Dilemmas in search of a code

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Psychoanalysis has a distinctive ethical quality based on both philosophical and technical principles. The existence of the unconscious and of transference and countertransference determine the analyst's frame of reference and behavior. Working with the intense instinctual pressures of analyst and analysand can strain the limits of the clinician's skills and tolerance. The author considers issues that call most urgently for controls in the consulting room and that reveal the complexities of making clinical decisions: boundary issues; self-disclosure; case selection; transference enactment; extra-analytic contact; informed consent; and end-points of analyses. Case examples highlight some of the dilemmas analysts face when confronted with behaviors that conflict with social mores or laws. The author concludes that the analyst's choices in these difficult situations are guided by consideration of the goals of psychoanalysis and the states of both analysand and analyst with respect to the transference.

Freud made clear the connection between ethics and instinct. What, then, are some of the issues arising from our instinctual tendencies that cry out for controls in the psychoanalytic chamber? What matters concern analysts, analysands, and the public? May we touch patients? May the analyst use the transference

to gain personal satisfaction, material goods, secret information? May the analyst embark on a personal relationship with an analysand or discharge a patient because of the analyst's personal discomfort with the material? Is there an ethical question in any of these considerations?

Questions abound. What if an action seems necessary on the part of the analyst to advance the treatment, to keep the patient in the room, to protect others outside the room? Could some action required by law interfere with the analysis? When and with whom is consultation about a case appropriate? How much may the analyst reveal? What are the rules of privacy for the treatment?

Groups concerned with public interest and professional image make strenuous efforts to define proper practitioner behavior. Both mental health professions and legislatures have established detailed sets of rules about many of these issues. Most professions require that members subscribe to a lengthy code of ethics, and professional organizations attempt to bind practitioners to these codes, adjudicating complaints in a process parallel to the judicial system. Mental health professionals are bound by the laws of their states, laws enacted according to the public interest and as a result of complaints on particular issues.

Psychoanalysis has a distinctive ethical quality based on both philosophical and technical principles. The former, the humanistic conviction of the value of truth, autonomy, and personal choice, guides the use of the latter. The existence of the unconscious and of transference and countertransference defines the analyst's frame of reference and guides his behavior. However, the practitioner dealing with the intensity of instinctual pressures within both the analysand and himself faces situations that tax the limits of "proper" technique and demeanor. Psychoanalysis is concerned with unconscious phenomena; it cannot alter reality. Like other authors, Holmes and Lindley (1989) maintain "it is as mistaken to argue that ethical questions can, through correct technique, be avoided altogether, as it is to confuse what is basically a transferential issue with one of ethics" (p. 116). But are these legitimately separate issues for the psychoanalyst?

Ethics implies rules and structure. It may also imply bigotry and prejudice—an artificial image of proper and improper ways to be and act. Can behavior that's subject to the constraints of an ethical code be an effective tool for the psychoanalyst? Structure protects the analyst from his own impulses and from the patient's impulses. But the most desirable structure for the psychoanalytic process is one that encourages the analysand to say everything. It seems possible that ethics in psychoanalysis may become a resistance to encouraging the patient to reveal all wishes, impulses, and fantasies. The analyst may also use rules and structure to resist unwanted feelings in the self.

In writing about the necessity of values in culture, Freud (1927) asserts that every civilization founds itself on a compulsion to work and on renunciation of instinct. Prohibitions bring about the frustration caused by unsatisfied instincts, however, Freud feels certain instinctual wishes must remain unsatisfied: incest, cannibalism, and the lust for killing. Each culture, he explains, has its own ideals, and individuals take pride in achieving these ideals. There is also narcissistic gratification in combating whatever hostility to civilization exists within the cultural unit. Cultural ideals act as psychological protection against human biological frailties and the inevitability of death. These ideals also guard against injuries that threaten human beings from within their own society. If psychoanalysts support Freud's theories of intrinsic human nature, isn't it desirable that they resist their own tendency to espouse rigid values that may be used to protect them against themselves, as well as to protect the other?

The most trying issues faced by an analyst arise in the consulting room. When the limits of her own skill or tolerance are reached, what becomes of the treatment?

Case examples

At an international professional gathering an experienced analyst said he had treated a young man who reported repeatedly sodomizing his invalid grandmother. The material was presented in the course of the analysis, and it was apparent that the man had no concern about the consequences of his behavior, no curiosity about his motivation, nor any intention of depriv-

ing himself of the pleasure gained in the act. The analyst felt unable to proceed with the treatment and discharged the patient. Was this an unconscionable abandonment of the patient or a well-informed judgment on the part of the analyst? Could the analysis proceed in tandem with such a gratifying extra-transferential repetition? Could the analyst have withstood the pressure for the action in the presence of the powerful destructivity? With no follow-up, there is no way of knowing what, if any, actions the analyst considered or carried out regarding the situation outside the treatment. The question remains: Can an ethical position assist an analyst pushed to the limits of his personal standards or to the limits of useful transference within the treatment relationship?

In another case, an analyst treating a young woman was aware that the patient was HIV positive. The patient persistently reported unprotected sexual encounters with numerous men, including her boyfriend. She spoke of her desire to infect him and others. As the patient reported more and more encounters, the analyst felt that she was pursuing a personal vendetta to rid the world of men. The analysand was unwilling and unable to reflect on her behavior, and the analyst was bound by law to keep the information private. Although he presented the case repeatedly to supervisors and colleagues, the analyst felt trapped, endangered, and unable to proceed, yet obligated to do so for the sake of his patient and her potential victims.

These case examples raise various questions: Who is treatable by psychoanalysis and who can treat what kind of case? What promise is the analyst making when she accepts an analysand? Who is behaving destructively in each of the above vignettes?

Analysts are concerned with the nature and utility of transference. What constitutes exploitation of the transference? What are the typical dilemmas we confront in the clinical situation? Can transference ever be resolved?

