

HEARING VOICES: THE FATE OF THE ANALYST'S IDENTIFICATIONS

Using detailed clinical examples, the author illustrates the function of conscious and unconscious identifications with former training analysts, supervisors, teachers, and theorists in the mind of the working analyst. As compromise formations, analytic identifications are the product of loving and aggressive wishes, defenses against those wishes, and self-punitive trends that accompany the analyst in the work. The analyst's stance at any given moment has an identificatory history that may become conscious at certain times with certain patients. While the analyst's identifications modify over time, following a predictable developmental path, they are never fully given up, but consciously and unconsciously remain an active part of the analyst's inner life. During the clinical hour they are responsive to both the analyst's and the patient's conflicts, and they coexist in a dynamic reciprocal relationship with the patient's inner life.

When I was a first-year resident in Boston in the early 1970s, we spent many hours watching Elvin Semrad. A large, fleshy, overweight man with a soft voice made hoarse from pipe and cigarette smoking, he was the finest interviewer of psychotic patients I ever saw. In just a few minutes even the most regressed patients might set aside their psychotic symptoms and tell Dr. Semrad about the misery in their lives. We watched and we imitated, and, in search of Semrad's wisdom, we inadvertently adopted his mannerisms and his voice. Healthy young residents could be seen walking and talking like old men. Years afterward in an hour with a patient I would sometimes catch myself rubbing

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a finger across my lower lip, just as he had done, to renew the identification at a crucial moment. And from time to time I still hear a certain quality in my voice alerting me that I have once again brought him into the room.

There is a vast literature on the role of identification in the training of psychoanalysts, much of it replete with cautionary tales. I am thinking, for example, of Heimann's warning from one side of the Atlantic that "identification . . . hinders understanding if it is not admitted to consciousness and controlled" (1954, p. 166), and Greenacre's echo from the other that "the student may make his identification on an infantile, imitative level in which interpretations are accepted compliantly" (1966b, p. 560) and that in highly idealized identifications "analytic concepts are . . . used too much in the service of defense" (1966a, p. 203). Despite such caveats there is widespread agreement on the importance of identification in learning. As Arlow has noted, "Identification is the central mechanism in all programs of education" (1972, p. 560; see also Meissner 1973).

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While identifications begin in childhood, a number of conditions make the candidate ready to seek identifications anew. I am thinking of the regressive nature of the training and the conflict stirred by the work itself. The candidate seeks models to relieve anxiety, aloneness, uncertainty, and self-criticism, as well as to learn, as Ornstein put it, "how to feel as an analyst"—not to mention how to "behave, talk, think, and listen" analytically as well (1967, p. 452).

These are elements common to any clinical training. In addition to weekly conferences with Dr. Semrad, we used to meet with him in groups of four to interview each other's patients. One day it was my turn. After the interview the other residents commented on how affectively available this young schizophrenic patient had been. Semrad said quietly, "He had some help." And then, recognizing my slavish imitation of his approach, he added, "One day Smith will make this his own." He used to say that the process of becoming a therapist took at least ten years.

Looking back, of course, Semrad was right about my enslavement. I remember feeling that if I could only immerse myself in the examination of the patient's affect as he did, I would be safe. Safe from what? From my own anxiety, from my patient's disappointment? From Dr. Semrad's criticism, which was just as surely my own self-criticism? I was halfway through my first year of residency, and

I was quite conscious of the imitation—a poor one, as it felt to me at the time.

In a recent contribution, Diamond (1999) demonstrates clearly and cogently his own efforts to break free of an imitative identification with his training analyst's technique, an identification that was contributing to an impasse in his supervised work with his first analysand. The discovery and working through in analysis of what he calls "persistent and compulsive early ego identifications" permitted him to develop a more authentic technique of his own.

Whereas Diamond illustrates a developmental process that takes place during analytic training, Fogel and Glick (1991) describe a continuation of that process, namely the shifting identifications of their postgraduate development and the role played in that development by a leaderless study group they formed to read Freud from beginning to end. Over the course of the group they discovered that through questioning, challenging, and competing with idealized figures of identification and their theories, and especially with the figure of Freud, they each seemed to work through their "incompletely resolved transferences to Freud, to personal mentors and institutes, and to theory itself" (p. 396) on the way to developing their own more stable analytic identities.

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Fogel and Glick thereby confirm that an aspect of one's own analytic voice can develop outside the confines of the training program as well as within it. In fact, as they see it, working through such transferences and identifications *must* take place after training. They write, "An essential aspect of a mature, independent psychoanalytic identity can only be fully acquired and consolidated some time after the completion of formal analytic training. We call this acquisition the analyst's autonomous 'theoretical identity'" (p. 397).

I agree with the position that Fogel and Glick artfully illustrate in their paper, and it accords with my sense that every analyst, under the best of circumstances, develops a personal version of what Rangell (1988) has called "total composite theory"—namely an idiosyncratic integration of the different theoretical and practical approaches with which he or she has identified over the years. And yet I have a reservation. When we suggest that some analysts will "fully acquire" and "consolidate" such an identity, I believe we propagate an idealization.

