

THE

ROUND ROBIN

Newsletter
of Section I

Psychologist-Psychoanalyst Practitioners Division of Psychoanalysis (39), APA

Volume XXIV, No. 1

Winter 2010

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Psychoanalysis is defined, not by frequency of sessions or the use of the couch, but by attention to transference and countertransference by an analyst in a particular state of mind. This paper is an exploration of Bion's attempt to portray that quality of mind. But first a caveat from Bion himself: In a seminar for clinicians given in São Paulo in 1978, Bion told his audience, "The way that I do analysis is of no importance to anybody excepting myself, but it may give you some idea of how you do analysis, and that is important," (2000, p. 224). I mention this here, not only because I think it is revealing as to the kind of man and thinker Bion was, but because I find it a useful perspective from which to approach Bion's work. We have much to learn from Bion, not because we ourselves will necessarily conduct analysis in just the manner he prescribes, but because considering what he has to say will make us more self-reflective about what it is we do, the choices we make as clinicians from moment to moment in our own work, and the state of mind we cultivate in order to do what we do. As Bion believed, the analyst's most crucial tool

is his own personality. This is the basis for all analytic creativity. "The analyst you become," Bion wrote, "is you and you alone; you have to respect the uniqueness of your own personality—that is what you use" (2000, p. 12).

Bion's work marks a departure from a deterministic model of human development. It introduces uncertainty into the heart of psychoanalytic investigation, transforming Freud's backward-looking reconstructionist orientation into a model of progressive growth based on the unique encounter between a patient and an analyst, out of which is generated an unpredictable array of possible meanings. Psychoanalysis, from this perspective, is less about uncovering a pre-existing truth, the repressed unconscious, and more about discovering an as yet unrealized truth emergent within the patient's psychic experience as it unfolds in the clinical hour. For Bion, the realization of this truth is not directly accessible through a conscious effort at knowing, but only through a process of becoming. In other words, this is not simply a cognitive process in

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which the truth is talked about, but an experience in which truth is that which is apprehended as it is lived by the analytic couple. One might think of the difference as that between the effect of explaining to a patient how his or her present difficulties are rooted in unresolved issues from the past, and experiencing with a patient, in the full drama of transference, the way in which the past lives on. Yet this is a risky journey, and experience shows that both patient and analyst alike are repeatedly tempted to evade truth and take shelter in what Bion refers to as lies (Bion, 1983, pp. 98-105), lies that protect both participants from the pain of facing the absence or unavailability of the objects of our love and dependent longings. Similarly, patient and analyst may cling to the untruth in a flight from uncertainty, impotence, awe, dependence, and responsibility in the face of ignorance. The role of the analyst in this process is not as the one-who-knows, poised to impart his expertise to the patient, but as a participant in a process, who, to the degree that he can sustain an analytic attitude in the face of his own inclinations to hide from experience, can offer the patient what Bion modestly calls a "second opinion."

Bion's work, for all of its originality, presupposes a deep immersion in psychoanalytic thinking. In that sense, he is like a jazz musician who, knowing his scales backwards and forwards, proceeds to create out of those scales harmonies and sequences of sound that have no precedent and yet resist devolving into formless noise. In the process, Bion draws attention to the most radical aspect of psychoanalysis, the aspect responsible for much of the ongoing hostility the discipline evokes in our culture, for psychoanalysis fundamentally asks us to abandon our ordinary ways of thinking and our ordinary view of ourselves as unitary, self-transparent subjects. Even the rituals of psychoanalytic space, such as the couch or the analyst's relative anonymity, are designed in part to promote a suspension of the ordinary so that something more strange and unique to the psychoanalytic encounter can emerge. Bion's work represents a

disciplined and concerted effort over years to build a language and a theory of thinking relevant to our clinical work, one that protects us from the habits of ordinary thought despite the enormous pull in our day-to-day clinical work to retreat to the familiar, the seemingly obvious, and the commonsensical.