All mental health professions address boundary violations, some with more vehemence and particularity than others. In psychoanalysis the issues are often addressed with the assertion that sexual activity of any sort between analyst and analysand is deeply damaging to the analysis and to the analysand

(Barnhouse, 1978; Dewald & Clark, 2001; Gabbard, 1989, 1994a, 1994b, 1995a, 1995b, 1996a, 1996b; Mann, 1999; Ross & Roy, 1995; Strean, 1993). There follows from this position the possible, and sometimes recommended, proscription of acts thought to have potential sexual meaning, for example, physical touch, the giving and receiving of gifts, sharing food, writing a book together, bartering treatment for goods rather than money. Likewise there is the view that aggression of any sort between analyst and analysand may be similarly damaging. Writers have cited as potentially damaging: criticism, intrusion, harsh tones or gestures, and discharging (abandoning) the analysand.

Analysts spend their days working with libido and aggression. What controls these forces, and how specific must our efforts be to maintain that control? Since sex and aggression inevitably manifest themselves in the transference, what are the proper boundaries of the analytic relationship? Which actions and enactments that occur in treatment do not require caveats? Should any actions be forbidden? Should the analyst reveal information about herself to the patient?

Therapist self-disclosure has received considerable attention in the literature. Inappropriate therapist self-disclosure, more than any other kind of boundary irregularity, most frequently precedes sex between analyst and patient (Simon, 1991).

Freud (1912) notes that confiding in one's patients achieves nothing toward the discovery of the patient's unconscious. It makes the patient less able to overcome the deeper resistances, and in the more severe cases it invariably fails on account of the insatiability it rouses in the patient, who then tries to reverse the situation, finding the analysis of the physician more interesting than his own. The analyst, writes Freud, "should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him" (p. 118). Although Freud frequently violated this directive in his own practice, his point is well taken. A neurotic patient may exploit the opportunity to feast on the analyst's psyche in order to avoid interaction with his own. However, a psychotic patient may, for the first time, be creating an object in his mind, or a patient resisting transference may require some proof that the analyst is like him. Although judging

what is of benefit to the patient may be difficult, the hallmark of therapeutic self-disclosure is that it is done for the patient's benefit within the context of the therapeutic process.

Spotnitz addresses this issue in the presentation of the case of a woman who, after many years of analytic treatment, demanded the analyst tell her his real feelings about her. She felt very hurt by his response, but she persisted in her efforts to wrest from him the truth of his feelings about her. She then reported a new emotional experience: intense loving feelings within herself. "The analyst's resistance to talking to the patient of his real feelings was resolved when the patient convincingly explained that she wanted an honest relationship with the analyst" (Spotnitz, 1995, p. 5). The analyst was then free to express his feelings about the patient.

In the same light, we must consider whether certain matters, such as the existence of an analyst's life-threatening illness or impending incapacity, should be revealed to the analysand. Contact with patients outside the session raises similar considerations. Should an analyst demur from greeting an analysand in the supermarket, from attending his wedding, from accepting the analysand in a workshop or lecture? Rigid adherence to the purity of transference experienced only in the consulting room may squash the opportunity for emotional encounters and inhibit the forces necessary for analytic progress.

Who is treatable?

Psychoanalysis began with the study and treatment of pathologies classified as neurotic. Psychic conflict leading to anxiety and the common neurotic defenses, along with "actual neuroses," were the early focus. Contemporary analysts have extended research and practice to the full range of psychically reversible conditions and are treating primitive as well as neurotic mental states. Ideally the analysand must come to the office, make a contract, and lie on the couch to facilitate his speaking freely and revealing his resistances to doing so.

The transferences of a preverbal patient may be expressed through psychotic, somatic, and sensory processes rather than

in language. Such patients are also action prone and at any time may act on their own bodies and their minds. An important part of the analyst's task is to control regression and to promote mentalization.

Freud's identification of transference as a phenomenon observable in general life situations and specifically powerful in the analytic frame marked the beginnings of a technique to free an individual's pent-up energies. Observing mainly libidinal impulses and impressions locked in the unconscious by static infantile imagos, Freud (1912) cited transference as the vehicle of expression of sexual energy undeveloped and underutilized by the neurotic personality. When this energy is allowed to fix upon "the person of the physician," transference develops and is, in the positive object state, an enfeebled form of sexuality, expressed as feelings of sympathy, friendship and trust. This formulation proved to be wishful thinking. Patients in transference ask the analyst to love them, to take them into their lives, to marry them, have sex with them, and in extreme situations to beat or torture them.

Negative object states also exist, perhaps as expressions of destructive impulsivity and of uneasy fusions of libidinal and aggressive flows. In preoedipal pathologies, the drives are expressed in transference states labeled variously psychotic (Searles, 1963) or narcissistic (Spotnitz, 1976, 1985; Spotnitz & Meadow, 1995). In these states, the caches of drive energy are locked in the self-fields of the mind, both conscious and unconscious. The analyst in such a transference aims to be unintrusive, allowing herself to be experienced as a part of the analysand's mind.

Though Freud and modern writers agree that transference serves as a resistance in analysis, it is also a source of energy to fuel the breaking of pathological chains. It is, then, a powerful tool as well as a powerful opponent, without which analysis has no momentum, no raw material. With transference comes countertransference and the ordinarily taxing dilemmas of everyday practice.

The power of transference raises questions about the definition of consent in psychoanalysis. The analysand comes to consulta-

tion with certain conscious concerns, but much of the problem is locked up outside of consciousness, as are certain aspects of the motives bringing him to the analytic setting. A great deal of the work that will go on takes place outside of awareness and may never be articulated at a cognitive level. Indeed the patient may give the analyst unconscious, repetitive consent to perform any number of actions and assume any number of attitudes. The patient may invite the analyst to rape, pillage, and plunder without any direct expression of these intentions. The analyst is in a position that he may easily abuse if he loses sight of or distorts the analytic goal.

If analyzing, not influencing, is the job of the analyst, what role does ethics play? Monitoring and regulating impulses in the session includes ongoing analysis of the analyst's own states and impulses. Arousal is always a problem when working with narcissism. Analyzing, just analyzing, moderates the dangers apprehended by Freud in the analyst's transference and countertransference to the analysand. It is important to know that one's own states may be induced by the patient's own history (Spotnitz, 1985) as well as from one's own insufficiently analyzed adjustment patterns.

How does the analyst manage tension? Is neutrality essential to effective analysis? Is it possible? Can the detached or neutral analyst penetrate the false self of the analysand, designed to appeal to the desire of the other?