As we have come to recognize over time that transferences are not fully resolved but remain active, ready to be revived at a moment's notice in a second analysis or even a follow-up visit, so too identifications

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are never completely worked through and a conflict-free psychoanalytic identity never “fully acquired and consolidated.” The problem with such idealizations is that they divert us from the reality, in my view, of the analyst’s mind at work, and reinforce the fantasy that, unlike ourselves, some analysts reach such conflict-free states, an idealization that is propagated by our sure-footed literature.

Let me hasten to add that Fogel and Glick do not insist that a conflict-free condition can be achieved, but the fantasy of such an identity persists in our literature, in our discourse, and, more importantly, in our own self-critical behavior. The analyst’s conscience is an essential point around which identifications accrete in order both to soothe and to sharpen its sting.

Furthermore, to the extent that Fogel and Glick are speaking of an identification or “transference to theory,” in Rangell’s (1982) words, they enter a particularly problematic area. Every transference to a theory is in part a transference to a person or a set of personal identificatory figures behind that theory—or behind theory in general. One has only to look at the marketing devices of book publishers to realize that even highly theoretical books are more likely to sell if there are a photograph and perhaps a few biographical details on the book jacket to facilitate the reader’s identification with the author. My sense, moreover, is that even after the postgraduate period, we may achieve at best a restless compromise with theory—both theory of mind and theory of practice. Friedman (1988) writes that psychotherapy takes place in a state of personal discomfort for the therapist most of the time and that theory serves to soothe the therapist in times of trial. If he is correct (and I believe he is, even if the therapist’s discomfort often lies well hidden) perhaps the factors that determine our uses of theory are less stable, more subject to shifting identifications—or to a good night’s sleep—than we like to think. I would like to suggest that our relationship to theory and to its role in practice is always in a state of dynamic tension, responsive to our own inner conflict and clinical uncertainty, as well as to the conflicts we face in the patient.

The examples we have considered thus far—Diamond’s inquiry into his identification with his training analyst, Fogel and Glick’s postgraduate experience, and Semrad’s own teaching—support the prevailing view that identification is a linear process beginning in childhood (or, by analogy, at the start of training), that early and primitive identifications are problematic, and that when things go well such identifications

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fade into the background. While I do not disagree with this in principle, and will present evidence to support it, I find that the analogy between candidacy and early childhood tends to promote a simplistic view both of the analyst's mind at work and of adult development in general.

I would argue that identification as a process is both lifelong and notably unpredictable. Human beings, in fact, appear to be highly promiscuous in their identifications over the entire lifespan, and even casual contacts can leave their mark. In a remarkable bit of sleuthing to document psychoanalytic genealogies, Falzeder (1998) provides evidence that the transmission of psychoanalytic ideas and practices is, at heart, a fundamentally personal one. As examples, he uses Ferenzci's and Rank's "filiations" in North America, including their contacts with analysands, students, and colleagues, to show that even brief encounters in adulthood may shape the individuals involved and their ideas.

IDENTIFICATION AS COMPROMISE FORMATION

Starting with the view that every mental event is a compromise formation (Brenner 1982) and hence everything an analyst says, thinks, feels, or does is constructed from his or her own wishes, defenses, self-punitive trends, and unpleasurable affect, I have been trying to explore the specific implications of this position for the analytic encounter. I have suggested, for example, that every interpretation carefully examined may be shown to serve the function of compromise for the analyst, and that in the defensive components of that compromise lie the seeds of the analyst's participation in, or mutual creation of, the patient's resistances (Smith 1997). More generally, it seems to me that the analyst's conflicts are always activated in response to the patient's, and it is this activation of conflict that in large measure is responsible for the analyst's very engagement with, and empathic understanding of, the patient. For analysts in their ordinary working mode, every thought, feeling, and action is the outcome of something stirred by the patient and their own conflictual issues. In other words, analytic listening is conflictual listening, and the analyst's conflicts—or neurosis, if you will—constitute the listening instrument (Smith 2000). If every analyst, consciously and unconsciously, inevitably listens *to* and *through* his or her own conflicts for what may be active in the patient, such conflicts lead the analyst simultaneously toward and away from

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the patient. They facilitate and interfere at one and the same time. This is no less true of the analyst's identifications.¹

As Sandler (1960) has detailed, identification is both a process and a product of that process. In other words, while we might think of identification as a lifelong process serving the needs of development, adaptation, and compromise, we can also think of it as the outcome of that process—in short, a compromise formation (Abend and Porder 1986). As such, analytic identifications are the product of loving and aggressive wishes, the defenses against those wishes, and frightening self-punitive trends of our own that accompany us in the work.