O into K

Our patients come to us for one of two reasons. Either they are experiencing a pain they cannot bear, or their pattern of attempts to evade pain have resulted in crippling characterological styles that have blocked their capacity for growth. Bion suggests that while such persons feel pain, they do not suffer it and hence cannot be said to *discover* it (1983, p. 9). The borderline patient who cuts her arms feels pain, but she cannot yet be said to suffer it. Similarly, the patient who blames her unhappiness on her neglectful mother may indeed *feel* her pain, particularly as displaced in the transference, but it may take years before she suffers the pain of living with the full knowledge of her mother's incapacity to care for her. Only then will she truly *discover* this pain as a truth for which she alone must bear responsibility. For Bion, the discovery of this truth is not an uncovering of a preexisting or independently existing truth but rather an evolutionary becoming consisting of the transformation of what he refers to as O into K.

O, for Bion, is the unknowable and inexpressible which nonetheless makes its impact felt as emotional truth demanding recognition. As experienced in the analytic hour, O is the Truth of the patient that is unformulated and beyond the truths of the moment. It is what the psychoanalytic process aims to approach but never fully grasps. Bion refers to O as the "world of darkness, the void, the formless infinite...the perfect blank" (2000, pp. 274-277). Elsewhere he speaks of it as the ultimate reality, the thing-in-itself (1983, p. 26). It is the ineffable and unformulated impact of a Real, in the sense that Lacan uses that term, that precedes and exceeds any representational container. Within the clinical hour, O (which is a becoming) is partially grasped to the degree that it is transformed into K, the latter being truths that represent the relational linkages between ourselves and the objects of our

knowing. K, in this sense, is distinguished from knowledge which one possesses *about* someone or something. For Bion, the evolution of emotional growth proceeds from O to K, not K to O. In other words, experience precedes thought. Minus K (-K) is that force or activity that reverses or stops the experience of understanding as it unfolds in a dynamically evolving intersubjective field, or in the internal dialogue within the subject's psyche.

For Bion, dreaming within the analytic session is the primary way in which we approach, partially contain, and ultimately submit ourselves to O. Dreaming, which can occur in both a state of wakefulness as well as a state of sleep, acts on experience. It is the process through which the mind digests emotional experience and transforms it in such a way that it can potentially be thought. For the patient, dreaming takes the form of a willingness to say whatever comes to mind, as free association. For the clinician it takes the form of a willingness to receive whatever comes to mind, whether it originates from the patient or the analyst's own psyche.

The symptom is that which cannot be dreamt. It is an attempt to evade an experience that is unbearable, that cannot be suffered. Such experience may present itself in the form of an affect, a drive, or an unconscious fantasy. The symptom, as that which cannot be dreamt, may be lodged within the patient's psyche, within the analyst's psyche, or in an impasse that occurs between patient and analyst.

Ms. Z

Ms. Z grew up in an enmeshed family with a highly disturbed younger brother. The parents, who themselves were characterologically infantile, depended on Z to absorb the emotional turbulence generated by this boy. Unable themselves to function as containers, the parents thrust her into that role, which she could not adequately fulfill. At the same time, the status of victim in this family was highly valued, and masochistic self-sacrifice for the good of the other was rewarded with special attention and recognition. O in this context, I would suggest, made its impact felt in the extreme disturbance emanat-

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ing from the brother that sent shock waves through both the family and Z's psyche. Her symptom, as it developed and made itself felt as response to the impact of O, took the form of an entrenched masochistic personality organization which, by late adolescence, was being enacted in near suicidal ways. While we have no direct access to the Truth of this O, we can approach an approximation of it through K, the knowledge that has evolved over my years of learning from experience with this patient. Thus I would suggest that her truth, the unformulated O as partially apprehended in K, was that my patient really was the victim of this familial pathology. Her evasion of that unbearable truth took the form of enactments in which she staged her victimization, thereby distorting the story in order to sustain her conscious identity as victim all the while supporting the unconscious omnipotent phantasy that she alone orchestrated her fate, a phantasy that evaded the truth of her helplessness. One could say she felt the pain of victimization but did not suffer it. To suffer it would involve facing her real vulnerability, her rage and disillusionment with her parents and the impossibility of claiming the childhood she never had.

