

## A Centenarian's Retrospective on Psychoanalysis -

### An Interview with Hedda Bolgar<sup>1</sup>

Interviewed by Michael J. Diamond in Diamond, M. J. and Christian, C. (Eds., 2011).

*The Second Century of Psychoanalysis: Evolving Perspectives on Therapeutic Action.*

London: Karnac Books.

#### **Biographical Sketch<sup>2</sup>**

Hedda Bolgar was born in Switzerland on August 19, 1909. She was the only child of two influential parents; her father was a social activist, history scholar, and diplomat representing Hungary, and her mother was the first female journalist on the staff of German language newspaper in Budapest. Her family's political position was considered controversial, as her mother was a feminist and socialist, and her father was involved in aiding the start of the Hungarian Revolution in 1918.

Bolgar completed her Ph.D. at the University of Vienna in 1934, taking psychology courses with Karl and Charlotte Bühler, studying infant observation and life cycle development, and gaining exposure to the group of Vienna psychoanalysts involved with Freud including Heinz Hartmann and Rene Spitz.

In the mid-1930s, Bolgar and Liselotte Fischer, who were close friends as well as psychoanalytically-oriented clinicians, collaborated to develop the "Little World Test" (also known as the "Bolgar-Fischer World Test", see Bolgar & Fischer, 1940). The test was developed as a nonverbal projective instrument through which a clinician could observe symbolic representations of human motivation, selection and creative behavior.

In 1938 at the age of 28 and already a strong public critic of the Nazi regime as well as being actively involved in anti-Nazi politics, she feared for her life and fled on the very day of Hitler's arrival. Upon arriving in the United States, Bolgar began a postdoctoral fellowship at Michael Reese Hospital in Chicago, in order to obtain her analytic training. At the time, she was the only woman in the Department of Psychology at the University of Chicago. While living in the Midwest, she gave training workshops in the use of the "Little World Test."

Leaving Chicago for a research position, Bolgar moved to New York for two years, where she arranged for her family and fiancé to immigrate to the United States. Unfortunately, she was unable to help her future in-laws, who perished in concentration camps at Auschwitz. After marrying in New York, Bolgar and her husband, Herbert Bekker, returned to Chicago in 1941.

Bolgar took a position on the faculty at the University of Chicago, and a few years later, she credits Franz Alexander for helping her gain entrance to the Chicago Psychoanalytic Institute. She subsequently became the first candidate with a non-medical degree to graduate from the Institute.

In 1954, Bolgar moved to Los Angeles and gained employment as a psychoanalyst/psychologist, soon working at the Psychiatry and Behavioral Neuroscience Department of Mt. Sinai Hospital (today Cedars-Sinai Medical Center), chaired by Franz Alexander. In 1970, she cofounded the Los Angeles Institute and Society for Psychoanalytic Studies (LAISPS) because she felt that Los Angeles offered insufficient training for non-medical analysts.

Her husband passed away in 1973 after 33 years of marriage. One year later, in 1974, Bolgar founded the Wright Institute in Los Angeles, a nonprofit mental health training and service center that today includes the Hedda Bolgar Psychotherapy Clinic, which treats people who can't afford quality mental health services elsewhere.

Bolgar continues as one of our profession's most accomplished and creative members having trained hundreds of psychoanalysts and psychoanalytically-oriented clinicians. She has been teaching and practicing psychoanalysis for more than seventy years. Her current interests focus on aging, feminism, political activism, and psychoanalytic training and practice (e.g., Bolgar, 1999, 2002, 2009).

Today, Hedda's comfortably elegant West Los Angeles home in Brentwood continues to serve as a welcoming center for many of LAISPS and the Wright Institute's functions. She currently hosts a salon on the first Wednesday of the month for colleagues to discuss a variety of topics ranging from clinical and theoretical psychoanalytic issues to the psychological implication of social problems (see Hollander, 2010). When recently asking Bolgar as to what accounts for her boundless energy, Hedda's answer is, as Hollander (2010) noted,

... always the same: "Diet, I've been a vegetarian for 85 years." And then she (Hedda) adds with a twinkle in her eye but quite seriously, "Oh, yes, and being engaged in the world, always fighting for the truth." [p. 2].

At the age of 101, Hedda balances a deep wisdom with an appreciation of the joy in life. She remains a practicing psychoanalyst who sees patients several days a week, supervises, teaches and lectures nationally. In concluding our interview for this chapter, Hedda noted that she still loves doing psychoanalysis but that she regrets that "really the

only bad thing about being old is that I can't start anybody new except for very brief consultations." And then adding, in her own inimitable fashion, "you live with that .... it's not tragic, that's the difference it isn't tragic, it just is!"

## **Interview**

MD: *It's such a pleasure to be able to do this with you. We'll start with the historical influence on your work.*

HB: I was fortunate in coming to psychoanalysis at a time when psychoanalysis meant the theories and techniques of Freud. I read the four-volume "Collected Papers" and enjoyed both the richness of ideas that were all new to me and also Freud as a writer. That was long before I thought of becoming a psychoanalyst.

Academically, I came from psychology and anthropology and the only course in psychotherapy available at the University of Vienna in Freud's city (and mine) was taught in the department of urology. Why? Because it seemed there was somebody in the medical school who thought that male impotence might have something to do with the mind.