Arlow (1972) suggests that analytic identifications ideally become “resistant to regressive reinvolvement in conflict” (p. 563). Over time, I have found this trend to be true, but I would argue that Arlow's position, like Fogel and Glick's, may be an overstatement. I agree with Abend and Porder when they write that while “some [identifications] may lose much or all of their overt conflictual quality . . . others may remain extremely troublesome and problematic. In all cases, however, the elements which are their constituents . . . may be the same” (p. 204). Conflict being ubiquitous, I would suggest that analytic identifications, like all compromise formations, remain embedded in conflict and continue to be shaped by conflict. The issue, then, is not whether they are—or are not—conflictual, but what conflictual function they serve at any given moment. While the analyst is continuously being drawn back into conflict, reawakening old identifications and initiating new ones, the intensity, form of expression, and function of those identifications may shift over time as the analyst gains increasing familiarity with his or her own conflictual inner life, finding a way to use it and the identifications embedded in it in the service of the patient's analysis. In this contribution I hope to show that while identifications modify over

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¹In suggesting that the analyst's neurosis is the listening instrument, I am deliberately blurring the distinction between normal and pathological conflicts and compromises. Considered at the level of detail at which the analyst works most effectively, such differentiations, in my view, are very difficult to make, and the attempt to do so may paint a misleading picture of the analyst's mind at work. To quote Brenner (1982), “There is no sharp line that separates what is normal from what is pathological in psychic life” (p. 150). The distinction between normal and pathological compromise formations is based on the degree of pain and inhibition the person suffers, the quantitative factor Freud so often invoked. The dividing line between the two is a subjective and, as Brenner indicates, “an arbitrary one” (p. 150). Contemporary conflict theory, as Brenner (1982, 1994) elaborates it, is not a theory of psychopathology but a theory of mind (Smith 1995b).

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time, following a predictable developmental path, they remain an active part of the analyst's inner life, responsive to both the analyst's and the patient's conflicts, and that they coexist in a dynamic reciprocal relationship with the patient's inner life.

DEFINITIONS

As a starting point, let us borrow Schafer's (1968) pragmatic rendering of *identification* as the "modifying of the subjective self or behavior, or both, in order to increase one's resemblance to an object taken as a model" (p. 16). Sandler and Rosenblatt (1962) define it in representational terms as "a modification of the self-representation on the basis of another (usually an object) representation as a model" (p. 65). Related to identification is the concept of *idealization*, which, for our purposes, we might take to be the experiencing of parts or all of an object in more or less exclusively positive terms.

For the most part we are speaking here of *secondary identifications*, wherein, as Sandler and Perlow (1987) put it, "the representational boundary between self and object is not lost, but the subject embodies in the self-representation attributes of the object, real or fantasied" (p. 10). This is in contrast to *primary identifications*, which are presumed to take place (a) in early infancy before the representational boundary has been established; (b) in states of psychosis, wherein the boundary has been lost; and (c) as a fleeting but "ubiquitous normal phenomenon," including moments of regressive empathic resonance in analysis (pp. 9–10). My sense is that when we begin to examine what might be called the regressions of everyday life, especially as they apply to the everyday life of the analyst, the distinction between primary and secondary identification is not as clear-cut as our theories might imply.

Valenstein (1961) describes four types of identification. In his view there is (a) identification with the loved object; (b) identification with the lost object; (c) identification with the aggressor; and (d) identification out of guilt. While I find this classification heuristically and diagnostically useful in singling out the more prominent features in the development or acquisition of any given identification, there is a clinically misleading aspect to any such typology, as there is with the classification of transference as positive or negative, maternal or paternal, erotic or aggressive. Just as in practice what we invariably see

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are mixtures of these forms of transference (Brenner 1982), so, in my experience, all identifications, when carefully examined, turn out to be mixtures of the four types outlined by Valenstein, as befits their multi-determined origins. Like all conflictual structures, identifications are always ambivalent, and as such they all serve both to advance and to obstruct the work. Freud put it clearly in 1921: "Identification, in fact, is ambivalent from the very first; it can turn into an expression of tenderness as easily as into a wish for someone's removal" (p. 105).

A colleague who read an earlier version of this paper took exception to this position, arguing from the point of view of attachment theory that many identifications are not ambivalent, namely those that develop out of an early secure attachment bond in which the primary object mirrors and extends the growing self-representation of the infant. There is, of course, a time-honored debate about the evidence for and against such nonconflictual mental structures in development. This debate would include consideration of Hartmann's "conflict-free sphere" of the ego (Hartmann 1964, p. x), along with questions as to when and whether such structures eventually become intertwined with conflict.

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Resolution of this debate is hampered by the fact that the data we gather to support one side or the other are shaped by our own definitions and by the theories through which we view such data, but in my experience there is no psychoanalytic evidence to support the notion of conflict-free mental activity. I would suggest that by the time we see any patient in analysis, all mental activity, including all attachments, are, as we observe them, so thoroughly intertwined with conflict that they must be regarded as ambivalent and, as Freud indicated, seem always to have been so. Indeed, remembering Sandler and Rosenblatt's definition of identification as the modification of the self-representation on the basis of an object-representation used as a model, it is difficult to imagine that however ego-syntonic that modification might be, there would not be a counteridentificatory pull against it—if only due to what Fonagy (personal communication) calls the "natural persistence of structures" or simply the "inherent wish to continue as one is."

Another difficulty in reconciling psychoanalysis and attachment theory on this matter is that they reflect such different frames of reference. Attachment theory distinguishes four different models of attachment: *secure*, the most common, followed by *avoidant*, *ambivalent*, and *disorganized-disoriented*. Of the four, only the last is con-

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sidered pathological (Silverman 2001). These designations are based on the young child's overt behavior under the particular circumstances of the "strange situation" (Ainsworth et al. 1978). While both attachment theory and psychoanalysis base their inferences on observable behavior, the data that shape attachment theory and the circumstances under which those data are obtained are in sharp contrast to the observational data of the psychoanalytic situation, on the basis of which analysts form conjectures about the patient's conscious and unconscious experience.

