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Feeding identity: The critical hermeneutics of contemporary Kleinian psychoanalytically oriented psychotherapy from the perspective of a novice

A Dissertation

Presented to the Faculty
of the Psychology Department
McAnulty College and Graduate School of Liberal Arts
Duquesne University
in partial fulfillment of
the requirements for the degree of
Doctor of Philosophy in Clinical Psychology

By

David M. Greco-Brooks

04/11/2003

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Copyright pending

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Rigidly supportive supervision and supportive therapy are ineffectual for the same reason: while soothing immediate manifestations of distress they do not sufficiently challenge one's preconceptions enough to foster genuine growth and confidence. I would like to thank Dr. R for introducing me not only to a way of working that has inspired my clinical work and deepened my understanding our human condition, but also to a caliber of intellectually and emotionally challenging supervision that has provided me with a firm foundation from which to grow as a clinician. Her unwavering attention to detail, embodiment of faith and hope in the transformative potential of learning from the "I-Thou" encounter, relentless pursuit of relational truth in the here and now, and her uncanny – at times poetic – ability to find the words to speak what needs to be said, have inspired and nourished my clinical aspirations for the last three years and, most likely, promise to do so well into the future.

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I owe many thanks to some of my colleagues who have helped me think through several difficult aspects of conducting and writing this study, particularly Andrew Felder, Jenny Hwang, Jacqueline Neilson. Fortunately, all three of them have been influenced by their own supervision

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Preface

It may be said that from the Kleinian perspective that happiness is having the freedom to live for those things and people for whom one ought to feel grateful.

"There was a patient in analysis with a Kleinian who had a dream that he told her. In this dream his mother sat on his face or chest and he wasn't able to breath. The analyst interpreted that his dream was evidence that he was envious towards her, and didn't want to take in what she was offering" … or something along these lines was the story I heard as a first year clinical student, offered as an example of the abusive potential of psychoanalysis. It didn't leave me with a burning desire to study Kleinian technique. I have heard other stories along these lines from clinicians, stories of perverse abuses of power in Kleinian therapy, offered like warnings of what I don't want to become or what they fear I might be doing, a scary image of procrustean bed technique.

When I started graduate school I had no interest in psychoanalysis, in fact I was hostile to it because as a gay man I had a similar stereotype, that the analytic couch is really a procrustean bed where patients have no say so with regard to their reality, since the analyst, like an arrogant surgeon, assumes a god-like perspective when it comes to ailments of the heart and head, disregarding and disempowering the person. Then, after listening to one lecture after another and one critique after another asserting that analysis, because of its very concepts and philosophical underpinnings, can be little other than a procrustean bed my stereotype gained that aura of a "natural attitude." According to this natural attitude, psychoanalysis reduces people to parts, dubious entities like egos, ids, superegos, some energy called libido, and worst of all, some bizarre and ridiculous notion of a death drive, the final proof of its status as a miscarriage of mechanistic thought that is incapable of doing justice to human existence. According to this natural attitude and its variants, analysts are cold,

detached, talk about the past in the most banal clichés, and force their victims' experience into the same tired storylines, like the story of the Kleinian analyst above. But if I was familiar with, and to be fair I participated in it as well, the contempt heaped upon Freud by some, I was not prepared for the – at times – downright hostility towards all things Kleinian.

Consider the following story. Not too long ago I met with a prospective supervisor – who is decidedly not psychoanalytic. This was our second meeting, although it had to be rescheduled two weeks prior because at the last minute, for unforeseen reasons, I did not have the car to take to the appointment. So I called to explain and apologize and see if we could have our supervision by telephone in any case. When she called me back she emphasized over and over again that this hour was one she set aside for me when she could have had a paying client use the time, etc. The nature of my circumstances had no bearing on her interpretation of my "inexcusable lapse" in "planning." So, walking into this, our first appointment since, I was anxious about discussing what had happened because I felt mistreated. After about twenty minutes of explanation, counter explanation, explanation, counter explanation, she asked me, after telling me it was no longer an issue for her, "so I'm wondering why you have a hard time letting me be angry about this." I replied that it wasn't her anger but the fact that I felt like no matter what I said on that phone she was going to interpret what happened in that one way. Without awareness of what she was saying, she said, "and I still do see it that way." Ergo, she is really still angry about it and I'm stuck in the same pigeonhole in her mind where I was placed *before* our phone conversation. This supervisor was no Kleinian, but her difficulty is the same one operating in the genre of abusive Kleinian stories I have heard (and stereotypes of psychoanalysis in general): the all too human difficulty and ultimate refusal to encounter the Otherness of the other, respect it, and dialog about it productively. Certainly, this is not a unique problem Klein invented or patented as a therapeutic technique; it is a problem of an

attitude towards Otherness in general.[1] On the basis of what I've learned about contemporary Kleinian technique I think these stories are caricatures of poor technique period, Kleinian or otherwise. However, it took a lot of work immersing myself in the worldview of CKPP to rearrange my ideas about analytic work, analysts, and analytic theory. The study that follows is an account of this immersion and rearrangement, a story of contemporary Kleinianism in its Otherness.[2] Far from finding its concepts and technique dehumanizing or reductionistic, I have found that they help me illuminate, examine, and engage – phenomenologically – with the experience of patients in a way that has transformative potential.

This irony of my graduate education called for an explanation, one motive for undertaking this study. I am convinced that to evaluate and critique clinical technique and theory it is not enough to do so as an "outsider." Certainly we would think it ridiculous for an anthropologist today to write a book about an indigenous society, making all manner of claim about the language and world outlook of the society, if he or she had never immersed him or herself in that society and studied it from the "inside," to the extent that this is possible. So why do we not bring that level of sophisticated understanding to the problem of understanding different, highly specialized languages and the subcultures that produce them within our own society and institutions? If there is always a surplus of Otherness no matter how much we think we may know someone, does the same principle not apply to the Otherness of a school of thought and practice?

[1] So, continuing the example, the analyst might have said, "your anxious and scared that there's not enough room in here for you to breath easy and have your own mind with me, so you feel compelled to say what you think I want to hear." Assuming the accuracy of this, it would have provided an understanding to bind the patient's anxiety and thereby the symbols necessary to open a discursive space to discuss this terror of attachment and how he's come to use an over practiced "habit" for dealing with it at his own expense.

[2] Of course the practice of CKPP has the potential for abuses of power like any other therapy. The point is that perhaps the abuses are not built into the theory, but reflect the limitations of the person attempting to employ them.

Whatever else may be said of her, Melanie Klein was a woman who stood up for her ideals with the support of those who believed in what she was doing despite the personal, professional, and political risks involved. Yet this appreciation is eclipsed by the negative stereotypes of her and her work – all the negative transference onto Klein that has and does go on today in some quarters. Perhaps it has something to do with "the objective reality" of Klein and what she did or did not do or say. Yet perhaps it has to do with a larger problem in our world, the problem of how to take and deal with people who are carried by their ideals to the point of working to change what has been handed down by tradition.[3] Klein's work, unlike Freud's and Lacan's, eclipsed the radiance of the Phallus with the shadow of the Breast in a deeply sexist society, a society that has long split itself off from a cultural image of an omnipotent woman (the non-threatening, idyllic and idealistic figuring of a Madonna – servant to *an infant male* – is hardly an omnipotent female figure). Look at what happened, how Klein has generally been recorded as a distorted character in, what was until recently, a sexist, heterosexist, white and upper middle institution with little in the way of a built in mechanism for self-correction and historical change: The American Psychoanalytic and its tributary scholarship. These are, in my view, equally important aspects of the historical record that contextualize her objectionable Otherness. This situation is only now, slowly, changing. Of course this does not mean that as a fallible person Klein was perfect or can never be critiqued for clinical or personal errors. It does mean that this study is about contemporary Kleinian work and some of its roots, not the merits or demerits of Melanie Klein as a person.

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[3] In this regard, perhaps fundamentalism is the symbolic representation of a global false-self idealism (inauthentic idealism). It – in all its forms – is the parody of genuine idealisms about a better future since they actually lead to self-destruction. I am not saying that all idealisms are equal or should be embraced unquestioningly, but in our age any idealism is dismissed as equally "fringe" so, instead, like a neurotic world, we keep going around and around on the same problems, rather than change course. Without realistic ideals, what or who can one expect to guide growth towards a better future? Our problem is we no longer seem to believe in following, renewing, or creating fresh ideals like our forefathers and foremothers. We rehash not political goals or moral goals but monetary goals. Our forefathers stood for a lot more than that. The Federalist Papers show how our forefathers struggled with the ideals we have reduced to consumer consciousness as their parody.

This work, the kinds of thoughts expressed above, and the following historical record of the kind of practice I've been doing are a few results of a process of subjection I began three years ago as an "novice" or "initiate" to the clinical working of contemporary Kleinian oriented psychoanalytic psychotherapy (CKPP), and an empirically based, rigorous and human scientific qualitative method for examining a human phenomena: an "interpretive methodology" as Dr. Packer has accurately described it in published and unpublished work. Indeed, this study, analyzing and interpreting my behavior during one session with one patient, has required assuming the perspective of a researcher to foreground and examine CKPP as an entity-in-the-world and report back from the front line, as it were, to an audience more or less unfamiliar with this phenomena.

What you read me saying and doing in the following pages follows a comportment pattern. This comportment pattern is the role, idiosyncrasies of the author aside, of a CKPP practitioner at a singular point in his training. It is therefore a historical account of a highly specific way of being in a relationship. This comportment pattern is the result of choosing to follow a discipline of training, for a period of time, and choosing to use the tools I've learned as a phenomenologist to take stock of what has been accomplished.

What is this comportment pattern? It is a way of learning from the Other that has transformative potential, more so for one participant than the other. So in addition to an account of practicing a subject-forming discourse, what follows is the record of a point in the author's transformation, the (re)production of his subjectivity by subjecting his Self to a specific disciplinary tradition – I deploy these loaded terms purposefully, since it strikes me as noteworthy that that they have come to have a distinctly negative connotation.

What Klein's work says to me as this (re)constituted subject is that subjection takes place in a context, the context of an extremely important relationship fraught with conflicts and existential

concerns. Will this Other break his or her commitment to my ontological security? Will I die when she's gone? Why does his love come and go? Is this pain going to kill me? Is this a betrayal? How can I get what hurts away? How can I say no if he can leave? Did she like what I just did so she won't be mad? Will my dream come true? Will this ruin me? Klein's outrageous (outrageously brilliant) conviction was that adult life is animated by concerns that have timeless salience in and for our lives, concerns we struggled with in infancy: these problems are first lived viscerally and play themselves out on the surface of that bodily ego, inscribing it with indelible marks. The human kind of being is both the same and different with each cycle of itself; the periodicity of becoming has priority over being – another similarity between the spirit of Klein's researches and Deleuze. This becoming is organized by a code of the virtual in response to the environment – the phantasies that govern the unfolding and evolution of development (i.e., becoming); the production of meaning must come before action as much as it may evolve through action. However, this development is not linear but rhythmic. The same "themes" or "melodies" of becoming are patterned and sequenced.

For example, Klein articulated the paranoid/schizoid and depressive position "melodies" as two essential moments of time and change (anxiety), which occur differently for people, yet are similar enough to be classifiable as clinical facts conferred with conceptual status. This shift away from Freud inaugurated the metapsychology of Object-Relations. Klein's refiguring of the therapeutic relationship, a shift to the metaphor of the mother-feeding-infant relationship foreshadowed by Ferenczi, changed the emphasis from being (Freud and Anna Freud's models were structural) to becoming (a developmental model), from what-ness to how-ness. With this change came an evolution in the psychoanalytic lexicon that she inherited from Freud, Ferenczi and Abraham, shifting the analyst's attention to the patient's anxieties and problems of becoming as a

patient in the room and, therefore, as a person in the "real world." If we conceive of self-initiated and self-determined change on the model of a birth or "re-birth" of the Self as different yet similar, then one can see how appropriate Ferenczi's metaphor of the analyst as obstetrical physician, the "midwife to thought," may really have been, lending itself to become the image of the mother-feeding-infant triad.

Therefore to help an adult deal with adult human problems, we must notice how they handle the infantile equivalent of these problems in the here and now of an ongoing relationship, because that is the location of these precursors of meaning, so to speak, that continue to deform the patient's quality of life; what's infantile in the here and now. Part of the problem is the conception of time. If it happened back then, why focus on the here and now as done in CKPP? This is usually conceived as a past trauma acting on the present, so that differentiating the past from the present is attempted by means of interpretive "reconstructions." CKPP, as I have learned it, makes little use of such reconstructions. Perhaps this indicates that it is not the past that needs to be separated from the present, but a way of becoming in the present that has never changed into a former present, recycling the same thematic memories and fantasies, albeit with apparently different content. In other words, perhaps relational time is always in the present (which is why one can have a close friendship for over ten years that both feels fresh and new yet like a historically permanent feature of one's life, "like I've known you forever" as the saying goes). In other words, for subjection to occur, for the patient to continue to develop as a subject – i.e., for the patient learn and grow from his or her own experience of becoming, attention must be focused on the contemporaneous dynamics of the relational context within which the original response patterns to subjection formed, persist, and continue to shape experience.

Clearly, the stakes are high in this way of working. Learning this approach to therapy has provided me with tools for listening and speaking to patients, a power for working with them. The following pages examine and explain these tools and describe the practices of this "power" as they are occurring. And with power come responsibility and ethical restraint. The Afterward will provide some discussion on the ethics and limitations of this power after it has been articulated.

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1. Introduction and literature review

Clinical supervision is required for every graduate student pursuing a clinical track in psychology. A clear example of its importance is that to be competitive for the required predoctoral internship, every trainee must complete at least 800 hours of supervised clinical work. It is generally expected that supervisors "deliver the requisite skills to the trainee in a deliberate and effective manner" (Halloway & Neufeldt, 1995, p. 212). The trainee expects and is expected to change, insofar as they develop these skills. Wampold and Holloway (1997) proposed a model to organize the accumulated research in supervision and guide future investigations. They argued that, "whether it be changes in skill level, attitudes, self-understanding, or some other characteristic, the effect of supervision results most proximally in some modification of therapists' characteristics. These changes in the therapist will then, it is hoped, result in the delivery of more efficacious treatment . . .. *all* effects of supervision are transmitted through therapist characteristics" (p. 12, italics in original).

Based on this assumption, the original aim of this study was to provide a new approach to the study of changes in therapist characteristics as an effect of supervised clinical practice, viewing them through the trainee's communicative competence in the practice of delivering psychotherapeutic treatment. While the study accomplishes the aim of articulating this communicative competence, the design did not allow for the examination of how this communicative competence was the direct result of supervision – that is, the design did not provide for a means to trace each aspect of the trainee's communicative competence to that of the supervisor. However, through the course of the analysis it became evident that the design was well suited for the study of the subject-forming work of psychotherapy in general, and contemporary

Kleinian psychoanalytically oriented psychotherapy (CKPP) in particular. Thus, the primary aim has shifted to addressing the subject-forming work of the trainee's communicative competence.

To date, there is no empirical literature on the subject-forming work of trainee characteristics while under supervision. Typically, researchers investigating how changes in trainee characteristics affect therapeutic practice have relied on rating/coding procedures to gauge trainee competence (cf., Guest & Beutler, 1988; Henry, Schacht, Strupp, Butler, & Binder, 1993; Krasner, Howard, & Brown, 1998; Newman, McGovern, Kopta, Howard, & McNeilly, 1988; Pierce & Schauble, 1970). Pierce and Schauble (1970) appear to have been the first researchers to investigate the effects of supervision on clinical practice. And while more recent studies, such as the often cited "Vanderbilt II," have begun to focus more on process, they continue to exclusively employ these rating/coding systems and statistical analysis, only in a more complex manner and with more sophisticated statistical methods. (Henry et al., 1993). Wampold and Halloway (1997) note that a weakness of using rating and coding procedures to assess frequency or sequence is that, "the construals of the participants (i.e., the meanings given to the events by the participants) are thought to be nonexistent or not important" (p. 17). This is no minor problem, since it is through the "construals" of the participants that the subject forming work of psychotherapy is accomplished as this study demonstrates. This is a problem of the interpretive framework and methodological procedures that quantitative psychological research has employed in the study of trainee change in the context of supervision, whether at the site of supervisor-supervisee interaction or supervisee-client interaction in the therapy room.

In short, when the coded event or statement is taken out of the context of the participants' immediate interaction and placed in the context of the raters' theoretical background and personal

preferences, important information is lost regarding the communicative processes involved in the interaction. This study was designed to explore the consequences of an alternative approach to the study of the effects of supervised clinical practice, one that does not employ a coding system and attends to the subject forming work of the psychotherapeutic encounter. It is the study of supervised clinical practice as an induction process into a specialized linguistic community, requiring the acquisition of new forms of communicative competence (whether psychoanalytic, cognitive-behavioral, narrative, or client-centered communicative competence).

Learning to become a clinician is a sort of induction, an initiation, of novices into the practices of experts. There are rituals and rights of passage that are involved – such as completing so many hours of training under supervision. Viewed as a cultural phenomenon, supervised "direct hours" are socially created and sustained events that provide a context for the acculturation of the initiate (supervisee) into the discourse practiced by more experienced members of the specialized linguistic community (licensed psychologists). More precisely, the interaction between the client and the supervised therapist is a primary site for practicing new forms of "communicative competence," which Habermas (1970) defined in Towards a Theory of Communicative Competence:

> it is not enough to understand language communication as an application – limited by empirical conditions – of linguistic competence . . . . On the contrary, in order to participate in normal discourse, the speaker must have – in addition to his linguistic competence – basic qualifications of speech and of symbolic interaction (role-behavior) at his disposal, which we may call communicative competence. (p. 138)

By examining Freudian psychoanalysis through the lens of communicative competence, Habermas argued that it is both a theory about systematically distorted communication and a technique for working through such patterns of distortion. Analysands suffer from deviations in the acquisition of certain "normal" communicative competencies, which the analysis seeks to correct by providing the

condition necessary for "subject-forming processes" to occur. (McCarthy, 1978) Yet to accomplish this requires a specialized communicative context (e.g., the 50 minute hour), where one participant in the dialogue (the therapist or analyst) relies "on theoretical perspectives and technical rules that go beyond the normal competencies of a speaker of a natural language." (McCarthy, 1978, p. 197)

This study addresses the following question: What characterizes the communicative competence of a supervisee's clinical practice after two years of specialized supervision in CKPP and how does it operate to produce occasions for the subjection of the patient, where:

> "Subjection" signifies the process of becoming subordinated by power as well as the process of becoming a subject. Whether by interpolation, in Althusser's sense, or by discursive productivity in Foucault's, the subject is initiated through a primary submission to power. Although Foucault identifies the ambivalence in this formation, he does not elaborate on the specific mechanisms of how the subject is formed in submission. (Butler, 1997, pp. 1-2)

Thus, what began as a method for looking into the effects of supervision became an examination of CKPP as a site of subjection.

The interpretive analysis of CKPP as a practice of subjection is particularly appropriate for three reasons. First, the contours or horizon of Kleinian discourse are defined by tropes of asymmetrical power and dependence – the infant relating to the mother's body on whom it depends for life as well as the conditions for becoming a person in his or her own right.[4] Within this tropography therapy is conceived as a feeding situation. The therapist may be a good breast, bad breast, devouring breast, empty breast, impinging breast, etc. Patients can be understood as getting rid of unwanted experiences on the model of the baby evacuating burning feces through "anal sadistic" and "urethral attacks" on the mother-therapist and so on. Klein's final model of

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[4] Following Fink (1997) I will use 'mOther' to denote the mother as both a person and a symbolic function – a basis of multiple meaning, a source of meaning. Likewise, ""Other with a capital "O" generally refers to a person or institution serving a symbolic function (legislating, prohibiting, putting forward ideals, and so on) …" (p. 232)

development portrays identity (the who one is) as founded on an economy governed by a dialectical tension between the desire to be (Eros) and the desire not to be (Thanatos) and how this tension plays itself out in relation to a feeding mother who contributes to the shaping of that identity by how and what she feeds her child, as well as how and what she does in response to the child's feeding reactions. This relation is viewed as the context within which every capacity the subject may be said to have is begun.

Second, for Taylor (1988) the notion of the self is a spatial one, a "moral topography" that has changed and changes through history and the configurations of different cultures:

> Being a self is not like having some biologically given organs, say eyes or faculty, like vision, which are there as part of our equipment regardless of how we understand them or interpret them. Being a self is existing in a space of issues, to do with how one ought to be, or how one measures up against what is good, what is right, what is really worth doing. It is being able to find one's standpoint in this space, being able to occupy, to be a perspective in it. This is what Heidegger was getting at in his famous formulation about Dasein that its being is always in "in question." (Taylor, 1988, p. 298)

Kleinian theory is a theory of the development of the self within a moral field. The infant-mother's body partnership defines the becoming-in-time for the infant within the contours of goodness (signs of life, the good breast) and badness (signs of death, the bad breast). The mother's body as the site of the infant's growing sense of self is a body that is experienced as good and bad, and towards which the infant loves, hates, feels loved, hated, persecuted, etc., as he or she negotiates persisting in time. Whatever the infant comes to believe about itself "inside" originally comes from "outside" in this relational matrix with the mother. In the context of the infant's hunger pangs, weaning inaugurates the inside of the infant's psyche predicated on its differentiation from its relation to the mother within a moral milieu and its struggle to come to terms with this differentiation process. From its inception, the Kleinian tradition has not viewed the ego as a "neutral steering mechanism"

that is encapsulated within its own hydraulic machinery, but as the nascent "I" existing, "in a space of moral questions, [where] that moral topography is not an external addition, and optional extra, but that the question of being or failing to be a self could not arise outside of this space" (ibid., p. 317). In fact for Klein, the nascent ego has its own practices for trying to shape this moral field, because its largest struggle is coming to realize that life means being dependently related to another, which initially, is a painful reality to be mourned. To be confronted with a world that is deficient is to be confronted with a primordial vulnerability towards a lack in the "in-itself" for "the for-itself," in Sartrean parlance, highlighting a dependence on a power external to the self's control. Moreover, this circumstance of infantile dependence and relating to those on whom it depends for survival is a universal circumstance that every person in every time and culture has confronted. And in so far as culture is transmitted through verbal linguistic practices, then those aspects of human being that can be said to be universally shared, will most likely by found at the pre-verbal level, the level most insulated, as it were, from cultural determination.

Third, Both Taylor and Butler are interested in locating the source of conscience. For Taylor (1988), its origin cannot be found by "radical reflection" inside the self, since that would be a solipsistic search for an inner essence (the fantasy of 'natural law') that is not interpretation-depended and contextualized by social relatedness. In CKPP the problem of the patient is not that he or she is unable to look inside the self enough, but that he or she has a problem "allowing another mind to think about their problems differently," as Dr. R, my supervisor would say during our supervisory sessions. It is a problem of authority and knowledge, particularly the violence that attends the forceful entry or extension of one field into another – as Phillips (1998) describes the Kleinian conceptions of projection and introjection. It requires seriously considering the

sighting/citing of the self from the vantage point of another, and then take that understanding into the self to broaden its scope.[5] This is why Kristeva (2001) can argue that Klein reformulated the analytic question in terms caring for the capacity for thought and the conditions necessary for "our capacity to become creatures of symbols" (p. 14). As Phillips (1998) argues in his deconstructive re-reading of Klein, she was a sort of phenomenologist of the unconscious for whom the question of how we can come to discern between phantasy and reality, between inside and outside, is the capacity, *sin qua non,* for "having" knowledge at all. This capacity begins with and depends on the psychic equivalent of the mouth:

> …the child is born not as a closed circuit of alternating impulses, a fragile entity at the mercy of external influences, but already as the enigmatic opening to the violence of the outside (its encroachment into the space of phantasy). This earliest position supplies the conditions for each occasion where 'external' events provide material for the 'inner' world. A fissure, as a kind of original opening to the outside, makes possible all relations. Out of this fissure comes every experience of authority [including the authority of knowledge], including both the death instinct and the super-ego. Each functions in the same way within the pattern of phantasy that must maintain absence, negativity, and mystery in the process of acquiring knowledge. In other words, these persecuting authorities represent and intrinsically unknowable element that, whether in phantasy or reality, makes knowledge and its acquisition possible. (p. 172)[6]

For Butler (1997) the problem of conscience and subjection is that the subject turns towards subjection and submits to it; the result of this is the installation of conscience as the paradoxical effect of power that both subjects us to cultural-moral imperatives and conditions the possibility for our agency, including any ability to subvert that very power-moral-knowledge complex. Therefore,

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[5] Throughout the text the signifier "sight/cite" and grammatical variations thereof are employed to indicate the inextricability of saying and seeing, of the saying power of the word to shape what we visually apprehend. In other words to see someone as a so in so is to inscribe their body with what one means to say about them. Conversely, to say someone is a this or that is to foreclose one's vision upon their potential as an Other. Perhaps one can say what one does not mean, but it seems impossible to see what one does not mean.

[6] Here one can argue that there is a basic agreement between the implicit ontology of Klein and Heidegger's notion of Dasein: that each person is fundamentally an opening onto the world, a "world spanning openness" in his terms (cf., Heidegger, 1926/1962)

the basis of this turn cannot be external for there would be an infinite regress of the same question – it cannot be that the subject turns to subjection because subjection made them turn, and so on. Butler (1998) ultimately turns to Klein to address the "ambivalence" and "paradox" of subjection, because Klein's account of conscience – figured as the "super-ego" – is based in ambivalence. The superego, under optimal conditions, becomes the source of prohibition *and encouragement*, for feeling both good and bad about one's persistence as a self in time – one's desires, aspirations, actions and moral identity (a.k.a., "self-esteem"). Butler's close reading of Klein emphasizes that conscience begins with the infant's desire to preserve the loved mother and source of life from its own destructive aggression and not with an external prohibition as in Freud and Lacan. Butler finds in Klein an account for the ambivalence of subjection, because the good mother figure – the superego as source of support and well-being – is preserved as a sign of life by the rerouting of infantile aggression into the creation of the super-ego as censorship and inhibiting citations on the self. In short, we want to hear the voice of the law in our heads to police ourselves because – optimally – it is the same voice that ensures the possibility of life, love, and belonging: *not just being-in-time, but well-being-in-time*. The desire to persist through subjection and become a subject stems from the "passionate desire to be" in Butler's terms, to be in relation with anOther. Thus, "By Butler's reading, Klein's account of an internal world ravaged by rage and guilt is not, as some of her critics have charged, simply a morbid and solipsistic model of intrapsychic relations: rather, loss, guilt and love in Klein reveal how the ego is always and precariously socially attached" (Stonebridge, introductory remarks, in Phillips & Stonebridge, 1998, p. 180)

The problem of being able to occupy a standpoint in a space of issues that confront one with possible commitments for action is the problem of being a subject whose configuration is

subject to conditions outside of one's control. The issues or exigencies of life figured as *the hailing call of reality* – everyday interpolation, as it were – require subjection in order for the subject to respond and make a dent in that reality (i.e., to exercise whatever freedom we may be said to have; subjection is both the condition and limit of freedom). When patients come to seek treatment, they are having some difficulty living this paradox of subjectivity, in the form of a problematic present that refuses to pass. In CKPP the therapist follows the trail of the patient's anxiety to examine and make explicit their self-defeating means of dealing with that anxiety.[7]

What for Butler and Taylor are serious theoretical concerns are vivid realities that come to life in the therapeutic office. The following case of "John" shows a young man who has tried to deny the paradox. By running away from the possibility of subjection he also runs away from the possibility of agency. At the time the following session took place John was a 35 year-old, Caucasian, gay man. He participated in one kind of therapy or another since the age of 18 for "depression" including several hospitalizations for suicidal behavior. John was dissatisfied with every aspect of his life. He had only ever worked in entry level, low paying, temporary clerical and retail positions. His relationships ended in the same way as his jobs – John would start to feel "suffocated" by their demands, become despondent and passive, and eventually his boyfriend would break up with him, or his boss would fire him for unexcused absences. The earliest memory he reported speaks volumes about his attitude towards life in general: when he was two or three years old he walked into a neighbor's house, saw his reflection in the hallway mirror, and became so frightened that he turned and ran away. In fact by the time of the following session, he had agreed

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[7] This is the condition of anguish that drives Satan in Milton's Paradise Lost. In that classic work of literature, Satan can be viewed as the allegorical representative of humanity, who, out of envy and greed, is forever trying in vain to become the basis of his own power and deny God as the creator to whom he is subject. Satan's frustration is his inability to realize his fantasy that he can become the basis of his own power, resulting in the compromise of existing as the problem of God, existing as a not towards creation and life.

in one of our sessions that "trying to be invisible" and "feeling like a fake" were two of the unifying themes of both his social life and his work life. By the time we terminated treatment, John and I had worked together for two years, twice a week, and for one year three times per week.

"I had a hard time coming in today," John begins after sitting down near the foot of the chaise in my office, opposite the window and close to the door. He says this with his head turned down a bit, his lips puffed out a little. He looks like he's pouting. John is about 6'2" with reddish blond hair. He makes no eye contact as usual. When we began working together he explained that that, "I can't make eye contact" because if people looked "at me in the eyes they'll see I'm empty and weak."

I write down what John says and he continues a minute or so later, "I almost didn't make it in today. I don't know why…" he begins as his voice starts to crack as if he wants to cry, "… why I get so upset about the bus. I was walking to the stop and I could see the bus leaving without me."

We waited a few moments in silence. John began to shift into the corner where the foot of the chaise meets the surrounding walls. His head drops a bit more as he speaks with the same distress in his voice, "I almost got killed last night after work. I was walking home after work and standing on the corner starting to cross the crosswalk. I turned to the right and there was this woman trying to turn right and she was only looking left, so I jumped up and down and waved my arms so she would see me but she didn't. She came this close" – gesturing with his fingers – "to hitting me!"

Having formulated something to say based on what I inferred from his examples, I told him, "I think that while a part of you wants to be seen by me another part of you is scared that no matter what you do I won't and you'll be hurt."

John nods his head up and down a bit before replying, "I want to lie down." After a moment of silence he scoots over to his right towards the middle of the chaise and begins to lean towards its head, stops halfway before reclining, and sits back up with his head still turned down.

"I'm scared to lie down," he states in a frustrated tone.

"Scared of?" I ask

"I don't know," pausing, he continues, "When I was a kid I remember finding this calendar on the bank behind our house. Someone had taken the time to mark appointments and things on it and it made me sad."

"Perhaps a part of you is scared about wasting time in here."

"No. I was sad because someone took the time to put things on it and now it's useless. It's useless."

"Useless" I repeat, not sure where this is going.

"I used to have this fantasy of getting away from it all where I drove out of town in a Volkswagen beetle and as I got out of the city limits a cop pulled me over for speeding and when he opened the door a wind blew me away and he saw I was made out of paper."

"So, even though a part of you wants me inside you, another part is scared that if you let me in I'll see you are useless and empty."

"Useless," he says as he nods in agreement and lies down, face up.

In terms of Taylor and Butler, John's fantasy encapsulates his life project as an attempt to deny the paradox of subjectivity. His being is not "in question;" it is foreclosed. His life is an argument that he invites others to participate in: the argument that he cannot assume a subjectivity that can alter the circumstances in which he finds himself because he is depleted of agency. "Getting away from it all" in his car is an attempt at escape from being "a self [as] existing in a space of issues, to do with how one ought to be, or how one measures up against what is good, what is right, what is really worth doing … being able to find one's standpoint in this space, being able to occupy, to be a perspective in it". This attempt is a failure because the law (reality, his job, his boyfriend, his therapist) pursues John and is bent on sighting/citing him, and in doing so making citations about the subject he is – and thereby requiring a response. However, John thwarts this effort to be reached by a trick. As a fake person (invisible) he tries to evade subjection, the obligations of being in relationships that matter. The long arm of subjection can't grasp him; as the simulacra of a subject he is "useless." At the same time however, he negates the only possible way to truly resist subjection. After all, an agent cited by the law could still choose to speed away even after citation. John's only option is to be carried by circumstances like a useless surface.

> As a form of power, subjection is paradoxical. To be dominated by a power external to oneself is a familiar and agonizing form power takes. To find, however, that what "one" is, one's very formation as a subject, is in some sense dependent upon that very power is quite another. … this fundamental dependency on a discourse we never chose, but that, paradoxically, initiates and sustains our agency. (Butler, 1997, pp. 1-2)

Thus, this study examines the paradox of subjectivity in the context of therapeutic practice. It employs a hermeneutic case study method to study some of the author's clinical work while supervised by a contemporary Kleinian psychoanalytic psychotherapist and reports the findings in a manner that draws from the creative nonfiction genre.

Case study methodology

The case study approach, utilizing the author's own clinical work, was adopted for three reasons. First, from the object-relations perspective, every case is a case study – quite literally. It involves the study of each patient's complex history and difficulties, largely through interpretations based on the therapist's participant-observation of the relationship that develops with each patient. Thus, the use of an interpretive study focusing on relational dynamics parallels the nature of the phenomenon under study.

Second, Clarkson (1995) and Pugh (1998) have argued that a disciplined and methodological case study conducted by the therapist using their own clinical data provides a means for an integrated approach to therapy and research. Noting the traditional separation between research and clinical practice, where research is often conducted as a means for securing a degree to be able to practice (that is, completing the dissertation requirement), Clarkson (1995) argues that therapy and research ought to be a simultaneous and ongoing processes with every client, providing the research is appropriate to the clinician's approach to therapy. Following Clarkson (1995), Pugh (1998) believes that encouraging doctoral students to study their own clinical process in depth, using a method like the one employed in this study, can provide a vehicle for enhancing their own sense of confidence, independence, and their ability to respond ethically to clients as psychotherapists.

Third, the case study approach is generally considered the appropriate method for conducting focused analyses of clinical processes, particularly the communicative interactions (including frequency, type, and patterns) between clients and therapists (cf., Clarkson, 1995; Martin, Goodyear, & Newton, 1987; Pittenger, Hockett, & Danehy, 1960; Pugh, 1998). While many authors offer little if any justification for this assumption, Pittenger, Hockett, and Danehy (1960) emphasize

one that is particularly well suited for this study. By concentrating their study on the first five minutes of a psychiatric interview, they were able to examine the communicative patterning between the psychiatrist and the patient in greater idiographic detail. They write:

> The members of any single human community share literally thousands of behavioral conventions which are as dominant as our rule of keeping to the right [while driving in America], but which are much more subtle than that because they are learned, acted, and responded to, and taught almost entirely out of awareness. Human beings live their lives, from day to day, and from centisecond to centisecond, in terms of such patterning. In the discovery and explication of [such] patterning, gross statistical methods are neither necessary nor possible; what is required, rather, is some method by which things we "really already knew" – but only out of awareness – can be more or less systematically dredged up for conscious examination. (p. 212)

And Yin (1984), writing on case studies in general, considers case studies to be appropriate for an inquiry that investigates a contemporary phenomenon within its real-life context, when the boundaries between the phenomenon and context are not clearly evident, and when multiple sources of evidence are used – all of which characterize the present study. In fact, from the perspective of hermeneutics the phenomenon and context under question for this study (or any study, for that matter) are inexorably linked.

Hermeneutic methodology

As one approach within the family of qualitative research methods, hermeneutics in psychology takes the position that the way to understand an action is to bring to light the world outlook of which it is a response (cf., Packer, 1985; Packer, 1993; Packer & Addison, 1989) and articulate the "rules" or interpretive framework that structures it. The everyday, practical activities in which we engage make sense when viewed in terms of human interests and purposes that are always

embedded in social and historical circumstances [8] – conventions that circumscribe the actors' grasp or understanding of a situation and therefore the range of behaviors in which the person is likely to engage.

Before I can venture any guesses as to why a particular chess player makes a certain move, I have to be familiar with the rules of the game of chess. Once I know these rules and have examined the unfolding sequence in which the player moves – what did the other player do before and after him/her? – I can interpret and make sense of the player's move, with or without using his or her own account of the move. For hermeneutics this kind of engaged, "on-line" activity is the focal point of analysis because every human action or practice is grounded in a network of shared, "constitutive" rules and conventions that give the action its meaning (cf. Kögler, 1996; Packer & Addison, 1989; Taylor, 1971; Thompson, 1981). Every human action is placed or situated in a myriad of other actions that change and unfold over time. The purpose of a hermeneutic study is to make more explicit the scope and character of the rules – often tacit and informed – that make sense of the action.

Psychotherapy is one kind of game people play. Psychotherapy is a game in the sense that every human interaction is a game: its central feature is communication, it has its own rules, legal and illegal moves, positions, field of play, values, and goals (cf., Packer, 1993; Taylor, 1971; Walsh, 1995; Walsh, Perrucci, & Severns, 1999). In therapy people make moves towards, away, and, often, against each other. Each participant agrees to meet and interact with the other in the ostensible hope that they "get somewhere" – namely, they get to a place where the person in the game position

[8] While this underlying assumption was argued nearly thirty years ago (Taylor, 1971) as well as in disciplines outside psychology (cf, Geertz, 1976/1979), its history can be traced back much farther. Its lineage reaches back to Hegel and Dilthey (Palmer, 1969), Heidegger (1926/1962), Gadamer (1960/1994), and Wittgenstein (Walsh, 1995).

of “patient” no longer needs the help of the person in the position of “therapist.” Therefore, to understand what happens in therapy one must examine what is done by means of words, the principle tools participants use to communicate while playing the game of therapy (Watzlawick, Bavelas, & Jackson, 1967). Hence, this study focuses on the pragmatics of the communication between the author and the patient included in the study. Pragmatics is the study of actual language as it is used in specific situations (cf., Levinson, 1983). As Nofsinger (1991) writes:

> The approach of pragmatics thus contrasts with the study of language’s system of sounds (phonology), its rules for constructing correct or valid words and sentences (morphology and syntax) and its system for representing meaning in linguistic form (semantics). Pragmatics is the study of how we use these various aspects of language to accomplish our goals and do communicative work (pp. 5 – 6).

Importantly, although the pragmatic approach applies to utterances, it can also be extended to emotions, which themselves are communicative acts (cf., deRivera, 1977; Parkinson, 1995). Parkinson (1995) describes the basic principle of pragmatic function as it relates to the communicative model of emotion:

> What we say when we talk in emotional terms is never intended simply to characterize something happening inside us, although such a characterization may be one of the effects achieved. Emotional representations are deployed in specific contexts to serve specific social functions. The nature of the function determines the content of the representation that is deployed. (pp. 287–288)

This communicative model of emotion views “getting emotional [as] making identity claims that are physically communicated via the various channels of individual emotional expression with socially appropriate level of bodily involvement . . . .to influence a specific target person” (Parkinson, pp. 264, 291). These claims have a context dependent function which usually involves defining a piece of reality or making claims about reality that cannot be maintained simply through supposedly

neutral, factual discourse (e.g., "the painting is ugly!" stated with anger as if socially claiming the identity of "angry person" legitimizes the speaker's position).

De Rivera's work (1977) provides a model for understanding how emotions comprise a significant part of our continuous, on-line interpersonal negotiations over our rights, obligations, and roles with respect to other people and the environment. Like Parkinson, on this view emotions are used to regulate our interactions. The interpretive methodology employed here draws on the work of de Rivera (1977) and Parkinson (1995) to interpret the emotional work that unfolded as a part of the clinical interactions. Recalling Foucault's (1982, p. 220) definition of power relations as those which act on the actions of others, influencing or shaping their experience and subsequent behavior, the importance of examining the emotional work of social interactions is clear. Getting emotional is an everyday practice of power that does more to shape everyday social reality than direct force.

Yet in order to study these actions, they must be "fixed" by some means, such as video, audio, or other type of recording. In this way they can become a text-analogue and can be interpreted (cf., Ricoeur, 1971). The author's supervisor required the use of detailed process notes written during every session and reviewed, line-by-line, during supervision. These verbatim process notes provide a record of such fixed actions, written as a participant in the midst of them. These notes, therefore, provided a record of the interactions that were used for the study.

This case study concentrates on the notes that were written during one psychotherapy session with one patient. The session was chosen on the basis that it seem to exemplify particular aspects of the technique the author had been learning. The session is analyzed to articulate the structure of the therapeutic game the author had been learning, drawing on the literature in the

pragmatic analysis of human communication (Levinson, 1983; Nofsinger, 1991; Watzlawick, Jackson, & Bavelas, 1967). First, a pragmatic analysis is done to articulate the moves that were made, what the author and patient were "up to" in terms of the communicative context. This is followed with an examination of how the patient and the author positioned themselves relative to each other in the communicative context that was articulated. This positioning is important because it is through the moves that were made with respect to each other and features of the communicative context that the constituting or construction of social reality, including the maintenance and alteration of identity and subjectivity, occurred. Taken together these steps constitute an interpretive analysis that moves beyond the patterning of the interaction to interpret how this patterning shapes the participants – the ontological work that is accomplished (cf. Packer & Greco-Brooks, 1999). As Packer writes:

> In broad terms our hermeneutic approach seeks to uncover and elucidate the ontological work that people accomplish in their everyday practical activity, including the interchange that takes place in therapy. This work includes the ongoing construction and reconstruction of social reality, and especially the production and reproduction of persons. Much of this work is done by means of (through the medium of) language, and so our interpretive methodology incorporates the analysis of language pragmatics: the conversational action that makes up discourse. (Packer, 2000, p. 1)

The result is that several aspects of the communicative competence that characterizes CKPP are articulated and related to several key technical terms and the tropography employed in the Kleinian literature. Terms and tropes such as central anxiety, transference, development, feeding, the breast, etc., will be discussed and explained to show how the theory and its underlying metaphors are related and constitute the practice, its "discourse" as defined by Ochs(1990): "... *a set of norms, preferences, and expectations relating language to context, which speaker-hearers draw on and modify in*

producing and making sense out of language [and behavior, I would add] *in context*" (p. 289, italics in original).

Creative nonfiction genre

The following study, then, "tells a story" of contemporary Kleinian clinical practice through the window of a novice's supervised clinical work – one who has been intent learning the practices and methods of understanding clinical phenomena inherent to this specialized way of working with people in psychological distress. In addition to articulating this form of clinical practice and examining its subjectivizing practice, there was the challenge to present the work in a manner that both reflects its complexity and communicates this complexity in a way that is accessible for both more general and clinical audiences – to offer a glimpse of this world, how it works, and a sense of what it is like to work within it. The creative nonfiction genre was chosen to achieve these aims for two reasons.

