specific aspects of theory or technique and, in that way, seemed to leave things out for expository purposes.

In contrast, in the neo-Kleinian seminar in Israel, we would take every opportunity to talk about countertransference, which was considered the key element in understanding the patient. We always took into account the emotional reactions of the group members and the atmosphere that was created in the group during the presentation and the discussion. These were seen as an inseparable part of the work and were used on a regular basis as an important source of data about the treatment. I felt that the attitude in the IPTAR seminar made the group more cautious and inhibited in comparison. The therapist and the group members did not readily share their personal reactions to the material, and there was a feeling that you should not say something unless you could prove it. Yet the stance of the IPTAR instructor showed a kind of respect for the defenses of the patient and perhaps, more importantly, for the defenses of the developing analyst. Both analyst and patient were allowed to move at their own pace. The instructor may have been more cautious and sensitive about the boundaries between the roles of teacher and analyst and about the difference between a group supervision setting, where self-exposure may be embarrassing, and an individual supervision setting, where it may feel safer to explore countertransferential issues.

In the next vignette, the supervisor considered himself an object relations-oriented Freudian. This supervision was more integrative and it helped me considerably with the integration challenge. We paid close attention not just to the verbal channel and its contents but also to the enacted dimension of the transference-countertransference matrix. The differences between this supervision and those I had at HALFABA were less obvious, and it took me some time to be able to sense and define them.

Vignette 3

Ms. C, a woman in her thirties, was concerned about her difficulty in forming intimate relationships because of her fears of engulfment. Whenever she immersed herself in close relationships, she usually lost her freedom and felt she could not express herself in the other's presence. When the relationship reached this level of depth, she generally separated from this partner and started all over again in a different relationship. The patient's mother suffered from a severe illness during Ms. C's childhood, which made the mother very needy and clingy.

In the early part of this supervision, we tried to understand and assess the patient's structural/developmental level. It was clear that Ms. C was concerned with separation-individuation issues. However, the fact that she had a rich and creative self and an ability to talk about her problems in a very articulate and self-reflective way suggested that her pathology was not one of the differentiation process itself but a later disturbance, a pathology of the relationship with the differentiated other (Pine 1979). To protect her needy mother, she regressed from later stages of development, not being able to express her differentiated self with the mother. We tried to understand and define her structure and her strengths and weaknesses, and to characterize her defenses. This focus on structural aspects was lacking in my supervisions in Israel.

The transference was seen in a more complex way. It was not perceived as a direct reenactment of the early relationship with the mother, but as a more complex, multi-layered and multi-determined phenomenon, reflecting compromise formations from all of the developmental

stages. When the patient was talking about other objects, even when it was understood as a displacement from the relationship with me, we stayed, sometimes for long periods of time, with that displaced relationship. We tried to elaborate on it and expand the experience of the patient with that object and waited until the patient was ready to experience it in the transference.

Not every object Ms. C talked about was seen as representing her experience with me. The scope of the treatment, which in the Israeli supervisions focused mainly on dyadic relationships, had now broadened to include different kinds of relationships with different objects; in this way, it opened up a world of triangular relationships. We also focused a great deal on her experience with me as a new object and not just on the transferential aspects of our relationship.

The countertransference was also seen as a complex phenomenon, an amalgam of my subjective, personal countertransference and the "objective" patient-driven countertransference. It was understood as including conscious and unconscious aspects. We paid a lot of attention to non-verbal enacted processes, unconscious actualizations that could sometimes become conscious and more available for analysis only after they occurred.

The Influence of the Freudian Model on the Learning Environment

The Freudian training helped me develop a more systematic and discernible way of thinking. I became more careful while listening to my patients, and I believe that my interpretations have become more responsible and modest. I am now more respectful of patients' defenses and the need to be much closer to their conscious experiences. I developed a better ability to make a distinction between the diagnostic categories and the therapeutic mode deemed necessary for each. I felt as if a more complex and differentiated internal model was starting to form within me.

Yet I felt as if the need to be very accurate and scientific sometimes blocked or hampered the more intuitive and creative processes in supervisions and clinical seminars. At times I felt that neither I nor my classmates had the courage to express these internal voices. There was a tendency to ignore or suppress the more primitive phenomena that were stirred up in the therapeutic process: sensations, bodily experiences and body language, non-verbal communication, and bizarre mental products that are there in the room all the time.

Countertransference, while readily acknowledged by contemporary Freudians as an important area of exploration, is seen differently by most Freudians. Countertransference, in the IPTAR program, is explored mostly when it becomes conspicuous enough or when it interferes with the psychoanalytic process, whereas at HALFABA, the supervisor's first question after listening to the patient's material might be, "How did it feel to be with the patient?," and a whole supervisory session might be spent discussing this. In the Freudian program, I would be more likely to report what the patient and I said, and only occasionally would the countertransference come to the fore. Most times it was my initiative to discuss a countertransferential issue and not the supervisor's.

Each of my trainings helped me develop different capacities, while sometimes hampering others. I wished I could find a way to combine the good qualities of both modes of functioning within me: creativity and freedom along with responsibility and structure.

Conceptualizing the Differences

The HALFABA Early Infant-Mother Program

In the Israeli program, the main focus was the early infant-mother bond and the way it shapes psychic life and structure formation. The developmental course covers only the first year of life. In terms of contents, we explored the development of the infant's emerging self and the transition from absolute dependence on the subjectively-perceived mother toward an ability to relate with the external mother who is objectively perceived (Winnicott 1953). In Kleinian terms, we explored the transformation of object relations from the part-object orientation of the paranoid-schizoid position to the state of awareness of persons as whole objects and the corresponding integration of loving and hating aspects of self and other in the depressive position (Klein 1952). We focused on developmentally-early anxieties about annihilation, disintegration, and persecution. Special attention was paid to preverbal and unconscious emotional development.

One of the courses designed to help us understand these processes was an infant observation seminar, during which we observed, over one academic year, a baby and his mother, from birth, in a family setting. In the sessions and class discussions, we traced the most minimal nuances, mostly non-verbal, that took place between the mother and the infant, and engaged ourselves in our own personal responses in order to become increasingly aware of our non-verbal emotional states and to develop the ability to discern and contain them.

The Oedipus complex was seen through the lens of the Kleinian and post-Kleinian models. It was not the classical oedipal complex but an early oedipal constellation, which is believed to exist from the first year of life in a pre-genital form (Klein 1945). The infant emerges from the exclusive relationship with the mother to meet the third, which can be the father, the father within the mother, or any other interference to the harmonious bond with the mother. This Oedipus complex coincides with and is integral to the mourning processes of the depressive position (Britton 1991).

The Israeli program did not offer different clinical seminars for the classical patient and the non-classical patient. Patients across the spectrum of psychopathology were discussed in the same seminar. This was a reflection of conceptualizing pathology more as a continuum and not so much as representing qualitative differences among the various diagnostic categories. The Kleinians believe that a psychotic core exists in every patient and that those deep psychotic levels and part-object relationships can be demonstrated and worked through in every analysis. For the Winnicottians, all psychopathology involves "corruption and constriction in the expression of the self" (Greenberg and Mitchell 1983, p. 200).

The underlying supposition is that the primitive mother-child relationship can be directly recreated in the analytic situation. It is the infant within the patient whom the therapist has to

reach. The Kleinians believe that in the analytic situation the patient fantasizes ridding himself of unwanted aspects of the self and putting these aspects into the therapist. The patient then exerts pressure on the therapist to experience feelings that are congruent with the projection. The analyst has to accept these projective-identifications (Ogden 1979), contain them, process them, detoxify them, and help the patient to re-internalize them in a metabolized way.

In every analysis (not only with difficult patients), beyond the more mature verbal layers, we always meet these more primitive pre-verbal layers of the patient. The focus moves from the verbal overt processes to focusing more on the non-verbal enacted processes, which are recreated in the room.

The Contemporary Freudian Program

At IPTAR, the developmental course covered all the developmental stages from infancy to adulthood. A special focus was put on the oedipal period, and the oedipal constellation was seen as a nodal point in development. There were separate clinical seminars for the classical patient and the non-classical patient; this implies an attitude that stresses the importance of diagnosing the developmental level of the patient and reflects the view that the mode of therapy and the stance of the analyst must change according to the developmental level of the patient.

In the first two years, through reading Freud and his early followers, I could sense what classical oedipal analysis was. In this model, the way of conceptualizing pathology presupposes a certain degree of structural differentiation. A relatively stable differentiation between self and object representations has to be established in order to experience the triadic interpersonal constellation of the oedipal situation (Killingmo 1989). The main focus in classical analysis is these triangular relationships with the primary objects (mother, father and siblings), who are experienced as separate whole objects. The analyst also represents a separate object and the transference is understood mainly as displacement from these prior object relationships. The patient who reaches this developmental stage is supposed to have formed a capacity for symbolization and thus can verbalize his conflicts and dilemmas. In classical analysis, the verbal channel is the main source of data.

The main therapeutic tool is interpretation, which gradually leads to the dissolution of the transference neurosis. Structural change comes about as a result of bringing formerly unconscious conflicts into consciousness and helping the patient develop higher levels of ego functioning. It is mainly a one-person psychology in which the therapist is an interpreter of the intrapsychic conflicts of the patient. The countertransference is also perceived, for the most part, as intrapsychic phenomena, reflecting the compromise formations that the therapist has formed and his own psychopathology.

In the classical model, the early relationship of mother and child is not given the same attention as in some other models. The assumption of modern conflict theorists is that early, preoedipal developmental conditions are transformed in the mind by the experiences of the oedipal phase and are, therefore, not directly available in the experiences of the adult personality.

As I proceeded in the program at IPTAR, the sharp contrast between this classical oedipal analysis and the preoedipal, pre-verbal analysis of the HALFABA program gradually began to soften. In classes, we began reading and discussing contemporary Freudian theorists who incorporated into their approaches the influences of Mahler, Klein, Winnicott, Kohut and others. These "developmental" or "self and object" Freudians have widened the "classical" scope and have introduced separation-individuation as a nodal point that shapes behavior and psychic life and that can be analyzed. Those analysts pay heed to the early structure-promoting aspects of the mother-child relationship (Loewald 1980a,b, Pine 1979, Druck 1998) and to the disturbances that can lead to deficits. The coexistence of conflict and deficit in many patients requires the appreciation of the additional "relationship" factors, like attunement, flexible responsiveness, and sensitivity to the changing needs of the patient, that are salient at every moment in the analysis. I gradually learned that the broader contemporary Freudian model encompasses many of the intersubjective, two-person perspectives, including the use of countertransference, with mindfulness of the patient's and the analyst's internal structure and transference.

While I found this broader contemporary model much more integrative, I still felt a remarkable difference between the two programs, especially in two important realms: a) the issue of relating to material from infancy and the resultant clinical implications, and b) diagnostic issues and their technical ramifications.

Infancy recreated in treatment. Although Freudian writers included the separation-individuation realm in treatment and spoke to reconstructions of preoedipal experiences (Blum 1977), the focus is on the later subphases of the separation-individuation process, mainly the rapprochement phase (Valenstein 1989), or on the role of retrospective fantasy later on in childhood that imparted meaning to the forgotten, preoedipal period (Blum and Ross 1993). In contrast, the Kleinians and Winnicottians believe that much earlier material can be represented in analysis in a non-verbal way. The bone of contention is whether preverbal material *from infancy* can be directly represented in the treatment.

In a paper on the relevance of the contributions of Winnicott (Blum and Ross 1993), the authors quote Ross: "We can be deceived by childhood phenomena that are revived in analysis, which, from a schematic point of view, look as if they belong to an earlier era" (p. 233). Ross concluded that we may sometimes see little babies in our patients when what is being perceived is the "baby" that was present in later childhood (in the fantasy of the older child). He suggested that "Not only do we not throw out the baby with the bath, but we do not discard the little boy or girl, the older child, as well" (p. 233). Reflecting on this debate, I thought that maybe it is true that the Kleinian and Winnicottian analysts sometimes throw out the older oedipal child from the analytic relationship, just as the Freudian classical theorists sometimes throw out the infant.

This difference in perspective has a direct impact on technique. Believing that experiences from infancy are recreated in the room, "infant-mother" analysts pay close attention to the non-verbal realm – sensations, feelings, and the general atmosphere in the room – as representing these primitive layers of the mind. The example that best captures the essence of the role of the therapist in these models is that of an early mother who contains her baby's feelings and uses her own feelings and reveries in order to understand and interpret his non-verbal communication. For most Freudian analysts who believe that these earliest experiences

are embedded in more developed layers and are mediated through them, the verbal realm remains the main source of data.

Diagnostic issues and their technical ramifications. In the Freudian model, there is a much clearer dichotomy between the classical (oedipal) patient, for whom the classical interpretive therapeutic mode is useful, and the non-classical (preoedipal) patient, who has difficulty utilizing the traditional psychoanalytic situation and with whom analytic technique needs to be modified. The way my instructors from the two programs interpreted Winnicott, for example, highlighted this difference. My Freudian instructors suggested that Winnicott's therapeutic mode is applicable mainly with disturbed patients who, needing to regress to dependency, require a period of steady "holding" rather than interpretive work. The search for the hidden true self is the main process in this regressive period. Interpretations are undesirable and liable to ruin the process. They become essential again only after the patient recovers from the regressive state. In this Freudian model, interpretation remains the most important tool, with other techniques only called upon when interpretation is not useful. As one of my instructors put it, tools, like holding, containing and soothing, are sometimes needed in order to consolidate the more primitive layers but they only "set the table for the dinner." Dinner is, of course, interpretation. In the Kleinian and the Winnicottian models, there is no such clear distinction between the diagnostic categories and the therapeutic mode deemed necessary for each. Holding, containing and empathic attunement are considered as important, if not more so, as the interpretive process itself with all patients.

Through writing this paper, the contrast between my two trainings softened. I became aware of a tendency in the field both to exaggerate and to minimize differences between the models. For example, after reading drafts of this paper, several people felt that I was flattening the complexity of the Freudian model by seeing it as a schism. As I reflected on these reactions, I suspected that while it is possible that I and others exaggerate the differences in theory for political or personal reasons, there is an equally prevalent tendency in the field to simply minimize the differences and say, "We do that, too." Having been through both trainings, I believe there is a real difference between the programs, and this has a substantive impact on candidate training and the treatment of patients.

Schisms in Psychoanalytic Thought

As my dilemma continued, I was able to define the split in a clearer way: The "early mother models" highlight the preoedipal earliest layers of the mind and their technical ramifications, and consider the "classical" oedipal layer as secondary or sometimes even marginal. The contemporary Freudian model highlights the classical Oedipus complex as the nodal developmental point. While extending their interest to separation-individuation issues, some contemporary Freudians still neglect earlier phenomena that are enacted non-verbally in the transference-countertransference matrix, since it is perceived as speculative and non-scientific. Each group of models highlights one aspect or one developmental stage, while ignoring or minimizing the other.

My research into the differences between the models revealed other authors addressing this schism. For Akhtar (2000), the oedipal-preoedipal dimension is only one vantage point from

which to view this schism. He writes, "This schism subsumes the following dichotomies: oedipal-preoedipal, psychopathological-developmental, one person-two person, verbal-non-verbal, conflict-deficit and so on. To be sure, each such conceptual pair has its own vantage point, its ups and downs in psychoanalytic history, heuristic accompaniments, and technical nuances" (p. 265).

Several analysts go further by specifying what is missing in a particular model and by calling for extending, expanding or revising the model to include those missing aspects. With regard to classical theory, Grotstein (1980), for example, criticizes the classical model as he writes, "The classical genetic theory is really handicapped in that it cannot allow for a mental organization in early infancy which can account for early infantile trauma" (p. 480). Ferguson (1981) points out how the psychology of the self filled a gap in the developmental picture of the infant between birth and the post-oedipal period, where the tripartite model begins to take over, and how the self conception is an important supplemental construct to the tripartite model.

Many analysts point to the limitations of the models that highlight the early mother-infant bond. Rangell (1982) talks about "a swath of avoidance circled around the role of the Oedipus complex in development and psychopathology" in these models (p. 38). Loewald (1980b) discusses the waning of interest in the Oedipus complex in recent decades. He suggests that the new trend in psychoanalysis underscored the primary unity with the mother. Accordingly, the focus of psychoanalytic investigation was directed towards the more disturbed patients, like the psychotics, borderlines and severe narcissistic patients. The diagnosis of neurosis, with its oedipal dilemmas, became less and less common, with analysts seeking to uncover deeper preoedipal issues.

Eagle (1984) talks about the influence of one's theoretical predilections on the way one sees the patient's psychopathology. One clinician can view a particular set of behaviors as indications of self-defects and developmental arrests (preoedipal psychopathology), while a clinician with a different theoretical inclination may see them as indications of oedipal pathology (neurosis) and will give a different meaning to these behaviors. For example, self psychologists usually see the introduction of erotic feelings to the transference as an effort to correct or make up for self-object experiences that were not sufficiently met earlier in development (Eagle 1984).

A Developmental Hypothesis

Continued reflection on the reasons for this split in psychoanalytic theorizing, and the tendency to highlight part of the picture and devalue the other, led me to believe that if I could understand the psychoanalytic meaning of this split, I could better integrate the different perspectives with which I was struggling.

A potential approach started to crystallize in my mind when I immersed myself in Loewald's (1980b) paper, "The Waning of the Oedipus Complex." He addresses an especially difficult stage in the development of the child, when the "incest barrier" is overturned. This is the moment when the person with whom the child had a primary identificatory bond (usually the mother) becomes an object of sexual desire. Prior to that moment, the relationship with the preoedipal mother is experienced as an innocent unity. The self-other boundaries are still blurred

and the nourishing, protecting mother is not yet perceived as an external object. The mother-infant unity is felt to be sacred. The incestuous fantasies are felt to be evil because they violate that sacred intimate bond. The incestuous object relationship, according to Loewald, serves as an intermediate stage in the global process of separation-individuation. The incestuous object is no longer just a merged object but it is not yet a fully autonomous object.

Loewald proceeds to explore the parricidal aspect of the Oedipus complex. He suggests that in order to gain full emancipation from the parents, the child in the oedipal period commits a symbolic parricidal act. He "kills" the parents and at the same time internalizes them by forming the superego. Parricide, again, is a crime against the sanctity of the bond with the nurturing and protecting parents. Loewald (1980b) postulates that the moral condemnation against these evil wishes "accounts for the blindness to infantile sexuality, including, at least in Freud's time, blindness to 'phallic' oedipal sexuality" (p. 396).

It occurred to me that this difficult developmental transition – from sacred merger with the identificatory objects toward relating with the parents as external objects of desire and parricidal wishes – may also account for the general theoretical split I have been addressing. There is a tendency to blind oneself to one dimension of development while being aware of the other. Whenever someone experiences the sacred unity with the early mother, he is susceptible to denial of oedipal wishes; in contrast, someone readily conscious of oedipal conflicts may tend to ignore that preoedipal sacred bond with the early identificatory objects.

We can discern this schism tendency in the pendulum-like movement in psychoanalytic thinking over time. Before psychoanalysis, the sacred family bonds made people blind to the Oedipus complex and its dilemmas. Freud dared to point out and explore the sexuality of the oedipal child. But because of his own blind spots regarding his relationship to his mother, he and psychoanalysis in the decades following overlooked the early phases of the primary union with the mother. The pendulum of psychoanalytic investigation thus began at the oedipal, incestuous end, leaving unexplored the primary maternal unity and its dilemmas. The Oedipus complex was considered to be the nucleus of all psychopathology, the central constellation that is responsible for the suffering of the guilty human being.

More recently, the pendulum has swung to the other extreme. As theoretical interest shifted to the primary unity with the mother, attention to the Oedipus complex waned. This swinging of the pendulum always illuminates and highlights one of the developmental phases while denying the other. The schism in psychoanalytic theory reflects the difficulty in containing both constellations together and remaining at this developmental juncture, where merger-differentiation issues and incestuous-murderous fantasies are experienced together. The real difficulty is that of integration, of being able to experience the sacred identificatory bond (the psychotic core) together with the oedipal strivings (the neurotic core).

Attempts at Integration

Rather than see them as two discrete developmental phases, Loewald stresses the connectedness and continuity of the preoedipal and oedipal states. He sees both as part of the global process of separation-individuation, in which the child gradually becomes an autonomous

person who is responsible for his own life. In this process, the incestuous object relationships serve as an intermediate stage, with the resolution of the oedipal complex as the final stage. The superego, which is an individual psychic structure formation, symbolizes the emancipation from the parents as well as their internalization, and represents something ultimate in the basic separation-individuation process. In Loewald's (1980a) view, earlier ego states continue to survive side by side with later stages of ego development:

> People shift considerably, from day to day, at different periods in their lives, in different moods and situations, from one level to other levels. In fact, it would seem that the more alive people are, the broader their range of ego-reality levels is. Perhaps the so-called fully developed, mature ego is not one that has become fixated at the presumably highest or latest stage of development, having left the others behind it, but is an ego that integrates its reality in such a way that the earlier and deeper levels of ego-reality integration remain alive as dynamic sources of higher organization (p. 20).

An attempt at theoretical integration is discernible in the work of other theorists as well (Akhtar 2000, Druck 1998, Killingmo 1989, Pine 1979, Rangell, 1982). Akhtar (2000) suggests that "the doctrinaire tendency of either/or thinking must be put aside in favor of a technique that oscillates in rhythm with the patient's level of psychic organization" (p. 274). The ideal to be approached is the acceptance of complexity, of paradox, of multiple determinations, and by implication, of a fluid though informed and thoughtful technique.

