Introduction: Moments of Waking and Reckoning

"*Now* What Do I Do?"

This book is about clinical moments of a certain sort – isolated instances in the course of an ongoing treatment that stand out because they present a clinical conundrum that leaves the therapist in a quandary about how best to proceed. The therapist's training along with his/her own clinical experience fail to provide much guidance about how to respond to what seems like a precarious predicament. Different options spring to mind, and much seems to ride on how he/she decides to respond to the situation at hand: A less than ideal intervention runs the risk of creating an unbridgeable rupture in his/her relationship with the patient; a more ideal intervention stands a chance of furthering the treatment by strengthening the therapist's bond with his/her patient. Under such conditions, anxiety rules the day, blurring the analyst's vision and making it hard for him/her to act in a clear-minded fashion. Maintaining or regaining the ability to think analytically when under fire is, in part, a product of the adequacy of the therapist's own psychotherapy or psychoanalysis, which helps him/her develop the ability to transcend the experience of being single-mindedly immersed in the emotions of the moment in order to think about the situation from a more distant and disciplined perspective.

This book is the outgrowth of the Clinical Moments Program that began in Michigan under the tutelage of Dr. Marvin Margolis, Training and Supervising Analyst at the Michigan Psychoanalytic Institute and Past President of The American Psychoanalytic Association.

When Dr. Lynn Kuttnauer, an analyst at the Michigan Psychoanalytic Institute, moved to Los Angeles, she brought with her the Clinical Moments Program, instituting it at the New Center for Psychoanalysis (NCP), where it is beginning its fifth year of operation. Each month, an NCP analyst hosts the program, inviting into their homes community-based psychotherapists, psychotherapists-in-training, psychiatric residents, and academics (anthropologists, sociologists, etc.) who are curious about psychoanalysis. Attendees are provided a meal, after which they are invited to participate in a discussion triggered by the presentation of a clinical moment in which a dicey situation has come to a head, leaving the treating/presenting analyst in a quandary about how best to proceed. Before sharing what he/she decided to do, the

floor is opened for participants to weigh in about their thoughts and reactions in response to the facilitators' instructions: If you were the therapist and found yourself confronted with this situation, how would you feel? How do you think you'd react? What would guide your thinking and your decision? What aspects of the moment did you consider salient? What sort of intervention do you think might best facilitate the unfolding process while also protecting the treatment? The goal of the exercise is to explore the range of ways in which therapists of every ilk think about the situation and think they might go about responding to the situation, revealing the participant's core beliefs about how therapy brings about change. While the presented moment lends itself to theorizing about how best to respond given the circumstances, in the final analysis determining how the treating had best proceed is frankly impossible. Facilitators work hard to help steer the discussion away from abstract theorizing about the case, which is largely considered irrelevant relative to the task at hand.

This volume contains a dozen such moments that had previously been presented either in Michigan or in Los Angeles as part of the Clinical Moments Program. In place of comments provided by the gathering's attendees, this book substitutes the responses of a roster of 25 invited commentators – outstanding, international psychoanalysts, each of whom has contributed substantially to the psychoanalytic literature. We refer to the book as the *Clinical Moments Project* to distinguish it from the *Clinical Moments Program* – the live, attended, monthly, in-home presentations of problematic clinical vignettes. The theoretical orientation of these master clinicians runs the gamut from modern ego psychologists, to Kleinians, to interpersonal psychoanalysts, to self psychologists – with a dash of Lacan, Bion, Green, Gray, Ferro, Winnicott, Fonagy, Ogden, Weiss & Sampson, and Kernberg thrown in for good measure. Half of our commentators serve on the editorial boards of major psychoanalytic journals (some serving as Editor-in-Chief or Associate Editors). Four were awarded the prestigious Mary S. Sigourney Award for Outstanding Achievement in the Advancement of Psychoanalysis. Our commentators are on the faculty at such prestigious universities as Harvard, Yale, Columbia, Rutgers, Cornell, NYU, and the University of London and while most reside in the States, practicing[1] in New York City, Englewood and Flemington (New Jersey), Boston, Brookline, and Lexington (Massachusetts), Bethesda, Philadelphia, New Haven, San Francisco, San Diego, and in Beverly Hills and Woodland Hills (Southern California), some commentators practice in London, Montreal, Bologna, and Jerusalem.

Each clinical moment is commented upon by two different commentators,[2] who were asked to comment on their assigned moment by answering the same sorts of questions listed in the previous paragraph. In most cases,[3] commentators offered their input without knowing how the treating analyst had decided to respond to the presented dilemma. The specific direction for commentators reads as follows:[4]

> We are hoping that you will react to the moment by reflecting on the situation at hand: What do you "make" of the situation? What does it bring to mind? What aspect(s) of the presented material strike you as salient, and why? What theories does the moment call forth? Which clinical experiences does it evoke? We are interested, first and foremost, with what the moment stimulates in the way of thoughts, feelings, and behavioral inclinations. Naturally, we are also interested in hearing about how you imagine you might have intervened, but that is secondary. Your chosen intervention does not throw into question the validity of the treating/presenting analyst's intervention, which was based on a somewhat different set of data that was then viewed from a somewhat different perspective vis-à-vis the material. We are also interested in hearing about how your imagined response to the situation is informed by your own theory of therapeutic action – how do you think your response might help further the treatment? In summary, we are interested in how you think and how you listen to the clinical material. What do you pay attention to, given that you can't possibly pay attention to everything? What guides your thinking and train of thought? How you think when you listen?

The roster of commentators includes (in alphabetical order): Salman Akhtar, Anne Alvarez, Rosemary H. Balsam, Rachel Blass, Stefano Bolognini, Fred Busch, Andrea Celenza, Susan Donner, Morris Eagle, Darlene Ehrenberg, Jim L. Fosshage, Robert Alan Glick, Jay Greenberg, Ted Jacobs, Judy Kantrowitz, Edgar Levenson, Joe Lichtenberg, Albert Mason, Nancy McWilliams, Robert Michels, Irma Brenman Pick, Dominique Scarfone, Donnel Stern, Alan Sugarman, and Mitchell Wilson. The Editors made efforts to assign commentators who would rely on different clinical theories to comment on the same clinical moment. We are indebted to these commentators, who've gone out of their way and rolled up their collective sleeves to help us out with this project.