The practitioner who can tolerate the impact of the feelings transferred by the patient and clearly identify his own feeling response has at his disposal what Winnicott calls the "'truly objective countertransference . . . the analyst's love and hate in reaction to the actual personality and behaviour of the patient, based on objective observation'" (qtd. in Spotnitz, 1985, p. 229).

Freud (1915) recommends a method for regulating impulses in the analysis:

> The treatment must be carried out in abstinence. By this I do not mean merely physical abstinence alone, nor yet deprivation of everything that the patient desires, for perhaps no sick person could tolerate this. Instead, I shall state it as a fundamental principle that the patient's need and longing should be allowed to

> persist in her, [to] . . . serve as forces impelling her to do work and to make changes. (p. 165)

Freud goes on to caution that the analyst must beware of allowing too much discharge of the energy needed to propel the analytic work. The analyst, he says, could not offer the patient "anything else than a surrogate, for until her repressions are removed, she is incapable of getting real satisfaction" (p. 165). Too much gratification of drives by the analyst then is a proxy for true satisfaction. According to Canestri (1993), such behavior impedes the analysis in two ways: it offers false satisfaction to a false self, and it neutralizes the energy necessary to propel the search for the true self and its desires. "The imposition of privation [abstinence] . . . favors the nonfulfillment of the wishes that keep the search in motion. . . . The analyst's desire for truth, together with his exercise of denial, permits the emergence of the patient's genuine desire and its analysis" (p. 157). Technically speaking, the sublimation of instinct by displacement of satisfaction into social conventions may also be undesirable. The outcome may be, as Canestri notes, the obfuscation of the truth of the patient's desire, representing an incomplete analysis.

The optimal balance of gratification and frustration is an ongoing problem for the analyst. Too much frustration may prove intolerable and undercut the arousal necessary to proceed. The analyst may choose to satisfy reasonable requests from a patient in the interest of maintaining arousal and engagement. A request from the analysand constitutes an emotional contact that needs to be understood and requires a response. The contact contains a clue to the conditions desirable for the analysand's engagement. The analyst, having studied the situation, may intentionally intervene in a way that brings the patient's state alive in the room.

The degree of tension necessary to promote the work of the moment is a matter of diagnostic apprehension. Sternbach (1975) tackles this thorny issue in an examination of Freud's second drive theory. He allows that too much tension in the analysand, that is, tension that cannot be discharged adequately or in which the release is not sufficiently neutralized, becomes

pathogenic. "In such cases," he writes, "treatment can consist in lowering of tension by appropriate measures." This does not necessarily entail inviting aggression, which may in fact lead to an increase in tension. "Aggression against objects can be of therapeutic help only if tension will be released by the aggressive action either through object libidinal gratification or narcissistic gratification, e.g., through experience of 'victories' or through lessening of anxieties" (p. 327).

In the case of narcissistic disorders, too much frustration of aggressive impulsivity may be problematic. Spotnitz (1985) quotes a letter from Freud to Binswanger (1913): "'One must always recognize one's countertransference and rise above it. . . . To give someone too little because one loves him too much is being unjust to the patient and a technical error.'" Spotnitz adds, "to allot too little hate to a patient who needs to learn to experience and sustain it comfortably is also unjust" (p. 227).

If the analyst's task in the transference is to monitor and adjust tension states, some tension being seen as necessary for the psychoanalytic pursuit and too much tension making the work impossible, is not the dilemma at hand the management of impulses in the analyst, in the presence of the powerful flow of energies within both himself and the analysand?

Can we prohibit enactment or action?

In psychoanalysis some enactments are spontaneous, the product of forces in the transference–countertransference moment. Others may be planned by the analyst in view of the current drive states in operation. Enactment brings the unconscious into the room in a palpable way. It acquaints the analyst with the analysand's desire. But what are the ethical limits, the boundaries necessary in the psychoanalytic experience?

Psychoanalysis deals with the deepest passions of human existence. Analysts are regularly under pressure from their own unconscious processes and from those of their patients. It is not surprising then that over the life of the profession the duration of training analyses has been extended. Nor is it surprising that practitioners since Breuer have struggled with

their sexual impulses and those of their patients. When Anna O hugged Breuer, he withdrew emotionally and wanted to discharge her. Anton Mesmer, a hypnotist of great animal magnetism, fell in love with a blind pianist he was treating and left his wife forever (Baur, 1997). The privileged of Freud's inner circle fell prey to their impulses and those of their patients though Freud claimed in his admonition to Jung to have escaped such entanglements himself. Otto Rank became sexually involved with his analysand, the writer Anaïs Nin. Ernest Jones made a reputation on two continents as a lover of women in his care. Freud found Jones incorrigible and recommended re-analysis. Ferenczi believed his women patients needed physical comfort and eventually married a patient who had been married to someone else during the treatment. He also fell in love with her daughter. Carl Jung scandalized Freud with his disingenuous involvement with Sabina Spielrein (Baur, 1997; Grosskurth, 1991).

The latter liaison still lives in the public eye; readers can examine the affair and the subsequent course of Spielrein's life in diaries, letters, and commentary (Baur, 1997; Lothane, 1999). Spielrein enchanted Jung for 14 years, at first as his psychotic inpatient, then as analysand, colleague, and lover. Baur wrote that the two were probably lovers within three years after treatment began. There was trouble in the relationship. When Spielrein reacted angrily to Jung's insistence that her mother pay for their meetings, he cut back on her time abruptly and wanted to end the liaison. Spielrein flew into a rage, brought a knife to the office, and some blood was shed. Spielrein involved Freud, and eventually, when the three split, Jung became psychotic, Freud remained rigid regarding loyalty and betrayal, and Spielrein, unhappily married, maintained an ambivalent desire for Jung throughout her life.

The Jung–Spielrein affair has been fodder for tens of thousands of words on the matter of eroticized transference and countertransference and the proper behavior of psychoanalysts (Baur, 1997; Gabbard, 1995a; Grosskurth, 1991; Schaverien, 1996). The literature is replete with references to Jung's devaluing attitudes and actions toward women (The Unfolding and Healing, 2005; Bair, 2003). Throughout his life he did use women, ending a

40-year affair with Antonia Wolff (another patient who became an analyst) to become involved with Ruth Bailey.