Akhtar notes that the two approaches (classical-romantic, oedipal-preoedipal, conflict deficit, etc.) can be reconciled on three levels of increasing complexity. The simplest stance is to view them as being suited for different kinds of patients. At a more complex level, it seems that both approaches are suitable for the same patient, but at different times during the treatment; when the patient's transferences reflect conflict-based sectors of the patient's personality (oedipal layers), the technical approach should be one of skeptical listening, a search for concealed meanings, and interpretive interventions. But when the patient's transferences reflect deficit-based sectors of the patient's personality (preoedipal layers), the technical approach should be characterized by credulous listening, validation of the patient's psychic reality, and affirmative interventions. Further, Akhtar (2000) writes:

> At an even more sophisticated level, it can be said that every patient's every association and every behavior can and should be understood from both approaches. The choice of perspective from which to address the material and of what facet to bring to the patient's attention then depends on the therapist's intuitive evaluation of the patient's capacity to hear and assimilate the information (p. 273).

Katz (1998) integrates the verbal and the non-verbal dimensions of the analytic relationship. He suggests that "transference may be represented not only on the verbally symbolized level but also on the enacted level, through psychic organizations and processes that use behavior, silence, and even speech as symbolic vehicles. Counter-transference too finds

representation within the enacted realm, in response to and in concert with the patient's enacted processes, though in more attenuated fashion" (p. 1129). Katz indicates that this continuously evolving enacted dimension "exists alongside, and inextricably interwoven with, the treatment's verbal content, with characteristics unique to each analytic dyad" (p. 1129). Attention to these unintended but meaningful and often elaborately developed characteristics of the treatment process furthers our understanding of the therapeutic action of psychoanalysis, and the process of integrating the enacted with the verbal dimension of treatment enables the analysand to achieve higher levels of psychic organization.

Akhtar (2000) suggests that, in fact, most practicing clinicians, like those integrative theoreticians, also intuitively attempt to strike their own varieties of a balance between these two conflicting approaches.

On a personal level, the integrative perspectives of Loewald and others help me with my own striving for integration. They assist me with my struggle to view each of the two approaches in which I have been trained as valuable and mutually enriching, and to incorporate both, in my own way, into my developing identity as an analyst.

The field does not seem as polarized to me now as when I started my training at IPTAR, as I am gradually more able to see nuances in both of the models and points of congruency between them. I see how most of the analysts I know, whatever their basic training, at least try to span both sides of the schism; some may succeed better than others, and anyone may succeed better at some moments than at others. I have also become aware of tensions within the Freudian model between adherents of different perspectives, some of them more oedipally oriented and others paying more attention to preoedipal issues.

Of late, a more integrated perspective has been crystallizing within me. I feel I can start taking from both worlds and combine the good qualities of both modes of functioning within me. I try to adopt the systematic, discriminative, and deciphering approach, along with the responsibility and modesty that the Freudian model represents for me, while at the same time keeping the qualities I value in the early-mother models, such as freedom, creativity, and the ability to make one's own self-object boundaries more elastic, which enables the therapist to receive the deeper non-verbal communication from the patient.

While sitting with a patient, I am more aware of the coexistence of oedipal and preoedipal contents in the clinical material and the ways they are intertwined. I find it easier not to oversimplify a patient's difficulties, viewing them as solely the result of preoedipal or oedipal factors. Rather, I try to see them as multilayered phenomena in an individual who is struggling with both kinds of dilemmas simultaneously.

I listen to the verbal realm, the more mature level of the person, and make interpretations; I also try to immerse myself in the earlier preverbal layers, which I can discern through my own countertransference (in the broad sense). I use my feelings, fantasies and reveries to enrich my understanding of what is going on in the treatment, yet I always wait until I find a way to relate my experience with the verbal material that is unfolding in the hour, and try to gradually bring the non-verbal experience into the verbal realm.

Many times, when complex enacted processes are unfolding in the room, I feel that my interpretations become more mutative only after they really "pass through me" – as I am able to identify myself with the self-component or with the object-component of the patient's internal object relationship (Ogden 1983). Only then can I understand the patient in a deeper way and interpret from within. I sometimes maintain this kind of internal process for a long period, during which I try to contain my feelings and reflect on them. When the patient starts to bring verbal material that implies awareness of the split-off parts, then I can use all the insight I have gained through this process and offer it to the patient.

As Akhtar (2000) suggests, I try to integrate the maternal element of technique (holding, facilitating, enabling and surviving), which meets the more primitive layers of the patient, with the paternal element (searching, confronting, deciphering and interpreting), which meets the patient's more developed and mature layers.

As I mature in my psychoanalytic training, I have begun to experience the containment of both perspectives as a relief and as an opportunity for growth, rather than as an overwhelming burden and restraint.

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Panel: Shame in Psychoanalytic Training

Introduction

In their enlightening and now classic papers on the education of psychoanalytic candidates in training institutes, Dr. Jacob Arlow (1972, 1982) and Dr. Otto Kernberg (1996) acknowledged the centrality of shame and humiliation in the candidate's experience. More recently, Dr. Sandra Buechler's ability to capture the candidate's shame experiences in her writings and presentations inspired the editors to investigate the role of shame in psychoanalytic training. We invited Dr. Buechler to formulate questions for the panel members. The panelists – analysts at various stages of their careers, from different institutes – used these questions (presented below) to facilitate exploration of their own thoughts about shame in psychoanalytic training. Dr. Buechler also contributes a paper to this online panel, incorporating the panelists' responses with her own views on the topic.

Questions

1. What could we do that would better foster each candidate's development of a unique analytic voice? Is analytic training, as it is currently practiced, unnecessarily infantilizing? For example, do some of our training practices encourage candidates to become "followers" of highly esteemed luminaries? Another related question: Should we encourage candidates to learn one particular style/analytic school at first, and then explore alternatives? Might being a follower of one style or school, at least in early training, be acceptable and/or even necessary? Or should training be eclectic from the beginning, fostering the candidate's process of comparing classical, self, interpersonal, and other approaches? Which approach inculcates more of a sense of inadequacy/shame? Are there ways we might diminish infantilization and shame?

2. Since candidates are [in the process of] learning [an] immensely complex and ambiguous analytic task, is it inevitable that they will, at times, feel inadequate / ashamed? Do some of these feelings follow from unavoidable comparisons with more experienced faculty and other candidates? Are there positive aspects of this? Do these feelings contribute to the candidate's growth? At the same time, what attitudes in supervisors, training analysts, [and] teachers, unnecessarily shame candidates? Is there anything we can do about that?

3. Does the current training model adequately prepare candidates for practice in today's world? If not, how would training have to change to address it? For example, is the tripartite model, with supervision, didactic courses, and a personal analysis as it components, the best way to nurture analytic talent? Do we shame candidates by expecting them to succeed at a process tailored for a climate that no longer exists? Or, is it still important to learn a method in its "ideal" form and later find ways to apply it?

4. Does the model of "training" psychoanalysts itself make shame an inevitable part of the experience of becoming a psychoanalyst? Is it possible to create an environment where people become psychoanalysts under significantly different premises? What would such an environment look like?

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The Social Psychology of Shame in Psychoanalytic Training

C.J. Churchill, PhD

> *The Educational Committee never came out with any official pronouncement about the student organization. About how it would interfere, how it would be extraneous – at best a waste of time, at worst a resistance….but I believe that that was their attitude. Let the children play. Analytic education is inescapably an infantalizing experience. Interesting, isn't it? That a profession which gears itself so much to progressive maturation should conduct its education as an infantalizing experience?* -- "Aaron Green" in Janet Malcolm's *Psychoanalysis: The Impossible Profession* (1980)

> *In shame, the subject's movement back into itself is simultaneously a turning away from itself. In shame, the subject may have nowhere to turn*. -- Sara Ahmed, *The Cultural Politics of Emotion* (2004)

Shame in an Institutional Context

When shame is found in a professional setting, those who are training in the profession may want to avoid discussing it, given that their focus is largely on establishing legitimacy. If the trainee's confidence seems undermined by shame, s/he may worry how well s/he will be received by those on whom s/he depends for professional opportunities. This is understandable, even though it could be helpful and might even solidify the candidate's reputation for self-assurance if s/he admits to being ashamed of early professional mistakes and uncertainty. A fictional analogy pertains here.

In John Cheever's story "The Swimmer" ([1964] 2000), the protagonist Neddy Merrill wends his way through his neighbors' swimming pools on a summer afternoon. At first we see him as an eccentric. In his affluent suburb, he arrives unannounced in backyards in his swimsuit, ready for a dip. Along the way, he is offered cocktails and pleasant conversation. But as the story progresses, one has the feeling that something is terribly wrong. Gradually, each new set of neighbors seems less accommodating. We do not fully grasp what is happening, though, until the last paragraph in which he ends up at the front door of his own home. A gutter is hanging off the house and the door is locked. No one answers when he knocks. We now see this is his former home. Somehow, he lost everything. Yet his neighbors never bring up *the real situation*. They effectively release themselves from responsibility for this man's life because they have managed to avoid his defining condition. One can sense the neighbors are ashamed for him and, by extension, they feel too ashamed themselves to articulate what is going on.

Neddy's neighbors' collective shame turns them as a group away from him. Through his elaborate delusion, Neddy similarly has turned away from himself. This illustrates shame's power to prompt us to turn away from something that makes us feel guilty for violating a moral or social tenet. Shame, in other words, disrupts or ruptures the bonds between people as well as the person's confidence in his/her own self. It clogs the channels for communication, both internal and external, which might otherwise diffuse shame's power and turn it into something more productive.

While we know almost nothing about the history of Neddy's involvement with his neighbors, we sense they behave as though nothing has happened because of the shame they feel around a man whose fall they may have contributed to, if only for their lack of interest or intervention in his troubles. The tragedy, then, is not Neddy's fall from a higher place but rather the power of shame to turn his fellow human beings away from him and to turn his own mind away from its real condition. The dynamics of shame will shift depending on whether it is shame felt by a group toward an individual or the shame an individual feels toward him/herself. But common to all is the tendency to turn away and, as a result, to exacerbate rather than solve the problem at hand.

In psychoanalytic training, there are many opportunities to feel shame, especially in the key rituals of the training experience. These include application for admission to an institute; establishing a fee for training analysis and supervision; undergoing a readiness for control evaluation; and, for candidates in New York State without a mental health license already in hand, coping with regulations governing how one may train and how one may see patients. In each of these ritualized spheres, there is the chance for shame to arise and, simultaneously, the temptation to avoid it.

The candidate's training analysis does offer a venue in which to work out these shame feelings. But does the general knowledge that the candidate is undergoing an analysis perpetuate an institutional sense that all parties are released from coming to terms with shame in other institutional settings? Or does the training analysis make people more likely to vocalize and struggle with such feelings in the open? The answers to these questions, of course, vary from institute to institute and from candidate to candidate. But the questions invite us to consider how candidates who find themselves compelled to avoid, repress, deny, or turn away from their shame in the presence of peers and superiors could end up like Neddy Merrill – traveling through pleasant yards of understanding neighbors in affluent estates, until one day they find themselves knocking on a door that refuses to open at a house they thought was their own.

For the candidate who chooses avoidance, problems that produce shame are likely to metastasize and upend one's training. The culprit may be the disposition of institute faculty who avoid the situation or the fear of the candidate who cannot voice his/her feelings of inadequacy and uncertainty. But in either case, the core problem is that *shame encourages an avoidance of the real*.

Some Perspectives on Shame

We should be able to look at the experience of shame in psychoanalytic training separate from the emotional constellation of the individual candidate who feels shamed. This is not to dismiss the significance of that individual's psyche but rather to say that the social conditions deserve at least equal consideration.[1] As a way of getting to the social conditions surrounding

[1] Erich Fromm, in a 1929 essay written while he was at the Frankfurt Institute of Social Research, makes a cogent claim for linking sociology and psychoanalysis, an intellectual union that has proven illuminating for the last several decades. He writes: "The application of psychoanalysis to sociology must definitely guard against the mistake of wanting to give psychoanalytic answers where economic, technical, or political facts provide the real and sufficient

shame, I review the comments of two psychoanalysts writing about shame in the individual, followed by a social theorist's comments about shame's collective function.

Jane Hall (2007) writes that rage serves to protect us from our shame, in part because we fear shame's destructive powers. Shame, she explains, will repeat itself if it finds no outlet for release and if the person finds no object relationship to repair the inner state that produces shame. We can imagine here Neddy Merrill's shame at losing his fortune and his family and his being so incapable of facing this that he wanders through the environs of his one-time neighbors acting as though nothing is wrong. The neighbors collaborate with him instead of confronting his condition, and they thereby worsen his situation. Rather than rage, Neddy cultivates obliviousness, but in the end reality comes back around to cruelly remind him of what he has become. Effectively, Neddy's relationships exacerbate rather than repair his shame.

Illustrating the rage Hall says shame may spark, one senior analytic candidate at a major institute was deemed by an evaluating committee to have fallen short of several standards of analytic practice in his/her control case. Perhaps reacting to the shame generated by this evaluation, the senior candidate turned to a junior candidate during an institute event and said, *sotto voce*, "You made a *big* mistake training here." The senior candidate's rage is projected onto the junior candidate in order to protect the senior candidate from the internally destructive power of shame rather than coming to terms with its source.

Casting light on this example, Benjamin Kilborne (2007) distinguishes between toxic shame (which negates and produces disgust) and humanizing shame (which embraces and produces acceptance). The senior candidate in the example above exhibits toxic shame, which now converted into rage, s/he uses to negate the junior candidate's training experience. Of course, the shamed senior candidate is also showing his/her anxiety. Kilborne states that anxiety can instigate feelings of shame and that shame tends to be ignored as an aspect of psychoanalytic training. But why? Does facing shame bring about a level of discomfort in both faculty and candidates that reminds them of moments of vulnerability they would prefer to forget? Is there something about the culture of psychoanalytic institutes that encourages candidates and faculty to avoid rather than confront shame?

Kilborne (2007) notes that shame tends to be diffuse within the self. It evades intellectual efforts to isolate and define it and is, therefore, difficult to confront. "The less conscious we are of shame dynamics in ourselves," he writes, "the less stable will be our sense of identity and the more we will tend to rely on omnipotent defenses and superego smugness" (p. 6). This applies to the senior candidate above who, in the face of shame produced by a lack of knowledge in the field (or a lack of familiarity with the field's defining rituals), converts shame into its toxic form by projecting it onto the junior candidate rather than embracing it and reaching out for clarification and assistance from peers and instructors.

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explanation of sociological questions. On the other hand, the psychoanalyst must emphasize that the subject of sociology, society, in reality consists of individuals, and it is these human beings, rather than an abstract society as such, whose actions, thoughts, and feelings are the object of sociological research." One of the books in which Fromm applies this idea most powerfully is *The Sane Society* (1955).

Kilborne also points out that shame has its developmental origins in the infant's effort to make the world safe by helping its mother "feel as she wants to feel in relation to him" (2007, p.4). If we apply this insight to candidates in analytic institutes (or to students anywhere), the candidate may seek to make institute culture safe for him/herself by helping instructors and others in the hierarchy feel in relation to him/her as s/he perceives they want to feel. If this is going on, it is unlikely that those in a position to help the candidate will do so, for they will not even know a problem exists. In other words, parties on both sides of the shame dynamic can collaborate (perhaps unconsciously) in denying its existence through negation (toxic shame). To shift from toxic to humanizing shame, institutes need to go beyond platitudes that proclaim an interest in hearing candidate concerns to implementing policies that prompt advisors to elicit from candidates discussion about their shame-fraught experiences and, in so doing, embrace and convert those experiences into productive change rather than destructive, internalized rumination.

In her book *The Cultural Politics of Shame* (2004), Sara Ahmed moves beyond the individual experience of shame to a consideration of how shame functions collectively. In a chapter titled "Shame Before Others," Ahmed looks at how some members of a given society or nation are made to feel like outsiders and, therefore, shameful. She describes those deemed "other" because of skin color and because they are non-heterosexual, or "queer." "The difficulty of moving beyond shame," she writes, "is a sign of the power of the normative, and the role of loving others in enforcing social ideals" (p. 107). This challenges the idea implicit in Hall, Kilborne, and many other psychoanalytic writers that love is a means to eliminate shame.

Ahmed's point is that in loving another, one can use love to suffocate the beloved's true self from emerging if the beloved can infer, deduce, or know that something about his/her self is unacceptable to the lover. In a family dynamic, it is easy enough to see how "queer" children will rigorously stifle their sexual identity if a parent makes it clear that being queer is not acceptable because it is not "normal." Ahmed broadens this point to include how a nation may look at ethnic or cultural outsiders in the same way a rigid parent looks at a queer child. She argues that minority skin color or folkways that deviate from the mainstream culture are often deemed shameful because they are "unreproductive: they cannot reproduce the national ideal" (p. 108). Similarly, the psychoanalytic candidate may experience shame if s/he feels at odds with an institute's theoretical expectations. Such a candidate is in the position of feeling queer – that is, different from normative expectations and by extension unworthy because s/he is potentially "unreproductive" because s/he lacks the ability or inclination to extend the ideas and practices by which an institute's culture may define itself. Commonly, graduate training programs are designed to extend an academic department's theoretical agenda through their students. But in psychoanalytic training, in an age in which psychoanalysis itself is theoretically and economically under siege, the institute's desire to entrench, sometimes stridently, its theoretical disposition may take an especially toxic form in its reaction to candidates who do not toe the institute line, be it classical, intersubjective, object relations or any of the many other orientations.

Ahmed continues, "Shame as an emotion requires a witness: even if a subject feels shame when it is alone, it is the imagined view of the other that is taken on by a subject in relation to itself" (p. 105). Here Ahmed refers to an internalized, punishing superego. We may wonder how the candidate who feels like s/he is at odds with theoretical and clinical expectations of his/her institute feels in the room with a patient when a clinical intervention seems at hand that

the candidate knows would be at odds with the institute's norms. One hopes the candidate will bring this to case discussions and that if a genuine mistake is made, it can be corrected and productively discussed. But when shame intervenes, along with its companions fear and rage, the candidate may feel s/he has "nowhere to turn" (p. 104) except in upon the self, hiding the perceived wrong and never dealing with it in the presence of teachers and peers.

This is not to say that teachers and peers should be uncritical in order to avoid inducing feelings of shame. Rather, an institute culture should be built and sustained in which the receiving of criticism is felt as supportive, productive, humanizing, and helpful instead of as cutting, destructive negation. It is also not to say that institutes should not have, defend, and perpetuate modalities of treatment but rather that, in preserving these, an institute also allow candidates to feel intellectually safe in exploring ideas and approaches that they know are heterodox, or "queer."

Shame in Psychoanalytic Training Rituals – Some Examples

To write sociologically about shame in psychoanalytic training, one would ideally interview candidates and faculty, compare their responses to more or less uniform questions designed to probe the topic, and write up an ethnographic report or translation (Churchill 2005) of the material. For this essay, it was not possible to execute that kind of project, but it is possible to take into account features of analytic training that have the potential to evoke shame and then consider them in social context. As both a sociologist and psychoanalytic candidate, I hope to bring some insight to that task.

Is it shameful to lack funds for psychoanalytic training? To some candidates, paying for the training analysis, classes, and supervision is a surmountable burden. It may be especially easier for those who enter training with full psychotherapy practices and/or who have spouses or life partners willing and able to subsidize this venture. But in the context of professional education in U.S. society today, psychoanalysis lacks the sources of support, like federally subsidized student loans, fellowships, and teaching assistantships, that, in some combination, are typically included in Ph.D., J.D., M.D., and other graduate programs. Moreover, for candidates entering analytic training already carrying student debt from undergraduate and/or graduate training, there is no opportunity to defer loan payments during training. For other graduate work, payment of these loans can be delayed while in school.[2]

Of the three major costs in psychoanalytic training, the most significant for the candidate is the training analysis. At the very least, training analysis will add up to several hundred dollars per month. For a person with modest income and student debt, this is a daunting and even prohibitive burden. Upon revealing early on that s/he would not be able to pay what the institute indicated was the minimum charge per hour for a training analysis, the institute advised one candidate to withdraw his/her application. The candidate observed to the analyst in charge of admission that this seemed to create an economic class barrier to many who were eager, prepared, and ready to train in psychoanalysis. The observation was met with mildly surprised agreement,

[2] At least one psychoanalytic institute housed at a major university in New York City cannot offer to its candidates the same federal loan deferment benefit to which the graduate students at the university are entitled.

as though this thought had not previously crossed the analyst's mind but was a good point nonetheless. The candidate's application deposit was returned without comment.

