JILL SAVEGE SCHARFF

RELATING 100 YEARS OF PSYCHOANALYSIS TO CLINICAL PRACTICE

The Psychoanalytic Century

Panel Discussion:

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Panel Discussion: Relating 100 Years of Psychoanalysis to Clinical Practice

Jill Savege Scharff (Chair)

Judith Chused, Steven Ellman, Ernst Falzeder, Iréne Matthis, and Imre Szecsödy (Panelists)

In this discussion, several speakers presented additional remarks in response to comments and questions from the floor. One speaker not otherwise represented in this volume joined the panel: Judith Chused (Washington, DC). She had given an unpublished paper "Why Theory?" in which she inquired into the origins of theory and its usefulness for the clinician. She concluded that what she valued most was theory she developed in the process of conducting clinical work. She preferred such an empirically derived framework to any slavish adherence to dogma, and spoke of the intertwining of personal growth with theoretical understanding: "Though our knowledge has increased, like Freud, we still must navigate from what we knew to what we know to what we have yet to learn."

Dr. Jill Savege Scharff began the panel by introducing the panelists

and then opened the floor to participants' questions.

Jill Scharff: This afternoon we're trying to explore the relevance of psychoanalytic theory in clinical work over the last 100 years. We welcome contributions as well as questions from the floor.

Charles Schwarzbeck (Seattle and Vancouver): A little bit ago David Scharff said, "Psychoanalysis rests fundamentally on what we learn from our patients." I think of myself as rethinking almost everything from my developmental work with babies. I also notice that as we think together today, there is a lot of movement, more and more toward theories of affect. There is a lot of emphasis on how we think about affect in our clinical work and so forth. When Jill Scharff was talking, she started to move toward some of John Bowlby's thinking about attachment theory, comparing Freud's notion of impulses with some of Dr. Bowlby's thoughts. I wanted to add an idea here, pretty close to what has already been said, but I think it should be formalized a little bit. When we evoke attachment theory, we think about the person that we're looking at as motivated by fear. Attachment theory comes from motivations that have to do with fear. Susan McDonald and some colleagues a few years ago talked about another motivation—to seek warmth. So there is the idea of warmth versus fear. Much of what one sees with babies and mothers in healthy situations seems much better explained by the wish for warmth rather than by avoidance through fear. If we shift and think a little more theoretically, we start with babies with arousal. We don't really think about impulse or

drive, and certainly not affect. Although many papers have been written about how we look at a baby's face, which we define as affect, we don't really know what we are doing when we do that. I would ask you to think about a hierarchy of development where we start with arousal, and then it is through the relationship with the primary caregiver—as the primary caregiver tries to help with transitions of state and eventually with the regulation of arousal—that the infant is able to regulate arousal on the right side of the brain. When that occurs attention is possible. Then the infant is able to do two things at the same time. The infant is able to focus on the primary caregiver, and at the same time the baby feels its body.

To hold these two events in mind, we need to look back at what Freud talked about when he talked about drive, and then see where we are today. The simultaneous feeling of the body and the capacity to pay attention to the primary caregiver allows for the development of affect. Only when we have the development of affect, can we think about whether the motivational system is one of seeking warmth, or one of fear about preventing separation or danger.

Jill Scharff: Let me see if someone on the panel would like to address that. Is anyone used to thinking in terms of warmth versus fear?

Steven Ellman: No, but I guess where I would start is the whole idea of Freud having multiple perspectives. For me, Edith Jacobson has said it best, and I think it comprised warmth

and fear. Freud was really trying to talk about very early bodily states. We get lost in how they actually influence the infant. Freud didn't put in mother, and he should have. Winnicott makes a big point of a footnote of Freud's in the 1911 paper, where Freud writes that he should be talking about the mother and the interaction between the mother and infant, but he focuses on the infant. But Freud was talking about that in terms of a pleasure/unpleasure sequence. If the pleasure is going well, then it seems to me that the infant will look as if it's warmth seeking. But, if it's not going well, the infant is going to look much more like it is trying to avoid experiences of fear. But Freud put this in a much broader perspective in the era that Jill Scharff talked about today when she talked about his main theory of drive. For a longer period of time than he referred to eros and thanatos, or to sex and aggression, drive for Freud had to do with the survival of the self and survival of the species. That was his "drive theory" for most of the time when he was actually seeing patients. So, when he was talking about that, I believe he had an object relations theory. He was talking about a much more complex system. One of the things that could eventually evolve out of that would be warmth and comfort—positive experiences and the pleasure/unpleasure sequence. If it's not going well in terms of the attunement between infant and mother, then it would be fear.