On the other side of the controversy are those who point out that Spielrein must have gained something in the transference since she was cured of psychosis and became a high-functioning professional woman. Baur (1997), an influential analyst, asks:

> [W]hat convincing evidence do we have that the same result would have been achieved if Jung had behaved toward her in the way we must expect a conscientious therapist to behave toward his patient? However questionable Jung's behavior was from a moral point of view—however unorthodox, even disreputable, it may have been—somehow it met the prime obligation of the therapist toward his patient: to cure her. (p. 38)

Gabbard (1995a) referred to the study of enactments of boundary violations in the history of psychoanalysis as "also the study of the evolution of the concepts of transference and countertransference" (p. 1117). He joined Haynal (1993), who wrote the introduction to the Freud–Ferenczi letters, in noting that technical considerations of transference, countertransference, and the optimal level of the analyst's emotional involvement evolve from the triangles formed by actions of the inner circle:

> First, Freud was the third party in the Carl Jung–Sabina Spielrein relationship, and shortly thereafter he was enlisted to solve the problematic involvement between Sandor Ferenczi and Elma Palos. Finally, a similar triangle was created when Freud analyzed Loe Kann, Ernest Jones' common-law wife. (pp. 1117–1118)

Freud placed himself in an oedipal context with his disciples, and they with him, and following his thinking at the time, dwelled on libidinal themes in his formulations. Nonetheless, the aggressive component of sexual behavior is equally apparent in his theories and in the accumulated understanding of a century of psychoanalyses.

Despite the political and technical problems posed by early analysts who took their patients as companions, lovers, and spouses, sexual liaisons between analysts and patients or students have continued throughout the history of the profession. A parade of analysts: Otto Gross, Oskar Pfister, Wilhelm Reich, Wilhelm Stekel, and Julius Spier, among the early practitioners, did not escape the erotic temptations of analytic practice. Victor Tausk

was engaged to marry a patient before his suicide; Sándor Radó's third wife was a former patient. Frieda Fromm-Reichman fell in love with her younger patient Erich Fromm, finished the analysis, and married him. Karen Horney had an affair with Fromm while he was married to Fromm-Reichman. Fromm too became an analyst (Baur, 1997).

Eroticized transference came to be seen as a form of delusional transference (Blum, 1973; Caruth & Eber, 1996), as did the analyst's eroticized countertransference (Shaverien, 1996). Sexual feelings were recognized as an occupational hazard in psychoanalysis. These theoretical developments coincided with societal changes, including the success of the feminist movement, the medicalization of psychiatry, the legislation of standards of practice, and the encroachment of managed care into therapeutic relationships.

Except for a few tentative articles in the 1970s, boundary violations and sexual behaviors with patients were not discussed in the professional mental health or medical literature until the 1980s although studies indicate the presence of more than random difficulties well before that time. It wasn't until a few sensational stories gained the mass-media spotlight and the public evinced outrage that the issues were publicly addressed (Gabbard & Lester, 1996).

In the mental health communities, debate was heated regarding sexual boundaries in clinical practice. Although the majority of professionals in most disciplines concluded that sex between practitioners and current patients must be deemed harmful and unethical, the appropriate policy regarding sexual contact between therapists and former patients was more controversial. Written codes were promulgated and given verbal support, but they had little effect on behavior. Sexual enactments continued both within the treatment and afterward, a tribute to the inability of prohibitions to control the powerful impulses arising from passions around intimate transference contact.

Traditional psychoanalytic formulations regarding transference adopt an oedipal view of the relationship. That is, the analyst functions as an adult (parent) to the analysand's child in both conscious and unconscious processes. This point of view makes

sex between the two symbolic incest. Analysts undoubtedly consider sex between analyst and analysand to be incestuous. The majority of therapists who have sex with their patients are male practitioners who become involved with their female patients (Gabbard, 1989). The feminist movement brought considerable pressure to bear on behaviors of this sort from the 1960s and 1970s onward when feminists spoke out against sexual harassment and/or exploitation in all areas of society. Interestingly, there are also feminist voices who speak against prohibition of sex with patients or former patients on the grounds that to do so reduces the female to a child rather than a consenting, equal adult in the therapeutic encounter. Some analysts question ethical dogmatism on these same grounds. Ross and Roy (1995) note:

> The correct psychological attitude insists, for instance, that the patient is never responsible for any kind of sexual acting out. If a patient and analyst decide to finish therapy and to begin an erotic relationship, it is still unprofessional and unethical, because even in this decision, the patient is the victim of the power of the analyst or the power of the transference. . . . We declare that a human being, a patient, an adult citizen, is an irresponsible abused child. . . . Is this not a devaluation of the human dignity of the adult patient? (p. viii)

Although most analysts agreed that sexual contact between them and their analysands should be prohibited, the pull toward ethical stances that insist on permanent prohibition was (and is presently) countered by proponents of the rights and autonomy of former patients. Codified definitions of "former patient" vary, however, from state to state and with the legal status of the treatment provider. A compromise has been struck in some disciplines, and by many states, officially viewing a sexual encounter as unethical for a specified length of time after termination of treatment. Today's codes balance theories about the nature of the treatment relationship against politically correct public policies. They take into account theoretically held ideas about the qualities of transference as well as society's shifting expectations about the proper treatment of vulnerable citizens and sensitivity to perceived abuses of specific groups, usually women in this case. Some experts in the field recommend lengthening the period of prohibition based on psychodynamic formulations and

potential ramifications of such sexual involvement (Gabbard, 1994a, 1994b). This debate raises important questions about the nature of the transference: Does transference last forever? Can transference be resolved during the termination process or when analytic contact ceases?

Case example

A patient was seen in consultation after having married her first analyst. She was young; he was a bit older, handsome, and analyzed by an eminent man. He decided to end her treatment because, he said, "I am in love with you." She was flabbergasted and asked for time for a termination process. He found this very difficult but struggled to accommodate her. "I privately questioned my motives; I questioned his," she said. He told her he had been presenting his dilemma to his analyst and to his supervision group for a long time. "Meanwhile," she said, "I pondered my options. The thought of losing him was intolerable. The thought of being with him in a more 'real' way was exciting and terrifying."