This illustrates a potentially destructive institutional feature of psychoanalytic training. The silence with which the applicant's critique was met effectively negated his/her assessment. Rather than engage the applicant, the analyst's silence implicitly conveyed the message that the critique pointed to the applicant's private trouble rather than to a public issue in psychoanalytic training.[3] The example also points to a form of economic shaming. Questions of how the fee for training analysis is established and then readjusted are legitimately linked to transference dynamics in the candidate's treatment, but that is not all they are. When a potential candidate is made to feel as though his/her bank account falls short of the psychoanalytic mark, the field, intentionally or not, effectively invokes status-shame as a means to preserve psychoanalysis as the domain of the affluent. It thus plays into one of the main caricatures thrown at psychoanalysis by those who seek to dismiss it.[4]

I am not saying it is or is not shameful for psychoanalytic institutes to restrict access to training to a small economic elite who can afford it. I am asserting that the shame that may be evoked in potential candidates who are made to feel unworthy of training because of their economic or social class positions may prompt applicants to turn away from training instead of doggedly pursuing it, despite daunting economic obstacles. This is not merely a problem for the applicant. If psychoanalytic institutes want to ensure that their training is not the exclusive domain of the financially well-off, it is their obligation to frame these economic obstacles differently, to meet applicants where they are financially, and to substantively alter the economics of training to account for the realities of those who want and are intellectually and psychologically qualified for it.

The admission interview process can be fraught with similar shaming moments. In one of several personal interviews for another well-known institute, one candidate was asked to explain why s/he was applying. It was known by the interviewer that the candidate was applying to several institutes and that s/he had been through several similar interviews. When the candidate began to answer the question, the interviewer interrupted and said s/he did not want to hear the polished answer the candidate had supposedly prepared for other institutes. The interviewer's framing of the situation seemed to assume the candidate's answer was in some way disingenuous, artificial, prefabricated. The prospective candidate in this scenario is faced with dealing with shame resulting from his/her veracity being called into question in an interview that touches on the most intimate aspects of his/her upbringing and personal life.

The readiness for control (RFC) evaluation is common for all candidates and represents a significant rite of passage. The question as to whether one has passed RFC or not can create a kind of public tension among candidates in the same cohort. Even while seasoned analysts now

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[3] Cf. C. Wright Mills, *The Sociological Imagination*, pp.8-9 for an explanation of the sociological distinction between "private troubles" and "public issues."

[4] When I decided to enter analytic training, a friend of mine opposed to analysis for a variety of intellectual and philosophical reasons posed the following question to me: "Do you really only want to treat people in penthouses?" When psychoanalytic training becomes available only to the well-off, such questions gain legitimacy.

respected by their colleagues may offer that they had to go through RFC more than once, the feeling for the individual candidate that s/he is in the spotlight on this subject is fertile ground for shame to develop, especially when it is known that others in a candidate cohort are also undergoing RFC.

Most psychoanalytic candidates already have a mental health license in social work, psychiatry, or psychology. Their psychoanalytic training may proceed without the state's interference since psychoanalysis is included in their scope of practice. However, a significant minority of candidates has no license; these candidates have backgrounds in social science and the humanities. Freud (1926) made a strong statement in support of these "lay analyst" candidates, but in the early medicalization of the field in U.S. society, physicians claimed to have special provenance in learning and practicing the technique. But over the last fifty years, lay analysts have carved out a space for themselves and are represented by several umbrella associations.

In New York State, the arrival in 2003 of a new license in psychoanalysis for these candidates brought with it special requirements placed on their training and practice. Fees for training analysis and supervision for these candidates now must be paid through their institute as though they were tuition. Their patients must pay fees to the institute; meanwhile, the candidate is not allowed to receive payment specifically for work with patients. In effect, the candidate pursuing the psychoanalytic license is segmented into a secondary candidate category by the state. Once licensed, s/he is not extended the full liberties in his/her practice enjoyed by other candidates who enter analytic training with a license already in hand. [5]

In the case of these "lay" candidates, no shame may be intended by the license restrictions, but a sense of secondary status within the field of psychoanalysis in general and within an institute specifically could obtain for them. This depends largely on the institute's culture and how it frames the experience of candidates pursuing the new license. But because of the special restrictions placed on their training and then their licensed scope of practice, lay candidates are in a position to feel as though they occupy a lower rung on whatever hierarchy may exist within psychoanalytic practice, even if other analysts do not feel they are of secondary status. The result has much to do with the atmosphere established by the training institute.

[5] Under a section titled "Boundaries of professional competency, the new regulations place the following clinical restrictions on New York State licensed psychoanalysts: "It shall be deemed practicing outside the boundaries of his or her professional competence for a person licensed pursuant to this article, in the case of treatment of any serious mental illness, *to provide any mental health service for such illness on a continuous and sustained basis without a medical evaluation of the illness by, and consultation with, a physician regarding such illness*. Such medical evaluation and consultation shall be to determine and advise whether any medical care is indicated for such illness. For purposes of this section, 'serious mental illness' means schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention-deficit hyperactivity disorder and autism" (emphasis added). Note that the statute says "physician" without specifying the physician be a psychiatrist.

Shame is an isolating experience. As Ahmed suggests, shame at once turns the person away from others and away from the self in its effort to hide. To the degree that our institutes perpetuate shame in the way they execute their rituals and requirements, they cultivate the conditions for infantalizing the candidate, causing him/her to feel (and act) as though s/he is not fully in possession of his/her agency. The ultimate negative result is the candidate who turns away from training as a means of turning away from the self.

We all do small things to defend against the feelings of vulnerability that shame creates. Aaron Green, the disguised main informant in Janet Malcolm's *Psychoanalysis: The Impossible Profession* (1980), describes how, after graduating, he buoyed his sense of security by purchasing a black and white herringbone sports coat at Abercrombie and Fitch. Green discerned this was the uniform of analysts at The New York Psychoanalytic Institute. He was brought up short two years after he bought it, though, when an older colleague showed up at a meeting with a newly purchased version of the same coat, this one from Brooks Brothers. The other man's coat was praised while Green's was ignored until all present realized the similarity and his colleague said, "But, you know, everyone at New York Psychoanalytic wears this kind of jacket" (pp. 53-54). Green realized then that at the Institute, in fact, "the jacket was all over the place" (p. 54).

We may surmise that the jacket made Green feel fashionable and, therefore, safe. But adherence to fashion frequently can cover up a deeply felt sense of inadequacy, especially in liminal moments like adolescence and professional training. Green notes that the jacket "corresponded to my adolescent idea of what good dressing was" (p. 53). Adhering to what we perceive to be the institutional and theoretical expectations of our institutes, and the teachers we find in those places, can serve the same purpose. We may take on their expectations like an adolescent wearing a stylish jacket because its enclosure prevents others from seeing the uncertainty it cloaks. It is when we manage to break free of this perceived safety that we may grow and become fully realized professionals with our own voices and security in our own technique, even while we are still in the position of being candidates.

Acknowledgments

The author thanks Sharon Lavon and one anonymous reviewer for their very helpful commentary on an earlier draft of this paper, and to Marilyn Herleth for copyediting. All errors are, of course, the author's.

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Reducing Shame in the Candidate Experience

Robert A. Glick, MD, and Deborah L. Cabaniss, MD

The fact that this candidate journal has chosen the problem of *shame and psychoanalytic training* for its inaugural online panel indicates that the experience of shame poses a bigger problem than many might assume, and that it is something that we, as students and educators, can and should address. We are grateful for the opportunity to participate in this dialogue.

Because learning means trying to do or know something new, all students face the risk of feeling shame. Candidates are students in a school; therefore, they risk experiencing shame. But although all students *risk* feeling shame, we do not think that shame is an *inevitable* part of the learning process.

To begin to address this issue, the first thing that we are inclined to ask is "What are some of the unique circumstances of psychoanalytic training that might predispose toward shame induction/production?" Here are some of our thoughts.

Variables Relating to Our Candidates

- **Candidates are often seasoned clinicians.** The fact that many of our students are mature and seasoned clinicians may increase their potential for experiencing shame during training. Candidates come to psychoanalytic institutes to learn something they know little about and, therefore, may feel insecure, doubtful, and vulnerable. It can be particularly difficult (and potentially humiliating) to feel like a novice again after many years of established competency. Add to this that what candidates know about analysis often comes from their own experiences as patients in the throes of powerful transferences to their analysts and to analysis. Attempting to learn something that demands intense self-examination invites uncertainty and uneasiness. Students may feel that they are often asked to unlearn things that they have been doing for years.

- **The question of "talent."** This is a very difficult subject to tackle; nevertheless, we will add it since it could increase the risk for shame. People vary in their empathic, self-reflective, and emotional accessibility. Some candidates are probably better suited for analytic work than others. Our selection processes attempt to assess a person's analytic potential and motivation. We have years of anecdotal experience but little useful data to predict those who will learn psychoanalysis. If we are trying to educate students who will ultimately be unable to learn psychoanalytic technique, this could vastly increase their risk for shame.

- **The crisis in applications.** Along those lines, the crisis in dwindling numbers of applicants could induce institutes to accept candidates who are destined to have difficulty with the rigors of training – again, a situation that is likely to increase the risk of shame. This is exacerbated by the fact that we lack guidelines for training and advancement.

Variables Relating to Our Pedagogical Methodology

- **We generally teach candidates in cohorts.** Most analytic institutes have "classes" that travel along together in their analytic training. The "sibling-like" relationships in these classes can breed competition among candidates that can lead to shame. As the group dynamic of a class gels, candidates may run the risk of feeling like the weak candidate, the problem candidate, the sick candidate, the uncommitted candidate, the rebellious candidate, the non-compliant candidate, etc. Comparisons in a candidate cohort run the risk of engendering shame and increasing fears of exposure and humiliation.

- **Most psychoanalytic classes are small and taught seminar style, emphasizing classroom participation.** This type of learning situation can increase the student's risk for feeling shame. The only way to hide in a seminar is to not talk, which in itself can produce shame. If the seminar is not well led, there is the potential for grandstanding, class domination, and even mockery.

- **Psychoanalytic teachers generally have little education in pedagogy**. This is a major problem. Since our educators have little formal training in pedagogy, it is likely that they are not schooled in how to conduct their classes in a way that diminishes the potential for shame induction. It used to be assumed that if you were an experienced analyst, you knew how to teach what you knew. Until recently, institutes did little to educate educators or to critically examine the effectiveness of their teachers. Sadly, it has taken the field considerable time to free itself from equating the knowledge and skill to conduct effective analysis with the knowledge and skill to teach effective analysis. This is true of both classroom teaching and supervision – which must also be considered when we think about psychoanalytic teaching. Without procedures and guidelines for critiquing the candidates' work, the potential for shame is great (more on this below).

- **Institutes and psychoanalytic educators often pathologize students rather than constructively assessing and teaching.** As we have mentioned, institutes are facing recruitment crises. Having students to teach has become an enormous anxiety for institutes and for the profession. This has engendered problems in recognizing and confronting candidates who are not meeting appropriate educational standards for reasons of aptitude or motivation. There is a tendency to "pathologize and analyze" students who are having difficulties in candidacy and prolong their training rather than addressing their learning difficulties and offering remediation.

- **Most institutes do not have guidelines for progression, learning objectives for classroom learning and supervised clinical learning, or methods for assessment.** Most psychoanalytic candidates are not explicitly told what they are expected to learn, how institutes will help them understand whether they have learned it, and the criteria upon which their capacity for progression and graduation will be based. The lack of guidelines, objectives, and assessment methods severely weakens an educational process, and makes students anxious, discouraged, and vulnerable to shame (Cabaniss

et al. 2003). We address the use and value of objectives and standards and their relation to shame production below.

- **Intolerance of multiple viewpoints.** If an institute advertises itself as teaching a particular school of psychoanalysis, idealization of that particular school and/or clinical method may create false comfort and impose constraints on students and teachers. If an ideology is prompted or fostered by such an educational structure, candidates may feel shame or may feel the need to defend against their shameful sense of lack of conviction, lack of commitment, or lack of faith in analysis. Commonly, candidates need a powerful idealizing attitude towards the analytic enterprise in order to motivate themselves to undertake and endure the demands and rigors of analytic training. Even institutes that embrace multiple psychoanalytic models may not welcome critical thinking about psychoanalytic outcome and efficacy, which are often viewed as "non analytic." Scientifically responsible candidates may feel shame at their concern about psychoanalysis as an effective treatment, or shame about the field's apparent intellectual and scientific insularity. Institutes risk serious intellectual impoverishment if critical thinking about psychoanalytic theory and its relation to clinical work is not explicitly fostered and time found for it in the curriculum.

Variables in the Field at Large

- **Lack of empirical evidence of efficacy.** Since we lack empirical evidence of efficacy, we rely on our students to develop "conviction" about analysis. Thus, as a field, we are vulnerable to suffer "crises of faith" and our students are more likely to suffer the shame of not being "one of the believers."

- **Lack of agreed upon standards and definitions of psychoanalysis leads everyone to fear that they are not practicing "real analysis."** This may be the biggest culprit of all in the discussion of shame in psychoanalytic training and in psychoanalysis as a field. Since the field continues to struggle and debate the definitions of clinical and theoretical psychoanalysis, we are all vulnerable to the shame of feeling that we are not "real analysts," or that we are not doing "real analysis." Orthodoxies arise to confront this problem – as in, "If you do it our way, you're really doing analysis." Even among the enlightened one hears *sotto voce* mumblings at meetings about the notion that someone's work was or wasn't "real analysis." This anxiety may underlie many difficulties in our field, including clinicians' inhibitions about writing about their work, presenting their work at meetings, applying for certification, and applying to become training analysts. Unfortunately, our candidates study and learn in this atmosphere of potentially being exposed as "not conducting the real thing." The definition of psychoanalysis and the knowledge and skills to be an effective analyst remain a challenge. We need the expertise to teach the nature and boundaries of the field, and the clinical tools to analyze. Expert consensus about the core of clinical and theoretical psychoanalysis is, therefore, essential for minimizing the risk of shame during training.

Given these different variables, we suggest that the field work on the following:

1. Defining selection criteria. Research on which candidates *do* well in psychoanalytic training would help the field create selection criteria that address the question of which candidates *will* do well in psychoanalytic training, and whether psychoanalysis can be taught to all students. We should be clearer and more flexible about what we are training candidates for and about what our and their goals are for analytic training. As with many professions, people use their training in different ways. Our analytic graduates apply what they have learned in our institutes across a wide spectrum of clinical and intellectual endeavors. Our educational structure should be clearer about the appropriate outcomes of training. A corollary to this issue is the particular personal characteristics that may predispose certain candidates to shame experiences in training and potential failures of complete training.

2. Developing and using explicit learning objectives and assessment methods for most (perhaps all) aspects of psychoanalytic education, e.g., seminars, supervision, criteria for progression and graduation. Students learn best when they know what it is they are supposed to learn. At The Columbia University Center for Psychoanalytic Training & Research, we have developed learning objectives for our curriculum, which foster clear and direct feedback about what teachers are effectively teaching and about what candidates are learning, and have found that candidates and supervisors find them helpful and clarifying.

3. Maintaining transparency in all education and administrative procedures. These include assessment of classroom learning and supervised work, as well as progression and graduation criteria. This is important not only for candidates, but also for post-graduate endeavors such as certification, becoming a training analyst, selecting graduates for faculty and teaching positions, and choosing committee chairs. The idea that faculty need opportunities for "secret" reports in order to say what they "really" mean rests on the distortion that educational evaluation is a clinical-pathological assessment. Faculty evaluations of candidate performance in class and in supervision should be completely open and available to the candidate. Being a student, especially an analytic candidate, inflicts "narcissistic wounds" in the form of inadequate knowledge and skill, not personal pathology. Educational records are essential forms of feedback to candidates, not clinical-pathological assessments. Reports should be read and discussed with candidates so that they can understand and improve their performance in training. The presence of candidates' organizations, candidate representatives to all standing committees, and elected faculty representatives to education/executive committees can be helpful in this regard. Candidate organizations, with opportunities for candidates to meet alone or with faculty, diminish candidate isolation, apprehension, and potential distortions about the training experience, especially about progression and administrative concerns. We have found that when candidates get together informally (e.g., over dinner at one of their homes), the group support fosters cohesion and provides valuable information and surprising "reality checks."

4. Promoting pedagogical instruction for classroom teachers and supervisors. Psychoanalytic educators should be offered the very best in pedagogical training to help them develop techniques for instruction that do not rely on exposure, humiliation, or other shame-inducing practices. Educators may not even be aware of the ways in which they are inducing shame. For example, teaching techniques such as asking students to "guess what I'm thinking"

and critiquing students in front of one another can often promote shame and are commonly used in psychoanalytic education. Creative methods that decrease competition among candidates, and promote collegiality among candidates and between teachers and students, can help create shame-free learning environments. As an example, the way in which process material is used pedagogically is critically important. If process class is seen as another chance for supervision, with the usual meta-comments such as "I would have done this or that," the atmosphere is competitive and shame inducing. However, if process material is simply viewed as examples from which to learn, the atmosphere is often much less competitive. This can take more work on the part of the teacher, e.g., selecting process examples ahead of time that illustrate specific teaching points rather than just hearing whatever the student brings to class. Similarly, we have found that use of the instructor's process material can be very helpful, since the instructor can bear the brunt of the criticism more easily than the students can.

5. Fostering critical thinking in classrooms, supervisory situations, and the institute at large. This will help identify and undercut potential sources of idealization and psychoanalytic ideology that spawn orthodoxies and the shame produced by being outside of the orthodoxy. Many institutes have added classes in critical thinking or which feature critical thinking into their curricula.

6. "Good behavior" among faculty. This may sound trivial, but faculty members can model situations when they are dealing with each other that can help reduce shame in the classroom. Our candidates watch us at committee meetings, society presentations, and national meetings, and they watch as we accuse each other of "not doing real analysis" or variations on that theme. Analysts need to create new ways of having intellectual dialogues that do not involve this type of shame-inducing atmosphere; that is, if they want their colleagues to share their work, their students to apply for certification and training analyst positions, and their classrooms to be safe environments for learning. Discussions of group dynamics that might foster shame could also be introduced into the curriculum and into faculty development meetings.

7. Psychoanalysts need to agree on operational definitions for what psychoanalysis "IS." That is, psychoanalysts need to come to some consensus about the technical and conceptual core of clinical and theoretical psychoanalysis. Without this, there will always be the potential for orthodoxies and the shame of dissenting or "not believing." Working to eliminate the problem of shame from education and training is part and parcel of working to eliminate shame from the field at large.

We would like to thank the organizers of this panel for including us and we look forward to a rich and fruitful dialogue.

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Reflections on Shame in Psychoanalytic Training

Arnold Goldberg, MD

I am pleased and even a bit honored to respond to these questions because I have thought about this problem for some time, but with little impact on my own institute. I suspect there is a wide variance in the particulars of the problem from one institute to another, but the very fact that these questions are raised seems to speak to a common malady.

Although I no longer teach or supervise at my institute, the complaints are familiar and seemingly unchanged. My friend Bonnie Litowitz said that our institute is like an animal that eats its own young. Rather than mentor and support our dwindling supply of candidates, we continue to oppress them with standards and imaginary goals of achievement.

The problem is easily explained by the clear differentiation between idealization and the exercise of power. We have an institute in our city, comparable in many ways to our analytic institute, which trains social workers in a rigorous psychotherapy program. Those students are markedly different from ours in their enthusiasm and eagerness. They do not feel diminished or infantilized. Indeed, when I was a candidate, I felt a similar enthusiasm in that I idealized my teachers and supervisors. The change that occurred was a gradual but clear one. The teachers and supervisors seemed to be less admirable and less significant. We had fewer teachers who wrote papers and/or participated in conferences. People who rose to positions of authority did so by dint of age and seniority. Where one's power was legitimized by idealization, it now became an end in itself.

The problem became apparent in the current arguments over certification and becoming anointed as a training analyst. It is clear enough to everyone that these labels do not reflect intellectual achievement as once they might have, but rather have become indications of positions of power. We have gradually shifted from idealizing our teachers to becoming either afraid of them or denigrating them. Power positions are maintained by rules and regulations, while relationships to ideals are maintained by connections of admiration. I hear over and over that classes are dull and unnecessary, and that supervisors are rigid and unhelpful.

Part of this move from idealization to power does indeed come from the pluralism of today's psychoanalysis. We simply do not have the brainpower to teach all the kinds of theory and practice that are extant. Faced with this obvious deficit, many institutes resort to championing one or two forms and treating the others with contempt. As a self psychologist, I have no trouble stating that no institute other than my own has teachers able to teach psychoanalytic self psychology, while I am sure this statement would be challenged in one way or another. A good friend of mine said that self psychology was taught in a course on "deviant" theories in analysis. The same might be said of my institute in terms of Bion and Lacan. We do a terrible job of trying to teach these masters. While a university would seek out and hire experts in new fields, our institutes more often than not have someone read a book and then tell students not to bother.

There is an intellectual crisis in psychoanalysis as it becomes less of an exciting field and more of a last ditch battle for existence. Our students rarely if ever idealize our teachers. There is no eagerness to read the latest books or journals. The field no longer offers a career of comfort and interest. With the failure of ideas, power becomes the significant issue. Power maintains the Board on Professional Standards and other symbols of lost meaning. With the struggles over status and power, questions such as these are raised that concern themselves with shame and infantilization. Alas, these are symptoms of a failing enterprise that can only be revived with intellectual fervor; little of that appears on the horizon.

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Shame, Empathy, and Analytic Training

Benjamin Kilborne, PhD

Because of the nature of analytic work, as well as the prevailing cultural ideals in the United States today, there is a raging conflict between humanizing and toxic shame. Humanizing shame can provide a resource for all analytic work by increasing the stores of empathy. By contrast, toxic shame (including the competitive, deprecatory, shame-inducing stances of groups and individuals whose allegiances to particular theoretical positions often lead to intolerance) is at cross purposes with Freud's ambitions for his discipline.