Eventually, the political events in Austria brought me to the United States and to clinical psychology, projective diagnostic techniques and re-reading Freud. And finally as a faculty member of the department of psychology at the University of Chicago, I was accepted for psychoanalytic training at the Institute for Psychoanalysis in Chicago. I was a "special" student because I did not have a medical degree.

Franz Alexander was the director of the Institute and his views on analytic theory and technique were of considerable influence in my early years as an analyst. However, I

had by that time attended seminars led by other analysts outside the Chicago Institute and I knew that there was considerable disagreement with Alexander's ideas.

### **Historical Issues**

MD: *I wanted to ask you about one of Alexander's main ideas and see how that might've influenced you. One of his ideas concerned the shortening of psychoanalysis.*

HB: Well, I think the really important issue was the battle about the corrective emotional experience. Which, I think, was largely misunderstood, but it really contained the essence of what he believed psychoanalysis was to become. I think the whole thing of flexibility, the non-orthodoxy, the idea that individual people and individual situations required individual treatment. Most importantly, he stressed that you should really understand the individuality of the patient.

As for the shortening the analysis, I don't know if there is such a thing as a short analysis. There is short psychotherapy, psychoanalytic psychotherapy, but there is no short analysis. The difference, I think, is important to keep in mind. There are different things you can do. You can solve problems, specific problems anyway. In psychoanalytic psychotherapy, you can certainly make symptoms go away. You certainly can help with maladaptive defenses as long as it's more or less limited to a certain type of pathology. But, psychoanalysis requires time. I don't think it can be shortened.

MD: *Some would say that analyses have gotten longer over the years.*

HB: Yes, they have gotten longer because we know more and because we will analyze people who, when I started up, were considered not analyzable. I haven't heard the

discussion about people who are not analyzable in a long, long time except for control cases of candidates. But, I think psychoanalysis takes time.

MD: *With a much wider spectrum of patients?*

HB: Wider spectrum of expectations. In psychoanalysis I think you're talking about a total makeover. It's not just solving one problem or two problems. People often come in with one problem, ...but as the exploration goes on the patient's whole life becomes involved. So it takes a while.

### **Influential Figures**

MD: *Who would you say is most influential on your work today?*

HB: I don't think any one theorist really. It's very hard to answer that. Everyone has been influential in a way. The so-called orientations (which I don't see as orientations), but I've always welcomed changes, just because well, no matter how wonderful Freud's contributions were, there are holes in his system. And, I always feel that with every new person who has emphasized one particular aspect and added to it, and developed it, we have gained. It's not disagreement with the original standard Freudian psychoanalysis, but I think everybody should welcome creative expansion and value innovation. I know the excitement I felt every time I learned about a new emphasis in psychoanalysis or a new "orientation." It was a gain. It wasn't like having to give up something. It was not an either-or, it was and, and, and.... It just made one's work richer and more effective, perhaps, and helped one grow as a person and an analyst.

MD: *Well, as you've observed these trends then over the years what makes you feel most hopeful about the future of psychoanalysis?*

HB: That psychoanalysis isn't static. It's not ... it's not a collection of what you cannot change out of veneration for the founder. I think the very flexibility of it, the openness to new ideas and to explorations. Psychoanalysis today is much richer. It is harder to imagine psychoanalysis without Klein, Hartmann, Kohut, Fairbairn, Winnicott, Bion, Lacan.

MD: *What gives you pause about the future?*

HB: Partly, the seeming forgetting of the original incredible discoveries of Freud. Partly the almost neglect, and even hostility to the whole idea of the unconscious. I think that was probably the greatest thing that ever came out of psychoanalysis. I also like the emphasis that not all of the unconscious is repression, but the unconscious that also happens to be there because you can contain just so much. A great many passing experiences may or may not become relevant at some point; [they] are not a matter of repressing.

MD: *It's not the dynamic of it...*

HB: It's not the dynamic, it's just somewhere there is a limit to the human brain and that things do come up, but they're not necessarily conflict. I have a feeling that psychoanalysis will last forever because you will just discover new things all the time.

### **Kinds of Analysts**

MD: *You've sort of answered this, but I'm going to put it to you again. What kind of analyst do you consider yourself to be?*

HB: Well, I've always thought that ideally you should leave everything outside the door of the office; your own past, your own authority figures, your analyst, your supervisors,

your institute and your referral sources. The “here and now” is a very valid and important concept. So is Bion’s “Without Memory and Desire” up to a point.

MD: *Do you believe though that you can leave that out of the room?*

HB: You can leave your own values out of the room at least as far as they are conscious. You can leave your own needs, to a large extent, out of the room. You can try and really listen and be what I used to call, “alone with the patient” and let the patients bring their past and their family and their important figures in. But, yours should preferably be outside, so that you can really concentrate. You can really listen; you can really be there. And let your own reactions at the moment be available.