Iréne Matthis: About this fear/warmth question: of course we would like that the warmth would be the primary affect between child and mother. But I agree with you, that if we look back in the evolution, it would be fear that would be the

primary affect. In all the physiological responses and experiments that have been done, it has always been the negative effects that have had the highest amplitude, and that is the marker. I am also associating to William James, the great psychologist. He gave this example, as you probably well know, of the bear. You see the bear, you are afraid, and then you run. That's how we talk about it. That's how Darwin also talked about it. You get afraid and you run away. James reversed the two things—you get afraid because you run away! There are some unconscious processes that go on before the affect. Of course, this is what Freud brings up when he thinks about whether we can have unconscious affects or not. That is still an open question. But I think fear is the primary target, and the warmth will of course come in, too.

Barbara Cristy (Washington, DC): I wanted to address the issue of therapeutic trust. We were looking at the therapist and the holding environment, but what about the need for the therapist to trust the patient at some level? The ability to trust that the patient is telling you truth about the patient's world, the respect for the patient correlates with the sense of really working together and trusting each other.

Steven Ellman: I agree with you. **I** wrote a paper on that—a termination paper that came out in 1987, that indicated that in a long-term treatment it didn't really start to become an analysis until I understood that process of starting to trust what the patient was saying. 1 tried there to talk about my difficulties in doing that.

Harold A. Clark, Ph.D. (Brigantine, New Jersey): **I** have struggled with how to translate drive theory into object relations terms. The thing that keeps being a block for me is, "Where is the energy? Where is the passion? Or where does rage come in?" I think of this baby in a crib, when its needs are not being met, shaking the crib with righteous indignation. I am trying to figure out how that works from an object relations point of view.

Jill Scharff: Fairbairn's response to that situation is that rage is always secondary to frustration. It is a response to the needs not being met. That is precisely what it is. That is in contradistinction to some other views that would hold that the infant is born with a constitutional amount of rage. For instance, in the Kleinian version of object relations theory, that infant would be constitutionally endowed with aggression due to the force on it of a constitutionally determined amount of death instinct that the infant is having to deflect by this motoric expression of rage. But in the kind of object relations theory I was talking about today—the Fairbairnian approach—that expression of rage has the purpose of cueing the mother to pay attention, to meet the infant's needs, and to allow the infant to resolve the stress. To the extent that the mother doesn't do so, then, the infant takes in a bad object experience, splits off the unmanageably bad part of the bad internal mother, and represses that rejecting object into unconsciousness where it reverberates and causes further rage reaction.

David Levi (Washington, DC): **I** have two comments. First, **I** was

reacting to the question of "Why Theory?" As somebody who doesn't feel very strong allegiance to one or another theory, I think that there's a kind of a theory about the clinical situation, that we have a place where something can be played out, where a patient can experience affect and you can be with the patient. But theory also connects me with a kind of professional identity—a sense of having something to offer there, and keeps me from getting completely taken over by my empathic identification with the patient's situation. It gives me some alternative perspectives to offer to the patient. Judy Chused talked about theories a lot in terms of conscious theories and I was struck. I'd been reading a piece by Joseph Sandler this week—strangely enough, the week after his death—in which he talked about unconscious theories. I think the theories we are *not* conscious of have a lot more to do with how we act in the clinical situation than some of the ones that we are conscious of.