After the treatment ended, she met with him, and he told her the story of his life. He said he was hopelessly in love with her. She delayed the marriage but eventually agreed after consulting, and entering treatment with, a second analyst. Later in the analysis, she said:

> We were married for a long time. He gave me children. I loved motherhood. I loved sex. And, I loved him. I was always surprised when he behaved in an unpredictable or unkind way. I guess I expected him to remain the totally benign and attentive person I had known for all those hours in the consulting room.
>
> I think some of our difficulties began when he could see that I was determined to develop my own career and to work with my new analyst. He didn't feel I needed treatment and said I was fabulous just as I was. He quoted his analyst as saying that psychoanalysis was like reinventing the wheel and a poor choice for the modern practitioner. I proceeded with my work and with my analysis, perhaps out of passion for both, perhaps out of defiance toward a husband presenting himself as an authority, perhaps because I felt he didn't want to know the truth and didn't want me to know it.

> In any event, eventually our marriage ended badly. I again questioned my own motives and held myself responsible for the failure. It makes me very sad. I just don't know whether my transference persevered in the face of reality and inhibited my ability to be the right wife for this man. I don't know whether it was him, or me, or the two of us together.

There is very little literature on the second analyses of patients whose first treatment ended in a sexual enactment with the analyst. While there are assumptions about "how iatrogenic of pathology the analysis that finishes in sexual acting out [is], how devastating its effects, and to what extent the patient's possibilities for benefiting from a new analysis are compromised" (Canestri, 1993, p. 162), the cases are not yet available for systematic examination. When they are, they will offer a valuable resource for clinical research.

Contact within the session: case example

The question of sexual contact raises other questions: Can patients be touched or patted in a soothing way? Is a handshake appropriate?

A modern psychoanalyst who was working with a narcissistic patient encountered a repetitive resistance in the treatment. The analysand insisted that she must be touched by the analyst; not having this experience, she insisted, caused her deep disturbance and resentment. The analyst explored with his patient what sort of touch would be necessary to alleviate her suffering. The woman settled on a touch, fingertip-to-fingertip, like the fresco of Moses and God on the ceiling of the Sistine Chapel. "She said she had to have it, and I believed her," reported the analyst. Eventually, the analyst offered his finger from behind the couch. The patient met his offer, and the tension of weeks of impasse was resolved. The analysand went on to present new material.

Despite an early assumption by classical psychoanalysis that all gratification was out of place in the consulting room, Freud himself was a generous analyst. He fed patients, lent them books, gave them small gifts. The prohibition of physical contact also seems to have been more myth than fact.

Fromm-Reichman and Searles employed physical contact in work with severely disturbed analysands. Winnicott's holding of Margaret Little is well documented in her book about the analysis. Little (1990) asserted that the physical holding was essential to her working through the deeply regressive states she experienced. Others have written of their own and others' use of physical contact in the analyses of regressed patients (Balint, 1952; Fosshage, 2000; Mintz, 1969; Oakley, 1989; Rosenberg, 1995; Smith, 1998).

Some authors take the more traditional position with regressed patients. Anzieu (1989) allows that such patients "need to introject a Skin Ego that can play a sufficiently containing role" but insists that the proper psychoanalytic technique in such circumstances:

> consists in re-establishing the sound envelope which lines the primary tactile envelope; in showing the patient that he can "touch" me emotionally; in achieving symbolic equivalents for the tactile contacts that are lacking, by "touching" him with true, full words, or even by meaningful gestures of the order of simulacra. (p. 141)

McLaughlin (1995), a writer on clinical and theoretical aspects of enactment in the transference, explored his own experience with touching in the practice of psychoanalysis. He agrees with most analysts that injunctions against sexual and aggressive excess in the analysis were necessary, but argues:

> I much prefer to be available to respond to what I have found to be the turmoil around early relational struggles that, more often than sexual or seductive urgencies, drive such reachings-out for hand touch or holding.
>
> I find that this responsiveness facilitates, rather than hinders, the patient's consequent analytic seeking. This stance has not prolonged or increased these interactions. The opposite tends to prevail: the need, now satisfied, tends to subside as fuller verbal contact becomes possible between us. (p. 442)

This point of view is echoed by contributors to an issue of *Psychoanalytic Inquiry* devoted entirely to the discussion of touch in the psychoanalytic situation (Breckenridge, 2000; Fosshage, 2000; McLaughlin, 2000; Schlesinger, 2000). The issue's editors invited contributors to discuss Casement's (1982) paper that introduces a case in which pressure for physical contact from the

analyst was a prominent feature while the patient relived early trauma in the transference.

Contact outside the session

Along with problems posed by the question of actions in the treatment are issues arising from extra-analytic contacts. Can these be prohibited? Sometimes there is a planned meeting between analyst and patient, as in the case of a wedding, funeral, performance, or presentation. At other times, unexpected encounters take place that are more or less beyond the control of either party. These situations might feel comfortable for both parties, or they might not. Regardless of whether the emergent feelings tend toward the positive or negative, any externally situated occurrence has the potential to affect the treatment and is worthy of investigation.

Freud (1912, 1915) equates the demeanor of the analyst with that of a surgeon, whose role in relation to the patient is strictly circumscribed, in the analyst's case to holding a mirror to the patient. He constructs rules of abstinence and cautions against breaching anonymity in treatment, warning that it would be detrimental to the work at hand. That he involved himself in treating persons with whom he also had personal friendships and mentoring relationships outside the office (even vacationing with some) leads one to infer that he meant his pronouncements in only the most narrowly defined sense (Lipton, 1977). He did not regard the social amenities as part of the analysis. Thus, he could feed the Rat Man, offer and accept gifts from and lend books to analysands when not engaged in the analysis proper (Shane & Shane, 1997).

The common denominator in every extra-analytic contact is that feelings will be experienced, possibly quite deep feelings, and in most cases by the analyst as well as by the patient. Since transference, countertransference, and resistance phenomena may be temporarily altered in some way, some analysts try to prevent such meetings at all costs. For example, Greenacre (1954, 1959), Langs (1976), and Paul (1959) believe that extra-analytic contacts undermine analyses by reinforcing resistances and subverting transference feelings. They advocate

purposeful avoidance of contact between analysts and their patients outside the office.

Most analysts who have published on the subject disagree with this specifically defined standard. Tarnower (1966) defines the wish of some analysts and patients to prevent such contacts as phobic, rarely helpful, and, in the analyst's case, defensively motivated. He believes a great amount of information can be garnered from both analyst and analysand after the contact and writes of the "unusual opportunity to help patients recognize conflicts which otherwise are well defended against" (p. 412).