The Analyst's Symptom

If the symptom represents the attempt to evade or distort an unbearable experience, then we can also speak of the analyst's symptom as it appears in response to the impact of the patient's O on the analyst. Some time ago I began work with a patient who had grown up with an undiagnosed paranoid schizophrenic mother. There was, in effect, no name, no container to mitigate the impact of this psychotic maternal presence in my patient's childhood. During the first eight months of our work, she would greet me with a polite, composed, "how are you?" then seat herself in the chair and begin to cry, weeping uncontrollably for the entire session. Tears poured from her eyes, mucous poured from her nose, the tissues in my office were not enough to catch all that poured out. It was as if misery and chaos seeped



from every pore of her body. At a certain point it was I who flagged in my ability to bear this O. Fooling myself into thinking that I was offering *more* help to my patient at a time when we were facing a temporary but prolonged separation, I suggested she might want to consider taking an anti-depressant medication. Her shocked response made it clear that I was the one symptomatically retreating from this almost unbearable experience, not my patient. To her, my suggestion meant that I was unable to bear her suffering, that I was retreating to a state of -K, an evasion of her truth, and that I had momentarily lost faith in my own capacity to serve as a container for her O.

Dreaming—Ms. A.

If the symptom signals an individual's defective capacity for dreaming, then one of the tasks of analysis is to restore the patient's capacity to dream (Ogden, 2009; Grotstein, 2009). The analyst, to the extent that he makes himself available as a container of the patient's projective identifications, participates in the thinking/dreaming of that which the patient has been unable to think/dream on his own (Ogden 2009, p. 6). This involves listening to the patient's material in the same way one would listen to a dream (Bion 1962; Ferro, 2005a) wherein characters or objects in the patient's narrative represent the patient's experience of the analytic couple (Ferro, 2005b) as well as displacements or disowned or lost aspects of the patient's self. At the same time, the analyst's interpretations become a part of the dream fabric being woven in the interchange between two minds.

Soon after returning from a long

summer break in which Ms A, along with her children, had visited her parents, she related the following events to me as if relating a rather unremarkable family episode. At the dinner table one night her eight-year-old daughter stiffened and appeared unable to breathe or speak. She emitted choking noises and seemed in a state of trance. My patient proceeded to recount how she calmly retreated with her away from the parental dinner table, speaking to her in soothing ways. After 20 minutes or so, the symptoms subsided. Within an hour, however, the symptoms reoccurred, with her daughter mute and gasping for breath. My patient explained to me that she became concerned enough to put her daughter in the car and drive to a hospital. The doctors could find nothing physically wrong but recommended that the child see a psychiatrist, recognizing, I am sure, the psycho-physiological nature of the symptoms. Ignoring the doctor's advice, she drove with her daughter to the beach where the apparent seizure happened again, this time with even more intensity. She related being unperturbed, calm, cradling her daughter in her arms, cocooned in their own private world, until the fit subsided. My patient then suggested that they take a carousel ride in the midst of which the fit returned, this time attracting a crowd of concerned onlookers. Ms. A ignored them, put her daughter in the car, and drove home. As an analyst I had a choice about how to listen to this story. I might have listened to it as a narration of "real" events, a mother coping calmly with her daughter's panic attack. I chose instead, for reasons having to do with this particular patient, to listen to it as if she were telling me a dream of what it had been like being away from me and how she had coped. I understood her daughter to be a displacement of her own traumatized child-self with no capacity to contain the bombardment of unmetabolized stimuli. Returning to the family setting with its traumatic associations, and without her analyst to help her contain the experience, she was afraid of losing her grip on her own sanity. Instead, in the dream, after projecting her anxiety into her daughter (who has an uncanny ability to function as container for her mother's unconscious), she became me. In a sense, she became the container she needed, weathering the emotional turbulence. At the same time,

she expressed her disappointment at me for being unavailable by denying her helplessness and assuming an omnipotent stance, declaring the child psychiatrist unnecessary.

Receiving the Dream

To receive a patient's communication as a dream demands a particular discipline and frame of mind on the part of the analyst. It requires at a minimum the ability to set aside our ordinary and taken for granted ways of perceiving and thinking. The clinician must be able to open him- or herself up to the widest possible spectrum of thought and feeling, both pleasant and unpleasant, to listen without listening *for* something, to listen in the here and now rather than there and then. It requires listening while suspending our own anxious desire to understand or to cure. Often our patients will ask us to define what is "normal", or worse yet, "healthy." To do so interrupts both the patient's and the analyst's ability to dream by feeding the desire to deal with only certain normative thoughts or feelings in the analysis, avoiding what is strange or disturbing. In a sense, as Godbout argues, "analytic listening requires a stance 'beyond good and evil,' a radical asceticism with respect to moral norms (except for the choice to listen, which is moral after all), a state of unconditional preparedness" (2004, p. 1129). For Bion, the state of mind that makes such listening possible is a form of dreamy reverie that he characterizes as listening without memory, desire, or understanding (1983).