We are equally indebted to those clinicians who generously presented their own clinical work and were subjected to the heavy editorial hand of one of the Editors (R.T.). The clinical moments that appear in this book have been contributed by analysts from both the New Center for Psychoanalysis in Los Angeles (J. Model Barth, R. Freedman, M. Gomes, L. Kuttnauer, J. Perkins, J. Smith, and R. Tuch – two moments) and the Michigan Psychoanalytic Institute (D. Harms, B. Kovach, N. Kulish, and S. Orbach). Presenting one's own clinical work is fraught with the dangers associated with exposing one's work to the potential critique of both readers and commentators, who – from the comfort of their armchairs – might imagine themselves responding to the moment at hand in a better way than did the treating/presenting analyst, which is a dubious claim to the extent that no one can know for sure how they'd respond if they were in the moment themselves. The advantage afforded the treating/presenting analyst by virtue of his/her having a first-hand

experience of the patient cannot be discounted nor replicated by those observing the process from a distance.

It is important that readers understand the influence that the Editors had in the preparation of this book. Dr. Kuttnauer, who heads up the Clinical Moments Program in Los Angeles, chose which moments would be included in this volume from among those that had been presented both in Los Angeles and in Michigan. The Editors collaborated in writing the *Editors' Introduction* that appears like an abstract before each moment. Furthermore, in certain cases, one of the Editors (R.T.) also penned some of the brief essays – *The Moment in Context* – which preface the moments themselves. Other than being provided help with editing what they had written, moment contributors had a relatively free hand fashioning the presentation of their work. The same applies to commentators who likewise had a free hand fashioning how they responded to the moment assigned to them save for the fact that some were asked to shorten their contributions, to conform to a strict word count limit.

Commentators' responses

One of the directions given to each of our commentators was to comment about how they imagine they might have *intervened* had they been in the treating/presenting analyst's shoes, which – admittedly – is a hypothetical proposition. The Editors recognized that such a request was unreasonable given the fact that commentators would be lacking the requisite experience of being viscerally in the room with the patient and, accordingly, would not be privy to the full expanse of potential data needed to know, with any degree of certainty, how they might have intervened had they been in the room. Accordingly, thinking that commentators are in a position to comment about how treatment *should* have been conducted, relative to how the treating/presenting analyst had handled matters, grants commentators undue authority. Despite this nagging limitation, we pressed on believing that our commentators' responses would still be of interest and might well prove valuable.

Our commentators' responses to the question "What do you think you would have done?" reflect the diversity of how psychoanalysts in general think about the task of conducting psychoanalysis. We had assumed from the outset that a significant number of commentators would continue to prioritize the *offering of interpretations* as their chief tool, with insight seen as the most efficacious method of bringing about psychoanalytically induced psychic change (making the unconscious conscious). This is epitomized in the comments offered by Rachel Blass (Chapter 2):

> The analyst's task is a limited one … It is not to respond to needs, to help attain designated life goals, or to improve the patient's feelings about herself or her coping capacities. Rather, it is to understand the

> unconscious dynamics of the patient's mind, the phantasies that determine how she sees the world and especially how she distorts it, including herself. It is to grasp what she doesn't want to know, the parts of herself that she has denied and split off because she has found them unbearable. And it is to convey these understandings to the patient in a way that allows the split-off parts to be reintegrated. In other words, coming to know unconscious truth is what is curative analytically.

Blass goes on to underscore that such insight is not meant to be gained didactically or to exist merely intellectually, writing: "It is because what's curative is not knowing *about* what's going on unconsciously, but coming to live it in an integrated way, that transference interpretation is, to my mind, the only possible analytic intervention."

There is general agreement that a patient's issues had best become actualized in the here and now – through enactments, transference reactions, and the like – bringing the patient face-to-face with his/her complexes on a gut level, thus ensuring that treatment is more than just an intellectualized exercise. Susan Donner (Chapter 9), writing in response to a clinical moment involving a 5-year-old boy named Adam who'd been treated in analytic play therapy, notes how the analyst's participation in play "was absolutely necessary for the meanings of the actions, symbols, roles, and affects to *come alive* and to help give meaning to previously unrepresented or sequestered … memories, fantasies, and internal states" (italics added).

Donner speculates that a play sequence might:

> allow Adam's terrors and traumas to be elaborated and re-experienced in a separate and different form, potentially less terrifying and toxic to Adam's experience of himself and his object … In an effort to master trauma, play sequences and enactments can operate as an opportunity to have a "do-over," as children call it on the playground.

The commentators' responses make clear just how hard it can be to demarcate related clinical phenomena: analytic methods (clinical approaches), theories of action (the mechanisms thought to account for psychoanalytically facilitated psychic change), and therapeutic goals (what is thought to result from successful analytic treatment). Our commentators' responses run the gamut, as would be expected of analysts chosen to represent a cross-section of analysts. Some prioritize certain sorts of interventions over others and they envision treatment resulting in different sorts of outcomes brought about as the result of an array of hypothesized therapeutic actions.

Some commentators think chiefly *intrapsychically* (Busch, Chapter 1; Celenza, Chapter 5; Scarfone, Chapter 7; Sugarman, Chapter 9), envisioning treatment – first and foremost – as resolving internal conflicts that had kept certain affects, memories, impulses, or split-off aspects of the self out of

conscious awareness. In this vein, Rachel Blass (Chapter 2) addresses the therapy-propelling effect that ensues when the analyst frustrates certain of the patient's needs, which the patient may interpret as indicating that they are bad or unlovable. This, in turn, unleashes murderous impulses toward the analyst, which – in turn – may trigger guilt, fear, and conflict over one's destructiveness. Blass goes further by offering an interesting perspective on the concept of empathic failures (the subject of Chapter 2): that the tendency to hold the analyst singularly accountable for behaving in ways that become designated as empathic failures *arguably reflects a short-sighted, one-person psychological perspective*; alternately, considering the same phenomena from a two-person, intersubjective perspective redistributes responsibility by envisioning the phenomena as co-constructed. This thought-provoking perspective on empathic failures places self psychology and the broader relational school in direct conflict.