MD: *Would you encourage someone to go into psychoanalytic training today? Assuming you would, what kind of person would you encourage?*

HB: Well, I think that what you need to do to be a really effective analyst is to have a very rich life yourself. When I think of my classmates from the Institute who came out of medical school, it was pretty much the same social, economic background, with very little awareness of the variety of the world, and who may or may not have had some additional interests. But their life seemed very limited. And I don’t think that helps because it’s hard to understand the patient, if you haven’t been somewhere there yourself. I have always like (Robert) Stolorow’s formulation of searching for the analog when the patient talks. Search your own experience and connect with the patient’s experience that way, so there is a readiness for identification. And it’s hard to identify if you haven’t had a lot of experience of great variety yourself.

MD: *Which certainly argues for having experience in the world before you go into analytic training, not the coming right out of medical school or graduate school.*

HB: Not unless you've had a really varied life, some people do. People who have had to, let's say, forcibly emigrate, leave their countries, leave their culture in their teens or later. Somebody did research on "normal people" and they turned out to be very boring and very dull. And, so I think a certain amount of abnormality in one's own life experience is a great help. Without that I think you get restless, you get bored, you get burned out. You're just not really fully there.

The other thing is language. Increasingly, I believe, we analyze patients whose "mother tongue" or original language is not ours or not the language in which the analysis is conducted. I think that a great deal of affect and unconscious communication is lost that way. When I analyze a patient with whom I do not share his or her first language I ask the patient to relate the significant events in their mother tongue. If I do not understand that language I ask the patient to translate later. That way the patient stays in the original experience.

I once listened to a colleague present his work with a patient whom he described as very difficult because she did not seem to connect with him. She would just talk without any feelings. In the history he mentioned that she spoke many languages and had lived in many different cultures. I asked my colleague which was her first language and he said he didn't know. I asked him if he knew what language she had spoken with her mother when she was very little. He became a bit irritated with me. He said, "I only speak English so why would I want to know all that?" I suggested that if he asked her to

talk about some important memories in the language that she spoke at the time she might develop some emotional connection with him.

### **The Psychoanalytic Process**

MD: *Let me turn then to another area we want to explore. That is, your thoughts about the psychoanalytic process and in particular what is it that makes for a psychoanalysis as opposed to a psychoanalytic psychotherapy?*

HB: As I said before about psychoanalytic psychotherapy, I think it is essentially problem solving, whereas psychoanalysis is the total exploration and remaking of one's self.

MD: *And can that be done in what some might consider more of a psychotherapeutic framework once or twice a week, for example?*

HB: Yes, it can be done once or twice a week with the right person. That depends really on the analyst of course, but also on the patient. There are patients who really do well with less than the standard 4 or 5 times per week. I've had those; I've had patients who've done a tremendous amount of work, psychoanalytic work on their own, in between the hours. Once-a-week I don't think is enough, but twice-a-week can be enough. I've had one patient who said, "I couldn't do more...process the hour and I need an extra day or two to do that. If I came every day it would all pile up, it would be too much and I wouldn't be able to deal with it." So, I thought there was a lot of truth to that for some people. Some people would walk out of the analytic hour and it's gone until they're back; and other people process it, quite consciously. It depends.

MD: *Would you be able to describe a case that captures something of how you work?*

HB: There are a number of issues there. I would like to tell you about one patient about whom I have never stopped feeling guilty because I followed analytic technique instead of following my own feelings and wishes. It was a patient whose mother died when the patient was 18 months old. She had one child and then developed cancer. She was told not to get pregnant again because it would be very dangerous for her health. She decided she wanted a second child and she got pregnant and she had my patient. My patient never really had a mother. Mother was constantly in and out of hospitals, in and out of the country searching for cures. My patient had a vague memory of a big house. Everything was white and there was a long corridor and she was taken to her room and there was her mother in bed and she was told to say goodbye to her mother. So, she said goodbye and she was convinced, as she said, the hole in mother's breast was her doing. She felt terribly guilty. Father didn't know what to do with the two children after mother died and sent them to his family in Europe to a country in which the language was very different from English. The children didn't know the language. The older sister was taking mother's place in a way. The patient became mute. She didn't talk at all. She was totally devastated from the loss of even a mother who wasn't much of a mother. She felt she was among strangers. She was a stranger and the only person she could relate to really was this one sister. Gradually things became a little better. Father re-married and the two children returned to the United States, to a well-run, caring household.

My patient developed a career. She was very creative. She was an artist. She did very well. She was a high functioning person with a trend towards being an alcoholic, but it didn't interfere with her profession and her creativity.

She was chronically depressed. Not suicidal but really depressed. Life was just negative. People were negative. Everything was basically dangerous and bad. She was in analysis and after 5 years she said to me, “The first three years I didn’t hear a word you said. I didn’t know what you were talking about. I only listened to your voice. I came to hear your voice.” I said, “How is it now?” “Now, I can listen to what you say,” she replied. But, she did something that I then called the waking dream. She would go into a dream-like state on the couch and she was almost always ending up in dark slippery dirty places and she was desperately looking for something which she couldn’t find. And, I figured she was looking for her dead mother.