Without Memory or Desire

Freud described psychoanalytic technique as consisting in listening with "evenly suspended attention." This technique, he wrote

consists simply in not directing one's notice to anything in particular and in maintaining the same 'evenly suspended attention ... in the face of all that one hears...For as soon as anyone deliberately concentrates his attention..., one point will be fixed in his mind with particular clearness and some other will be correspondingly disregarded, and in making this selection he will be following his expectations or inclinations

...if he follows his expectations he is in danger of never finding anything but what he already knows; and if he follows his inclinations he will certainly falsify what he may perceive...

...The rule for the doctor may be expressed: "He should withhold all conscious influences from his capacity to attend, and give himself over completely to his 'unconscious memory.'" (1912/1958 pp. 111-112).

Bion appears to be alluding to something very similar when he writes, "There are minimum conditions necessary for the activity we call psychoanalysis. Some of these conditions lie within our own control: that is to say, we can avoid being in an unsuitable frame of mind; we can avoid being a prey to what I can most easily describe as a state of rhapsody, of being in such good humor that we allow our emotions and wishes and desires full play. That is not much more use than it would be to arrive heavily drugged, literally with alcohol or metaphorically with our optimism or pessimism or despair. In this respect," Bion concludes, "it is therefore important to be rid of memories and desires" (1997, p. 43). For Bion, such listening involves what he calls an "act of faith."

The discipline that I propose for the analyst, namely avoidance of memory and desire, in the sense in which I have used those terms, increases his ability to exercise 'acts of faith'. An 'act of faith' is peculiar to scientific procedure and must be distinguished from the religious meaning with which it is invested in conversational usage; it becomes apprehensible when it can be represented in and by thought. It must 'evolve' before it can be apprehended and it is apprehended when it is a thought just as the artist's O is apprehensible when it has been transformed into a work of art (1977, p. 34).

Further on Bion writes,

The 'act of faith' has no association with memory or desire or sensation. It has a relationship to thought analogous to the relationship of a *priori* knowledge to knowledge. It does not belong to the +/- K system but to the O system. It does not by itself lead to

knowledge 'about' something, but knowledge 'about' something may be the outcome of a defense against the consequences of an 'act of faith.' A thought has as its realization a no-thing. An 'act of faith' has as its background something that is unconscious and unknown because it has not yet happened (1977, p. 35).

For Bion, then, the "act of faith" that listening without memory or desire entails is an act of opening receptively onto the unknown, the not-yet-thought, a state of patient waiting for something to take shape in the clearing. Prior to this shape-taking, this "something" has existed only as what Bion refers to as a "preconception," the "something unknown that has not yet happened."

The Custodian of the Patient's Communication

Bion's recommendation to listen without memory or desire is, like Freud's recommendation, an attempt to describe a certain state of mind, a dreamy wakefulness that is wide open, passive, unfocused at the same time that it is ultra-receptive to the unconscious communications of the patient. It means being attuned to the thoughts or associations that float into the analyst's mind unbidden. Such unbidden thoughts may indeed be memories but they are to be distinguished from attempts at conscious recall, the latter being more useful as we puzzle about an hour after it is over. It means being the custodian of the patient's communication, receiving what the patient cannot yet contain and preserving it even in the face of the patient's wish to disassemble meaning and reduce it once again to non-sense. It means listening for the psychic reality of the patient as it makes itself felt as a shadow to the sense-based reality in the room. To listen without desire requires that the analyst exercise the discipline of maintaining the inner world of the patient against his own pressing needs and desires for recognition, discharge and omniscience, for the reassurance of understanding and curative power—in short, the narcissistic needs which we all experience as clinicians but which we must suffer and contain as best we can.