First, creative nonfiction provides a rhetorical style that is appropriate for coping with three challenges inherent to this kind of study. Perhaps the biggest challenge in learning (and understanding) clinical practice is integrating and appropriately utilizing a wealth of theoretical concepts and constructs to help this particular live-blooded person sitting across from you who never fits neatly into psychological constructs. A second challenge for this kind of study is the balance to be sustained between a detailed and specific "first-hand" account of the phenomenon under study with the appropriate distance of the researcher-observer who draws on the body of academic knowledge to make sense of the details encountered as a participant. And third, a study such as this ought to be rigorous, informative, and interesting. Unfortunately, reading clinical

material overloaded with technical jargon in standard expository format tends to be not only burdensome, but often results in boredom and lack of interest. As a rhetorical form, creative nonfiction deals with all of these challenges, because it moves between describing concrete, historical events and tying them to more general ideas and issues. It depicts concrete instances of an idea, ethos, or aesthetic for the reader to measure what is happening in some part of the world, a depiction for the reader's comparison between what "goes on" in one place and how it "goes on" differently for the reader in their own place (cf. Gerard, 1996). Moreover, it accomplishes these things with the underlying aim of offering a gripping account of a real-life event of set of events.

Secondly, misconceptions and, I believe, often misguided critiques have been lodged against psychoanalysis, because too often psychoanalytic discourse has not done a good enough job of linking abstract constructs to concrete clinical happenings. The "story telling" approach allowed each concept to unfold with the clinical material that is presented. Showing how the terms inform practice, the pragmatic use of these constructs, is different from the more typical context-less wrangling over abstract terms that characterizes clinical literature. Moreover, each "school" of psychoanalysis has somewhat different ways of understanding the same concepts such as transference, projection, etc. Like the narrator of a film whose cuts back and forth in time, between past, present, future, and horizontally across multiple context of the protagonist's life to present a three dimensional character, this study tacks between the concrete to and fro of an actual session, the analysis of what is happening in the talk as it unfolds, and a retrospective view of the narrator who wants to tie these elements together and use clinical work as the basis for telling "a story" about contemporary Kleinian psychotherapy practice and how it works to foster subjectivity.

Gerard (1996) outlines five characteristics of creative nonfiction. One of the primary aims of creative nonfiction is teaching. "Creative nonfiction contains a sense of reflection on the part of the author." (p. 10). This reflective exposition, at the heart of creative nonfiction, is part of what motivates the reader to read on: "One important distinguishing factor is this teaching element – a reader reads on to learn something. It's not just personal experience" (Gutkind, quoted in Gerard, 1998). I would add that the organizational structure of creative nonfiction, the tacking back and forth between moment or event and context, also contributes to its efficacy at teaching readers something – helping the reader to see that there might be an alternative to the way they are seeing the world, that there may be another way of doing things than the way they are familiar with doing, conceiving, and talking about them.

Two related characteristics of creative nonfiction are that it tells a story and uses literary devices to make it a gripping. "Creative nonfiction is [also] narrative, it always tells a good story.... It takes advantage of such fictional devices as character, plot, and dialogue" (Gerard, 1996, p.9). This study employs different literary devices throughout to achieve distinct purposes. For example, the text includes turns of phrase, metaphor, and the like to enhance the descriptive quality of the setting and the story. Also, technical concepts that figure as "central players" in the game of contemporary Kleinian technique are entirely capitalized without necessarily providing immediate explication of the concepts. This is done to mark the special place these terms hold and signify where they are figuring into ongoing action. It is hoped that with subsequent exposures to these marked terms across multiple contexts that the reader will develop a sense of the terms through how they are used, where they figure into the clinical discourse, the supervisory discourse, and the discourse of the clinical literature. This approach also parallels the process by which the author gradually came to

understand and integrate the concepts and theories with the clinical work over the course of the supervision.

The study deviates from the standard approach to organizing the description of the study, including its participants, purpose, development, as well as its place in the current literature. Rather than summarizing this information up front, it is woven throughout the work as it has been done in other works of creative non-fiction (e.g., Hersch, 1988). In general, this information is introduced as it becomes relevant to the ongoing story. For example, informative digressions are used to provide additional information on technical concepts as the dissertation progresses. In this study, and as Hersch does, the "voice" of the participant and the researcher-observer are combined through tacking between a description of the context of the ongoing experience and the context of the literature that is relevant to the action.

The fourth and fifth characteristics of creative nonfiction are also related – and perhaps the most important from the standpoint of this study. Creative nonfiction "has an apparent subject and a deeper subject" (Gerard, 1996, pp. 7-8). In her book A Tribe Apart: A Journey into the Heart of American Adolescence, (Hersch, 1998) follows the lives of several teenagers through a few years of their adolescence. Yet her book is also a study in the estrangement and isolation that plagues not only teens but their families. There is a duality of focus in creative nonfiction.

And the last characteristic, related to the fourth, is that it is "grounded in paradox" (Ibid, p. 9). This paradox is between the story as a concrete historical happening and its function as a window into subjects that confront people (including the reader) in other places and times. Take the following excerpt from The Culture of Desire: Paradox and Perversity in Gay Lives Today. In it the author uses a memory from his childhood (the surface content) as a window into a broader,

culturally bound pubescent experience (the "deeper" subject Gerard discusses) of grappling with eroticism as a facet of one's existence, and the role of peer story telling in this process:

> One image rises from a strawberry field. Two teenage boys are bent down between the rows, boasting to a third, much younger boy about what they'd got and who they'd gotten if from. The younger boy, eager to keep the talk going, hungry to make it more explicit (and to expand his own secret library of masturbatory fantasies), plies them with dumb questions about body parts and places.
>
> "You just find the hardest place on you and the softest place on her, and then . . . you know," the older braggart says.
>
> "Like your big toe?" the little boy ventures.
>
> "Haint your daddy learned you nothing with all them books? the big boy snorts, reaching down through the bushy strawberry vines to grope himself. "This here's all you gotta know," he says, laughing with his buddy.
>
> The mystery of what "this here" was also took in the fantastic and delectable notion that if you really knew what to do with *it*, you magically discover who *you* were. You would discover that you and your body were in fact one whole being. You would discover that the growing adolescent physicalness of your body was not disconnected from the self that hid within that strange gangling thing – and then, privy to the mystery, you would enter into the brotherhood of the knowing, the brotherhood of men who knew, men (boys?) whose solidarity with one another had guided and released them into the natural bodies of women (girls?) – released them from the terror of their aloneness. All that from a grope and a dirty joke. (Browning, 1993, p. 13, italics in the original)

This is an example of the way in which creative nonfiction effectively articulates a foreign event or series of events with an interpretation that invites readers to reflect, consider, and use to learn something new about themselves and/or the world around them beyond the obvious content of the story. In this case, the occasion of a grope and a dirty joke can provide a window to notice how our identities (maleness) become inscribed in our bodies (the phallus) through the sightings/citations of others: the "self that hid *within* that strange gangling thing" (emphasis added). In Taylor's terms, it is a glimpse into how the self, as "a space of issues for acting" is enlarged as the gangling thing becomes a new term for questions of how to act and who one is that incorporates the thing within that space of the self. Importantly, it shows a way that the terms of the incorporation – and hence

of one's identity – are fundamentally dependent on a more powerful Other whose defining (symbolic) function is willingly turned to as definitive by the subject under construction, as it were.

In other words, it shows how our bodily organs – and the sensations of those organs – are interpreted in relational terms because they are defined within a relational context. For example, when the boy gets horny he fantasizes someone else who gratifies the urge. As the following chapters will show, this process is not unique to puberty or adolescence. Within the critical hermeneutics of the Kleinian tradition it is the starting point for having a self at all, with its roots in infancy – particularly the ongoing process of weaning. In so far as one's subjectivity changes throughout life – or doesn't in the case of pathology – weaning is a real and foundational aspect of the adult subject. Clinically speaking, there is always already an infant-in-the-patient.

Critical hermeneutics of CKPP

> The way of disclosure, in which Dasein [the human kind of being] brings itself before itself must be such that in it Dasein becomes accessible as *simplified* in a certain manner. With what is thus disclosed, the structural totality of the Being we seek must then come to light in an elemental way.
>
> As a state-of-mind, which will satisfy these methodological requirements, the phenomenon of *anxiety* will be made basic for our analysis…. As one of Dasein's possibilities of Being, anxiety – together with Dasein itself as disclosed in it – provides the phenomenal basis for explicitly grasping Dasein's primordial totality of Being. Dasein's Being reveals itself as *care*. (Heidegger, 1926/1962, pp. 226-227)

As a philosopher of ontology, Heidegger was interested in the question of Being (capital "B"), the fundamental structure of "isness;" he was not interested in the being (little "b") of any particular thing or person. However, since this philosophical question only exists for humans, his strategy was to examine the fundamental structures of human Being. This is the aim of <u>Being and Time</u> (1926/1952), which inaugurated ontological and methodological hermeneutics. He formulated his answer to this question through the interpretation of humans in their "average everydayness"

rather than as objects detached from the contexts in which they existed. His famous answer to this question: human Being is being-in-the-world (*Dasein*), as opposed to defining humanity it terms of some inner faculty like reason as had been argued by most philosophers since Aristotle, or "the mind" divided into and ego, id and superego as in the case of Freudian psychoanalysis. Thus, with being-in-the-world as the starting point, methodological hermeneutics in psychology examines the context in which the person finds him or herself to understand the basis of what they do, think, and how they view themselves (cf., pp. 13-16 above). Importantly, as a method or strategy for articulating the structure of an entity, ontological hermeneutics is not concerned with what ought to be or not, simply the examination of what is and how it can be what it is. In other words, its focus is on something's conditions for being-in-the-world, not the conditions for its well-being-in-the-world.

Critical hermeneutics, it may be said, by contrast, seeks to go beyond the conditions of being-in-the-world to articulate the conditions of well-being-in-the-world for particular peoples:

> Critical hermeneutics refers to work that seeks to expose and criticize ideological underpinnings of all social practices, including political and scientific activity. It attempts, in particular, to reveal the sources of domination and coercion that prevent open discourse, the free exercise of reason, and the enhancement of possibilities for human self-determination. (Woolfolk, Sass, & Messer, 1988, p. 4)

This concern with emancipation is what led Habermas to examine Freudian psychoanalysis to generate guidelines "for the logic of critical science in general" (McCarthy, 1978, p. 201), since Freud combined interpretation with a normative-explanatory theoretical apparatus into a method of identifying, intervening and correcting oppressive patterns of individual action. In order to be able to evaluate social practices as oppressive, liberating, moral and immoral, there must be some framework of values as a backdrop for sighting/citing this or that practice as good or as bad – in the

case of psychotherapy, this or that behavior as normal or pathological. The problem with this given the work of Foucault is: who's to say and to whose benefit is this normative scheme being employed?[9] Is one person's emancipatory understanding another person's oppression? How do the human and social scientist understand the other without assimilating their otherness – understanding them primarily in terms of one's own framework? An obvious example of the danger of this predicament is the grotesque history of trying to convert homosexuals to heterosexuals on the basis of traditional conceptions of normal subjectivity by employing various disciplinary technologies such as chemical injection, electroshock, castration, emotional manipulation, and so on.

Kögler, a student of Habermas, (1996) argues for a critical hermeneutics that allows for an understanding of otherness without its erasure by turning every form of life into another version of one's own world outlook. His solution is an interpretive theory and method that balances the view that social power shapes every person's understanding of themselves and reality without robbing them of the possibility to achieve the critical distance necessary to act on and change those power-knowledge structures for the betterment of their lives. Engagement in his version of the critical dialog is where both participants come to understand more of their own respective preconceptions about reality through understanding them in terms of the other's perspective. The "subject" in such a study, say a person from another culture, may come to learn through *the difference* between his or her world and that of the researcher something about the taken for granted cultural "rules" that shape their lives. And subsequently, they may choose to alter some aspect of these rules once he or

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[9] Foucault's work can be characterized as the investigation of the transformation of human subjectivities (sociohistorically contingent manifestations of the subject) as embedded within complex relations of power and semiotic practices. The possibilities for relations between subjects are conditioned by the operation of power-knowledge complexes, "a moving substrate of force relations" (Foucault, 1980, p. 93). These relations operate within a sphere of power that circumscribe its possibilities, shaping subjectivity along lines of specific, historically contingent subjectivities (e.g., mad-sane, (Foucault, 1965), the criminal (Foucault, 1979), homosexual-heterosexual (Foucault, 1980), etc.)

she has become more aware of its limiting consequences. Likewise the researcher may learn through the differences something about his or her own background that he or she may want to change. It is the encounter *with difference* that produces the "discursive space" necessary for critical self-distanciation, not with a master text (normative-explanatory scheme) that captures reality outside of the language within which it is inscribed.

The following chapters show how the communicative competence of CKPP constitutes a critical hermeneutics that uses dialog to provide occasions for emancipatory subjection by means of the confrontation with difference in the context of asymmetrical power and dependence. The encounter with difference is necessary for patients to change their background assumptions of reality, habits for relating to other people, and gain a greater sense of agency in their experience. This confrontation is between who and how the therapist is and who and how the patient wants the therapist to be to purge anxiety-producing reminders from his or her experience. In this view pathology stems from inappropriately using other people to help manage one's anxiety, that is, from the inappropriate assimilation of the other to serve a function for the self.

When patients come in for treatment, they have a problem in their experience, an agitating gap or lack in their understanding as it were, something, an *it*, that they want help to figure out -- whether *it* manifests itself as a phobia (e.g., lack of ease with spiders), depression (e.g., lack of fulfillment), sexual compulsion (e.g., lack of restraint on a desire that causes problems), etc. Something is felt to be lacking and chronically subverts the patient's sense of well-being-in-the-world. However, since this gap is in their experience it (1) is their way of experiencing that must change to include whatever is missing, and (2) means the patient's experience with the therapist will be subject to the same problematic conditions. Borrowing Butler's language (1997), the patient

when he or she walks in the door of every session is a "subject already formed" and it is the conditions of its formation that therapy risks if the subject is to be reformed and include whatever human possibility for experience they feel they are denied. In CKPP the patient is subjected to their experience in a different way so that an opportunity is created for patients to gradually assume a different kind of subjectivity in relation to their experience.

While Heidegger the ontologist used anxiety as the window to expose Dasein's basic structural characteristics as being-in-the-world, Klein the psychoanalyst discovered that infantile anxiety was the window for understanding the obstacles her child patients confronted with well-being-in-the-world. The examination of death anxiety became the path to the truth of their experience, and later, the method for laying bare the structure of adult experience as well. Chapter two provides an overview of the Kleinian tradition in terms of the central role it ascribes to anxiety, particularly death anxiety as the manifestation of the death (aggressive) instinct. The chapter will begin with a synoptic view of Klein's life up to her invention of her play technique.

Chapters three and four articulate eight characteristics of CKPP through the analysis of one session's verbatim record using the interpretive method outlined above. At the relevant moments during the analysis digressions are included to (1) explain some of the technical terms of CKPP and (2) point out how the characteristics of CKPP work within the parameters of critical hermeneutics as outlined by Kögler (1996). The overall strategy is to show that CKPP differs as a specialized form of communicative competence by examining the difference between the communicative patterns of the therapist with those that characterize everyday conversation. This includes what, how, when, and why utterances are deployed and their pragmatic effect on the communicative action. These interpretive utterances are geared to reveal something about the difficulties the patient

has taking an evaluative stance on his or her (1) assumptions about social reality, (2) over-practiced methods of impacting others, (3) personal experience, and how these ‘unconsciously’ constitute the problematic experience(s) the patient recurrently faces, known in the psychiatric community as symptoms.

Through the close interpretive analysis of the interaction between the author and a patient during in chapters three and four, chapter five summarizes these findings to provide a basis for studying the subjection process in CKPP. The work of Judith Butler will be used to augment the analysis of the conversation done in chapters three and four, since she provides a language for examining the process of subjection in the record. The critical hermeneutics of contemporary Kleinian psychoanalytically oriented psychotherapy is examined as the weaning of subjectivity. On the side of the therapist, weaning is the occasion to provide the conditions necessary for the patients to begin to *experientially* understand themselves and operate differently in relation to anOther. On the side of the patient, weaning is desired and feared as the paradox of subjection. Weaning is the occasion to reunite with a range of experience through another; what becomes a reclaimed possibility for the self is possible on the basis of dependency on that Other. The fear or anxiety of weaning is the specter of the dissolution of the self as it engages this project by means of this Other. The allure of weaning is a greater sense of togetherness in the world (as in “I do/don’t feel very together today”) and with the world (as in less loneliness and isolation). The implications of weaning for subjection will be discussed, as well as an evaluation of the methodology employed in the study and its implications for further research.

2. Some context for an induction into the Kleinian tradition

> We have never prided ourselves on the completeness and finality of our knowledge and capacity. We are just as ready now as we were earlier to admit the imperfections in our understanding, to learn new things and to alter our methods in any way that can improve them.
>
> According to Grosskurth (1986, preface) these were "the first words Melanie Klein ever heard Freud utter."

Freud first postulated the conflict between Eros and Thanatos, the life and death instincts, in Beyond the Pleasure Principle (1920). However, when he died in 1939 he had not decided whether the idea of a 'death instinct' was central to human existence or as "is felt by many people …a most undesirable [innovation] which should be gotten rid of as quickly as possible" (Freud, 1933/1965, p. 103). Melanie Klein took the former position. Her use and development of the death instinct as a heuristic devise in theory and in practice is one of the important ways she extended Freud's work as a psychoanalytic pioneer, and made claim to legitimacy in Freud's own name. For some like Freud, Anna Freud and her followers, Klein's extensions ultimately amounted to a heretical departure from psychoanalysis and made her a target of derision and contempt. Yet for others, her innovations provided an illuminating source of inspiration for extending the reach of psychoanalytic thought and practice.

These contrasting reactions to Melanie Klein highlight the idea that conflict resides at the heart of people's relations with others who are different, and require an ability to tolerate the loss of sameness between un-equals for the various forms of good will to prevail in parenting, our friendships, partnerships, and professional life. For Klein the root of a person's inability to tolerate this loss is the hatred of dependence manifested as ENVY of the Other, who has that of which one feels deprived. The aggression over this experienced deprivation is the origin of the anxiety that threatens one's existence as persecution from external sources or the destruction of the

loved and needed Other at the hands of the self. Klein's clinical and theoretical innovations developed out of the psychoanalytic play technique that she invented over several years beginning in 1919.[10] By 1940 her theories and technique had gained enough social stability and currency in the analytic community that a reaction had formed against them as such a heretical departure from Freud's psychoanalysis that Klein's legitimacy (and that of her followers) as an analyst was attacked by Anna Freud and her adherents. Since Klein and Anna Freud had both emigrated to England to escape the rampant anti-Semitism of the continent, the tension between them almost proved too much to be contained by the tent of the British Psycho-Analytical Society, which led to the Freud-Klein controversies between 1941 and 1945 (cf., King & Steiner, 1991). Since there are several biographies of Klein that cover her life, work, and the controversies surrounding her technique and departures from Freud from different angles (e.g., Burston, 1996; Grosskurth, 1986; King & Steiner, 1991; Kristeva, 2001; Likerman, 2001; Segal, 1979), this chapter will not attempt an exhaustive account of her life and work or its historical place in psychoanalytic thought. This chapter provides some historical context for CKPP as it developed from Klein and the subsequent work of her followers as they have continued to refine the practice of "getting to the root of anxiety." For Klein this anxiety is proportional to the patient's inability to tolerate deprivation of some kind.

Given that Klein's own career as an analyst began with her own analysis as a recurrently depressed young woman caught at the intersection of several depriving relationships, it is not ironic that her last major paper Envy and gratitude (1957/1997), written with the hindsight of a grandmother, struggled with the issue of how such deprivations affect the mental health of people. Perhaps Klein's unwavering conviction that

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[10] Except where indicated, the biographical information and quotations are taken from Grosskurth (1986) Melanie Klein: Her world and her work.

there are innate factors that predispose some people to have more problems with environmental deprivations than others came from her own experience as an analysand who was confronted with how she contributed to – and therefore could change – the recurrence of misery in her own life.

Melanie Klein

> From the envy, aggression, and sibling rivalry within her own family, Melanie Klein had abundant material from which to formulate her later theories. …
>
> It was a family riddled with guilt, envy, and occasionally explosive rages, and infused with strong incestuous overtones. Melanie's impending marriage was the prelude to Emanuel's death through disease, malnutrition, alcohol, drugs, poverty, and a will to self-destruction. Melanie Klein was made to feel responsible for his death and she carried the guilt with her for the rest of her days – just as Emanuel had probably intended she should. (Grosskurth, 1986, p. 20)

Melanie's father Moriz Reizes was born into a strictly Orthodox Jewish family in a small town known since World War II as Lvov, Ukraine. Against the wishes of his parents he pursued a career as a physician, hiding his studies for matriculation to avoid their interference. His move towards independence required not only supporting himself financially through school, but also severing a prearranged marriage. He met his future wife Libussa Deutch by chance on a trip to Vienna, where they both happened to by staying in the same boarding home. They soon married in 1875 and settled in what is now Burgenland, Austria, about 70 miles from where they met. A year later their first child Emile was born. Emanuel and Sidone were born in 1877 and 1878, respectively. Melanie, the last of their four children, was born seven years after their marriage in 1882. Given a social climate of ramped anti-Semitism, Moriz's attempts to provide for his family as a physician failed and he settled for dentistry, contributing to the family's financial strains and Libussa's apparent disdain for her husband.

Libussa was in her mid-twenties at the time she married Moriz, some twenty-four years her senior. From Grosskurth's available sources, what seems clear about Libussa is that she was black-haired, of fair complexion, and intelligent. In addition to her native Slovakian, she had a adequate grasp of German and French, the latter of which she taught herself in addition to playing the piano while Melanie was growing up – facts to which Melanie would refer in her idyllic reminiscences of her mother's influence on her own character.

> She had a far closer relationship with her mother, whom she remembered as a woman much younger than her father, very beautify, warm-hearted, courageous and enterprising. Not only did she keep a shop – an unusual thing for a doctor's wife to do in those days – but later, when Melanie was finishing school and her father became ailing and somewhat senile, it was her mother who supplemented the family income and held the family together. She spent the last few years of her life in Melanie Klein's own home, which was a great solace to Melanie at a generally happy time in her life. … Melanie was deeply moved by the serenity and courage with which her mother approached her death after a long-drawn-out illness, and often spoke of it in her old age. (Segal, 1979, p. 28)

In contrast to the rosy picture of her mother that Klein describes in her unpublished autobiography, both Grosskurth and Kristeva (2001) depict Libussa as autocratic, manipulative, and overbearing, a sort of parental parasite on the young Melanie. Kristeva writes, "Not surprisingly, the biography of Melanie Klein reveals that the childhood experienced by this discoverer of the "object-mother" and of matricide was dominated by the imposing figure of her own mother, Libussa Deutsch" (p. 17). This aspect of Libussa will be most evident when she insinuates herself into Melanie's young family after Klein married.

About a year after the death of Sidonie, Melanie began her education at a local state school with eagerness and dedication: "She had also inherited the family passion for knowledge and soon became an ambitious student, very conscious of her marks; it was particularly important for her to receive a report with the words *wurde belobt* (commended)."

(Grosskurth, 1986, p.9). Grosskurth explains this ambition in terms of the competitive dynamics and likely childhood resentments Klein faced, motivating her desire to stand out and be noticed. First, Melanie was the youngest of four children, born four years later and she was an unexpected child. Second, her father was fifty years old when she was born, and in addition to having publicly told the young Melanie that Emile was his favorite, he never seemed to notice her, as Klein could not recall one time he ever played with her – although she could remember a time that she tried to climb up his knee and he pushed her away. Third, it seems that Melanie's siblings were generally antagonistic towards her except for Sidonie. Fourth, while Melanie resented and envied Emile's favored status in the eyes of their father, she wanted her father's approval just as she wanted the approval of her brother.

Around the age of fourteen Klein decided that she wanted to pursue a career in medicine. Apparently, Melanie overheard her father boast that she would attend the gymnasium – an event that ignited her decision. Yet it was her brother's approval and tutelage in Greek and Latin that enabled her to qualify, and provided her with a circle of young intellectual and aspiring friends, including her future husband Arthur Klein.

The transitional years just before and after the end of the 19th century brought many difficult changes for Melanie to cope with emotionally, and perhaps further predisposed her to take an interest in a discipline focused on the suffering of the psyche. The changes began with her father's death in 1900, adding to the family's financial burden. In the wake of his death Emile was quickly married, Melanie quit her plans to pursue medicine and was engaged, Emanuel quit his studies and departed for Vienna to live his last two years, and Libussa's attempts to control the members of her family put Melanie in the middle of power conflicts and resentment between Libussa, Emanuel, and Emile. Added to the burden of mediating these conflicts and suffering their passive-aggressive abuses, Melanie was

embarking on a loveless marriage to the wrong man, which she seems to have known as soon as they were engaged.

Emilie married a young doctor named Leo in December 1900. Libussa had the young couple move into the Reizes' flat, and compelled Leo to assume Moriz's dental practice despite his own reluctance. As Leo assumed Moriz's place to provide financially for the family, Emilie became a substitute for the life Libussa so eagerly wanted to leave behind: the home-bound wife and mother of a financially unsuccessful doctor-become-dentist, confined to a cramped flat. Emilie resented this and occasionally her envy was subtly expressed to Melanie in their correspondence:

> When I read your vivid letter I could hardly suppress certain sadness. Not that I am jealous; you know that I have no strong inclination for traveling, although I would not object to it if the opportunity presented itself. … And I do almost get jealous of your talent for expressing so beautifully everything you have seen. Well, that's an old story, and it tells you that there is hardly anybody else who loves you as I do. … Then it is spring again, and it draws her [their mother] to her beloved Rosenberg's [Melanie's in-law's] and its over with Emilie, Leo, and Otto! [Emilie's son] Why does she neglect us so?" (Quoted in Grosskurth, p. 45)

Meanwhile, Emanuel had been traveling when his father died. His health had deteriorated, apparently due to tuberculosis, to the point that he became convinced that his death was quickly approaching. In early 1900 he transferred from the medical school to the Faculty of Arts to pursue writing. Soon after he withdrew from school altogether and with a small allowance provided by Libussa, he was able to travel, write, and "seek lands of sun and beauty in the traditional pattern of the dying artist." (Ibid., p.18). Yet his departure was an auspicious occasion for Libussa who wanted to move Emile and Leo into their flat. In fact, just three days after her husband's death Libussa wrote a letter to Emanuel describing her plan, written with enough detail to suggest that it was a well thought out plan in advance even though her tone is one of sharing a new surprise. As Grosskurth explains, his romanticized escape may have felt more like an exile: "Emanuel, in his quest for sun and

creativity, brooded constantly on the pittance he was given for an allowance … His dead father's clothes were made over for him, another one of the grievances he was accumulating, particularly as he saw the finery bestowed upon his sister [Emilie's trousseau]" (Ibid., p. 20)

Emanuel also disliked Libussa's increasing emotional and financial focus on Melanie, including her dowry, as it diminished both the money and affection he received. He dislike the prospect of her marriage to Arthur – even though it was his endorsement that led Melanie to accept the engagement – because it meant that he would have a rival for her attention. Not only did he seem to write letters that preyed upon Melanie's anxieties about her pending marriage and his pending death to secure money from her, he acted like a lover who starts a fight with the beloved to test his or her dependence by threatening withdrawal. Such a letter of Emanuel's drew the following response from Melanie:

> But perhaps it is because you are so far away now that I feel so driven to ask you for your confidence. I would, with regard to you, be so much calmer, if I knew that I could share everything with you that concerns you … you will never find a more loyal friend and person who understands you better than I. Let me be your confidante, and be convinced it will be reciprocal! (Quoted in Grosskurth, 1986, p. 33).

Apparently her letter is what he wanted. Emanuel responded to her reply by proclaiming that Melanie and Libussa were the true loves of his life and decrying her use of the word "friend" instead of "brother".

In addition to using the allowance he received from Melanie and Libussa for legitimate expenses, Emanuel spent it on gambling, morphine, cocaine, and other vices. Emanuel was in Genoa when he died. His corpse was found on an April afternoon in 1902 by a hotelkeeper. A short card was found, written to Melanie, which complained about the "scantiness" of her last letter to him, which he blamed for putting him in a bad mood! (Ibid., p. 36). About a year later on March 31, 1903, Melanie Reizes became Mrs. Melanie Klein, and in just under a year she bore her first child, Melitta, in January 1904.

In Klein's own words, "I threw myself as much as I could into motherhood and interest in my child. I knew all the time that I was not happy, but saw no way out" (quoted in Grosskurth, p. 42). However, the distraction of motherhood could not wholly cover a gnawing sense of unhappiness, caught at the intersection of pressures from her mother's impositions, the growing "weakness of [Melanie's] nerves" and depression, as alluded to in correspondence, her unrelenting grief over Emanuel's death, and the pressure to sacrifice her own interests and social life to follow a distant husband as he advanced his career.

While marriage often means a further separation from the influence of one's parents, for Melanie it came to mean the opposite: the history of her short marriage shows the increasing intrusion of a controlling mother as Melanie's own mental health deteriorates: "By May 1909 her fits of weeping and despair had reached such a point that she went to a sanatorium in Chur, Switzerland, for two and a half months …" (Ibid, p. 56). As happened during Melanie's many other departures from home to recuperate, Libussa assumed control of the Klein home, which had increased by one two-year old named Hans, born in 1907. While Libussa's willingness to take parental responsibilities from Melanie may seem like the support of a caring mother, it should be kept in mind that Libussa's correspondence suggests that she herself engineered some of Melanie's absences and used them to escape from Emile's household in Vienna. Grosskurth writes:

> It is a chilling conclusion that Libussa did not want her daughter to be happy, that she did not want her to find fulfillment, and that she begrudged her the enjoyments of which she herself had been deprived when she was young. One remembers that when Melanie was a small girl her mother had told her that she was a surprise – that is, unwanted. It is not at all unlikely that she was subtly emphasizing that no man could ever love her, either her father, her husband, or anyone else. Perhaps it was Libussa herself who had told her that Emile was her favorite. Libussa had been in fierce competition with Melanie over Emanuel [Melanie's brother]. According to Libussa, Arthur [Melanie's husband] blossomed when she was away, the children were much better off without her, and her own mother needed the absence in order to achieve serenity. Melanie was a pampered object, not a loved daughter, but a lap

> dog, who had been taught to sit up and beg and to lie down passively. (Grosskurth, 1986, pp. 57-58).

Perhaps the contrast between this depiction of the relationship between Melanie and Libussa with the one cited above (p. 32) can be reconciled through one of Klein own memories. Regarding her sister Sidonie's death at the age of eight, Klein comments in her autobiography, "I have a feeling that I never entirely got over the feeling of grief for her death. I also suffered under the grief my mother showed, whereas my father was more controlled. I remember that I felt that my mother needed me all the more now that Sidonie was gone, and it is probable that my spoiling was due to my having replaced that child (quoted in Grosskurth, 1986, p. 15). Where Klein remembers the "spoiling" as having been due to becoming a substitute, it seems she does not remember the cost of that spoiling: feeling unwanted as a unique person, a failure unless she lived up to expectations designed for someone else. Both Libussa and Klein's brother Emanuel tended to treat others as plugs to fill a hole of loss within themselves, perhaps leaving Klein with an "unsatisfied longing for an understanding without words … [a] sense of loneliness and derives from the depressive feeling of an irretrievable loss" as she would later describe the sense of loneliness (Klein, 1963, p. 301). In the case of Melanie and her mother, it was a loss of autonomy, acceptance and approval, which foreshadowed her controversial (aggressive?) rise and aspirations within the psychoanalytic community. This sense of "not measuring up" may be one factor that predisposed Melanie to strive for excellence and renown, dovetailing with what Grosskurth described as competitive family dynamics.

Saddled with a yearning for a self free of an oppressive future, Melanie was able to persuade Arthur to move the family (now including Libussa) from the stifling provincial town where they lived to Budapest in the winter of 1909. Meanwhile she had befriended an older woman, Klara, who became a confidant, ally and source of confidence and inspiration

to assert her dominance in the Klein household. Not surprisingly, it was during this period that Libussa suffered the "breakdown" and was sent away to recuperate. "On September 18, 1911, in a letter to Melanie, Libussa expressed relief that Melanie's health seemed much improved. She also proposed to ask Klara to go shopping with her to advise her on purchases for the children. Libussa was beginning to realize that she was no longer indispensable" (Ibid, p. 59). Melanie's recovery was to last until 1914, a year that would radically alter the course of her life.

In July of 1914 her last child Erich was born. By October Libussa had become ill, dramatically loosing weight, which suggested to Klein she had cancer. Klein nursed her mother during her rapid decline in health until her last week of life. Libussa died on November 6, 1914. And (coincidentally?) according to Klein's autobiography, it was "about 1914" that she read Freud's paper <u>On Dreams</u> and knew, "that that was what I was aiming at, at least during those years when I was so very keen to find what would satisfy me intellectually and emotionally. I entered into analysis with Ferenczi, who was the most outstanding Hungarian analyst" (quoted in Grosskurth, p. 69).

When Klein entered analysis with Ferenczi she suffered from acute depression exacerbated by the death of her mother. She was also struggling with a growing dissatisfaction in her marriage and resentment toward Arthur. Her divorce – finalized around 1925 – was precipitated by growing anti-Semitism in Hungary in the wake of the First World War, since it forced the Klein's to leave Budapest. In 1919, the year of her first psychoanalytic presentation and acceptance into the Hungarian psychoanalytic society, Arthur and Melanie separated. Arthur moved to Sweden where he secured employment, and later, citizenship. Melanie and the children returned to her in-laws' in Rosenberg (renamed

Ruzomberok by the new government) until 1920, when she moved to Berlin to pursue a new life as a single mother determined to forge a career in psychoanalysis.

From Crisis to Career

> Accordingly, it is mistaken to view the Kleinian infant as a destructive, schizoid being, because he uses aggressive defenses for a purpose, and only becomes habituated to them in the event of undue suffering and anxiety. And yet, even with this thinking, there is no complacency in Klein's vision. Her infant never becomes an ideal heroic fighter against environmental privations or ill treatment. He remains a tragic being, and himself creates some of the worst obstacles to his own development. This becomes especially evident in Klein's last major paper, her 1957 work on primary envy. (Likerman, 2001, p. 170)

Klein's development as a psychoanalytic pioneer was influenced by two psychoanalyst-mentors, Sandor Ferenczi and Karl Abraham. (Caper, 2000; Grosskurth, 1986; Kristeva, 2001, Likerman, 2001 #48) Melanie Klein developed her ideas and expanded the field of psychoanalysis with their tutelage, as her personal analysts and teachers, to become what Kristeva calls "the boldest reformer in the history of modern psychoanalysis" (2001, p. 16). These reforms were made possible by her invention of the "play technique" and its theoretical and practical implications during her analysis of her own son Erich, known as "Fritz" in The development of a child (Klein, 1921/1975).

The following is a summary of the "play technique" based on three of her papers (Klein, 1926/1975; Klein, 1932; Klein, 1955/1975) First, "it was always part of my technique not to use educative or moral influence, but to keep to the psycho-analytic procedure only, which, to put it in a nutshell, consists in understanding the patient's mind and in conveying to him what goes on in it" (Klein, 1955/1975, p. 129). Second, this "conveying" occurred in the form of interpretations that were spoken in terms the child understood, that were (third) offered from the beginning of the first session and geared towards the level where the child's anxiety was the most active. However, the graphic and bizarre nature of her interpretations

have led detractors of her approach have accused Kleinian, and particularly Melanie Klein, of making 'wild' interpretations, particularly when it came to the things she said to her child patients. Likerman characterizes it this way:

> Technique is psychoanalysis is obviously intimately related to the theory that gives rise to it, and with Melanie Klein this is no exception. Her forthright technique, based on what she called deep interpretations, consisted in addressing the child's unconscious mind directly, hence talking immediately about the hidden symbolic meaning of his play. This was done without first addressing the child's conscious frame of mind and own version of what his game meant. This technique still comes across as blunt because, as initially described by Klein, it appears to bypass the child's conscious participation in the process of exploration, and so trespass uninvited into the child's unconscious mind…. Klein's intention was not to barge into her child patient's mind, but to reach its more inaccessible crevices on the basis of carefully judged and fully contextualized observations. (2001, p. 49).

Fourth, one way Klein inferred what was happening in her patient's minds was on the basis of "contextualized observations" – what occurred between the child and herself in the immediacy of their ongoing relationship. In the jargon, her focus was the TRANSFERENCE understood as the child's whole experience of the analysis (and the analyst) in the present as the reiteration of the child's unconscious phantasy originating in his or her infantile anxiety situations. Thus, her interpretations emphasized the present transference as related to earlier situations. With adults one makes use of reconstructions, whereas with children their conflicts are "directly represented" through their play. Thus, play became the means for gaining access to the child's unconscious thoughts as free association was used when working with adults:

> Take for instance, the case of Ruth who, as an infant, had gone hungry for some time because her mother had little milk to feed her. At the age of four years and three months, when playing with the washbasin, she called the water-tap a milk-tap. She declared that milk was running into mouths (the holes of the waste-pipe), but that only a very little was flowing. This unsatisfied oral desire made its appearance in countless games and showed itself in her whole attitude, For instance, she asserted she was poor, that she only had one coat, and that she had very little to eat – none of these statements being in the least accordance with reality. (Klein, 1926/1975, p.136)

This quote also indicates a fifth characteristic of the play technique: that that content of the interpretations was derived from the symbolic meanings of the child's play within the context of the child's relation with the analyst. Through the use of this technique, first with children and then with adults, Klein:

> aroused a good deal of controversy, she assumed from the outset that a child analysis was to be conducted in exactly the same way as an adult one – except that the analysis of verbal associations was to be supplemented by the analysis of play. She assumed that the transference was possible, observed that a super-ego, though a more rudimentary one, was present, and believed that no moral or educative pressure was to be exerted by the analyst. In other words, she adopted Freud's transference analysis both for adults and for children; and if she later introduced any changes at all these were in the direction of purer transference analysis, her role becoming more and more confined to interpretation. A characteristic which was perhaps the most specific for her technique was that, from the beginning, she always gave preference to the interpretation of unconscious anxiety based on unconscious phantasy wherever she could see it – even when the first results of this appeared to be an increase in anxiety (Introductory remarks of R.E. Money-Kyrle in Klein, 1975)

What was particularly controversial and disturbing for some about Klein's ideas and technique involved the counterintuitive implications of her work, specifically the intense and graphic nature of the aggressive phantasies that she ascribed to infants and children as the cause of pathogenic anxiety and therefore pathological symptoms. Consider Klein's description of the case of Trude:

> I will now turn to consider the content and the causes of these early feelings of guilt by reference to another case. Trude, aged three years and nine months, repeatedly played 'make believe' in her analysis that it was nighttime and that we were both asleep. She then used to come softly over to me from the opposite corner of the room (which was supposed to be her own bedroom) and threaten me in various ways, such as that she was going to stab me in the throat, throw me out the window, burn me up, take me to the police, etc. She would want to tie up my hands and feet, or she would lift up the rug on the sofa and say she was doing 'Po—Kaki—Kuki'. This … meant that she wanted to look inside her mother's bottom for the 'Kakis' (faeces), which signified children to her. On another occasion she wanted to hit me in the stomach and declared that she was taking out my 'A—A's' (stool) and was making me poor. She then seized the cushions, which she repeatedly called children, and hid herself with them behind the sofa. There she crouched in the corner with an intense expression of fear, covered herself up, sucked her fingers and wetted herself. She used to repeat this whole process whenever she made an attack on me. It corresponds in every detail with the way she had behaved in bed when, at a time

> when she was not yet two, she started to have severe night terrors. At that time, too, she had run into her parents' bedroom again and again at night without being able to say what it was she wanted. By analyzing her wetting and dirtying herself, which stood for attacks on her parents copulating with each other, the symptoms were removed. Trude had wanted to rob her pregnant mother of her children, to kill her and to take her place in coitus with her father. She was two years old when her sister was born. It was those impulses of hatred and aggression which, in her second year, had given rise to an increasingly strong fixation upon her mother and to a severe anxiety and sense of guilt which found expression, among other things, in her night terrors. (Klein, 1955/1975, p. 5)

Ultimately, the recurrent presence of aggressive phantasies directed at the destruction of the parents, a parent, or a part of the parent, led Klein to believe she had found empirical evidence of Freud's death drive Thanatos. Specifically, the earliest manifestation of this drive was figured as constitutional ENVY, the urge to destroy difference and change by destroying the differentiator that causes it. This begins with the mother's breast as its first object, occasioned by the painful frustrations of weaning. In a state of hunger the infant wants milk but there is not any there; there is a difference between what it wants and what it has. This difference is hated and the angry infant blames the breast for causing it. The infant wants to destroy the "withholding breast" and the milk he or she wants inside it. The infant has a grievance over his or her dependence. In the case of Trude, described above, it was no longer her mother's breast that she envied but her mother's womb that she wanted to destroy by greedily devouring what the mother had but Trude did not – special objects of her father's desire. However, this hatred was attributed to terrifying imaginary characters at night. Trude's anxiety of death was anxiety over her own aggression and its ramifications.

Either too much constitutional envy (aggression), inadequate mothering to help the youngster deal with painful experiences (which also gives rise to envy), or some combination of the two, will impair development of the capacities to love, feel secure, and have a sense of

confidence and autonomy, since this aggression that has been unmitigated remains a source of self-destructiveness:

> In contrast with the infant who, owing to his envy, has been unable to build securely a good internal object, a child with a strong capacity for love and gratitude has a deep-rooted relation with a good object and can, without being fundamentally damaged, withstand temporary states of envy, hatred, and grievance, which arise even in children who are loved and well mothered. Thus, when these negative states are transient, the good object is regained time and time again. This is an essential factor in establishing it and in laying the foundations of stability and a strong ego. In the course of development, the relation to the mother's breast becomes the foundation for devotion to people, values, and causes, and thus some of the love which was originally experienced for the primal object is absorbed … the feeling of having injured and destroyed the primal object impairs the individual's trust in the sincerity of his later relations and makes him doubt his capacity for love and goodness. (Klein, 1957/1997, pp. 187-189)

Klein's work as a whole testifies that she wanted a complicated picture to account for the person's inability to deal with life's hardships – not just an overly simplistic account that blames the environment on the one side or the person on the other. Her account of envy straddles this opposition by accounting for two innate factors that cannot be easily differentiated. One is that the person is born with too much constitutional anti-life force. However, this is related to the second, one is born with too weak an ego to deal with the same amount of destructiveness that everyone else is born with. In either case these factors contribute to the person's ability to handle deprivations in their dependency on others and the world. Anxiety is the result of feeling unable to cope with the vicissitudes of having and not having what one expects.

For Klein the capacity to tolerate anxiety and deal with it in the most adaptive way by strengthening one's attachments to depended upon others, depends upon the firm establishment of a good object in the ego, the sense that the self is sturdy, creative, safe and capable of recreating security and love in the face of events that show these necessities of life are missing. In other words, externally viewed, the good in the world can be lost because it

can and will be recreated; internally viewed, one can tolerate one's shortcomings and acknowledge one's flaws without disproportionate anxiety because the loss of the sense of the good in one's self (i.e., guilt) is also temporary and can be reversed by the self (i.e., reparation).