I have another point. I was looking at the title of this discussion, which focuses on the evolution of psychoanalysis during 100 years. There has been a huge evolution even since I began in the late 1960s! In some ways the Dora case illustrates it. Freud had to have a theory, and he had to propagate the theory. He wasn't so interested in Dora being empowered to get with her own experience and express herself, or to help her develop her capacity to express herself. He was interested in getting the content of his theory over to her! You see this again in the Rat Man, which is a more elaborated case history in some ways. Some people would talk about

Freud's promotion of theory as a phallocentric action, a man having to "put it out there" and show that he knows something, in contrast to a more maternal nurturing position where you try to help people express themselves, make it a safe place for them to express themselves. In this thirty years, there's been a tremendous shift from the analyst "having to know," to the analyst helping patients develop their own knowledge of themselves.

Imre Szecsödy: It's a very central question: What is the difference between prejudice and theory? I can't imagine that we can meet the world without having some kinds of preconceptions about it. Then it is important how you acknowledge what kind of unconscious preconceptions you have towards this patient. There is a fantastic study done in Switzerland. An interview with a patient was watched independently by eighty analysts. The question was how soon could they make up their minds about the patient's analyzability. Most of them made up their minds in six minutes. Surgeons would have made up their minds in two seconds, I think. For analysts it took six minutes. Then, the most important thing was, "How open were people to reexamine their preconceptions about such a judgment?"

David Tuckett wrote a very interesting article in the next to last *International Journal* about evaluating scientific papers. He writes that it's not so difficult for us to embrace new ideas, but we have terrible difficulties rejecting old ones. So, this is one of the problems. When I revisit the Dora case I try to empathize both with Freud and with Dora. I think that it is

easy for us now to have perspective, to be critical. But I have seen us do many times as many mothers do. The important thing is to be able to give the child the possibility to "reflect herself in the mother's eyes," as Winnicott put it. But many times the mother is reflecting her own feelings and not the child's. To be able to be playful with the child, and to be able to be playful with your analysand or patient is extremely important. The question is: How can we maintain this platform—to remain playful—when our work is blood serious at the same time?

Jill Scharff: Since Dr. Levi's was a three-part question, we are going to have three responses. Dr. Chused, next please.

Judith Chused: You know, David Levi is obviously right. There are unconscious theories, and as I discussed, there are multiple unconscious determinants of theory. But there are also unconscious determinants of all kinds of points of view. I would like to address the last thing that you said. Yes, we want to enable patients to know themselves. But to refer only to a maternal nurturing point of view misses another task of the therapist. At some point the therapist, whether an analyst or psychotherapist, needs to be aggressive, assertive, intrusive in part. I think that is probably harder for many people than to be maternal and nurturing.

Ernst Falzeder: Regarding the question of whether theory affects our clinical practice, and whether it is at a conscious or unconscious level, I would like to highly recommend a book, *The Analyst's Preconscious,* written by Victoria Hamilton,

from the Institute of Contemporary Psychoanalysis in Los Angeles, formerly from Scotland and London, as a very good book. She conducted interviews and sent out questionnaires to analysts in different countries with different orientations, about their preconscious theoretical background and how that affects their handling of transference, for instance.

Robin Gerhart (Washington, DC): I am grateful for object relations and the intersubjective approach and two-person psychology, because it has created a space for me in an analytic world where there once was no space for my theoretical orientation. But often as I hear these concepts discovered for the first time, I find myself thinking "where were you all twenty years ago?" when the existential therapies and humanistic therapies were flourishing, talking about the space between the therapist and the patient and the interactions—simple things, like Carl Rogers talking about taking an empathic reflective approach that allows the patients to develop their own voice. I was reminded, when Ernst Falzeder was talking about the repression of the origins of object relations, being in part due to a prohibition of the words of Ferenczi and Rank. We had to disavow those roots of our thinking. I wonder if there might not be a parallel process going on in the interpersonal theories, where analysts who in the past have denigrated the "supportive therapies" cannot now say names like Carl Rogers, Irving Yalom, or James Blumenthal. On the one hand I want to say, "Well, you must not have known." But then I realize that it was known, because it was criticized. So I am interested in your own awareness of these lines of thought.