One day, she was lying on the couch and she was very restless. She said there was something strange happening to her. I was inside her body. No, she was inside my body and she was being born and would I hold her. I sat down on the top of the couch and I put my arm around her shoulder and it was a long journey and a dangerous journey and eventually she was born and now she had a mother. She was very happy. She gave herself a new name, which in translation meant reborn. We didn’t have anything about “born again” in those days. It didn’t mean anything of that sort. She was a lesbian. I knew that all along but it had not entered into the analysis at that point. She left very happy. She came back the next day and she wanted me to hold her again and she wanted me to sit on the couch with her, lie on the couch with her, whatever. And here is where I committed probably the gravest mistake in my analytic practice. I wouldn’t do it. I couldn’t decide whether this was the beginning of a lesbian seduction or really she was the one-day old infant that she said she was. She said, “You know I’m only a day old. I’ll grow up, don’t worry. I will grow up, but right now I’m an infant and you’ve got to

treat me like an infant, you have to hold me.” And I made the wrong decision. I said maybe we ought to continue with our analytic work. She stayed in analysis a long time. She continued. We resolved some problems, but she never lost the depression. It was better, it was less self-destructive, self-defeating. She found a life-long partner later on, but she never lost the depression but instead of being depressed, she started to develop a number of psychosomatic illnesses. And she never was as happy as she was on that first day after she was born. I think it was a mistake. It was too early in my life, in my career, and I fell into the frame.

MD: *How did she experience your holding the frame that tightly?*

HB: I talked to her later about it, one day. And I said I really have been wondering all along and I really felt I did not do the right thing. She had become a therapist actually and along the way, an analyst. And, I reminded her when she had forgotten the whole episode and she looked at me and she said, “Well, I would’ve done what you did. I wouldn’t hold the patient.” So she had forgiven me in some way, or had identified with my mistake.

MD: *And you think if you had held her it would’ve made for a very different outcome?*

HB: I think so. (I think so.)

MD: *um hm*

HB: Today I think so. So that’s it. I was thinking that that sort of situation never came up again. I don’t know whether I am careful to not have it come up, or whether I can now be a “mother” to a patient without holding her, I don’t know.

MD: *Well, and of course you’re suggesting that it was earlier in your career.*

HB: It was earlier.

MD: *Your training, your supervisors, your psychoanalytic superego, they all played a part.*

HB: I was still using Alexander's couch, which I somehow inherited after he died. I still believed in one kind of frame, which actually was not Alexander's frame.

MD: *Interesting.*

### **The Analytic Frame**

HB: In the meantime the frame has become a little more flexible. One day I asked myself if that frame is a wonderful thing what's it made of?

MD: *What was your answer?*

HB: Well, I said it isn't iron and it isn't very hard wood, it's something that is more like rubber, something that's flexible that will bend with the need.

MD: *And of course that always brings up that kind of touchy area, no pun intended, concerning how flexible you can be.*

HB: What is essential and what isn't, that's really the question. And I think that what is essential is part of the analysis, you have to know a patient well enough to know what's essential. And you have to be able to let the information come to you, from your own inside and from the patient. When the patient objects to something, it's not just resistance. I think resistance is an over-rated notion anyhow. I never use it -- I say it's self-protection, so that it has to come from the patient. For one patient, it's all a terrible constraining thing, for another patient it's very welcome because they come from a chaotic, dysfunctional background and any order and any system and any regulation is welcome. And that's the corrective emotional experience. Patients need some things,

they want some things, and they don't want some things. And you have to understand what that is and what it means.

MD: *And you're suggesting with the patient you described that you did know her well enough, but that you didn't trust yourself?*

HB: Absolutely. It was breaking the rules; it was violating, it was breaking the frame. I don't think it was threatening me particularly, but the patient was using an experience from yesterday to exploit it for her unresolved needs. It was always the patient, remember, it was never us.

### **Therapeutic Action**

MD: *The theme I'd like to pick up on now is the idea of therapeutic action. Why don't we start with your thoughts about the goals or aims of psychoanalysis?*

HB: Well, I don't think there are any concrete goals and I don't think there are any overall universal aims. I think it all depends on who the patient is, who the analyst is, and what's possible and what's needed or what's needed and what's possible. Um, I hardly ever think of psychopathology anymore. I think of the total existence of a patient and I think that whatever they bring in makes sense somehow. It has a reason, [and] it helps to discover the reason. It helps to really understand what's going on. Why the patient is here. What he or she expects or needs. How much or what you can do as an analyst. So it's a total understanding, but not just a simple understanding of one feeling or one reaction or one trauma, but really to understand the total existence of the other. And that takes time, it takes a certain amount of knowledge and a certain a kind of broad perspective on life, it takes a respect for the external reality of the patient.

I think it has been a problem in psychoanalysis until relatively recently and there are some notable exceptions. People who are really aware of the fact that people don't only live in the childhood family and they don't only live in their adult relationships or the lack of it, but there is a whole social and cultural life that people live in and that we somehow have to also understand and understand the patient's place in it. So it's a very complicated thing. Perhaps if there's one word that conveys what I hope patients will get out of the analysis, it is "liberation" -- a sense of real freedom. A sense of self-determination, a sense of knowing oneself, of accepting oneself, of accepting other people. Empathy is sort of a word that's being thrown around an awful lot and it has become a technical term almost, but actually if you go to the origin of the word, it is really suffering with. It takes some respect for the patient's suffering and a capacity to identify with it, even if it really is not part of your own life.