While it is beyond the scope of this study to fully explicate the complexity of Klein's metapsychology, the point of examining envy is that Klein shifted the definition of analysis by articulating a feature of every patient to some extent or another in terms of the anxiety of destruction that is built into the person and the importance of analyzing the patient's self-destructive tendencies as they manifest themselves in the transference anxiety:

> This leads me to a conclusion regarding technique. During an analysis the psychoanalyst often appears as an idealized figure. Idealization is used as a defense against persecutory anxiety and is its corollary. If the analyst allows excessive idealization to persist – that is to say if he relies mostly on the positive transference – he may, it is true, be able to bring about some improvement. The same, however, could be said of any successful psychotherapy. It is only *by analyzing the negative as well as the positive transference* that anxiety is reduced at its root. (Klein, 1950/1975, pp. 46-47, emphasis in original)

Analyzing the negative transference is crucial because as it is traced it will lead to examining the patient's difficulties dealing with deprivation and the habitual ways of not understanding and relating they have used to avoid this unavoidable element of any significant relationship. Stated differently, beginning with Klein but extending beyond her as the Kleinian tradition has expanded, the focus on the deepest source of anxiety has resulted in concepts and techniques for examining how a patient's habitual ways of relating are used to avoid the recognition and understanding of the painful aspects of experience.

> Because Klein understood anxiety, that conduit of pleasure, more deeply than anyone else, she turned psychoanalysis into the art of caring for the capacity for thought. Attentive to the death drive that Freud had already incorporated into psychic life … Klein considered the death drive to be the primary agent for our distress, but also – and especially – for our capacity to become creatures of symbols…. Under what conditions are the anxieties that tear us apart amenable to symbolization? That is the question that Klein uses as she reformulates the analytic

> problem, a question that places her work – unwittingly so since she was most notably a courageous clinician and in no way a "master of thought" – at the heart of humanity and the modern crisis of culture. (Kristeva, 2001, p. 14)

A story of Induction

As in the case of biographies on Klein, there have been several works within the psychoanalytic literature that explicate how her pioneering work has developed beyond her into what has been called neo, contemporary, and even post-Kleinianism.[11] These texts emphasize the evolution of her basic tenants such as the DEPRESSIVE POSITION, PARANOID/SCHIZOID POSITION, SPLITTING, PROJECTIVE IDENTIFICATION, INTROJECTIVE IDENTIFICATION, PHANTASY through the work of her protégées and those who have studied under them, as well as new concepts and techniques that they have developed (cf., Caper, 2000; Hinshelwood, 1994; Mitchell & Black, 1995; Ruszczynski & Johnson, 1999; Sayers, 2000; Schafer, 1997; Spillius, 1988a; Spillius, 1988b). Since many of these concepts will be introduced and explained in the context of the session to be studied in the following chapters, they will not be explicated here. This section, then, provides a segue to the rest of the study by describing how the author was introduced and became involved in the Kleinian tradition.

Competence is an "anxiety arousing area for the novice therapist," as Teyber(1992) understated, and probably most clinicians remember. It has been argued that a central feature of anxiety is the ability of the anxiety-provoking situation to "reveal affectively to the individual his/her now uncertain power to realize his/her projects and self understandings" (Fischer, 1982, p. 75). Training in clinical psychology offers many venues for facing one's

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[11] To date the author has not found a definitive source that differentiates the terms neo, contemporary or post-Kleiniansim.

abilities in an uncertain light, and one's sense of one's self put into question. "What am I doing?" "What just happened in there?" "Did I do it right?" – whether "it" refers to psychotherapeutic interventions, paper presentations, lectures delivered to undergraduates, or written reports. Throughout the first few years of clinical work to become a psychologist there are moments of feeling a sense of greater competence, reaching a moment of clarity and slightly altered perspective. Then, self-doubt and confusion set in again. Learning to be a therapist is more akin to dancing on carpet than a vertical climb: each shuffle stirring static anxiety we discharge on those around us. During fleeting moments of savoring pride, we may reflect and smile to ourselves, "I think I've finally gotten it." But what has been gained and how are the changes to be understood?

During the first two years of supervised clinical training I struggled to integrate theory and practice to develop my sense of confidence and competence. The first year was strange. I felt more like a fraud than a therapist – that while I was trying out the role of a therapist the identity of a therapist did not yet fit with my sense of who I was. I did not feel I had a coherent way to think and speak about my cases, let alone supervise and guide myself through the course of treatment, which I believed being able to integrate theory and practice would allow. I had a vocabulary of technical concepts, but I did not have a way to discern if what the client was doing and saying was an example of one of these concepts. Even more distressing was the realization that I did not have a way to discern whether what I was doing was an example of one of these concepts. My professor would ask, "Why did you do that?" I would think to myself, "How should I know why, I'm not sure what it is you've noticed I've done!" I wanted a language for understanding my clinical experiences – not to naively try and fit the client into a box, but to empower myself to be able to learn from texts that

used these concepts and employ the theory to help deepen my relationship with my clients and provide more effective interventions.

While having been exposed to several theoretical orientations, the one I became most interested in pursuing was object-relations theory. During my third year of doctoral work I was required to be supervised by a licensed psychologist practicing in the metropolitan area. The department had a list of several psychologists who had been working with the department under individual contracts as adjunct faculty. Near the end of my second year of training, I learned that two of these adjunct faculty supervisors were resigning. I saw an opportunity and received permission to contact Dr. R and asked her to supervise my work for the following year.

I became interested in working with Dr. R after hearing secondhand tales of her group supervision and staff presentations on working with personality disorders to the community mental health center where I had been working for twelve months. A "yes but no" refrain characterized the other therapists' reactions to her work and her style: "I was really impressed by the level of insight, but I could never say things like that to my clients – they'd leave the room!" "It's amazing . . . But she's too direct for me;" "I'm sure she'd make you work hard as a supervisor, but she's not for the faint-hearted." Who was this woman who drew such strongly ambivalent reactions from professional clinicians? My sense was that Dr. R was one of those people whose direct manner can put-off some people, yet they couldn't completely dislike her because on some level they liked and respected what she had to say. All I knew at the time was that she had been trained by James Masterson, earning certificates in the practice and supervision of psychoanalytic psychotherapy, and was currently on the faculty of the Masterson Institute for psychoanalytic psychotherapy. It was not until I started supervision that I learned, she had been supervised for six years by

Alberto Pieczanski, MD., a Kleinian analyst trained at the Tavistock and Portman Clinics and a member of the British Psychoanalytic Society – supervision that she continues to this day.

Perhaps what appealed to me about this was that I still felt frustration about the quality of my work. I believed I hadn't harmed any of my clients, but I wasn't sure I had helped them either, let alone be able to critique and redirect my work on my own. Retrospectively, I was frustrated that a broad exposure to different therapy schools left me without a solid foundation from which to evaluate the relative merits or demerits of the different schools of thought and practice. It's like the difference between deciding to become a martial artist but instead of picking one martial art and devoting years to its mastery you train for two years in Judo, two years in Karate, and two years in Kung Fu, and then believe you're a martial artist of six years. Well, you may be in the sense you can practice a little of each, but you're not going to be able to handle the challenges that a person who has spent six years studying one of them will be able to, let alone handle them with the grace and artistry that only comes with *focused* discipline.

From reading object-relations theory and examples of its clinical application, I had come to appreciate it for its conceptual complexity and clinical application for the treatment of persons struggling with what are known as the "personality disorders." I had developed an interest in working with people who struggled with personality issues, but I did not feel equipped to work with the unique challenges these clients present. In short, after two years of clinical work I did not feel as though I had a good enough grasp on what I was doing, nor how to monitor, learn, and grow more independently as a clinician. So I thought Dr. R might be the right person to supervise my work.

"Since we have never met before, what happens if after working together for a while you decide to change your mind?" Dr. R asked, having heard my request and a description of the university's contract. I told her that the only time I had been angered by a supervisor or professor's ego was when it got in the way of doing the work, and that that was the only way I could see things becoming a problem. We next spoke three or four months later to schedule our first meeting.

I began thinking about this study in the context of my excitement and enthusiasm about working with Dr. R: using her suggestions in the treatment of my clients, noticing how things changed in the treatment, and noticing the interest of fellow students when I told stories about my experience. After discussing with some of my fellow students her supervisory style and some of the Kleinian techniques and conceptual terms I had been learning, I decided I wanted to study "what was happening" in my sessions in some way as a result of my supervision.

The following chapters employ an interpretive methodology to articulate "what was happening" in one session with one patient after two years of supervision with Dr. R, participation in my own psychotherapy, and readings in Klein and contemporary Kleinians who:

> differ from Klein in their de-emphasizing and deferring detailed reconstructions of early developmental history. They prefer instead to stay, for as long as possible, close to, almost fixed to, the shifts of unconscious fantasy in the here-and-now clinical situation and most of all the transference. … These Kleinians further differ from Melanie Klein in their emphasis on induced countertransference as an invaluable form of communication or least a source of information. Specifically, they try to understand countertransference in terms of projective identification, that is, the analysands's unconsciously allocating to the analyst negative or positive aspects of his or her own self or other internal objects in order to get rid of them, use them for the control of others, or protect them from internal destructiveness … these Kleinians no longer [unlike Klein] consistently or prominently emphasize bodily organs as primitively conceived part objects representing total relationships (e.g., the devouring breast). They focus much more on what might be called organ modes such as taking in or emptying out, and also on functions such as thinking,

> understanding, connecting, and remembering. In general, they use terms that correspond closely to conventional experience in human relationships, such as *hope*, *despair*, *dependency*, *denial*, and *idealization*. Additionally, they no longer engage in rapid-fire, symbol-laden interpretations of whatever manifest content comes their way, being rather measured in the speed and quantity of their interpretations, as well as oriented toward gathering immediate evidence on which to base each aspect of their interventions. They favor "showing" over "telling" what's what … these Kleinians seem to find signs of transference in everything, I shall discuss next this way of looking at events in the analytic session. In order to do so, it will be necessary to take up as well countertransference, projective identification, containment … for these concepts are intertwined with here-and-now transference analysis. (Schafer, 1997, pp. 4-5, emphasis in original)

Likewise, the following chapters aim to examine and articulate "this way of looking at events" from the perspective of a novice who has been intent on learning and integrating it with his own practice of psychotherapy even though it is not psychoanalysis. If the following interpretive analysis is successful, the reader who is not familiar with the technical jargon in the quote above, will, by the end of the dissertation, be able to understand the distinctions Schafer is making. For the reader who is familiar with the technical terminology, my hope is that by the end of the dissertation my work bears some resemblance to what Schafer is describing.

3. The feed

> With regard to the symbolic level, the interpreter has to deal with implicit, deep-seated ontological assumptions held by the subject she investigates. These assumptions provide a "horizon of intelligibility" for an infinite number of possible utterances and applications that are open to subjects within the realm of a specific symbolic order. Thus, the target of critical interpretation is this existing "ground of possibility" that makes specific beliefs and convictions look rationally acceptable to the subjects themselves. Kögler (1996, p. 259)

> In their developed forms, phantasy thinking and reality thinking are distinct mental processes, different modes of obtaining satisfaction. The fact that they have a distinct character when fully developed, however, does not necessarily imply that reality-thinking operates quite independently of unconscious phantasy … In our view, reality-thinking cannot operate without concurrent and supporting unconscious phantasies; e.g., we continue to 'take things in' with our ears, to 'devour' with our eyes, to 'read, mark, learn and inwardly digest', throughout life.
> These conscious metaphors represent unconscious psychic reality. It is a familiar fact that all early learning is based upon oral impulses. The first seeking and mouthing and grasping of the breast is gradually shifted to other objects, the hand and eye only slowly gaining independence of the mouth, as instruments of exploration and of knowing the outer world. … Perception and intelligence draw upon this source of libido for their life and growth. Hand and eye retain an oral significance throughout life, in unconscious phantasy and often, as we have seen, in conscious metaphor. (Isaacs, 1952, pp. 108-109)

Imagine a home where there is a baby and his mother. The baby is on a feeding schedule and around the time he is due for his next feeding he starts to move and sound in such a way that the mother turns to you, her friend, and says, "oh, he's cranky, he must be hungry. Let me get his bottle ready." The mother gets everything ready and sits down to feed him, talking to him the whole time as if he understands what she is saying. She burps him, returns to you at the table and continues your conversation while intermittently turning to him to keep him entertained. This vignette is not surprising. Everything seems completely plausible. Yet what may seem odd is to characterize it as an example of Foucault's definition of power relations: relations where actions act on the actions of the participants to influence or shape their experience and subsequent behavior. (cf., Foucault, 1982, p. 220). Of course the power relations are asymmetrical since the baby

is utterly dependent on his mother for all of his survival requirements, whereas she has other sources and resources at her disposal for securing her own.

This is one way that the therapeutic interaction of CKPP "is a feeding on the model of a baby and its mother" as Dr. R had told me time and again. It is viewed as an asymmetrical relationship where the patient is dependent on the therapist's specialized practices and understanding to examine what he or she needs and is unable to provide for him or herself – hence, the reason the patient ends up seeking a therapist. There are other similarities as well. The times of these feedings are regular – if it were a psychoanalysis they would repeat daily at the same time, four or five days a week. Third, the feedings are focused on the requirements of the patient and the therapist's role is to figure out the requirements with the patient and provide them within that role, which, as Segal writes "is confined to interpreting the patient's material, and all criticism, advise, encouragement, reassurance, and the like, is rigorously avoided" (Segal, 1981, p. 3). Fourth, the setting of the feeding is set up so the patient, like the baby, is made to feel as comfortable and secure as possible – a feeding baby is spared anxieties about being dropped, for example, while feeding (the mother holds the baby so all he or she has to focus on is the experience of feeding, as it were.). Likewise, the patient is assured that the room within which the feeding occurs is free of outside distractions, including privacy concerns so he or she can focus on purpose of their visit.

Finally, there is the expectation that what the patient and therapist do together is based on how they understand what each other is doing. The mother's actions depend on how she interpreted his sounds and gestures – his communications. Her interpretation that "he's cranky. He must be hungry…" is made possible by a backdrop of understanding, her preunderstanding that "is internally differentiated into a symbolic sphere of basic beliefs and

assumptions [of what constitutes baby reality], a practical sphere of acquired habits and practices [how she's learned to handle feeding], and a subjective sphere that reflects biographical events and experiences [he likes to be held this way and not that]". (Kögler, 1996, p. 251). But can the same be said of the infant's actions? In what sense can an infant be said to have a preunderstanding? Is not the infant's "relief" and "pleasure" after feeding just a physiological reflex? Can it be characterized as an understanding? Within the Kleinian tradition, the answer to that question is an unequivocal yes. The baby is born with an apparatus (a PRIMITIVE or early EGO) for understanding what the mother does through his or her experience of the mother and a repertoire of "practices" (called PHANTASIES) for dealing with its ongoing developing set of basic beliefs and assumptions about his or herself, the mother, and the world (called OBJECT RELATIONS). Moreover, the set of basic assumptions of the Kleinian tradition includes the beliefs that these infantile practices persist through adult hood, informing or shaping the person's sense of who they are and what constitutes reality between people, particularly the painful realities that motivate people to come into therapy.[12]

The following analysis shows that CKPP is a kind of critical hermeneutics in so far as critical hermeneutics:

> …undertakes to lay out a concept of reflexivity-in-interpretation that allows the individual to distance herself from the taken-for-granted background of symbolic assumptions and social practices. The critical practice of self-distanciation is to bring about a heightened sense of self-understanding, and enlightened insight into usually hidden linkages between symbolic relations and social networks of power. Such critical practice aims at a reflexive understanding of the usually unnoticed implications of meaning in the reproduction of social power mechanisms. (ibid., pp.251-252)

[12] As Segal writes regarding a primary difference between classical Freudian technique and Kleinian technique: "All the patient's communications in the session are viewed as containing an element of unconscious phantasy, though they may seem concerned with incontrovertible external facts" (Segal, 1981, p. 8)

In this citation, Kögler is referring to "social networks of power" in the sense of macro social networks that regulate entire cultures or subcultures. However, social relations of power exist at the level of two people, like the mother and the infant and the patient and the therapist. The way CKPP employs "reflexivity-in-practice" that allows the patient to self-distanciate is through the communicative behavior of the therapist; the therapist performs it, embodies it – feeds it to the patient as a practice by making assertions about the patient's sense of herself as she experiences her interaction with the therapist, providing an occasion for her to notice how she participates in constructing and relating the identities that structure her experience. In other words, by communicating as a certain kind of Other, the patient has the opportunity to gain potentially emancipatory insights into him or herself. In Kögler's language, "With the loss of the Cartesian and Hegelian subject, the other becomes the point of departure for critical insights into the self" (p. 252).

Specifically, the analysis below shows how the author, as therapist and novice of CKPP, communicated or "fed" such "critical insights" to the patient, Mrs. P, about herself. The "insights" are sightings/citations of alterity, which ultimately raised the saliency of a fearful voice that belongs to a dying orphan-self, which, ironically, perpetuates its orphanness (self-understanding/experience) through employing a practice of power – deflecting speech practices to distance the Other. The how of this citation making is broken down into three aspects: the setting or 'scene' of the feeding, 'the food,' and the manner or approach of 'the feeding' – how it was adjusted for consumption. While all three of these aspects were operative throughout the session, overlapping with one another, it would be too cumbersome rhetorically to examine them all at once. So, as is the case with many things, what can be separated for purposes of analysis cannot be in practice.

The scene

It's about 2:55 on a late September afternoon, 2001, barely a few weeks after the disastrous attack on the World Trade Centers. I will be seeing Mrs. P in a few minutes for our 6th meeting together since she started treatment. It's our last session before she takes time off to attend her daughter's wedding out of state. It is also our last week of once- a-week therapy as Mrs. P agreed with my recommendation that she come for therapy at least twice-per-week. Outside the office I hear the outer door open and some wheels roll into the waiting area. The rolling wheels belong to a medium-size suitcase Mrs. P uses as a portable office, pulling it to and fro from one end of the campus to another – highlighting her hurried look, like a stewardess crossing from one late plane to another, putting out customer complaints along the way with pressurized warmth and smiles.

The office is rectangular in shape, with an east-west orientation – when the doors are open to the outer hall I can see the morning sun as it rises in the east. The desk faces north at one end of the room, opposite the door. The chair Mrs. P uses faces me but not directly. Her direct line of sight intersects mine at an obtuse angle, such that she must turn her head to the right at about 2 or 3 o'clock to make direct eye contact. Mrs. P, a thin, handsome, late-middle-age woman, mother, and intern in pastoral counseling, works for the same university based hospital that sponsors the psychology internship program where I am working.

I open the door and call her name, leaving the door open as I return to my chair behind the desk. Propping one ankle on the other knee while leaning back in the chair creates just enough room for my arms to rest comfortably on the tablet in my lap. Mrs. P rolls in her carry-on office, sits down, and then gets up, remembering that she has something she wants to give me. Following Dr. R's instruction some two years earlier, I say nothing

once I sit down and wait for Mrs. P to start talking – or doing whatever she feels the urge to do.

Mrs. P found the envelope she's been looking for and hands it to me, explaining:

001 The three or four of these are the silences that I wasn't able to come up with anything for. I'm trying
002 to survive his week.

After writing down what she says, I open the envelope and see that she has handed me a 'Sentence Completion' form – two pages of incomplete sentences that require the respondent to write in the answers. The "silences" Mrs. P mentions (001) refer to three blanks or sentences that she did not complete, even though she had the form for three weeks.

Mrs. P, by taking the initiative to talk, shows that she understands my silence as a sign that she should begin the session by taking the first turn. Her opening utterances (001-002) are explanations for the incompleteness of the form – much like the fact that one feels the need to explain a "no" when invited to do something, but not a "yes" since "yes" is the culturally preferred response to a request. It is as if Mrs. P is saying, "I'm too busy to do them." After all, in work settings the expression "I'm trying to survive" is usually taken as an expression of busyness. Emotionally, it is not clear how she is grasping the form, herself or myself. Is she too busy as in too busy to bother with such a stupid request, or too busy as in I'm sorry I've failed and feel bad? In any event, her second utterance is unclear with regard to the context against which "I'm trying to survive" is to be understood. Is she trying to survive at this moment, yesterday, the last two days, etc.?

"One of the easiest ways to hurt me is…," "In relationship to me I wish men would …," "In relationship to me I wish women would…" I read over the sentences she left

blank. While I don't recall what I thought, here is what I wrote down before I said it to Mrs. P:

003 I think you're feeling overwhelmed inside and don't know quite how to deal with the feelings of
004 being scared inside.

In conversation analysis (CA) one examines a subsequent utterance to discern how the participant understood the prior one. This response shows that I understood the topic Mrs. P forwarded for discussion was something about her state-of-being at the moment – the temporal context is the on-going moment of "you're," the second-person singular contraction, present tense of 'to be.' This state – or identity – was understood as being desperate, based is seems on her identity claim, "I'm trying to survive this week." However, it should be noted that this is an unconventional move, since most of the time if one hears comments like Mrs. P's one interprets them lightly, as if mere tongue-in-cheek hyperbole, particularly if one is speaking in the work setting to a coworker.

In terms of the interpersonal movements or pragmatics of emotion, my move shows interest in who she is as the focus of my attention, an attempt to move closer to her concern. However, as an initiate of CKPP there is a body of knowledge and tradition of technique that talks about what I was doing in a highly specialized way. Specifically, part of my role as Mrs. P's therapist is to maintain the optimal conditions thought necessary for therapy to occur; these optimal conditions are called the FRAME of therapy. The rules that make up the FRAME include the fee, time of regularly scheduled appointments, privacy, and guidelines for when, what, and how to speak, as well as guidelines for when, what, and what not to do.

One of the first 'rules' I learned from Dr. R was to stop saying anything at the beginning of the session and to let the patient begin, unless there is something I need to mention that requires an exploration of the patient's reaction – as in the case of having to

cancel an appointment. The reason for this is that even something that seems benign, like, "How are you today?" can impinge on the patient, since it invites an "fine" or could invite a report on things, which some people (including the therapist) can use to avoid talking about what is really bothering them (and may be upsetting for the therapist to hear). So, if I were to start the session by speaking it may restrict Mrs. P's freedom to begin wherever she wanted to begin, which is what I was interested in – because where she begins and what she begins with provides the entry point for examination. In the event I have something to tell Mrs. P that alters the frame (like changing appointments) that warrants exploration, her response to what I have introduced becomes the entry point. In the jargon, by refraining from speaking at the outset, I minimize possible "contamination" of the patient's presenting MATERIAL – whatever they say and do, in this case at the beginning.

In other words, the FRAME I have learned is made up of rules; it is an apparatus of controlled conditions – for the operation of establishing and testing hypotheses or preconceptions as they structure the "horizon of intelligibility" in Kögler's language.[13] They are the conditions that allow the phenomenon to be examined, just as scientific experiments require controlled conditions. In the laboratory of therapy, however, it is about exposing through trial-and-error hypothesis testing the regime that governs the occurrence of misery in each unique patient's life, component by component. And by exposing these components, patients have the chance to recognize them, how they figure into their problematic experiential present, and to decide what they want to do about them now. In short "maintaining the frame" as the topic is called in the literature, is about maintaining the

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[13] Of course, this is not to say that the manner of speaking is not important. The statements I make in the following sessions can be said with a soft tone, for example, while still not conveying either approval or disapproval of the patient's experience, beliefs, or behavior. The tightrope here involves showing acceptance (interest + compassion = acceptance) without indicating either approval or disapproval.

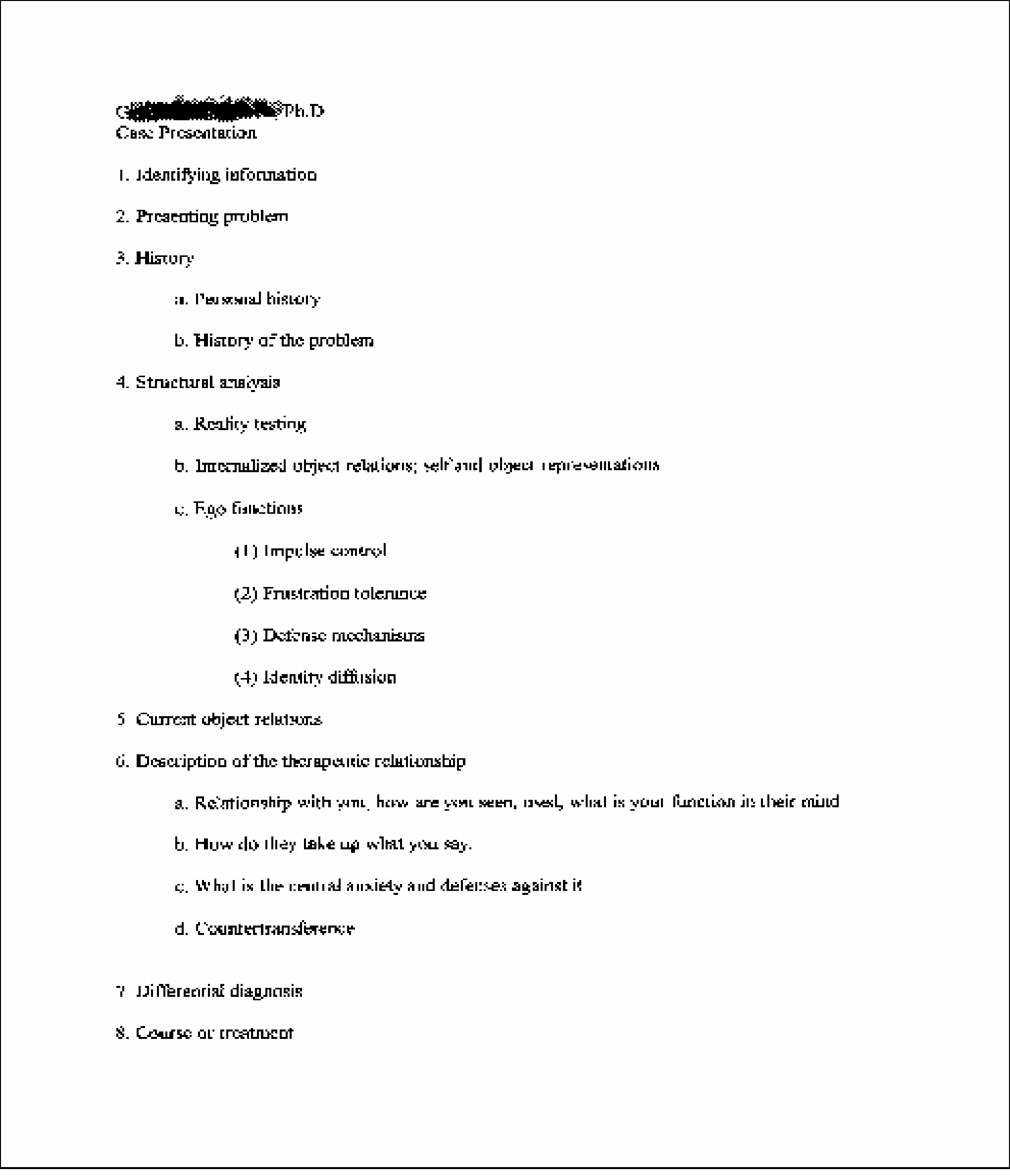
conditions necessary for examining together at the edges of the unknown in the person's life (the UNCONSCIOUS), so it can be thought *as* it is experienced.

Early in my training with Dr. R she gave me a sheet of paper entitled Case Presentation, which has been scanned into this document (Figure 1, p. 60, below). This sheet provides an outline for formally presenting a psychoanalytic case. Dr. R told me that our supervision – and my therapeutic practice – would focus on the questions listed under section 6, the "Description of the therapeutic relationship." Although listed as four items, over the last two years I have memorized them with slightly different wording and broken the first question into two separate questions to make remembering them easier, I suppose: "What is the main anxiety?" is one of the questions. The others are: "How does the person see you?," "What does the person do with what I say?," "How are they trying to use you?," and "What does it feel like inside to be with this person?" These questions provide a structured entry point for examining the patient's PSYCHIC REALITY and how it is organized – created, recreated, maintained, and perpetuated. – outside their everyday awareness.

In the lingo of contemporary Kleinian psychoanalytic psychotherapy (CKPP), the phenomenon to be jointly examined is the patient's PSYCHIC REALITY (cf., Caper, 1999; Hinshelwood, 1994; Segal, 1964; Spillius, 1994), specifically, the part of PSYCHIC REALITY that causes misery, the PATHOLOGICAL ORGANIZATION (cf., Steiner, 1993). While there terms will be defined more fully as this interpretive study proceeds, a bit more detail is in order to explain why my speech specified (003-004) "inside" as the context for the topic of Mrs. P's feeling "overwhelmed" and "scared."

As I have learned from Dr. R, the opening speech of the patient is very important, since it gives the clearest indication of the patient's MAIN ANXIETY of the moment, prior

to any input from me during the session, an anxiety that shapes whatever the patient says or does during the session and therefore provides the touchstone for the therapist's interventions. This anxiety is based on the patient's INTERNAL OBJECTS – his or her early ways of experiencing states-of-mind in relation to important people (a.k.a. EXTERNAL OBJECTS) that are felt to be inside, what we "contain" within the boundary



G[illegible] Ph.D
Case Presentation

1. Identifying information
2. Presenting problem
3. History
    a. Personal history
    b. History of the problem
4. Structural analysis
    a. Reality testing
    b. Internalized object relations; self and object representations
    c. Ego functions
        (1) Impulse control
        (2) Frustration tolerance
        (3) Defense mechanisms
        (4) Identity diffusion
5. Current object relations
6. Description of the therapeutic relationship
    a. Relationship with you, how are you seen, used, what is your function in their mind
    b. How do they take up what you say.
    c. What is the central anxiety and defenses against it
    d. Countertransference
7. Differential diagnosis
8. Course of treatment

Figure 1

Psychoanalytic Case Presentation Document

of the "me" – the "parts" of ourselves that make up our sense of identity. PSYCHICH REALITY is made up of INTERNAL OBJECTS that mediate how events and people are experienced (interpreted, understood, and related to), because:

> Our internal objects are manifestations of both how our objects feel or act towards us and how we feel and act towards our objects. The two combine to produce an object that we unconsciously experience as being inside us in a very specific state; we are in a very specific relationship to them, and they are in a very specific relationship to us. That is, we are doing something to them and they are doing something to us in kind to us. … while what we call a state of mind may be the same as an internal object, our internal objects – detailed unconscious phantasies of what we contain – are far more vivid, detailed and varied than our ordinary vocabulary for states of mind – such as depression, guilt, love, security, elation, and so on – can convey. A large amount of the time consumed by psychoanalysis is devoted to capturing the very details, nuances, and ramifications of the states of mind so crudely represented by these terms. (Caper, 1999, p. 56)

PSYCHIC REALITY, then, is made up of INTERNAL OBJECTS which are far from static, discrete things; they are made up of micro, narrative-like structures called PHANTASIES (spelled with a PH to denote that they are unconscious) that are graphic recordings of (1) our external objects existing inside us in (2) some condition or other as a result of our relationship to them, displaying (3) some intention towards us on that basis. (cf., Isaacs, 1952) In other words, INTERNAL OBJECTS refer to our dynamic and recycling identity dramas – our shifting "states of mind" as people say – with self-part A doing something X to object-part B, which in response wants to do Y to A, and so on, all linked by a logic of emotion that predates linguistic understanding.[14]

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[14] Hinshelwood(1991) offers the following definition of the UNCONSCIOUS as it is understood by Kleinian in terms of PHANTASY and OBJECT RELATIONS:

> The unconscious is structured like a small society. That is to say, it is a mesh of relationships between objects. And unconscious phantasy is a state of activity of one or more of these 'internal' object-relations…. Thus a somatic sensation [instinct] tugs along with it a mental experience of a relationship with a object that causes the sensation, is believed to be motivated to cause the sensation and is loved or hated by the ego according to whether the sensation is pleasant or unpleasant. In this way a sensation that hurts becomes a mental representation of a relationship with 'bad' object that is intending to hurt and damage the ego. *The unconscious – and, indeed, the mind, – is constructed of sensations interpreted as relationships with objects.* This concept eventually departed from the classical psychoanalytic theory of mental energy. (pp. 467-468, emphasis added)

Continuing the example of the mother feeding her baby can illustrate how this process might occur. Suppose the baby is a six month old, lying in his crib around feeding time. His mouth is puckering and he is making a sucking motion with his lips. After some time he starts to cry for food, but his mother is too busy to come for some time and when she finally does he continues to cry even when presented with the bottle. After some cooing and comforting, he finally settled in for a good feeding. From the Kleinian view, we could say he initially soothed his hunger (urge or INSTINCT) for food by hallucinating the experience of being fed by the gratifying breast (hence, sucking at the air is the bodily expression of the phantasy). However, as the pain grew in his stomach, this distortion of reality no longer worked (his mother was not really there) and in his pain he began to feel as though he would die. Outraged, he phantasizes that he was pained on purpose by a nasty, withholding breast (persecutory object) that he hated. When his mother finally arrived (the external object) was resisted at first because within the context of pain and anger she was grasped as bad and persecuting (a distortion of her identity). The language of phantasies and internal objects is thus a way to articulate in language what was a sequential chain of experiences before language that constituted the infant's experience based on his sense of himself (identity) in relation to his sense of his mother (how he sighted her identity). "The earliest phantasies, then, spring from bodily impulses and are interwoven with bodily sensations and affects. They express primarily an internal and subjective reality, yet from the beginning they are bound up with an actual, however, limited and narrow, experience of objective reality" (Isaacs, 1952, p. 93).

Hence, while Mrs. P's speech was vague in regard to the context to which she was referring in her opening utterances, mine was not. I sighted/cited "trying to survive" as her state of mind tied to her insides ("inside you" 003) as she sat across from me, invoking that

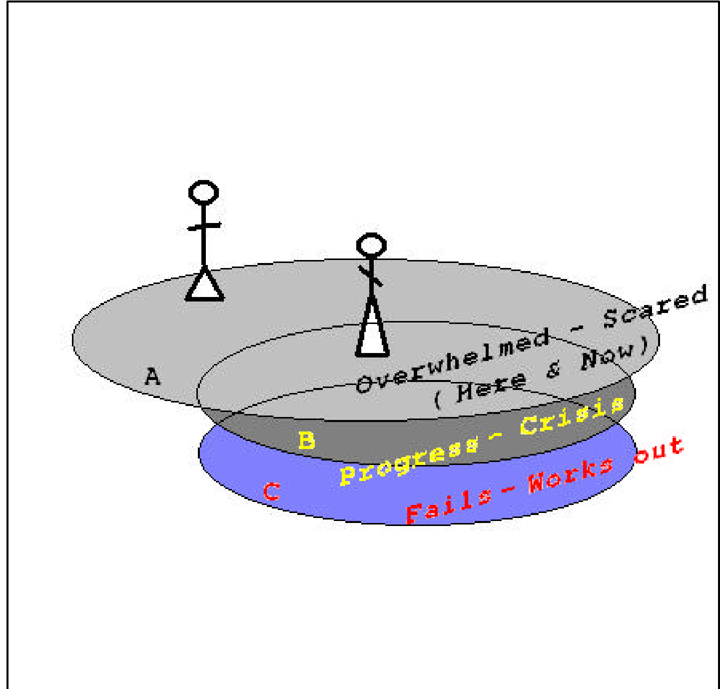
elastic, vague, and invisible yet experientially real boundary line that divides the sense of oneself from someone else, the "me" from the "not me" – referred to in the jargon as one's PSYCHIC SKIN (cf., Bick, 1967/1988). In regard to the question of what is Mrs. P's MAIN ANXIETY, my utterance, an assertion, was positing the theory that it had to do with "feeling overwhelmed" and "scared," although it could not be more specific without further MATERIAL to interpret.

005 Mmmhmm…[T] Yeah, and it's ironic too because at the same time I feel like I'm making progress
006 in my new post and in a way my confidence in growing. In one sense it's all brand new and in
007 another it's what I've always thrived on – it's like crisis. It's not always successful – the visitations
008 with patients. When people in crisis or end of life issues, but it somehow works out – but it's a
009 success when I make out a report and evaluate my work, but I guess at the same time I go with
010 whatever is my fear or maybe I'm making someone else's fear my own. Oh, in chaplaincy I saw it
011 addressed this week on television this whole things of counselors being sought out like madmen doing
012 all these services and work. It's what people demand or ask for. But the chaplains are probably the
013 most pathetic ones when you get a group together you say, "I don't know what to say," which gets
014 people to talk about fear. Whatever I'm afraid of when someone is going to get in there, on my fear
I 015 deflect them.

016 And I'm seeing it in here that when I just approached your fears of falling apart a part of you got
017 scared and deflected us by focusing on crisis as an abstract concept. It's like you drop your feelings
018 that feel overwhelming as if we couldn't tolerate them.

Initially, Mrs. P ratifies my understanding (003-004) and interest in her fear about being overwhelmed – the [T] in my notes indicates moments where Mrs. P began to tear. She then describes something (her state, her identity, her week, both?) as "ironic" (L 005), not what it seems. Given the "it's" point of contrast is "progress" and "confidence," (L 005-006) she seems to be elaborating on "overwhelmed" (L 003) and "scared" (L 004). However, she has shifted the context from the here and now of the relationship with me to the context of her work – her "new post" (L 006). She continues the parallels of progress-confidence with "not always successful" (007) – "somehow works out" (008) to my original overwhelmed-scared. Schematically, Figure 2 (below, left) shows the progression of these topics in three different contexts. My comment was geared at context A, the here and now

concern of Mrs. P and her emotional state. She shifts to her work context in the hospital (B), in which case lines 006-007, "In one sense it's all brand new and in another it's what I've always thrived on – it's like crisis" may be a narrative abstract, summarizing the point of the story(ies?) she wants to tell (context C, the 9/11 crisis). However, her utterances never tell a complete narrative; they offer fragments of narratives – a character here, a situation there, but nothing complete.



Indeed, with the speed of an on-line conversation, or even an initial reading, her responses produce a dissonance of understanding. If this were said in an everyday conversation the expected reply might be, "What?" even though Mrs. P returns to the topic of her fear at the end. So, the pragmatic effect of her speech practice is to derail understanding or "alignment" in the terms of CA.

This is important, because Mrs. P's move in response to mine is to produce speech that cannot be interpreted using the basic set of conversational principles that make everyday conversation possible – Grice's cooperative principle and maxims: "say no more or no less than is necessary," "be relevant," "say what you believe to be true and can back up," "be clear" (cf., Nofsinger, 1991, pp. 36-39). Yet the conversation continued. I made a response. So, there must be a conversational principle governing CKPP that informed how I made sense of her extended turn.

My response to her extended turn shows that I understood her utterances in the context of her experience of herself and myself in the therapy – "And I'm seeing it in here…" I understood the "people" in "gets people to talk about fear" and the "someone" in "when someone is going to get in there on my fear" to be my references to myself. I'm the one who brought up the topic of fear and the one who is posing the subject as something "inside" her while she is sitting across from me.

Again, this indicates that another conversational principle is at work that differentiates this kind of therapeutic conversation from an everyday conversation. In an everyday conversation someone listening to Mrs. P would probably initiate some kind of repair, perhaps saying something like "What? I didn't follow you." Utterances in everyday conversation can certainly have more than one meaning. This is the assumption of symbolic expression that calls for interpretation, as defined by Ricoeur (1970, p. 18):

> A symbol exists …where linguistic expression lends itself by its double or multiple meanings to a work of interpretation… No doubt a symbol is, in the Greek sense of the word, an "enigma"… Enigma does not block understanding but provokes it; there is something to unfold, to "dis-implicate" in symbols. That which arouses understanding is precisely the double meaning, the intending of the second meaning in and through the first.

However, to respond as I did requires the assumption that these meanings are not randomly organized. In this case they seem to be viewed as able to designate a second thing (our relationship) through a first (what she does with some other). Thus far, the scene is a set up for a conversation where Mrs. P's identity and the practices subtending that sense of herself are the subjects to be understood in the context of our ongoing relationship, in the here and now context. So, in addition to the other elements of the FRAME discussed above, a central part of the scene of feeding might be stated as the following conversational principle: "listen to what the patient says as though he or she were talking about herself, you, or the two of you." In other words, the second meanings inferred from this are presumed to

have a direction as a response to the "feeding situation." Perhaps Mrs. P's response has to do with the food and the elements that make up its formulation.

The food

Retrospectively, Mrs. P's extended turn shows that she ratified or showed agreement in another way – she performatively showed me herself as "overwhelmed," projecting it as an actor projects a persona. She did *being-overwhelmed* by speaking in a way that was too much to understand, a cul-de-sac of thought that, a few months later, she would come to call her "curlicue thinking." In terms of the feeding trope, the question might be: what was she reacting to in the food? Just as people sometimes say, "he was feeding me a line" or "I'm not going to swallow that," what was I feeding her that she had a hard time swallowing?

This section addresses the question through analyzing the turns we took in more detail. First, through a closer examination of her response to my first speaking turn, the interpretive analysis shows that it was the notion that I as *needed Other* might understand her as *fearful-in-a-state-of-crisis*, a notion to which she reacted with anxiety manifested as deflecting speech. In other words, her extended turn reveals that she understood my utterances as identifying her in relation to myself, a move to which she has a reaction. In the jargon, what was upsetting was a kind of OBJECT RELATION that she understood me to be talking about in my response to her. This communicative move is one characteristic of CKPP. Second, analyzing my subsequent response and comparing it with the first yields six other characteristics of CKPP. These elements make up the ingredients, so to speak, of the food I have been learning to feed as an initiate of CKPP; they allowed me to "formulate" my INTERPRETATIONS. Finally, a closer look at her next turn reveals the pragmatic effect of this kind of feeding: it puts the patient in a self-distanciated position for examining her experience as a self – a linguistically embedded subject or perspective in a field of issues. My

interpretive utterances provided an opportunity for noticing how her own social practices contribute to that self, which, in turn, provided an opportunity *to be some other way* in relation to the Other in that field of issues as a subject. However, this opportunity is not easy to take in practice, as the remaining section of the analysis will show.

Contrary to the apparent senselessness of Mrs. P's first extended turn, her utterances were an attempt on the part of Mrs. P to swallow (or not) an identity that is disturbing – a struggle, or conflict of identity.[15] Based on her responses, my utterances 003-004, in effect, project an image of Mrs. P as a person facing questionable survival and desperation, who needs help – and implied by the therapy context, one who is there for my help as *the needed Other*.