Traditionally, attachment theorists have not focused on the child's capacity to introduce conflict into his or her identifications. There was felt to be no inherent conflict or distortion in the representation of the object because the young child was considered a veridical observer of the external environment. Hence, it was the "actual relationship" that drove the process, and distortion was introduced only by the caregiver (Fonagy, personal communication; see also Erreich 2000). Note that even with these qualifications, an unambivalent attachment could only derive from an unambivalent caretaker, a dubious concept psychoanalytically, which brings us back to the problem of definitions and frames of reference.

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More recently, certain attachment theorists seem to be abandoning the notion that initial attachment representations are veridical, as they observe that "comparable caregiver behavior may be experienced and encoded differently by different infants" (Fonagy 1999, p. 468; see also Eagle 1995, 1997). Thus, in the effort to account for the various subjective states of the young child, a convergence may be developing between the two theoretical approaches (Erreich 2000). In this light, Silverman (2001) has stressed that "the adaptive or pathological features of the attachment system entwine with conflicts generated by libidinal wishes" (p. 329). I would add that if we were still to conjecture that some of the earliest identifications are conflict-free, we would be left with the problem that, as development proceeds, infantile fantasies and wishes would inevitably begin to remodel even these earliest templates and so create conflictual structures where once there may, hypothetically, have been none.

Despite their ambivalent nature, Freud (1921) argued that identifications enrich the ego, and idealizations impoverish it. Although the two remain, in my view, separate processes, my sense is that some degree of idealization inevitably accompanies the beginning of an identification. As Hartmann, Kris, and Loewenstein (1951) put it, the child

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identifies with an idealized parent “to escape the conflict between love, hate and guilt and the torments of anxiety” (p. 33). As I see it, the individual must perceive some aspect of the other in an idealized light in order to want to modify him or herself accordingly. This holds true even, and perhaps especially, in instances of identification with the aggressor.

In fact, one might say that with every analytic identification we tend to retrace the path of idealization in development. I am thinking of the child’s developing ego ideal that seems in early childhood to shape itself initially around magical, monstrous, or other-worldly heroes and heroines; these, in turn, evolve through latency into increasingly humanoid figures, including sports heroes and celebrities, and finally emerge in adolescence and early adulthood as more realistic, ambivalent identifications with parents and teachers. So, too, it seems to me, there are moments early in training, at the start of work with an admired supervisor for example, when the mentor may be highly idealized—like a mythical hero, barely existing with his or her own history, and present only to impart knowledge and to help master the terror of aloneness and incompetence. Gradually, as the candidate succeeds and fails, and other supervisory figures succeed and fail to transfer their magical powers, idealized supervisors begin to assume more realistic proportions.

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VIGNETTE 1: A NEW SUPERVISORY VOICE

While the supervisor of my first analytic patient was a child analyst, keenly attentive to the vicissitudes of ego development and the content of fantasy, the supervisor of my second patient was skilled at teasing apart bits of process and momentary defensive shifts. He had an uncanny ability to notice the throw away line or neglected phrase that might otherwise go unobserved. The female patient I brought to him frequently concluded a series of especially telling remarks with a vague, distracted, “Anyway . . .” We were well into the analysis when, at the prompting of my supervisor, I asked my patient, “What is this ‘Anyway’?” I discovered that I had happened upon a thorny moment of conflictual interference and her habitual way of disguising it.

One day I found myself listening to my first patient with my second supervisor’s ears. This first patient was in the habit of sprinkling her remarks with a throwaway line of her own. At moments of

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heightened transference excitement, she would frequently say, “Ay-yi-yi” (pronounced eye-eye-eye). Over the course of our work together she had said it many times, but on this occasion I asked her, “Where does ‘Ay-yi-yi’ come from?”

She was surprised and clearly annoyed by my question. “I used to say that all the time when I was a kid,” she said curtly. “Haven’t you heard that before?” I had, of course, heard it many times from *her*, but I had never asked her what it meant because I had not considered how to make it a point of observation for the two of us. As I have detailed elsewhere (Smith 1992), what unfolded was an elaborate web of meanings, identifications, and compromises, as we came to understand this simple phrase as a multiply determined condensation.

Patients often react as mine did when their analysts speak in unfamiliar voices to challenge what has heretofore been collusively avoided. During our training years, patients may uncannily sense when we have just returned from a supervisory hour to approach them with a stranger’s words. Such moments can be explosive. My first patient was often slow to speak at the beginning of an hour. I usually waited silently. One day, I again borrowed the voice of my second supervisor. I said simply, “You seem to be having more trouble than usual speaking today.” It unleashed a storm of several days. When she was finally able to reflect on it, she told me, “You said I have a lot of trouble talking. I wasn’t having trouble. I didn’t *want* to talk. . . . I want to kill you when you hit that nerve. . . . I want to cut you up in little pieces. . . . You really have become this hostile side of my mother.”