Analytic work deals essentially with human suffering. Suffering calls up human limitations and loss. Shame dynamics often stem from discrepancies between ideals of oneself (superego injunctions) and experienced feeling states. The more ashamed one is of having certain feelings, the more severe is the judgment brought to bear on both the shame and the feelings in question, and the more painful shame is. Shame then becomes toxic when it is unbearable, and is experienced to indicate that one is not fit to be human, must exist in isolation, cannot but be isolated and is condemned to a purgatory of unmitigated suffering alone. Sometimes such toxic shame can be the result of trauma, as in the case of childhood sexual abuse. In such cases, the child cannot give voice to his or her sense of being deceived, overwhelmed, confused, injured, and stimulated all at the same time. Often the adults do not want to know. So the shame of the experience goes underground, and the child becomes mistrustful of others, learns to react to shame with signal anxiety, and assumes that self-expression is impossible when it deals with shameful injuries. The vulnerability of the child then gets lost in favor of identification with the aggressor.

As I see it, American cultural ideals mitigate against a sense of human tragedy, against a recognition that "there for the grace of God go I." Psychoanalysis, beginning with Freud, has attempted to draw on the Sophoclean tradition of tragedy, but has often subordinated the dynamics of tragedy (shame, blindness and rage) to some theoretical consideration (e.g., the elaboration of the Oedipus complex). The result is a departure from the Aristotelian definition of man as essentially a social animal, ennobled by the emotions of catharsis.

For example, I remember coming to my first supervisor of my first analytic case seriously rattled because my patient had a dream of her cat, with which she was identified. In the dream, the cat was caught by wild dogs, leaving a head here and a paw there, a tail there and an ear here. I was frightened of what I perceived as psychotic madness. My supervisor, however, shamed me into believing that my fear was a function of my ignorance and inexperience, and that when I had seen as many patients as he had, I would no longer be troubled by such dreams, would no longer be frightened by such patients. As it turned out, this patient dropped out of treatment shortly thereafter, and I eventually concluded that she was really psychotic and that my supervisor had been wrong. But the tendency of this supervisor to present himself as without fear, and to use my shame of my own fear to drive home how much more competent he was than I could ever hope to be, proved to be unfortunate. Our fear is indispensable as a mark of our humanity, and a manifestation of our ability to respond to human tragedy. For a supervisor to minimize the fear of candidates, as mine did, seriously impairs the need for candidates to use their curiosity about

their own fears (and the nature of their shame dynamics) as an indispensable resource in analytic work.

Such situations are as those described by Ferenczi in his paper, "The Confusion of Tongues Between Adults and the Child – The Language of Tenderness and of Passion." Here, in a way directly pertinent for analytic training, Ferenczi describes the confusion between what he calls the language of tenderness and the language of passion. The language of tenderness is one that calls up singing to a child in tears, an expression of human warmth, a longing for human connection. The language of passion, by contrast, is one Ferenczi associates with adult sexuality, competition, and indifference or sadistic hostility to the vulnerabilities of the child. In the contrast between the two, one can see implicit the relationship between Ferenczi and Freud. Freud wanted to be seen as the powerful teacher; Ferenczi wanted Freud to see how vulnerable he (Ferenczi) felt, how incomplete, how much in need of Freud's approval and friendship.[1]

Seen from the vantage point of contemporary analytic training, the language of tenderness is obviously essential in allowing candidates the security of being able to explore their own uncertainties and ambivalences with that humanizing shame from which so much can be learned. Freud dismissed Ferenczi's sensitivity to shame dynamics in the Freud/Ferenczi relationship.

In associating the language of passion with competition and the language of tenderness with the need for connection, it seems likely that Ferenczi had Freud in mind. Freud could not understand Ferenczi's need for tenderness and jumped to the conclusion that he was insufficiently masculine, that he "mothered" his patients. For me, the analytic process and the process of supervision do best when they can pass from one level to the other easily and without making either the opposite of the first. Put differently (although these are terms with which I am not very comfortable), pre-Oedipal and Oedipal dynamics need not be mutually exclusive, and if they are, toxic shame is likely to be the result.

Unfortunately, the injuries suffered in analytic training are too often dismissed as the necessary consequences of the school of hard knocks, with serious effects that shame candidates. Those shaming experiences are rendered toxic when the analysts make narcissistic use of the candidate's shame by not recognizing it or using it against the candidate; the analyst "knows" and the candidate is ignorant, inept, and in serious need of correction. Such an attitude mocks the candidate's real dependency on the analyst/teacher/supervisor and makes it shameful to learn and to be curious. Analytic training necessarily involves feelings of dependency, inadequacy, confusion, curiosity, and vulnerability. These feelings deserve serious respect, tolerance and encouragement if they are not to become sources of toxic shame. It is then the responsibility of the supervisor/teacher to recognize the toxicity of shame, and to do everything possible to help the candidate detoxify it.

Imagine the range of feelings bound to come up in case presentations by candidates to

[1] See particularly Ferenczi's paper, "Confusion of Tongues Between Adults and the Child – The Language of Tenderness and of Passion," and his Clinical Diary. See also my paper, "Human Foibles and Psychoanalytic Technique: Freud, Ferenczi and Gizella Palos," in a forthcoming issue of the *American Journal of Psychoanalysis*.

teachers. The purpose of the supervision is not the narcissistic gratification of the teacher or supervisor; rather it is to turn a potentially shame-inducing situation into an inspirational educational experience in which the curiosity, enthusiasm and imagination of all participants can be kindled, and the presenter can return to his or her analytic work with renewed dedication and open-mindedness.

As for toxic shame and humanizing shame, I would say that shame in the analytic setting and in supervision is inevitable. However, the supervisor can make use of the candidate's shame to call attention both to the humanity of the supervisor (and his or her limitations and fallibility) and the humanity of the candidate. Or the supervisor can make the candidate ashamed of those emotions needed in response to experiences of human tragedy (as did my supervisor in the case of the patient who dreamed of the cat caught by the wild dogs). If the supervisor is perceived as being above whatever conflicts or fears the candidate is wrestling with, that is a bad sign, and is likely to have a shaming result.

This loops back to notions of catharsis and Greek tragedy. Greek tragedy was intended to be ennobling because it allowed the spectators to empathize with the characters, and to realize that they were not above the struggles they witnessed on stage.[2] The livelier the sense of tragedy, the more socially and personally responsible and responsive people were thought to be. This relates to my idea that humanizing shame is shame responded to by another person (thus, it can serve the strengthening of human bonds), so that one's own shame can be experienced as something to which one also can respond oneself. Spectators of Greek tragedy witnessed the horrifying shame of Oedipus, who blinds himself because (in part) he is so ashamed of his own blindness, and because they could respond to it, found themselves better able to respond to the shame of those they loved, as well as to their own shame.

Ideally, therefore, analytic training should serve some of the vital functions of Greek tragedy: It should enliven the sense of empathy for patients (and all those around one); should increase the sense of social responsibility and strengthen the commitment to ethical behavior without stoking the furnaces of severe superegos or feeding hubris and narcissism; and should allow for greater imagination and responsiveness, both to oneself and to others. This requires a tolerance of shame dynamics, an ability to detoxify one's own shame in the service of human dignity. As human dignity is often related to human suffering in Greek tragedy, so it is with dignity in analytic training. It is my hope that training analysts and all those responsible for analytic training can be ever mindful of the essential importance of helping those they train to be able to tolerate their own shame, to bear the fears of madness called up by analytic work, and to enliven their sense of human suffering as an essential resource of analytic work. No theories, however important, can take the place of the responsiveness and empathy that Aristotle associated with the primary function of tragedy. And no analyst responsible for training, however distinguished, can ever place himself or herself above what T.S. Eliot referred to as "the rag and bone shop of the heart" without damage not only to candidates but also to the discipline and profession of psychoanalysis.

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[2] For a fuller explication of my ideas about the essential importance of literature for psychoanalytic practice and training, see, for example, my paper, "Shame Conflicts and Tragedy in *The Scarlet Letter*."

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Shame in Psychoanalytic Training

Andrew P. Morrison, MD

Shame, alas, is ubiquitous. It is the fog that descends before our eyes as we peer outward. It is the queasy, unpleasant affliction as we turn our gaze inward, finding ourselves wanting in any number of vital dimensions. Shame is essentially about the sense of self – who we are, how we view ourselves alone or in the world around us – and as such, it is the recurring escort of narcissistic phenomena. Like narcissism, shame can be either grandly overwhelming, or slight and manageable. We can keep it in check, learn to handle it, or become desperately inundated by it. We "shameniks" (as Helen Lewis called our small crew early interested in studying shame) have come to think in terms of shame's intensity, its bearability or unbearability. In their attention to shame, intersubjectivists look for natural openings in defensive grandiosity to try to identify and talk about triggers to one's conviction of shame. Kleinians, who have not seemed to pay much heed to shame, might nonetheless consider unbearable shame a reflection of the paranoid/schizoid position, in that it can be expressed through projection into a destructive, humiliating other. Bearable shame, reflecting the depressive position, is tolerated and accepted by the self, thus sparing that other from distorting projection.

The goal in approaching shame is, it seems to me, to help nudge it from the unbearable to the bearable, from the disavowed to the acceptable. Any process that achieves this movement will help to lessen the intensity of shame, such that it becomes tolerable and, hence, invite new learning and even self-acceptance. Such self-oriented compassion also may alter severe narcissistic pathology, leading toward those inevitable, more subdued companions to human existence – mere manifestations of narcissistic "phenomena." I am not one of those shameniks who attributes a positive valence to shame *per se*, but certainly feelings of competence and self-esteem can complement the effective management of shame and shaming situations. Attainment of competence in understanding and dealing with shame might be built in as a goal of psychoanalytic training, as a companion to that competence implicit in learning the art of analysis itself.

A major impediment blocking attention to shame in psychoanalytic training has been that it has remained a veiled participant in the pantheon of traditionally taught and practiced psychoanalytic phenomena. Starting with Freud himself, shame has been ignored or denied, both because it does not readily fit into a tripartite conflict model of the mind, and because it arouses such pain and despair in the analyst him/herself that it has traditionally been pushed aside. Among emotions, shame can be uniquely painful and contagious. Dealing with our patients' shame usually evokes our own, leading toward collusion to avoid the mutual exploration of this excruciating experience. Shame has tended to be dismissed analytically as superficial, social, or defensive against underlying libidinal conflicts. Until narcissism and attention to the self and self-experience became a legitimate focus of analytic interest in the 1960s and '70s, shame was not deemed to be of analytic significance. It was treated as a non-event, and the shaming impacts within psychoanalytic training were not of concern to curriculum and education committees. The various sources of humiliation among candidate groups or from teachers, supervisors, and training analysts were ignored.

In order to consider particular means of minimizing shame and shaming in analytic training, we must first attend to the broader matter of heightening the awareness of shame and its lethal impact as a crucial element to patients, analysts, and students. Optimally, presentations on and discussions of shame in contexts like this one will help remind and alert faculty and students alike of the significance and distress caused by shame, as well as of its ubiquitous and expectable presence. Only when faculty and supervisors in analytic training settings become aware of shame's impact will they entertain the shaming implications of aspects of the student role.

Shame sensitivity evolves out of failure in one's quest to attain one's ideal. As the gap widens between aspirations toward and perceived realization of the ideal, shame intensifies. Among the ideals that we set for ourselves are those reflecting comparison and competition. To the degree that we fall short in comparison with others, that we fail in competition, we feel shame, especially as the relevant concerns remain essential aspirations for our sense of well-being and competence. These matters – attainment of ideals, success in comparing and competing – are clearly factors built into training contexts.

Dr. Buechler's questions tend to focus on specific technical and administrative elements of analytic education, with the goal of diminishing or eliminating the impact of shame and shaming in training situations. There may be some specific recommendations to alter these elements, but, as I have mentioned, the broader resolution of shame relates to an awareness of and sensitivity to the shame-producing potential of all phenomena in training, at all levels in the training sequence. As an example, emphasis on one clinical theory as a background to training, or on many in a comparative approach, offers potential shame experiences. A candidate may feel inept at understanding and applying a classically Freudian, Bionian, or Kohutian perspective, if one of these is the predominant element of a given training program. As well, an institute that emphasizes a comparative theoretical approach may cause candidates to feel unable to master the network of interlocking and competing viewpoints, or to determine when, and with which patient, to apply one or another stance. In each of these dilemmas for the candidate, matters of competition and comparison with other colleagues or teachers can lead into the thicket of shame.

One factor closely related to shame in training (as elsewhere) is the phenomenon of idealization (Morrison, unpublished data). On the one hand, we need and use ideals to give meaning and purpose to our lives. It is the ideal of depth of understanding and ultimate reworking of fixed perspectives, for instance, which leads most candidates (and their teachers and analysts) into psychoanalysis in the first place. On the other hand, we have just considered that the falling short of or failure to attain ideals leads to the discrepancy between the sense of ideal and the actual self that defines the shame experience. Idealization of another may give sustaining value to a relationship, but it can also lead to feelings of inferiority, competition, and to that pernicious reaction driven by shame – envy. Idealization itself also frequently leads to the presence and pain of disillusionment.

Nonetheless, as Dr. Buechler suggests, idealization plays a big part in psychoanalytic training, permeating most of the issues that she has laid before us. It often infuses choices and decisions made by candidates regarding selection of institute for training, personal analyst, supervisors, and patients for treatment (e.g., Is the selected institute part of the American or International? Is my analyst high on the scale of administrative power or theoretical contribution?

Does my supervisor have recognition for her importance or clinical skill?). What if these elements do not rank high on the "idealizable" scale in the mind or value system of a candidate? How does the candidate feel if the institute/supervisor/patient that he covets does not select him? These potential sources of shame inhere in analytic training, following as they must the human need and tendency towards idealization. We each have envied a colleague with a fuller or more substantive practice; felt left out because someone else's "great" supervisor or analyst is better or bigger than our own; suffered writer's block because we are sure we cannot articulate what we are striving for as well as Kernberg or Schafer. These frustrations and instigators of shame do not cease with graduation, but continue to plague analysts affiliated with institutes throughout their professional lives. The certification and training analyst (TA) system, dominating as it does the hierarchy of so many institutes, is a vivid example of a systemic structure inclined to produce shame in those aspirants who fail in their quest.

We are confronted, then, with the shaming potential of much that inheres in psychoanalytic training, whether through challenges to competence, or through comparison, competition, or idealization. It is likely that certain structural and administrative changes in institute policy might alleviate some of the contributing shaming factors in analytic training. As a member and participant in two institutes in Boston, I have observed and pushed for certain conditions and changes that, implicitly, might reduce shame induction. In one institute – relatively new and established as a free-standing structure independent of the American and International Associations, with a vision of comparative theoretical presentation and empowerment of candidates in its structure and committees – efforts were made from the beginning to minimize barriers and distinctions that could generate shame. There is no TA system, and candidates are free to choose their own supervisors and devise electives of interest to them. My other institute, originally one of the more conservative of the American Psychoanalytic Association, has been moving, with considerable internal conflict, toward greater autonomy for candidates, some modification in the TA and supervisory systems, changes and modernization in the curriculum, and streamlining of the governance process. Both institutes are mindful of the broad fundamental changes in climate for the practice of psychoanalysis, and are expanding criteria for "analyzability." Acknowledging reality, both institutes are providing for attention to respected training tracks in analytically-informed psychotherapy, thus providing substance for what in most instances will be the "bread and butter" of clinical practice.

While these institutional changes tend to diminish instigation of shame in training, by no means are shame and humiliation eliminated. Potential confusions generated by a comparative approach are implicit in Dr. Buechler's challenge to us, especially for those candidates who seek a clear, discrete concept of the analytic process. The absence of a TA system does not eliminate hierarchies or idealizations, in that certain highly valued analysts in the younger of these two Boston institutes tend to be selected as supervisor by a majority of candidates. Some candidates tend inevitably to be favored, and they are likely to rise more rapidly in the institute structure. Other candidates, not so privileged or without supervision from coveted mentors, are liable to feel "lesser," inferior, insignificant. Similarly, competition and comparison among candidates – for attention, acclaim, referrals – occur inevitably in both settings. None of the potential alterations in structure can do away with these shaming elements intrinsic to the training and learning context.

How, then, can shame and shaming phenomena best be diminished as part of analytic training? I believe that the focus of attention should be on the ethos of an institute as much as, or even more than, on structural changes. As with the treatment of shame in our patients, a central factor in working with shame consists of identifying and *naming* it as an important and destructive force – here, in the analytic training process. The intrinsic pain of shame may lead, as mentioned, to a collusive avoidance of those factors that initiate and support it. This mutual collusion might be manifest in denial, by either instructor/supervisor or student, that shame/shaming plays a part in their interaction, or may even lead to reaction-formation against the possibility of a shaming dynamic. For example, a clinical supervisor may, at times, be exceedingly gentle or non-critical about a clinical moment in which she feels that the candidate missed an opportunity to deepen his understanding of the patient's dynamics. While this approach may minimize active humiliation in the supervisory encounter, it may simultaneously cause in the supervisee a sense of being handled "with kid gloves," generating shame from the feeling that something is "'wrong' with me – I don't have the metal to withstand corrections."

Certain instigators of shame and shaming do, in fact, stand out in analytic training. Particular teachers are known for their brilliance and articulateness in propounding a given theoretical position, but may be equally harsh in meting out criticism when a student advocates a disparate point of view. The candidate-recipient may feel victimized and trivialized in front of her classmates by the pronouncement of the "expert." Similarly, students are often expected to turn in written accounts of their work with control cases, and these write-ups may, at times, be met with sharp criticisms or disagreements, amounting to "You call *this* psychoanalysis?" In classes, some candidates may devote all of their energies and efforts to learning the process of psychoanalysis. All of their free time might be committed to reading, studying, or to their clinical practice. This attentiveness may contrast with other classmates, who may devote time, for example, to writing poetry or courting a partner as well. For the latter individuals, an attitude may evolve among faculty and classmates alike that they are not serious about becoming analysts. After all, doesn't this exercise require total absorption?

An approach to working with shame in training situations must be based on a process of bringing to awareness, at all levels of analytic education, shame's ubiquitous and potentially destructive qualities. Such an approach might be attempted in the context of faculty seminars or workshops; paper or panel presentations and discussions at scientific meetings of the institute or society; or through feedback on faculty evaluations by candidates. Awareness of shaming potential might be introduced into “retreats” for evaluation of missions and structure of contemporary analytic settings. Faculty might be made aware of their own proclivity to generate or feel shame (through faculty and TA appointments or rejections, referral patterns, the current status of psychoanalysis within the communities of psychiatry and mental health, etc.), with parallels suggested to the status of candidacy.

The next step in working with shame – following its identification and articulation – involves the much more challenging process of "working through." This process might call for active, repeated attention to shaming elements in training, including those to which I have already alluded. Optimally, though doubtfully feasible, an open-ended, ongoing discussion group among institute members might address these various shame-producing aspects in analytic training. An effective method to shape such a discussion might be to consider the comparative

parallel process of shaming inherent for patients in analysis (e.g., dependency, passivity, neediness, authority differential, etc.). While ongoing members' seminars addressing matters of shame and shaming seem less pressing than some other matters, and hence unlikely, perhaps one or two training/discussion sessions might be feasible and potentially useful.

Of course, the most significant step in working on shame would be to evolve methods helpful to candidates in dealing with and modifying their own inevitable shame experiences, whatever might be the stimuli from training matters. I have addressed the importance of failure with regard to ideals in the generation of shame. One factor in helping to ease shame, then, is attainment of greater *flexibility* in the structure and rigidity of those ideals that we carry into and through training – ideals particular to training and necessary to develop skills and passion for the analytic enterprise, but which often become too rigid, heightening our vulnerability and leading to shame experiences.

For example, to the degree that strict interpretation of ego psychology remains an ideal of a given training program, any personal deviation from that perspective is likely to evoke scorn, and thus to generate shame. However, when candidates are encouraged to develop their own technical approaches to work with a given patient, they might become more appreciative of the legitimate range of options that comprise the analytic stance. Attaining greater flexibility in the conception of analytic method can be enhanced by respect given to a wide range of analytic personalities and theories within the training setting, thus offsetting shame generated by rigidity of theory.

Another manifestation of rigid ideals that can generate shame is an image of psychoanalysis as the “only” relevant form of therapy that an analyst should practice. Thus, a candidate having difficulty finding appropriate control cases, or one whose clinical practice largely comprises weekly therapy or psychopharmacology patients, may feel that she is not living up to her professional standards. A broadening of the treatment model, with flexibility in application of method and frequency, especially in line with the climate of contemporary practice, can help to ease the humiliation and embarrassment of rigid adherence to a harsh psychoanalytic formula. Generation of professional flexibility may be advanced through broad and tolerant instruction and, of course, through flexible personal analysis.

Shame in analytic training may be lessened through a growing sense of competence and *effectiveness* in theoretical knowledge and analytic technique. Optimally, these qualities accrue over the course of time and effort spent during the training process. A sense of competence must evolve as a manifestation of work at the analytic project, but it may also be aided by flexibility in aspirations, support, and compassionate encouragement from within the training community. Heightened awareness within the training setting of the ways we shame each other may help to modify shame's noxious impact.