It raises the question of the similarity or difference between the patient and the analyst which is a very interesting and very complicated question. How similar do you have to be, how different do you have to be? How able are you to really deal with and accept and respect and get to know the difference?

### **Differences between patients and analysts**

MD: *Let's get back to the idea of difference, and how you're able to navigate the idea of difference, particularly if someone's difference is troubling for you?*

HB: O.K. One day, a young man came in. I forget how he was referred to me. He came in. He was at a loss. Things were not going the way he wanted them to. He was fired from the police department because he was too violent. And that takes some violence, I

guess. He was carrying a gun all the time and driving around the freeways, hoping he could catch “some nigger” doing something wrong and shoot him. He slept with a loaded rifle, hoping somebody would break in so he could shoot and kill him. And he looked at me and he said, “I don’t like doctors and I don’t pay my bills.” And I remember saying to him very quietly, “You’ll pay mine.” And he said, “Wow, you think so but I know I won’t.” He told me that many times, that’s all he was talking about, how angry he was and how the world wasn’t treating him right. I was listening. I hardly ever said anything and one day I decided to make one intervention. And as he was raving about “the niggers” and everybody else who was doing wrong things and the police department guy who fired him because he was doing his job. I said as quietly as I could, “You must’ve had a terrible childhood.” And he looked at me and he burst into tears and he said, “How did you know? I never talk about that.” And I said “Yes, I noticed that.” And everything changed. Everything changed totally. One comment and everything changed. But the fact is, everything changed. He found a girlfriend who was really lovely, who made him pay his bills, who helped him with everything, who didn’t criticize him no matter what he did.

*MD: What was it in you that allowed you to overcome whatever disturbance you were feeling when you were hearing about his violence, his racism?*

HB: He was my patient and really different from me. He’d had a terrible life and then he told me about his terrible life, it really was terrible. I mostly felt compassion for him.

And I was lucky because I never knew such experiences.

### **How psychoanalysis works**

MD: *I wanted to ask you about how psychoanalysis works, along with the theme of the book, of course. How do you think it works, and why doesn't it work for certain patients?*

HB: It works I think primarily because it's not a repetition in the reliving of the past only. Mostly it's different, because it happens in a relationship that is like no other. Because it's new, ... because it's something that never happened to them before. I think you need to certainly go over the past and to look at the past together, but even in the looking at it together, it is different from the way it was when it happened. Because there is somebody who cares about you, there is somebody who wants to know, there is somebody who doesn't judge. There is somebody who really wants to be with that child that is abused or non-understood, or neglected, or over controlled, or whatever it is, or intruded upon. You really have to go through it. But you go through it, [and] by going through it, it changes. The difference is [one] now becomes an adult. The ego psychologists are big on that. That was the Chicago phrase: "that was then, and now you are an adult and you can cope with it." Well, you're not much of an adult maybe, but you have somebody who looks at it with you [who] is sympathetic and understanding, and doesn't judge you. I think those things are still very important.

MD: *It's very much along the lines of what Strachey wrote about.*

HB: Yes, I think that's valid. I think that every single one of those things, the absence of traumatic experience, the presence of a caring attuned person matters. But it takes a longtime for the patient to really trust that. And then we go back to Erikson and "basic trust." The analyst has to be really trustworthy. And you have to demonstrate that for a while to sink in, so that's why analysis is long.

MD: *And when it doesn't work?*

HB: When it doesn't work it's because one of those things are not there. Because with an analyst who is not *alone with the patient* and *with the patient* (*alone* is important just as *with* is important), can't be as helpful. An analyst I think who values his difference and who prefers his experience to the patient's experience and stays there ... conveying, "You should be the way I am" -- that doesn't work.

### **Interpretation versus Relationship**

MD: *We're getting back to how analysis helps a patient. Well, I have an idea of what you're going to say here, but I want to give you a chance to talk about the dichotomy that's often made in psychoanalytic thinking about the role of interpretation versus the importance of the relationship. What do you think?*

HB: I don't know why psychoanalysis loves these either-or statements. Of course both are important and there's no question in my mind. I don't like the word interpretation because it really means I know something you don't know. I usually call it intervention and sometimes it's a clarifying intervention and sometimes it's a reminder of something. We can describe whatever the intervention is, but of course it is in the relationship. And there's no question that you say things to a patient in a situation in an analytic hour that is different from what you say to your friends or what you say to an acquaintance or what you say to a child. So, it is very much part of the relationship as it exists between two specific people. And it's a very specific intervention each time you make it. But it's not often the "ah ha" experience because you now have said something totally fitting and real.

MD: *You are more dubious as to the so-called "magic" of interpretation?*

HB: The magic of interpretation and the fact that there are things that are endlessly repeated. The patient repeats it, relives it, retells it. You may say the same thing in different words and different aspects of whatever it is the patient talks about. Very often it's really a test of the degree of the analyst's understanding. Sometimes you're wrong. Maybe you're not wrong, but for the patient at that moment you are wrong. Is that helpful? You're lucky if it isn't hurtful. And that's the struggle that goes on between patient and analyst. Sometimes, you think you know something and the patient can't let you know it. Can't let himself or herself know it. It's too painful. It's too reminiscent of the real suffering. There are many reasons why interpretations really can be good or not so good. So, you have to be careful with it. And the relationship really governs the interpretation.