Many of our commentators do not agree with the proposition that transference interpretations and insight are the quintessential curative agents in psychoanalysis. In Chapter 11, Edgar Levenson notes:

> Of dynamic formulations, there is no end. There is never a clear priority amongst often mutually exclusive perspectives on events. The mutative impact may come more from the expansion of the narrative and the patient's subsequent tolerance of multiple viewpoints and ambiguity than from the achievement of some superordinate view that make it all clear at last; or, even, some superordinate experience with the therapist that makes healing possible.

Darlene Ehrenberg, working from an interpersonal theoretic perspective, notes "I do not make 'interpretations' … I agree with Winnicott (1969) that this often prevents the patients from being able to come to things on their own." Some "classically oriented" analysts will likely argue that by offering *tentative rather than conclusive* (saturated) interpretations, they signal to the patient their openness to a patient's saying it isn't so, but Ehrenberg is likely to retort that this does not go far enough to mitigate the chance patients will hear interpretation as if spoken by an oracle, no matter how humble his/her delivery may be.

Fred Busch (Chapter 1), working in the tradition of a modern ego psychologist, somewhat surprisingly (given his more classic-seeming approach to treatment), also eschews the direct offering of interpretations and favors "working at the surface" by, first, drawing a patient's attention to behaviors that he believes are indicative of the fact that underlying psychological factors are at work behind the scenes – factors he wishes to explore with the patient as the two collaborate to understand what such behaviors might mean. Busch eschews doing the patient's work for him/her by spoon-feeding him/her interpretations; rather, he works to make clear to the patient the identified evidence (e.g., manifest behaviors) that is leading him to form certain conclusions. Busch tends to share his observations of the patient with the

patient rather than cutting to the chase by telling the patient what his/her behavior means. He takes care, in particular, to avoid "saturated interpretations" that proclaim, in no uncertain terms, what an identified bit of manifest behavior means, which leaves the patient no opening to entertain alternate possibilities or disagree with the analyst's interpretation. Writing about the patient presented in this first chapter, Busch writes:

> Notice I'm not telling [the patient] what's making him uncomfortable, but leaving it open for exploration … if he's able. Why is this important? Mainly because I believe we can only explore with the patient what he's ready to explore. Prematurely suggesting ideas to a patient usually closes thinking rather than opening it.

These ideas are in line with those offered by James L. Fosshage, who references his work with co-workers Lichtenberg and Lachmann (Lichtenberg, Lachmann, & Fosshage, 2003) in their description of how an empathic listening stance helps create a "spirit of inquiry" – which they believe to be the most efficacious prevailing psychoanalytic stance an analyst can assume.

Some of our commentators believe that certain patients can tolerate neither interpretations themselves nor the experience of being interpreted because they have yet to sufficiently formulate (symbolize) their experiences to then be able to retrieve those experiences from the recesses of their minds in a *fully formed format*, as is thought to be the case when it comes to psychic content that has been repressed and is, accordingly, formatted and hence ultimately reportable by the patient once the need to repress recedes. Donnel Stern (Chapter 5) writes that "Interpretation just doesn't work when you're dealing with psychic states that haven't been symbolized, because while there's 'something' there, the something is not recognizable." He further argues that one needn't make the unconscious conscious in order to foster psychoanalytically induced change; rather, all an analyst need do with certain sorts of patients is transcend inclinations to see the patient in a limiting way, which then frees the analyst to begin to interact with the patient in a somewhat different fashion, from the vantage point of a more expanded view of who the patient is. Stern concludes by noting: "because I see him differently I will now treat the patient differently than before, and in response he will feel differently than before."

Some of our commentators theorize that treatment exerts its effect by providing the patient with developmentally needed experiences (e.g., selfobject needs) that the patient hadn't been provided during his/her formative years. Controversy is particularly intense when it comes to the question of whether such a provisional model of therapeutic action (framed by Janet Smith in Chapter 7) can adequately account for the sorts of changes that come about as a result of an analysis. In Chapter 4, Anne Alvarez opines that analysis can repair deficits leading to a patient's potentially experiencing the transference as healing. Referring specifically to the patient presented in the moment she

was assigned for comment, Alvarez notes how the analyst had acted in ways that encouraged the patient to feel that she had "finally been welcomed into the analytic family" – that the analyst was going to "stick with her" and would not be driven away by the patient as past experiences had primed her to anticipate would always be her fate. By contrast, in Chapter 7, Greenberg questions the wisdom and utility of trying to assume the role, as analyst, of "the good object" – a better object "who is more empathic and/or compassionate than her family members" – and in Chapter 11, Levenson echoes these same sentiments:

> In actuality psychoanalysis is a game, play, circumscribed and defined by rules – the containment of the frame – and would be otherwise impossible to sustain. One would be asking the therapist to be the one thing therapists aren't – wonderfully superior people able to undo the vicissitudes of their patients' lives … I do not believe that therapy proceeds by the therapist providing some restorative love or empathy experience for the patient. I believe the cure comes via the working through, the traditional arduous replay of show and tell that epitomizes psychoanalytic psychotherapies.

Our commentators hold a wide array of theories about therapeutic action. Some think in terms of the "containment" (Celenza, Chapter 5) – the analyst's successfully surviving (without withdrawing, retaliating, or de-compensating) in the face of a patient's projections or expressions of intense affects or powerful (aggressive or libidinal) impulses. Patients may express hostile aggression toward the analyst then wait to see whether the analyst will "pass the test" (per Control-Mastery theory;[5] Weiss et al., 1986) by not reacting as the original object had or as they themselves had reacted in their formative years when treated comparably at the hands of careless caregivers. In Chapter 6, Glick notes how:

> The therapist is saying, wisely and generously, we have lived through versions of this before, we are in this together, nothing truly bad has happened, we both survived the upset and we are continuing on together. This is an excellent example of how a therapist "self-rights" and effectively rebounds from an intense attack on her as an uncaring, failing person. This goes to the heart of the clinical reality in our work. We are unleashing powerful, primitive forces that are real for the patient and become real for us.