Shame, then, cannot be eliminated from psychoanalytic training, as it cannot be wiped out of any other corner of existence. Shame is not, in and of itself, useful as a tool or as a process. Given that its presence is inevitable, however – "Shame Happens!" – what *is* useful is the effective management of shame: minimizing its toxicity, dealing with or changing its manifestations, putting it into useful perspective, and finally, mastering its pervasiveness.

Essential to mastery of shame, in analytic training as in life, is a sense of *self-acceptance*. As shame is about self-experience, ultimately any resolution of shame must reflect broad acceptance of self – with one's limitations, warts, and flaws, as well as with one's attainments. I have thought about this process as one of *coming to terms*. While by no means specific to analytic training, I hope that some of these principles in managing shame resonate usefully in the process of candidacy, as we all continue in the ongoing process of self-acceptance and coming to terms.

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Observations from Thirty-Five Years as an Analytic Educator

Ralph E. Roughton, MD

Miss Ellen was the legendary first grade teacher in my small town elementary school. To generations of parents, she was the strict disciplinarian who shaped their unruly children into obedient students. But to generations of children, now senior citizens of the town, she was a screeching harridan, whose piercing eyes fired lightning bolts and whose classroom methods ran the gamut from intimidation to shame. An elderly friend still recalls the humiliation of having to stand in front of the class while Miss Ellen ridiculed her for not knowing that squirrels have bushy tails.

I was already an inhibited, eager-to-please little boy, even before starting school, so my sister's tales about Miss Ellen filled my preschool year with anguish and dread. Some day Miss Ellen would expose me as less than perfect, and – right there in front of the class and everybody – I would dissolve in a pool of tears and shame. However, as the fall of 1939 and my first day of school approached, we learned that there were enough new students to require two first grade classrooms – and I was to be in the other one. I felt that my life had been saved.

Thus began my school experience, the goal of learning completely overshadowed by the perils of shame. Fear of being humiliated by Miss Ellen was, of course, only one source of my sensitivity to shame. But the memory plays in the back of my mind even now, keeping me tuned to more subtle forms of intimidation and shame in our institutes, and nudging me toward more egalitarian structures, policies and attitudes.

Psychoanalytic candidates are not vulnerable six-year-olds, but they are immersed in the hothouse scrutiny of a psychoanalytic institute, where decisions about success are largely subjective and sometimes biased. This can intimidate, evoke shame, and interfere with learning, even for mature adults. So I use Miss Ellen as a cautionary tale, writ large, to alert us to ways in which authoritarianism, idealization, and secrecy create a learning environment of intimidation, conformity, and shame. Such an ambience may produce diligence, anxious preparedness, and conforming disciples, but it is antagonistic to curiosity, creativity, and freedom of expression. It is the faculty's responsibility to provide an atmosphere conducive to learning and growth.

Here are some things I have observed, in my 35 years as a psychoanalytic teacher and administrator, about the structure and operation and the ambience of psychoanalytic institutes in regard to shame.

Individuals Are Different. All of us, candidates and faculty alike, carry our individual life experiences that make us more or less vulnerable to shaming and more or less prone to eliciting shame in others. We structure our institutes for the average expectable tolerance and leave it to the candidate's personal analysis to address the problems that lie outside the normative experience.

That said, I believe that our faculty members should all be aware of how our structures and policies and, above all, our attitudes may unnecessarily place candidates in one-down

positions. There needs to be an optimal balance between egalitarianism and hierarchic order, and that balance requires ongoing monitoring. What is less often addressed is the occasional teacher or supervisor who is excessively intimidating or shaming. This should not be ignored by the Education Committee. I once heard a colleague defend his teaching style by saying that candidates learn better if they are anxious, and a supervisor insisted that "You have to keep telling them what they're doing wrong or they won't learn anything." One might argue for a smidgen of truth there, but it is the dismissive attitude that concerns me. Faculty members are mostly volunteers without a background in teaching methods, and some institutes have found it helpful to bring in educational consultants to work with faculty to improve the quality of teaching. I applaud this effort.

Being a Student Again. Is there something inherently shaming in being a psychoanalytic candidate? Psychoanalytic candidates typically are in their 30's, 40's, or 50's, usually already having completed a graduate school or professional education, perhaps already having achieved status in a profession. Becoming a "student" again can easily feel like a regression in status or, for some, a diminishment of self.

Being a psychoanalytic candidate also means being in your own personal psychoanalysis, which at times has its own regressive pull on your life and on feelings in the classroom. Working in analysis on conflicts about authority, about speaking in public, or about competition with peers may spill over into the classroom or supervision.

Words Matter. Two words should be eliminated from our psychoanalytic lexicon: "training" and "technique." During my term as director of a psychoanalytic institute, I asked our community to speak of "education" and "process" instead. It didn't catch on.

It is true that the words have become semi-autonomous concepts in the psychoanalytic world and, in that context, no longer carry the full weight of the common associations to conformity, rote execution of a routine, and unquestioning allegiance to authority. We train dogs and soldiers and bonsai. Psychoanalytic candidates need educational opportunities, not training.

Yes, the words have become shorthand, and we really have something else in mind. Or do we? How committed are we to intellectual freedom and individuality, to curiosity and creativity? Why, as people so concerned with words and the meanings they convey, have we clung to words so antithetical to what we are about? A candid discussion might be revealing as to how we actually do conceive psychoanalytic "training," and it could help us move toward a more flexible educational philosophy.

At Least, Do No Harm. On the other side of this issue, we should recognize that psychoanalysis unleashes powerful emotions and desires. Part of what motivated the "training" mentality was the uneasiness, both realistic and exaggerated, that things would get out of hand in the intimacy of the analytic encounter. As educators, we are responsible to the public to ensure that the label "psychoanalyst" implies integrity, safety and respect, without exploitation of vulnerable people. The proper balance between self-discipline in the analytic setting and freedom to be spontaneous and creative is an important issue that needs to be addressed openly.

Becoming a Psychoanalyst Is as Much About Who You Are as About What You Know. Gone are the days of the anonymous, objective analyst who only dispenses interpretations, with countertransference regarded only as an interference and relegated to private self-analysis. That does not mean that supervision and clinical case conferences should be turned into "analyze the analyst" sessions. But it is inevitable that presenting your clinical work involves a great deal of self-exposure – both the novice's errors and the revelation of personal limitations and anxieties. This potentially shaming experience can be minimized by faculty tactfully limiting excessive intrusion into private spaces and by always treating candidates with respect.

Faculty Attitudes. The optimal learning environment in psychoanalytic education is a collegial one in which faculty pass on their greater knowledge and experience to candidate colleagues. The faculty also has the responsibility to evaluate suitability and learning, which should be approached with the minimum necessary hierarchy and authority and a maximum of respect and nurturing of individual development. Within that matrix, there is room for inspiring teachers and challenging supervisors, as well as for tough standards and exacting requirements. There also should be room for candidates to question received ideas and to speculate with new ones. Our goal should be to help each candidate become the best analyst that he or she can be, in his or her own way, rather than turning out cookie-cutter trainees. These attitudes and goals are more important than the exact structure of the educational program.

Supervision. This point about individuality is especially important in supervision. Most institutes require a candidate to have at least three different supervisors, thereby giving an opportunity to learn from a variety of approaches. I believe it is equally important for supervisors to help candidates develop their own method and style. Those who simply try to mimic what the supervisor would do may learn the words and miss the music. The result may be a sterile parroting that does not work. We learn from experienced clinicians, but becoming an analyst requires integrating what has been learned within the strengths and limitations and styles of our own individuality.

Evaluation. Unavoidably, shame often occurs in the necessary evaluation process. Traditionally, this process occurs more or less in secret. Prior to the 1970s, when reports from training analysts were still required for candidates' advancement (yes, that actually did occur, as unthinkable as it seems now), candidates had to assume that their lives were pretty much open books within the inner sanctum of the institute. The focus on evaluating candidates' personality functioning has now shifted to supervisors' observations of how the clinical work is affected. Still, one's person is being evaluated, not just one's knowledge or skill. In psychoanalysis, the analyst is the instrument that is evaluated, so there is the potential for exposure and shame.

Faculty should be scrupulous in keeping boundaries around the evaluation process. In our institute, for example, we limit the evaluation input strictly to observations by teachers and supervisors. Anyone with privileged information about the candidate is excluded from the discussion – training analysts, certainly, but even former therapists or spouses' analysts leave the room during the discussion.

I believe most faculty members maintain their attitudes of respect for candidates, as well

as a touch of humility, having been in similar situations as candidates. There should be no gossip or idle chatter about candidates in the evaluation discussions. Faculty should keep in mind that we are not immune to our own biases and idiosyncratic judgments, and those leading the evaluation team should not allow one dominant voice to prejudice others.

Secrecy. Candidates should be able to trust that evaluating faculty respect their privacy and keep information about them secret. However, we tend to operate with too much secrecy from candidates. Too often, decisions are made without their input. I favor an evaluation process that includes the candidate, similar to one at the small, seminar-based college that my grandson attends. At the end of the semester, each student attends a meeting in which all of his tutors are present to discuss his work. The student only listens, but is then invited to submit a written response. This, of course, would be unwieldy in a large school, but our psychoanalytic institutes could manage it. A process of this kind eliminates secrecy, invites input from the candidates, and exposes inappropriate information or individual bias that sometimes influences decisions.

Further, this open approach would bring candidates in on the concerns of the faculty much sooner than is often the case. Too often, we discuss for years our concerns about a candidate's capacity for analytic work, but decide to wait and see if more personal analysis will solve the problem. Years later, we are still kicking that can down the road, postponing a decision. Rarely is the decision to drop a candidate an easy one. Some years ago, I was on the site visit team for an institute that had unusual difficulty making these decisions. One person had been a candidate for over twenty years. The institute did not know what to do with him, and he was just hanging on because no one had sat down with him and frankly discussed the problems. Given the opportunity to talk with an outsider, he spoke freely about his discouragement and his anger and shame over the way his situation had been handled; he chose to resign.

There is no question that such a discussion is difficult, but when conducted tactfully, it can stimulate necessary analytic work or lead to a more timely conclusion of the candidacy. There is also the possibility that the candidate's input might give the faculty a different understanding and lead to a different decision. I also have known other candidates who took much longer than usual to develop analytic skills and to mature personally, but who eventually became competent analysts.

Including Candidates. Most institutes have moved toward greater involvement of candidates in the life of the institute. In the old days, when maintaining anonymity of the training analyst was paramount, some institutes did not even allow candidates to attend scientific meetings with faculty or to receive the institute newsletter. Now it is common for candidates to be active and valued members of various committees, and feedback is solicited. Such changes indicate a fundamental shift toward a more egalitarian ambience in the institute, with greater respect for candidates as colleagues and lessening the unnecessary causes for shame.

Different Educational Models. This is a time of increasing diversity in psychoanalysis. It is also a time of experimentation with different educational models. Along with other educational issues, we should consider models that encourage individuality and creativity and that reduce the likelihood for intimidation and shame. For example, the French model

completely separates the candidate's personal analysis from the institute, making analysis a prerequisite to beginning candidacy. This raises the question whether the educational value of being in personal analysis concurrently with supervision outweighs the risks of feeling exposed, controlled, and shamed by having the analysis be part of the institute's business.

In our institute at Emory University, we are taking advantage of our status within the university to plan for a model more like graduate school. There will be a two-year core curriculum open to a wide diversity of applicants who could then choose different tracks to follow for subsequent study. Clinical psychoanalytic candidates would continue with our usual curriculum, but other clinicians might choose to follow a shorter and different supervisory track, with the goal of enhancing their work as psychoanalytic psychotherapists. For academic scholars and researchers from various backgrounds, the core curriculum could be structured into university programs for advanced degrees in psychoanalytic studies. Psychiatric residents and clinical graduate students, who are interested in psychoanalysis but not yet ready to make the full commitment, might choose to begin the core curriculum and later decide to continue in the clinical track.

Among other advantages, diversity of students and flexibility of study tracks will naturally move away from cookie-cutter training concepts and focus more on individual plans. Giving students more choices will decrease the Big Daddy, monolithic aspect of psychoanalytic education and, with it, some of the potential for intimidation and shame.

On the question of beginning with thorough grounding in one theoretical approach versus starting with an eclectic approach, there is a good case to be made for both. I favor a compromise, which begins with an introductory course giving an overview of the various theories, emphasizing the important strengths and differences of each, and tracing the historical points of divergence. This is then followed by a series of more in-depth courses in the major psychoanalytic schools. An approach like this avoids the idealizing of one theory, while also providing sufficient depth for candidates to make their own evaluations.

Gay and Lesbian Candidates. In addition to the general opportunities for shame to crop up in psychoanalytic education, gay and lesbian candidates may face an additional source. Until 1991, there was a de facto exclusion of homosexuals from being accepted as psychoanalytic candidates. Prior to that, some of us did become analysts by staying in the closet, but if a "known homosexual" graduated from one of the institutes affiliated with the American Psychoanalytic Association before 1990, it remains a well-kept secret.

This all began to change following the adoption of a non-discrimination policy in 1991. However, actual changes came slowly and too often relied on the pioneer gay candidates themselves to educate the faculty as to what needed to be changed. It was not just the new policy of accepting gay and lesbian candidates. It involved attitudes of teachers, the lack of faculty role models to pave the way, replacing outmoded literature, and speaking up in class when something was said that needed to be challenged. That was a lonely, painful burden added to the role of being a candidate.

The first openly lesbian candidate at one of the larger institutes talked about the times she

would leave class in tears, seething in rage, and would have to work herself up to be able to return the next time. Fortunately, she was resilient and bright and not easily intimidated, and she paved the way for others, but at a cost to herself.

Others were not so successful. One applicant, whom I knew well and considered highly qualified, was turned down by an institute after having a bad interview experience. His interviewer grilled him about details of his sexual practices, implying disapproval and pathology, in a way that he knew a heterosexual applicant would not have been questioned. In discussing his experience with me, the applicant made a very important observation, one which I think is applicable anywhere that shame shows up in an educational enterprise. He became so angry at the way he was being interviewed, and the denigration of his sexuality so triggered old internalized anti-homosexual feelings of shame, that he became rather frozen and actually did not give a good impression of himself in the interview. His point was this: The combination of anger and shame is paralyzing. We must consider how often we trigger such feelings that then interfere with a candidate's ability to perform well in class or in supervision.

Most psychoanalytic institutes have come a long way since 1991 in being not only more open, but more understanding and accepting – and, therefore, less shaming – for their gay and lesbian candidates.

In general, as much as we want to design our structures and policies to minimize unnecessary experiences of shame, it is ultimately the attitudes of faculty members and their relationships with candidates that are of even greater importance. As we have come to think of psychoanalysis more as a two-person experience, rather than simply a one-person, intrapsychic focus, it makes sense that we would give greater credence to the relational aspects of the educational programs that we design. Teachers and supervisors who shame their students can ruin the best designed programs; empathic, respectful teachers and supervisors can make the worst designed programs at least a little better.

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A Culture of Honesty: One Positive Function of Shame in Psychoanalytic Training

Jason A. Wheeler Vega, PhD

I could not do justice to all the important questions framed by Dr. Buechler for this panel, so I will concentrate on one. As when one speaks to the quiet side of a conflict, here I aim to explore positive functions of shame in psychoanalytic training in contrast to the vividly negative aspects of this emotion. I argue that a positive function of shame in psychoanalytic training institutes may be to inculcate a culture of honesty among trainee analysts. Differences between the objects before whom one feels ashamed may influence the quality and effects of this emotion.

A Culture of Shame

Shame has been examined by the philosopher Bernard Williams (1993), particularly in its psychological and moral aspects within Greek poetry. Williams notes that the ancient Greeks have been described as having had a "culture of shame," and thus criticized for not having a "culture of guilt." A culture of guilt is ostensibly superior in that it is concerned with the harm done to others, with a commitment to reparation, and is governed by internal moral agencies. Cultures of shame, on the other hand, have been seen as "concerned only with one's appearance and…based merely on what others think" (p. 81), thus both egoistic and lacking in internal moral structures. Williams attributes the valuing – over-valuing – of so-called cultures of guilt to the influence of Kantian ethics, which are based on adherence to unqualified rational principles and have no patience for personal failings and limitations of character.

The shame of the Greeks, Williams argues, is richer than many modern thinkers have recognized. He argues, correctly I think, that both guilt and shame may be directed by an internalized other (internal object) before whom one must act morally (normatively) in order to feel like a full member of society. Further, whereas shame is usually assumed to have a basically privative function (one acts so as to avoid feeling ashamed), it may have wider functions.

The Greek word Williams examines is *aidōs*, from the verb *aideomai* (Liddell and Scott 1996; Williams 1993, p. 194, Note 9). This is a term, like some noted by Freud (1910), which encompasses antithetical meanings: "shame," "honor," "scandal," "reverence," and "dignity" are all translations for uses of *aidōs*. Similarly, *aideomai* can mean to feel ashamed, awed, respectful, or to feel regard for someone. For example, avoiding shame is a motive for behavior in epic literature – a battle cry in the *Iliad* for Greek and Trojan alike (Williams 1993, p. 79), and an impetus to honorable action in the *Odyssey* (p. 83).

Williams argues that the concept *aidōs* applies widely to instances that we might differentiate today as either guilt or shame. The breadth of this concept also shows the important relationship between these emotions and a person's identity and character. He writes: "*What I have done* points in one direction towards what has happened to others, in another direction to what I am" (p. 92). Guilt points towards another's interests, and shame towards what kind of person one is in the social world, i.e., broadly, contemnable or honorable. Shame gives guilt a constructive purpose: "The structures of shame contain the possibility of controlling and

learning from guilt, because they give a conception of one's ethical identity, in relation to which guilt can make sense. Shame can understand guilt, but guilt cannot understand itself" (p. 93). I have done wrong and must be punished and make amends; but what does it mean for me to do wrong, to accept punishment, to offer reparation? These are questions that make sense in relation to how I see myself (ideally) as a member of an *ethnos*, as someone who is contemned or honored in my society. Guilt, on the other hand, may remain a narrowly dyadic emotion, which may be felt even if in isolation from or opposed to one's social affiliations.

Varieties of Shame

Williams, then, argues that shame may be felt in relation to internalized objects, that guilt is the heir to shame but not its replacement, and that shame provides the basis for identity and moral conduct. Martha Nussbaum (2004), influenced by Williams's interest in these topics, has come to related although not identical conclusions (p. 191). Although she is not as explicit about this as Williams, Nussbaum also sees shame as something that may be felt in relation to internalized objects (p. 191), as opposed to *embarrassment,* which she sees as irreducibly "social and contextual" (p. 205). In contrast to Williams (and in accord with the Kantian tenor of many discussions of cultures of shame), Nussbaum sees guilt as more advanced developmentally and ethically, as it need not infiltrate every aspect of the person, as shame arguably does, and because guilt aims at restoring our relation to whole objects, not restoring infantile omnipotence. This disagreement may turn on different concepts of shame, to be outlined presently, with Williams's wider concept of *aidōs* including two varieties of shame that Nussbaum elsewhere distinguishes; here she has in mind a narrower, wholly negative concept of shame in contrast to guilt.

Nussbaum distinguishes two varieties of shame: *primitive shame* and *constructive shame*. Primitive shame is conceptualized as a defense that supports infantile omnipotence by repudiating dependency needs: "[Primitive] shame involves the realization that one is weak and inadequate in some way in which one expects oneself to be adequate" (p. 183). This emotion is enflamed by any situation that threatens to overwhelm illusions of invulnerability by the evident need for objects and the things only they can provide (p. 210). Aimed at enacting a fantasy of absolute self-sufficiency, primitive shame "is a threat to all possibility of morality and community, and indeed to a creative inner life" (p. 208).

Nussbaum also suggests, like Williams, that "shame can at times be a morally valuable emotion" (p. 211). We might ask when is it appropriate for ourselves and others to feel ashamed and when might we even encourage others to feel ashamed? This kind of *constructive shame* might be felt by members of a community who are pursuing "valuable ideals…within a context where one already renounces the demands of narcissism" (p. 208); Nussbaum asserts that this kind of "moral shame" or "aspirational shame" is common to mature adults who have relinquished fantasies of omnipotence (p. 215). Far from the alienating effects of primitive shame, constructive shame may function as "reinforcing a sense of common human vulnerability, a sense of the inclusion of all human beings in a community, and related ideas of interdependence and mutual responsibility" (p. 213). This, one might say, is why calling someone "shameless" is both a criticism of his or her character and an ethical reproof.

Nussbaum raises the possibility that feelings of shame in particular contexts and before particular others may differ in quality and in function. What objects might induce more destructive or more constructive feelings of shame? To feel shame before a bad object and before a good object, and before different species of each genus, are experiences that are likely to differ in quality and intensity. A couple of clarifications are in order here (and could perhaps be expanded upon elsewhere). First, while I think the subjective experience of objects will usually be a primary determinant of emotional experiences, here shame is being considered in a developmental context, and so the objective qualities of external objects will also be relevant. This developmental aspect is prominent in training. Not only what we bring to our institutes and teachers, but also the qualities of those institutions and people may affect the likelihood of feeling one or another sense of shame. Second, while I focus on the qualities of internal objects here as governing the particular experience of the ashamed, the ability of other ego functions and defenses to maintain self-esteem in the face of shaming objects will likely be influential, too. For example, talented users of denial, devaluation, and projection may be able to limit the shame they experience, as might people with solid bases of realistic self-regard who can keep a sense of proportion about such feelings.