MD: *What do you think of the idea of the so-called 'deep' interpretation?*

HB: Well it better be deep or it doesn't make any sense. I mean what does deep mean? Deep means that so far it hasn't occurred to the patient. And so it's something really new and it may be challenging depending on the relationship -- maybe something worth thinking about. It may come up again and again and again, in a memory, in a dream, in the transference, in the so-called enactment. It comes up in a variety of ways and so should the interpretation vary with whatever comes up. It should not always be the same. I think interpretation tends to be repetitious. Sometimes it has to be, but again, if we can adapt it to the content and the feeling and the quality of the memory as it comes up, it's more effective than if it's just the same interpretation over and over again.

MD: *Some analysts say that the deep interpretation, the deeper interpretation emerges from an experience that the analyst is having with a patient.*

HB: Yeah, absolutely.

MD: *As opposed to it's deriving from theory, or .....*

HB: Absolutely, that's the way everything you say should come. I really think theory is a something you refer to when you don't know what's going on. It's an aid. It's really an aid and there's nothing wrong with trying to understand theoretically what a patient's association might mean. You can think about it, but those are the times when your own insides aren't working. It's a lot better if you wait and see what comes up in you. I have always felt that there was what people now talk about, the unconscious communication; the patient's unconscious to the analyst's unconscious and vice versa. We are really motivated in our expression when this communication takes place.

MD: *I want to ask you about Freud's pessimism late in his life, in "Analysis Terminable and Interminable." And of course that essay was before countertransference was acceptable and understandable and an important source of data. So, I'm wondering, as you are in the latter stages of your life and your career, do you feel any pessimism about the future? And, how do you understand Freud's pessimism?*

HB: Well, Freud was still a medical man. He still somehow thought about cure. He still thought about fixing something. Analysis would somehow fix something rather definite, I think. Not just make life better, make the person liberated. End up the analysis with a sense of self that's positive and gratifying. I think he still had a feeling that there was a goal to each analysis and that that had to be met. In a way, the pathology had to be removed. And that makes for pessimism. Because you know sometimes what we call, what we used to call pathology, is not terribly harmful, it's part of the character, part of the person's experience, and certain experiences make for certain development. I am

referring to personality's character, the real person. And sometimes that can't be changed and doesn't have to be changed.

MD: *Well, I think what you're really saying is that in analysis we can develop a different relationship to our psychopathology.*

HB: Yes.

MD: *It doesn't necessarily get rid of ....*

HB: No, no and it may not be psychopathology.

MD: *Yea, right.*

HB: I mean what is 'pathology' is a whole other thing. And I don't really think in terms of pathology anymore.

**Termination: Can you ever really go back?**

MD: *Well, that being said, then, what do you think of when you think about the notion of terminating an analysis?*

HB: I don't terminate, the patient does. And then we talk about why.

MD: *So you wait until it comes from the patient.*

HB: Yes. I remember one patient who I thought really was ready to go. Some things had changed and some hadn't. He was doing really well and he was lying on the couch and it was one office where the couch was parallel with the door and suddenly, I noticed that he was always looking at the door. Not always, but in certain parts of the hour he would sort of turn towards the door. And so I said at one point, "are you thinking of leaving? You are looking at the door." Now I could've said, are you afraid someone's going to come in? But what I thought was my association to it -- was he was looking to escape, while he

was looking at the door. And he said, “Well, uh, I guess maybe I have been thinking what it would be like if I didn’t come anymore.” So then we started talking about what brought that up. Why and how and what did he think it would be. Gradually you set a time and you allow plenty of time. That’s another thing.

MD: *What criteria do you look for to make a decision that it’s in the patient’s best interest?*

HB: Well, I would sort of listen to my reaction to it. At some point I would think that it’s an escape, at some point maybe I would even think that he was also looking at someone coming in, maybe someone to rescue him. Maybe somebody to attack him. Maybe going back over the entire experience, how more liberated does he feel now than he did when he came? Where does he feel like he can really act and do and say and be himself and accept himself and be accepted, feel accepted? So, termination is a very mutual review of something. It’s not just saying goodbye.

MD: *It’s an unfortunate word, “terminate.”*

HB: In Chicago we didn’t use it.

MD: *What did you use?*

HB: Interruption.

MD: *Oh.*

HB: We also assumed that people would come back.

MD: *I was going to ask you about that. What do you think of Freud’s idea that every five years one returns to analysis?*

HB: Every five years (said simultaneously). Well as candidates we were told to re-read, Freud every five years completely. Which I thought was a good idea.

MD: *It's a very different book every five years.*

HB: It's a very different book. It's a very different book after 40 years. But, analysis my own personal experiences, I knew I should've gone back. When I left my analysis, I said we only scratched the surface -- it was a pretty good ego-psychology, psychoanalysis. It was. My analyst had a very interesting idea that I've sort of agreed with it more or less. She said that the transference can only be resolved in the friendship with the analyst, a post-analytic friendship. I said that seems to be working for candidates who grow up in the Institute and stay in the Institute and eventually we sit in committees, and disagree and in the meantime, we have season tickets together. And (laugh), we never talk about the analysis anymore. No matter what we think. And sometimes we go back and sometimes we don't and I was very clear that I could not get myself to go back and live through another transference. It was too hard and too painful. I just didn't feel I wanted to do it again.