In response to my move, Mrs. P shifts from a focus on a familiar "crisis" (007) aspect of <u>her</u> life to another person who is in crisis, the crisis of facing the loss of losing him or herself ("end of life issues", 008). In picking situation C, she is choosing a context where she is in the role of helping the person in crisis – Mrs. P uses her speaking turn to shift from talking about her crisis with me as her therapist, where her identity is *patient*, to a situation where she is the needed one helping someone else in crisis – that "works out"(008), is a "success" when she reports on it (009), where her identity is that of *healer*. Adding to this successful healer identity is the notion of one who is needed, having, "what people demand or ask for" (012) as she shifts tracks again to a context where ministers are sought after (in the wake of September 11th). In other words, she moves from so-so healer, to successful

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[15] The notion of "swallowing identity" is purposely left ambiguous here. On the one hand, the expression indexes a variant of colloquial expression, as when someone says, "he's trying to feed me a line" or "I'm not going to swallow that bull shit." On the other hand, the deployment of the expression here anticipates the further explication in the following chapters of Kleinian discourse as a symbolic system circumscribed by the bodily tropes of the infant-mother dyad (the tropography of CKPP). The fullest explication will be addressed in the final chapter of the study, where the swallowing of identity is argued to be a very material discursive accomplishment: the appropriation of a new or altered sense of the self – the understanding of bodily experience as it is brought into language and interpreted relationally.

healer, to needed-healer-in-demand, inverting the valence of the identity she herself agreed with at first (005), from "one down" to "one up," as it were, as if my observation and the identity put forth registered as an affront or risk to her sense of status.

In terms of emotional work, de Rivera contends that anxiety is the emotion we employ when facing an identity that exposes us to danger, in the attempt to deny the new identity and hold on to the previous one that promises interpersonal security.[16] Perhaps, then, Mrs. P's opening lines and hurried behavior were pragmatically geared to argue or make the communicative case for an identity of the *too-busy-needed-successful-healer-to-those-in-crisis*, to which my opening remarks would fly in contradiction, leading her to expand her case, so to speak, in her subsequent talk by providing evidence through shifting contexts to B and C.[17] Yet, she also agrees with my assessment both verbally and non verbally, contradicting her own identity-argument. And it is the identity of *overwhelmed-fearful person* that she returns to, "But the chaplains are the most pathetic ones when you get a group together you say, "I don't know what to say," which gets people to talk about fear. Whatever I'm afraid of when someone is going to get in there on my fear I deflect them." (lines 013-015) This return provides some important clues for interpreting her difficulty with the identities I forwarded in 003-004 relating who I was in relation to who she was as fearful-in-need-of help.

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16 De Rivera writes, "Later the experience of anxiety occurs when the person considers accepting responsibility for actions and emotions that would lead to an identity that, he believes, would occasion withdrawal of the other. The anxiety essentially instructs the person to deny this responsibility, to say "that isn't me," and thus hold on to the old self and relationship whose abandonment is threatened. While this moves the person away from the new identity, it defends him against a loss of belonging to the other." (deRivera, 1977, pp. 49-50)

17 In CA an argument is viewed as interactive disagreement over either (1) the failure of one participant to respond in the desired way to a preceding action, for example, getting a "no" instead of a "yes," or (2) the propositional content of a turn. (cf., Nofsinger, 1991, pp. 146-154) Applying this view to the communicative account of getting emotional, then, suggests that non-verbal arguments can occur over identity claims since emotionality is motivated by "identity goals" using "identity claims … to influence a specific target person" (Parkinson, 1995, pp. 274-291).

The interpretive analysis shows that Mrs. P grasped my initial utterances anxiously, not wanting to be grasped by me as *the-needed-other* by her as *fearful-in-need-of-help*, and she tried to hold onto her identity as overworked-in-demand-healer-to-others to “deflect” me and her own grasp of me as her needed Other. First, her utterances (013-015) are vague regarding the context to which they refer – is Mrs. P still talking about the chaplains attending victims of the World Trade Center crisis? Is she referring to her work at the Hospital? The last comment is an expressive utterance that brings the subject and object of the action back to herself – “I’m afraid …” – although the time and place of the situation is not clear, since “whenever” is not spatio-temporally specific. Second, Mrs. P belongs to the category of chaplains; it is her “new post” (006), while I belonged to the category of “people” who talk about fear. Third, consider that the sequence of the events she describes mirrors the events that happened in the session so far: she starts the session talking about some “silences” (moments where she doesn’t know what to say), then I talk about fear that is “inside” her (004), and then she reports on a general rule of certain – but vaguely situated – times of her life that she is afraid of people getting “in” there “on” (i.e., sighting/citing) her fear and responds by “deflecting them.” What I am arguing is that these last two lines are a metacommunication, as if Mrs. P shifts concern from her identity in the moment to what just happened between us in our communication. Stated differently, Mrs. P indexes the here and now context by virtue of the sequence of events and general (vague) categories she describes, rather than the usual indicators of time, space and person (in here, over there, this here, that there, you, me, and so on), resulting in the apparent lack of contextual referents. Furthermore, to the extent these lines describe what has been happening in the here and now, Mrs. P believes that she herself is “pathetic” for not having completed the sentences – a chaplain who produced “silences” rather than living up to some expectation.

To feel pathetic is to feel inferior, to fearfully grasp the world as looking down on one as imperfect with an urge to hide from view; it is a species of shame. It is not a pleasant way to view the world and oneself; particularly compared with viewing the world as applauding one for successfully living-up or exceeding what is expected. In other words, it is the opposite identity to that Mrs. P tries to project in lines 006-012. And since – from the pragmatic view – every emotional grasp of situation implies an other to whom it is experienced as a response, we can hypothesize that Mrs. P sighted me as a *contemptuous-needed-Other*, looking down at her identity of fearful as insignificant, without legitimacy – one from whom she should hide her identity as unacceptable to a dangerous, rejecting Other. [18] The way she 'hides' herself – how she 'does' shame in this instance – is to try to maintain the opposite identity of too-busy successful-needed-healer-to-those-in-crisis and to produce speech that would not make sense, preventing her from being understood – sighted/cited – as someone *fearful-in-need*.

To recap, the interpretive analysis shows that Mrs. P became anxious at the prospect of being identified in a way that felt shameful as if she sighted/cited me as a *rejecting-needed Other* rather than a *helpful-needed-Other*. Considering this opening section of conversation spans but minutes in the on-line interchange of the session, a considerable amount of work has been accomplished. Schematically, this can be summarized in the following way (Figure 2, below).[19]

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[18] Regarding this point, de Rivera (1977, p. 48) writes, "I shall postulate that this is so, that in each of the emotions where the self is an object of the emotion [anxiety, guilt, panic, security, humility, serenity, depression, shame, sorrow, confidence, pride, and joy] the self is the object for the movements of an implicit other." Importantly, in a footnote to this passage he remarks, "As Dahl (see p. 6) suggests, such a conceptualization is related to the Freudian conception of internalization. Hence it may possibly serve as a link between psychoanalytic thought and the ideas of George Herbert Mead and the symbolic interactionists."

[19] This figure is an adaptation of The Ontological Blueprint (Packer, 1993) used to visually represent how experience is structured based on Heidegger's ontological hermeneutics. To summarize simplistically, the emphasis is that experience is based in the structure of understanding. To apprehend something is to do so in

Mrs. P forwards or projects (again, as actors "project" a persona) the identity ( ) of important-busy-minister-to-the-fearing-death-needy **T1** (time 1). My opening speech forwards a contrary identity; I showed her that I understood her as needy-one-trying-to-"survive"-at-the-moment **T2**. In response to my move, she agreed then repositioned or "resubmitted" her initial claim, so to speak, out of anxiety about a shameful or humiliating identity by shifting the focal point for alignment (➔**T2**) to her identity as a more-or-less successful healer (**m.**) to the fearing death needy (**n.**) in the context of her work in the hospital (**End of life ministry** context). However, this attempt to 'justify' the initial identity she argued leads her to shift again. This time it is an appeal to the category to which she belongs as minister-in-demand-by-those-facing-death-crisis (**m** to **n**, **9/11 ministry situation**). This move leads to a shift in the meaning of chaplain identity from "counselors being sought out" to "pathetic" and unable to lead a discussion about fear (➔ **T3**), and how she hides ("I deflect them") when someone is going "get in there on" that identity. In a way, it is as if Mrs. P started to tell parables about her own two contesting identities – stories that depict qualities or attributes of the characters, geared to encourage the listener/reader to make comparisons between the details of the story to the details of

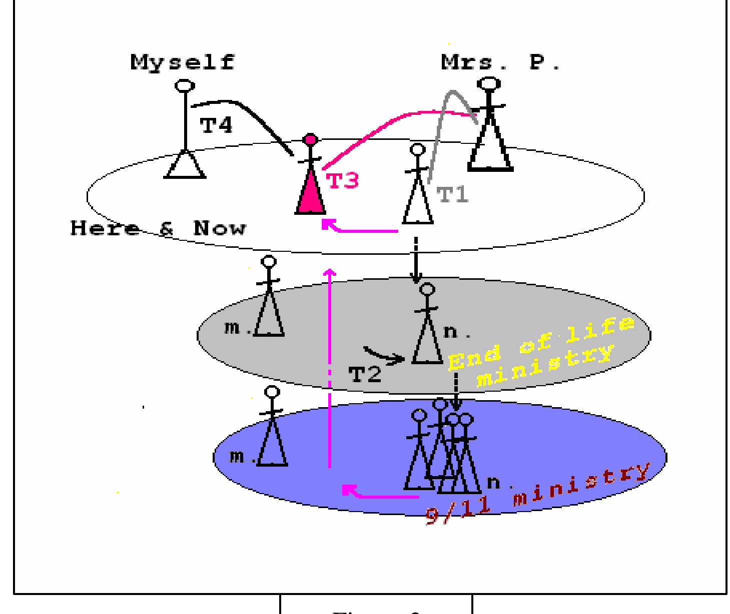

Figure 2

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some context of activity, which, along with one's aims and the concepts at one's disposal, structures the entity's meaning.

some other system of relations. At least this is one way to understand interpreting what she talks about as an allegorical or symbolic way to communicate about the therapeutic context.

In CA terms, part of the ongoing work of conversation is "topical coherence" and my subsequent utterances in the session (**T4**) function – in part – to mark the topic as her behavior of the moment as it was related to her ongoing experience by means of a "collaborative completion." In effect, I complete her utterance in 015.

016 And I'm seeing it in here that when I just approached your fears of falling apart a part of you got
017 scared and deflected us by focusing on crisis as an abstract concept. It's like you drop your feelings
018 that feel overwhelming as if we couldn't tolerate them.

Collaborative completions are a conversational device that "displays alignment [understanding] between participants." (Nofsinger, 1991, p. 122) through the completion of the first speaker's utterance by the second speaker, followed by an acceptance or rejection in the next turn. My speech indicates the nature of my understanding such that I was able to anticipate what Mrs. P could recognize about her action and experience closely enough that it might be accepted. Whether or not Mrs. P would have completed her assertion as I did, or related what she said (as if to herself) to her current relationship with me, she does agree with the prepositional content of my speech: "Yeah, I've always done that [Tears streaming] Yeah, I…" (lines 019, below).

Thus far, seven patterns characterize my speaking turns during the session – what I was feeding. First, they are made in the form of assertions that show my beliefs about Mrs. P's reality of-the-moment. They are not directives that operate to commit the addressee to do something, either in the form of questions, such as the cliché "so, how do you feel about that?" or mild orders, like "tell me more about that." Second, they are more or less strongly anchored to the here and now context – in lines 016-018 "I'm seeing," "in here," "when I just approached," "you got," etc., point to the immediate on-line relationship between Mrs.

P and myself. Third, their topic is selected from what Mrs. P has either said or done first. Fourth, this topic is selected either from the concepts she employs directly or indirectly. An example of the latter is “feeling overwhelmed” (003), which describes one way people belonging to the category of survival-mode would grasp their situation, just as “panicked” or fear of things “falling apart” (Cf., line 016) might also capture their experience – particularly if they witnessed the twin towers collapsing. And fifth, these assertions can also take the form of short narratives in so far as narratives involve the telling of how two or more events are logically, causally, chronologically or experientially related. Again:

16 And I'm seeing it in here that when I just approached your fears of falling apart a part of you got
17 scared and deflected us by focusing on crisis as an abstract concept. It's like you drop your feelings
18 that feel overwhelming as if we couldn't tolerate them.

In this case the plot involves something that happened in the moment between the participants; this is also the first time the first person plural forms (“we,” “us”) are used. And the final assertion proposes a theory linking how she experiences with what she did. Summarizing the story: You grasp our identity (“we”) as excluding (can't “tolerate”) so you disconnect (“drop”) from an experience (“feeling …overwhelming”).

Sixth, as done previously, this response reflects some of the specialized knowledge I have learned about CKPP as an initiate. As noted above, my assertion was in the form of a small narrative articulating or joining her way of getting emotional (marked as “inside” her in line 003) with her manifest behavior towards me, her object, on the basis of how she may be grasping my identity as a participant with her. Stated technically, I was marking an OBJECT RELATION pattern for her and I to talk about – that is, MAKING IT CONSCIOUS by pointing out how it happened in the room.

In the parlance of CKPP what I did with my speaking turn was to INTERPRET her DEFENCE against feelings that she was not able to grapple with, “as if we couldn't tolerate

them." (018). This interpretation shows the heuristic application of the questions I learned from Dr. R (cf., pp. 58-59, above). It consisted of tentative answers, hypotheses, to several of the questions that shape the investigative apparatus of CKPP. Mrs. P's MAIN ANXIETY was cited as "fears of falling apart" (016). What she did with what I said was to change the subject, "you got scared and deflected us" (016-017). How Mrs. P seemed to be trying to use me was to help her talk about something else, to avoid feeling shame. She seemed to be seeing me as one who can't help her with the magnitude of her upset, "as if we couldn't tolerate them" (018). And what it felt like to be with her? I felt anxious about being able to hold onto her as a patient. Since she had told me that she was taking a week off I was worried that she was going to terminate therapy. Yet while speaking with her I, at times, like when Mrs. P would tear, felt that she also needed me. The way I described it for a case conference presentation was that if there were a caption to the first few sessions it would read, "I don't need you please don't leave me."

The purpose of these questions about the therapeutic relationship is to provide an entry point for the on-going elucidation of the problems Mrs. P has dealing with unmanageable anxiety, "After all, the reason which brings patients into analysis is fundamentally that they cannot manage anxiety, though it does not mean of course that the patient is consciously aware of this" (Joseph, 1977/1989, p. 106). And it is through participating, observing and making judgments about how the patient doesn't deal with anxiety in the live, pulsating, on-line relationship with the therapist that each component of the misery regime can come to light. "In this view, the analyst is not someone who maintains a 'neutral' stance above the fray, but someone who is always being drawn into the fray, could not do analysis if he were not in the fray, and who does analysis largely by figuring out what kind of fray he is in."(Caper, 1999, p. 28).

The technical term for “the fray” is the “TRANSFERENCE AS THE TOTAL SITUATION” as articulated by Joseph (1985/1989, p. 167): “…a living relationship in which there is constant movement and change… [where] everything of importance in the patient’s psychic organization based on his early and habitual ways of functioning, his phantasies, impulses, defenses, and conflicts will be lived out in some way in the transference.”[20] “Total situations” are whole experiences or an experience as a whole. Whole experiences are the stuff of transference – what the patient perceives and believes about him or herself and the therapist in relation to that self – as manifest in the patient’s communicative behavior and the therapist’s experience of the patient. As Hinshelwood writes:

> Joseph’s (1985) idea of transference as the ‘total situation’ is not simply restricted to isolated references to the analyst about which the patient and analyst converse. The very function of cooperation between them, the arena in which the psychoanalysis works, is a fulcrum of the patient’s conflicts***… In everyday social contact, people say things ‘for effect’, and this is no less prevalent in the fraught world of the psychoanalytic consulting room.*** What the patient does to the analyst, the effects his words have, have a long history in the patient’s life with his objects. In this sense there is ‘always something going on’. ***And so we are more concerned with the kind of use to which the patient puts the object in order to still anxieties and conflicts. The patient’s use of the analyst replicates the use of objects in infancy and childhood.*** (Hinshelwood, 1994, p. 193, emphasis added)

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[20] The trope of therapy-as-mother-feeding-infant has its origin in the assumption that transference (i.e., experience) is first structured in infancy, therefore adult experience as the superstructure on this primordial base is conditioned by its structure. Klein writes:

> I shall now draw a conclusion on which the present paper rests: I hold that transference originates in the same processes which in the earliest stages determines object-relations. Therefore we have to go back again and again in analysis between objects, loved and hated, external and internal, which dominate earliest infancy. We can fully appreciate the interconnection between positive and negative transferences [experiences of the analyst] only if we explore the early interplay between love and hate, and the vicious circle of aggression, anxieties, feelings of guilt and increased aggression, as well as the various aspects of objects towards whom these conflicting emotions and anxieties are directed. (Klein, 1952, p. 53)

Furthermore, it is this assumption that underlies the interpretive tactic of listening to the patient’s current life stories “as containing an element of unconscious phantasy, though they may seem concerned with incontrovertible external facts … To say that all communications are seen as communications about the patient’s phantasy as well as current external life is equivalent to saying that all communications contain something relevant to the transference situation. In Kleinian technique the interpretation of the transference is often more central than in the classical technique” (Segal, 1981, p. 8)

Transference TOTAL SITUATIONS occur in a repetitive fashion and are the attempt to maintain and repeat being a certain kind of subject that involves actions to get the therapist to be (act, feel, talk) a certain way that enables the repetition. The therapist's job is to be able to apprehend and effectively show the patient what they are up to, how they do it, and how it relates to their difficulties. In this sense, the relationship between the patient and therapist, their respective experiences and communicative behaviors act as a prism to refract the patient's OBJECT RELATIONS for careful analysis and interpretation. The Kleinian conceptions of SPLITTING, PROJECTIVE and INTROJECTIVE IDENTIFICATION, The PARANOID/SCHIZOID and DEPRESSIVE POSITIONS, ATTACKS ON LINKING, OMNIPOTENCE, PATHOLOGICAL ORGANIZATIONS, and so on, are heuristic tools that inform one's attempt to grasp CLINICAL FACTS – the time sensitive emotional realities of the session (cf., Caper, 1997; O'Shaughnessy, 1994; Riesenberg-Malcom, 1995).

In technical terms, for example, the notion of an ATTACK ON LINKING was invented by (Bion, 1957/1988) to point to a primary means people can use to not understand and remain unaware of their reality. He conceived of these as attacks on anything that joins any couple – two thoughts, two feelings, a thought and a feeling, a feeling and a person, a feeling and a behavior or perception, two people, a mother and a child, a patient and their therapist and so on. The therapeutic encounter is ripe for these attacks because the whole point is for two people to come together and jointly solve problems.

And while I never said either "you're attacking a link" or "you're experiencing a paranoid/schizoid anxiety" the assumption of these terms – implicit ontological assumptions of Kleinianism – did inform what I said. Mrs. P's speech (007-015) was an example of an ATTACK ON LINKING in that she had trouble putting her thoughts together, linking

them, which would simultaneously prohibit someone else from being able to put their thoughts together with hers – resulting in unintelligible speech. And the notion of "fears of falling apart" draws on Klein's exposition of the PARANOID/SCHIZOID POSITION, since the danger of 'falling to pieces' might have been a manifestation of "the primary anxiety of being annihilated" (Klein, 1946, p. 5) due to the defense of SPLITTING off "parts" of her self (her identity).

Klein's most innovative works came through her psychoanalysis of children, where she developed beliefs about infantile experience and development – her innovations are based on an infant ontology, as it were. According to this ontology, the infant's sense of himself lacks coherence; he begins life in a state of primary unintegration; he has experiences but at first these are not integrated into one "I." The "I" or ego begins to integrate around positive or pleasurable experiences, like the satiation of a good feeding. Painful experiences like hunger, excessive gas, burning diarrhea, etc., threatens this collection of "good" experiences and therefore must be kept separate. In normal development the mother does a good enough job helping the infant manage his anxieties about integrating the "good" and "bad" senses of himself. The mother, or part of the mother since the infant cannot yet perceive her as a whole, is central to this process:

> As regards splitting of the object, we have to remember that in states of gratification love-feelings turn towards a gratifying breast, which in states of frustration hatred and persecutory anxiety attach themselves to the frustrating breast. Idealization is bound up with the splitting of the object, for the good aspects of the breast are exaggerated as a safeguard against the fear of the persecuting breast. While idealization is thus the corollary of persecutory fear, it also springs from the power of the instinctual desires which aim at unlimited gratification and therefore create the picture of an inexhaustible and always bountiful breast – and ideal breast. (Klein, 1946, pp. 6-7)

In his attempt to control the 'bad' experience the infant mobilizes aggression to eliminate the painful experience, to get rid of it, by means of a PHANTASY of SPLITTING it off from

the self and PROJECTING the self-experience (part of the self) into the mother and thereby identifies her as a dangerous being that contains these dangerous parts: the persecutory breast. So, the primary anxiety of this early position is paranoid in nature – the fear of a persecutory, annihilating object – and the self is split by the schizoid mechanism of splitting; hence, the PARANOID/SCHIZOID position and its "fear of falling to pieces." Klein refers to this as a "position" because it is an always-available state rather than a "stage" that is traversed once and for all. In its garden-variety manifestation: someone hurts us, we get mad and feel as if they did it on purpose, like a persecutor. This question is not that an adult deals with this position; the issue is how and to what extent is the anxiety unbearable. Where Freud gave priority to castration anxiety in the etiology of neurosis Klein traced its origin to the PARANOID/SCHIZOID position as the ground of its possibility. Castration anxiety is but one manifestation of a persecutory anxiety based on projective identification.[21]

In this way all infant experiences begin to be organized around the poles of good and bad or painful and pleasurable by means of SPLITTING, PROJECTIVE IDENTIFICATION and its inverse INTROJECTIVE IDENTIFICATION– the early means of discriminating what belongs "to me" or "not to me." Under normal conditions the good experiences become the context for the bad; in adult terms one may have bad experiences but within an overall sense of security and confidence in one's basic goodness and worth as a person.

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[21] Likewise, the "renunciation of Oedipal strivings" is but one manifestation of the DEPRESSIVE POSITION where fear of the loss of the Other motivates INTROJECTIVE IDENTIFICATION. The terms DEPRESSIVE POSITION and INTROJECTIVE IDENTIFICATION will be explicated in chapters 4 and 5. The point is that the Kleinian tradition has historically aimed to identify and conceptualize features, processes, and technical strategies that are common to all pathologies rather than focus on character types. For example, in the contemporary Kleinian literature the notion of PATHOLOGICAL ORGANIZATIONS is used where others might specify "borderline," "narcissistic," "obsessional," and other types. Rather than focus on how they are distinct and mutually exclusive, Kleinians may focus on how each one as a PATHOLOGICAL ORGANIZATION manifests a common problem such as resistance or difficulties making "contact" with the object as displayed in their particular manner of deploying projective identification and so on.

This brief and oversimplified exposition of some Kleinian terms, then, can help contextualize not only my comment about "fears of falling apart," but also my opening utterances and why I took Mrs. P's comment "I'm trying to survive this week" (002) more literally that she seemed to intend it. And from the Kleinian angle, an ATTACK ON LINKING is a manifestation of SPLITTING since a part of the self, an identity, cannot be verbalized if it is split off. Hence, I interpreted her speech (007-015) as a DEFENSE (attempt to deny an emotional reality) by "linking" the fear of fragmenting ("falling apart") to her communicative behavior.

Of course, there is a seventh common element to my response that is not mentioned in the talk – the note taking. At the time of this session I had been taking detailed process notes – writing down every word (more or less) spoken during the session while in the session – for two years. I write down what I am going to say before I say it to (1) foster the discipline of carefully choosing my words based on (2) what has just been said and happened in the session as I have recorded it – it's a way to "fix" the action of the session so I can analyze and try to formulate it while writing my response, or, later after the patient has left to review the session.[22] (3) Writing my responses ahead of time allows me a few extra seconds to watch the patient as he or she hears what I say and reacts to it, so I can monitor or track how what I say registers (or not). And while the reaction of many to my note writing (expressed by colleagues) is that they would feel it takes away from their ability to "be present" or "pay attention" to their patients, I have found that – once I became used to it

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[22] The idea of "fixing" action so it can be read as a text or text analogue is central to interpretive inquiry. In short, since social interaction is fleeting it must be fixed for its patterns to become the object of scientific study (through audio taping, video taping, etc.), as writing fixes speech and makes it available for interpretation. (Cf., Ricoeur, 1971; Taylor, 1971). This fixing provides the kind of distanciation that Ricoeur had in mind when he wrote, "This way of putting my action at a distance in order to make sense of my own motives paves the way for the kind of distanciation which occurs with what we called the social *inscription* of human action and to which we applied the metaphor of the "record." The same actions which may be put into "records" and henceforth "recorded" may also be *explained* in different ways according to the multivocity of arguments applied to their motivational background." (1971, p. 552,)

and worked out my anxieties about it – the opposite is true. The note writing slows the process down and provides a record of what happens, which makes it easier for me to formulate my interventions by paying close attention to everything the patients says and does in reaction to what I say and do. While it's true that less gets said in the sessions and that my writing slows the pace of talk, I think too often one can equate the quantity of talk with quality, or the quality of it "feeling good" or "feeling right" can obscure what is going on through the talk.

Indeed, the first hurdle I faced trying to write during the sessions was my anxiety about not maintaining eye contact. When we discussed this during supervision, Dr. R summarized by saying, "Let's put it this way, eye contact may be gratifying but it is not necessarily therapeutic." She continued, explaining that the writing "communicates that you are there to do your work, and doing your work means having a separate mind to think about their problems …which patients don't like because they want you to think about their problems the way they do." In another supervision session where my anxiety about the writing came up, she remarked: "so, it creates a distance, a separation, between you and the patient that makes both of you anxious." And in response to my other big concern about the note taking, that it took away from the freedom of the patient and that I was being too controlling and calculating by writing things out, she responded, "and what's wrong with being calculating?" I told her what the patient had said – a view that made sense to me at the time – and Dr. R stated, "So, it's as if your patient thinks you'll be more help to her if you say the first thing that comes into your head rather than taking your time to think about what's happening before you say it … and I'd tell her that." Dr. R maintained a position that the note writing was as necessary for the job my patients were hiring me to do as a

hammer is necessary for a carpenter. Some three years later, I can agree whole-heartedly with that. I would only qualify her statement by saying *if you want to do this kind of work*.

Mrs. P has not mentioned the note taking in her response. At times she sees me starting to write and waits for me to finish and say what I have come up with. At other times she keeps talking and I hold up my hand or say "hold on a moment" so I can finish, because I believe what I have to say too important to be glossed over.

Mrs. P ratifies my hypothesis linking what she has just said and done to me with her previous speech – ostensibly about some other context than the therapy:

019 Yeah, I've always done that. [Tears stream] Yeah, I'm probably going to be processing 15,000
020 different things. Yeah, processing things to do with my daughter's wedding all this introspective stuff
021 between now and Tuesday when I leave.. . . .

Mrs. P is moved by my speech. It seems that I have "touched" on something as people say. This turn of events is one that is and will be repeated many, many times during our work together. She wipes the tears from her eyes as she talks and reaches for a tissue – hospital stock tissues she has often complained about, saying they are not soft enough for "people with alligator tears."

In the terms of CA, her response here (019-021) constitutes a positive assessment secondary to the previous assessment (what I'm calling the theory I proposed in CA is an assessment, an utterance of evaluation). Her second utterance (020-021) specifies or expands on what she is going to be processing, introducing another topic and context into the conversation: "my daughter's wedding." Notice, however, that her expression both confirms "feelings that feel overwhelming" (trying to process 15,000 different things would be quite overwhelming to say the least) yet negates the here and now indicators of "you drop," "you're," and "we couldn't" by shifting to the future conditional of "I'm probably going to be" (019) "between now and Tuesday" (021) as if it's not what she was just doing in

the moment. Although her previous speech did not contain 15,000 different things, it did contain that many in the sense that the point of the remark is (005-015) "too many things to make sense of at once."

The third time that Mrs. P spontaneously began tearing occurred right after she mentions the date of her departure for her daughter's wedding. The first two incidents of tears followed comments I made, but not the third, which began with her self-selected turn (021, below). What all three tear events have in common is that they coincide with shifts to the here and now situation – Mrs. P's experience and reaction to that experience of herself during the therapy, either when she aligns her grasp of things with my grasp of the here and now or reintroduces it herself. In this last case, Mrs. P gets emotional and does getting emotional by tearing after she shifts her own grasp back to the here and now, focusing on something "deep" for herself.

The pragmatic function of getting emotional in this way is not clear as I report on it now. At the time – and currently – I take Mrs. P's tearing as, at the least, an indication that what I've said has touched on something, as an indication that I'm on the right track, so to speak. Are they tears indicating sadness, relief from being understood or what?

However, this temporal shift that provokes tearing does not last. After Mrs. P begins tearing she self-selects a turn to continue talking, and my silence indicates that we both share the sense that it's her turn to continue. "This isn't very deep … I'm feeling guilty because" (021-022, below) indicates a return to the here and now before another shift to the wedding context (022), and finally the context of mothering and being a child in the distant past of " it goes way back …I can't remember anyone in my family who..."(023).

. . . [Tears stream] This isn't very deep -- no for me it is -- I
022 think one of these things is I'm feeling guilty because I haven't been able to help out too much with
023 my daughter's wedding and it goes way back because I can't remember anyone in my family who
024 hasn't really been totally involved in their daughter's wedding plus the problems I have with the need

025 to control, usually mom's do their daughter's weddings. But I'm still from that tradition, so I'm
026 probably feeling a lot of conflict about -- emotionally I have some input into this. Intellectually I've
027 tried to let my children make all the major decisions on their own. I think maybe I've identified
028 with my own mother who was major controlling, which is what dynamic women are. And the sister
029 I was in the arms of -- I think I used her or she filled the shoes of my mother. I think I haven't
030 looked enough at the input she [the sister] had on my life because she went off when I was ten. I still
031 have my own mother [her mother died in the 80's] but she was -- I don't know -- an institutional
032 mother. It was an institutional type relationship a parallel between my mother sending me off to
033 school at an early age and my sending my kids away.

034 I think one way you are trying to keep some powerful feelings away is by turning our conversation to
035 events in the past that are easier to talk about.

My response to her extended turn indicates that I understood her speech to be an agreement with the theory I had previously proposed, tying her practice of "turning our conversation" to her emotional grasp of the moment. Her turn constitutes a collaborative completion of my assessment by doing what I (and Mrs. P herself in 014-015) had described. Although worded a bit differently ("powerful" instead of "overwhelming" and "events in the past" instead of "like an abstract concept") the point is the same. She disengaged from the experience by changing topics and contexts. In her first extended turn she "dropped" her feelings by changing logical levels from particular to general; in this turn she changed from an approaching specific event to specific and loosely linked events in the past. Both of her extended turns are characterized by speech that is confusing when heard in a real-time discussion, which affect communication by disrupting what one experiences as the seamless and transparent "exchange of information" or "flow" of words, as talking is often described. As noted earlier, this kind of speech Mrs. P and I have come to call her "curlicue thinking;" it is a kind of speech that disrupts both understanding the speech and the identity of the subject behind the speech. In stark contrast, her response to my second interpretation is tight, to the point, and focused:

036 Yeah to make the comparisons. I'm trying to figure out why I'm so sad. I'm in extreme
037 circumstances – my daughter's wedding and the recent terrorism.

So, what happened? In other words, what's the pragmatics of making a pragmatic comment in therapy – proposing a theory to explain why she produced talk that had the pragmatic effect of shifting the focus of the conversation to change her experience?

Here, and in preceding instances, "Yeah" is an "agreement token" that also serves to indicate the speaker's desire to take a turn (cf., Nofsinger, 1991 p. 74). "… to make the comparisons. I'm trying to figure out why I'm so sad …" This utterance is another assessment, an explanation, to account for "turning our conversation to events in the past" (034-035). Importantly, it differs from her previous assessment (019-020) in that at this point she has turned to assessing herself in the context of talking to me in here and now situation, rather than about some upcoming one. Her sadness is active in the moment and not one among "15,000 things" to be "processed" in the coming week. Let's call this an assessment-explanation adjacency pair,[23] where the explanation part of the pair is maximally relevant to the first-part assessment. In other words it is as if I said, "you're changing topics again" and she explains, "yeah, to figure out how I'm feeling" versus, "Yeah, and two weeks from now I'll be upset."

So, the pragmatic effect of pointing out to Mrs. P the pragmatics of what I believed she had just done is (1) to move Mrs. P into selecting the position of sighting/citing herself as the subject of action in the here and now, an action that is the correlate to her immediate sense of herself and what was happening (her position as a perspective facing a field of issues, in Taylor's (1998) terms), and (2) from this position Mrs. P explains what she's doing ("trying to figure out") and identifying the who she is that's doing it ("I'm so sad"), which,

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[23] In CA adjacency pairs have the following characteristics, "(a) It is a sequence of two communicative actions; (b) the two actions occur adjacent to each other; (c) they are produced by different speakers; (d) one action is a first *pair part* and the other is *a second pair part*, that is, they are sequentially ordered; and (e) they are categorized or type-connected so that any given first pair part must be matched with one of a relatively few types of second-pair parts." (Nofsinger, 1991, p. 51)

overall, (3) tightens her sense of a few things – rather than 15,000 – so they can fit into three utterances that comply with Grice's cooperative principle.

In the language of critical hermeneutics after Gadamer and Foucault, the effect of this power play, where my speech has the effect of inviting Mrs. P to respond by explaining herself, is to insist on practicing the "concept of reflexivity-in-interpretation." (cf., Kögler, pp.251 –260). Mrs. P's response to my speech is to interpret her own action in the here and now, to say that her confusing speech was not just a sign of an attempt to avoid powerful feelings, but was a sign of working on her problem, "trying to figure out." Her responses (036-037) are a reflexive explication of meaning – the meaning of her behavior and her identity. By assuming this position for the first time in the session, Mrs. P engaged me as a dialogic partner – a "cosubject" or co-interpreter – on the topic of who she is in the context of what she is doing:

> In the *ethical* dimension [of the critical dialogic model], the subjects are dialogically constituted as autonomous cosubjects and are thereby seen as having a right to their own conceptions of self-realization. The conceptions, however, may be undermined or constrained by the concrete contexts in which subjects find themselves…. The *critical-hermeneutic* objective consists precisely in correlating these concrete visions of the good and just [i.e., of self-realization, of identity] with contextual practices of power.
>
> Thus, although the interpretive practice of critical dialogue pursues the goal of subjective self-distanciation so as to make possible greater self-realization, it leaves it to the subjects themselves the actual use of critique in terms of enhanced self-determination. (Kögler, 1996, p. 253, emphasis in original)

Part of speaking as a cosubject in our critical dialog was trying to shape my understanding of her identity and the identity of what she does. Mrs. P's utterances in this turn are qualitatively different from her previous speech and my response, a difference that is reflected in my subsequent turn.

Mrs. P's utterances were aimed specifically to me in response to what I said, less stream of consciousness – more about what I just noticed as another person in the room and

less like I am confined to be a spectator of different things going on in any number of situations where she is not with me. Better yet, in her previous speech it's as if I functioned as a chronicler (cf., "what you record" line 059, below) of different things she's dealing with in her life rather than an interlocutor – just a sounding board for the happenings in different areas of her life. The explanation Mrs. P's offered was geared to shift my understanding from sighting/citing her previous speech as merely another deflection to an attempt on her part to make further sense about her "extreme circumstances," (her words) of "falling apart" (my words).

038 Perhaps a part of you is feeling sad, scared, and angry at your daughter for getting married as if
039 she were deserting you now like you felt by your sister, and the problem is you don't feel you have a
040 way to contain these feelings inside.

These utterances show that her move to repair alignment by explaining and thereby shifting my understanding of her prior move worked. I changed from speaking about what I understood her to be doing to avoid a feeling to commenting on her identity as it struck me, as if she had said, "what kind of person am I that I am in this state?" In my response I aligned with the topic of her identity in relation to her daughter, her sister and her feelings, an identity textured with "feeling a lot of conflict" (026) – "part" "sad," part "scared," and part "angry" in relation to her daughter's wedding. Mrs. P's self-initiated repair worked. I realigned my understanding of the topic and added to it.

In terms of CKPP her move was an example of speaking from the DEPRESSIVE POSITION. This will be addressed in the next session, since it is related to how the "feeding" is adjusted during the course of the session. The task of this section has been to articulate the characteristics of "the food" offered in CKPP in the form of interpretive utterances. The examination of these utterances led to the inquiry into their pragmatic effect to understand "the food" in terms of its communicative purpose.

The interpretive analysis reveals that the pragmatic effect of the food I was offering as an initiate of CKPP is a self-distanciated position for the patient to assume that involves critical reflection on the identity she adopted, which involves communicative behavior in the form of speech and emotional states, bound up with contextual social practices of power – social practices geared to act on the actions and understanding of another. Moreover, adding to the findings from the first section that CKPP requires the assumption of a principle of symbolic expression as a part of its frame of controlled conditions, this "formula" has seven characteristics:

- The use of specialized technical knowledge to inform how one understands and responds to the ongoing therapeutic conversation, stated in experience-near terms (i.e., without technical jargon)
- The use of more or less verbatim note taking to "fix" the to and fro action of the conversation, and provide data or MATERIAL from which understandings are formed before being offered to patients in the form of:
- Interpretations. These interpretations are assertions that show the therapist's beliefs about the patient's experiential reality of:
- The moment. The here and now is the context the assertions index, usually through very explicit references, and
- These assertions often take the form of a hypothesis or theory, in so far as theories involve a proposal telling how two or more events are logically, causally, chronologically, or experientially related.
- The topic is taken from what the patient says or does first,
- Either implicitly or explicitly – the principle of symbolic expression

In one way this finding is unexpected, for the guiding metaphor of a mother feeding an infant would seem to suggest that the speech of the CKPP practitioner would be infantilizing, talking to the patient as though he or she were an infant. In one sense this is accurate, since the fostering of infantile dependence is necessary for the "infant-in-the-patient" to be addressed, be seen and understood by the therapist as a participant of the

therapeutic conversation. However, it is not accurate in the sense that the practitioner of CKPP is somehow making the patient into an infant, anymore than a good-enough mother is bent on deforming the subjectivity of her children that she raises in a relationship of asymmetrical dependence.

The paradox seems to lie in the approach of addressing or feeding the infantile-in-the adult *as* the subject of his or her experience, with the ability to critically reflect on painful experience and do something about it now. As Mitrani writes:

> Such experiences, as I have attempted to convey in this chapter, have convinced me that careful analytic listening and consistent interpretation of the ordinary patient's experience in the here-and-now of the hour facilitate the emergence of the infantile transference, bringing it out into the open while at the same time mobilizing and mitigating certain anxieties and those protections constructed to deal with them. (Mitrani, 2001, p. 18)

This paradoxical quality will be examined further in the next two chapters, since it requires a fuller articulation of CKPP's approach to "feeding identity" that mobilizes anxiety (Chapter 4) before examining (Chapter 5) how the "infantile transference" is fostered and examined simultaneously through interpretive utterances that convey a sense of being "understood without words" (cf., Klein, 1963/1975, p. 301).

4. A formula for recognition

> An interpretation should convey no more exhortation or suggestion about what the patient should feel or do than a line call in tennis. The linesman should simply report on whether the ball looked in or out from his point of view, with no claim to omniscience, and with no implication of what it *should* have been. The impact that a good interpretation has on a patient is partly due to the fact that it is so free of exhortation, a fact that contributes to it being such a unique way of talking about intimate matters. (Caper, 1999, p. 135, emphasis in original)

This chapter addresses how CKPP uses the content of the patient's speech and the sequential turn taking of the dialog to comprehend the patient's situation and formulate interpretations. These interpretations do not come from a "god's eye view." They are formulated and evaluated on the basis of their effect on the joint exploration of the incomprehensible problem the patient seeks help with in each session. Caper continues:

> The reason that something about the patient is obvious enough to be detected by the analyst, but unobserved by the patient is not that the analyst is especially perceptive or intellectually acute, but because the patient is especially unperceptive in the area needing to be interpreted. The patient's lack of perceptiveness is connected with his being in the grip of unconscious delusions, which makes critical, perceptive thought about them impossible. (Caper, 1999, p. 135)

Framing our question within the tropes of the feeding infant, the mother has an approach to feeding that takes into account the state of her baby. She doesn't try squirting the formula from a distance into her baby's mouth or offer it with ice, for example. Nor does her set of feeding practices include the act of holding her child upside down over the bottle. And she doesn't try – hopefully – feeding her crying baby if the cries are a response to a soiled diaper. Feeding requires a process of adjustment: the right temperature, head held at the right angle, intervals between putting the nipple to her child's mouth and letting the baby ingest, and so on. Moreover, as the last example implies, it requires the mother to adjust her interpretation of what the baby needs based on her infant's means of communicating (cries, gesture, etc.). From the Kleinian perspective there is more

involved than the physiological pleasure of being fed; there is the matter of how the experience registers for the infant: the primordial feeling of being understood by the mother without words – the prototype for the capacity of enjoyment and a circumstance where the self gains a sense of security, belonging and meaning through being grasped by anOther. Beyond, or better yet, along with the milk formula is a formula for recognition that is required for the nascent person to develop a sense-of-self and its contents (possible meanings or identities), as much as proteins, vitamins, and minerals are required for his body and its contents (physical organs) to grow. This recognition is required for the infant to develop sufficient capacities for managing existential anxieties: anxieties about having and not having, loving and hating the same person, making up and repairing its loving relationships, being and not being, and so on.

Likewise, formulating interpretations requires a process of adjustment based on the responses of the patient – literal, symbolic, and nonverbal. This section takes a closer look at this adjustment process, particularly as it relates to the aims of CKPP, which have now come into focus as (1) engaging the 'infant-in-the-patient' in a way that (2) fosters the capacity for reflection on the self in the context of its Other-relating practices that shape the self's experience. Specifically, the interpretive analysis will show that the adjustment process relies on (1) the symbolic inference of the emotional difficulties that Mrs. P confronts that are tied up with conflicts of identity, and (2) determining when she is engaged in understanding his or her problems – a self-distanciated position.

In the terms of Habermas, this adjustment process leading to a self-distanciated position is the occasion for the "emancipation" of the patient by "becoming a subject."

> Analytic insights possess validity for the analyst only after they have been accepted as knowledge by the analysand. For the empirical accuracy of general interpretations depends not on controlled observation and subsequent communication among investigators, but rather on the accomplishment of self-reflection and subsequent

> communication between the investigator and his "object," … In the case of testing theories through observation … the application of the assumptions to reality is a matter for the inquiring subject. In the case of testing general interpretations through self-reflection … this application becomes *self-application* by the object of inquiry. … The subject cannot obtain knowledge of the object unless it becomes knowledge for the object – and unless the latter thereby emancipates himself by becoming a subject. (Habermas, cited in McCarthy, 1978, pp. 203-204)

Thus, CKPP is a subjectivizing practice and the aim of this chapter is to show how it operates to provide the occasions for subjectivity to become. This is accomplished by addressing the anxiety inherent in assuming the position of self-subject formation.