Here follow some possible varieties of internal objects and their effects on the quality of the feeling experienced by the ashamed. Shame may be a humiliating oppression before someone who wishes to deprave or subjugate. Persecuting objects threaten destruction. A perceived moral failing before someone indifferent to one's interests might be felt as insignificance or worthlessness. These reactions may be of such intensity that hiding or destroying either the shameful self or shaming other become compelling options. Such defenses as hiding, lying, attacking, and devaluing are well known in narcissistic and paranoid people, who are notably susceptible to feeling ashamed and then, in an effort at mastery, trying to shame others (identification with the aggressor).

One might also feel ashamed before a good object. There are some good objects, one might call them "Kantian" objects, before whom one feels approved of and virtuous when complying with the moral laws they represent. Nevertheless, these objects might provide only a rather austere satisfaction to one who is stung to act with rectitude, if our interests are not held to heart by the overseeing object (much as Kant's ethics is disinterested in actors, personally, beyond their ability to perceive and follow moral imperatives). In contrast to Kantian objects, before a sympathetic or loving good object shame may be infused with a surge of desire to be good, to deserve the love of the loving object, and to be capable of loving in his or her manner (anaclitic identification). Although either kind of good object, and perhaps others, could encourage the development of valuable ideals and a renunciation of unnecessary degrees of self-involvement, it seems at least plausible that shame before loving objects would be more effective for the development of an ability to work toward one's aspirations and ideals; this is perhaps an empirical question, and may depend also on other features of the subject's personality. Perhaps one reason for the existence of antithetical meanings of "shame," noted earlier, is that different qualities of this emotion may be experienced in relation to different kinds of objects.

A Culture of Honor

Norms inhabit internal structures of shame, and these, in turn, may generate cultures that reflect and perpetuate them. One such culture is the "culture of honor" in the American South, described by Nisbett and Cohen (1996). Cultures of honor are typically found in small communities where male-male violence is prompted by challenges to reputation that can have serious negative consequences for those who accept affronts unreturned. The emphasis on appearance, reputation, and the law of talion prompts comparisons with the Greek culture of shame. Nisbett and Cohen quote the historian Wyatt-Brown on Southern honor: "An impotence to deal with such wrongs carried all the weight of shame that archaic society could muster" (p. 5). Alongside these historical comparisons, they conducted a series of social-psychological experiments to explain how a culture of honor might cause the disproportionate rate of murder by White men in the South compared to White men in the North.

Some of these experiments also speak interestingly, if indirectly, to the question of whether shame is a purely interpersonal emotion or whether it might be spurred also in the presence of internal objects; these ideas were not considered by Nisbett and Cohen. Their basic paradigm was to use research assistants (engaged to deceive subjects) to insult experimental subjects in some way, verbally or physically; also, in some variations, the subjects would be observed by and later interact with other research assistants.

One experiment found no differences between the private and public insult conditions, although Southerners who were insulted had significantly greater reactions than non-insulted Southerners or insulted Northerners. If shame, as we usually understand it as an interpersonal emotion, is the psychological mechanism that supports a culture of honor, then should not a public insult have greater effect than a private one? Nisbett and Cohen consider the possibility that their method was weak, as perhaps insults before strangers are not very likely to trigger strong "honor" reactions; perhaps having engaged friends of the subjects as confederates might have been a more powerful experimental manipulation (p. 53). Alternatively, it may be that both privately and publicly insulted Southern subjects, members of a culture of honor, did, in fact, have a shame reaction, and that a private reaction before an internalized other was equivalent to being insulted before an actual other.

In a similar experiment, there was no later behavioral effect of being publicly insulted; these subjects were not more likely to be aggressive with a research assistant who was evaluating them. However, Southern males who had been insulted in the presence of the evaluator reported imagining that he would rate them as less masculine, less courageous, and more cowardly (p. 50). Nisbett and Cohen suggest that "the southerner's tacit representation of the 'generalized other' includes the notion that failure to respond to insulting behavior will be met with contempt" (p. 83). One may feel shame before one's internal objects, fearing to relive the scorn that once may have been experienced for socially unacceptable behavior.

Again quoting Wyatt-Brown, Nisbett and Cohen note a possible role for mothers in inculcating a culture of honor into their sons, with analogies drawn between mothers of the South and of ancient Sparta (p. 86). Quoting a veteran of the Civil War: "We were afraid to stop….Afraid of the women at home…They would have been ashamed of us" (p. 87).

Interestingly, the investigators observe that having a mother from the South was a better predictor of an aggressive response to insult than having a Southern father (p. 88). Given that at least some of the mothers, sisters, wives, and others at home were loved, sympathetic figures (compassionate and not merely Kantian good objects), it is plausible that constructive shame was the result – shame sufficiently integrated with one's identity and moderate enough in intensity that it could drive one to uphold what *was conceived as* a noble purpose. No doubt primitive shame prompts some murders, and identification with the aggressor others, but the modest evidence of a role for shame in the Southern culture of honor points more towards an internalization of good object relations.

A Culture of Honesty

To compare psychoanalytic training institutes directly to a culture of shame in archaic Greece or a culture of honor in the American South or elsewhere would be simplistic. Yet there are some commonalities: Analytic institutes are small communities built upon personal relationships and within which mechanisms of shame – this panel presumes – may function to inculcate and maintain certain norms and attitudes. Just which ones is likely to remain an open question, but here is one suggestion. Honesty, unflinching truthfulness, is a psychoanalytic value if anything is. In "Observations on Transference-Love," Freud (1915) counsels against taking easier, non-analytic routes to managing the transference: "My objection to this expedient is that psycho-analytic treatment is founded on truthfulness. In this fact lies a great part of its educative effect and its ethical value…Anyone who has become saturated in the analytic technique will no longer be able to make use of the lies and pretences which a doctor normally finds unavoidable…" (p. 164). Technically, this counsels that one should weather the storms of demand and offer a model of honest self-knowledge to analysands. But further, this attitude is suggested to be mutative for the analyst also: Living psychoanalytically, accepting honestly the best and worst of humanity, becomes part of one's identity and aspirations, such that easy dishonesty is no longer easy, but becomes shameful.

Nussbaum's description of a context for constructive shame to function positively – a community committed to valuable ideals and renouncing narcissism (2004, p. 208) – describes, I think, some basic goals of a training Institute. Renouncing narcissism cannot mean giving up all self-interest and defenses that protect self-esteem, but it might entail a commitment to take these needs no more seriously than necessary, and to be prepared to subject them to analytic exploration. To become increasingly responsible for one's attitudes, to honestly face the contents of one's unconscious with the help of another, to claim what is one's own, are basic goals of an analysis. Analysis is an ethical project to the extent that the greater responsibility we have over our attitudes, the broader are our roles as moral agents who can claim authority over our thoughts and actions. This is a background assumption of analytic training – to try one's best to be honest with oneself through exploring one's resistances to being honest with another. There are limits to the structural changes that may occur by the time someone gets to analytic training, but this does not vitiate the project.

Here follow some examples of attempts – not explicit, perhaps, but purposeful – to establish a culture of honesty in analytic training along these lines. Although shame often arises for the socially proscribed, it is not only tabooed or antisocial attitudes for which it can be hard

to claim authority. One can feel shame also for tender feelings: A narcissistic obsessional patient blushed and giggled quite against her usual serious and poised persona when she realized she was feeling grateful towards her therapist; she felt ashamed at having experienced this emotion *so little*, and noticing its immediate presence made her feel its more frequent absence. She then went on to feel a mixture of sadness and further gratitude for this realization.

In a case conference, an instructor emphasizes the value of a genuine and spontaneous technique, calling it "dishonest" to say something or make some "mistake" just to provoke a reaction or for a particular effect. A difference between analytic techniques and other therapies is that analysis aims to eschew suggestion, charisma, and other artificial ways of having (therapeutic) effects on patients. Honesty in technique, a forgoing of gimmickry and artifice, is absorbed as a value in this way. The teacher is seen as someone with values that the trainees want, and to become like the teacher in this way is a means to avoid feeling ashamed before this admirable model.

During a discussion about fees, a teacher pauses to digress on practices like raising one's fee above one's regular rate for patients with insurance. Discussion of this arguably fraudulent practice (a faculty member called it fraudulent, and the point was briefly argued) leads into other disputed questions, such as whether to bill patients for one's full fee to submit to their insurance companies for out-of-network benefits but to accept a reduced fee from the patients. Opinions are mixed, but afterwards some share their thoughts more candidly than in class. Inhibited by anticipated shame before a teacher viewed at that moment, perhaps, as a Kantian moral object, attitudes may be tried out and claimed more openly before peers who are seen as just as honestly intended but more sympathetic, and substantial questions can be addressed: What effects might collusions – illegal, legal, or intermediate – have on the conflicts and characters of the patient and the analyst, and on the security of their working relationship? What is given up by an analyst who feels a little compromised in his or her own honesty when dealing with aspects of dishonesty in patients? There may be more freedom to think about ethical matters when moral imperatives are not pressing; as in analysis more broadly, one aims to bracket judgment to broaden experience.

Though not drawn from a training context, a similar clinical example is relevant. A long-term member of Alcoholics Anonymous discusses with her therapist the practice of "counting days," where one counts how many days one has sober and notes particular milestones, such as ninety days, six months, one year. While she recognizes the value this practice had for her in the past, and its social mechanism, she feels too ashamed to begin counting days again after a recent relapse within her current meeting group. Exploring the rewarding and shaming features of counting days, she realizes that her current group does not hold for her the sympathetic atmosphere of a previous meeting, in which she relapsed and counted days successfully to a long remission. Though her current meeting is filled with people sincerely committed to their recovery, they feel merely good and not both good and caring. She ponders whether finding another meeting might help her in recovery, and particularly in relapse. After some time, she switches to a "beginner's meeting," and finds counting days again tolerable and supportive.

A scrupulous, committed trainee analyst presents process notes in a case conference and admits, with some embarrassment, to having cut out remarks he thought were silly and wishes he

had not made. In re-establishing his commitment to his analytic values – admitting and exploring the omissions, managing his feelings of shame – the analyst learns more about his urges to make supportive interventions to reduce his analysand's anxiety. Shame at not keeping closely to an analytic technique – eschewing supportive interventions – could be tolerated and made constructive in this context, where the others present were felt to be sympathetic and similarly committed. As others shared having done similar things, the private shame became dispersed and seen as a regular feature of developing an analytic identity, as a member of a culture of honesty.

In this response to one of the questions raised by Dr. Buechler, I have explored positive functions of shame, drawing from work on different concepts of shame; suggesting that shame before different objects may vary in quality and effect; and linking mechanisms of shame to the development of cultures of honor and honesty. Although any recommendations can only be tentative, it seems likely that psychoanalytic training institutes and teachers can harness positive functions of shame to the extent that they love their candidates, and help them feel both that the values they are acquiring are worth the narcissistic injuries sustained and that (anaclitic) identification with these (loving) good objects is a preferable way of managing shameful feelings. This said, and recalling the influence of good objects in cultures of honor, there are no guarantees that even constructive shame may not lead in destructive directions.

Acknowledgments

I am grateful to Lucy La Farge for thought-provoking discussion about different kinds of internal objects. My thanks to Edward Dewey and David Cole for perceptive comments on a previous draft of this paper. I would also like to thank Jason Hershberger for suggestions that sharpened the final exposition of several ideas.

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The Medium Is the Message in Psychoanalytic Education

Sandra Buechler, PhD

If the process of becoming an analyst gratuitously shames, it won't enhance the candidate's capacity to treat self-esteem issues. If analytic education stifles the candidate's unique voice, it won't hone his ability to help his patients individuate. *How* we teach shapes *what* is learned. The medium is the message.

My response to this rich array of papers on shame in psychoanalytic training begins with a list of some important sources of candidates' shame. I highlight what I consider to be gratuitous or unnecessary provocations – most especially, assumptions of the candidate's lack of relevant clinical and theoretical expertise. Particular attention is paid to some potentially extremely damaging consequences of the candidate's willingness to "go along to get along" with these assumptions. After mentioning some shame experiences involving faculty and supervisors, I briefly address whether shame is ever necessary or useful in training, and close with some remarks on the role of love and other positive feelings.

Some Sources of Shame in Psychoanalytic Training

For the sake of brevity, I will merely list some sources of shame in training. Most are mentioned in the other papers, but I focus on the question of how the medium becomes the message, or, how shaming candidates can compromise their subsequent ability to deal with self-esteem issues in their patients and in themselves.

To quote from Davidman (2007):

> The question I wish to address is not simply what ought to be included in a psychoanalytic curriculum, but what is the effect on the candidate of the indeterminate nature of psychoanalysis? In other words, when we choose to pursue an education in a thing called psychoanalysis, what are we studying? (p. 77).

1. I think Davidman is pointing to a significant source of shame in training. While analysis is inherently complicated, and over-simplifications must be avoided, we also must guard against making the work more mysterious than it has to be. The use of unnecessary jargon is one example of this. Faculty reluctance to expose our own clinical work is another. If candidates are expected to learn to conduct a process that is not clearly defined, and then be judged on the results, shame is likely. We should heed the call of Robert Glick and Deborah Cabaniss for greater clarity about the supervisory and analytic processes. Many have promoted demystifying psychoanalysis for *patients*. What about for candidates and graduate analysts as well? Are we afraid that, along with our mystery, we would also lose our status in the hierarchy of treatment forms?

2. Shame is likely to result if the candidate feels she has to hide approaches to treatment that would be deemed "non-analytic" if exposed. I will not attempt to address the larger

question of whether psychoanalysis and psychotherapy differ quantitatively and/or qualitatively. Regardless of our position on this matter, the assumption that what is analytic is more intellectual and superior is a prejudice that breeds what prejudices usually breed – scapegoating. Jason Wheeler Vega makes the excellent point that if we create such an atmosphere, we tempt candidates to lie about what they really do with their patients. This will surely foster shame, but perhaps just as importantly, it will fail to nurture what I have elsewhere called "clinical values" (Buechler 2004). Faith in the value of truth, authenticity, curiosity, hope, courage, a sense of purpose, and integrity is necessary to the analytic process, as I see it. These values play a role in enhancing our conviction that our work has inherent meaning and purpose. They give us strength in the painful, confusing, challenging moments we all face clinically, and they also protect us from early burnout. Without sufficient hope, courage, and clarity of purpose, we can too easily succumb to the forces of cynicism about whether our field has a future.

3. Along with shame resulting from exposure of clinical interventions that might be seen as "non-analytic," we sometimes shame candidates for their "non-analytic" feelings, reactions, personal interests, and life experiences. Ralph Roughton and Benjamin Kilborne provide particularly poignant examples of this. Roughton's Miss Ellen and the supervisor mentioned by Kilborne used shame/fear as their "teaching" medium. Kilborne's first supervisor shamed him for feeling afraid of what his patient's dream meant about the degree of her pathology. I imagine a fledgling analyst profoundly wanting to help his first patient, and also wanting his first analytic supervisor's approval. We can probably all identify with this! The patient's dream elicited Kilborne's concern. In a moment when Kilborne needed his supervisor's empathy, the supervisor chose instead to highlight his own greater experience, expertise, and equanimity. This was hardly likely to enhance Kilborne's courage to face the risks clinical work entails.

The supervisor *may* have meant to communicate something like, "Don't be afraid of your patient's pathology. With more experience, you will become calmer, just like me." But what was communicated was probably more like, "What is most relevant is the *comparison* of your clinical capacity with mine. Compared to me, Kilborne, you are inexperienced, frightened, incompetent." This supervisor may have thought he was prodding Kilborne to be less afraid, but his method probably had the opposite effect. We don't enhance clinical courage by intimidating candidates! The intimidated candidate is less likely to be able to nurture courage in his patients. Thus, shame/fear can pervade both the supervision and the treatment.

Another problem evoked by the isolation and idealization of the "analytic" is the tendency to encourage candidates to dissociate their life experiences from their work as analysts. That is, the climate in an analytic institute may not foster the sense that the experiences candidates have in other walks of life are relevant to their clinical and theoretical efforts. For example, candidates who are parents are not often invited to think about what they have learned from parenting that might inform their work with analysands, who may themselves be parents and certainly have been sons and daughters. This interferes in the development of a unique analytic voice, since I believe our voices are grounded in our personal life experiences. But candidates are often subtly warned against dwelling on the lives they have had before entering training. Perhaps not unlike what goes on in cults, habits formed in previous clinical careers and experiences in other walks of life are not valued in analytic training. Candidates get the message that what was fine in these other endeavors might be harshly judged as "non-analytic" at the

institute. Also, the theoretical jargon that still permeates our writing can communicate that what the candidate learned from her aunt, or from her son, or from Tolstoy or Rembrandt is not relevant to her training and work as an analyst.

The soil that could grow unique voices is, in effect, treated as mere dirt, to be swept away or disregarded. Of course, this fosters shame. If the message I get is that everything I have previously experienced does not count now, I can hardly feel well prepared. Implicit triangles are created that further complicate the development of a unique voice. If a candidate is proud of his career as a therapist, but the message he gets is that being a therapist is anti-analytic, how can he develop an authentic, unique voice? Would he not have to have at least two voices? And wouldn't each be the poorer for it? Might he feel that having an analytic voice is a betrayal of his other professional allegiances?

4. Another source of shame and confusion is the difficulty in sorting out how much one's problems with the training stem mainly from personal issues vs. other sources. This issue is addressed in C. J. Churchill's forthright and incisive essay. How difficult it can be to expose that one didn't understand a concept in class! It is tempting to hide in silence and forever assume one is not intelligent enough to "get it," rather than risk exposure and, perhaps, find out that no one "got it," because it was not presented clearly, or for some other reason.

In supervision, confusion about what constitutes the candidate's "defensiveness" vs. what constitutes the candidate's differences of opinion and/or style can stifle lively encounters and curiosity. If the supervisor's instinctive responses to the patient are taken as the "norm" (implicitly or explicitly), this makes it likely that the candidate will feel shame about any "deviations" from that norm. For example, if, in a session presented by the candidate, the supervisor would confront the patient, but the candidate chose a less directly confronting approach, how should this be understood? Should our first assumption be that the candidate was *unable* to confront as the supervisor would have done? Do we make room for the possibility that the candidate used good clinical judgment? During the discussion in supervision, do we assume that the candidate is rationalizing if he believes in the choice he made?

5. It is very important to distinguish gratuitous shame induction from other sources of shame. Elsewhere (Buechler in press), I have tried to distinguish anxious shame from angry shame and regretful or guilty shame. I think when shaming feels gratuitous, it often evokes an angry shame. The intensity of the feeling comes from the combination of emotions. When the training process feels unnecessarily shaming, the candidate may react something like, "You didn't have to make me feel this. It was not necessary. You chose to shame me, when you could have chosen otherwise. Maybe you like to see me squirm, or you enjoy feeling superior to me, or you revel in your power."

I recall from my own experience a horrific example of gratuitous shaming. A teacher I once had was explaining the idea that obsessive people often overly complicate their language. As a way to make the point, he wrote one student's words on the blackboard as an illustration of obsessive wording. While I was not the unfortunate student, I felt terrible for him.

Part of the legacy of this experience is the painful feeling that, in my silence, I collaborated. The feeling that one has collaborated in being shamed oneself, or in allowing another to be shamed, can be especially damaging. The candidate who sits in silence as her work is trashed in class, or in supervision, goes home with the shame of feeling exposed, but perhaps even more painfully, with the feeling of self-betrayal for not standing up for herself. I believe that this can be one of the most damaging shame experiences in training (or elsewhere). "Going along to get along" when we are being shamed gratuitously leaves a destructive legacy that, I suggest, is especially difficult to bear and especially hard to alter.

6. Although this is not our main topic, I want to mention that shame is not the exclusive concern of candidates. I have certainly known moments of shame as a supervisor and as a teacher. Institute life, with its intermingling of the personal and professional, with its peculiarly complicated politics, can engender shame in senior faculty as well as newer members.

I believe that how I handle moments of my own shame says a great deal about who I am as a human being, what I value, and ultimately helps to shape my impact as a teacher, supervisor, and analyst. How I deal with my memory lapses, mistakes, slips, and other human foibles tells a lot about me. When a silence builds in class to a point where it can feel like a negative statement about my ability to evoke curiosity, how do I respond? Once again, the medium is the message.

Arnold Goldberg's contribution spurs me to look beyond sources of individual shame and consider the question of *collective* shame. Is our profession, as a whole, ashamed of itself? Should we be ashamed? Have we sunk from a profession guided by worthy, idealized, wise elders to a bureaucracy ruled by the ambitious and powerful?

First, I would say, let's not idealize idealization. To the extent that it prevailed in the past, it did not provide an optimal learning environment, from my point of view. I think it failed to nurture the talents of the many, and glossed over the shortcomings of the chosen few.

Like the theater, psychoanalysis is frequently pronounced dead. Both have their dry seasons, but also manage to have revivals. I believe psychoanalytic principles will remain vital to the extent that we *choose* to find their application to today's world. If we look around (and within), we will still find people unable to live fully, relate freely, work playfully, and richly imagine. Human beings still fail to reach their fullest potential. Couples still founder trying to overcome obstacles to loving and being loved. Children still suffer and turn away from life.