MD: *It seems that many analysts, experienced analysts, still carry some sense of shame though about the idea of going back.*

HB: That's because they were raised when pathology was 'bad' and it was supposedly resolved -- whereas going back means that I'm still 'pathological.' That never bothered me.

MD: *As if it were a failure.*

HB: No, that never bothered me. But I would really have loved to go back to a very contemporary analysis -- an intersubjective one.

MD: *What would be different about that?*

HB: Oh, everything would be different. I would say all the things I didn't say in my original analysis.

MD: *Why wouldn't you have said it in your original?*

HB: Because I was in an Institute. It was a non-reporting Institute theoretically. But, I was a special student. I had to be really on my best behavior.

MD: *So you are really bringing up one of the problems with training analysis per se.*

HB: Absolutely. There is an education committee, there is a progression committee ...

MD: *Sure ....*

HB: Your analyst walks out of it, but...

MD: *And you're going to have to live in the same world [with your analyst] .... so part of what you're saying is that it's a lot harder to bring out the negative transference in the training analysis.*

HB: Absolutely, and things that you are ashamed of about yourself.

### **The Real Person of the Analyst**

MD: *Sure.... I want now to bring it to the heart of what you originally suggested that your interview-based chapter might be about, which is the "real person" of the analyst and the patient-analyst match. So, first of all could you say a little more about what you mean by the real person of the analyst?*

HB: The short form of that is: everything other than analytic theory and analytic technique. That's the short form. And the long form is everything that the analyst has experienced early and late and is experiencing in relationships, interests, participation in society, appreciation of the real life of both the patient and the analyst. And the space,

the social space they live in, the allowing of social issues to enter into the analysis. I always say that when a patient comes in limping for six weeks and doesn't mention it, eventually, you will say, "I noticed you are limping and you haven't talked about it. What's that all about?" That's a legitimate question. But I say, what do you think of Bush? It's not a legitimate question. In my waiting room there are a bunch of magazines and I remember one young patient who walked in here one day and he looked at them and said "If my dad knew what you are reading, he wouldn't pay for my analysis." That's the real analyst.

MD: *That's quite a change from the old blank screen idea.*

HB: Absolutely, the blank screen was really I think the undoing of analysis for so many years. You can't be a blank screen. You are not a blank screen. You sit here for 50 min. or now 45 min and things happen in you all the time, you have thoughts, you have feelings, you have bodily reactions. So that's the you. And you have them for good reasons. But also, I was thinking of (Christopher) Bollas the other day. I was reading one of his case histories where he made a wonderful interpretation on the basis of King Lear and Hamlet, the fact that he knows Shakespeare as well as he does is part of the real person of Christopher Bollas. When you read, Grotstein's book about who is the dreamer, it's full of classical education. It's full of knowledge of a lot of things in the world. When you think of Kohut and his self-psychology and all the rest of it, he also was really consumed with music. Music was an important part of his real life. And I'm sure it entered into how he worked. And what he associated to. I think what we associate to during an analytic hour when the patient talks about whatever they do, is part of our personality -- it has nothing to do with theory. Sometimes it has to do with theory.

Sometimes we will think “Oh yeah, Klein said such and such. And do I want to use or don’t I want to use it?” But, and sometimes, you remember what you were taught about boundaries and do you want to use it or don’t you? And whether or not you want to use it has to do with who you are. So, it’s there all the time, it’s basic. When a patient tells me “You are so contained. You sit still. You look at me. Your face hardly ever shows any expression. [You are] so contained.” Well, is that good or bad, (laugh) and is it true? And am I really that contained? Well, maybe with that particular patient during a number of hours I am because it’s necessary and that’s my judgment that it’s necessary and that’s also comes from the fact [of] who I am.

MD: *You’re talking about the analyst’s subjectivity now.*

HB: Yes.

MD: *As an instrument of the therapy.*

HB: Absolutely. It is an instrument if it’s used with a certain amount of permissiveness (within ourselves). When it isn’t, “I mustn’t think about that I’ve got to listen to the patient.” Well, I listen to the patient really carefully and this is what comes up in me. And is this me, [who has] learned the theory? Or [who has] been trained in a certain technique? Or is it me, [who has] lived in a lot of different cultures and a lot of different languages, and social changes? Is it the me that has political opinion? Is it the me that has been interested in Buddhism? Which me is it? Is it the me that prefers the stage to movies?

MD: *You’re saying something that I think is a very important notion, the whole idea of what we go through in analytic training and then in a sense what has to be unlearned so we can be free to decide to be spontaneous with ourselves, to be permissive.*

HB: And, be able to see what's going on with the patient other than in a given [theoretical] framework.

MD: *Yes.*

### **What is a good match?**

MD: *I wanted to ask you about a kind of a match, the whole idea of the matching between patient and analyst and what makes for a good match, or at least a 'good enough' match?*

HB: I had one patient with whom I really failed and I think it was a bad match because he was a minimalist. He walked in here and he said, "My god, this is terrible." "What's terrible?" "All that stuff you have around." So I asked him what particularly bothered him. He said, "everything." I said, "What would be a good place for you to be in?" He said "I would want a whitewashed office, with a couch and one chair maybe two." So then he told me that he had a fairly high position in a big business. He lived in a totally substandard apartment. He told me he owned one fork and one plate. And he never turned on more than one light at a time. He never went on vacation. And after four years, well, he changed considerably. He bought himself a Porsche. And he built a house for himself in Malibu of all places.