Steven Ellman: Well, I, for one, was teaching Carl Rogers and Sullivan when I started as a professor in the graduate program at City University in 1971 or so. I still sometimes will refer to that, but I am still critical. I would say Kohut, in a more systematic way, has developed the space, yet I am critical of him, too. For me, the intersubjective position has brought up important issues that I think were present at that time as well, and that I tried to answer then. I'm still trying to answer them in a different way. But, there are some things they don't do. For instance, it's hard sometimes to be aggressive, interpretive, intrusive, or, at times, to allow the patient be alone. I have actually listened to many tapes of Carl Rogers, and I think he had difficulty doing that. He was effective in a variety of ways, but I think he still had a difficulty in allowing patients to be alone to hear their own voice more clearly, which to me is an important aspect of allowing transference to emerge.

The same caveat applies to a radical intersubjective approach, which I would guess not many people take now, although five years ago some people espoused it. That position is now being withdrawn. A radical intersubjective approach also does not allow patients to hear their own voice. It's always "the two of us." I said the same thing about Jodie Davies in a discussion, when she said, "It's always the two of us. We have to do it together!" at a time when I thought the patient really wanted to talk about himself and where he was, *without* her. I have to talk about development in the same way. When Allan Schore is talking about the mother-infant interactions all the time, he is not looking at the massive

amount of development that is spent in sleep. Much of the time there is very little interaction except that the mother is holding the baby over her shoulder or trying to get the position right, and a variety of things like that. There are a variety of vegetative functions where the mother is not interacting—but is there much more activity toward what Winnicott described in his ideas about supporting absolute dependence?

Judith Chused: I would like to extend our thinking also. I know Carl Rogers, and I know Irving Yalom. I think Steve Ellman is right. I would put it slightly differently, but it's the same idea. One of the most difficult things when you are doing analysis is for a patient to develop a transference to you. It makes you uncomfortable, and it makes the patient uncomfortable. And to sit with it and allow it to develop, to not interpret it away and to not smooth it away, and to have the patient leave your office in pain, and have him come back still in pain—and to listen to it and to tolerate it. That is also something Winnicott talked about. All too often in some intersubjective approaches—although I'm very much an inter-subjectivist I guess—and in some of the object relations approaches, there is an assumption that if one is a good object, that will do the trick. That doesn't do the trick!

Ernst Falzeder: I would like to second that, and to recommend Winnicott's paper, "The Capacity to be Alone." He describes how that capacity can develop when the infant is allowed by the caretaker to be alone in a safe environment without intrusions from the outside. To some extent, David Cooper

expressed the same idea.

Imre Szecsödy: I would like to add that for me as an analyst the most important thing is to be available. But availability means also to be available as a dead object for the patient, not only to be there to be reassuring. I like very much the concept of the analytic trust. To me it would be translated into being available. And at the same time the enactment that the patient does is extremely important for the patient to be able to understand herself. Now, the analyst should try not to be too enacting, which we many times certainly do. Dora is a marvelous example of parallel enactment. What is crucial is to be able also to stand the patient becoming, and to stand being used as that object, and only then to make that understandable for the patient.

Jill Scharff: I would like to give Iréne Matthis the chance to answer the challenge of "where were you when?" if she wishes.

Iréne Matthis: We had nothing of object relationships in Sweden in the 60s and 70s, so it slowly evolved. We shall not be proud that we evolved in that way, because we still probably have some blind spots in our own views of the world. It is very important to learn from history. We will of course repeat the faults of our ancestors, but we will at least acknowledge it and be open to discussion and critique.

Jill **Scharff:** Now is the time for the audience to use the panel in discussion as that kind of background object in this setting.

Please do give us your comments and questions. We'll move on now to one from Michael Moskowitz, one of tomorrow's speakers.

Michael Moskowitz: This is actually a follow-up to a comment by Allan Schore pertaining to the use of the couch. In his remarks, Allan was saying that particularly with patients with early self-pathology you have to meet face-to-face. I know I don't do that and I know that from my many discussions with Steve Ellman about this, he feels it's preferable at times to see these patients on the couch. So I wonder if I am answering correctly for you, Steve? And what do the other panelists think about that as a technical issue?