Anna Freud (Sandler & Freud, 1981) delineates the lack of opportunities the analyst has of "observing the patient's whole ego in action," instead of just her unconscious on the couch, implying that seeing a patient in real life could be helpful (p. 7). Fenichel (1945), Lampl-de Groot (1976), and Stone (1961) are also willing to modify the treatment relationship to include external involvements. Strean (1981) remains neutral when working with "the patient's wishes and fears regarding these outside contacts." He recommends analyzing the communications in neither an encouraging nor discouraging fashion and presents a case in which the transferential and resistant components progressed because of a well-analyzed contact outside the office (p. 256). Weiss (1975) agrees, writing that "special events" can be helpful in "mobilizing, highlighting, and clarifying transference phenomena" (p. 69). He describes transference communications about such events as "crucial" and recommends that the analyst always be attuned to the richness of them.

Case examples

One analyst reported an encounter with an adolescent patient, walking with her parents down the street of a busy shopping district on a Saturday:

> What stood before me was a father sticking out his hand to shake mine, a mother in the middle of a pleasant salutation, and a shocked 14-year old girl, rolling her eyes angrily and blushing red in the cheeks. Somewhat to my surprise, the girl loudly commanded the following to her parents: "Don't even start with him!" She then grabbed my hand and led me to the corner with a quick,

secretive dismissal: "I'll see you on Wednesday but you should get out of here now. It's like I've told you, those people are crazy!"

In another case, a woman remarked how strange it had been for her to see her analyst walking toward his office before her appointment early one morning. "I was in the window of the coffee shop," she said, "and you passed right by, with your legs moving at quite a clip." Believing the analyst had seen her but paid no attention, she scolded him for always getting ahead of her in the sessions. She went on to describe how it felt to her to be "abandoned and left behind" by her father who left home when she was very young.

Another patient, several years into his analysis, requested that his analyst see him perform in the theater. A number of sessions ensued in which the analyst explored what such an audience would mean to the analysand as well as what was wished for concerning the analyst's presence at the performance. "Should I go backstage afterwards and say good show? Will I be introduced to the other players?" she wondered aloud. She also asked what came to mind at the thought of her attendance and how fantasies related to this proposed enactment might affect the analysis? The analyst attended one performance and continued to discuss the experience with her patient.

Can technique be unethical?

If a primary intervention of psychoanalysts, the interpretation, is seen as planting the analyst's values in the psyche of the patient, the question arises as to whether the interpretation is in some way unethical. The intersect of theoretical normative assumptions in the mind of the analyst with the psychic functioning of the analysand makes any interpretation a risky endeavor. Any interpretation is an interruption in the process of what the patient is saying at a particular time. What the patient might have said had the interruption not occurred is unknown. What element of the ongoing process might have developed had the analyst not intervened at that moment in time with that particular interpretation? The interpretation itself is imbued with the analyst's standards of normal and pathological, perhaps also of right and wrong.

The analytic process in its most basic form is simple. The analysand receives the instruction to lie on the couch and talk. The role of the analyst in this model is to listen. If the analysand could put every thought, feeling, idea, memory, and dream into words without intervention by the analyst, he would be cured without an utterance from the analyst. This never happens because analyses include resistance related to the transference and to those processes unique to the mind of the analysand.

Many analysts believe that interpretation is best used to promote exploration of the patient's mental life and ultimately, like any other intervention, to resolve a resistance at a particular time in the process. That is, the goal of interpretation is to promote the analysand's free production in the session. Nonetheless, the analyst is responsible for the interpretation's influence on the ongoing functioning of the patient's psyche. A neutral interpretation may not be possible.

Is self-disclosure unacceptable?

Along with the problem of action in the transference comes the taboo on self-disclosure by the analyst. Recent trends in movement toward intersubjective treatment speak to a theory of a two-person analysis (Kirman, 1998). This runs counter to the psychoanalytic concept of two people working toward the goals of one of the partners, and the analyst working silently to resolve those elements within the relationship that would get in the way of concentrating on that goal.

Ferenczi was the first to challenge the psychoanalytic taboo on self-disclosure. The question of self-disclosure continues to be discussed because some psychoanalytic thinking requires suppression of the analyst's spontaneity and self-expression (Orange & Stolorow, 1998). The debate about self-disclosure comes down to when to disclose and what to disclose. The modern psychoanalyst may use self-disclosure to resolve resistance (Spotnitz, 1985). For example, the analyst might acknowledge familiarity with a film or book in the interest of encouraging the analysand to proceed with his associations.

Intersubjectivists argue for self-disclosure as a generally useful technique (e.g., Auerbach & Blatt, 2001; Hirsch, 2002; Ogden,

1994; Renik, 1993, 1995, 1999; Spezzano, 1995; Stolorow, 1998), and they consider it an enhancement of the therapeutic process. They desire to demystify the analytic myth, establish mutuality and collaboration in the relationship with the patient, and deemphasize the role of the unconscious. Proponents of two-person psychology focus on such issues as the analyst's authenticity and contribution to the therapeutic situation.

In the analysis of repressed patients, can the analysand know certain things about the analyst and use them to arrive at a deeper understanding of his own motives? Most analysts would say that especially in the preliminary stage of treatment, input should be given judiciously. When the transference is narcissistic, the analyst is not a separate person. Confusion between the mind of the other and the mind of the self is characteristic of borderline and narcissistic states.

Both self-disclosure and refusal to disclose can result in abdication of the responsibility to analyze. For example, some analysts will not discuss their current illness or impending death. Freud never wrote about how his work with patients was affected by his 33 operations for progressive oral cancer. He saw his illness as an intrusion, not as part of his work (Dattner, 1989). If the analyst feels it will kill him to discuss it, he won't discuss it. Epidemiologic data strongly suggest that those who are ill and use denial as a defense live longer than those who are ill and do not deny (Dewald, 1982; Schwartz, 1987).

Lasky (1990), in discussing the situation of the analyst who is ill, recommends that the analyst should give the greatest freedom he can to permit imagination and fantasy and transferential components of the meaning of the experience for the patient to emerge. Pizer (1997) feels there is a responsibility to disclose, whereas others feel they betray their contract when they draw attention to themselves.