Beyond the fact that patients do not like it when their analyst’s voice suddenly sounds foreign to their ears, each supervisory triad of patient, analyst, and supervisor assumes its own dynamic shape, fueled by multiple triadic identifications (Smith 1994). When it is disrupted by a different voice, a collusion may be exposed within the triad, leading to the analysis of an unrecognized aspect of the transference. This phenomenon is similar to those times when a consultant points out something hitherto unnoticed in a patient and suddenly we see it everywhere—in all of our patients, as well as in ourselves. Our own listening is in dynamic balance with the intrapsychic life of each of our patients, and we form collusive avoidances all the time that no one wants to disrupt—not patient, analyst, or supervisor.

There is a leap forward in the developmental sequence of the analyst’s identifications when the candidate takes one supervisor’s

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approach to another patient, trying out different ways of listening (Ornstein 1967). In such experiments we challenge our separate identifications, making them more consciously available as we test each approach in the laboratory of the consulting room.

VIGNETTE 2: FREE-FLOATING IDENTIFICATIONS

All psychoanalysts have their own histories of analytic identifications, buttressing their own particular conflictual vulnerabilities, and every analysis has its own identificatory shape. Whereas most of the clinical vignettes in our literature give the appearance that the analyst is speaking autonomously, in my experience it is never so. In spite of the daunting isolation of our work, we never go unaccompanied into the consulting room.

792 I have noticed in myself that wholesale identifications have waned over time, as Semrad indicated they might, but I still hear their more conscious echoes under certain circumstances, and I have come to think of them as providing a background to the clinical hour that we might call *free-floating identifications*. I am speaking here of those identifications that I become aware of during the hour, when, evoked at a particular moment, the thought of my analyst or a former supervisor flickers across my mind and becomes one of the precursors in the “genesis of an interpretation” (Arlow 1979). You remember Arlow’s description:

The thought that first appears in the analyst’s mind rarely comes in the form of a well-formulated, logically consistent, theoretically articulated interpretation. More often what the analyst experiences takes the shape of some random thought, the memory of a patient with a similar problem, a line of poetry, the words of a song, some joke he heard, some witty comment of his own, perhaps a paper he read the night before, or a presentation at the local society meeting some weeks back. The range of initial impressions or, more correctly, the analyst’s associations to his patient’s material, is practically infinite [p. 200].

My point is that figures of identification that originally served to calm anxiety, to provide mastery, and to teach, may return later in the analyst’s career in bits and pieces when evoked by specific patients at particular moments. In this regard the appearance of such figures is an expression of countertransference broadly defined (Smith 2000), and they function in dynamic balance with the intrapsychic life of the patient; that is, they are prompted by both the analyst’s and the patient’s

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conflicts, and they reinforce the analyst's dispositions both to advance and to retard the work. I see them as just the conscious edge of those identifications, which by now have become inseparable from the analyst's identity and a part of his or her unconscious conflictual life.

There are, of course, many other identificatory figures that may appear in the analyst's consciousness during an hour, including the analyst's parents, grandparents, siblings, and children. Evoked by the states of mind of both patient and analyst, they, too, become part of a free-floating process of attention that leads the analyst toward—and away—from an understanding of the patient's unconscious life. My focus here, however, is on a subset of such phenomena, namely those figures familiar to us from our training as we remember them in our analyzing. Many hours do not contain such conscious figures of identification, but here is one that does.

It is the end of March. I have been away for a week, and my patient is twenty-five minutes late. I am a bit apprehensive about his lateness. As I walk into the waiting room, he looks sheepish. I feel slightly annoyed. I think of looking at my watch. I do not, but it reminds me of being late for my analyst. Occasionally I would see him glance at the clock. My obsessional patient is frequently late. We have worked on it, and I have a brief sense of failure. Twenty-five minutes seems at the moment a long time, perhaps a deliberate challenge. The week's interruption, the beginning of the hour, my patient's lateness, and my anxiety, annoyance, and sense of failure all prompt this momentary thought of my analyst. A call on him for help? An identification with what I imagine to have been *his* annoyance? I am not sure. My patient lies down and says, "I thought you'd be annoyed by my being so late. Then I thought maybe you'd have a bill to give me." This is a familiar sequence for us.

I say, "So you might annoy me and then appease me?"

He says, "It doesn't feel like it's my goal to get you angry."

I backtrack, another supervisor vaguely on my mind. "What do you suppose is behind the lateness?"

He says, "As I was coming here I thought I would ease back into this. I thought, I don't want to be here. Half a session will be fine today." I start to comment. He interrupts, "It's like a herring sandwich."

His remark takes me by surprise. I think of the Rat Man, who did not like the herring that Freud (1909) wanted to feed him either. I have no reason to think my patient has ever read the case report.

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I say, "Getting back into it feels like a herring sandwich?"

He says, "Cold and slimy and tastes like fish."