I usually took a month of vacation. I don't know what happened in the first three years, whether those years I didn't take quite so long a vacation in the summer. I told every patient before we started that I take one month in the summer and I take two weeks at Christmas and two weeks during the spring so I don't know what happened. What

happened in the fourth year, I took my usual vacation and when I came back he left me. He would not even come back for the traditional one-hour to talk about it.

I thought he felt that I used the money he paid me to go to Europe and leave him. And, I didn't care what happened to him during those four weeks. And he said he had had it with me. And that was it.

MD: *But you said you'd failed with him? I'm curious about why you think that.*

HB: Because I did not see that my leaving him at that particular point in the analysis was different from the earlier times. I did not see that I was becoming important to him.

MD: *You feel you missed that somehow?*

HB: Yes. I somehow missed that. It was the timing more than anything else. I'm sure I took long vacations even in previous years, but he wasn't involved as he was then. I just somehow did not see that.

MD: *What would you have done differently if you had seen that?*

HB: I would have talked about it; I would've made him talk about it. I would've taken him back to the point where he thought he didn't deserve anything but one fork. More so than I did. I did, but I didn't do it in relationship to me. And I was delighted when he got that car, and I was delighted when he started building that house. And I thought we are really getting somewhere. He was still living in the substandard apartment.

MD: *Let me ask you about when you make a referral to another psychoanalyst. How do you decide who to refer to, what goes through you?*

HB: Well, in reality, I would like to give you a theoretical answer, but in reality, what I do is I never refer to anybody I have not analyzed or supervised. I really want to know

how they work. You know, people write beautifully, and they may not be such good analysts. So that's one thing.

MD: *You want to really know them.*

HB: I want to know what they do and I want to have heard it from them. And I don't want to see it in beautifully edited theoretical papers. I mean some people write beautifully, and some people are good analysts, and some people do both.

### **Analytic Curricula**

MD: *Let me ask you then, staying with the idea of the real person. What do you think is most useful for analysts who are going to read and listen to you talk about this? What is most useful for them to know that they can do in order to develop that 'subjective' person inside?*

HB: Well, they might want to expand their lives. They might want to do things that might be interesting to them. They might read a novel occasionally. They might um, well, what, go to a concert; they might even go to an opera maybe. They might decide to go to Europe on their vacation, or to Asia. Or to Africa. They might want to read different things than they have been reading. They might look at paintings. They might really read Shakespeare and forget that they had to read it in high school. I don't know.

MD: *Do you think of anything in a psychoanalytic curriculum might be changed to foster more of that?*

HB: Well, certainly there should be at this point, a course on growing old. I don't use aging, because we age from the day we are born. So, aging is a euphemism, it covers old. And when I talk about it, I talk about growing old. That I think is just from a practical

point of view, the population that we're going to see is going to be older. The other thing is, when I was a candidate at the Chicago Institute we had an elective course in Greek tragedy.

MD: *You are stressing the value of life experience and liberal arts education.*

HB: ... And humanities and history. And sociology and anthropology. It's tremendously important. It's really much more important than the medical background. And some of us knew that early.

MD: *Well, Freud wrote about that, didn't he?*

HB: Right, right. And I would add to it to have a richer life and a variety of relationships.

MD: *And you certainly model that as you continue to live life so fully.*

HB: So far, yeah.

MD: *Hedda, we're going to stop here. Thank you very much.*

HB: Thank you!

-----

## **References**

Bolgar, H. (1999). Regression, re-living and repair of very early traumatization.

*Psychotherapy in Private Practice, 17: 39-51.*

Bolgar, H. (2002). When the glass is full. *Psychoanalytic Inquiry, 22: 640-651*

Bolgar, H. (2009). A century of essential feminism. *Studies in Gender and Sexuality, 10:*

195-199.

Bolgar, H., & Fischer, L. K. (1940). The toy test: A psychodiagnostic method.

*Psychological Bulletin, 37: 517-518.*

Sohi, S. & Rutherford, A. (2010). Hedda Bolgar. Retrieved January 1, 2011, from

<http://www.feministvoices.com/hedda-bolgar/>. Reprinted from *Psychology's feminist voices* (<http://www.feministvoices.com/>).

Hollander, N.C. (2010). *Uprooted Minds: Surviving the Politics of Terror in America*. New York: Routledge.

---

<sup>1</sup> This two-hour face-to-face interview took place at Hedda Bolgar's home on August 11, 2010. This chapter is an edited transcript of the interview. Edits were made to facilitate reading and understanding – such as making complete sentences, omitting disfluencies, and adding references that were mutually understood. We have minimized our inclusion of laughter, pauses, and overlapping commentary that characterized this lively interchange.

<sup>2</sup> Portions of this biographical sketch were used with permission from the website: <http://www.feministvoices.com> (see Sohi, S.& Rutherford, A., 2010).