In Chapter 9, Donner, writing comparably about the treatment of a 5-year-old boy, notes:

> [The analyst's] test, over time, would be for her to not only bear the affects, tolerate his aggressive and erotic attempts to engage her without rejecting him or withdrawing from him, and survive his real and fantasied

attacks in a way that his parents couldn't, but to turn the unspeakable into words.

Another way in which some of our contributors see therapy working is either by helping patients retrieve and integrate formerly split-off, dissociated "not me" aspects of the self (a more interpersonal or relational perspective) or by helping patients cease to rely upon defenses that not only require energy and effort to maintain but which preclude the patient's access to the breadth of potentially available ego functions (from a more mainstream, North American, modern ego-psychological perspective). Patients are also thought to improve when they have words with which they then can think about, and outwardly express, their emotions (increased affective vocabulary – Busch, Chapter 1). Sugarman (Chapter 9) addresses the use of play therapy to help patients overcome their fear of knowing their feelings, and he also sees treatment as aimed at helping patients better understand how their mind works.

One group of commentators conceptualize certain sorts of patients as suffering from unrepresented, "unformulated" (Celenza, Chapter 5; Stern, Chapter 5), un-symbolized, or dissociated experiences that – if given form and provided voice – can help facilitate psychic change. In Chapter 5, Andrea Celenza describes how therapy provides a "pathway to becoming whole" when unrepresented self states are helped to gain acceptance and expression:

> What is actualized in enactments are those selves or potential selves that are forbidden to be realized, "bad" aspects of a self *not yet represented or formed* for fear of its potential strength, aggression (or other passions) that are the basis of its expression. This sense of oneself … is dangerous, prohibited, or desires something threatening … These parts of the self [… are] walled off or left unpotentiated in some unformulated haze.
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> (italics added)

Analysts who rely upon an intersubjective perspective, which views patients' manifest behaviors as mightily influenced – to the point of being chiefly determined – by the particulars of the analyst's personality and reactivity (also known as a two-person perspective), tend to reconsider phenomena that other analysts deem to be "defensive" alternately as reflective of self-protective and/or self-promoting motives (Fosshage, Chapter 1).

Some contributors see therapy facilitating a patient's capacity to differentiate self from other – resulting in the analytic couple swimming to shore after floating adrift in an enactment or an instance of projective identification. For example, Celenza (Chapter 5) notes: "The analyst's first task is to sort out what belongs to whom and to own what is ours … [in] a deft retribution of introjections and projections (from both the analyst's and patient's perspectives)," which is in line with Stern's (Chapter 5) observation that when patients are on the verge of having to accept dissociated ("not me") aspects of

themselves in the context of treatment, they "treat the other person as if *they* are whatever it is that I must not be."

Commentators note how certain patients are on the lookout for evidence indicating that they are having, or have had, a powerful, demonstrable effect (impact) on the analyst (Chapter 6, Chapter 9, Chapter 12), illustrated dramatically in the final chapter of the book, in which the analyst becomes worried sick about the whereabouts of his patient. In response to the patient presented in Chapter 6, Glick writes:

> The patient's underlying rage and vulnerability demanded that she test the therapist's resilience and reliability in order to free herself from her narcissistic emotional bunker. The patient needed to feel she had *real* impact on the therapist "where she lived." She had to knock the wind out of her, to attack her moral core as a therapist. She had to find out that the therapist, unlike the internal representations of her primary objects, was truly strong enough, real enough, concerned and caring enough, to survive the test, and that they would both continue together.

In Chapter 5, Celenza refers to a previously published case study (Celenza, 2014) in which her patient, Michael, harbored a fantasy "to stab me repeatedly with a knife … [out of need] to see me overwhelmed." Celenza concluded that therapeutic progress wasn't furthered by her ability to handle the situation "*expertly*, as one would in retrospect," but – rather – was a function of her finding ways to have one's "authentic, experiencing affective self converge with your asymmetric analytic stance."

Some commentators appreciated the *power of exceptionality* (e.g., "now moments," "moments of meeting"; Stern et al., 1998) – instances in the course of the treatment that stand out in bold relief insofar as they aren't at all what the patient had expected from the analyst and, as such, have a powerfully disruptive effect on the patient's view of himself and of his relationship with others. In Chapter 10, Wilson writes:

> If we are too interested in "connecting the dots," then moments of newness, surprise, oddity, confusion, contradiction, and repetition tend to get ignored. "[T]he unconscious is what closes up again as soon as it has opened, in accordance with a *temporal pulsation*," Lacan stressed repeatedly in Seminar 11 (Lacan, 1981, p. 143, my emphasis).

In response to the patient presented in Chapter 6, Glick notes how:

> The therapist calls the patient by her name: "Oh Roberta." I find this a very powerful and crucial personalizing action. It says: "This is us, affectively stepping outside the constraining roles as therapist and patient (and into an authentic, affectively real interaction). We are talking to

> each other; I take you into account. I am not speaking as a disembodied, objective judgmental voice. You are making me feel what you felt with your mother, that crushing, isolating cancellation. I am living in your shoes. I get it; I feel it; I am truly here for you."

Commentators also talk about the importance of the patient feeling "known," "seen," "recognized for who they are," or "heard" by the analyst – particularly insofar as the patient felt deprived of such experiences when young. The patient may struggle with his/her sense of identity, and may respond well to the recognition/confirmation of an alternate self relative to the particular self that they had been presenting in session, which is a more pathologic or limited iteration of the self that they seek to have disconfirmed, in the Weiss and Sampson sense, because it fails to represent the fullness of him- or herself. The patient may expose and express this alternate self in relatively unconventional ways relative to the fundamental rule that dictates communication ought strictly to be limited to the use of words. For example, in response to Ms. B. presented in Chapter 8, Joseph Lichtenberg writes:

> Ms. B brings into the consulting room not only her associations and dreams but her artwork. I regard Ms. B as saying, "If you want to know me, to really get who I am, you have to see what is central to my sense of self, my identity. Much of my heart and soul is in my creativity – and here it is. Look, share, react, respond. My narrative comes in two forms – verbal and visual."