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While Bion's dictum to listen without memory or desire resembles Freud's description of free-floating attention, Meltzer (2008) points out that, in fact, there is a crucial difference. "The idea of free-floating attention seems to be a simple one, conceived as simple to accomplish, on the model of free-floating in water, which does not require an act of faith in the buoyancy of the human body but merely a realization of it for a moment...Bion's act-of-faith would correspond more to floating free in shark infested waters. It assumes that everyone has a fiend following him, is on the verge of hallucinosis, megalomania, delusions and catastrophic anxiety" (p. 369). As Meltzer suggests, this act of faith is not something one can exercise by free will. Rather, it consists of a gradual transformation of someone into a psychoanalyst, assuming that psychoanalysis exists as a thing-in-itself. In other words, it requires that the analyst open him- or herself to experience in such a way that the fiend in her own mind can be subject to thought, the price of becoming O. Thus, there is nothing necessarily calm or serene about Bion's recommended state of mind. In fact it requires of the analyst a courage in the face of turmoil, uncertainty, doubt and impotence.

Bion is not suggesting that we abandon all intellectual preparation or disciplined training, neither is he championing a naive romanticism suggesting that truth can be known in an unmediated direct fashion. In fact, for Bion all we can know are the truths of our experience as dreamt in the present, ultimate Truth forever eluding us. Furthermore, Bion counsels that the analyst must cultivate ideas that are accurate enough and robust enough to help him survive the emotional turmoil of the session (Bion, 1983, p. 95), even while he holds these ideas lightly and loosely enough to avoid premature closure of the experience. It can in fact be a delicate balance, for as Godbout observes, "the analyst inhibited by too many theoretical ideas is likely to miss the experience and only 'observe' his inner theory; the one which carries none is likely to slip into a static folie a-deux with the analysand and will no longer be observing anything what-

soever, or will take for observations on his part interventions that are really verbal enactments" (2004, p. 1130). Minimally, Godbout explains, the analyst should continuously ask himself, what is going on here? How is the patient affecting me, and how am I affecting the patient? What is the emotional experience here that needs containment? What is being enacted? The analyst, in effect, finds himself inside an experience which he must first encounter and then think (p. 1130), the latter ultimately involving complicated retrospective theorizing (Bion, 1965, p. 126).

The Transference

Bion offers up a number of justifications for why this state of mind is critical to the realization of psychoanalysis (Meltzer, p. 371). He believes such a state of mind is necessary for developing a mode of thought which permits correct clinical observation. In addition, he believes that the development of the transference depends upon the analyst sustaining this state of mind. Such a state of receptivity facilitates the analyst's usefulness as a container for the patient's projective identifications. Bion also believes that the exercise of memory and desire aggravates the state of envy in the transference, for if the psychoanalytic method is narrowly conceived of as consisting of the accumulation of knowledge, the patient is left feeling that the analyst possesses all that he lacks. Finally, Bion believes that reliance on memory and desire plays into the patient's resistance. A patient may resort to stimulating the analyst's memory, desire, and understanding in order to protect against the possibility that the analyst's mind might be open to receiving the experience alive in the immediacy of the moment, which the patient might unconsciously wish to avoid. The latter is well illustrated by the patient who fed me, her analyst, the raw materials for my so-called smart sounding interpretations, thus protecting herself against the feared possibility that she would be disappointed in me should I prove inadequate, as did her parents in the past. In this context, these so-called "smart" interpretations represented not K, but -K. In another case a patient spent the session excitedly detailing the objects in her bridal registry as protec-

tion against the emergent romantic and sexual longings in the transference, thereby directing my awareness of desire elsewhere, in this case my desire to see her as on her way to a happy fulfilled life. Finally, all our patients, I would suggest, stimulate our desires to "cure" in an attempt to forestall our experience of the limits of our abilities to provide the wished for restitutions for the traumas of the human condition.

Symbolization

Bion's conception of analytic work is ultimately about the process of symbolization and the transformation of emotional experience into thought. This is not, however, as Godbout argues, "antagonistic to what analysis literally designates, namely a process of 'analyzing,' decomposing or undoing representational networks. Rather, analyzing [can] be seen as a *step toward synthesizing or symbolizing*, in the sense that undoing tight networks or representations allows the emergence of unstructured affects which were barred by this network; it allows these affects to emerge and be contained *symbolically* for the first time" (2004, p. 1132).