While I would not want to return to the old days of idealized gurus, I do agree that we still need to be inspired in order to avoid cynicism, demoralization, and burnout. Personally, I am inspired by the candidates, who still put much of their lives on hold to get the best training available and to hone their clinical skills. I am inspired by the very visibly pregnant woman I met at a lecture in Mexico. As we left, I asked her whether she would like to join some of us for the evening. She said she could not because she had to drive all night to reach her town in time to begin her work day. With astonishment, I asked her why she had traveled so far, to which she responded that no one lectures about psychoanalysis in her town, so she had to come. A field this inspiring is not ready to die! Our job is to *forge* its applications. If we work hard to find

ways to use our resources to reduce pain and wasted potential, our field will not hand its next generation a legacy of collective shame.

Is Shame Ever Useful in Psychoanalytic Training?

There seems to be some controversy on this point in the essays I am discussing. Andrew Morrison and Jason Wheeler Vega seem to differ the most, with Wheeler Vega seeing some positive role for shame, and Morrison doubting it. Of course, gratuitous shame is harmful and never constructive. But what about the shame that stems from the feeling of inadequacy brought on by the huge, profoundly consequential, confusing challenges we face clinically? I am not sure this shame is useful, but I do think it is inevitable.

It is difficult to imagine an educative process more acutely conducive of shame than analytic training. Our relationships with our supervisors, teachers, patients, and colleagues (even with the institute itself) are all emotional relationships. Inevitably, these people matter to us, and we care what they think and feel about us. Self-attention is intense in training, since heightened self-awareness plays such a crucial role in every part of the learning process. The candidate must be extremely self-observant. Without self-observation, every aspect of training, including supervision and even theoretical coursework, would be a sterile exercise.

To reiterate, all the ingredients needed to induce shame are present in analytic training. The supervisee is looking intensely at herself as she is being evaluated by people whose opinions of her matter deeply. But yet another pressure is often added. She is frequently aware of an expectation that not only should she be able to reveal herself while being evaluated, but she should be able to do so relatively *comfortably*. To put it briefly, the candidate is expected to open herself up to an unusual degree of personal scrutiny and still maintain enough equanimity to function in her new professional roles. Since she often incorporates these expectations, she also expects herself to be comfortably self-revealing. At the same time, she may be involved in a personal treatment process that facilitates less reliance on accustomed defenses and, therefore, is confronting anxiety that her defenses had previously kept at bay. She is learning a new, highly ambiguous task, absorbing complicated theoretical material, making new friendships, and attempting to integrate this new life with her previous responsibilities and relationships. Often, any discomfort with this process is seen as problematic by the candidate herself, as well as by others.

In institutes we train people to do something that is intensely personal. Our hopes for our patients reflect our deepest, intensely personal values about life. The outcomes of the first analyses we conduct can have a powerful long-term impact on our own sense of self. Analytic training inculcates inevitable feelings of inadequacy and shame because the task is often ambiguous, with results that are enormously important and deeply personal. Its moments of progress and despair feel reflective of who we are as human beings, of our essential worth. It requires profound self-reflection and the capacity to face painful aspects of our human and individual limitations. Inevitably, we compare ourselves to our much more experienced supervisors. The task of helping people live richer lives is daunting in itself. Added to this, the candidate is constantly evaluated by supervisors and teachers, and is often engaged in intense self-reflection. He also may be subjected to negative judgments from his patients, as well as

cynicism about analytic treatment from the wider culture. The candidate may feel called upon to uphold the value of what he is learning to do when he is questioned at cocktail parties, when he faces the financial consequences of his career choice at the end of each month, and when he has to confront devaluing managed care companies. His faith in himself may be tried by patients' sudden departures from treatment.

The role of shame in training might be similar to shame's role in early life. Shame, in tolerable amounts, can motivate the child's development of objective self-awareness and social attunement. The analysts that candidates are in training to become need high degrees of attunement, self-awareness, and sensitivity to their interpersonal effect. They are preparing for a professional life uniquely dependent on painstaking self-awareness, honest self-scrutiny, and a willing acceptance of responsibility for negative interpersonal impact. It is human nature to feel shame when a spotlight is thrown on our significant limitations. As Sullivan (1953) suggested, part of how we learn to be social creatures is through experiencing varying degrees of failure, with its attendant discomfort. So shame in training is inevitable. The supervisee revealing how her limitations as a human being affect her clinical work inevitably feels some shame, as would any other human being acculturated in our society.

What Does Love Have to Do With It?

I would like to close with a few remarks about what can help strengthen the candidate, and, most particularly, whether love has anything to do with it. Wheeler Vega seems to think it does. What can bolster the candidate to withstand the shame he encounters in training? In other words, what can make analytic education a strengthening rather than a debilitating process? First, I think we should answer Glick and Cabaniss's call for greater clarity about the supervisory and analytic processes. I also very much agree with Wheeler Vega's emphasis on honesty as a psychoanalytic value. The education process, much like the analytic process, must privilege truth seeking over immediate narcissistic gratification. But how do we encourage this? I would say, first and foremost, by modeling it. Ironically, perhaps, I think if we (supervisors, candidates, patients) can feel proud of our willingness to confront ourselves honestly, our well-earned pride may mitigate our shame. That is, *feeling proud of the courage to look at ourselves* can modify whatever shame we feel because of what we see. I have found this idea immensely helpful in both clinical and non-clinical walks of life.

Wheeler Vega's conclusion is so apt that I would like to quote from it:

> ... it seems likely that psychoanalytic training institutes and teachers can harness positive functions of shame to the extent that they love their candidates, and help them feel both that the values they are acquiring are worth the narcissistic injuries sustained and that (anaclitic) identification with these (loving) good objects is a preferable way of managing shameful feelings (p. 7).

The mention of love stood out for me. Although our profession has sometimes addressed the analyst's love for his patients, in my experience love for candidates is not often mentioned. What might this mean? Is it an even more taboo subject? Why?

It seems to me to be true that our love for our candidates can play a role in how potentially shaming moments are experienced. When a teacher (or anyone else) clearly cares about our welfare, it affects what it is like to bear shame's sting. Shame, like all feelings, can connect us more closely with the human condition, and, therefore, with each other.

Members of the analytic community share an overriding purpose – to become better clinicians tomorrow than we were today, to help more, to hear more openly, and see more feelingly. With that purpose in mind, shame about our limitations may shrink, and may fulfill its own best purpose, as potential information about ourselves and, more broadly, about what it means to be human.

Years ago, I read a paper in which Alberta Szalita, even then an elder member of our community, was interviewed and asked how her work had changed over the many years she had practiced psychoanalysis. Her answer was: "It boils down to one thing: to what degree you are concerned with yourself and to what degree you are, as a therapist, concerned with the other person" (Issacharoff 1997, p. 627). I have taken from this, and from many other sources, the sense that, in training, our job is to cultivate the candidate's capacity to have a relatively non-narcissistic investment in the lives of others.

We foster that capacity when we become part of the sustaining "internal chorus" that I believe training should develop in the candidate. Ideally, I think each candidate finds teachers, supervisors, analysts, and others from whom he takes in something memorable. It might be a phrase, a tone, an idea, or a spirit. Those who train are, in my view, auditioning for inclusion in candidates' internal choruses. If we are chosen, we may serve to guide, comfort, support, and inform these developing analysts throughout their professional careers.

We can have a positive impact on candidates if our words and actions reflect integrity. If how we teach matches what we teach, we can get a clear message across. Trying to impress a candidate with the supervisor's superior empathy teaches the candidate about competition (and, perhaps, about hypocrisy), not about empathy. Again, the medium is the message.

We cannot nurture candidates' capacity for non-narcissistic commitment to the field if we gratuitously shame them during their training. Shaming candidates debilitates the centeredness they need in order to face a lifetime of clinical challenges. Only a confident, centered analyst, with a strong, independent voice and a passionate love for the truth, can make an abiding commitment to life and growth.

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Book Review

***From Both Sides of the Couch: Reflections of a Psychoanalyst, Daughter, Tennis Player, and Other Selves.* By Fern W. Cohen. North Charleston, NC: BookSurge, LLC, 2007, 204 pp., $16.99**

Reviewed by Chap Attwell, MD, MPH

Fern Cohen treats the reader to a wonderful trip through her mind as she details –in an appropriately freely associative yet meaningfully organized way – her memoir. Through the lens of psychoanalysis, Cohen weaves multiple personal strands of her developmental and athletic lives and professional histories into a fabric worthy of study by any analyst who wishes to know more about the depth of impact excellent analytic work can yield. Cohen, writing from a senior point in her career and life, shares a breadth of perspective that accompanies a lifetime of analytic work. In her refreshing and rigorous emotional honesty, she warmly and respectfully invites the reader into her world, perhaps mirroring the healthy creation and maintenance of relationships shared with her family, patients, and friends. Cohen shares her journey, one that successfully metabolized the proverbial ghosts – real and intrapsychic – of her past into the ancestors of her family history (an idea of Loewald's), transforming past introjects into ones allowing for improved mental functioning, and displaying a passion for the field of psychoanalysis that would infect any potential analysand, resident or candidate in training, graduate student, or scholar of psychoanalysis. The profound impact of this memoir stems from the major reactions it elicits.

Cohen's memoir seems to blend the tradition of two important contributions to psychoanalytic writing. The first is Robert Morley's *The Analysand's Tale* (2007, Karnac Books). Morley notes the paucity of published accounts of analysands compared with those of analysts and assembles under one title numerous published analysands' tales. He does so with the express aim of seeking parallel themes useful for identifying the core of therapeutic work. Morley wishes to assess if the patient's recollection of what seemed the most influential in the work might be as valid as the analyst's, a question which Cohen – as analyst and patient – is uniquely suited to answer. In so doing, Cohen adds a rich voice to the literature that Morley gathers in part III of his book – accounts of patients in training to be psychoanalysts. The second is Lora Heims Tessman's *The Analyst's Analyst Within* (2003, Analytic Press). Tessman researched, through detailed interviews with analysts of different gender combinations and age ranges, the question of what makes, years later, the recollection of one's training analysis satisfying or dissatisfying, growth promoting or thwarting. Tessman concludes that the quality of affective engagement between analyst and analysand transcends the analyst's decade of training and/or theoretical orientation in yielding a productive analytic experience. Cohen's account supports Tessman's hypothesis, in that Cohen describes the level of affective engagement with each of her three analysts over different decades of her life. The moving experience and efficacy of her third analysis and the strong affective bond between herself as analysand and her analyst is testament to the power of the right fit between analyst and patient (as well as to the delivery of good interpretations and the successful internalization of the analyst's analyst into the working procedural memory of the analysand as analyst).

A summary of Cohen's well-written account – unable to capture the depth of detail, sequence of associations, and engagement with the reader – does an injustice to the memoir and that which can be gained only by spending time with her movingly personal text. Core themes emerge, however, which serve as evocative signposts. In her first chapter, *mostly about my father*, Cohen introduces us to herself as a girl and to the beginning of her lifetime passion for tennis. In her lucid account, we learn of the intimate connections between her and her awe-inspiring yet distant and rigid jurist father, the late Judge Edward Weinfeld. As she describes the inseparability between her childhood trips to the tennis courts and her relationship with her father, we see the wiser, insightful adult looking back and making sense of the struggling adolescent. Cohen fights to understand her formidable tennis talent, along with her intense conflict over winning that comprises so much of her sense of self. She tells us about her profound anxiety in the face of aggression and the meaningful roots of its psychic danger, her fears of gaining too much weight, and her struggle to feel she could be safe and sexual in the intimate company of a man. She retraces her breakdown in college, re-affirming that it and its delivery of her to psychoanalysis is the best thing that ever happened to her. Cohen's plain language makes what once plagued her unconsciously as accessible as the significant relief she experienced from her own hard work and the insight gained in a good treatment.

As the story unfolds, in *mostly about psychoanalysis*, we learn of the middle phase of her life and meet the professional Cohen, already an accomplished psychologist and psychotherapist, as she decides to pursue psychoanalytic training and a third analysis. We hear her speak knowledgeably of psychoanalysis as a practitioner one moment and as a patient the next. The style works well to convey her evolution in each realm, particularly as she describes her first two analyses, one while away at college and the other as a young, single woman in New York City. Cohen's training allows her to reflect even more deeply on the technique and style of these two analyses, which add to the history of psychoanalysis. For instance, her first analyst, Dr. R, a man, required that she break up with a boyfriend in order for the analysis to continue; her second, Dr. L, a woman, failed to address Cohen's constant five or ten minute struggle to start talking in a session. Cohen convincingly interconnects her fear of authority, the exclusion of this critical transference symptom from meaningful inclusion in the work, and her second analyst's withholding, silent style. For all that Cohen accomplished in these two analyses (she married a loving, available man, had children, profoundly enjoyed the vicissitudes of motherhood, and established herself professionally), she poignantly convinces us of the merits (and pain) of the regression to a childlike state and its careful analysis in reconstructing the pivotal pre-Oedipal roots of her conflicts with aggression and fluctuating sense of self accomplished in her third analysis. She shows us, and the writing of this book is further evidence, of its utility in the creation of scrupulous honesty and the ability to bear its affects. For example, Cohen states:

> In the contemporary light of hindsight, and the works of Klein, Winnicott, and others who have become so integral to understanding the psychic world, what I now know is that Dr. L's insistence on my wish for a baby (which wasn't unconscious at all although some of my conflicts about having one were) shut out the significant domains of deprivation, envy, and their consequences. Left as I was for more than two decades with pockets of unconscious turmoil in those areas, for all that I had learned, I could not decipher the clues that kept getting in my way on the tennis

> court, especially since I considered myself to have been well-enough analyzed to have acquired the requisite tools to help me figure things out. Sometimes I could and I did, but for the most part I lived an uneasy truce with them, little realizing that significant pieces of the puzzle had been left unexamined and untouched (pp. 97-98).

This last sentence perhaps serves as the fulcrum of the chapter, and Cohen goes on to portray vivid examples of work with her patients, vignettes from the tennis court, and exchanges with her third analyst, Dr. Stephenson, which capture her working sense of a traditional but flexible approach to psychoanalytic theory and technique.

The third and last chapter, *mostly about omissions and consolidations*, reads like a moving analytic session from a patient nearing the end of treatment, one who brings into the room past and present, transference then and now, the healing force of treatment, a sense of what can never be, and a peaceful resolution of all of the above, blended with an appreciation for the depth of commitment sustained by both members of the dyad. Cohen brings together much of what has been left unanswered – what more about the emotional relationship with her mother? – into relief; she also goes deeper. We gain a telescopic look into the families of her mother and father and learn what forces and circumstances prompted them to deal with their own tragedies as they did. And in one of the more electrically descriptive sequences of analytic prose this reader has yet to encounter, Cohen connects early strain trauma from her own early life; notions of Phyllis Greenacre's "excluded-in vs. included-out;" denial; fear of competition and the consequences of success; the connection between psyche and soma; ambivalent feelings in intimate relationships; sexual curiosity; money; courtship and marriage; penis envy; narcissistic vulnerability stemming from a lack of self-soothing and poor internalization of maternal functions; and ramifications of each through the Rosetta Stone behavior of her life on the tennis court. In portraying the depth of her lifelong mental struggles, as well as the relief she derived from her analytic experiences, Cohen illustrates the very method of therapeutic action in language available to any lay person. In rooting out the bereft, longing, homesick, and empty feelings so pervasive to what might seem an ideal childhood from a distance, she replaces, via the internalization of so many functions of her analyst, the relentless invitations to join in with forces from the past with optimistic, balanced, flexible approaches to what life deals her. Rather than needing to prove herself as a cover for feelings of insecurity, as her former self would seemingly have done, Cohen writes this memoir with a sincere, genuine tone – one of vulnerable, trusting honesty so respected in work as penetrating as Cohen's last analysis – and simply shows us the real thing that she has been all along.

Cohen's work belongs in our curricula at institutes and with the greater public. Whether in courses of analytic writing, therapeutic action, analytic narrative, outcome studies, importance of fit in the dyad, the value of reconstruction, the force of transference, the psychic internalization of one's analyst, or the impact of analytic work over a lifetime (including the need for re-analysis), *From Both Sides of the Couch* will prove a useful, articulate addition. For any potential analysand, Cohen's book will open a door to understanding the impact a treatment of this magnitude might have. Whether a patient of Dr. Cohen's from the lay public crosses paths with her book, and what impact her book may or may not have on the treatment of any given patient (given the complexity of any individual's life history), remains to be seen. What seems

clear is that Cohen has taken the courageous leap of bearing her soul, and the profound impact psychoanalysis has had in its mending, for any potential reader's benefit. I highly recommend this work.

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Book Review

***The Road to Unity in Psychoanalytic Theory*. By Leo Rangell. Lanham, MD: Jason Aronson, 2007, 133 pp., $34.95**

Reviewed by Edward H. Dewey, PsyD

Leo Rangell begins his book with a quote that orients the reader to his theoretical leanings: "The trunk of the psychoanalytic tree is the Freudian theory of the mind." Other theories, he argues, grow out of this main trunk and should not be conceived of as separate. He does not contend that the original Freudian theory is incontrovertible and should remain unmodified. Instead, he argues that what remains enduring about it should be gathered with the useful ideas that have grown from it, and at times away from it. He encourages us to synthesize apparent disparities into a growing, consistent and functional theoretical whole. However, this book is not generally about theory, and he makes only a summary attempt here to describe his particular version of a unified, total composite theory. Although he does discuss theoretical issues in broad strokes, this book is mostly a social commentary of his experiences during his life as a prominent figure in both the American and the International Psychoanalytic Associations. He is interested in reviewing his perception of the major events and logical errors that have lead both to the present-day multiplicity of theories as well as to a general disinterest in and degradation of cohesive theory making.

As the title suggests, the major thrust of this book is a strong caution against theoretical pluralism. Rangell states in his introductory chapter that "What was hoped to be a science of the mind has been overrun by social values belonging to communal and political life but not appropriate to the life of science" (p. 2). He speaks to numerous external factors (economics, pharmacotherapy and other quick and more gratifying cheaper cures, and broader philosophical trends that he finds antagonistic to scientific and intellectual pursuits) that have threatened the field and have had an impact on what he sees as a dissolving theoretical whole. However, what he seems most interested in discussing are the more dynamic social and psychological factors within the group life of the psychoanalytic community that have influenced the ways different theorists have split from each other. The results of these splits were new "replacement" theories that throw the proverbial baby out with the bathwater. Rather than replacing previous theories, he argues, theory ought to develop by "accretion," with new ideas being added to what endures from the original, modifying and enlarging it. He states clearly: "…I feel that a more important source of our intellectual decline has been a continuous inhibiting and erosive force within the field itself. … In my view, the most significant agent of this interior disarray has been the fragmentation produced by the various stages of theoretical pluralism" (p. 5). Rangell believes that the loss of a unified theory has caused both a loss of inspiration in the field and a loss of interest in theory in general, and he seeks to repair this problem by pointing out what he believes has caused the splits.

Much of the history of psychoanalytic theory formation and group life that Rangell sets out here, as he sees it, can be found in his prior book, *My Life in Theory* (Other Press, 2004). In his present work, however, he has a sharper focus, directing most of his efforts towards, in a sense, interpreting the various group conflicts that have, in his opinion, moved psychoanalysis

into an increasingly precarious position. Being an analytic candidate, relatively early in my career, I am in no position to critique Rangell's version of history, most of which he lived through while I did not. Certainly, there are other authorities who would and do disagree with his views of both history and the importance of basic theory. Nonetheless, his arguments are strong, and he describes logical and factual inconsistencies in the numerous arguments that have historically served to divide people and that continue to energize theoretical pluralism. For example, he points out that in the United States, many current analysts, most notably "lay analysts," had been stung during their training in the past due to the requirement of medical education for certification. He points out that a faulty argument, a stereotype, emerged from that problem that essentially blamed classical Freudian theory for the exclusion of lay analysts, many of whom sought training and validation outside of the American Psychoanalytic Association in institutes where they were more welcome. Freud's legacy, then, became imbued with a sense of rigid, doctrinaire exclusionism that survives in some circles today. Yet Freud was the first proponent of lay analysis, Anna Freud was a lay analyst, and there was no clear division of theoretical camps over the dividing line of this issue. Rather, prominent classical Freudian theorists and alternative theorists could be found on either side of the issue of lay analysis. Freudian ideas and the exclusion of lay analysis are probably unrelated or may even be inversely related, although some continue to propagate the myth that such exclusionism is a direct result of Freudian rigidity. This book is a catalogue of such divisive and inaccurate arguments that have negatively influenced the development of the field, the cohesion of its membership as a group, and the consolidation of a theory.

Dr. Rangell's book was a stimulating read, partly because it helped contextualize the many divergences in the field that have led ultimately to its somewhat confusing and pessimistic current state. He gives alternative ways of viewing the old divisive arguments and why they may have developed. More importantly for me, however, his book stimulated my own thinking about the current confusing atmosphere in which I am learning and how to situate myself within it. I expect that any candidate would be stimulated by it in his or her own way.

Perhaps to new analysts and candidates in the field somewhat less involved, less solidly tied to any one group or perspective, and less bruised by personal experiences, the arguments for schisms that continue to exist today become less solid than for those deeply immersed in them for deeply personal reasons. I hope so. In graduate school, intervening professional life, and now in candidacy, the stereotype I hear frequently bandied about by some people, in a way that almost seems reflexive, is the view that Freud and anyone too closely affiliated theoretically are old hat, stodgy or just plain mean-spirited, and that any viable current theory that is progressive, egalitarian, and up-to-date has to distance itself from its Freudian base. This has struck me, a relative novice, as odd and rather like scapegoating. It brings people together to distance themselves together from something else.