And it isn't just the analyst who needs to wake up, listen, and learn who the patient is. Patients themselves are often limited by their own self-conceptions that fail to take into account hidden, unrecognized aspects of the self. Levenson (Chapter 11) writes:

> The mutative impact [of psychoanalysis] may come more from the expansion of the narrative and the patient's subsequent tolerance of multiple viewpoints and ambiguity than from the achievement of some superordinate view that makes it all clear at last, or even some superordinate experience with the therapist that makes healing possible. Patients refuse new experience and insight; that is what resistance is about. Mutative change depends more on the patient's grasp of what is happening around and to him than any explanatory set.

A final note before we launch into a description of the sorts of clinical moments we have in mind. We might ask the following question: "If commentators' reactions to these presented moments cannot realistically be translated into concrete recommendations about how the case might have been better handled, what is the relevance of their feedback and how is this

Clinical Moments Project a legitimate exercise?" To this, we respond by answering: What this project does achieve is the illumination of theories that each of these 25 commentators carries with them into session where they implicitly operate to organize the material, shaping the way in which these analysts listen to the material, serving to determine what aspects of the observable data will be deemed salient – prioritizing certain classes of data over others (Tuch, 2018). Based on such selective perception of the clinical material, the analyst reaches a conclusion about what is troubling the patient and what needs to happen for these issues to be worked through psychoanalytically. This, then, is the ultimate lesson of the Clinical Moments Project – to learn how to listen to how the treating/presenting analyst, the commentator, and the reader of this book each listen to the unfolding material.

Examples of clinical moments appearing in the literature

Let's consider some examples that illustrate just such moments. The first example is notoriously historic (though factually mythic) – a dramatic construction invented by Sigmund Freud decades after the incident that he was describing had occurred. In a letter to his friend Arnold Zweig (E. Freud, 1970), Freud describes how Josef Breuer's treatment of his patient Anna O. (Breuer & Freud, 1895) ended abruptly when Breuer happened upon his patient writhing in abdominal pain, declaring, "Now Dr. Breuer's child is coming!" Freud claims this incident so unnerved Breuer that he ran from the room in a cold sweat, transferring the patient's care to another physician. While Freud's tale has now been roundly debunked (Hirschmuller, 1978) and persists merely as myth, his claim that Breuer fumbled the ball at the precise moment when a timely interpretation of Anna O.'s "transference love" was clinically indicated *still stands*, since that claim doesn't require one to place stock in the pseudo-pregnancy myth.[6] The fact that Freud's construction turns out to be nothing more than myth doesn't disqualify it as an example of the sort of moment likely to challenge a therapist's clinical acumen and his ability to muster a response under duress.

Let's now turn to an actual clinical moment that is no less shocking in the degree to which it represents an extreme form of acting out. This is the case of Mr. A., a gay man I'd (R.T.) been treating who behaved in the most challenging and outrageous fashion (Tuch, 2007). The patient would physically trespass upon me in every imaginable way, acting as if I had no privilege or say in the matter. He would rifle through my desk drawer against my protestation and took extraordinary license by touching me whenever and wherever he chose. Efforts to engage the patient in a process aimed at understanding the meaning of these behaviors were dismissed by him out of hand as a colossal waste of time – as something that served my need, not his. Each instance of just such boundary-violating behavior constituted a clinical moment, taxing my capacity to conduct analytic treatment as I saw fit. The

one moment that stands out is the time Mr. A. disrobed before me, largely, I suspect, to completely unnerve me – which it indeed did. Had I kept my wits about me, the situation would not have thrown me to the degree it did. But this was not how the situation played out: I'd been temporarily psychically disabled, which kept me from considering the possibility that the patient was "asking" me to contain his own feeling of being completely unnerved by aspects of our relationship (an instance of projective identification) so that he might be relieved of having to feel such feelings. That realization only occurred to me *after the fact* once I'd come to my senses and regained the ability to think.[7] How I handled the incident isn't nearly as important at this juncture as is the illustration of the sort of challenging clinical moments that can arise during the course of a treatment that seriously challenge the analyst's ability to find ways to therapeutically manage the situation.

Let's consider another example that demonstrates how the impact of a patient's behavior can move the analyst to react *unthinkingly*. Jody Davies (1999) presents the case of Daniel that illustrates how a patient's behavior may so affect the analyst that she finds herself acting in a highly uncharacteristic fashion in accordance with pressures arising from her unique countertransference reaction. The incident in question occurred as the patient was relaying a story from his seventh year of life when his father had treated him in an abusive fashion in response to the patient's crying over not having been adequately tended to by his yet again heavily sedated and depressed mother. The drunken father berated his son, calling him a "sissy" and a "weakling," and set about teaching his son a lesson about how hard life could *really* be by ordering him to strip naked and stand outside in the freezing snow for an extended period of time. The patient, who'd subsequently grown to see himself as someone who was literally inured to the cold (arriving to this first session in thin socks and sandals on a bitterly cold day), was suddenly shaking violently and uncontrollably as he relayed this story in session.[8] Davies writes:

> The next thing I knew, I was standing next to Daniel's chair wrapping a blanket around his shoulders, *not quite sure how I ended up there.* I remembered reaching with a disembodied arm into the cabinet where I kept the blanket for my own occasional use, and then getting up out of my chair, *but these were not considered actions.*
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> (p. 193, italics added)

While analysts typically like to think of themselves as being in better control than Dr. Davies found herself to be, we have little doubt that many analysts from time to time react just as unthinkingly as Dr. Davies had when confronted with a clinical moment that triggers an intense countertransference reaction. Davies goes on to explain how she and her patient came to terms with this event, making clear the extent to which this incident constitutes the sort of clinical moment we'll be referring to in this book. At such times, the intensity

of the analyst's countertransference reaction may be so overwhelming as to move her from her typical stance of "considered reflection" to one of immediate action, which can be a feature of clinical moments of a certain sort.