Working without Certainties

As analysts and clinicians, we do not pretend to have the answers, despite our patients' fervent wishes. At best we bring to our work an understanding of the vagaries of human development and the significance of the intersubjective matrix out of which psyche emerges. Beyond that, we can model for our patients a way of listening, a respect for the limits of our knowledge and compassion for our own and our patients', at times, limited capacities to bear that which we are asked to bear. This takes willingness on our part to take risks, as well as a great deal of tact. It by no means suggests that we as clinicians behave in a cold, withholding, unrelated way to our patients. In fact, I would say the demands for emotional engagement are intensified when we step outside of conventional sociability and meet our patients in uncharted waters that may well be the frontier of both patient's and analyst's zone of comfort. This is not easy work. Certainties elude us. At times we will feel our way forward in the dark.

Bion refrains from the temptations

of closure and neat endings by celebrating the gaps and loose ends that open outward toward a future as yet unknown. He invites us to take risks, to make mistakes and, above all, to learn from our experience. "As the analyst," he tells us, "one hopes to go on improving—as well as the patient. That is why I think it is a good thing to leave oneself a chance of learning something and not allow the patient, or anyone else, to insist that one is some sort of god who knows all the answers. If I know all the answers I would have nothing to learn, or chance of learning anything...What one wants," he concludes, "is to have room to live as a human being who makes mistakes" (2000, p. 6).

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President's Column

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which then has an impact on the methods of teaching and using technique.

Luckily this danger is recognized, and is not yet endemic. In fact, I recently attended a conference in which the work of Joyce McDougall was featured. In the example chosen, she had drawn deliberately on "wrong" technique, but had helped her patient greatly, based on her keen intuitive sense and unconscious resonance with where she and the patient were. Her technique was informed by her art, and both operated in concert with each other. As analysts we don't paint by numbers or, hopefully, interpret dogmatically according to a particular theory.

So a word of caution and a wish, that we keep on being open to the art in technique and not think of technique apart from art. The pursuit of a formula like that for the Golden Mean in art will not serve us well.

A further note:

I recently saw the work of Magritte at a conference on "Time" held at the New York Psychoanalytic Institute. Of particular interest is his familiar painting *La Reproduction Interdite* (1937). It shows a picture of a man looking in a mirror, but the reflection he sees in the mirror is his own back (not his face as one would normally expect). So both the man looking into the mirror and we as observers

seemingly positioned behind him see the same image—his back. What is of interest to me and to analysis is the notion that the future is often seen and/or constructed to be a function of the past, which indeed it is. I call it looking in the rearview mirror; where we don't see ourselves. Indeed, we select our love objects based on past experiences, and hold onto objects through the wish to refind. But I would like to continue suggesting that the technique and art of analysis is not only to find and deal with what is repeated from the past but also to promote the creative discovery of what is new, uncertain, and evolving. Such discovering is as important as refinding. Freud, too, believed in this.

So I leave you with this final Presidential column, It has been good to be the president of a vibrant and forward looking section that does not always see its "back" when looking in the mirror, nor believes solely in a deterministic past but also in the discovery of what's next as a way of getting there, wherever that may creatively be.

Section News:

First, congratulations to our new, incoming President, Gemma Marangoni Ainslie, who will now preside (as of January 1, 2010). She has been an exceptionally creative and active force in Section I, very much one who understands the art in psychoanalytic technique. I am happy to be leaving the Section in such good hands.

Then, our October 2009 Section Visit to the Southwest Psychoanalytic Society in Tucson was a great success. John Rosegrant, President of the Society, assisted by Lane Harmon, Ina Milloff, and Pam Hayes, smoothly and wonderfully organized both presentation time and opportunities to get to know each other, generously ending the visit with a warm reception and dinner at the home of John and his wife, Donna Bender. Our program, Looking at Psychoanalytic Diversity and Controversy: Enactment in the Treatment and "In Treatment," which I co-chaired with John Rosegrant, engaged the audience in a discussion of two papers, first an overview by Helen Gediman on controversies currently in the forefront of psychoanalytic theory and treatment, and then a clinically illustrated paper by Batya Monder on enactment as a ubiquitous but still undefined aspect of treatment. In addition, Gemma Marangoni Ainslie and Jane Kupersmidt presented and analyzed enactment scenes from the HBO series "In Treatment," and led a discussion of the representation of analysis depicted there. The event was well attended, and we made a number of new good collegial friends in Tucson. They are a vibrant and serious group.

More recently, on November 20th, I had the pleasure of a special invitation by the Argentine Psychoanalytic Association and their "Comision de Cultura" in Buenos Aires, to present my work on the "Psychopathology of Love

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