Symbolic inference

Provisionally, symbolic listening is the inference of meanings from the patient's speech and other communicative behavior that are not explicitly expressed in their utterances.[24] Let us call this the decoding practice of CKPP. To the extent this decoding practice requires communicative moves that differ from everyday conversation, this interpretive analysis should be able to identify the decoding as the adoption of a particular position towards the content and sequence of Mrs. P's speech. Since this involves doing something through talking, thinking through the pragmatics of Kleinian symbolic interpretation may refine our grasp of this positioning. In terms of the pragmatics of human communication, this decoding involves the translation of the patient's analogic communications into the digital mode so that a problematic relational commitment can be made explicit and discussed.

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[24] For example, in the case of "John" described in the introduction above (pp. 9-10) it was inferred from his story about the car nearly hitting him that John was communicating about his anxiety in the session. In that case the car symbolized the therapy, the driver was the therapist, and John's gesticulating referred to his opening utterances of the session which were attempts to draw my attention to his suffering, and to which I did not respond, like the driver who was dangerously focusing on something else other than John's crisis of the moment.

The quotes below refer to one of the "axioms" of the pragmatics of human communication outlined in Pragmatics of human communication: A Study of interactional patterns, pathologies, and paradoxes (Watzlawick et al., 1967). What these authors argue is that in order for the content of any assertion or statement to be correctly understood the listener has to grasp the kind of relationship that is defined by the communication:

> *Every communication has a content and a relationship aspect such that the latter classifies the former and is therefore a metacommunication.* (Watzlawick et al., 1967, p. 54, original emphasis)

> The ability to metacommunicate appropriately is not only the *conditio sine qua non* of successful communication, but is intimately linked with the enormous problem of awareness of the self and others. (Watzlawick et al., 1967, p. 53, original emphasis)

"That's an order" or "I am only joking" are verbal examples of such communications about communications that one may hear spoken when the speaker perceives the listener either did not "get to it" in the former or took unintended offence in the latter example (cf., Ibid., p. 53). This relationship aspect of every communication commits the speaker and listener to a kind of relationship. In the case of "This is an order" the relationship is an asymmetrical relationship of authority; in the case of "I am only joking" the relationship may be that of a friend, passive aggressive enemy, etc.

The relational aspect of communication is meaningfully conveyed by analogic communication, which the authors define as nonverbal communication. They caution, however, that by "nonverbal communication" they include gesture, the sequence, rhythm, and composition of words and utterances, as well as the context in which the communication takes place. (Ibid, p. 62). In the following excerpt, the cat communicates its relationship by means of acting it out. The cat cannot say "be my mother" so it acts as if it were kitten with its owner, as if it were in the context of mothered:

> Thus, to take one of his [Bateson's] examples, when I open the refrigerator and the cat comes, rubs against my legs, and mews, this does not mean "I want milk" – as a human being would express it – but invokes a specific relationship, "Be mother to

> me," because such a behavior is only observed in kittens in relation to adult cats, and never between two grown-up animals. Conversely, pet lovers often are convinced that their animals "understand" their speech. What the animal does understand … [is] the wealth of analogic communication that goes with speech. Indeed, wherever relationship is the central issue of communication, we find that digital language is almost meaningless …e.g., courtship, love, succor, combat … *in all dealings with very young children* or severely disturbed mental patients. Children, fools, and animals have always been credited with particular intuition regarding the sincerity or insincerity of human attitudes, for it is easy to profess something verbally, but difficult to carry a lie into the realm of the analogic. (Watzlawick et al., 1967, p. 63, emphasis added)

The phrase "in all dealings with young children" is particularly relevant considering that Melanie Klein's technical and theoretical innovations grew out of her analysis of young children. In short, Klein translated the symbolic texture of her child-patients' play through a process of identifying the child's anxiety, interpreting what the child was communicating about a relationship through the play (the child's metacommunication), and monitoring the child's response to make adjustments to her understanding for the next round of: play-moves, identifying anxiety, interpreting, observing (cf., Hinshelwood, 1994). In the terms of Watzlawick, Bavelas, and Jackson (1967) she was engaged in trying to adequately translate from the analogic into the digital, to talk explicitly about the relationship and the problems the children had with the commitment inherent in the communication – to the extent they engaged in symptomatic behavior.[25] For Watzlawick, et al., a symptom is a non-verbal communication. In terms of the case of Trude, described again below, the communication was on the order of, "It's not me that wants to prevent Mom from making daddy's babies at night because it's hateful to me; it's my night terrors and bed wetting." It was the hateful relation that she had difficulty committing to – except in play – until Klein digitalized it through interpretation.

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[25] Watzlawick et al. (1967) note that since analogic communication is characterized by the lack of negation, lack of qualifiers to indicate which of two discrepant meanings is implied, and the lack of temporal markers, that "Freud's description of the id becomes virtually a definition of analogic communication." (Fn8, p. 65)

> I will now turn to consider the content and the causes of these early feelings of guilt by reference to another case. Trude, aged three years and nine months, repeatedly played 'make believe' in her analysis that it was nighttime and that we were both asleep. She then used to come softly over to me from the opposite corner of the room (which was supposed to be her own bedroom) and threaten me in various ways, such as that she was going to stab me in the throat, throw me out the window, burn me up, take me to the police, etc. She would want to tie up my hands and feet, or she would lift up the rug on the sofa and say she was doing 'Po—Kaki—Kuki'. This … meant that she wanted to look inside her mother's bottom for the 'Kakis' (faeces), which signified children to her. On another occasion she wanted to hit me in the stomach and declared that she was taking out my 'A—A's' (stool) and was making me poor. She then seized the cushions, which she repeatedly called children, and hid herself with them behind the sofa. There she crouched in the corner with an intense expression of fear, covered herself up, sucked her fingers and wetted herself. She used to repeat this whole process whenever she made an attack on me. It corresponds in every detail with the way she had behaved in bed when, at a time when she was not yet two, she started to have severe night terrors. At that time, too, she had run into her parents' bedroom again and again at night without being able to say what it was she wanted. By analyzing her wetting and dirtying herself which stood for attacks on her parents copulating with each other, the symptoms were removed. Trude had wanted to rob her pregnant mother of her children, to kill her and to take her place in coitus with her father. She was two years old when her sister was born. It was those impulses of hatred and aggression which, in her second year, had given rise to an increasingly strong fixation upon her mother and to a severe anxiety and sense of guilt which found expression, among other things, in her night terrors. (Klein, 1955/1975, p. 5)

In this example, Klein demonstrates how she contextualized her symbolic interpretations of her child-patient's behavior and speech. Klein repeatedly emphasizes in her writings that "the generalized translations of symbols are meaningless" (cf., Klein, 1926/1975; Klein, 1932/1975; Klein, 1952; Klein, 1955/1975), and that their interpretation must be contextualized to the transference – what they say and do with the therapist. In other words, the symbolism that needs to be translated and interpreted is the symbolism that has to do with the relationship – that is, the analogical or metacommunicational aspect.

So, the decoding of CKPP is not just, "the inference of meanings from the patient's speech and other communicative behavior that are not explicitly expressed in their utterances. (p. 91, above); it is translating the symbolic communications *that tell the therapist how the patient is defining or trying not to define the relationship*. The "architecture of meaning" that

CKPP subscribes to can be characterized as follows: the secondary meanings that are inferred in and through the first are analogic metacommunications conveyed in and through the digital as well as non-verbal messages of the patient.[26] Moreover, since Kleinians believe the unconscious is structured of sensations interpreted as relationships (cf., fn 14, p. 61, above) from early childhood, the roots of these analogic meanings are the body and its functions in relation to the mother's body; the baby's body—mother's body dyad are the metaphorical basis of language.

So, for an example with regard to Kleinian theory, when Segal writes about a patient's capacity to use words as symbols – a developmental achievement – she does so with reference to fecal attitudes in relation to the mother's breast. For purposes of illustrating the following passage, imagine a child that cannot play with clay, paint, or dirt. She has panic attacks around these substances because their identity is not distinct from her interpretation of them in terms of her phantasies. The clay does not function as something that could mean any number of things – that is, as a symbol – its meaning is locked into that of persecutory-thing and is therefore sighted/cited as a frightening object – a symbolic equation, in Segal's terms.

> When a substitute in the external world is used as a symbol it may be used more freely than the original object, since it is not fully identified with it. In so far, however, as it is distinguished from the original object it is also recognized as an object in itself. Its own properties are recognized, respected, and used, because no confusion with the original object blurs the characteristics of the new object used as a symbol.
>
> In an analysis we can sometimes follow very clearly the changes in the symbolic relations in the patient's attitude to his faeces. On the schizoid level the patient expects his faeces to be the [introjected] ideal breast; if he cannot maintain this

[26] Compare, "Symbols occur when language produces signs of composite degree in which the meaning, not satisfied with designating some one thing, designates another meaning attainable only in and through the first intentionality …What gives rise to this work [of interpretation] is an intentional structure, which consists not in relation of meaning to a thing but an architecture of meaning, in a relation of meaning to meaning … regardless of whether that relation be one of analogy or not, of whether the first meaning disguises or reveals the second meaning. This texture is what makes interpretation possible, although the texture itself is made evident only through the actual movement of interpretation." (Ricoeur, 1970, pp. 16-18)

> idealization his faeces become persecutory, they are ejected as a bitten-up, destroyed and persecuting breast. If the patient tries to symbolize his faeces in the external world the symbols in the external world are felt to be faeces – persecutors. No sublimation of anal activities can occur in these conditions.
>
> On the depressive level, the feeling is that the introjected breast has been destroyed by the ego and can be re-created by the ego. The faeces may then be felt as something created by the ego out of the object and can be valued as a symbol of the breast and at the same time as a good product of the ego's own creativity.
>
> When this symbolic relation to faeces and other body products has been established a projection can occur on to substances in the external world such as paint, plasticine, clay, etc., which can then be used for sublimation. (Segal, 1955/1988, pp. 167-168)

However, with regard to current Kleinian practice, "… the general tendency…is to talk to the patient, especially the non-psychotic patient, less in terms of anatomical structures (breast, penis) and more in terms of psychological functions (seeing, hearing, thinking, evacuating, etc.). Together with this emphasis on function, concentration on the patient's immediate experience in the transference often leads to discovery of deeper layers of meaning, some of which may be seen to be based on infantile bodily experience" (Spillius, 1988b, p. 9). To say, then, that the aim of CKPP speech is to "reach," "address," or "make contact with" the "infant-in-the-patient," is to say that CKPP is focused on infantile messaging and message interpretation – the elements of communication that index the mothered context.

The emphasis of CKPP on the relational dyad, viewed in terms of infantile modes of understanding is consistent with the view of Watzlawick et al., that the more "mature" and "healthy" the relationship the more the relational aspect of messages "recedes into the background" (p. 52). This is due to the fact that "all analogic messages are invocations of relationship, and that they are therefore proposals regarding the future rules of the relationship" (p. 101). Theoretically, then, the healthier the relationship the less conflict there is about who is what in their obligations to the other. In contrast, infantile messaging and message interpreting is very much concerned with regulating the maternal relation, since

adequately 'instructing' the mother in terms of it's needs (appropriately defining their identities vis-à-vis each other) is necessary for the infant's survival, and infants do not have the capacity for digital communication, since digital communication requires words, syntactic logic, and the ability to translate from the analogical into the digital and back again.

A characteristic that sets CKPP apart from everyday communication is CKPP's emphasis on *how messages are to be taken and given as invocations of relationships, their relational implications, rather than the surface content aspect (informative value) as is the case in everyday conversation.* Perhaps, then, rather than refer to a principle of "symbolic expression" the rule of CKPP might be characterized as the principle of analogic decoding – the symbolic interpretation of the patient's material in terms of his or her ongoing relational commitments and the identity *claims* and *goals* involved in those commitments. Let us call this the "analytic attitude" of CKPP. The adoption of this attitude by the therapist towards the patient's speech is confirmed by the five questions Dr. R provided this author, since all of them point towards the live ongoing relational positioning of the patient-therapist dyad (cf., pp. 58-59, above).

Formulating and reformulating

> … any communication, as we shall see, implies commitment and thereby defines the sender's view of his relationship with the receiver. (Waltzlawick, et al., p. 51)

Communicating commits one to an identity and the sighting/citing of the other in one way or another in relation to that identity, as well as the possibility of having one's identity commitments (claims and goals) contested. And from the preceding section: (1) this kind of communicating is done symbolically through analogic communication, which (2) in CKPP is subject to analogic decoding – the symbolic interpretation of the patient's material in terms of relational commitments and the identity *claims* and *goals* involved in those

commitments *as they occur as a part of the ongoing conversation between the therapist and the patient*. Thus, the governing question for this last leg of the interpretive analysis is: How do the seven characteristics (Chapter 3), with particular emphasis on symbolic decoding (Chapter 4, previous section), figure into the construction of the ongoing therapeutic conversation in such a way that they contribute to the self-distanciated pragmatic positioning that characterizes "the food" of CKPP?

According to CA everyday conversation has a turn taking structure. So, to the extent the game of CKPP is "up to" something other than an everyday conversation, we can hypothesize that there will be a departure not only in terms of what is said and how it is said, but *when it is said* through the course of the ongoing construction of the dialog. The seven characteristics already outlined in the preceding chapter deal in one way or another with what is said and how the interpretive utterances are structured, but they do not provide a guideline for the way the therapist takes his or her turns when speaking with the patient. The eighth characteristic of CKPP is its turn taking structure.

In other words, formulating these recognitions in interpretive utterances requires communicative work between the patient and the therapist. Our primary interest is in the therapist's side to this communicative work, which involves a further explication of CKPP's hermeneutic presuppositions of understanding and how they contribute to what is said (the content of utterances), how it is said (the structure of utterances), and when it is said (how they affect the turn taking system).

This does not mean, however, that the patient is seen as simply a passive receptacle for the therapist in the position of absolute objective-truth-speaker – a common misunderstanding of psychoanalytic practice in general. Quite to the contrary, the following will show how the author's understanding and communicative behavior was modified by the

patient's actions. Paradoxically, it will show that the turn taking system of CKPP is organized around instances when the patient is not participating as an "autonomous cosubject" (cf., Kögler citation, p. 85, above) of the critical dialog, even if that dialog occurs within a fundamentally asymmetrical power relationship of dependence. In CKPP one intervenes when the patient is not working to understand his or her problems for his or her self.

034 I think one way you are trying to keep some powerful feelings away is by turning our conversation to
035 events in the past that are easier to talk about.

036 Yeah to make the comparisons. I'm trying to figure out why I'm so sad. I'm in extreme
037 circumstances – my daughter's wedding and the recent terrorism.

Again, Mrs. P corrected my understanding of her second extended turn by means of initiating a repair of alignment. This was done through a retrospective sighting/citing of her turn and who she was as the subject of that turn: the identity of "trying to figure out why I'm so sad. I'm in extreme circumstances" (036-037) as she grasps "my daughter's wedding and the recent terrorism." (037) My subsequent utterances show alignment to her assumption of the position "trying to figure out…" by giving her a characterization of herself in her "extreme" situation. But how did I arrive at this characterization, since it includes terms not employed by Mrs. P such as "anger", "contain…inside"?

038 Perhaps a part of you is feeling sad, scared, and angry at your daughter for getting married as if
039 she were deserting you now like you felt by your sister, and the problem is you don't feel you have a
040 way to contain these feelings inside.

Following from the previous section, this requires interpreting the relational implications of Mrs. P's communications, but how? Taking an interpretive look suggests that it was based on adopting a particular position (analytic attitude) towards the content and sequence of Mrs. P's speech thus far in the session, and towards her second extended turn in particular.

Mrs. P applies a specific emotional term to her identity – “I’m feeling guilty” (022). This shows that she understood my previous observation, “It’s like you drop your feelings that feel overwhelming as if we couldn’t tolerate them” (017-018), as indicating a problem to be corrected, since she agrees with the assessment and picks one feeling to focus on out of the miasma of “overwhelming” feelings. In short, in response to “you drop your feelings” she names one, picking it up, as it were, to look at it rather than just standing in it.

Mrs. P justifies her extended turn by explaining, “Yeah, to make the comparisons” (036). What Mrs. P appears to be comparing are two different contexts in which some emotional component of the “extreme circumstances” is at work. The first context for this upsetting state is motherhood as a backdrop of roles for evaluating her own role in her daughter’s wedding. It is as if Mrs. P had uttered, “Is the feeling because I’m not taking care of things for her as a mother should, or maybe I’m a controlling mother like my own and I have no control that I feel I should?” Yet in 028 she abruptly changes the context of the upsetting feeling(s) – is she still working on the feeling she called guilt? – to childhood (“I’ve tried to let my own children,” lines 026-027, is followed by, “the sister who I was in the arms of,” lines 028-029). In the context of childhood the upsetting feeling is linked to her grasping her mother as institutional, and her sister as a mother-substitute-sister who, while more caring than an “institutional mother,” “went off” when Mrs. P was still a child in need of more than an institutional mother.[27] The basis of the “parallel,”(032) then, is her grasp of significant people as leaving her, whether because they withdraw from her by leaving (the sister), sending her away or responding only out of duty (the institutional mother), or as a result of her decision (her sending her children away).

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[27] In a previous session Mrs.P had mentioned this memory as her first memory, back in infancy, of being held by her sister, wearing tartan, in front of a fireplace.

And if one assumes that these two ‘bad’ feelings are linked by virtue of their sequence in her speech – just as the last word of a sentence can change the meaning of the whole, or in CA the subsequent utterance shows how the preceding is to be interpreted – then Mrs. P’s “guilt” has to do with feeling guilt about the overwhelming sense of loss – grasping her daughter as leaving *her* by getting married. Moreover, the other part of her “extreme circumstances” is the “recent terrorism” – i.e., people afraid in a situation involving the collapse of security and the loss of life (“end of life issues”; 9/11 context). So, the extreme circumstance is feeling scared in the face of the loss of life (sadness) and feeling guilty about the magnitude of this feeling because it is interfering with her ability to fulfill her role as mother to her daughter.

So, the position that changed towards Mrs. P’s extended turn and allowed for the formulation had to include grasping Mrs. P’s turn as an attempt to figure out what is upsetting her rather than just a deflection. This involved the seven characteristics of CKPP already outlined (p. 87, above). First, note taking was used. Second, her material that was recorded provided the basis for my response. Third, specialized technical knowledge was drawn upon to formulate how I understood and responded to her material (where did “angry” and “contain …inside” come from?). Fourth, analogic data was inferred from her material and used to try and understand her immediate problem (“trying to survive this week” (001-002), facing “extreme circumstances”). Fifth, explicit or digital data was employed to understand the problem. Sixth, the responses were made in the form of interpretive utterances that asserted my beliefs about her experience in the moment, and seventh, these assertions took the form of a hypothesis.

In Kleinian terms the analytic attitude is that her speech contained “representational content” that needed to be understood within the context of “[her] particular emotions and

anxieties and in relation to the whole situation which is present in the analysis" as Klein articulated the principle of symbolic interpretation in regard to her play technique (Klein, 1955/1975, p. 137). This implicates practices and underlying assumptions of CKPP.

Mrs. P is ostensibly talking about what the separation from her daughter is to her, how she is painfully grasping it. But this speech is produced in a session that is her last before she separates from the therapy. Furthermore, she began the session talking about an "irony": how in her new post her confidence in growing yet she is afraid. Therapy is a work situation and Mrs. P is new at it – she has only been a patient for five weeks. So, by this point in the session I was decoding that Mrs. P was distressed by the pending loss of me, as one on whom she depends like her sister-daughter-institutional mother (Compare, 067-068, p. 119, below, where I first explicitly stated this hypothesis to Mrs. P). Furthermore, clinical tradition assumes that breaks in the treatment, whether holiday, sick days or sometimes even weekends, register as a significant loss for patients and that "you are safe in assuming that it will come up," as Dr. R would say, regarding themes of loss before and after breaks in treatment. And, as happened in this session, I often times forget this piece of wisdom until contexts of loss were implicitly or explicitly indexed during a session before a break.

Translating the symbolic content (i.e., not just what she says but how she says it) of what Mrs. P says is a critical interpretive act. And, as a critical interpretive act, it has a "ground of possibility" that "is made possible by a largely implicit preunderstanding. This preunderstanding is internally differentiated into a *symbolic* sphere of basic beliefs and assumptions, a *practical* sphere of acquired habits and practices, and a *subjective* sphere that reflects biographical events and experiences" (Kögler, 1996, p. 251, emphasis in original).

Retrospectively, for example, my use of the word "angry" could be an example of the subjective sphere, the symbolic sphere, or both informing the interpretive act. In terms

of the symbolic register of Kleinian beliefs and assumptions, using “anger” instead of “guilt” may have been a misinterpretation based on the understanding that Mrs. P’s guilt was a result of unconsciously projecting and identifying her daughter as angry towards Mrs. P. The assumption in this case is that Mrs. P was unable to explicitly index (identify herself) as an angry person. Instead she positions herself as guilty in the face of someone else’s anger – a punishment phantasy – which is really Mrs. P’s grasp of her daughter’s wedding. In other words, a part of her would like to punish her daughter for leaving her, which is why she sights/cites her marriage as a bad thing. In this case, citing “anger” is an example of trying to fit Mrs. P’s experience into a theoretical preconception that either does not match the situation at all or is not the salient issue in terms of her main anxiety of the moment.

On the other hand, or perhaps in tandem with the symbolic aspect, it may have been that I uttered “anger” from the subjective register, where biographical events and experiences shaped my understanding as a critical interpreter. In this case I derived “anger” from how I would feel if I believed someone were abandoning me and leaving me to fend off fears about death all by myself, or my own reaction to the twin towers attack. “Anger”, then, would be an ASSOCIATION on my part that is not based on a theoretical presumption, but rather my own personality and personal experience.

Finally, it could have been that Mrs. P struck me as angry – she might have referred to her daughter’s wedding in a derogatory tone. In this case, to be with Mrs. P at this moment of the session would have been like being with a resentful person. Using my experiential reaction to her self-presentation in this way would have been shaping or formulating my utterance in terms of the COUNTERTRANSFERENCE – recall that one of the five questions for framing the interpretive apparatus of CKPP is: what is it like inside to be with this person? (cf., pp 59-60, above).

Articulating "the problem" as Mrs. P not feeling she "has a way to contain these feelings inside" (039-040) also stems from the symbolic sphere of Kleinian presuppositions about reality. In colloquial speech, people sometimes say things like "I'm so excited I just can't contain myself." This notion of containing oneself is also a technical concept developed in the Kleinian tradition, referred to as CONTAINING or CONTAINING FUNCTION. To simplify the explanation, imagine a baby is crying at the top of his lungs. His mother is instantly alerted and scurries it to make sense of the cry. It doesn't stop when she holds him or offers him a bottle. She checks his diaper, talking to him in a calming way. But as her baby screams louder she may begin to panic and believe her baby is also panicking. Eventually she figures out he has an earache and puts some medicine in his ear while continuing to offer reassuring words. In Kleinian lingo, the baby, unable to communicate through words, resorts to communicating by giving a piece, as it were, of the experience to his mother. He "evacuated" his unbearable anxiety by putting it in his mother (SPLITTING it off and PROJECTING IT into her) who was able to make sense of it because she experienced it as in herself (she "swallowed" the PROJECTIVE IDENTIFICATION), resulting in her doing things to help him tolerate it (she acted to CONTAIN it, provided a CONTAINING FUNCTION). Ultimately this means putting words to the experience, since at some point the child can say, "mom I have an earache" rather than just start screaming (i.e., containing it himself). Through the rest of his childhood there will be countless occasions where the mother will model how he is to handle states or situation that seem overwhelming. It is this model that becomes his GOOD INTERNAL OBJECT whose primary function is to contain – i.e., make manageable – painful emotional experiences, so that they can be understood and communicated through words.

Asserting, "the problem is you don't have a way to contain these feelings inside" (039-040) is in response to "I'm in extreme circumstances" and "overwhelmed." In other words, through her speech, Mrs. P was PROJECTING (as in actors projecting an emotional identity claim) distress, which stirred up some anxiety in me and I was trying to give it back to her through what I said in an altered form (the sense I made of it) – that might help her make more sense of it.

But why did I provide the interpretive utterances *when* I did? Up to this point the interpretive analysis has not examined how the turn taking system of everyday conversations is modified (if at all) for a CKPP therapeutic conversation. We have just examined how the content and, to some extent, the construction of interpretive utterances is related to the critical hermeneutic preunderstanding of CKPP. Now the challenge is to look at how the content, construction, and *deployment of interpretive utterances* worked together to constitute the author's work during the therapeutic conversation. This will be the eighth characteristic of CKPP tied to the practical, symbolic, and subjective spheres that govern the other seven.

In CA turns are constructed around "transition relevance places" (TRPs): "the spot that participants recognize as the potential end of a turn, [the] place where a transition from one speaker to another becomes relevant" (Nofsinger, 1991, p. 81). TRPs can be words, phrases, clauses, or entire utterances. So, did I understand the last word or entire utterance as the TRP of Mrs. P's prior speech? (036-037)

041 It could be. Yeah. I feel like I'd add to them remorse. Is remorse a feeling or are
042 sad and remorse the same thing? Remorse is the biggest and that comes to how I
043 feel. It's limiting my concept of my daughter's freedom. It's not like she's being
044 taken off to jail…

Neither. I argue that identity claims can function as TRPs, conveyed through emotional signaling. Simple behaviors may also function as TRPs in everyday

conversation.[28] Mrs. P's response, in fact, suggests that the TRP I recognized was her attitude displayed through her talk: "I'm trying to figure out why I'm so sad" (036). My interpretive utterances (038-040) provide something to help Mrs. P "figure out why". Mrs. P's conditional agreement and adding of "remorse" shows that she understood my utterances as a means for comparing what she is feeling to how I described it, refining her own sense of what it is that she is having difficulty with, "I'd like to add to them remorse."

In Mrs. P's next turn she continues to talk about her problem with the wedding. She not only remarks that "remorse" is the "biggest" problem, but comments on how it is affecting her grasp of her daughter: "It's limiting my concept of my daughter's freedom." This last remark suggests that in Mrs. P's remorseful position she grasps herself as a defective mother ("feeling guilty" in 022) because the feeling of loss ("so sad," line 036) was limiting the extent to which Mrs. P was open to her daughter having interests distinct from her own. In fact her following utterance, "It's not like she's going off to jail," could be an attempt to cheer herself up, as if I came out to my car to discover a flat tire and said, "well at least I didn't get killed from it blowing out on the freeway."

Mrs. P continues to speak of the wedding although the tone changes with her grasp of what the event will entail for herself, particularly her "all [her] hopes, wishes and ambitions for a daughter that I'll keep repressing." Notice the change in position that occurs in her next speaking turn if we divide her utterances into two units for closer examination: 041-046 and 046-049. Mrs. P explains that she is going to repress these things because she believes she is not supposed to cry. Beginning with the next turn (halfway through line 046) she shows that she has changed her understanding from wedding *as disaster* to wedding *as*

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[28] Take, for example, a child whose mother turns to her and says, "don't do that." The mother self-selected a speaking turn based on the child's misbehavior. Similarly, "don't talk back" exemplifies a TRP based on an offensive attitude from the perspective of the parent, and so on.

having something good and even something great, exceeding expectations ("the most you could ask for," line 049).

044 … She's getting married and she's fine and I'm keeping all my
045 hopes, wishes and ambitions for a daughter that I'll keep repressing because I'm
046 not supposed to cry at the wedding. So I probably feel good about the ceremony
047 itself, ca use it's being worked on by both sides of the family. But I guess the
048 greatest thing about it is how both planned the ceremony should go, which is the
049 most you could ask for in an interfaith wedding.

It is as if she collaboratively completes the injunction not to show how upset she is by doing the "repressing"; she aligns with herself behaviorally and chooses to focus on the pending loss of her daughter as really a positive event after all. Mrs. P does "repressing" by using her subsequent speaking turn to change her identity from mother-to-the-bride-painfully-sighting/citing-her-separating-daughter to the ceremony critic who approves of "interfaith weddings." Rather than using her speaking turn to continue talking about her painful sense of her daughter's wedding, Mrs. P interrupts herself as a mother and speaks from the identity of chaplain. With this shift of identity she alters her emotional grasp of her daughter's wedding. Yet, it is not the chaplain who has the problem with the wedding; it is Mrs. P as the mother. By shifting to her chaplain identity Mrs. P has stopped speaking about her problem, "why I'm so sad …in extreme circumstances."

And, like a collaborative completion, her utterances "makes relevant an acceptance or rejection in the next turn." I self-select a turn to accept her repositioning as a rejection of speaking about her problem, an assertion that Mrs. P ratifies in her next turn:

050 Just now when you began to feel unbearably bad about your wishes for your daughter's wedding you
051 began to focus on the bright side.

052 Yeah, that's the annoying thing that happens. Yeah. Because I've always done that and I don't
053 keep going and I don't know why or where I stopped but something over and blocks whatever I try to
054 get at. I'm sure that happens when I'm doing my work. My PC Response score is totally on the
055 supportive side [some personality type test they are given] It goes from authoritative to instructional
056 to all way over to empathic and supportive responses – my natural responses are empathic and very
057 supportive. But I'm naturally that way, but I cannot keep going [with what she is feeling as first

058 mentioned], but that's kind of improved since I started coming here as it's been reflected in my
059 verbatims [group supervision]. I want to know why I do the little cheery deal, which you record as
060 my dramatic voice.

Again, my response emphasizes some element of the action in the here and now of our conversation ("Just now when…") and articulated a sequential relationship between what Mrs. P experienced and what she did in response to avoid that experience. Mrs. P's response to this shows she understood it as a move on my part to select her behavior as the topic for conversation, since she starts to talk about it as "the annoying thing that happens" and cites it as a problem for discussion ("I've always done that…I don't know why or where… whenever I try"). This exchange is another assessment-explanation adjacency pair, like that noted above (pp. 84-85).

However, she changes the topic of the action from herself (I asserted, "you began to focus on bright side") to some thing that "happens" to her in the passive voice ("that's the annoying thing that happens"). Notice also that her description, "I don't keep going", applies to this extended turn as well, since her talking about this "annoying thing that happens" is interrupted briefly by describing her identity as a chaplain *again,* as defined through their evaluation instruments ("My PC Response score is totally on the supportive side") before returning to me as the one who makes an evaluation of her ("…which you record as my dramatic voice").

So far, then, the interpretive analysis shows that there is a to and fro quality to the turn taking in which Mrs. P and I engaged.[29] Mrs. P talked about a problem to some extent, then talked about something else, which I countered with interpretive utterances that had the

[29] While there is a distinction, I think it is obvious that turn taking is related to the content of what is said, even if Nofsinger never explicitly states this. Otherwise there is no way to account for a person abruptly changing topic (interrupting and usurping another speaker's turn) when they are bored with what is being said by the current speaker. The point of this section is that the turn taking structure of CKPP, as a facet of its communicative competence, involves "rules" for the exchange of talk based on what and how the patient is speaking and what is or is not being accomplished by his or her talking.

effect of shifting the topic of the conversation back to a problem of Mrs. P's. In turn, Mrs. P talked in a bit more detail about the problem until she stopped. This pattern is not random. It reflects a specialized communicative practice on the part of the practitioner of CKPP in response to a particular move or moves of the patient. Provisionally, the eighth characteristic of CKPP can be characterized as: *make interpretive utterances when the patient has stopped talking about his or her problem in a way that provides more detail about her experience of it.* This shows that there is more than formulating what one says; there is the issue of adjudicating the right moments for making one's moves. So, in addition to the content and construction of interpretive utterances, the practical, symbolic, and subjective spheres must figure prominently in shaping how the practitioner of CKPP participates in the turn taking system of the therapeutic conversation – *the deployment* of interpretive utterances. *Practically,* there are specific practices regarding when to make interpretive utterances; *symbolically,* these practices are derived from assumptions CKPP makes regarding infantile existence, particularly infantile modes of communicating and thinking; *subjectively,* it was through my supervision experiences and communications with Dr. R that I learned most of the elements of the practical and symbolic spheres of CKPP.

As Dr. R described it, in the discourse of the Kleinian tradition "interpretations are food and therapy is a feeding." How to interpret – the deployment of interpretive utterances – is as complex as the mother learning to feed her baby. Just as the right combination of nutrients, provided in the right amounts, at the right time, are required for the baby's body to develop, so too the baby-in-the-patient needs a recognition formula, as it were – the food of identity. Just as mother's milk contains the nutrients for the baby's body, this identity-food (more colloquially referred to as understanding) is contained in the therapist's utterances (usually called "demonstrating empathy" in therapy speak).

A baby learns to feed as the mother learns how to feed her child. At the time the baby refuses its food for different reasons. What does the mother do at these times? Sometimes the mother persists because she believes the baby needs to eat even if a fever makes him cranky or he doesn't like the new kind of food or flavor. Sometimes the mother recognizes she has tried feeding too much at once and gives him a smaller portion or spoon. Sometimes she notices the richer formula causes diarrhea so she may dilute it a bit or hold off on changing the formula until she believes the baby is ready. All of these adjustments require the mother to use her judgment and attend to the baby's ways of communicating for her to decide what's the right way to feed this particular baby – especially if her baby has problems feeding, digesting, metabolizing or excreting waste.

The same sorts of complexities face the therapist trying to make interpretations. Throughout my supervision with Dr. R, the topic of making INTERPRETATIONS has been addressed in terms of a few guidelines concerning when, what, and why. On numerous occasions I was anxious before supervision, afraid of having made a mistake and said something wrong or stupid. And every time Dr. R emphasized how what I said effected the "flow of the material": "It's not about whether or not what you say is right or not; it's about how it effects the flow of material … like a river and you are moving rocks and want to see how it changes the flow." This flow of material is the feedback of the feeding baby, how the baby comports him or herself in response to "the flow" from the mother. "What [she] just did is like the baby turning her head and spitting out [her] food … notice how [she] had a hard time taking it in, it was too much" is one way Dr. R would talk to help me see how my attempts at feeding were going. According to Dr. R, every patient presents with "a problem of feeding" and the therapist's job is to feed and point out the problems with feeding, where "food" and "feeding" are the guiding metaphors for gaining greater experiential

understanding of themselves, that is, INSIGHT. An understanding about their experience is spoken by the therapist (food), which the patient may or not: hear ("take in" or "ingest"), consider (work to "metabolize" or "digest" what's been said), or respond to in a productive way (the excreta, as in the case where the patient may be said to "soil" the therapist's work and negate what understanding he or she was able to consider).

This INSIGHT consists of who the patient – in PHANTASY – believes they are, and how and what they do with significant others to participate in creating their conscious reality. In CKPP this goal is conflict ridden for patients, particularly those with a reduced capacity for tolerating some of the painful emotional realities that are a part of the human condition.

Recall that the PARANOID-SCHIZOID POSITION is the condition where the person is faced with an unbearable emotional grasp of a situation and SPLITS it off – attempts to get rid of having to experience it – by attributing either the emotion or the practice that gave rise to the emotion to someone or something else, who/which is then identified on the basis of this disavowed part of the person. In the PARANOID-SCHIZOID position the focus is on preserving the self against destruction. The evacuated aspect is felt to be persecutory, a threat to the self and therefore must be annihilated. Since the other is seen as possessing the dangerous aspect, he or she is sighted/cited as threatening – "his faeces become persecutory," as Segal might say (cf., Segal citation, pp. 95-96, above), or in garden variety manifestations, one might accuse someone of being a "shit" when they don't give what one wants or expects.

As long as this aspect of the person is disavowed in this manner then it cannot be understood as a part or product of the self; it belongs, it *is* someone else. And, therefore, any attempts to understand the aspect as an experience of the self will be RESISTED

because it will intensify the MAIN ANXIETY that caused the aspect to be split off in the first place. This is a simplified way to explain how "the use of primitive splitting defenses …are working against understanding" (Josephs, 1982/1989, p. 140).

On the other hand, in the DEPRESSIVE POSITION the foregrounding concern is the preservation of the other as the source of goodness upon whom one depends. Returning to our hypothetical infant, suppose the infant has begun teething and biting on the mother's breast while feeding. The mother begins weaning, which the baby experiences as a frustrating reality that he is forced to deal with. Around the same time the baby has begun to acquire the perceptual and motor capacity to perceive the mother as a whole person, which makes it harder for him to separate the good and bad experiences into two separate images of the mother. He begins to have to deal with the fact that the good and bad breasts are aspects of the same whole embodied person. In this circumstance, his hateful feelings, when frustrated, conflict with the desire to love the same person. The baby must then deal with another set of anxieties besides those of fearing for his own existence; he begins to have concern for the good-but-now-attacked-and-therefore-damaged-mother. He now has to struggle with the painful feeling of causing the loss of the good (guilt) and the fear that the good-but-damaged mother might retaliate as he wanted to destroy her (as bad):

> I said that the baby experiences depressive feelings, which reach a climax just before, during and after weaning. This is the state of mind in the baby, which I termed the 'depressive position', and I suggested that it is a state of mourning in *statu nascendi.* The object which is being mourned is the mother's breast and all that the breast and the milk have come to stand for in the infant's mind: namely, love, goodness, and security. All of these are felt by the baby to be lost, and lost as a result of his uncontrollable greedy and destructive phantasies and impulses against his mother's breasts … There is a constant interaction between anxieties relating to the 'external' mother … and the 'internal' mother, and the methods used by the ego for dealing with these two sets of anxieties are closely related. In the baby's mind, the 'internal' mother is bound up with the 'external' one of whom she is a 'double', though one which at once undergoes alterations in his mind through the very process of internalization; that is to say, her image is influenced by his phantasies, and by internal stimuli and internal experiences of all kinds. When external situations which

> he lives through become internalized, people, things, situations, and happenings – the whole inner world which is being built up – become inaccessible to the child's accurate observation and judgment, and cannot be verified by the means of perception which are available in connection with the tangible and palpable object-world, has an important bearing on the phantastic nature of this inner world. ***The ensuing doubts, uncertainties and anxieties act as a continuous incentive to the young child to observe and make sure about the external object world, from which the inner world springs, and by these means to understand the internal one better.*** The visible mother thus provides continuous proofs of what the 'internal' mother is like, whether she is loving or angry, helpful or revengeful. The extent to which external reality is able to disprove anxieties and sorrow relating to the internal reality varies with each individual, but could be taken as one of the criteria of normality. In children who are so much dominated by their internal world that their anxieties cannot be sufficiently disproved and counteracted even by the pleasant aspects of their relationships with people, severe mental difficulties are unavoidable. (Klein, 1940/1975, pp. 345-347, emphasis added)

Thus, the DEPRESSIVE POSITION is the position of doubting one's own understanding of reality by working to differentiate the identity of the Other-in-a-situation from one's own PHANTASIZED presupposition of the Other's being *as* a such and such. One's own emotional states are not immediately attributed to another as either their cause or effect. The thing or person can begin to be differentiated from one's emotional grasp of the object. This is the "depressive level" of using symbols rather than the "symbolic equation" type of thinking Segal writes about in her above-mentioned paper.

In the DEPRESSIVE POSITION there is "continuous incentive" to observe and makes sense of how the "external object world" matches or does not match one's own preunderstanding of the people and events that world. It manifests itself as a concern for others as separate persons – who they are, what they think, feel and need – outside the self's own agenda. Therefore, it is a situation where the person is able to differentiate a position they are taking on the world from a definitive grasp of the world or the Other in that world. Is the breast destroyed or just absent? Am I hungry because the breast is withholding from me to punish me or do I see the breast as mean because I can't stand feeling hunger pain? Is my wife a bitch because dinner isn't on the table as soon as I walk in the door when I expect

it, and therefore I should abuse her as she has 'abused' me – the paranoid/schizoid response – or is the missing dinner and hunger pain a sign my wife had some problem that she might need my help overcoming – the depressive position containment of aggression and concern for the object? In other words, in the DEPRESSIVE POSITION one can understand aspects of self experience as *aspects of self experience* – not someone else's experience – because they are able to CONTAIN them "to emotionally manage the likely vicissitudes of human relating, be that the therapist-patient relationship or the parent-child relationship (or the intimate adult couple relationship)" (Ruszczynski, 1999, p. 103).

Thus, in CKPP DEPRESSIVE POSITION functioning is a required for critical self reflection, for INSIGHT into the self:

> All our patients come to us, we and they hope, to gain understanding, but how they hope to gain it must vary, I am suggesting, according to their position; that is, according to the basic nature of their object relations, anxieties, and defenses. The very nature of the defenses used in the paranoid-schizoid position in itself militates against understanding; understanding is frequently, but not always, not what these patients want. In fact, many are against understanding despite their protests to the contrary …I suspect that it is only those patients in the depressive position who can use understanding in the sense that we tend to think of the term ordinarily, I mean in the sense of discussing, standing aside from a problem, seeking, but even more, considering explanations … " (Joseph, 1982, p. 140)

In terms of technical implications for CKPP, Joseph's and Steiner's work (cf., Steiner, 1993) has emphasized the importance of monitoring "the position from which he or she [the patient] is operating, so that contact can be achieved and with it real understanding, as opposed to subtle acting out and pseudo-understanding" (Josephs, 1982, p. 150). Optimally, in other words, one becomes more proficient at feeding, offering the addition of some new element of understanding about the patient's PSYCHIC REALITY in a useable form to help the patient with the task of figuring out his or her own problems – who they are, what they feel, what they want, what they say the want but don't want, etc. With this understanding it is assumed that the patient will be free to make decisions about what they

do or do not want to do with regard to what they previously did not know they did, the components that contributed to their problems.

Dr. R offered the following as a rule of thumb regarding when to interpret: “You only need to intervene when the patient is defending.” This piece of advice was offered in the context of explaining that one can look at the flow of material in terms of three basic moments. The first is ACTIVATION, where the patient is actively working on his or her problem from the DEPRESSIVE POSITION. The second is ANXIETY or DEPRESSION where the patient begins to experience emotional upset from working on his or her problem. This upset, at some point or other, becomes too much to deal with, so the patient then DEFENDS against the feeling and against working on the problem that brought up the discomfort. It is this last moment of the three that Dr. R marked as the time to offer an interpretation, because if the interpretation is close enough to what the patient can recognize he or she will go back to ACTIVATION and the cycle starts over.