Clinical moments that appear in this volume

Few if any of the clinical moments presented in this book are instances of clinical extremity. No patient is writhing in pain as they prepare to give birth to their analyst's child; no patient disrobes before the analyst. Only a few of the moments presented in this book are so extreme as to reduce the analyst to the point of acting in an unconsidered manner, as was the case with Jody Davies. But while the examples in this book aren't so extreme, they nevertheless are bona fide examples of clinical instances when the analyst found him- or herself in a state of not knowing – a state of uncertainty about how best to proceed given the unusual and challenging nature of what was happening in the room at the time.

Different circumstances give rise to the condition we refer to in this book as a clinical moment. What these moments share in common is the degree to which the analyst feels challenged by uncertainty as to how to proceed, which contrasts with the more usual level of comfort and confidence he/she had previously felt up to this point in time with this given patient. His/her level of confidence, along with a sense of how he/she and the patient traditionally "got along," suddenly lessens as the analyst's deliberations become more labored – as he/she finds him- or herself working harder than usually to figure out his/her next move. Calling it "a move" gives the wrong impression – this is no game! But moments like these are ones that strike the analyst as potentially "dicey" to the extent he/she comes to believe that more seems to be riding on how he/she responds at this precise moment than is usually the case. At this point in the treatment, the analyst may be struck by the thought that his/her particular response – how and whether he/she chooses to act, whether he/she will interpret or let things be, whether he/she will share an observation or allow the patient to proceed without interruption, and so on – will likely have greater consequences than most other times in treatment when his/her way of being on the whole seems to seamlessly facilitate the unfolding process. Because of how critical things now seem, the analyst is a bit on edge, more vigilant about what's about to happen, more careful in his/her consideration of alternatives, and more inclined to employ the rational, decision-making part of his/her brain rather than rely on intuition or a gut feeling about what he/she should do next. In particular, the analyst wonders to him- or herself, "*Now* what do I do?" – which he/she is much less inclined to wonder during the rest of treatment that operates more automatically.

Sooner or later, most analyses arrive at a point when the immediacy of the moment captures the analytic couple's attention, awakened by the glare of the moment that seems pregnant with possibility. Such moments have been

referred to alternately as "now moments" (Stern, 2004; Stern et al., 1998), as the sudden emergence of a striking resistance (e.g., a sudden rupture in the patient's ability to freely associate), an acute countertransference enactment (Jacobs, 1986), a powerfully felt and expressed transference, a "disjunction" (Ogden, 2016), and the like.

Stern et al. (1998) describe a "now moment" as an instance:

> That gets lit up subjectively and affectively, pulling one more fully into the present … [requiring] a response that is *too specific and personal to be a known technical manoeuvre*. Now moments … demand an intensified attention and some kind of choice of whether or not to remain in the established habitual framework. And if not, what to do? They force the therapist into some kind of "action," be it an interpretation or a response *that is novel relative to the habitual framework*, or a silence … These "now moments" are often accompanied by expectancy or anxiety because the necessity of choice is pressing, yet there is no immediately available prior plan of action or explanation. The application of habitual technical moves will not suffice. The analyst intuitively recognizes that a window of opportunity for some kind of therapeutic reorganization or derailment is present, and the patient may recognize that he has arrived at a watershed in the therapeutic relationship.
>
> (pp. 909–911)

Note that we are not suggesting that each of the clinical moments presented in this book constitutes a "now moment," though we are quite sure a number are similar to this concept.

The advent of a clinical moment of the sort presented in this volume can be set in motion either by the therapist's actions or reactions, or by the patient's actions or reactions, though it can sometimes prove hard to tell from a chicken-or-egg perspective who was reacting to whom – whose action got the ball rolling in the first place. The analyst's chosen intervention sometimes appears to be the apparent trigger for a given moment. So too might his/her unwitting participation in a countertransference enactment, which hadn't been the product of conscious choice but, rather, turns out to be something he/she finds him- or herself doing unwittingly, as had been the case with Jody Davies. Extricating oneself from an ongoing enactment often requires the analyst to gather his/her wits about him/her in order to, first, recognize that he/she has become drawn into an enactment so that he/she might, then, begin to make sense of why he/she has reacted as he/she did, so that he/she – ultimately – comes to an understanding about what his/her reaction says about the dynamics about the case, using his/her countertransference to make his/her way back to the patient's situation.

Sometimes, it appears clear that the patient was largely responsible for initiating the moment under discussion. For example, powerful transference

reactions can constitute a significant and memorable moment in the course of one's analysis. The intensity of affects that are felt and expressed heightens the immediacy of the moment, which many analysts believe is necessary in order for the transference to become animated rather than being appreciated intellectually as a reconstruction of "what must have been back when" – driving home the point Freud was making by noting how one cannot hope to work through problematic interactions of yesteryear without their first becoming tangible and immediate in the form of the manifest transference ("when all is said and done, it is impossible to destroy anyone in absentia or in effigie"; Freud, 1912, p. 108).

Other such moments involve what Ogden (2016) refers to as "disjunctions" – points in time when there is a "seemingly incomprehensible gap between what one person says and how the other responds," creating an emotional climate:

> in which both participants experience some degree of feeling lost, confused, perplexed, at sea, and almost mystified … The analytic pair can no longer rely on what they thought they knew, for what they have known no longer feels sufficient to meaningfully contain the elements of experience now in play.
>
> (p. 413)

Feeling lost, confused, perplexed, and at sea defines the features of an immediate moment that stand out in ways that require the analytic couple's immediate attention.

The immediacy of all of these sorts of clinical moments can be likened to an awakening when business as usual is suddenly dispensed with as the analytic couple begin to relate to one another in a somewhat different fashion. Such moments are lively, filled with spontaneity, and ripe with possibility. Helping patients experience such moments so that they may go on, more of the time, to live life in the moment can be considered an important though unrecognized goal of psychoanalysis.