Judith Chused: One thing that Steve Ellman touched on in his talk is the value of the tone of the analyst's voice and of the mother's voice. I did two years of infant research with some blind infants when I was in training, and those that were relatively healthy had mothers whose voices were very soothing. To my mind, a patient with difficulty with self-regulation or sense of self could do quite well on the couch. It's really what helps establish the trust, which doesn't have to be a careful following of the gaze. I think it can be following the tone of voice as much as anything.

Imre Szecsödy: There is research evidence that the baby does not always directly reflect the mother's facial expression of affect. When you look very closely at mother/baby interaction and how the baby is imitating or responding to mother's facial expression of emotions, there is a very

interesting response: When mother shows disgust, the child shows disgust; when mother shows fear, the child shows fear; but when mother shows rage, the child smiles! That's a fantastic response, a very good defense. Secondly, according to the studies conducted by Rainer Krause, an analyst who is professor in Saarbrucken, Germany, on affect and nonverbal communication, therapists who are closely following the patient's facial expression have less success with treating psychotic patients. That is an extremely interesting finding.

Steven Ellman: Let me respond to these issues on the centrality of gaze and the difficulty with treating psychotic patients by saying two things. First, Goldie Alfassi Siffert did her dissertation with me on gaze aversion. One of the things we saw is that infants who seemed in particular distress had a very difficult time holding gaze with their mothers. They were only at ease when the mother really allowed them to look away and then gaze back spontaneously. Siffert tried to train the mothers to allow their infants to come back, because you would observe the mothers of these infants trying to stay continuously in front of the infant and keep their gaze fixed on the interaction. Secondly, something comparable is true for psychotic patients—who were most of my practice for the first 10 years. It is hard for them if the therapist is scrutinizing their gaze. I don't think you can set an absolute rule, but the idea that you have to be getting information and keeping emotional contact visually, I believe, is a mistaken idea on three grounds: (1) it may be very difficult for the patient to do it; (2) the therapist may find it difficult to contain the patient's responses when there

is direct visual contact; and (3) psychotic difficulties and some borderline disorders may be much earlier difficulty than is encoded in terms of visual elements, particularly facial expression. The channels of expression may involve early sounds, smells, etc.

Imre Szecsödy: I would like to add a comment that follows on the importance of differentiating right and left hemisphere functions, as Dr. Schore did in his paper. I would like to refer to Peter Fonagy's studies on "mentalizing" or reflective functioning, which is a first capacity to conceive of oneself and others in terms of mental states: feelings, beliefs, intentions, and desires. Mentalizing also refers to the capacity to reason about one's own and another's behavior in terms of mental state, and to be able to reflect about it so one has this capacity to be able to see the intentionality in one's self and in others. This capacity involves a synthesis of right and left brain functions.

Warren Sibilla (South Bend, Indiana): This has been an amazing conference. My head is full of a lot of ideas, so please be patient as I try to formulate my comments. I have been thinking about this idea of the baby, and the blending of drive theory and object relations theory, and how the introjection of the object is the beginning of an unconscious. People have asked how does that fit? And in the spirit of the conference, I am wondering about some of the opposing ideas in psychoanalysis. For example, there is Jung's idea of an archetype—that there is an organizing center in the psyche, the self, that combines affect and image as a unifying

force. In the Jungian formulation, what one sees on the surface is the complex, but underlying that there is a unifying force. That idea might be a useful idea to help bridge the two. Jungians are studying this material quite a bit, and talking neuro-biologically about deep structures and how some of this fits in with their ideas. I wondered if I could hear a comment on that.

Jill Scharff: I think perhaps no one here is as qualified to respond as you were to ask the question, but I appreciate your comment, which will have to stand as its own contribution.