I hear another supervisor—I do not know who—describe an association between water and tears, and then I remember that the week before I was away my patient had been struggling with grief over the impending death of his grandfather. Every day he fought back tears. He found them unpleasant and distasteful, but he was allowing himself to experience them with a newfound sense of relief for us both. We had been breaking through a wooden resistance to his sadness and his fear of his passive longings for me, his father, and his grandfather. Again I think of my analyst, his way of picking up the patient's metaphor. Again I think of the wetness, and I say, "Something unpleasant about it, cold and slimy. Those tears were cold and slimy." He relaxes. I have a warm and positive feeling for him, akin to my feeling for my analyst and what I imagined my analyst's feeling might have been for me when he would just capture my experience. I relive that now with my patient.

794 But he is in another place. He says, "When I wasn't here I stopped thinking about those things. Is it always going to happen like that? You're like a drill sergeant. You want me here shoes shined, spit-polished."

This too surprises me. The Rat Man again, who insisted on calling Freud "Captain." I hadn't been feeling like a drill sergeant. It is one of those attributions so completely unlike my own conscious state that I feel momentarily caught in my patient's transference, rather as Bird (1972) describes the transference neurosis coming to life at the very moment when the analyst has become so incorporated in the patient's internal life as to feel like a part of the patient's neurosis itself. More immediately I feel he is pushing me away, pushing away my sense of closeness to him, along with his tears of the previous week. I disrupted that closeness with my leaving. He disrupts it now with the drill sergeant, which at the same time seems to excite him. There is a long history to such excitements.

He says, "How could I dare to come in here so late? Last year when I went on vacation I was terrified I would be drawn and quartered. It was a horrible feeling. I like to eat sushi; had it three times this month. I've had enough of it for a while. The herring didn't taste like sushi." I wonder silently about what sounds to me like emerging homoerotic fantasy. He continues, "I had a cold last week, tired every evening. It seems like I was just here."

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I say, "The taste of herring still in your mouth."

He says, "I've done enough this month, wait until April."

With his retreat to this more passive position, I stay with his opposition to the sergeant and nudge him a little, "But you *should* be doing this." This nudge and the emphasis on "should," the manifest resistance, also reminds me of my analyst, and I pull out the stops. "I suppose you also enjoy telling the sergeant to go fuck himself: 'I'll come in when I want.'"

He hesitates, then joins me and tells me something I did not know. "I hate to think I have that much anger at you. But there is some anger *for your not being here last week*." Then he gives me evidence, "When I made that comment about the herring, I cut you off in mid-sentence." I hadn't noticed it at the time. He adds, "There is this angry feeling behind it." The hour is over.

This hour illustrates a number of moments when a supervisory voice or the thought of my analyst floats across my mind. Notice that as the hour begins my analyst accompanies me into the room. I frequently become aware that I am not alone at both beginnings and endings of hours. At the end of an hour, as I become aware of the particular way I am slumped in my chair, or notice a familiar posture I adopt as I walk to the door, just for a moment I may feel like my own analyst—feel as if I am he, that is—a brief moment of primary or total identification. Beginnings and endings of certain hours, like other moments of joining and separation, stir, sometimes imperceptibly, our anxiety. They evoke a particular kind of conflict, more prominent, no doubt, for some analysts than for others, but, I suspect, problematic for all. Amongst other things they can revive, ever so briefly, the analyst's own sense of loss and aloneness, especially the loss of his or her own analyst.

I remember leaving my analyst's office the last day of my training analysis. I walked to my own office about fifteen minutes away, a walk I had taken many times in both directions. That day I felt different, lighter, expectant, but also apprehensive and bereft. What surprised me was my reaction when my next analytic patient lay down on the couch. I felt a palpable sense of relief that analysis itself would continue, my patient's if not my own, and that the intensity of transference, which had been so essential to me in my own analysis, would continue to fill the room and in some sense help to sustain my own further growth. Over the ensuing weeks I found that each time I returned to my office,

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I revived in my work some aspect of the identification with my own analyst. Over time, my conscious awareness of that phenomenon has faded, but I still feel it occasionally under certain circumstances, as I have tried to indicate here.

Indeed, if we remember *Mourning and Melancholia* (Freud 1917), it is not surprising that at the beginning or ending of an hour the analyst may reach for his figures of identification. As Strachey pointed out in his introduction to the paper, Freud felt his most significant contribution in that work was his account of the process by which the loss of an object resulted in an identification. At that moment, you recall, “the shadow of the object fell upon the ego” (p. 249), and the ego in its critical functions—soon to be called the *superego* in Freud’s evolving nomenclature—turned back upon itself. Thus it is also not surprising that at such moments of felt aloneness, at the beginning or ending of particular hours, for example, the analyst may be more uncertain and self-critical than at others.

796 I usually find that even these awakened conflicts are not only an expression of my own state of mind at the moment but that they are also a response to the patient’s state of mind at that same moment (Smith 2000). In this regard, notice that the look at my watch at the beginning of the hour, which I associate with my analyst and which I inhibit, anticipates my patient’s transference to me as the drill sergeant who insists on “shoes shined, spit-polished,” and no vacations. While the initial thought of my analyst, then, serves both to calm my momentary anxiety and aloneness, as well as to give me a countertransference vehicle for an annoyance of which I am otherwise barely aware, it is simultaneously a response to (or anticipation of) my patient’s transference, not yet verbally expressed in the hour. Fighting with the sergeant is far more tolerable to my patient than the herring sandwich, the sadness over my absence, and the passive longings it contains. Moreover, my sense of loss and my reaching out for my analyst, prompted by my patient’s twenty-five-minute absence, anticipate his sense of loss and his reaching out for me, as well as for his father. Thus the revival of my analyst—both the impatient one and the empathic one—is shaped by both my own and my patient’s conflict. In sum, the conscious and unconscious identifications that fuel the hour reflect not only the analyst’s current compromises but also, simultaneously, the nature of the patient’s transferences and internal objects.