A somewhat flawed experimental design

The task outlined in this book represents an experiment of sorts: The same clinical vignette is presented to two commentators, who are then asked to weigh in on *what they think about the moment* and *how they believe they might have responded* were they to have been in the analyst's shoes. Many of our commentators address the near impossibility of knowing with any degree of certainty how they themselves would have responded given the circumstances. Naturally, these analysts speak at arm's length from the gravitational pull of the affective to-and-fro taking place in the consulting room. In his response to Dr. Smith's presented moment (clinical moment #7), Jay Greenberg notes:[9]

> I have not seen the patient. I have seen only the analytic dyad, and I have ineradicable impressions of the interaction between the two participants and, perhaps most important, of the analyst's countertransference ... If I were the treating analyst, of course, everything would be different. The analytic conversation would not have gotten exactly to this point, I would have my own countertransference, my own vision of where I would want the conversation to go would be my own. So when I am invited to think about what I would say in a given moment, what I would say is as much about the dyad as it is about the patient.

When Greenberg speaks about his perception of the dyad at work, and his belief that he would have conducted himself differently, he is addressing the limits of a commentator's ability to imagine "substituting in" for the treating/presenting analyst. Accordingly, the question "What would you do if you were in the analyst's shoes?" may amount to one that no commentator can honestly answer.

Echoing these same sentiments, Irma Brenman Pick responds to Dr. Perkins' dicey face-off with a patient who threatened to quit treatment if Perkins didn't back off (clinical moment #3):

> It is interesting to be invited to consider how I might orientate myself to thinking about what might be my reactions, as analyst, faced with this ultimatum; of course, anything I write now may have little bearing on what might have been my actual reaction in this situation. And reading the account of this treatment I am bound to say – like the Irish joke of the man asking for directions from X to Y – that X wouldn't have been the place to start from in the first place.

As mentioned earlier, the Editors of this volume recognized at the outset that it is somewhat unrealistic to ask commentators what they imagine they might have done given the circumstances and expect them to be able to speak authoritatively about the treatment itself. Several commentators note as much. In clinical moment #7, for example, Dominique Scarfone writes:

> A preliminary warning. Since I am not the analyst in the room and am therefore not exposed to the affective load that the patient's words, both in content and tone, would have put on me, I can only try and imagine what I would do or say.

In response to the patient presented in the first clinical moment (Chapter 1), Fred Busch writes:

> there is so much a respondent does not have access to, like the affective coloring of words, the multitude of observations that leads the clinician to

think this or that, the subtle mood shifts in both participants, the analyst's reveries, and so on. Given this sizeable handicap, in order to fill my role as respondent I will proceed as if *I really* knew what was going on.

Reiterating what was mentioned previously, we must acknowledge that the experimental design of this clinical moment exercise is somewhat flawed to the extent it is unrealistic to believe that commentators who have no experience with the patient in question, who lack a first-hand, visceral sense of what it is like to be in the room with such a patient, and who haven't been exposed to the affective interchange that inevitably tugs on the treating analyst's innards – generating countertransferences or evoking reveries of whatever sort – can seriously opine about how they think they would handle matters had they been in the analyst's shoes. The entire experiment reeks of what Greenberg[10] (Chapter 7) refers to as the *illusion of expert advice* – the idea that the supervisor/commentator is in any position to speak authoritatively, in retrospect, about how a clinical moment should have been handled. Writing about the process of supervision (Tuch, 2018), I assert that "supervisors are better situated to make out what is going on between the candidate and his patient, *yet poorly positioned to precisely know what to do with this knowledge*":

> Supervisors oftentimes see the case more clearly because they are unencumbered by the sorts of distractions that can interfere with the treating analyst's (supervisee's) ability to devote his/her full attention to a reflective consideration of the unfolding material. The supervisee's need to be available to the patient by being fully present in the room, in combination with the distractions created by a multitude of subtle interactions and varied affects flying about the room, takes a toll on the supervisee's ability to maintain sufficient presence of mind to be able to fully dedicate himself to the task of figuring out what is going on in the room on multiple levels – to see the forest for the trees [... Hence] the supervisor is better situated than the supervisee to be able to make out the dynamics of the case and to ascertain the nature of what is going on between the supervisee and his/her patient; on the other hand, the supervisor is poorly positioned to know how to make the best use of this knowledge in the actual treatment setting ... The supervisor may think he substantially grasps the nuances of the case – and well he might – but that does not translate into his/her knowing how the supervisee should proceed, since the supervisor lacks essential knowledge that he would need to be able to claim authority to direct the treatment from where he sits. When a supervisor comes to believe that an interpretation he's fashioned is precisely what the supervisee "ought to have said," that supervisor has ventured on to shaky ground and may, furthermore, be oblivious to the fact that he is claiming greater authority than circumstances allow.
>
> (pp. 217–227)

There is one other problem with the experimental design of this project that has to do with the myth that analysts give due consideration to most everything they do, which makes their interventions seem more consciously calculated than they often turn out to be. Since one of the main topics of this book has to do with the question of how and why analysts "choose" to intervene in the way they do in treatment, it is important to keep in mind the extent to which "choice" isn't always evident, as was illustrated in the previously mentioned vignette involving Jody Davies. The myth of the carefully crafted intervention involves the belief that the analyst's interventions are by and large the result of conscious deliberation. After all, one thing that psychoanalysis arguably "stands for" is the refinement of the ego's capacity to gain more and more say over one's actions, resulting in a lessening of the tendency to "act out" and a heightened proclivity to think before one speaks. While psychoanalysts tend to go to great lengths to carefully weigh the potential consequences of a considered intervention, this does not mean the analysts' activity is rarely the result of unintended and unconscious psychic processes. As we consider clinical moments of a certain sort, it is important to keep in mind the extent to which the analyst may be intervening unthinkingly before regaining his/her momentarily absent capacity to think analytically.