As a candidate trying to learn a way to observe, understand and treat minds, the tension between loyalty to a specific theory and openness to multiple theories in an atmosphere of equality can be both freeing and confusing. I am searching, and I assume other candidates are as well, for a relatively clear road map, but at the same time want the freedom to discover and to avoid aspersions cast for what seem to be unorthodox ideas and techniques. Personally, I find the present multiplicity of theories somewhat disheartening because one of the things I have felt

to be so compelling about the psychoanalytic point of view is its interest in creating a theory that can include all mental phenomena. In my opinion, part of its value flows from the fact that it does not preoccupy itself so much with particular, rigid diagnostic categories, nor propose absolutely different rules for those deemed abnormal versus those deemed normal. Rather, it tries to explain mental phenomena along a continuum. In a sense, this theoretical attitude brings everyone together as one species. The notion, for instance, of using Kleinian theory for borderline pathology and ego-psychology for neurotic pathology has always seemed like an unsatisfying concession between camps at odds with each other, making an uneasy truce over the territory of pathology rather than a sophisticated suggestion of how to widen the scope of our practices. If there is something about these theories that is helpful for different patients, it seems to me there ought to be some way to eventually integrate them.

Rangell points out that technique cannot be unhooked from theory. Everyone has a theory that guides how they listen, whether or not their theory is explicit. One cannot have a blank mind, short of a neurological disaster; something informs our analytic perception and reflexes. As to the argument between "one theory, many treatments" versus "one treatment, many theories," Rangell aligns himself with the former. He laments the broad acceptance of the idea that there are two viable types of theory, one having to do with basic meta-psychology and the other having to do with clinical matters and technique. These two types of theory have been conceptually separated. As a candidate, such an arrangement raises serious questions. If I were to believe that these two types of theory are truly separate, then why bother with the former at all? The former becomes practically irrelevant because, if they are truly separate, then a theory of the mind can have nothing to say about treatment and, therefore, understanding treatment and, thus, understanding minds. I don't believe that, however, and I find it hard to believe that anyone else truly does either. At least I've never heard a convincing argument for it. I believe that the theory of technique rests explicitly or implicitly on basic beliefs about how minds work. If this is so, to avoid making those basic beliefs as explicit as possible seems like a mistake. I want these basic beliefs about mental functioning to be explicit so that they can be examined, modified and taught, becoming progressively more accurate and useful over time.

As a candidate, I feel shortchanged by this atmosphere of not just disinterest in basic theory but almost antagonism to it, as though it is seen as both unnecessary and responsible for creating social conflicts in and of itself. The possibility that some theoretical disputes may partly serve as explanations or rationalizations for conflicts engendered for other reasons seems often to be ignored and the disputes often seem to be taken entirely at face value. The field is still very young, and it strikes me as supremely pessimistic to throw in the towel on basic theory formation simply because many have been hurt in the course of debates, and no universally accepted solid conclusion has yet been made. Frankly, it is the purpose, in part, of the next generation to make a contribution in this regard, not to be dissuaded from thinking about theory because the previous attempts have not resulted in a perfect solution. It seems to me that perfect solutions are never achieved; they are simply strived for in a constant struggle.

There is always a tension between tradition and change, and I want to situate myself somewhere between them rather than at one pole or another. Exuberant enthusiasm about radical changes gives me pause but so does authoritarian rigidity, which is not built into most theoretical

ideas but is rather built into the people who use the theory. Freudian theory can be used to make arguments that are rigid and caustic or *not,* depending on the arguer.

As someone at the beginning of his career, I am aware of my desire to discover, or say something new, to find a new territory. I assume that most people, if not all, share this desire to some extent, just as I assume most people have the alternative desire to belong to something that already exists. I think there is room for comfortable individuality in a total composite theory, but it seems like there is a lot of differentiation and rapprochment continuously repeated. Maybe the current pluralism is an intermediate stage as people try to come together again with a keen sensitivity to avoiding insult, given or received. I hope that as tensions ease, more interest in debate can be engendered. Although egalitarian pluralism manifestly seems like a way to keep people together, as Rangell points out numerous times throughout his book, it latently serves the opposite purpose and undercuts learning and reflection. People would be more unified, in my opinion, working toward a total theory where the virtue is not so much in having been the one to discover something new or to be affiliated with someone who had, but rather in the ability to debate, reflect, notice one's own mistakes, and modify the theory cooperatively, with the understanding that the process is uncomfortable. It is of great concern to me that I experience a field that could be partially characterized as intensely interested in understanding and developing the ability in people to reflect on themselves, and yet has so much difficulty reflecting on itself, and so much worry that careful reflection will lead only to conflict and disarray. A unified theory does not produce schisms, although the way it is propagated may, but pluralism is by definition schismatic and doesn't even hope for anything more than uneasy peace based on avoidance of conflict. This atmosphere is not an encouraging one to enter. Whether Rangell's version of a unified theory is the right one or not, it seems hard to argue for multiple theories as an end state to the process of theory formation, or for that matter, as a lasting solution to social ills within the membership of the analytic community at large.

I highly recommend this book to anyone in the field, but particularly to candidates, for its thoughtful historical review of our field and for its relevance to the current atmosphere in which we are developing our thinking and clinical skill. Whether you agree or disagree with Rangell's point of view, this book is likely to stimulate your thinking on the prominent current issues that may determine the future direction of psychoanalytic thought, practice and training.

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Book Review

***Hate and Love in Psychoanalytic Institutions: The Dilemma of a Profession*. By Jurgen Reeder. New York: Other Press, LLC, 2004, 308 pp., $30.00**

Reviewed by Jason D. Greenberg, PhD

I recently finished Jurgen Reeder's book about psychoanalytic education, *Hate and Love in Psychoanalytic Institutions: The Dilemma of a Profession*. In addition to a brief summary of the book, I offer my reactions to his ideas from a candidate's perspective. Reeder begins with a chapter on his view of a psychoanalyst's function. I found it hard to follow his language at times, but he captures the analyst's attempt to understand an analysand and his experience of the world, in order to help the analysand better understand these perceptions for himself. Reeder indicates that the analyst attempts to convey a certain kind of "love" for the analysand through curiosity, open-mindedness, and acceptance, among other virtues.

In contrast to this "love," Reeder asserts that there is a "hate" that exists and flourishes in the organization and running of psychoanalytic institutes. He outlines candidates' development of a "professional superego," or an internalization of the norms and values of their institute, conveyed by the training analyst, supervisors and instructors. At the same time that a candidate develops this identity, he or she is brought into the "superego complex," a system by which the institute and/or society perpetuates norms for analysts' thought and behavior outside the analytic hour. Reeder believes that candidates and new graduates develop a sense that in order to be accepted by their peers and the powers that be (i.e., the training analysts who hold the real power and status at an institute), they must adopt the prevailing theory and approach or suffer ostracization. He adds that this system leads to a feeling of paranoia, a lack of pursuit of or acceptance of divergent thinking, and, for those who take the risk to be different than the norm, alienation from the institute or society.

Reeder suggests ways to improve psychoanalytic training and thus lessen the adverse impact of the superego complex and "hate" in psychoanalytic institutes. First, he recommends doing away with the training analysis as a focal point of training. He suggests this maneuver would have a tremendous impact on the culture of the institute/society; candidates would undergo a personal analysis that may be a requirement either to enter or to graduate, and they could enter an analysis with anyone who was considered "experienced," rather than with someone from a more exclusively chosen group. Having more potential analysts for a candidate to choose from would alleviate the shortage more isolated institutes have, as well as the problem of analysts and candidates dealing with the probability of interacting outside of treatment (e.g., in the educational setting). Second, he recommends that more emphasis be placed on training analysts becoming supervisors. Again, this would ensure an abundance of competent supervisors. Other recommendations include encouraging more theoretical work, promoting more research, and making training more accessible to individuals coming from disciplines other than medicine or psychology.

Although this book seems intended for analysts in positions of influence in their institutes or societies, it also inspired me, as a candidate, to take a closer look at my own institute. Specifically, I asked myself:

1) *Does my institute encourage or discourage independent thinking?* I do not have a simple answer. I have given much thought to this question, particularly while observing classroom interactions between faculty and fellow candidates. In particular, I notice that many candidates seem hesitant to speak up during class and/or to challenge a faculty member's point. Is this candidate fear? Is it fear of losing the validation of institute "elders," especially at the beginning of our careers when the anxiety and uncertainty about developing an analytic mindset and approach is so high? It seems plausible, although I have not discussed this with classmates or fellow candidates. This lack of discussion may itself be a symptom of the kind of fear Reeder chronicles.

2) *Does my institute subtly or not-so-subtly try to inculcate candidates with a prevailing theoretical viewpoint?* Although most faculty and candidates at my institute would likely agree that the prevailing theoretical viewpoint is based on ego psychology, divergent views also are welcome, including those regarding ego psychology. Supervisors who profess a background in ego psychology are open-minded and flexible in their feedback and stories about their own work. I am also pleasantly surprised by the differences in opinion I encounter regarding theory, technique, and case material. At the same time, it is difficult for me to step outside of my conscious experience as a candidate to answer the questions: Am I idealizing my institute, faculty, supervisors and analyst because I want to "be them" one day? Am I afraid of going against them? Do I have a realistic appraisal of them?

Overall, Reeder has written a very interesting, compelling, and thought-provoking book. He describes the evolution of the psychoanalytic institute and society, as well as of the training analysis, in great detail. It is a fascinating read for anyone interested in learning the roots of the system in which we operate and learn today.

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Theater Review

Psychoanalytic Themes in *The Vertical Hour*

By Jason D. Greenberg, PhD

The Vertical Hour, a Broadway play starring Julianne Moore and Bill Nighy, received mixed reviews from the mainstream press, as well as from friends not in the field, during its 19-week run. The consensus was that the play was difficult to follow at times. However, as a candidate, my experience of the play was quite different. Viewing the play through a psychoanalytic lens transformed the experience to one much more enthralling.

The play is about Moore, a Yale professor of international relations, who worked previously as a foreign correspondent in the Balkans. In the opening scene, she meets with a male undergraduate business major, attempting to persuade him to care more about international relations. The student, engaged to be married, professes his love for Moore and tries to convince her that, based on his three-week undergraduate study of Freud, they should be together. His statement, "[t]here's this whole other person inside of us," who exists underneath what we as individuals reveal, is a central theme in the play. It also sets a psychoanalytic mood for what follows.

We follow the professor and her student boyfriend to rural England to meet the boyfriend's father, once a prestigious doctor. The audience learns that the father and son have a distant and somewhat contentious relationship. The father had numerous affairs throughout the son's childhood, leaving the son to take care of his emotionally debilitated mother. Later in the play, the father reveals that he and his wife married with an understanding that they would have an open relationship, but that the mother changed her mind. The first half of the play depicts the son's conflict between his desire to impress his father and his wish to outdo him. Notably, the son is a physical therapist who attempts to prevent the problems that the father, in his medical practice, would treat (the son's desire to prevent problems before they occur is one of many ideas the father holds with disdain). The Oedipal rivalry between father and son is evident throughout the play's first half, with many of its usual dynamics: the son's identification with his father, his urge to outdo him, and attempts to fix someone before he or she becomes too broken – a repetition of trying to fix his mother?

My impression is that the professor/girlfriend serves two purposes up to this point. First, she plays a stand-in for the mother, although the son does not appear to be ambivalent in his connection to his girlfriend, as he likely would be towards his mother. Second, she extends the father's relationship with his son. When the father and the girlfriend engage in a debate over the war in Iraq, the father is against it and the girlfriend supports it, stating, "We had to do *something.*" Is her statement an attack on psychoanalysis's attempts to put feelings into words rather than into actions? The father views his role in the debate as having to put her, an extension of his son, in her place, as if he were the king who would not be dethroned.

As the first day ends, the play and the relationship between the father and girlfriend begin to intensify. After drinking a lot of wine over dinner, the father insinuates wanting a sexual

relationship with the girlfriend, stating he will be in the backyard reading until late if she wants to "talk" more. The sexual undertone is obvious and punctuated by the son's insistence that his father is not to be trusted. When the girlfriend cannot sleep, she does seek out the father. They engage in deeper, open conversation about the car accident that ended his career as the "expert" and the marital problems that preceded it. The girlfriend shares her decision to teach at Yale as a retreat from the pain of rejection by a fellow journalist in Iraq. The common bond the father and girlfriend share is their retreat from painful feelings.

Aside from the father's self-disclosure, the scene plays out like an analytic session, or an abridged treatment. If one accepts the premise that it is an analytic session of sorts, then the professor is the patient presenting with complaints of work dissatisfaction. She cannot reach her students, who are more interested in immediate gratification than in her world of ideas. Initially, as much as she would like to trust the father/analyst, part of her, represented by the boyfriend, feels the father is a sexual predator who wants to break them up. This anxiety could be a projection of or disavowal of her sexual desires, as well as a way to justify her resistance to change. She also thinks he's superior and quick to criticize her every thought, perhaps an externalization of her harsh superego?

Over the course of the treatment/act, a more trusting relationship develops, and the professor opens up to the doctor/father. She reveals the pain of her break-up and subsequent flight into academia. At this point in the scene, the doctor is empathic, listening patiently without criticism, even holding her hand at one point, a gentle and loving but respectful gesture. She accepts his interpretation that she is a journalist who likes to be near the action but one who, in an unsuccessful attempt to avoid her emotional pain, has taken flight and cannot change who she is. In the final scene, the professor, about to leave Yale to cover the war, seems more at peace and insightful. She discusses with a female student this student's displacement of her feelings toward a recent ex-boyfriend onto the U.S. government's role in the war; she also mentions having broken up with her boyfriend. We assume she has changed in direct response to her interactions with the doctor, a model for therapeutic action?

One of the play's overriding themes is that you cannot change who you are but that you can accept yourself and act accordingly. The play touches upon many of the same questions with which I struggle as an analytic candidate. Does analysis help people become more comfortable with who they are, or change their character in a deeper way? What about the use of touch in the play; are comforting words not enough? Which is relatively more important, external reality or perception? Are Freud and psychoanalytic theory used by the public to justify people's behavior and/or to avoid personal and social responsibility? Does self-disclosure have any place in treatment? It is refreshing to recognize analytic training's positive influence on my experience of this play, as well as its fostering of my own personal and professional growth.

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Book Review

***Transforming Lives: Analyst and Patient View the Power of Psychoanalytic Treatment.* Edited by Joseph Schachter. Lanham, MD: Jason Aronson Publishers, 2005, 200 pp., $40.00**

By Doonam Kim, MD

As an analytic candidate, I thoroughly enjoyed "*Transforming Lives: Analyst and Patient View the Power of Psychoanalytic Treatment,*" edited by Joseph Schachter. Written by experienced analysts and candidates, the book comprises an introduction and 10 chapters that present seven analytic cases to illustrate the positive effect of psychoanalysis on patients. The series uniquely includes patients' written reactions, reflections, and views of their analytic experiences. Of particular interest, Schachter examines whether the impact of sharing an analyst's views of a treatment and collaborating with a patient in the writing about analytic treatment might be damaging, helpful, beneficial, or exploitive. He discusses the meaning and effect of contacting a former analytic patient post termination and quotes patients' reactions to requests to contribute to the book.

The introduction clearly conveys the book's approach and purpose. In the first chapter, Schachter introduces Freud and smoothly compares and contrasts the differences between Freud's original theories and the practice of psychoanalysis today. The initial chapter is constructively honest and critical of Freud's technique, which, Schachter emphasizes, was centered more on "elucidating theory than emphasizing actual treatment, as self admitted by Freud." He notes that Freud's immediate followers may have misapplied psychoanalytic approaches by strictly adhering to theory in an attempt to be "more Catholic than the pope." Describing analysis today, Schachter writes, "… treatment is now patient-centered and therapy-focused in comparison to Freud's early work rather than theory driven."

The next seven chapters present patient case reports. One chapter discusses a man struggling with issues of competition, aggression, and homosexual ideas that contributed to a fear of academic success. Another discusses a ballet dancer with a chronic disease who grew up in a privileged family. Her fear of abandonment prevented her from expressing anger and resentment towards others. A third case describes a woman with a significant history of trauma who lacked the capacity for self-reflection. Her treatment relationship with her analyst, along with the analytic frame, contained her, which provided a start towards positive change. A fourth patient, whose mother often left him as a child to be with other men, struggled in an unfulfilling marriage and lacked any sense of himself. In another case, a man who approached life and relationships passively hoped analysis would help him to stay in his career as an architect, despite his desire to be a painter. He grew up concerned about money and picking the ideal job while often worrying about being a "sell out," having been raised by a father who had plenty of money but did not share it.

Reading the patients' reactions to their own analyses, after having read their analyst's ideas about the treatment, was enjoyable. For example, Chapter 4 discusses the case of a man ambivalent about his sexual identity. The patient had tried a gay therapist who worked to help

him accept his homosexuality. He had also tried a therapist who encouraged him to score his desires, fantasies, and activities objectively in order to come to a rational conclusion about his sexuality. The patient agreed to embark in analysis to gain a deeper understanding of his whole self, not just his sexuality. The analyst and patient explored the patient's desire to placate powerful men and worked to better understand his aversion to dealing with depressed women (who reminded him of his mother). The chapter presents an interesting discussion and commentary on one's sexuality as not only a product of nature/nurture, but also as a functional defense against depression and anxiety. A nice excerpt written by the patient clearly conveys his positive reaction towards his analytic experience:

> Suddenly, the issue of being gay or straight was replaced by questions like "Why didn't the men in my life care about me?" or "Why did they always make me feel like baggage?" It was through this relationship with my therapist that I began to understand that what I wanted from men was love, acceptance, and a sense of inclusion in their world. Who knew that you could learn so much about yourself by avoiding talking about yourself?

> Chapter 5 reviews the case of a woman with the chief complaint that "everything's really wrong and nothing's really wrong." The woman struggled with depression and anxiety, but refused medication. She was in a committed romantic relationship, but often imagined what it would be like to be with other people. She grew up with a mother who "needed her to need her." The case report conveyed the patient coming to understand her worries of losing her sense of self in situations of closeness with others, particularly with her analyst. This reminded her of her childhood experiences with her mother. She wrote:

> It was murkier and messier than that for me and yet somehow, like a rock that has the waves wash over it for a century until its shape is different even though there's no perceptible change from each wave, I did change.

She also described how the analysis helped her enjoy her sex life and, because of analysis, "Money is something that got better and better over time in my analysis. I once calculated that based on the promotions and raises I'd received, analysis had more than paid for itself; I would never have anticipated doing so well financially without analysis." In conclusion, she wrote:

> It remains hard for me to explain to myself exactly how analysis does what it does, but I see in a daily way in so many thoughts and feelings and actions that it does work even if I still can't explain how. I found it very hard to dive in at the beginning, but I hope that this book will encourage others to have the trust in the endeavor needed to take the plunge. I can pretty much guarantee that it'll be the swim of your life.

The penultimate chapter offers an interesting commentary and discussion on the current state of psychoanalysis. The editor questions whether the analyst's or the patient's perspective defined a successful analysis. Schachter asserts that a step in the direction of improvement and consensus in psychoanalysis requires feedback from *both*. He discusses the interesting challenge

of presenting analytic case material while at the same time protecting patient confidentiality and properly "disguising" the patient. Disguising information might never be good enough, resulting in a patient feeling exposed and betrayed when faced with the material. Disguising information might also be problematic in that material may be changed so much that the meaning or significance of the report diminishes in worth, validity, and realism.

The concluding chapter is a nice review of psychoanalysis and its transformation over the years. It clearly discusses the probable transformative elements of psychoanalytic treatment by reviewing the common factors present in all the cases discussed.

As a candidate struggling with my own analytic identity and development, the book provided me with an encouraging peek into the potential impact I might have as a future psychoanalyst. It also helped tie together a number of analytic ideas and concepts that, until recently, were a little "fuzzy." The book is written in a cohesive, concise, and clear style that I have not often encountered in my reading of the analytic literature; I found it refreshing. Concise reviews and discussions of different analytic ideas from different theorists were smoothly woven together as issues were presented in the cases. The case material is nicely condensed but detailed enough to get a rich sense of the patient. Sometimes I read the chapters wishing more was discussed regarding analytic technique. The challenge of summarizing cases also led me to think that some case issues might be over-generalized. As well, I sometimes had an uncomfortable, awkward sense that I was being led behind a mysterious Oz-like curtain of analysis, only to be left disappointed. But after completing the book, I felt more optimistic about and more focused on continuing down the path of analytic exploration.

Overall, the book accomplishes a great deal. It presents thoughtfully formulated cases, unique written reactions of patients regarding their analyses, a review of the changes and developments in the practice of psychoanalysis, a discussion relating to the future of psychoanalysis and psychoanalytic research, and even suggestions to prospective patients considering psychoanalytic treatment.

Transforming Lives is worth reading for anyone involved with, curious about, or considering analytic treatment and/or analytic training. It is a positive contribution to promoting our field at a time when analysis might be looked at with apprehension or suspicion by the general public. Although it may not definitively answer questions regarding how analysis works, it helps clear some of the smoke that, I believe, blocks analytic treatment from being more socially acceptable. In particular, it presents a useful review of some of the transformative elements in a psychoanalytic treatment. I will not divulge the information here, but recommend reading the book.

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