I repeat that these identifications usually take place either at edge of—or just outside of—awareness, despite the artificial prominence I

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have given them in the narrative of this hour. If I hear them at all, they pass by in a flash, an event I cannot convey accurately, for it is impossible to capture in writing the complexity and rapidity of the analyst's mind at work. Because of these limitations, in writing about the analytic experience we inevitably exaggerate the importance of one aspect or another (Smith 1997). There is, however, another artifact. I am presenting this vignette and those that follow to illustrate a particular phenomenon, my conscious experience with brief moments of renewed identifications, and this agenda may in fact shape my associations in the hours themselves. I noticed, for example, that while writing this paper my clinical work seemed to offer more evidence of my voices than usual, but once an earlier draft was completed, they quieted considerably, to the point of disappearing for weeks at a time.

These realizations are not as undermining of my thesis as you might think, however, for if I am correct that my voices break through to consciousness when summoned by the particulars of my patient's conflicts and my own conflictual responsiveness to them, then my sense is that even in those hours in which my identifications are totally silent, they are, nonetheless, operative either just below the surface or buried in the depths. In this regard, it seems to me that if an analyst were to take any given intervention and associate to his or her analytic stance at that moment—put the analyst on the couch, so to speak—we could begin to derive an identificatory history for that intervention. As in associating to a dream, the identificatory components of the “preconscious” or descriptively unconscious background of an analysis might thus begin to show themselves, and every momentary aspect of an analyst's stance might reveal a history of identifications behind it. Our modes of analyzing are precipitates of our identifications and counteridentifications.

I do not mean to suggest by this that all identifications are encoded in discrete recoverable and verbalizable memories. Many identifications must be largely procedural, preserved, like the capacity to ride a bike, in bodily memories never to be articulated. Some of the reflections I am describing, in fact, were merely vague bodily sensations, of which I was barely conscious during the hour and which I have struggled to articulate only for purposes of this exposition.

If the analyst is immersed in the work with the patient, that work takes shape in the momentary shifts so well described by Arlow (1981) between identification *with* the patient and thinking *about* the patient.

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Looked at another way, however, because the analyst's "thinking about" the patient is, in my view, always shaped by his or her own identificatory "voices," there is a tension moment by moment between the analyst's identification with the patient on the one hand and with these figures from his or her professional life on the other. In other words, identification with admired supervisors, teachers, and analytic ancestors anchors the analyst in his or her analytic stance to help keep the analyst from getting "lost," so to speak, in identification with the patient and in the continuous process of enactment that inevitably accompanies the work (Smith 1993, 1995a). This phenomenon may be especially prominent in the early years, but one can still see its more finely tuned operation in seasoned analysts.

THE BATTLE OF VOICES

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While identifications initially soothe anxiety and self-critical trends in the candidate, over time they can be used to amplify those same self-critical trends. The period following the termination of one's own analysis, compounded by the loss of valued supervisors, can be a crucial time of potential growth, but also one of loss and confusion when, as I have indicated, the shadow of the object may fall upon the ego and yield a number of competing and potentially self-critical voices. These are the more aggressive components of what were once primarily loving and idealizing identifications. A colleague of mine calls it her Greek chorus. In my head it used to sound more like a Woody Allen movie: "Did you hear what Smith said?" . . . "Dr. X wouldn't say it like that." . . . "Do it this way." . . . "No, do it *this* way." . . . "You call *that* analysis?" Over time the warring voices may quiet as the analyst makes peace with and among them, and he or she may even hear a more harmonious sound as they are woven into the self-critical functions of analyzing, but I still recognize the darker voices on a bad day or with a patient who demoralizes me.

The self-critical voices I am describing here may sound to you more like introjects than identifications. While the line between introjection and identification is frequently blurred, Sandler and Perlow (1987) distinguish between "*identification* as a modification of the self-representation" and "*introjection* as the setting up of unconscious internal 'phantom' companions, felt to be part of one's inner world, yet external to one's self-representation" (p. 11, emphasis added). If

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we take the view that there is a developmental path for many internalizations, running from imitation to introjection and finally to identification, my sense is that while all of the “voices” I am describing were conceived in imitation, some, to be precise, might fit more appropriately into the category of introjects, some derive from true identifications, and still others fall somewhere in between or represent mixtures of the two, including what have been called *identifications with introjects* (Sandler and Rosenblatt 1962; Schafer 1968). My aim in this article, however, is not to illustrate clear-cut distinctions among types of internalizations, but rather to examine a range of clinical phenomena as they reveal themselves in certain analytic hours.