The risks of analyst self-disclosure include closing off the analytic space and communicating in a manner that feels toxic to some patients—for example, the analyst's self-disclosure of his countertransference feelings and eliciting of the patient's interpretation of the analyst's motivations. Bernstein (1999) cautions that disclosure may promote the air of a "personal

relationship," setting aside the analytic focus on unconscious processes. The analysand may feel misled by such communications (Shill, 2004).

Case example

In his biography of Winnicott, Kahr (1996) says that by the late 1960s, Winnicott, then in his early eighties, looked old and craggy and was virtually unrecognizable (p. 113). His hair had fallen out, his teeth had started to rot, and he was drinking more. Despite his evident decline, he refused to stop work or slow down. His intelligence and critical acumen remained to the end, but his judgment was clearly deficient. He knew he was dying and was prepared to die, but did not prepare others.

Hopkins (1998), writing of Winnicott's analysis of Masud Khan, discusses Winnicott's incapacity to engage with patients' destructiveness or their expression of hatred. For example, he could not engage with Margaret Little's destructiveness and lacked the energy or the emotion to handle her regression. Hopkins notes, "it is most ironic that Winnicott had [a] coronary after presenting a paper that discussed the vital importance of the object of aggression surviving an attack" (p. 36).

Khan experienced Winnicott as passive and physically vulnerable to stress in the analytic situation and felt Winnicott could not survive his own aggressive attacks (Hopkins, 1998, p. 23). Winnicott never confronted Khan's grandiosity. He backed off from confrontation and placated Khan by agreeing to end the analysis and intensify their extra-analytic contact. Thus, he let Khan terminate the analysis "with substantial sectors of his personality unexplored and unintegrated . . ." (p. 25).

Winnicott taught Khan to break the frame and modeled deviations from the frame. Khan tells of being offered alcohol by Winnicott when Khan was struggling with alcoholism. Khan was no longer his patient, and Winnicott was drinking at the time, but this invitation was clearly analytically incorrect. They coauthored works, Winnicott referred patients to Khan, and after the analysis ended, they continued to meet weekly for ed-

iting sessions on Winnicott's material until Winnicott's death. At the end, Khan was essential to Winnicott and would leave his phone line open at night for Winnicott to call him. Khan needed Winnicott to stay alive even after the analysis ended. He never found a replacement for Winnicott and could not thrive without him.

Winnicott's cardiac condition may have played a major limiting role in his analyses (Hopkins, 1998, p. 34). Winnicott suffered from periodic angina and had several heart attacks. He tried to hide signs of failing strength, but he often fell asleep during sessions. Winnicott's coronaries and his depression were not subjects to be discussed. He needed to keep his health a private experience. His health and his reticence to discuss it compromised his treatments. Khan said that any sign of failing strength in Winnicott made him very anxious. "Winnicott," Khan added, "tried to hide it from me and I pretended he'd succeeded" (p. 34). Patients like Margaret Little and Khan did not want to cause Winnicott emotional stress. Little believed emotional stress had led to each of his heart attacks (p. 36). In his analysis of Guntrip, Winnicott avoided difficult issues in the transference and seems to have rationalized his technique in the interest of his own comfort.

Winnicott's difficulties maintaining the psychoanalytic frame in turn led to what Sandler (Sandler & Godley, 2004) calls "the transgenerational transmission of boundary violations and the special problems they present to organized psychoanalysis at every level" (p. 27). Khan was accused of numerous instances of inappropriate behavior with patients, training candidates, and colleagues and was eventually removed from membership in the British Psychoanalytical Society.

Is informed consent possible?

Laquercia (2002) calls attention to the fact that at the outset of a psychoanalytic treatment an agreement is established that the analysand cannot have fully grasped. The patient is unprepared for a relationship that will include the tensions and rigors of arousal and deep feeling. These states will disturb, evoke, provoke, and arouse the analysand in ways that are necessary

for the treatment to be effective, yet in no way could have been known to him before actually experiencing them:

> One might postulate that the analytic agreement is flawed with an unethical imbalance right from the beginning. The potential for profound attachment to occur is a factor that makes the analysand a potential victim, regardless how benign, beneficent, or therapeutic the intentions of the analyst. The power and, indeed, the efficacy of this intense treatment method relies on a very lopsided condition because it is the power of the transference and the concomitant resistances and enactments emanating from it that allow the analyst to make interventions to foster progress. Interventions, consequently, devolve organically from the analysand's productions because of the lack of knowledge he has about the analyst and the process. (Laquercia, 2002, pp. 1–2)

This complicated experience, in its purest form, is limited to the two parties in the consulting room of the analyst. Experiences outside the sessions by either party discharge some element of the session. Laquercia (1985) notes that analysts believed for many years that by virtue of that leaking some change in the treatment dynamic occurred. An analysand talking to a friend or spouse about a session or telling a dream was thought to modify or modulate elements of the analytic work. It was thought that the discharge in talking about dreams outside the session could result in patients forgetting to tell the analyst the dream or in losing the dream memory altogether.

Similarly, the analyst's talking about a patient, even with confidential sensitivity, has been thought to have an effect on the process of the analysis. Ordinary discussions or writing a paper including clinical material about the analysand could make changes in the relationship. Most professional associations and training institutes encourage and expect production of papers, books, and clinical presentations by the analyst, all of which could have a material effect on the treatment relationship. The analyst's narcissistic gratification in these productions has great secondary gain potential that is both separate from and beyond the agreement with the analysand.

Concerns about confidentiality are ancillary to this discussion. Analysts since Freud (1905) have offered standards for selection and disguise of case material, striving to preserve both the

accuracy of dynamics and process and patient's privacy (Aron, 2000; Gabbard, 1997; Goldberg, 1997; Lipton, 1991; Stein, 1988). Some authors have stipulated that analysands provide consent (Michels, 2000; Stoller, 1988). Is informed consent possible when unconscious factors in the transference influence the decision?