In terms of the inquiry into the turn taking system of CKPP, this suggests that the TRPs of everyday conversation are modified in CKPP to include the identification of a pattern of speaking: an attitude towards the self and the subject matter under discussion. In the portion of the session examined above, this turn taking pattern can be seen in my interpretive utterances (016-018) where I interpreted Mrs. P to be “deflecting” for the second time in the session against “overwhelming feelings … fears of falling apart.” Mrs. P ACTIVATED in her subsequent speech (019-023), beginning to talk about her guilt and relating it to problem. I understood the rest of her turn (021-023) as a DEFENSIVE maneuver, judging by my response (034-035) to her turn, sighting/citing her speaking about her past as “turning our conversation to events of the past that are easier to talk about.” However, her next turn initiated a repair, to realign my understanding of her turn as an

example of ACTIVATION, turns where she was "trying to figure out" a problem in her experience. In response, I realigned my understanding, showing I agreed with her, by formulating interpretive utterances (038-040) regarding why I believed she was in such "extreme circumstances."

Mrs. P ACTIVATED again in the first portion of her subsequent turn (041-046). This time the painful feeling was called "remorse" which she was able to experience and talk about for five lines or so (041-046) before DEFENDING by focusing "on the bright side" as I described it (050-051) and she ultimately renamed "my cheery deal" (059) – after briefly DEFENDING again (054-057). Notice how ACTIVATION depends on something new being added to the discussion on the table, more detail about her problem is added to the ongoing construction of the conversation. This is one way to identify if the patient is speaking from the DEPRESSIVE POSITION.

In the terms of CKPP, most of the additions comes in the form of an ASSOCIATION, which Dr. R defined roughly as "when the patient takes something from the here and now of the discussion and adds something to it." The same definition also applies to the therapist, since the therapist's associations (again, loosely defined as 'what comes to mind' while listening or talking about something) also shape what he or she says. For example, I told Mrs. P that (lines 038-039) "Perhaps a part of you is sad, scared, and angry …" For any of the reasons discussed above, "anger" was largely my associations to "my daughter's wedding and the recent terrorism," which I dropped as an explicit topic when Mrs. P brought up (added) "remorse" in her subsequent turn.

What you interpret ideally includes "something she doesn't already know about herself." For when Mrs. P explained (036-037) "Yeah to make the comparisons …I'm in extreme circumstances – my daughter's wedding and the recent terrorism" I could have

MIRRORED her by replying with something like, "your daughter's wedding seems like a catastrophe on the scale of the World Trade Center bombings." In effect, I would have been highlighting what she was experiencing or believed to be true about the state of things, but not adding some other element for her to consider how *who she is* (or what she does being the kind of person she is) is implicated in what and how she experiences (cf., "…and the problem is you don't feel you have a way to contain these feelings inside," line 039-040). As Dr. R reiterated, "your job is to make the unconscious conscious." So, another part of keeping the "flow of the river going" is the process of making something that Mrs. P does known to her that was unknown – although recognizable when shown to her – as in 052 above, she agrees by asserting "that's the annoying thing that happens." "That's" was recognizable when point out, but simply done moments before and moments later (beginning with "My PC Response score…," line 054), as seamless and un-thought-worthy a shift as changing gears while accelerating your car.

This extended turn of Mrs. P's (052-060) also reveals something about the clinical phenomenology of SPLITTING, which up to this point has been described as trying to get rid of awareness of part of the self (pp. 76-77, above) that is rejected as part of the "me" (p. 78, above), because it is experienced as unbearable (p. 111, above), and therefore impedes understanding one's self in relation to others in a more differentiated manner (pp. 113-115, above). As in Mrs. P's extended turn above, throughout the session SPLITTING occurs *when the subject who is speaking – the voice, the "I" of the utterances – abruptly changes because an emotional grasp becomes too much so it can no longer be the foreground subject matter of the talk.* Thus, one "I" starts to talk about "the annoying thing that happens … I'm sure that happens when I'm doing my work" (055). But instead of say, going on to give an example and "make comparisons" to "figure out why" as she did in her second extended turn, the chaplain "I"

resurges again and relates it to how empathic she is. Yet the ascendancy of the chaplain "I" does not last and her figuring-out voice, so to speak, regains saliency: "I want to know why I do the little cheery deal, which you record as my dramatic voice." In fact, the rise and fall of the chaplain "I" is one way to trace Mrs. P's movements to the SPLITTING DEFENSE: "the most you could ask for in an interfaith wedding" (049); "processing things to do with my daughter's wedding all this introspective stuff between now and Tuesday when I leave" (020-021); and the analysis of 005-015, where it was already shown to be a struggle to maintain the saliency of the chaplain "I" and its perspective on things. Furthermore, notice that there is not a resurgence of her chaplain voice in the latter six-eighths (021-033) of her second extended turn, which I had erroneously sighted/cited (034-035) as defensive speech.

Now, in CA 'occasioning' is the way "[participants] are skilled in using utterances as a resource for constructing another utterance. We will say that one utterance *occasions* a later one, or that certain talk was *occasioned by* certain earlier talk." (Nofsinger, 1991, p. 69, emphasis in original). Therefore, this interpretive analysis shows that more than utterances are occasioned in CKPP; a change of position was occasioned by my prior interpretive utterances.

Mrs. P's last utterance 059-060 is a question, which, based on my subsequent utterance, I understood as a request for a response to understand ("get at" or grasp) more about her "cheery deal" that "over and blocks" the emotion(s) she tries to speak about. In this position, Mrs. P is ACTIVATED, sighting/citing one of her own social practices (the identity "cheery deal") as the topic for discussion. And this sighting/citing is occasioned by her alignment with my prior understanding, where I sighted/cited her deflecting speech.

So, another way to talk about the cycle of ACTIVATION ➔ ANXIETY/DEPRESSION ➔ DEFENSE ➔ INTERPRETATION ➔ ACTIVATION is

that it defines a turn taking system organized around the occasioning of a position where the patient sights/cites something he or she does automatically, without awareness and how it affects some aspect of his or her experience. I am arguing on the basis of the empirical data that *just as one can align with the topic of talk to achieve understanding, one can also align with the position one takes towards the talk for understanding to take place.* I am also arguing this on the basis of theory since *analogic alignment (understanding) is required for digital alignment.* (cf., Waltzlawick et al.) In the terms of Waltzlawick et al., my prior interpretive utterance analogically communicated a "proposal regarding the future rule of the relationship … by my behavior I can propose love, hate, combat, etc., but it is up to you to attribute positive or negative future truth value to my proposals" (p. 101). What I proposed wasn't hate or combat but *critical self-reflection.* This is the physiognomy of "reflexivity-in-interpretation" (cf., Kögler citation, p. 85, above). I showed or projected reflexivity – a reflective position towards one's messaging – to Mrs. P, a sighting/citing of herself that she could (and did) align with by reflecting on her position. In Kleinian terms this might be called an INTROJECTIVE IDENTIFICATION move on her part – "taking in" what I fed her.

To the extent the relationship I proposed (a stance for herself to adopt towards her messaging) was critical hermeneutic reflexivity, we can expect the feeding to address the symbolic, practical, and subjective spheres as discussed above (cf., p. 102). Recall Mrs. P just expressed a desire, "I want to know why I do the little cheery deal …":

061 Like I've been saying. I think these fears of falling apart or being overwhelmed get dropped and
062 perhaps it's because you don't expect another person to stay with you and help you make sense of
063 what feels overwhelming inside.

064 Yeah. [tearing] that make sense. Yeah because principle people at crucial ages for me they
065 disappeared whether death or loosing a sister going to college or marriage is like a death. Yeah.

066 So, perhaps inside you feels out of control because of there are several death-like changes you are
067 dealing with right now – the bombing of the terrorists, your daughter's wedding, and the fact that we
*068 won't be meeting next week because **you** won't be here*

The feeding is another assessment of her identity, sighting/citing her as too afraid of being left on her own to deal with "fears of falling apart or being overwhelmed." I was sighting/citing her identity in relation to another person as the reason she does the "little cheery deal," that "annoying thing" that "blocks" whatever she "tries to get at." Thus, along with all eight characteristics already articulated, these interpretive utterances tie Mrs. P's "cheery deal" way of dropping "fears of falling apart" (a social practice of the practical sphere) to beliefs about "another person ['s]" reality (symbolic sphere) based on personal experience (subjective sphere)

Of course the "another person" indexed here was myself; Mrs. P did not expect *me* to help her "make sense." The first introductory remark, "Like I've been saying" indexes the first and second responses I offered to Mrs. P in the session: "I think your feeling overwhelmed inside" (003), "your fears of falling apart … it's like you drop your feelings that feel overwhelming as if we couldn't tolerate them" (016-018). In fact, these interpretive utterances are *almost* a verbatim repetition of my second turn.

Compare this recent exchange (below, box on the left) to the second one of the session (below, box on the right). The difference between the two assessments is that the early one (at right) describes how she "deflected" us and offers a theory about why – as if she sighted/cited us an unable or unwilling to "tolerate" them. The latter assessment does not mention how her "fears…get dropped" but specifies how we might not "tolerate them"; the dropping is related to how she is grasping some other person – me – as leaving or not staying "with you to help you make sense of what feels overwhelming inside."

Notice that in the beginning of the session I indexed our immediate here and now relationship using "I" and "we" whereas in 062 I said "another person" instead of "me." In so far as the instruction of anxiety is to hide one's identity that may offend the other, one may argue that it was out of my own anxiety that I said "another person" rather than "me"

061	*Like I've been saying. I think these fears of falling apart or being overwhelmed get dropped and*
062	*perhaps it's because you don't expect another person to stay with you and help you make sense of*
063	*what feels overwhelming inside.*
064	*Yeah. [tearing] that make sense. Yeah because principle people at crucial ages for me they*
065	*disappeared whether death or loosing a sister going to college or marriage is like a death. Yeah.*

And I'm seeing it in here that when I just approached your fears of falling apart a part of you got scared and deflected us by focusing on crisis as an abstract concept. It's like you drop your feelings that feel overwhelming as if we couldn't tolerate them.

Yeah, I've always done that. [Tears stream] Yeah, I'm probably going to be processing 15,000 different things. Yeah, processing things to do with my daughter's wedding all this introspective stuff between now and Tuesday when I leave. [Tears stream] This isn't very deep -- no for me it is -- I think one of these things is I'm feeling guilty because I haven't been able to help out too much with my daughter's wedding and it goes way back because I can't remember anyone in my family who hasn't really been totally involved in their daughter's wedding plus the problems I have with the need to control, usually mom's do their daughter's weddings. But I'm still from that tradition, so I'm probably feeling a lot of conflict about -- emotionally I have some input into this. Intellectually I've tried to let my children make all the major decisions on their own. I think maybe I've identified with my own mother who was major controlling, which is what dynamic women are. And the sister I was in the arms of -- I think I used her or she filled the shoes of my mother. I think I haven't looked enough at the input she [the sister] had on my life because she went off when I was ten. I still have my own mother [her mother died in the 80's] but she was -- I don't know -- an institutional mother. It was an institutional type relationship a parallel between my mother sending me off to school at an early age and my sending my kids away

to avoid identifying (and thereby implicating) myself as the object of her fears. In retrospect I did not want to be identified as so self-absorbed as to think that after only five sessions Mrs. P would need my presence so badly that the possibility of not having it for a week would register "like a death." In retrospect that is what I should have said, and what Dr. R would have pointed out as my own defensive maneuver to avoid something – perhaps the intensity of the patients' TRANSFERENCE, or to avoid "being wrong," or to

avoid feeling like a "narcissistic fool" as Dr. R once called it. This is an exa mple of how my COUNTERTRANSFERNCE anxiety (subjective sphere) shaped my utterance.
Recall that Mrs. P and I had only met five times before, so it seemed like it would be the epitome of my own grandiosity to explicitly say "me" when all this time she has ostensibly been talking about World Trade Center bombings, her sister, mother, daughter, etc. – even though, as noted previously, I was indexing our relationship earlier in the session.[30]

The second utterance in my response (062) shows that I have understood the point of much of her previous talk to be about Mrs. P being left, and modified what I understood to be the reason she was not talking about her feelings that "feel overwhelming" (003,017-018), "some powerful feelings" (034) that she experienced as "unbearably bad" (050), "falling apart … feels overwhelming inside" (061-03). The reason changed from her sighting/citing our identity as a couple "as if we couldn't tolerate" to Mrs. P sighting/citing her own identity as left-alone to-deal-with ("you don't expect another person to stay with you and help…" 062) that she will eventually identify as being an orphan (cf., 069-070, 071, 078, below)

Mrs. P ratifies this assessment in her next turn and elaborates. Yet notice how different Mrs. P's elaboration is to my assessment here when compared with her two extended turns in the beginning of the session. Here her response is an explanatory compliment to my move. She is speaking from the position of the identity *left-alone-to-deal-with*, (i.e., in the face of "principle people" who have "disappeared") and from the vantage point of that identity she grasps deaths: "death or loosing a sister going to college or marriage is like a death." And by speaking as the subject of this identity, she is showing that

[30] There was also another aspect to my COUNTERTRANSFERENCE anxiety. Up until this session I had been worrying that Mrs. P was not going to come back for treatment after her holiday, which manifested itself in prior sessions when I would interpret that she wasn't coming back or through double checking with her that she was planning to come back for her sessions the following week.

she is aligning with and ratifying *left-alone-to-deal-with* as the kind of person I had understood her to be.

However, this explanatory compliment is much more succinct than her attempt at the beginning of the session (cf., Box at right, page 121), which is both more wordy and less coherent due to her anxiety as already shown (Chapter 3). So, in this instance the pragmatic effect of "feeding" critical hermeneutic self-reflexivity – offering through discourse the occasion to assume a self-distanciated, sighting/citing of her identity – in a way that she could align with was that her speech became more coherent. Thus, her anxiety was lessened; the urgency for avoiding an identity through deflecting speech recessed in saliency – at least for the moment. In Kleinian terms my interpretation had a CONTAINING effect – I had "taken in" some of the anxiety Mrs. P was showing ("projecting"), "metabolized" it or made some sense of it, and fed it back to her as an understanding which she "took in," and it helped reduce her MAIN ANXIETY through recognition. Through feeding recognition came acceptance and an identity that had only been indirectly heard from the beginning of the session. This identity has a voice concerned with losses in the situation of "like a death" (065). The loss of a significant Other on whom she depended in an asymmetrical relationship is grasped as death, and it's an overwhelming place from which to take a perspective and talk about. This voice is in stark contrast to her "dramatic voice" as Mrs. P. characterized it above (060), that does its "cheery deal."

Indeed, Mrs. P described events linked with death in her first two extended turns: "people in crisis or end of life issues" in the context of her work (008); "the whole thing of counselors being sought out like madmen" in the context of 9/11 (011); the motherhood context of "my daughter's wedding" (023); the childhood context of the sister who "filled the shoes" (029) of Mrs. P's "institutional mother," (031-032) who sent her off to school as

Mrs. P sent her own kids off to school. Perhaps, then, these other contexts must be viewed in light of a supra-ordinate context, the context of death-like changes *as mothered*.

In terms of the pragmatics of analogical and digital messaging, Mrs. P's communicative behavior might be understood in the following way. Mrs. P gave me the form that contained three "silences" that deal with analogical aspects of messaging. If she had been able to translate her analogical propositions into digital language she might have completed the sentences with: "One of the easiest ways to hurt me *is to desert me in my neediness because it's like death*"; "In relationship to me I wish men would *not leave me at "principle times""*; "In relationship to me I wish women would *not leave me at "principle times"*." Mrs. P then said that she was "trying to survive" the week. Translating this digital content in terms of the analogical proposition, her message is "I'm in a state of panic because the rule of this relationship is annihilation by abandonment, so I don't want to talk about it to you."

In my previous (066-068) turn, I showed that I understood her to be grasping her absence from therapy in similar terms – as a "death like" change, which she selects as the topic among the other events I mentioned:

069 Yeah cause I like routine right and I'm not going to be here next week and I'm like one of those
070 orphans – the smartest kids are the one's who get abandoned in hospitals and learn to have to get
071 along by being nice which fends off being orphaned. Yeah, because that image just came to me right
072 now I can – those little orphaned AIDS babies who have been dropped like a hot potato.

Mrs. P ratifies my addition of the absence of therapy from her life next week as another topic to be understood within the set of other death-like changes. Indeed, she self-selects it to continue talking about. Missing therapy is a death-like change for "one of those orphans," who like Mrs. P, must "fend off being orphaned." How does an orphan fend off being orphaned? Unless, perhaps, what this contradictory statement implies is that as an orphan she is trying to fend off being kicked out of the therapy-orphanage by her new

institutional mother. An orphan without an orphanage is on the street, homeless, and struggling to “survive this week.”

In terms of emotional pragmatics, Mrs. P has a fearful grasp of having her existence negated (denied) by the withdrawal of the depended-upon Other. She was sighting/citing a needed Other in an asymmetrical power relationship as reacting with dread in the face of her being too-much-to-handle, like a “hot potato.” For de Rivera (1977, pp. 62-65) this is the grasp of panic, the emotion that instructs the self not to let the offending behavior, speech, or identity exist. The orphan who has to act “nice” to “fend off being orphaned” is an orphan who cannot show her own distinct interests and concerns, like “those little orphaned AIDS babies” whose needs are so taxing and extensive that their mother’s leave them out of dread in the face of the challenge, dropping them “like a hot potato.” Yet, it also seems to describe Mrs. P’s predicament in regard to her daughter’s wedding – she has to be the “nice” mother who doesn’t cry too much at her daughter’s wedding. Mrs. P who previously described her mother as an “institutional mother” (031-032) now describes herself as an institutional orphan – one left in the hospital facing death, terminally ill no less. Cast in this light, her second remark of the entire session, “I’m trying to survive this week” takes on a literal significance as a expression of panic, particularly given the fact that her first utterance is an admission that she was not compliant – not the “nice orphan” – not having completed the form as I had requested weeks earlier.

The verb “dropped” is noteworthy, since the other things that have been assigned as the objects of dropping during our conversation are her feelings in relation to another (“It’s like you drop your feelings that feel overwhelming as if we couldn’t tolerate them” 017-018, p. 63, above; “these fears of falling apart or being orphaned get dropped … because you don’t expect another person to stay with you and help you make sense…” 061-062, p.121,

above). It is Mrs. P's AIDS baby (a baby feeling overwhelmed) identity that has been dropped by her speech that deflects, even though she has been attributing that dropping to her sister, daughter, mother and me as the therapist-mother; in Kleinian terms she has been PROJECTIVELY IDENTIFYING her sister, daughter and me as "institutional mother[s]".

So, when Mrs. P self-selects to speak in this turn by choosing the topic of her absence from me in the week to come, she has turned and grasped her therapy with me as an institutional relationship where she is terminally ill and under the threat of abandonment for her neediness by me, identified as the institutional mother. Hence, Mrs. P was grasping me as a dread-filled institutional mother and her grasp was that of panic, the panic of having her existence as a separate being negated should it be sighted/cited.

073 What I'm hearing is that right now you live with fears of being dropped by me like you felt dropped
074 by your mother as a baby

However, I was not the one who has been dropping her orphaned AIDS baby identity through deflecting speech. As this record shows, I was doing the opposite. I was actively pursuing this voice through refining my grasp of who Mrs. P was: forwarding a grasp of her identity and adjusting it based on what she said and did through her responses, then forwarding it again in three or four successive cycles.

Yet, it seems that this is not the only grasp Mrs. P may have of me at this point, since she is continuing to talk from the perspective of the AIDS baby-self. Recall, in the beginning of the session she said, "…and it's ironic too because at the same time I feel like I'm making some progress in my new post. In one sense it's all brand new and in another it's what I've always thrived on – it's like crisis" (005-006, p. 63, above). So, if the "crisis" she has always "thrived on" is her state of panic as left-alone-to-deal-with (p.121, above), and then what is "all brand new" might be the contradiction that I was not leaving-her-alone-to-deal-with now, in her "new post" as a patient. In other words, the "irony" she

mentions is that something about this relationship is not how she expected it to be, like the other relationships of asymmetrical dependency in which she has been.

This section has examined these cycles as the turn taking system of CKPP that is organized around occasioning not just understanding, but a specific position or attitude towards what is understood and how it is understood. The analysis showed that the pragmatic function of these cycles is grounded in the critical hermeneutics of CKPP and its presuppositions of understanding. Their purpose was shown to give feedback – pun intended – that is characterized by reflexivity-in-interpretation, where the analogical aspect of the patient's messaging is translated into digital interpretive utterances. When Mrs. P recognized her situation in what I said it contained the anxiety that made it difficult for the patient to digitize the analogical aspects of her experience. Finally, when the patient momentarily swallowed the feeding, she assumed a self-distanciated position of critical self-reflection where she worked to translate the analogical aspects of her experience into digital communication.

However, showing the positioning of the patient in front of a point where she may or may not pivot, turn and adopt the role of critical self-reflection does not address how talking to the "infant-in-the-patient" is necessary for subjectivizing work of CKPP. This following chapter, after a summary of findings from the first two, will look into this question.

5. Weaning: Discussion and conclusion

> At weaning time the infant feels he has lost the first loved object – the mother's breast – both as an external and as an introjected object, and that his loss is due to his hatred, aggression, and greed. Weaning thus accentuates his depressive feelings and amounts to a state of mourning. The suffering inherent in the depressive position is bound up with an increasing insight into psychic reality, which in turn contributes to a better understanding of the external world… Failure in working through the depressive position is inextricably linked with a predominance of defences, which entail a stifling of emotions and phantasy life, and hinder insight. … It is only *by analyzing the negative as well as the positive transference* that anxiety is reduced at the root. In the course of the treatment, the psycho-analyst comes to represent in the transference situation a variety of figures corresponding to those, which were introjected in early development (Klein, 1929; Strachey, 1934). He is, therefore, at times introjected as a persecutor, at other times as an ideal figure, with all shades and degrees in between.
>
> As persecutory and depressive anxieties are experienced and ultimately reduced in analysis … the earliest frightening figures undergo an essential alteration in the patient's mind. … Good objects – as distinct from idealized ones – can be securely established in the mind only if the strong split between persecutory and ideal figures is diminished, if aggressive and libidinal impulses have come closer together and hatred has been mitigated by love. Such advance in the capacity to synthesize is proof that the splitting processes, which, in my view, originate in earliest infancy, have diminished and that integration of the ego in depth has come about. When these positive features are sufficiently established we are justified in thinking that the termination of an analysis is not premature … (Klein, 1950/1975, pp. 44-47, emphasis in original)

TERMINATION is the term for the situation where the therapist-breast disappears "irrevocably." This chapter will argue that contemporary Kleinian psychoanalytically oriented psychotherapy *as a whole* and *as the turn taking system governing each session* may be understood as *weaning*. Provisionally, then, *weaning* is the situation of asymmetrical dependence where self-subject formation is fostered at the same time that infantile desires, fears, and phantasies are elicited *so they can be mourned* – not reinforced. This, then, is the endpoint or "goal" of CKPP viewed as a language game, as a specialized type of communicative competence.

This study has employed a hermeneutic methodology to articulate the specialized communicative competence of CKPP. It has shown that CKPP is a specialized discourse and as such it has a unique way in which it coordinates behavior with, "… *a set of norms, preferences, and expectations relating language to context, which speaker-hearers draw on and modify in producing and making sense out of language*" (Ochs, 1990, p. 289, italics in original). And, as a specialized discourse it requires the therapist to possess a specialized communicative competence, "basic qualifications of speech and symbolic interaction (role behavior) at his disposal" (Habermas, 1970, p. 138). The aim of this discourse is an environment for "self-formative processes" (cf., McCarthy, 1978, pp. 203-205).

This environment is made up of controlled conditions that include everything from the length of the sessions and the fee to seven characteristics that typify how, what, why (Chapter 3) and when (Chapter 4) the therapist speaks. The therapist uses interpretive utterances to occasion the self-initiated positioning of the patient in a critical self-reflective manner (Chapter 3) – where the patient examines his or her experience in terms of basic background assumptions, social practices of power, and biographical events (Chapter 4). Formulating and reformulating these interpretive utterances in terms of relational content (analogical decoding) and timing was shown to draw on the presuppositions of understanding – symbolic, practical and subjective spheres – that make up the critical hermeneutics of CKPP (Chapter 4). This process of formulating and reformulating, in turn, defines the turn taking system of CKPP that requires the seven characteristics of CKPP already outlined (Chapter 3). Finally, the turn taking system of CKPP that organizes interpretive utterances by governing their deployment defines the self-formative processes of CKPP as weaning.

However, what remains to be discussed is the implication of this communicative competence to understand the paradox of subjection, defined as the longing to submit and be subject to a power in order to become as a subject. How does CKPP address this paradox of subjection? And how is the handling of anxiety in CKPP the means by which the "infantile transference" or situation of infantile dependence is created through the deployment of interpretive utterances that articulate the sighting/citing of identity? In other words, what is the allure and anxiety of weaning?

The anxiety of weaning is posited as the anxiety of existing as a separate being-in-time with another who demonstrates the capacity to articulate aspects of experience and motivations better than the patient does for him or herself. The transgressively intimate utterances of the therapist create an intimacy in a conversation that is lopsided and therefore intimidating.[31] Thus, the asymmetrical relationship of dependence is a necessary condition for CKPP to operate, since it simulates (or indexes in CA terms) the asymmetrical relationship of dependence in infancy. In so far as the experience of the mother's body is being-in-time for the infant, becoming a separate self in time involves a loss, a negation within this pre-dualistic milieu to for recognition of the infant's separate being. Thus, the absences of the mother in weaning, as the first signs of her existence as separate from the infant, are experienced as the sign of death – a threatening negation within the infant's existence, of separation from the source of the self's meaningful recognition.

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[31] According to An elementary Latin dictionary (Lewis, 1891/1993) the word "intimate"(verb) is derived from the Latin *intimates*, pp. of *intimare* "to put in," "announce," and the superlative *intimus*, "innermost," "deepest," and "profound." Likewise the adverbial form *intime* is defined as the "inwardly." Thus, as intimate utterances about the patient, the interpretations of CKPP are announcements of the inward or innermost. In so far as the indexical preposition "in" populates my interpretive utterances and Mrs. P. aligns with them this characterization would appear to hold true. Tracing the process by which the therapeutic discourse of CKPP, as an ontological accomplishment, creates this "inner" is one aspect of CKPP that will not be addressed in this study.

On the other hand, the patient desires alignment with the therapist's interpretive utterances because learning how the self works within the attentive gaze of a depended upon other mitigates the anxiety of being a separate self in time – one feels one belongs to another on the very basis one fears not belonging. This reverses a double estrangement (within the self who speaks and between the self and the other) by a double recognition (by the self that recognizes the experience in the sightings/citation of the other). In other words, whatever aspects of being-a-self-in-time cannot be brought within the set of sharable experiences on the basis of language remain terms of exclusion from others and from the self that is one subject among others, by virtue of a shared communicative competence in time – hence, they are terms for a sense of a present and future isolation both inside and outside the self.

Thus, the discussion will require some further analysis within an altered interpretive framework. For what will be shown (next section) is that in CKPP the therapist's utterances transgress the range of the patient's experience (the "horizon" called consciousness) and thereby open a site for the patient's unnamed anxiety to be worded within the discursive site occupied by therapist who works to sight/cite it. It is hypothesized that these transgressive utterances are alluring because they satisfy the following condition. In so far as they are based on decoding the cryptic expressions of the patient, they re-create the situation where the part of the self that attempts to be understood without having to communicate explicitly can be satisfied – that is, it can avoid the paradox of adult subjectivity by exempting itself from the communicative requirements of intelligibility as an adult subject. In short, the transgressive utterances provide the occasion for the pleasure of being intimately known. They are literally *intimate* utterances characterized by announcing what is inside the patient. This pleasure, in turn, is related to the isolation from a lack of intimacy and the anxiety involved in production of this intimacy.

It turns out that the paradox of subjection is the paradox of being together with and yet separate from the therapist. CKPP addresses this paradox in that the job of the therapist is to embody the displacement or deferral of this paradox for the patient by articulating the patient's preverbal expectations of the therapist, thereby dislodging them from their definitive role in defining the patient's reality with and towards the Other.

Weaning: The allure and anxiety of becoming a subject

This section examines how CKPP addresses the patient as the subject of his or her experience and shows the patient how and what they unwittingly do to prevent self-subjection. Self-subjection is an intimate sighting/citing of experience in language, which allows problematic experience to become the subject of the patient's conscious understanding and thereby his or her conscious action. This is what Dr. R referred to in her injunction to "describe the patient's inner experience." In other words, the patient can gain greater subjectivity in his or her life and feel less subject to problematic experiences. This will require adjusting the interpretive framework of the analysis to re-examine how the discursive work noted in the previous chapter contributed to subject formation. It turns out that addressing the infant-in-the-patient is central in CKPP because the infant-in-the-patient is the boundary where problematic experience can be materialized in discourse. The infant-in-the-patient is a nascent (pre-verbal) self-possibility. Once materialized, it can become a basis for the self to subjectify its own experience.

> In Freud's theory the structure of the mind is composed of three main parts differentiated by their functions. The id, most closely related to the body, is the reservoir of the instincts and thus the source of all mental activities. This means that it is the dynamic matrix from which the other systems, ego and super-ego, derive. The id represents a person's unconscious, most primitive and elemental urges, which

> are dictatorial and do not know compromise or renunciation. The ego is the interpreter and intermediary between the various parts of the mind and the outside world. The super-ego is the internal representative of the person's most important objects, his parents, the internal residue of his earliest and most important emotional ties. It is the system of all morality, conscious and unconscious.
> These differentiations are brought about by the fact that the individual exists in a world on which he is dependent by virtue of his instincts: his wish to keep alive, his desire for pleasure and his fear of destruction.
> It seems evident that an organism, which depends to vast extent on organisms and powers outside itself, for attaining its purposes, must be influenced and changed by such contacts. Now what are the processes by which these alterations (*differentiations of the original substance*) are brought about? I intend to show in this section the role, which the mechanisms of introjection and projection play in relation to these changes. (Heimann, 1953, p. 122, emphasis added)

In the Kleinian tradition INTROJECTION and PROJECTION serve as the terms for trying to understand the development of the person *by means of exchange* between inside and outside to avoid the mind-body-world cleavages.[32] The phantasies about the inner world are the relational meanings ascribed to the infant's bodily experiences: breathing, eating, voiding, burping, cramps, sounds, lights, etc. Trying to imagine this requires suspending one's adult natural attitude where the body operates as a backdrop for whatever we see, say,

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[32] Heimann, Isaacs and Klein were aware of the problem of using dualistic terms for explaining how the infant comes to have a self be virtue of its relations with others:

> The phantasies about the inner world are inseparable from the infant's relation with the outer world and real people. It is only a limitation in our means of description, which makes it appear as if there were two distinct entities, which influence one another, instead of one whole, one multi-faceted interacting experience. (Heimann, 1953, p. 156)

> It was said by Dr. W. C. M. Scott, in the Discussion at the British Psycho-Analytical Society, 1943, that the adult way of regarding the body and the mind as two separate sorts of experiences can certainly not hold true for the infant's world. It is easier for adults to observe actual sucking than to remember or understand what the experience of sucking is to the infant, ***for whom there is no dichotomy of body and mind, but a single, undifferentiated experience of sucking and phantisizing. Even those aspects of psychological experience which we later on distinguish as 'sensation', 'feeling', etc., cannot in the early days be distinguished and separated***. (Isaacs, 1952, Fn2, p. 92, emphasis added)

The Kleinian doctrine of phantasy can be viewed as an attempt to overcome the dualistic constraints of language. In order for there to be a shared world, there must be a way to account for that which is not shared, figurable in spatial terms of inside and outside. Phantasies are 'distortions' of the shared world embedded in the body. Thus, the concept of phantasy is an attempt to overcome the mind/body self/other dualisms. Furthermore, if there were only one world as some would like to think, then how could there ever be creativity or alterity? A monism of Being is not the only alternative to Descartes' ontological dualism.

hear, and do (cf., Merleu-Ponty, 1962/1992). For the infant the body and its mobile flux of experiences are in the foreground of its awareness, since it has to learn how to exist as a body-in-time with Others. If the light is too bright then close your eyes and turn away; if the colors are pleasing to the eye then stare and grab the thing being dangled. The first challenge for the infant to master – one that is so overpracticed for adults that we are scarcely aware it goes on – is how to gain some control over what goes in and out of his or her body, physically, perceptually, and emotionally:

> Life is maintained through an organism's intake of foreign but useful matter and discharge of its own, but harmful, matter. Intake and discharge are the most fundamental processes of any living organism. The mind, also a part of a living organism, is no exception to this rule: it achieves adaptation and progress by employing throughout its existence the fundamental process of introjection and projection. The experiences of introducing something into the self and expelling something from it are psychic events of the first magnitude. They are the basic processes, not only for maintaining life (as in physical metabolism), but for all differentiations and modifications in any given organism. Such taking in and expelling consists of an active interplay between the organism and the outer world; on this primordial pattern rests all intercourse between subject and object, no matter how complex and sophisticated such intercourse appears. (I believe that in the last analysis we may find it at bottom of all our complicated dealings with one another.) The patterns Nature uses seem to be few, but it is inexhaustible in their variation.
>
> The combined action of introjection and projection accounts for the change of a part of the id into an ego; disturbances in this interplay lead to failures in development…
>
> The view that introjection and projection are the architects of the mental structure and that they build up the ego [and super-ego] from the beginning of life is not held universally among psycho-analysts. It is mainly the work of Melanie Klein's researches, which have yielded the data enabling us to appreciate this role of introjection and projection. (Ibid, p. 129)

Take the following situation as an example to illustrate internalization. One week you visit your friend with her infant and, like dozens of times already, she changes his diaper by holding onto his legs at the ankles and lifting his bottom to pull out the soiled diaper while talking to him in "you" terms ("You're such a good boy," "Oh, you're all dirty," and so on as mothers can do). Two weeks later you visit her again but you notice that while you are playing with the baby he suddenly lifts his legs while on his back, a behavior you haven't

seen before. You ask and his mother says, "Oh, that means he has to be changed … You're such a good boy!" The baby has managed to connect the internal sensation of discomfort with a behavior to make a claim on mother and thereby effect a change in the flow of his sensory experiences. All this is tied together with the auditory sensation of "you're …"

Throughout the duration of infancy and early childhood he or she will hear thousands of "you" predications. It is through bringing his or her experiences into material language that the subject is formed from "the original substance" Heimann refers to in the quote above. Yet for this to happen the infant and child must gradually give up the phantasy of OMNIPOTENCE that has been easily assumed by the infant, given the scenario just described, since it lends itself to the experience that he controls his world (his body-mother's body) as an extension of his desire of the moment:

> The essential difference between infantile and mature object-relations is that, whereas the adult conceives of the object as existing independently of himself, for the infant it always refers in some way to himself. It exists only by virtue of its function for the infant, and only in the world bounded by his own experiences. Whilst in reality the infant is utterly helpless and depends for the maintenance of his life completely on his mother (or her substitute), in phantasy he assumes an omnipotent position to his objects; they belong to him, are part of him, live only through and for him – he continues the pre-natal oneness with the mother….
>
> Two main patterns follow from the operation of introjection and projection in early object-relations, and their interaction leads to confusing and unstable situations.
>
> (1) The infant's feelings about his objects essentially revolve around their being 'good' or 'bad', 'inside' or 'outside' (and they are closely knit with his sensations)
>
> (2) Within the fusion between self and object the infant tends to usurp the object's 'good', i.e., pleasurable qualities, and treat them as belonging to the self, and to disown his 'bad' painful qualities and treat them as belonging to the object. In other words, there is a tendency to introject what is pleasurable and to split off what is painful. The connection between projection and badness is of particular significance for the understanding of infantile anxiety[33] (Heimann, 1953, p. 142-143)

However, the omnipotent attitude is also the source of death anxiety. Just as omnipotent gratification is interpreted as oneness with a perfect being, so omnipotent hatred

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[33] Heimann notes in a footnote to this passage the example of "the little boy who, seeing his baby sister sucking at his mother's breast, pointed to it and said to his mother: 'That is what you bit me with.'"

is interpreted as the threat of Armageddon; if love can conjure a heaven of perfect being then hate conjures hell and the end of being. If all goes well, this anxiety and omnipotent attitude motivates the young child to learn language and play with things as symbols, since he or she seeks to discern, confirm, and disconfirm phantasies in every tangible thing (blocks, trains, words, pets, the therapist's body parts and faculties) representing his or her own organs and their functioning in the context of a relationship.[34] Indeed, in the Kleinian tradition the acquisition of language and development of cognitive capacities, contra the classical Freudian position, is motivated by the drive to better manage the anxiety and emotional pain of life – not to get rid of them as so many discharges. Language helps the young child to deal with his or her anxiety as a temporal being facing the recurrence of painful and pleasurable experiences.

Klein postulated that the sense of time begins with the birth experience – the prototype for a sense of before and after or "periodicity" (cf., Klein, 1923/1975, p. 99). This implies that for Klein a baby's being as a being-in-time is to be understood as repetition that first occurs in the context of the changing relationship to the mother's body. Being heaved into the world from the comfort of the womb is the prototype for time, life, and death. It is a prototype for life in that the infant has a phantasy of the oneness that was. In other words the longing for the lost oneness within the mother becomes the prototype for the sense of

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[34] Isaacs offers a vivid example where this process can be derailed into a neurotic symptom:

> …a little girl of one year and eight months, with poor speech development, saw a shoe of her mother's from which the sole was flapping about. The child was horrified, and screamed in terror. For about a week she would shrink away and scream if she saw her mother wearing any shoes at all, and for some time could only tolerate her mother's wearing a pair of brightly coloured house shoes. The particular offending pair was not worn for several months. The child gradually forgot about the terror, and let her mother wear any sort of shoes. At two years and eleven months, however (fifteen months later), she suddenly said to her mother in a frightened voice, 'Where are Mummy's broken shoes?' Her mother hastily said, fearing another screaming attack, that she had sent them away, and the child then commented, 'They might have eaten me right up'.
>
> The flapping shoe was thus *seen* by the child as a threatening mouth, and responded to as such, at one year and eight months, even though the phantasy could not be put into words till more than a year later. Here, then, we have the clearest possible evidence that a phantasy can be felt, and felt as real, long before it can be put into words. (Isaacs, 1952, pp. 90-91, italics in original)

"life," the breast identified *as* good. Similarly, the urge to reject the painful change of birth becomes the prototype for the sense of "death," the breast identified *as* persecutory, and, together with the sense of time, paranoid anxiety – the possibility of being persecuted by the future, by what might come next as the sign of a "death," a bad breast. The baby has an urge to be (Eros) and a hatred for what it does not want to be (Thanatos) in time, since his/her being is bound to repeat itself in one way or another. This implies that the infant's relationship to the mother's body is the paradigm for time and how he or she will fair (good=life or bad=death) from one moment to the next.[35]

Thus, at some point the baby begins to differentiate painful states (loss of being = loss of oneness with the mother) from death and does this *with and only with* the help of the mother, who CONTAINS the anxiety, particularly as the baby begins the process of weaning, when "oral aggression" is at its peak (the baby can now bite the unsatisfying breast).

> Coming to our main problem, we find that the child feels, when the breast is wanted but not there, as if it were lost for ever; since the conception of the breast extends to that of the mother, the feelings of having lost the breast lead to the fear of having lost the loved mother entirely, and this means not only the real mother, but also the good mother within. In my experience this fear of the total loss of the good object (internalized and external) is interwoven with feelings of guilt of having destroyed her (eaten her up), and then the child feels that her loss is a punishment for his dreadful deed; thus, the most distressing and conflicting feelings become associated with frustration, and it is these which make the pain of what seems like a simple thwarting so poignant. The actual experience of weaning greatly reinforces these painful feelings or tends to substantiate these fears; but in so far as the baby never has uninterrupted possession of the breast, and over and over again is in a state of lacking it, one could say that, in a sense, he is in a constant state of being weaned or at least in a state leading up to weaning. Nevertheless, the crucial point is reached at the actual weaning when the loss is complete and the breast or bottle is gone irrevocably. (Klein, 1936/1975, p. 295)

[35] For Phillips (1998) the "violent encroachments" of the "accidental eventness" is the ontological boundary that Time itself presents, inciting the infant to "dramatize spatially" through phantasy and create the inner-outer distinction as well as the impetus to knowledge of the unpredictable "outer" world. "In this sense, external reality is an a priori condition of infantile development, as the 'outside-in-the-inside' or the enigmatic object in the phantasy" (p. 172).

The baby needs the mother to help him differentiate what possible experiences put him in the face of death and which do not, so that every frustration from change does not feel like death – an unbearable state. Where she is successful the baby is able to INTROJECT this security – make it a part of self-experience. The painful experience can be CONTAINED, and later, understood and communicated through verbal language. This is the contemporary Kleinian conception of EMPATHY.[36]

For Bion the elements of the baby's (or patient's) experience that register but have no distinct meaning are "beta elements." The mother (or therapist), by CONTAINING, uses her "alpha function" to make the beta elements less concrete and material by putting her baby's experience into words ("Oh, its O.K., you just have an ear ache"). Again, the soothing and cooing and sensuous qualities of the words "bind" the anxiety of death the pain of the earache stimulates. While the earache may still hurt, the infant can suffer the pain more easily because the edge of the annihilation fear has been removed by the mother's understanding. Beta elements are one example of ♂ Bion's symbol for the contained. Alpha function is an example of ♀, his symbol for the container.

> The archetype for ♀♂ is the mother's breast/infant. The scene … is of an infant in pain (patient's mind) searching for and being found by the mother's breast (analyst's mind). Bion's conceptualization is that the personality is constituted out of dual elements: ♀♂. In this case the patient's mind had not developed the concept of a strengthening ♀♂ . This is neither a static situation nor one in which the infant is passively being 'held'; Bion's theory is that it is dynamic. There is a ♂ seeking a ♀ , and there is an intercourse between the two. (Symington & Symington, 1996, p. 52)

So, for Bion, the baby searches for a sense of itself in the mother's mind, an identity that can make sense of an experience that registers but has no determinate form, an agitating gap, as it were, in his or her sense of self-in-a-situation. Following this line of thinking, the therapist

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[36] For an explication of the Kleinian conception of empathy in terms of projective identification, container/contained, beta elements, and alpha function see Etchegoyen (1977).

job is to contain the patient's unbearable experience through his or her understanding and model for the patient the ♀♂ so the patient can gain a sense of confidence in the strength of their self to bear pain by understanding it.[37] Yet, how can this process be examined as a result of productive dialog? Gadamer's examination of the relationship between the word and experience may shed some light on this question, since the therapist is not aiming to provide an experience that never occurred but a new experience through his or her discourse:

> Although in bringing up children, for example, parents may try to spare them certain experiences, experience as a whole is not something anyone can be spared. Rather, experience in this sense inevitably involves many disappointments of one's expectations and only thus is experience acquired. That experience refers chiefly to painful and disagreeable experiences does not mean that we are being especially pessimistic, but can be seen directly from its nature. Only through negative instances do we acquire new experiences, as Bacon saw. Every experience worthy of the name thwarts an expectation. Thus, the historical nature of man essentially implies a fundamental negativity that emerges in relation between experience and insight. …
>
> [Insight] always involves an escape from something that had deceived us and held us captive. Thus insight always involves an element of self-knowledge and constitutes a necessary side of what we call experience in the proper sense. …
>
> In it [experience in general] all dogmatism, which proceeds from the soaring desires of the human heart, reaches an absolute barrier. Experience teaches us to acknowledge the real. … Real experience is that whereby man becomes aware of his finiteness. (Gadamer, 1960/1994, p. 356-357)

For Gadamer consciousness is the experiencing self; every new experience is a moment of self-awareness since it involves the thwarting of a prior desire for what was anticipated in experience. Thus, having been thwarted, the desire that conditioned the object as it was anticipated becomes both an object of self-awareness and the limit of the self. Hence a real experience "is that whereby man becomes aware of his finiteness." Moreover, the medium of this real experience is language, since:

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[37] For Bion ATTACKS ON LINKING are attacks on the process of ♂ and ♀ uniting to form an understanding, a conception.