Having owned the limitations of this particular experimental design, we nevertheless believe there is considerable value reflected in what our commentators have crafted, which can be appreciated just so long as the reader doesn't succumb to the misguided belief that there are those who know better about how a clinical conundrum had best be handled. We encourage the reader to consider the commentators' comments in this spirit – not so much as having specifically to do with the case at hand but, rather, as valuable clinical ideas stimulated by the consideration of a given case, whether or not those ideas meaningfully can be translated into clinical recommendations about how the presented case itself might best be handled. These moments create a springboard for some very interesting thinking, which is why the Editors emphasized in their instructions to commentators, first and foremost, the task of discovering what the moment brings to mind and, only secondarily, what the commentator thinks he might have done given the circumstances.

Clinical moments presented in this book

This volume contains a dozen clinical moments, each of which addresses a somewhat different sort of clinical situation or dilemma. These 12 clinical moments are grouped according to the predominant clinical dilemma illustrated in each. The first group of three moments (CM #1–3) illustrates instances when the analyst finds him- or herself grappling with the question of whether to speak up, in the hope that doing so will deepen the treatment, or whether it is best to keep his/her thoughts to him- or herself for the time being, out of concern that the current state of the therapeutic alliance won't

permit him/her to intervene in the way he/she is considering doing. The second group of two moments demonstrates the handling of *countertransference enactments* – in one case (CM #4), a series of three enactments, the last of which lands the patient face-to-face with the analyst's mother; in the other case (CM #5) we are presented with an enactment that leaves the analyst defensively insisting that she *does* in fact understand the patient's position in opposition to the patient's claim to the contrary. The third grouping of three moments involves the matter of provision – what the patient seeks to receive, or demands he/she must receive from the analyst in order for the treatment to work. In the first moment (CM #6), a patient who felt she'd been shortchanged by the analyst takes her to task for not providing the agreed-upon allotment of time. In the second moment (CM #7), a patient demands that the analyst provide her with guidance, answers, and solutions that she steadfastly insists she must receive if she is to improve. In the third moment (CM #8), a patient hopes the analyst will accept an invitation to attend an event that is personally meaningful, and would be made more so by the analyst's attendance. The final grouping of four moments involves the issue of the degree of impact the patient is having, or is trying to have, on the analyst – touching on the issue of interpersonal power. In the first instance (CM #9), a 5-year-old boy invites his analyst to participate in a game that assigns her a role that would leave her in a precarious position – with a bag over her head, blinded from witnessing what is about to happen. In the second instance (CM #10), a family secret defines the patient's life, which he enacts by leaving his analyst in the dark, pulling the wool over her eyes about an essential truth of his life, about which she only comes to learn years into the treatment. In the third instance (CM #11), the patient sadistically plays with the analyst in a cat-and-mouse fashion, toying with what he knows to be a soft spot in her heart, and positioning her to have to decide where her allegiance lies – with him or with the helpless kitten he has brought to treatment whose well-being – he suggests – might be in jeopardy if the analyst doesn't wisely intervene. Finally, in the fourth instance (CM #12), the analyst is greatly affected by a patient's sudden disappearance, resulting in him worrying himself sick over the patient's whereabouts.

The goal of this volume is threefold: to stimulate readers' thinking about clinical dilemmas, to introduce psychoanalytic societies and institutes to the value of conducting their own Clinical Moment Programs, and – finally – to set the stage for another such book containing a series of other clinical moments, submitted by analysts throughout the country (and beyond) who believe they have just such a moment in mind that might be fruitful to present and discuss. Those wishing to submit moments of their own for inclusion in *Volume 2* may do so by sending vignettes either to Richard Tuch at rtuch@aol.com or to Lynn Kuttnauer at lynn.kuttnauer@gmail.com. Moments should be no longer than 4,000 words.

A few final notes before we proceed: one having to do with experimental design, the other with the use of pronouns when referring to analysts. For the most part, commentators had no idea how the treating/presenting analyst would choose to proceed after the moment in question arose. The only exceptions are moments that are presented as a series – where commentators were asked to weigh in at different points along the way as a series of moments unfolded. Commentators did not know the identity of the other commentator with whom they were "paired" in writing about the same moment, nor did they know what that other commentator had written about the situation at hand. Furthermore, those who contributed moments had no access to the commentators' comments until they had finished writing their moments – with no modifications permitted after they had read the commentators' comments. Undoubtedly, some moment contributors would have relished a chance to respond to the commentaries by offering clarifications or even a rebuttal, but space does not allow for such activities. As for the matter of pronouns, the clear majority of moment contributors are female analysts – 9 of the 11 (two moments are written by Richard Tuch). In chapters where the analyst is male, references to "the analyst" in the "moment in context" will use masculine pronouns. In all other instances (the majority), when the moment has been written by a female analyst, the associated "moment in context" will refer to analysts using feminine pronouns. In this Introduction, we chose to use the convention of "he/she" or "his/her."

Notes

1 Shamelessly organized in NYC-centric fashion.
2 In the case of Chapter 7, there are *three* commentators – the result of a simple error on the part of the Editors who erred in assigning the Moments.
3 Save for those clinical moments that contained more than a single designated moment and are presented as a string of moments.
4 Unfortunately, a few commentators who were first invited to participate weren't provided with such a list of specific instructions.
5 Both Morris Eagle (Chapter 8) and Nancy McWilliams (Chapter 11) address Weiss and Sampson's Control-Mastery theory in greater detail.
6 Though Anna O.'s transference didn't in fact play out as Freud later claimed, that doesn't negate the fact that she likely experienced a powerful transference reaction in response to the extraordinary attentiveness of Dr. Breuer, which was relatively unheard of at the time.
7 An alternate interpretation is suggested by Ehrenberg (2003), who writes: "Some patients have described how important it was to them to know they could frighten me, unnerve me, even tyrannize me, by 'regressing.' The regressing was therefore not 'innocent' at all. Regressive behavior actually can be manipulative to the extent that the intention is to upset the analyst. It can be a weapon in a kind of psychic battle" (p. 590).
8 Which might well have represented a reliving of the event in the analyst's presence.
9 Taken from a segment of Dr. Greenberg's comments that have not been included in his formal comments that appear in this book.