Stephen Skulsky (Omaha, Nebraska): I would like to take a stab at answering Warren Sibilla's question, because I have an interest in Jungian thought as well as psychoanalytic object relational thought. I would cite two brief quotes or paraphrases. One is from James Hillman, who said that the goal of dream work is not to bring the dream up to rational thought alone, but to pickle the rational mind with the dream juices of death. That notion reminds me very much of something I heard Arthur Hyatt Williams say in a workshop when talking about Bion. He said that the id is as much threatened by the ego, as the ego is by the id. Why am I saying that? I think one of the real struggles that we have going is that it is important to value words and the capacity to use words to process experience. But so much of what gets conveyed to us, especially if we use countertransference, does not have to do with words alone. According to Jung, it has to do with images. I don't think Jung paid enough attention to bodily sensations separate from

images, because so much gets conveyed in that channel alone. But Warren was referring to the tough balance that has to be struck: "How do we stay open to what's preverbal or preconscious or unconscious when it's impinging on us in ways that aren't just rational, when we also value rational thought and capacity to process so much."

Jill Scharff: Thank you Steve. Now we'll take another question.

Michael Sharps ton (Washington, DC): **1** would like to go back to the first speaker from the floor [Dr. Schwarzbeck], who was talking about arousal. Supposing there is sexual arousal. That could elicit pleasure, anxiety, or anger from the same primary source, depending on context, on perception, or on past experiences. I wonder if the panel could help me with how that relates to the different schools.

Judith Chused: Of course you are right. And it's not just sexual arousal that can elicit such different responses. A variable response to attachment is quite common. Patients have widely varying capacities to tolerate our helping them, to tolerate trusting us, or to tolerate being vulnerable. For some people that's quite a pleasurable state, or at least it is not unpleasurable. That's why Steve Ellman's response to the question about arousal is so important; the question is pleasure or unpleasure? I have certainly had my share—as I expect many of you have—of patients who as soon as you make a connection with them and they begin to feel some relaxation of their defensiveness, they feel enormous fear. That's a very painful state. One hypothesizes that these are

people with difficulties with insecure attachments early in life. So, that would also be my answer about sexual arousal: It depends on whether it's pleasurable or unpleasurable and, as you said, that is determined by the context and its meaning to the person.

Iréne Matthis: I think that points out the kernel of the whole Freud Exhibition, which is titled "Conflict and Culture." What you pointed out is the conflict that is always aroused when there is any affective arousal. Because when culture is added to fear, pleasure, and lust you have this conflict. I would say that goes for any subject you could imagine. Not only sexuality, but we do emphasize sexuality because it is the basic force in evolution not only of human beings, but in every species.

Jill Scharff: Would any of the panel members like to offer a closing remark? Something you think is important to pick up or a question you wish you'd had a chance to answer?

Judith Chused: It's not necessarily a closing remark. But **I** would like to remind you of what was said a few minutes ago, which struck me as so important: that it is terribly important for the therapist to allow himself to be used as a bad object as well as a good object; to not deny the patient the opportunity to use us as fully as he wishes.

Steven Ellman: I feel lost in thought about two comments that have come up. One, I was asking myself why I don't know more about Jung. I realized it had to do with my own

psychoanalytic history and the political difficulties in psychoanalysis that interfere with knowing alternative perspectives, even though I have tried to be informed about them. The second thing I would say, since this is a conference about Freud, is that Freud didn't really have a theory of the mind. He had a lot of questions about the mind. He had a theoretical scaffolding that was about the mind, and about the relationship between mind and bodily experiences. The trouble in the United States is that we prematurely give answers. We said, "Well Freud said this, so this is right." At one point in my psychoanalytic education I remember I couldn't believe that people seriously considered these ideas as correct. I had come from graduate school, and so I thought at first that they were kidding, that this was an elaborate joke. Surely, they were testing me just to see what I could believe, as opposed to considering Freud as a developing clinician/theorist who was asking a variety of questions. Freud was a very sophisticated version of William James in terms of this capacity to question—I think much deeper and more sophisticated. But his early formulations should be seen more in that light. I hope this conference does something to move us toward that end.

Jill Scharff: Please join me in thanking the panel and members of the audience for their stimulating examination of Freud's ideas and clinical practice.