> Being that can be understood is language. … To be sure, what comes into language is something different from the spoken word itself. But the word is a word only because of what comes into language in it. Its own physical being exists only in order to disappear into what is said. Likewise, that which comes into language [as the totality of meaning] is not something pregiven before language; rather, the word [as a part of the totality of meaning] gives it its own determinateness. (Ibid., pp. 474-475)

Similarly, a desired experience (expectation) outside of language is not an experience subject to a consciousness. It is an indeterminate urgency from which experiences can be brought into language and given a place within what can be understood as the self. Trude could not tell her parents what was terrifying her at night, nor could the little girl Isaacs describes (cf., fn 34, p. 136, above) say what horrified her about her mother's broken shoes.

Just as Gadamer is not arguing that all Being is reduced to language, this does not mean that the indeterminate urgencies do not exist or find alternate expression, just that that expression is not one that can be consciously understood as a piece of self-knowledge, and therefore remains as a foreign body to conscious experience. Instead it "comes out" in some other analogical (pre-digital) way as a symptom (in the case of pathology). Furthermore, since the desired experience cannot be renounced before *it is announced* it prevents new experiences from occurring, which is another way to describe the "repetition compulsion"; the patient has a block in terms of being able to learn from experience and thereby the generation process of new experiences from the old grinds to some kind of halt, whether it is experienced as anxiety, depression, a compulsion, obsession, and so on:

> That is why the person who is called experienced has become so not only through experience but is also open to new experiences… the perfection that we call "being experienced," does not consist in the fact that someone already knows better than anyone else. Rather, the experienced person proves to be, on the contrary, someone who is radically undogmatic; who, because of the many experiences he has had and the knowledge he has drawn from them, is particularly well equipped to have new experiences and to learn from them. The dialectic of experience has its proper fulfillment not in definitive knowledge but in its openness to experience that is made possible by experience itself. (Ibid., p. 355)

On this account, to view pathology as the result of "developmental arrest" is to view pathological expressions as the clues to areas where new experiences are not possible and avoided: every patient is inexperienced in some area and is struggling with the allure and anxiety of becoming more experienced in this or that area of life by bringing these experiences into language. There is a tension involved in leaving the comfort of familiar experience and with it the deep-seated or "sedimented" ontological preconceptions about the self and the world. In this sense there is always a virtual "infant-in-the-patent" in the process of languaging experience and on the verge of a breakdown in its virtual (expected) world, which is an anticipation of the destruction of his or her familiar life. Becoming, then, can be conceived as iteration or the repetition of the self that has been modified through the languaging of some new aspect of experience. *Weaning* as the becoming of the self is the unfolding of a new time in a new space of issues by *means of the word and the relational context of power, difference, and repetition (where time = the repetition of passing presents) within which the word is uttered.*

The word organizes a heterogeneous network of events, compressing as it were, the urges and sensations that impinge from within and without into the ready-made, molded, acoustic surface of the spoken word. Figuratively speaking, the result is a moment of subjectivity embossed from the flows of inner and outer perception – a space for the "you're" cited by mummy at a point in time for the infant to occupy as part of the intelligible human world. The baby projects a distress and introjects from the mother a material understanding that binds the distress – in part – by organizing it among her other "you"s (the "You're so dirty" depends on a "You're so clean," since the meaning of either one depends on the contrast with the other). Every apparently wonderful, ecstatic, terrifying, outrageous, and overwhelming experience of the child's can find a home in a predicate of

the mother's utterances.[38] However, to benefit from this seemingly magical transformation of terror and distress into belonging, the infant must subject him or herself to the "saying power" of the mother's words.

The infant is not forced from the outside to accommodate itself to the structure of language, because in order for a desire to produce its effect it must register its claim upon the world; verbal language becomes a new vehicle for its expression and organization. Getting emotional is the infant's means for expressing desire, betraying a grasp of its situation in need of expression by analogical (nonverbal) or, later, digital (verbal) means:[39][40]

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[38] Heimann's paper does not address how introjection and projection operate as the infant begins to acquire language explicitly. Although given the notion that it is the digital aspect of language that admits of logic, time, syntax, etc., the following passage suggests that the greater organization of the id into a dynamic relation with the ego and super-ego is a function of the child's induction into linguistic competence:

> … the phantasies about internalized objects are uncoordinated, full of contradictions and of changes from one extreme feeling to another, and highly unstable. Experiences with the outer world, with real people, are taken over and continued, partly with great distortions, under the sway of the instinctual urges. In accordance with the modifications of instinctual aims, which, represent instinctual development and interacts with the progressive development of the ego, the infant's phantasies about his internal objects also change. ***The process can be described in terms of unification, consistency and stability; gradually the 'internal objects' assume an abstract character. Phantasies about living entities within the self develop into ideas and mental work with concepts***, a process which begins in quite young children. At the height of maturity this system of phantasies is resolved into the formation of an integrated ego and a uniform super-ego. That this, however, is achieved only in varying degrees, and may be again disrupted under conditions of strain, with the result that the primitive phantasies reappear, is a daily observation for the analyst. (Heimann, 1953, pp. 156-157, emphasis added)

[39] Although this follows from de Rivera's account of emotions, it may also provides a solution to a problem he was unable to address. He argues that, "The idea of a matrix of emotions suggests that any particular emotion is the outcome of a pattern of "choices" that organize our relationship with another" (deRivera, 1977, p. 71) DeRivera distinguishes between a "decision" (conscious choices) and a "choice" (unconscious choices that structure how an event will be construed by emotional understanding). However, he does not explain why one "choice" should be made over another. It may be better to conceive of unconscious desire as the governing factor. Just as perception is an interpretation based in an intention of the body which can only change with action (cf., Merleu-Ponty, 1962/1990), so an emotional apprehension of a situation depends on a governing desire that can only change with a change in desire as it is experienced (i.e., not simply by means of intellectual knowledge).

[40] The research of Stern (1985) is an example of how current developmental research has verified the notion that infants have an inborn capacity and means for interpreting their experiences. From the perspective of cognitive science, Lakoff and Johnson argue that the sensorimotor systems of the infant are the basis of the "embodied mind" and rationality in a "cognitive unconscious," which develops out of the metaphorization of sensorimotor experience:

> Our most important abstract concepts, from love to causation to morality, are conceptualized via multiple complex metaphors. Such metaphors are an essential part of those concepts, and without them the concepts are skeletal and bereft of nearly all conceptual and inferential structure.
>
> Each complex metaphor is in turn built out of primary metaphors, and each primary metaphor is embodied in three ways: (1) It is embodied through bodily experiences in the world, which pairs

> From the moment of birth, the drive engages in a binary expression: sensation/affect and the object both coexist, and the presentation of the object clings to sensation. The Kleinian phantasy is the mechanism of this juncture, of the drives' destiny to be both inside and outside: it is an "object-seeking" drive. (Kristeva, 2001, p. 142)

However, this does not mean that the process of accommodating itself to spoken language by means of INTROJECTION and PROJECTION are conflict free. For Butler this is the site of subjection, its paradox and ambivalence:

> In Althusser's essay "Ideology and Ideological State Apparatuses," the subordination of the subject takes place through language, as the effect of the authoritative voice that hails the individual. In the infamous example that Althusser offers, a policeman hails a passerby on the street, and the passerby turns and recognizes himself as the one who is hailed. In the exchange by which that recognition is proffered and accepted, interpellation – the discursive production of the social subject – takes place. Significantly, Althusser does not offer a clue as to why that individual turns around, accepting the voice as being addressed to him or her, and accepting the subordination and normalization effected by that voice. Why does this subject turn toward the voice of the law, and what is the effect of such a turn in inaugurating a social subject? … To desire the conditions of one's own subordination is thus required to persist as oneself …. It is not simply that one requires the recognition of the other and that a form of recognition is conferred through subordination, but rather that one is dependent on power for one's very formation, that that formation is impossible without dependency, and that the posture of the adult subject consists precisely in the denial and reenactment of this dependency. The "I" emerges upon the condition that it deny its formation in dependency, the conditions of its own possibility. *The "I," however, is threatened with disruption precisely by this denial, by its unconscious pursuit of its own dissolution through neurotic repetitions that restage the primary scenarios it not only refuses to see but cannot see, if it wishes to remain itself. This means, of course, that, predicated on what it refuses to know, it is separated from itself and can never quite become or remain itself.* (Butler, 1997, pp. 5-9, emphasis added)

For Butler (1997) to be a subject is to have been given a place in language (subjection), "to occupy the site of the subject" where one can "enjoy intelligibility only to the extent" that one is "established in language" (pp. 10-11). In other words subjection is fulfilling the conditions of intelligibility, where the person occupies a site worth the sighting/citing of the Other on whom the person depends. In turn, by desiring subjection

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sensorimotor experience with subjective experience. (2)The source-domain logic arises from the inferential structure of the sensorimotor system. And (3) it is instantiated neurally in the synaptic weights associated with neural connections. (Lakoff & Johnson, 1999, p.73)

one is enabled to exert power on the social order; one assumes a position of social weight, as it were, and can make a sense that has (discursive) effects on others. This is how subjection is also the condition of possibility "to be a site of alteration" (p. 11). If the baby doesn't submit to the mother's understanding of his cries, how can he ever hope to be understood and secure his food by crying and gesturing in the "hungry" way rather than the "wipe my bottom" way? Drawing on Butler's work suggests that the desire and fear of the therapist's utterances stems from a primary "passion to be," as Butler argues, but also a passion to not be dependent – "what it refuses to know" – because this dependency in an asymmetrical and intimate relationship has become the sign of the formed "I"'s extinction. The therapist's voice, then, is the sight/cite for hope and danger.

Subjection requires mourning for desires that are prohibited if status as a subject is to be granted by the loved and needed Other(s). In Gender trouble: Feminism and the subversion of identity, Butler (1990) used Freud's account of melancholia to think through a new way to understand gender identity and sexual orientation based identity as performatives: the iteration through bodily action and expression of a claim upon which the "I" that says I am "man," "woman," "heterosexual" or "homosexual." To preserve the love from the parents that embody and speak the taboo against homosexuality, for example, the child gives up homosexual desires, gratifications, and fantasies by becoming their negation, a subject who could then utter in latter life with certainty "I could never be gay." Thus, Butler argues when examining identity as performative in general, "The formula "I have never loved" someone of similar gender and "I have never lost" any such person predicates the "I" on the "never-never" of that love and loss. Indeed the ontological accomplishment of heterosexual "being" is traced to this double negation" (Butler, 1997, p. 23). Extending this process to identity formation in general, this double negation is the "foreclosure of desire"

that is the condition of the subject, the "I" that speaks, because it not only denies the desire but denies its loss which is the trace of what was lost. To admit the loss forces a turn to see what was lost and face the terrifying consequences: not being.

Thus, one should find ambivalent reactions in the discursive wake of a therapist confronting the patient with the denied "I"s. On one side the allure of the therapist's sightings/citations is that they hold the promise of reunion with an unknown that is felt to be missing, the mark of an incomplete mourning for a possibility of *having the other be involved in the creation of the self*. At the same time the sign of this incomplete mourning is the occasion of anxiety for the "I" that he or she has come to be *bent on being*, an "I" that is performed (as in the repetition compulsion) to quell the very anxiety over having the other involved in producing self-recognitions that transgress its restricted scope.

Anxiety agitates "the subject already formed" (again, the patient) to turn away from the production of self-recognitions required for becoming since they are subversive to the "I"'s formation:

> What would it mean for the subject to desire something other than its continued "social existence"? …. The subject is compelled to repeat the norms by which it is produced, but that repetition establishes a domain of risk, for if one fails to reinstate the norm "in the right way," one becomes subject to further sanction, one feels the prevailing conditions of existence threatened. And yet without a repetition that risks life – in its current organization – how might we begin to imagine the contingency of that organization, and performatively reconfigure the contours of the conditions of life? (Butler, 1997, pp. 28-29)

So, what is the paradox that confronts the unhappy "subject already formed" when he or she walks into the therapy situation? The therapist's job is the paradox. The therapist's job is to provide the occasions for "a repetition that risks life" as revealed by what is repeated in the patient's communications. The sum of the predicates produced by the "I" are the contours of the condition of its formation and limitation: what is "in" the "I" is in his or her discourse.

In CKPP, then, the therapist's transgressive understandings short-circuit this anxiety and its maneuvers of denial. By transgressing the conscious content of the speaking "I" the patient is suddenly confronted with the sight of an identity that has already been invoked by the desire of the therapist – who has selected it as a topic for discussion. If the reflexive self-understanding does not destroy the other *with whom one can identify*, then perhaps to speak it is not the sign of the end of the world. It can be a "site of alteration" and articulation (ibid, p. 11) instead of a site (site, cite and sight) of extinction.

When Mrs. P was ACTIVATING the discussion orbited a gap, as it were, in her understanding of a range of her experience (e.g., "why I'm so sad…"). In this sense, the gap instigated the sites of the conversation between our "I"s because it was agitating, a problem to be talked about, a disturbing present that refused to pass. Hopefully, Butler's language provides a way to examine the sites of subjectivity in the session and how their constitution figured into Mrs. P's turns towards and away from subjection.

However, a person is not just a subject in the sense that a subject the term "subject" indicates the site a person occupies within the ever-mobile contours of discourse as a shared system of symbolic beliefs and practices of power (e.g., speech acts). Nor is a person just a self in the sense that the self is a consciousness operating in a field of issues that originates in the visceral experiences of the body-in-the-world. To acquire verbal language requires new experiences of a nascent self-possibility, an "infantile self" as a subject – a place or position – put into a structure of symbols and practices already formed within a context of belonging to another, a context of intimacy. To be a person is to be both a self and subject, to inhabit physical, symbolic and psychological space – where psychological space cannot be reduced to language

In de Rivera's terms, the psychological space that seems most relevant for the study is the dimension of intimacy. The Kleinian account suggests that the paradox of subjectivity facing the infant and the infant-in-the-patient is its conflicting experience of intimacy, since paranoid anxiety can be understood as the anxiety of having the other involved in one's own concerns and depressive anxiety as the anxiety of having the self be involved in the concerns of the other. These are the two poles of de Rivera's conception of intimacy as one dimension of the psychological space between people organized by the binary emotional pairs of fear and anxiety, love and security, desire and confidence, hate and depression. Along this dimension one can move the object towards (desire) or away from the self (hate), or the self towards (love) or away from the object (fear). Therefore, if ACTIVATION is the conversational moment where the patient is positioned to align with the therapist's understanding (to open him or herself to it and accommodate it), then it is also a conversational moment where the patient is positioned to accommodate more of his or her own experience to the extent that that is the only subject matter the therapist talks about. Conversely, if DEFENCE is the conversational moment where the patient moves away from ACTIVATION, then it is a moment where the patient fears (moves him or herself away) or hates (moves the therapist away) his or her own experience – again, assuming a situation where the therapist's observation is accurate. The analysis, therefore, should show how intimacy figures into the paradoxical person-forming process of CKPP that occurs in the discourse.

But another framework is needed to understand how putting words to the "agitating gap" in her experience operated, if 'making the unconscious conscious" is the moment of bringing some set of aspects of experience into language so they can be understood.

In Rhetoric as philosophy: the humanist tradition, Grassi (1980) argues that rhetoric is the basis of any rational discourse (i.e., the digital aspect of communication in the terms of Waltzlawick, et al.). Grassi's interpretation leans on Dante's theory of true language as the expression of human historicity (pp. 76-82). The power of this language is held in the power of the metaphor, or speech that allows people to imagine possibilities of relatedness to things and each other:

> It [the "archaic" speech] is metaphorical, i.e., it shows something which has a sense, and this means that to the figure, to that which is shown, the speech transfers (*metapherin*) a signification; in this way the speech which realizes this showing "leads before the eyes" (*phainesthai*) a significance … [it] sketches the framework for every rational consideration … rhetorical speech "comes before" every rational speech, i.e., it has a "prophetic" (*prophainesthai*) character. (p. 20)

Rhetoric is the basis of language because throughout human history language has changed when its guiding metaphors have changed as the result of human labor. Through changes in human practices "tensions" are encountered in experience that require new names so that the foreign elements of experience can be assimilated within the governing symbolic order of the epoch: "through work, in temporal and spatial relationships … The concepts through which we come to understand and "grasp" each situation come from our ingenious, metaphorical fantastic capacities that convey meanings in the concrete situations with which we are confronted" (p. 100).[41] If this account holds for the history of the individual beginning with birth, as well as the individual in therapy seeking to change through discursive work, then a possible "site of alteration" will be a moment in the record

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[41] For a historical example, Harvey's treatise On the circulation of the blood (1955) was one aspect of a larger change that occurred in Europe: the change of the metaphorical basis of the human body. His work facilitated the ascendancy of the mechanical metaphor for rational discourses on the body.

Harvey presents convincing arguments that can be substantiated by anyone who follows them in the text. However, the power of his claim that the heart *is* a pump was relational. He argued for a new way to relate to this material thing called the heart: relate to it *as a pump* without spirit.

where new language and metaphors will be uttered by virtue of the assumption of a site that incorporates a new aspect of experience.

These aspects of Butler's and Grassi's frameworks will provide an interpretive counterpoint to Bion's ♀♂ and enable the interpretive analysis to move forward with an altered texture.[42] First, we turn back to some passages already examined to understand how Mrs. P was enabled to turn towards, and momentarily assume, a site of alteration before resuming the analysis of the last few exchanges of the session:

061 Like I've been saying. I think these fears of falling apart or being overwhelmed get dropped and
062 perhaps it's because you don't expect another person to stay with you and help you make sense of
063 what feels overwhelming inside.

Like other interpretive utterance already examined, the parameter of my subjectivity as disclosed to Mrs. P through these comments is a vision of herself that transgresses the sense she has been making in prior turns – transgressing the "cheery deal" (059) "I" formation, "that you record as my dramatic voice" (060).

The discursive site occupied by my "I've been …" at this moment is predicated on her existence "you…you" (062) of the "because" clause. This is a conception (♀♂) , a creation within the range of my subjectivity that uttered it. For me to have existed at that moment as the subject producing these utterances required her to exist within the boundary of my uttering "I" as a subject with a gap in her experience that I desired to fill (♀♂). In this sense, a "part" of Mrs. P was a component of the foundational conditions for my "I" formation to perform as a site of articulating, "because you don't expect …" (062). In other words, as the basis for my intelligibility, an aspect or *part* of Mrs. P's existence was proposed in the "because" clause (062).

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[42] By "counterpoint" I mean in the sense of a musical composition where two independent melodies are combined to accentuate in a way that neither could on its own.

So, my “I” was the product of the interaction; its possibility was intertwined with the birth (♀♂)of “part” of her subjectivity within that “I” formation. Let us call this the “baby-self”, defined as *a range of sensuously or viscerally apprehended experience* (**b** elements) *that is ill defined* (not understood and therefore “in need” of **a** function) and *has the potential to become organized into an intelligible aspect of the self that can be spoken about* (a conception ♀♂ that can be put into words).

At the same time the “you … you” opens a site for her baby-self to occupy a place in intelligible social existence – to be brought into language. Thus, if she recognizes her baby-self it is within this site of articulation, opened within my subjectivity, as *the creative product* (fecal gifts) of our verbal intercourse (♀♂) rather than *a toxic product* (persecutory feces) that must be kept away from both of us. Also, if she recognizes the baby-self within this site then it becomes a possible site of articulation for her to occupy as a cosubject of the dialog – another ♀♂ . So, what does Mrs. P do with the site of articulation opened within my transgressive utterances?

064 Yeah. [tearing] that makes sense. Yeah because principle people at crucial ages for me they
065 disappeared whether death or loosing a sister going to college or marriage is like a death. Yeah.

Notice there is no “I” spoken in her utterances. Instead, its place in language is occupied by tears (She could have said, “I want to cry that makes sense”). The “sense” it made registered viscerally, she was “moved” by my speech as people say. It seems that the “I” she invoked in prior utterances is in background; what is foregrounded is its condition of possibility, “because …”. It is an unhappy “I” “because … for me”. However, instead of choosing to speak her tears as the subject of the utterance (064), she occupies the syntactic place of a direct object in a sentence (“for me.”), where “principle people” are the subject of the “disappearing” action. At this point, Mrs. P is not the subject of her experience,

occupying a site of alteration; she is speaking as the direct object (D/O) subjected to an experience.[43]

Yet her "because" clause (064-065) is an elaboration within the parameters of the "because clause" in my prior turn (062-063), as if to say, "yes, the opening in your uttering 'I' matches this content' ♀♂) – "because …"" (064-065). The "because" clause shows that the baby-self conception (♀♂) she aligned with was an experience analogous to death: "loosing principle people … is like a death."[44]

In terms of the constitution of subject sites, then, by opening a place for the baby-self within my experience – the reflexive limit of my uttering "I" – Mrs. P, likewise, opened a space for her baby-self within the parameters of her uttering and passive "I" (passive in the sense that she was subjected to the baby-self rather than the subject of it as a range of her experience). In Butler's terms the baby-self is the "discursive limit" of Mrs. P's reflexivity, because it required the transgression of that very limit through my interpretive utterances for it to begin to be articulated by her. At this point in the session, Butler might say that Mrs. P was facing the "temporal paradox" of the becoming subject:

> The temporal paradox of the subject is such that, of necessity, we must lose the perspective of a subject already formed in order to account for our own becoming. That "becoming" is not simple or continuous affair, but an uneasy practice of repetition and its risks, compelled yet incomplete, wavering on the horizon of social being [or not] (Butler, 1997)

Moreover, this point for turning away or towards becoming a subject involved the transformation of Mrs. P's emotional grasp of me. As the person through whom the account of her becoming a subject already formed was taking place, she "met the other"

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[43] This suggests that while Mrs. P was working on a problem in her experience, she was doing so in a way that blamed the Other, dealing with depressive anxiety in a paranoid way.

[44] Thus, in Butler's terms, the repeated experience of having lost "principle people" is an unmourned loss that has conditioned the formation of the unhappy, tearing "I" that is facing "a death" – "the loss marks the limit of reflexivity, that which exceeds (and conditions) its [the subject's] circuitry. Understood as foreclosure, that loss inaugurates the subject and threatens it with dissolution" (Butler, 1997, p. 23).

(me) to "take hold" of the reality I was offering, "bring it in", and "show" me the baby-self that corresponded to my citation. For de Rivera, these are the instructions of joy, confidence, security and self-regard, respectively.[45] In other words, for Mrs. P to ACTIVATE to the extent she could, and face a painful aspect of her experience, she had to grasp me as a helpful (good) figure and within that figure catch sight of a range of her experience (the bereft baby-self) that was more or less off limits to the reflection of the subject already formed up to that point. Aligning with a "good" me as I transgressively sighted/cited her, then, facilitated her speaking "I" to incorporate the baby-self within its utterances, so that it might become – quite literally – the subject of her talk. If I was a good enough figure, then what I offer (a "part" of her) may not be so dangerous. By desiring the baby-self and speaking it I demonstrated that the anxiety surrounding the identity has been overcome, thus making it easier for the patient to align with the production because it becomes a sign of belonging to the therapist, to life, and distinguished it from being a sign of estrangement from the therapist, that is, death.

The next interchange shows the relevance of facing death for the appropriation of a site of subjectivity. Mrs. P selects her vacation as the "death like" change to talk about in response to my interpretive utterances. Like before, these utterances (066-068) appear to transgress the limit of her reflexive awareness, since she elaborates in her subsequent turn (069-072), *giving a name* to the baby-self:

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[45] According to de Rivera's model of emotions, emotions are what define psychological space along the dimensions of status, openness, and intimacy (cf., deRivera, 1977). Each emotion has an "instruction" by which it regulates our behavior in this psychological space. For example, anxiety is "keep world out of the self." Obviously, his scheme has limitations. However imprecise his model may be for deducing the patient's emotional state, reasonable inferences can be made based on the interaction. For example, in this instance it seems clear that Mrs. P agreed with my utterances, therefore she was not keeping the "world out", so anxiety can be ruled out.

066 So, perhaps inside you feels out of control because of there are several death-like changes you are
067 dealing with right now – the bombing of the terrorists, your daughter's wedding, and the fact that we
068 won't be meeting next week because you won't be here

069 Yeah cause I like routine right and I'm not going to be here next week and I'm like one of those
070 orphans – the smartest kids are the one's who get abandoned in hospitals and learn to have to get
071 along by being nice which fends off being orphaned. Yeah, because that image just came to me right
072 now I can – those little orphaned AIDS babies who have been dropped like a hot potato.

Here (069-072) Mrs. P selected her absence from therapy from among the other discursive sites from which to constitute an "I" to speak about "death-like change." In general terms, by aligning with the therapist who has just offered a sighting/citing of the missing sense of the self, the patient aligns with "a part" of herself that intuitively satisfies the contours of the gap in intelligible experience (again, ♀♂) – the mysterious source of distress for the subject already formed. *Through inclusion* of the baby-self this reunion, in turn, pushes the limit of the "I" that speaks; it is an elaboration of that "I" from within itself (so that in this example, Mrs. P goes on and offers a name for her baby-self, "orphaned AIDS babies…"). At the same time this reunion ♀♂ occasions putting the limit of her reflexivity in play by occasioning my next turn:

073 What I'm hearing is that right now you live with fears of being dropped by me like you felt dropped
074 by your mother as a baby.

073 is another assertion ♂, showing that I understood her "little orphaned AIDS babies who have been dropped" to describe her identity in relation to me, where I am identified as the deserting or withdrawing institutional mother. Within the "I'm hearing…" is a discursive site ♀ for Mrs. P as the D/O of my action, where I am figured in exclusionary terms. Thus, it ♀♂ opens a discursive a place ♀ within the site of my subjectivity for her subjectivity ♂ figured in overwhelming terms (dropped, overwhelming with need, AIDS baby-self), and thereby contradicts the propositional content of her analogic presupposition (recall, that analogic messages propose a definition of the

relationship; it this case it is "you are abandoning"), since an orphan♂ without a ♀ faces an end of life situation.[46] The first few utterances of her next turn indicate three truth conditions for ♂.

075 *Well maybe but that's if I don't come back, because then essentially I would have been dropped by*
076 *you. [asked to repeat, she did then began] No, the only parallel is if you went out in front of a*
077 *truck and got killed, that's the logical parallel to that ….*

The first two truth conditions involve Mrs. P eradicating the possibility of treatment by leaving. This is the "I" as a site predicated on "don't come back," a withdrawal of♂ from ♀ and the possibility of ♀♂. This a part of Mrs.P's "I," her subjectivity already formed (the "essentially I" in fact) that rejects the possibility of being within the site (sightings/citations) of my uttering "I" as her therapist who "I would have been dropped by."

This indicates a temporal ambiguity, since the beginning of this utterance projects an ending that one would expect to be in the future conditional tense rather than the past ("I would be dropped by you" rather than "I would have been dropped by you"). So, the first truth condition could be interpreted as her not returning to therapy after her holiday. However, the second seems more likely given the context of the communicative work so far in the session; it seems that the "would have been" condition refers to the session itself, and the moments where I could have dropped her (i.e., made no room within my discoursing subject site) but did not, thus contradicting her expectation with each repetition. The iteration of my "I" was a paradox. On this account her deflecting talk was the attempt to

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[46] In Kleinian terms, this was a TRANSFERENCE interpretation. Notice that it structurally corresponds to a PHANTASY (cf., p. 61, above): As Mrs. P's. EXTERNAL OBJECT I exist in the condition of deserting mOther (an identity) as a result of her orphaned-AIDS-baby relationship to me. That my condition of deserting depends upon her action towards me is underscored by her response that at face value does not seem – nor did it sound at the time – logical.

"not come back" and each time the deflecting "I" repeated this performance I brought her back, so to speak, providing a place, for the orphan baby-self.

The third truth condition is formulated on the basis of negating the first two ("No…"). In this scenario I am destroyed because I have put myself in harm's way ("if you went out in front of a truck and got killed" 076-077). Now, a truck belongs to the category of containing ♀♂ vehicles that carry ♀contents ♂ for consumption (produce, fuel, productive things like machines, etc.) or destruction (garbage and wastes of various kinds). Using this translation, the phantasy is that the attempt at containing her will destroy me, or she might be overrun by the therapy, since its aim is to deliver ♀♂ as a vehicle for insight.

Yet I just contradicted one option by performing a subjectivity predicated on including her baby-self within its parameter (073-074), which Mrs. P confirms in her next utterance with a conditional clause "But …." She has finally incorporated ♀ the conception ♂ offered in 073-074 (the ♀♂ of my prior turn becomes a ♂ for her to deal with in her subsequent turn). Notice what happen to the "I" that "contains" the conceived baby-self, so to speak, for under 14 words. Its position as the "I" that speaks is taken over, or perhaps run over, in the attempt by the minister "I" which is bent on being the "I" that offers me conceptions rather than taking in conceptions. In other words, the self she is "wanting to have" in response to having the conception of the baby-self is the minister self that is not dependent on a mother-therapist in a hospital setting; she *does* the self she wants "to have", she performs it to make baby-self disappear. Previously, this pattern (cf., pp. 107-109, above) has been articulated in terms of a "collaborative completion":

077 … But yes it could play right into not wanting
078 to be orphaned, wanting to have a self. I was doing reading on disappearance of the self into pre-
*079 existence and **there is** literature on disappearance into pre-existence [stated in an emphatic tone to*
080 emphasize she is right]

This kind of collaborative completion, then, is a means to exclude the baby-self from her conscious experience of the moment – to close the site for its possibility of becoming intelligible as an uttering "I." This is a double exclusion. On the one hand, the baby-self (a range of her sensuously or viscerally apprehended experience with the potential to be brought into language) is excluded from her own awareness; "a part" of Mrs. P that has to deal with loss in the face of change is lost and avoided. At the same time, the baby-self is also excluded from social reality because it cannot be spoken about, for to speak about loss would risk its resurgence. Thus, it is impossible for Mrs. P to talk with others to secure their support in the face of losses since the hegemonic "I" wants nothing to do with loss, so to speak. Its formation is predicated on the negation of loss in Butler's (1997) terms. Hence, loss also becomes the source of alienation or isolation from others ("its not like she's being taken off to jail", i.e., incarcerated and off limits to Mrs. P)

In other words, her final utterance in this turn shifts topic and context away from her fear in the context of her relationship to me, her Other. She interrupts herself – or better yet, the orphaned self that was speaking, forwarding a topic that is completely foreign to what has been talked about in the session, *but not foreign to what she has been doing through her talking*. In 077-078 Mrs. P shifts from what she does not want to belong to her identity, her self – "be orphaned" – to what she does want to belong to her identity – "a self." The following utterance has a self, so to speak, she says "I was doing reading … ," which suggests it is a different self ("I") than the one previously speaking, not an "I" afraid of being orphaned, but an "I" that studies and ministers on "disappearance into pre-existence." It is another example of "dropping" herself, "deflecting," that "annoying thing that happens…and blocks whatever" she tries to "get at." At least that is how it seems I understood it at the time based on my response to her turn:

081 You are disappearing from here right now because we just touched on your fear of being orphaned by
082 me so you mentally moved away to thoughts of before you existed.

Clearly the "you" in this utterance is not referring to Mrs. P in her physical presence as if she were teleporting out of the Enterprise on Star Trek. Yet in a way she was teleporting herself out as the cosubject of a conversation in which I could participate. I can contribute nothing to her understanding as a fetus (before existing as a baby how can one be said to exist?). In effect, my assertion was pointing to how she extinguished her existence with me in the room as the orphan I was talking and listening to, "disappearing from here right now…"

As with my previous utterances throughout the session, this assessment links her action in the here and now through her speech to her emotional sense of things, falling within the eight characteristics of CKPP outlined so far. The pragmatic effect of my sightings/citation was to open a discursive site within my uttering "I" for Mrs. P to sight/cite herself *as a subjectivity of her experience* and not a D/O (I did not say, "oh, there's that annoying thing that happens to you again"). The description I uttered occasioned a moment for her to recognize her "I" in a moment of its formative repetition (performative iteration in Butler's 1991, 1997 terms) based on a fear of loss – "the annoying thing that happens." Thus, the citation provides an occasion to alter that subjectivity by means of a double recognition that transgresses what she could apprehend in her experience – as the "subject already formed" on the ground of denying that aspect of her experience. Apparently, the effect of this double recognition was to move Mrs. P:

: *083 [Tears start streaming, nods in agreement, I let a few moments pass]*

Of course what you, as the reader, cannot know since you weren't there is how different it felt to be with Mrs. P by the end of the session. Gone was the kinetic energy that projected the stress of busyness. Gone was the see-saw smiling polite tone, the "cheery

deal" as she called it herself (059)– the traces of that presence crumpled on the desk in a small pile of used white tissues beside her, with one still clasped in her hands as if weighing them down in her lap. Her face looked sad between those tears – cocked a bit towards me as her lips cocked to one side as though they slid there, as though repeating some form from Francis Bacon's visual lexicon of anguish – tearing and nodding. I waited a few moments:

084 Our time is up for today

This section has argued that the allure of the therapist's voice stems from the longing to be understood without having to say what had been unspeakable out of the anxiety over the paradox of subjection. The patient has a desire for life to be different in some way, yet is communicating in a way that the denial of who he or she could be organizes the performance or iteration of his or her "I":

> The foreclosure of certain forms of love suggests that the melancholia that grounds the subject (and hence always threatens to unsettle and disrupt that ground) signals and incomplete and irresolvable grief. Unowned and incomplete, melancholia is the limit to the subject's sense of *pouvoir*, its sense of what it can accomplish and, in that sense, its power. Melancholia rifts the subject, marking a limit to what it can accommodate. Because the subject does not, cannot, reflect on that loss, the loss marks the limit of reflexivity, that which exceeds (and conditions) its circuitry. Understood as foreclosure, that loss inaugurates the subject and threatens it with dissolution. (Butler, 1997, p. 23, emphasis in original)

Through discourse in an asymmetrical relationship of intimacy and dependence the patient was positioned to become the subject of her own experiences that had been excluded from occupying a space within her conscious subjectivity – the space of the self.

This was achieved by addressing the infant-in-the-patient through transgressively intimate utterances. The orphaned AIDS-baby self was recognized and occasioned by the therapist's utterances for alignment by Mrs. P as the self of the subject already formed who was in

crisis. Once she aligned with the "baby-self" its experience was verbalized by her self as part of her conscious self – that is, it become a possible object of knowledge for Mrs. P. as a subject in discursive co-existence with the therapist-mother. Thus, the section has provided an account of how the self-subject forming process works in CKPP.

To be understood as a preverbal infant is to be understood without having to say what one is experiencing. The experience is materialized in the discourse[47] of the Other and thereby signifies a possibility for relating to that Other – a sign of mutual belonging and accommodation of the self to the Other and the Other to the concerns of the self (reciprocal love in de Rivera's account of intimacy). On one side, the yearning to be understood and sighted/cited differently fueled the patient's utterances, since the symptoms are the pressing disruptions in the story of which she is conscious, the inscriptions of an unhappy "I" or "I"s on the text of her life. They are not "the scars of a corrupt text" but the traces of a nascent *who, a lonely ~~voice~~ in the room trying to be heard*.[48] That there are absences in what the patient could sight/cite about herself is a given, since the "I" that speaks is predicated on what cannot or must not be allowed to be heard lest it risk falling out of the range of human

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[47] For Butler (1993) discourse has material effects as a reiterated acting (a pragmatically performative network of norms) that stabilizes over time to produce the effect of boundary, fixity, and surface. On this account, the self is the more or less stable reiteration of patterns of relating that is materialized "on" or "within" the site of the body, creating the effect of a pre-given fixity or substance. Hopefully, the parallel between this and the Kleinian account of phantasy, internal object relations, introjection and projection is clear.

[48] I think, however, that Butler's points apply both to pathological and non-pathological situations. Referring to pathological cases as instances of a "corrupt text," as McCarthy cites Habermas, implies that the communication of 'normal' people is without ambiguity or contradiction. There may be less in non-pathological cases but no one is completely self-transparent. Compare, McCarthy (1978):

> As Wittgenstein stressed in his account of "language games," the "grammar" of ordinary language games governs not only the connection of linguistic symbols but also the interweaving of speech, action and bodily expression. In a normally functioning language game, the different classes are complementary. In pathological cases, however, they no longer fit one another; actions and nonverbal expressions belie what is expressly stated. The acting subject either does not observe the discrepancy or is not able to understand it. Nevertheless the symptomatic expressions … are expressions of the subject. They cannot be dismissed as accidents: "their symbolic character, which identifies them as split-off parts of a symbolic structure, cannot be permanently denied. They are the scars of a corrupt text that confronts the author as incomprehensible." (p.197)

intelligibility: a state of no meaning for anyone (psychosis) – against a backdrop of psychological death, a "disappearance into pre-existence."

> A satisfactory early relation to the mother…implies a close contact between the unconscious of the mother and the child. This is the foundation for the most complete experience of being understood and is essentially linked with the preverbal stage. However gratifying it is in latter life to express thoughts and feelings to a congenial person, there remains an unsatisfied longing for an understanding without words. …This longing contributes to the sense of loneliness and derives from the depressive feeling of an irretrievable loss.
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> ~ Melanie Klein (1963), *On the sense of loneliness*

Conclusion

> The error [the structural model of psychic apparatus based on non-observable entities] becomes obvious if one examines more closely the evidential basis of psychoanalysis, namely, the clinical experience to which Freud himself constantly referred in defending the scientific status of his work. The analytic dialogue between patient and therapist was the sole empirical basis for the development and quasi-experimental testing of psychoanalytic theory; thus the meaning of its concepts and hypotheses must be explicated in connection with the analytic situation and not in terms of an empirically unjustifiable energy-distribution model.
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> (McCarthy, 1978, p. 196)

While the practice of contemporary Kleinian psychoanalytically oriented psychotherapy has been described in other works of varying degrees of clinical-theoretical sophistication (e.g., Hinshelwood, 1994; Joseph, 1988; Ruszczynski & Johnson, 1999; Solomon, 1995), what is new about this study is the method by which it has been conducted, the genre in which it is written, and the extent to which it has attempted to reconcile the practice of CKPP with contemporary philosophical works that address the problematic conceptions of selfhood and subjectivity; specifically, what it means to be a self, a subject and how therapy is one culturally created and perpetuated arena within which selfhood and subjectivity are produced through discourse.

The primary aim of this study has been to show through a detailed analysis of one session how the practice of CKPP operates: explaining its assumptions, practices, and the involvement of the therapist. As worded in the introduction, the study has deployed a hermeneutic methodology and nonfiction genre to tell a story of contemporary Kleinian psychoanalytically oriented psychotherapy from the perspective of a novice. The study has empirically shown that as a form of communicating it involves patterned linguistic usage and role behavior that are coordinated into a specialized "communicative competence" with the aim of an ontological accomplishment: self-subject forming processes.

Like the account of a zoo provided by a tour guide, this account is a systematic yet idiosyncratic report on the workings of CKPP from the inside. Just as the tour guide would adjust his account of some aspect of the zoo or animal's behavior depending on how your questions required more detail – explaining this building in environmental or historical terms, those animals in zoological terms, and perhaps both in commercial terms ("you can buy pictures of that tiger in the gift shop") – the cyclical form of hermeneutics required the interpretive framework to change along with the evolution of the governing question as the analysis proceeded. Thus, a creative nonfiction genre was chosen. The nonfiction is in the "facts" of documented utterances exchanged during the session and the literature cited throughout the analysis; the creative is in the weaving together of a wide array of different perspectives and shifting narrative voices: here the therapist speaking to the patient – there the supervisee listening to the memory of the supervisor offering guidelines and bits of clinical wisdom, here the researcher of the communicative exchanges – there the theoretician grappling with complex conceptual issues. The result is an idiosyncratic story of CKPP as a "system of possibilities and resources, frustrations, and obstacles, and two [researchers] will find both commonalities and differences in their accounts of it" (Packer, 1985, p. 1093). Nine characteristics stakeout the territory of CKPP viewed as a specialized communicative competence. These are numerically indicated in the following paragraphs that descriptively summarize these findings.

From the patient's perspective, imagine you walk into the same room every week, perhaps two or more times per week, at the same time for an uncanny conversation with a stranger, who, by virtue of their strangeness, is able to tell you secrets about yourself with unflinching candor that you never knowingly told them – and at times these secrets were things you never knew until they were first mentioned by this stranger. This makes him or

her stranger and not less so, particularly because all you see him or her do is (1) write down everything you say, think about it, and tell you things you don't know about yourself as he or she learns about you. You pay for this doubly strange person to learn with you and about you in an uncanny relationship. You are assured that whatever you say and do during that hour will never be revealed to anyone else without your permission. All of this is intimidating because this person knows you intimately while you know nothing about his or her private life. You are letting this stranger matter so much in your life that you want to depend on them to help you change yourself, while you have little if any idea of how your words affect them other than how they speak to you about yourself. Built into the other stable elements that frame your visits is (2) an asymmetrical relationship of dependence and power.

From the perspective of the therapist, each session is also a brush up against the uncanny. The patient comes in with a problematic present that refuses to pass. Each session involves some anxiety. No matter how many times you've done it in your career or with this particular person, you can never predict how you will be implicated in that problematic present. Neither can you predict with any certainty how he or she will respond to your (3) descriptions about the patient's reality that, by the standards of every day conversations, are transgressive in form and function since they aim to foster a metamorphosis in the patient's life, one intimate session at a time.

Moreover, this task involves resisting what one habitually does in everyday conversations with friends who have problems: you may not give advice, must resist asking questions, offering reassurance, offering prescriptions for what he or she should or should not think or do, or telling stories about yourself to show that you can relate. While your comments are (4) grounded topically in what the patient says, they must go beyond that to

show the patient experientially in (5) the here and now of their relationship with you what he or she does, does not do, and the consequences of their action for contributing to their experience of the problematic present that refuses to pass. In other words you are restricted to offering (6) descriptive hypotheses about the form and sequence of the patient's experience and how its elements are related outside their everyday awareness.