Treating candidates in a psychoanalytic institute raises a special issue of informed consent. Laquercia (1985, 2002) has conducted research on clinical and training matters affecting the analyses of students. He observes that there has always been significant concern about such matters as reporting and evaluation of candidates in the course of their training, including who is approved to conduct a training analysis, whether it should be concurrent with training or completed before training begins, and whether the gender of the analyst should matter. Informed consent in this setting has further complications for the candidate. Requirements are established by the institute, and such pre-stated standards as the minimum number of hours imply a norm for treatment. An analytic candidate may be less spontaneous as a patient, more compliant, for example, so as not to jeopardize his progress through the institute. New requirements or changes in requirements of the institute, introduced during the process of the analysis, may place the candidate in a position of diminished capacity to resist. An institute may require a certain frequency of sessions, a group analytic experience, an experience with an analyst of a different gender from the primary analyst, or that the analyst be in supervision. These requirements compromise the treatment of the candidate in a way that raises concerns of institutes, training analysts, and candidates themselves.

Psychoanalytic candidates are faced with more issues in their personal training analyses than the typical patient. In the usual process of establishing a treatment contract, the analysand agrees to certain things, for example, to come to sessions for a particular fee for analysis only. The candidate's agreement to be a subject in the professional activity of his analyst is not an articulated part of the contract, and its effect on his treatment may never be known. Kernberg (2000) addresses some of these issues but does not resolve how analysts and candidates deal

with them nor does he address the effects of extra-analytic contact on the treatment. In an analytic institute, the interaction of the analyst with his analysand outside the consulting room is sometimes happenstance or the result of shared professional activity, in educational seminars, classes, or presentations. The interaction is not insignificant because the treatment continues whether in the session or out in the world.

Can a code end an analysis?

Is it possible to codify the responsibility of colleagues to recommend termination of an analysis based on knowledge of a deficiency in an analyst or does the analytic endeavor demand that the community honor the analysand's transference wishes and the analyst's goals?

When should an analyst stop doing analysis? What about therapist denial? How do the analyst's needs interface with issues of patient welfare? Does one continue to refer patients to an impaired colleague who needs to work to live? When the analyst enters into a lingering death, he makes decisions regarding the treatment of his patients. Can an analyst on morphine make such decisions? What if the analyst thinks he has a chance to recover? Barbanel (1989) asks whether we can tell an analyst whose life depends on working not to work. What if neither analyst nor patient is able to have or verbalize all the relevant feelings? Won't colleagues consider the analyst whom they know over patients whom they don't know? Patients treated by a deteriorating analyst may develop numerous fantasies and fears, as well as wishes, concerning the object's impending death. In fact, analysands may harbor such ideas about an analyst of any age, that is, the patient may have an unconscious wish to go where the analyst is.

Still, analytic writers take some very firm positions on the matter. Firestein (1992) states that once terminal illness is known the treatment should be considered terminated. Eissler (1993) feels that when an analyst passes his sixth decade, he should look for a time to tell each patient whom to turn to should he die. But is it in the best interest of the patient to continue treatment with an analyst the dying analyst has chosen? Halpert (1982)

reports on a patient who terminated with him as abruptly as the former analyst had terminated with her, thereby repeating actively what she had experienced passively. On the other hand, the communication of a terminal illness does not seem real if there is no planned termination of treatment. What is the role of confidentiality in cases in which the analyst selects a new analyst for a patient and informs that person of the details of the case? Cohen (1983) suggests that the analyst's responsibility in the event of death overrides issues of confidentiality.

Withholding information regarding serious illness of the analyst may be considered appropriate abstinence. But if the death of the analyst is not a subject for fantasy and exploration with the patient, is this a failure on the practitioner's part? Is it possible that in the very selection of an analyst some patients are able to repeat the losses of an unmentalized past? May this not occur in the transference, whether or not the analyst dies during the treatment?

The loss of one's analyst is a traumatic event. Dattner (1989) finds that the gender and relative ages of patient and analyst, as well as the phase of treatment at the time of the analyst's death, have no influence on the patient's mourning reaction. When the patient feels abandoned by his analyst's death, unresolved conflicts and themes from childhood and adolescence may be reactivated. There is a loss of self-esteem, a shattering of the ego, a feeling of powerlessness; one is left with unresolved ambivalence (Sacks, 1998). Previously held beliefs and illusions, mostly unconscious, are destroyed. The death can be experienced as a narcissistic injury. A feeling of incompletion overshadows the analytic process.

Freud (1917) distinguishes between mourning and melancholia. In mourning, there is nothing unconscious about the loss. Melancholia is related to an unconscious loss of a love object in which the loss of the object becomes transformed into a loss of a part of oneself. Some of the features of melancholia are borrowed from grief, while others come from regression from narcissistic object choice to narcissism. Like mourning, melancholia is a reaction to a real loss. In melancholia, the mourner feels he is to blame for the loss (i.e., he desired it). Self-torment

suggests that sadistic tendencies and feelings of hate are being gratified. These feelings relate to the object but have been turned against the self.

Biochemical changes take place during grief states that may be permanent and can compromise immune system functioning. Abandonment by one's analyst has the power to arrest and alter functioning, experience, and character and can result in death to the survivor.

Since any change involves loss, each change in the patient's life can reactivate the loss. How complicated or chronic the abandonment becomes depends on the quality of the relationship to the analyst, one's genetic predisposition or vulnerability, the particular circumstances surrounding the loss, and the level of maturation of the person. When the relationship to the analyst is a preoedipal transference, the death may be experienced as a self-annihilation (Sacks, 1998).

An analysand may choose to stay with a practitioner who is deaf, demented, or dying. The choice is guided by unconscious forces privileged to the analysand. If he leaves such an analyst, who is to say he won't select another with whom to relive the experience?

Conclusion

Analytic decisions have to do with the goals of the analyst. If we are to say that we don't sleep with patients, we must say why not. The analyst may want to refrain from having sex with patients because the surrogate gratification of libidinal and/or aggressive impulses is contrary to the aim of the analysis.

Is it the goal of the analyst to free the analysand's blocks to genuine satisfaction? If so, it is not our business to evaluate what is going on behind the closed doors of colleagues. We have no direct knowledge. Is it not desirable that analysts have the freedom necessary to work with the unconscious for as long as it takes to achieve integration? Likewise, psychoanalysis values the freedom of the unconscious of the analysand to choose a transference and stick with it if she cares to.

Put this way, implicit in psychoanalysis is an ethic of assertion—of the unconscious, of wishes, longings, and fantasies, of truth and freedom. Action is selected after taking both parties into consideration with respect for the patient's transference.

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