In addition to the challenge of formulating these interpretive utterances that articulate – optimally – something new and unpredictable and the facing the consequences as the patient responds, there is the challenge of knowing when to say them. Unlike the turn taking structure of an everyday conversation, you try to speak (7) only when you think the patient is not engaged in a critical self-reflection of their problematic experience. How do manage all this? What are your tools? One tool is the note writing that provides a record of what has been going on in relationship for you to use to (8) decode the patient's stories and patterns of communicating in terms of his or her main anxiety and the relational practices of power that subtend the problematic present that refuses to pass. Another tool (9) is the set of theoretic-clinical concepts and techniques that you have learned from readings and from supervision, which include five guiding question to govern learning about the here and now of the other: how does the patient see me? How is the patient trying to use me? What does the patient do with what I say? What is the main anxiety? And, what does it feel like inside to be with this person?

The nine characteristics described above constitute the communicative competence of CKPP. Originally, it was hoped that the design of this study would be able to show how this specialized communicative competence was the direct result of supervised clinical practice, since it is assumed in the empirical literature that supervision works by means of "changing trainee characteristics." However, as the analysis proceeded it was realized that

while the communicative competence could be articulated that a longitudinal element was needed to trace the changes in communicative skills as the direct result of the supervision. Yet, it also became apparent that the communicative competence of CKPP was geared towards subject formation by means of a paradoxical communicative effect. Thus, rather than include the longitudinal element, it was decided to focus on the subject forming processes as an example of the "paradox of subjection."

Given the tropography of CKPP is coordinated by tropes of mother-breastfeeding infant dyad, the paradox of subjection was examined as the operation of weaning, which defined the specialized communicative competence of CKPP taken as a whole – a framework for the conversation as well as the communicative patterns operating within that framework. This paradox refers to the notion that in order to become a subject that can have effects on others and the larger social world one must desire subjection; in order to have a recognizable form with social weight, one must desire and submit to a process of formation. This paradox was redescribed for research purposes as the subject-forming process of CKPP. Examining these subject-forming processes occasioned by the transgressive utterances of the therapist required looking at the instances where preverbal aspects of experience were languaged to try and articulate how this process worked.

More concretely in terms of this analysis: Mrs. P came to the session with a problematic present that refused to pass. This began with a fragmenting anxiety over feeling "so sad." However, as she and I worked to learn more about it, the anxiety became articulated as the grasp of herself as being deserted by her mother and sister in the past, her daughter in a pending marriage, and ultimately, deserted by me as one of a string of "principle people" that "disappeared" when she needed them – that is, when she was confronted with a situation of deprivation. This evolution of learning involved a paradox.

One the one hand the orphaned AIDS-baby self is a definitive identity, a metaphor that sketches out the framework within which she understands the repetition of time in her life – a reiteration of desertion where her concerns are the reason the other flees ("disappeared" or they push her away ("dropped like a hot potato"). This orphaned identity was the correlate of an institutional mother identity. On the other hand, as a mother figure, I was not abandoning her concerns in the session. I was pursuing them through interpretive utterances.

Thus, in general terms, it seems that the paradox of subjectivity, through the specialized communicative competence of CKPP, is for *the therapist to become the paradox of the patient*: the Other who could be what one always expects yet discursively effects a displacement of one's expectations, thereby opening the possibility of a new relationship.[49] Furthermore, it is by embodying (i.e., verbalizing) the displaced expectation that a new experience of another is made possible and the problematic present might begin to pass.

CKPP addresses the paradox of subjectivity through discourse in an asymmetrical relationship of intimacy where the patient is positioned to become the subject of his or her own experiences through a discursive subjection to them. In Habermas' and Kögler's terms: in a productive dialogue of asymmetrical power and dependence, knowledge *about the self* becomes *knowledge for the self* through the *alterity of the Other* by means of *the experience of a difference in a relational repetition*. This is the critical hermeneutic formulation of CKPP as weaning.

Additionally, in its creative non-fiction aspect, this study has provided a window into a therapeutic method that is based on a radical shift in the history of psychoanalysis: the

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49 By "discourse" I mean the entire interactive process of sense making between participants that involves the embodiment of role behavior, speech, and affective expression, that draws from "*a set of norms, preferences, and expectations relating language to context, which speaker-hearers draw on and modify in producing and making sense out of language*," as described by Ochs (1990, p. 289, italics in original)

shift from the governing trope of the surgeon to that of the mother-feeding-infant. While it is beyond the scope of this study to address this topic with the thoroughness it deserves, a discussion of its impact regarding the understanding and handling of the transference requires discussion. The ethical implications will be addressed in the Afterward, along with a self-appraisal of the study.

As already noted, Grassi (1980) argues for the primacy of metaphor in the contouring of any rational discourse, the speech that frames the speaker-hearer's possibilities for imagining relatedness to things and each other. As argued by Stepansky (1999), the dominating trope upon which Freudian discourse has been erected, practiced, taught, defended and criticized is that of the surgeon. Although he carefully explicates and examines the real and possible dangers inherent to metaphorizing psychoanalytic therapy along the lines of surgery, he also argues for it when used in a sophisticated and elastic manner. In short, the problem is not inherent to the metaphor, but how it is appropriated: is it used as a starting point for imagining the benefits and the risks to deepen and complexify discourse, or as tunicate on critical reflexivity at the expense of those who are really suffering, or worse, to justify abuses of power?

> The problem, I submit, has never been with medicosurgical analogies per se. Rather, it has always resided in the truncated vision of medicosurgical activity that underlies and informs such analogizing – and in the tendentious use of such analogizing by the supporters and detractors of classical psychoanalytic technique…. Modern surgery, both in its therapeutic obligations and in its technical ministrations, opens to a wealth of metaphoric possibility that awaits appropriation by contemporary doctors of the mind. We have briefly considered Ferenczi's transmutation of Freud's surgical metaphor into an obstetrical metaphor, with analytic treatment figuring as a "midwifery of thought." This image, which fruitfully combines elements of passive receptiveness (the analyst as "onlooker at a natural proceeding …") and active intervention ("… but who must be at hand at the critical moment with the forceps in order to complete the act of parturition that is not progressing spontaneously") has yet to be pursued beyond Ferenczi's early writings of the 1920s. Yet the obstetrical metaphor approximates Selzer's vision of the modern surgical act, of operative restraint in the service of a creative therapeutic task, far more adequately than Freud's original metaphor did. (Stepansky, 1999, p. 223-224)

However, Stepansky is in error with regard to the fate of Ferenczi's obstetrical metaphor. As Ferenczi's analysand and pupil, Melanie Klein pursued and transformed it into the image of the mother-feeding-infant with important consequences for the theory and practice of psychoanalysis, particularly with regard to the notions of phantasy and understanding transference as "the total situation."[50]

Burston (1996) rightly notes that for Freud and his followers, "unconscious fantasy is a device to avoid the experience of something real" while for Laing (like other existential-phenomenologists) the true function of fantasy, "is to express the truth of lived experience in symbols and metaphors, whose intuitive and poetic insights often exceed our conscious

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[50] As noted in the beginning of Chapter two, it is beyond the scope of this study to provide a comprehensive analysis tracing the complex web of the development of Klein's thought and her place in the history of psychoanalysis. Many aspects of this have not been addressed such as the political context within the early psychoanalytic movement (e.g., the mixture of theoretical and personal animus that characterized the schism between Klein, Freud, and Anna Freud), how the specific conceptual and technical innovations of Klein's developed on or out of the work of her analyst mentors Ferenczi and Abraham, the negative consequences of her decision to analyze her own children, including the schism that developed between Klein and her own daughter who sided with Grover, Anna Freud, et al., during the Freud-Klein controversies, etc. Furthermore, there is the lingering controversy over how Freudian Klein was or was not. In the early phase of her work Klein and her followers were adamant that their work represented the logical extension of Freud's and that therefore it was legitimate despite the protests of Anna Freud and Freud himself. Burston (1991, 1996) characterizes Klein as a "crypto-revisionist" who, while identifying and speaking with the tongue of the orthodox, was actually subverting the orthodoxy in an self-deceptive or sneaky manner. I disagree, or rather, I think the matter is too complex to be resolved since Klein, Freud, and Anna Freud openly disagreed on Klein's assertions about phantasy and the priority of the internalization of good objects in the depressive position for the resolution of the Oedipal drama to occur (recall that for Freud internalization of objects only begins with the resolution of the Oedipal situation well after infancy).

Since I doubt Klein was so dense as to not notice that Freud and his daughter rejected her clear divergence publically and in writing, for example, with respect to phantasy and the development of internalized objects in infancy (cf., Sayers, 2000), one may wonder what was her interpretation of orthodox Freudianism to which she proclaimed allegiance? Could it have been Freud's commitment to explore the unconscious and adapt theory and technique to evolve with clinical findings and material? Since Klein used the classical technique with children whereas Anna Freud did not, does this mean that Klein was more Freudian than Anna Freud and Freud himself? Clearly there was a political interest in claiming legitimacy by invoking the name of Freud. Perhaps there was also a psychological benefit for a female, divorcee, lay analyst, who followed her clinical instincts into the hitherto fore unexplored terrains of children and psychotics which both Anna and Sigmund had written off as unanalyzable according to their version of classical technique. Perhaps Ms. Klein needed the psychological support of identifying her exploratory zeal with the earlier Freud's to overcome her own anxieties about diverting from the popular path of least resistance. Perhaps Ms. Klein secretly hoped to curry the favor from a surrogate father figure that she never received from her own father, another Jewish doctor who rejected Melanie publicly while glowing in the accomplishments of his other daughter. As a student of contemporary Kleinian technique these questions continue to have historical and political interest, but they have little bearing on the practice of CKPP, and I doubt the historical evidence exists to conclusively decide the issue.

rationality and acuity. If fantasy in this sense is allied to our conscious adult selves, we become more, not less, in touch with reality" (p. 215). Freud's conception of fantasy as necessarily and only distorting was related to the Freudian conception of transference as something to be removed, for, by definition, the transference is the distortion of the analyst due to unconscious fantasy. The goal of Freudian analysis was to remove the transference, like a surgeon removes an excess of the body that hampers normal functioning.

For Klein, phantasy can be distorting but is also necessary for participating in a socially agreed upon reality ("reality testing"), as well as creativity. Consider the following hypothetical examples for illustration. Two different patients see the therapist smirk a little when he hears their responses to an interpretation. After a few minutes, patient A draws the therapist's attention to it and says, "you know I'm sure this is just my reaction, but when you smirked while I was talking I felt like you were telling me my reaction was stupid and it really hurt." Patient B notices the smirk and starts yelling at the therapist, accusing him of plotting to cut off his penis, and no amount of apology or reassurance seems to soothe patient B. In both these cases phantasy is at work and in both cases it can be viewed as an expression of "the truth of lived experience in symbols and metaphors" (ibid., p 215).

For patient B, his persecutory castration phantasy is "true" in the sense that *he felt* his right to assert his viewpoint was cut off by hurt feelings due to the therapist's gesture. It is metaphorically true. However, his persecutory castration phantasy is distorting in the sense that the idea of cutting off his penis due to his speech was nowhere in the therapist's mind, the therapist had lapsed into a daydream about his pending vacation. His phantasy was distorting his sense of his therapist's identity and his identity in relation to the distorted therapist. His phantasy was distorting in that it has the weight of an ontological and epistemological conviction that if the patient has a perception that it must be true and not

subjection to negotiation with other people ("omnipotent phantasy" in the jargon). His phantasy was also distorting by attributing a motive without any evidence of its veracity (a "projective identification" phantasy), and, because of the omnipotent phantasy, it was impossible to assess or question the veracity of the attributed motive. Furthermore, because of the above phantasies, it was impossible for the patient to notice that his radical shift in identifying the therapist was related to his emotional pain of hurt and anger, and that when he feels angry he sees others as attackers. This hypothetical case is one where paranoid-schizoid phantasies dominate the transference. The fact that his castration phantasy may be a poetic description of his actual experience does not mean that it is an accurate appraisal of social reality, however that may be locally defined by consensus. The therapeutic goal is not so much to surgically remove the transference but to provide the necessary conditions for the patient's phantasies to mature through understanding – from *surgery* to *growth and development* in a "holding" relationship. It is not just the sense of the therapist that is transferred, it is *the whole experience of the "total situation," the relational context is transferred*, as noted in Chapter 3 above. Stated differently, perhaps more hermeneutically, because a pre-reflective, bodily sedimented, relational context is transferred, the therapist "shows up" as this or that depending on the phantasized context of the relationship activated at that moment.

Like patient B, patient A's had a phantasized reaction to the gesture. But the nature of his phantasies were on a depressive order, and therefore resulted in thought and speech that made it possible to negotiate the meaning of the event with another person, before the rapid foreclosure of possible meaning as in the case of patient B. Notice patient A said, "it felt like you were …" indicating his grasp of the demeaning significance as a possible meaning, it was "as if" the therapist had purposely hurt him. The persecutory interpretation

is still virtual, because it contrasts with other possibilities that he uses verbal language to try to sort out before committing to an interpretation of the therapist (significantly lower omnipotence). Patient A also acknowledges that may be "just [his] reaction" indexing his idiosyncrasies as a factor contributing to his understanding (the phantasy that his participation has a causative effect on the attitude of a separate and important object towards himself). The fact that he initiates a reparative conversation with the therapist indicates that he values the therapist as a good other whose "goodness" or good will he has a responsibility to maintain through accommodating the therapist's perspective. Thus, the hypothetical case of patient A shows how depressive phantasies are necessary for "reality testing," understood as the ability to negotiate social reality between two different yet related people. Removing depressive phantasies is neither desirable nor possible.

One may question the use of the term phantasy in this latter case. Although patient A has better "reality testing" than patient B, the term phantasy is still appropriate because the disturbing, possible meaning that patient A described was *one possible meaning.* As a possible meaning that patient A spontaneously produced it was neither a fact nor a given. It was an intended relational meaning that may or may not have been true – a virtual reality about the therapist, as light emanates from the sun's reflection on a plane mirror from a virtual focus. Phantasies may be thought of as virtual foci, possible points from which an interpersonal event can be illuminated in different ways, can mean very different things. The virtual precedes the actual in creation, including the creation of the meaning (shared or not) of an interpersonal event. Transference as the total situation can be developed and differentiated to broaden the patient's range of tolerable interpersonal meaning in therapy, but not removed from examination as long as the therapist maintains the blankness of the screen, to the extent this is possible.

Methodologically, this study has implications for supervision and psychotherapy research. Every psychotherapy session or supervision meeting, to some extent, depends on communication between the participants, and this study has demonstrated an empirically grounded, systematic, and rigorous interpretive method to articulate such communicative patterns. Demonstrating efficacy in either of these arenas would require studies designed to assess longitudinal effects of the communicative work by comparing changes in communicative competence, which can be traced to the communicative work of the supervisory or therapeutic encounters – bearing in mind that not all intervening variables can ever be ruled out when studying human phenomenon from any perspective.

The method demonstrated here may also be used for the comparative study of therapeutic approaches in terms of their theoretical constructs and practical implications. For example, "empathy" is a key word for many different schools of therapy although it is by no means clear that they define the concept the same. One idea for a future study might be to elicit verbatim session records or excerpts for Kleinians, ego psychologists, self-psychologist, and Rogerians who have defined them as exemplifying "empathy." These records would then be analyzed for their communicative patterns to discern what characterizes "empathy" in these various therapeutic discourses, as well as any patterns that characterize patient responses to these "empathic" moves.

Similarly, within the Kleinian tradition, one interest of the author's is to solicit session vignettes from Kleinians that exemplify various central anxieties that can be articulated into patterns of distorted communications and communicative aims. For example, in so far as a clinician can diagnose a patient based on the kind of transference the patient enacts, can "Schizoid," "Narcissist," and other "personality types" be reconfigured as

certain patterns of distorted communicative agendas? One benefit of such a project is to produce research results that have immediate clinical relevance, since it would provide clinicians – inside and outside the Kleinian orbit – with clear, participant-observer accounts that may be used to identify patterns in their everyday practices.

This would take clinical research in the direction of fulfilling Habermas' goal of reconstructing psychoanalytic theory as a theory of systematically distorted communication -- using Kleinian theory rather than Freudian. Kleinian theory is well suited for such a project, since it is already "purged of [Freudianism's] neuropsychological trappings" (McCarthy, 1978, p. 198); contemporary Kleinian psychological theory is a purely psychological account of relational dynamics between people, viewed as dynamic organizations of composite parts, functions, and modes.

Unfortunately, this study did not address one significant area of Kleinian ontology and ontological work of its technique: for Butler the "inner" of the subject is a result of melancholia through discursive interaction and not an unproblematic pre-given that is "discovered" by clinicians and social theorists. Kleinian theory implies this in that the mechanisms of introjection and projection are the means by which the "internal world" is built up – that is, it is a construction for navigating the vicissitudes of social attachment.

A related problem this study has highlighted – although not addressed directly – is the problematics of the terms "self," "subject," "mind," "ego," etc. Are these the same? Do they each indicate one facet of a multiplicity we might designate as the "person"? Butler, following Foucault, reserves "subject" to indicate a placeholder in a discursively circumscribed cultural milieu. But is there not more to being a person than the point of interface within language? Has the "linguistic turn" in philosophy and the human sciences

of the 20th century culminated in an early 21st century “linguisticism” just as the dawn of the 20thjCentury was struggling with psychologism, historicism, and sociologism?
True, the “linguistic turn” has provided a way out of the mind-body, subject-object cleavages called intersubjectivity. Yet if there is more to personhood than being a subject, a node in language, then intersubjectivity has split us off from this extra-linguistic. Rather then being an “encapsulated ego” we are encapsulated within the horde of a *sensus commnis*.

The Kleinian thesis of phantasy, the examples provided above involving Trude and the child terrified by her mother’s broken shoes, as well as the therapeutic encounter itself, attest to the fact that there is a sense outside of language, a sense about which language must organize itself. In the case of Mrs. P, her “I” was threatened with dissolution by the encounter with loss as a transcendental empirical problem (it was transcendental in the sense of transcending the range of her linguistically mediated empirical perception). The discourse of the therapy became organized around this problem. The problem was realized in language but it constituted the language as much as the language realized it. Love, hate, guilt, reparation, envy, greed, anxiety, depression, death, loss, these are all so many problems of becoming as a person that have organized literature, poetry, and visual art across cultures and history as much as these artistic forms have realized various expressions of these problems for various peoples.

Examine the painting of Francis Bacon's at left (*Head 1*, 1948, Richard Zeisler Collection; Louisiana Museum for Moderne Kunst, 1998). At an initial glace this image is disturbing. Attempts to say, "what it is" are thwarted despite the fact that one's words try to cling to its sense like antibodies swarming a foreign protein. "Oh, my gosh," "Gross," "ugly," "you call that art?" "I could do that." One can imagine the words that go out to attack the disturbing sense that disrupts the common sensibility of art, threatening the "I" that utters them. Our language faculty hits its limit in the attempt to comprehend Bacon's image. His image is an imaginary that resists inscription, like a bloodstain in the wash.

His image is a new presentation of an affect and perception that could only be realized by an artist that imposed restrictions on his palette of color (e.g., reds, purple's),

visual lexicon of images (e.g., the gaping mouth, fragmented body parts tenuously held together/confined by external structure), techniques for brushing (e.g., construction of tense geometric spaces through the use of line), and philosophical interests in subject matter (e.g., visceral experience) to create his works on canvas. Similarly, CKPP utilizes a disciplined communicative competence – the discipline of techniques and the techniques of discipline – to occasion

self-creative moments in therapy out of something that is there to be realized, a virtual reality of and for the patient, as much as its disciplined use of language shapes what is realized.

So, if there is sense, perception, and affect outside of language, how then to conceptualize the person? Kleinianism is a doctrine of parts – aspects of experience (emotions), faculties (seeing, talking, thinking, imagining), and modes (taking in, putting out). This suggests an image of the person that is both a one and a many at the same time: a diacritical unity. Indeed, the notion of splitting implies that the overly defended person is trying not to be more than one thing – i.e., trying to avoid feeling good and bad, happiness and loss, to avoid thinking about a feeling, etc. Its "integrated ego" is not a monad of experience, but a unified multiplicity confronted with potentially rapturous encounters. In the case of Mrs. P., for example, the session could be characterized as helping her encounter loss as a unified self composed of parts, which threatened the "I" with rupture as a totalized unity, a multiplicity confined to one possibility. How can this conception of the person be used productively in psychopathology as the study of deformations in learning from experience?

The author is interested in pursuing this doctrine of parts and its theoretical implications by the critical and reciprocal examination of Kleinianism and Deleuze's transcendental empiricism. Deleuze writes the following about learning:

> For learning evolves entirely in the comprehension of problems as such, in the apprehension and condensation of singularities and in the composition of ideal events and bodies. Learning to swim or learning a foreign language means composing the singular points of one's own body or one's own language with those of another shape or element, which tears us apart but also propels us into a hither unknown and unheard-of-world of problems (Deleuze, 1968/1994, p. 192)

Deleuze's conception of learning is based on that of the person figured as a diacritical unity rather than a totalizing unity: a composition of parts that reconfigures its organization in terms of a localized field of problems *like every other organism.* For Deleuze the singularity of

the human organism resides in how it approaches some problems differently.[51] While it is beyond the scope of this paper to explicate his work, the author is interested in the exploration of dialoguing Kleinianism and Deleuze's transcendental empiricism to articulate a conception of the person that avoids dualizing knowledge, the person, the person in the human world, and the human world from the rest of nature.

Finally, Deleuze succinctly questions a basic premise of psychoanalytic theory that has not been adequately addressed:

> Consider the two presents, the two scenes or the two events (infantile and adult) in their reality, separated by time: how can the former present act at a distance upon the present one? How can it provide a model for it, when all its effectiveness is retrospectively received from the later present? Furthermore, if we invoke the indispensable imaginary operations required to fill the temporal space [e.g., Lacan's object *a* or Kleinian phantasy], how could these operations fail ultimately to absorb the entire reality of the two presents, leaving the repetition to subsist only as the illusion of a solipsistic subject? (Deleuze, 1968/1994, p. 104)

Deleuze offers a solution to this problem in theory; however, if it is to hold weight it must bear itself out empirically. The hermeneutic methodology employed in this study is well suited to examine this question and explore the implications of Deleuze's philosophy for conceptualizing the person, and specifically, the person as the patient in a contemporary Kleinian psychoanalytically oriented psychotherapy.

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51 Take for example "the problem" of light. Photosynthesis is one of the plant's responses to the problem of light; the bee, like other insects, responds to light by using it for navigation and the temporal organization of its activities; the mosquito, like many organisms, has developed a special kind of eye that is particularly attuned to blues, purples, and reds, since these colors predominate in the evening and the morning. Deleuze writes regarding animals that "An animal forms an eye for itself by causing scattered and diffuse luminous excitations to be reproduced on a privileged surface of its body. The eye binds light, it is itself bound light. This example is enough to show the complexity of synthesis. For there is indeed an activity of reproduction which takes as its object the difference to be bound" (Deleuze, 1968, p. 96). In terms of the faculties such as memory, thought, sense, language, etc., for Deleuze these work in concert – giving the appearance for common sense of a unity of the faculties under one "I" – but really work independently. So for example, the painting of Bacon's forces one to comprehend it primarily through sense perception and affect since the language faculty meets its transcendental limit – i.e., the limit of what about the painting can be put into words. (cf., Deleuze, 1968, pp. 138-147)

Afterward

I would like to take this moment, and I mean "moment" because I am evaluating some personal implications of this study at this particular time in my training. I am going to discuss what I think are the implications of the paradox of subjection, but this time from the perspective of my story. Immersing myself in CKPP and subjecting myself the discipline of it's technique, under the tutelage of Dr. R. in supervision and putting my skills in the interpretation of texts to work, so I could allow the literature to teach me as I learned the power practices of its knowledge-power complex, has changed my subjectivity.[52] As Judith Butler says, it has changed my subjectivity by inducting me into a symbolic order, situated in a power-knowledge complex. But, also like she says it should work, in order to do so I had to desire and have faith in some inarticulate notion of the kind of clinician I had hoped to become; I had to turn to it from inside; the desire had to motivate me to become the kind of subject one has to be in order to do work within its symbolic order.

This means risking for both patient and training therapist. To believe in a life – that is point of *faith* in Kierkegaard's use of the term. To have an authentic dream is to believe in a life, to dream it up and change to continually approximate it – that radical idea of self-creation that the Enlightenment philosophers gave us as part of our tradition, culminating in one strange historical form – the original Euro-American way. Does the fact that this was dangerous and involved other ideological aspects that led to genocide and now environmental degradation mean that none of it should have happened?

My point in this is to refigure the "concern" for abuses of power in CKPP. I think this may, has, have, and unfortunately does happen. With power comes responsibility and

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[52] I am forever indebted to my undergraduate education at St. John's College for providing an intellectual climate that fostered self-directed learning in such a disciplined way.

part of the point of training is develop that sense of responsibility and respect for the new powers you have. The implication of this work is that I have been learning to practice wielding a subjectivizing voice and receive payment for it. I have been learning how to be able to "call it as I see it" as a therapist, to speak in a voice that is challenging for the patient to hear and for me to utter. The damaging subjectivizing voice is one that chronically closes down on possible meaning too quickly without self-correction and is not based on the clinical evidence – like the stereotypes of Kleinian work and, as I see it, poor therapy in general. What are the institutional safeguards for this? Humility, close supervision, and my own therapy. I am told Betty Josephs continues in her own group supervision with her peers and she has been practicing for fifty years!

So, I would also like to discuss some of the ethical issues around deploying a subjectivizing voice. For if Judith Butler is right about subjection then that means some kind of new power will be the outcome, as what practices (repeated behaviors with an intended effect) I need to operate in this new way develop and the one's I don't need will atrophy – a loss of certain desires. The lost desires demarcate the outer parameter of my becoming self as it becomes.[53] (I would like to thank Roger Brooke for pointing this out, although in analytic terms of the Oedipus complex).[54] So as a therapist this requires I not exhort the patient to do this or that, because the patient has to decide to keep going and in

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[53] What are these lost desires for me? One has been the desire to go into academia, which I had originally wanted to do. Do I miss it? Not really, I would still like to teach but not in that context. Another, more difficult one to work through, has been the loss of desire to maintain or cultivate certain friendships, since the demands of this way of working require a certain kind of support. This has been a cost that, while unfortunate, was consciously accepted because I believe this way of working is worth it for me and also for the people who come to me for help. It has caused some tension in my relationship with important thinkers in my life who have had to struggle to listen to my use of concepts that seem too "realist" or simply, too anachronistic for their taste. Of course some doors close as others open.

[54] This is where I question how much post-structuralists, other than Judith Butler and her followers, really understand the psychological implications of their notions. Foucault, for example, I think used the term "subject" without ever defining it because if he defined it he would see Oedipus starring him in the face. In other words, how is it that the human subject is shaped by change in time without it – *a priori* – having the kind of subjectivity that can be subjugated, an embodied subjugation of desire? I think this is the point Dr. Butler makes in the *Psychic Life of Power.*

which direction to change for him or herself, out of desire and in the face of anxiety around the losses becoming a new kind of subject require.

So what is this power? It is the power of wielding a subjectivizing voice in a highly structured communicative context potentiated by its very structure with emancipatory potential –– the nature of which I have phenomenologically described in this study. Self-subjection into CKPP has yielded some other derivative consequences – for once you subject yourself to a specific symbolic order and its attendant power-knowledge complexes your worldview changes as well. You may start interpreting world events in its terms if you want. You might reel at the implication of how much we communicate in our everyday interactions without any awareness of the messages we're sending out if you decide to focus on that. One also has to face many of the issues your patients deal with and it is very emotionally challenging work. In order to speak to the patient where they are in a fresh and genuine way you have to be able to identify its analog in yourself as the point from which to speak. This kind of work has challenged me to grow emotionally as a person.

So what are the limits of this power? That is an ongoing question for me. It has been suggested that as a dyadic metaphor that the mother-infant metaphorizing would preclude dynamics that are triadic. Theoretically, I do not agree with this since the infantile feeding situation is triadic and not dyadic for Klein. By three months the infant recognizes that the milk is the term for struggle with the mother. That is when the Oedipal struggles begin.[55] Clinically, the four times patients have prematurely dropped out of treatment I have been able to find problems in my ability to accurately show them that I see and can name their anxiety. So, based on my experience with dozens of patients and their wide range of

[55] Not to mention the fact that the note writing creates a triadic dynamic in the therapy – the patient has to watch your mouth "mate" with the words you write down – watch you have a relationship with your own mind that they are excluded from.

presenting problems, the limitation so far indicate my lack of experience more than an inherent blind spot in the theory or practice as it stands. This does not mean that there are not any blind spots. And if there are, and when I find them, I am free to try and understand them in terms of this tradition and work to alter it if that is necessary, or go somewhere else. Practically, there is the problem of what to do with this kind of work in our managed-care age. How amenable is it to working on a short-term basis? Is there an ethical way to do that?

A central component of this voice is its focus on the here and now relational transactions as they occur. It has been asked, “What are the ethical consequences of this aspect of the technique in terms indexing the symbolic content in terms of the patient’s relationship to the therapist?” Specifically, what about the real unethical activities the patient may come in and describe and what about the self-aggrandizing stance that relates what the patient does to the therapist?

One of the difficulties I struggled with to work in this way was accepting the idea that as their therapist, I could matter as much as these kinds of interventions suggest. It takes courage and discipline to engage in a relationship that can matter that much to someone, precisely because of the emotional challenges and the responsibility involved in the work. From the “outside” it seems off the charts that this level of attachment is at issue so quickly, therefore to talk about it with the patient must be off and a sign of making “wild interpretations,” or could only be the product of the need for narcissistic supplies from the patient. I can relate to that sentiment. I thought it too at the beginning. But from the “inside,” what I find more strange and continue to be surprised by is that once I muster up the courage to make one of these comments, how, when accurate, the patient agrees and seems a bit more relaxed or comforted by hearing it. All I can say at this point is that this

level of attachment is always at stake for everyone to the extent we are precariously attached as subjects. I base this assertion on both my clinical experience and the work of Judith Butler, because that is her point in the *Psychic Life of Power* – subjection is our paradoxical and ambivalent basis for attachment to others – "intersubjectivity" in newer terms.

As far as the patient's extra-therapeutic activities that he or she presents in the session is concerned, these are important as objects of projection. In other words, two different personalities will describe the same event it different ways; their experiences will be different. What is more clinically important is how they systematically interpret the events and people in their lives, because this one means for identifying with how they are constituting their experience. Of course this does not mean that, for example, John wasn't almost hit by a car, or that a married man who describes compulsively cheating on his wife isn't really doing it, or that it does not have an adverse effect on his wife. But his ethical consciousness is *his* responsibility to develop, as part of developing as a subject with a conscience that is robust enough to commit and authentically see and care for the good of anOther. And developing a network of supportive friends is part of what it would mean for John to slowly give up trying to be invisible out of a paranoid anxiety. A free subject needs others on whom to depend and must be able to be the dependable other for someone else, able to sustain and nurture a social bond with another person.

This brings us to another paradox. The paradox of not exhorting patients to be a this way or that – the restraint (not hiding) of neutrality and note writing – yet by your very way of comporting yourself the patient becomes a certain kind of subject, in the sense of new capacities as a self. Is this the hidden normative agenda at work? Probably, although I'm not so sure it is hidden in CKPP, as I have described some of its values in the preceding paragraph and the study itself. But as Judith Butler also points out, there is no outside

power and discourse for a socially intelligible subject. Perhaps we need to be discussing this question more: what kind of subjects our psychotherapy practices are fostering in society and as a society in general? It would seem like a good idea to believe in the kind of subjectivity that one is endeavoring to foster, both in terms of consciously accepting responsibility for what you are doing and in terms of professional integrity. As I understand them, I accept the values implied in CKPP about developing subjectivity.

Of course it might be asked, "What if the patient doesn't share the values in CKPP? How would it respect that difference of the Other in terms of treatment and isn't it contradictory to think of CKPP as a universal model and claim that it is a model that respects difference?

There was a patient I worked with for six months, Jean, who, after six months of therapy, decided she wanted to terminate psychotherapy to pursue pharmacotherapy and social activism groups to deal with her problems – bear in mind I had referred her for psychiatric evaluation and medication but she refused. During our final termination session she explained that she had finally realized that when she first came to see me she wanted me to help her forget her unprocessed (my paraphrasing) experiences of childhood sexual abuse rather than deal with them, and that I wasn't going to help her do that. Jean was right on both counts, so we ended therapy because she decided that what I was offering was not what she was looking for. However, it did help her to clarify what she did and did not want in a therapy at this time in her life.

My point is: how can Joe or Jane public-at-large make a truly informed decision about whether or not their values in a therapy are a reasonable match with the therapist unless they make *and renew* the decision based on their experience? And if it is true that CKPP fosters autonomy and a greater sense of possessing freedom-of-mind, then it is up to

the patient to decide who and how they want to become based on their experience, including the length of treatment. Similarly, if I think a patient has a problem that I am not qualified to help them with or do not want to help them with for whatever reason, I can and should refer them elsewhere. Perhaps this issues points to the fact that respecting difference involves determining to what extent one can or is willing to accommodate it.

The question of "universal applicability" is more complex. If Judith Butler is correct about her universal claim for a paradox of subjectivity, and CKPP is a subject forming kind of work, then it would follow that CKPP could have a universal applicability even if not universally distributed as a cultural form. Similarly, if I drove a car into the deepest recesses of some unexplored land and came across an indigenous human group without auto technology, my car would still exist and work for them if I showed them how to drive. So, the car has (virtual) universal applicability even if it is not universally distributed or realized. The issue of an imposition of values is of another order: the ethics of introducing a foreign technology into a culture and the unforeseeable consequence of such an introduction to the vernacular society. Again, the principle of self-determination seems to be the best safeguard for respecting cultural and individual integrity. What I am arguing about CKPP is that it is a model that respects differences by fostering individual subjectivity.

Coming full circle, then, it seems this qualitative study lends support to Wampold and Holloway's argument that, "whether it be changes in skill level, attitudes, self-understanding, or some other characteristic, the effect of supervision results most proximally in some modification of therapists' characteristics. These changes in the therapist will then, it is hoped, result in the delivery of more efficacious treatment . . .. *all* effects of supervision are transmitted through therapist characteristics" (1997, p. 12, italics in original). However,

the vehicle of “transmission” is not the therapist’s “characteristics” if this is understood simply in behavioral terms. This study suggests that it involved a change in the therapist’s being-in-the-world.

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APPENDIX A

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE: Feeding Identity: The critical hermeneutics of contemporary Kleinian psychoanalytically oriented psychotherapy from the perspective of a novice.

INVESTIGATOR: David M. Greco-Brooks, MA

ADVISOR: Dr. Martin Packer, Ph.D.
Associate Professor, Duquesne University

SUPPORT: Self-Supported

PURPOSE: The purpose of this study is to fulfill partial requirements for a Ph.D. in Clinical Psychology. It is intended that this research will contribute to the growing research on supervision and the quality of student training. The focus of the project is to examine how the training of the investigator, working under the supervision of licensed psychologist with a neo-classical Kleinian orientation, effected the investigator=s approach to clinical work.

Since the focus of the study is on the investigator=s conduct, he only will be using the process notes written during two sessions (maximum) from meetings with different clients that occurred prior to the date of this consent form. Additional information about the supervision itself will be drawn from post-supervision meeting notes and personal communications with the supervisor.

Three faculty members from the Duquesne University Psychology Department are supervising this project: Dr. M. Packer, Dr. R. Brooke, and Dr. R. Walsh. Dr. B. Cohler of the University of Chicago is providing additional research supervision.

RISKS AND BENEFITS:

Since your anonymity will be assured as described below, there are no risks or benefits for you that will occur as a result of your participation.

COMPENSATION:

You will not be compensated for providing consent to the investigator to use his notes from two meetings with you. However, this is the extent of the participation required of you for this project, and your participation will require no monetary cost to you. An envelope is provided for return of your consent form.

CONFIDENTIALITY:

Your name will never appear on any materials related to this research project. All names, places of residence, and other identifying information will be altered to protect your privacy and confidentiality, as well as that of any persons mentioned on any materials related to this project. All written materials and consent forms will be stored in a locked file in the researcher=s home. All materials will be destroyed at the completion of the research.

SUMMARY OF RESULTS:

A summary of the results of this research will be supplied to you, at no cost, upon request.

VOLUNTARY CONSENT:

I, ___________________________, have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time and for any reason prior to the completion of the research project. On these terms, I certify that I am willing to participate in this research project.

I further understand that should I have any further questions about my participation in this study, I may call Mr. Eugene R. Mariani, Chair of the Duquesne University Institutional Review Board (412-396-5098) and will be given an opportunity to discuss, in confidence, any question with any member of the Institutional Review Board. I may also contact the principle investigator and/or his research advisor, Dr. Martin Packer, through the Psychology Department of Duquesne University, by calling 412-396-6520, or by writing to them at:

Department of Psychology
Duquesne University
544 College Hall
Pittsburgh, PA 15282

Participant Signature:_______________________________ Date: _________________

Investigator Signature: _______________________________ Date: _________________

APPENDIX B

SESSION TRANSCRIPT

(Original notes not corrected for spelling and grammer)

Key: Black type = Subject's utterances
Blue type = Therapist's utterances
Brackets = Editorial and non-verbal notations from original notes

The three or four of theses are the silences that I wasn't able to come up with anything for. I'm trying to survive this week.

I think your feeling overwhelmed inside and don't quite know how to deal with the feelings of being scared inside.

Mmmhmm.[slight tearing] Yeah and its ironic too because at the same time I feel like I'm making progress in my new post and in a way my confidence in growing. In one sense it's all brand new and in another it's what I've always thrived on -- its like crisis. It's not always successful -- the visitations with patients. When people in crisis or end of life issues, but it somehow works out -- but it's a success when I make out a report and evaluate my work, but I guess at the same time I go with whatever is my fear or maybe I'm making someone else fear my own. Oh, in chaplaincy I saw it addressed this week on television this whole thing of counselors being sought out like madmen doing all these services and work. Its what people demand or ask for. But the chaplains are probably the most pathetic ones when you get a group together you say, "I don't know what to say" which gets people to talk about fear. Whatever I'm afraid of when someone is going to get in there on my fear I deflect them

And I'm seeing it in here that when I just approached your fears of falling apart a part of you got scared and deflected us by focusing on crisis as an abstract concept. Its like you drop your feelings that feel overwhelming as if we couldn't tolerate them.

Yeah, I've always done that. [Tears stream] Yeah, I'm probably going to be processing 15,000 different things. Yeah, processing things to do with my daughter's wedding all this introspective stuff between now and Tuesday when I leave. [Tears stream] This isn't very deep -- no for me it is -- I think one of these things is I'm feeling guilty because I haven't been able to help out too much with my daughter's wedding and it goes way back because I can't remember anyone in my family who hasn't really been totally involved in their daughter's wedding plus the problems I have with the need to control, usually mom's do their daughter's weddings. But I'm still from that tradition, so I'm probably feeling a lot of conflict about -- emotionally I have some input into this. Intellectually I've tried to let my children make all the major decisions on their own. I think maybe I've identified with my own mother who was major controlling, which is what dynamic women are. And the sister I was in the arms of -- I think I used her or she filled the shoes of my mother. I think I haven't looked enough at the input she [the sister] had on my life because she went off when I was ten. I still have my own mother [her mother died in the 80's] but she was -- I don't know -- an institutional mother. It was an institutional type

relationship a parallel between my mother sending me off to school at an early age and my sending my kids away.

I think one way you are trying to keep some powerful feelings away is by turning our conversation to events in the past that are easier to talk about.

Yeah to make the comparisons. I'm trying to figure out why I'm so sad. I'm in extreme circumstances – my daughter's wedding and the recent terrorism.

I hear that a part of you is feeling sad, scared, and angry at your daughter for getting married as if she were deserting you now like you felt by your sister, and the problem is you don't feel you have a way to contain these feelings inside.

I could be. Yeah. I feel like I'd add to them remorse. Is remorse a feeling or are sad and remorse the same thing? Remorse is the biggest and that comes to how I feel. Its limiting my concept of my daughter's freedom. Its not like she's being taken off to jail. She's getting married and she's fine and I'm keeping all my hopes, wishes and ambitions for a daughter that I'll keep repressing because I'm not supposed to cry at the wedding. So I probably feel good about the ceremony itself, cause it's being worked on by both sides of the family. But I guess the greatest thing about it is how both planned the ceremony should go, which is the most you could ask for in an interfaith wedding.

Just now when you began to feel unbearably bad about your wishes for your daughter's wedding you began to focus on the bright side.

Yeah, that's the annoying thing that happens. Yeah. Because I've always done that and I don't keep going and I don't know why or where I stopped but something over and blocks whatever I try to get at. I'm sure that happens when I'm doing my work. My PC Response score is totally on the supportive side [some personality type test they are given] It goes from authoritative to intrstructional to all way over to empathic and supportive responses – my natural responses are empathic and very supportive. But I'm naturally that way, but I cannot keep going [with what she is feeling as first mentioned] , but that's kinda improved since I stared coming here as its been reflected in my verbatims [group supervision]. I want to know why I do the little cheery deal, which you record as my dramatic voice.

Like I've been saying. I think these fears of falling apart or being overwhelmed get dropped and perhaps its because you don't expect another person to stay with you and help you make sense of what feels overwhelming inside.

Yeah. [tearing] that make sense. Yeah because principle people at crucial ages for me they disappeared whether death or loosing a sister going to college or marriage is like a death. Yeah.

So, perhaps inside you feels out of control because of there are several death-like changes you are dealing with right now – the bombing of the terrorists, your daughter's wedding, and the fact that we won't be meeting next week because you won't be here.

Yeah cause I like routine right and I'm not going to be here next week and I'm like one of those orphans – the smartest kids are the one's who get abandoned in hospitals and learn to have to get along by being nice which fends off being orphaned. Yeah, because that image just came to me right now I can – those little orphaned AIDS babies who have been dropped like a hot potato.

What I'm hearing is that right now you live with fears of being dropped by me like you felt dropped by your mother as a baby.

Well maybe but that's if I don't come back, because then essentially I would have been dropped by you. [asked to repeat, she did then began] No, the only parallel is if you went out in front of a truck and got killed, that's the logical parallel to that. But yes it could play right into not wanting to be orphaned, wanting to have a self. I was doing reading on disappearance of the self into pre-existence and **there is** literature on disappearance into pre-existence [stated in a tone to emphasize she is right or not crazy]

You are disappearing from here right now because we just touched on your fear of being orphaned by me so you mentally moved away to thoughts of before you existed.

[Tears start streaming, nods in agreement, I let a few moments pass]

Our time is up for today.