In an earlier contribution, Skolnikoff (1988) took a similar view of the analyst's critical voices, proposing that the privacy, isolation, and mutual regression in the analytic situation stimulate in both patient and analyst the fantasy of a “silent observer.” He suggested that analysts respond to the emotional involvement of the work by “projecting their shame onto a critical or benign silent observer. This person can be fantasized as many different people: supervisor, analyst's analyst, friend, patient, patient's spouse, parent, or child, etc.”

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Elaborating on this position, I would argue that my critical voices are and always were my own voice. In fact, the person with whom we identify, or whom we introject, is always, in my view, a fantasy of our own making, however veridical the representation may seem. As Schafer puts it, we do not identify “with a person but with one or more representations of that person,” with our own “conception or experience” of that person (1968, p. 142). In that sense we might say that all identification is “projective” identification (Smith 2000).

I have come to feel that the battle of voices is part of the development of the analyst's autonomy. In this respect, too, we might make a comparison with voices from childhood that were—and to some extent remain—in conflict with each other. This raises an important pedagogical question: how best to assist each candidate in the development of his or her own clinical voice. I remember one consultant pointing out to me that I was operating with “two conflicting models of analysis.” I thought perhaps I was being asked to choose one or the other. Gardner (1994) addresses this problem with his attempt to listen for the supervisee's “hidden questions,” those self-inquiries at edge of awareness that may advance the process of integration, rather

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than forcing a choice. Mindful of Gardner's teaching, I have found that, as with conflicting childhood voices, we do not ever fully reconcile conflicting analytic identifications, but may in time find a place for them where they remain in relatively peaceful if somewhat contradictory coexistence, not unlike Sandler's (1983) place for preconscious part-theories. And yet, like transferences, contradictory voices too can be revived at a moment's notice and for a variety of purposes.

The process of integration and reconciliation may be more problematic in this pluralistic era, when territorial battles are given legitimacy in the marketplace, and we are lobbied to ally ourselves with one "position" or another. But even without such cultural and political backing, alliances can form prematurely to abort the painful process of finding one's own voice. Identifications then rigidify, no longer responsive to the clinical context. When this happens we lose sight of what Freud (1897) discovered at the birth of psychoanalysis, when he wrote to Fliess, "I am beginning to perceive in the determining factors large, general, framing motives, as I should like to call them, and other motives, fill-ins, which vary according to the individual's experience" (p. 274). In technique, as well as in theory, it is always tempting to return to the general application and lose the essential "fill-ins" and flexibility.

I have previously described my discovery that a closely attuned way of working, with which I was solidly identified and tended to apply under all circumstances, opened some aspects of the work with a certain patient but seemed to close off others, as she and I both grew to prefer this way of working to any other. It served us both in our effort to avoid her wish to demean me at a time, early in my training, when I was particularly vulnerable to such denigration. A consultant helped me to find a longer focal lens to disentangle the enactment, along with the capacity to shift more flexibly from one position to another. The work with my patient then became considerably more contentious and, as it turned out, more productive (Smith 1997). I want to emphasize that I am not criticizing any particular technical approach here, only highlighting the student's more heavy-handed and, at times, inappropriate use of it. Disciples frequently turn out to be more zealous than their teachers, stemming in part from the more aggressive and competitive components of their identifications with them.

VIGNETTE 3: IDENTIFICATION COOPTED BY THE COUNTERTRANSFERENCE

More recently I have noticed that particular identifications may be commandeered by the dynamics of a specific analysis to collude, often quite subtly, with a countertransference disposition. A number of years ago, a woman in her early forties had been telling me repeatedly that she felt I was ignoring her erotic excitement and focusing, to her great dissatisfaction, on her wish to be mothered. I thought I could see her moving defensively from one position to the other in an effort to avoid the conflicts attendant on both. She thought I was afraid of her sexuality. One day she was telling me about how old she felt, how old her husband seemed, what a mess her house was in, and, by extension, her life. "Do you think I'm awful for that?" she asked. I felt the tug of her request for reassurance, and at that moment I became momentarily distracted, my attention caught by an item beside my chair.

"What are you doing?" she said, challengingly. And then, without missing a beat, she added, "You are simply adjusting your chair. I am so good; I don't turn around and look."

"Looking would be too aggressive," I said.

"It would startle you," she added. She paused, silent for half a minute, and then in a markedly quieter tone she said, as if explaining her silence, "I suddenly got aroused."

I was struck that her sexual excitement seemed prompted by my distractedness, and I thought momentarily of the potential embarrassment for her of her arousal. I remembered a patient who told me that she had had an orgasm during an hour with a previous analyst. A supervisor of mine had commented at the time that if the analyst had been more attuned to her experience, he might have spared her the humiliation of the orgasm. That supervisor would, I thought, have attended to my patient's experience of my lapse in attention. I also thought briefly of the use of erotic fantasy to reach out to someone one has momentarily lost, and so I said, "Notice that you got aroused just after you felt you had lost me."

She said, "Perhaps." She wasn't convinced. I felt I was, for the moment, off the mark. But at the same time the tone of her voice stirred a rapid realignment in my own thinking, and I found myself responsive to another aspect of her emotional state and of our history together. My supervisor no longer on my mind, and with no conscious substitute,

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I said, "Or perhaps your arousal started when I said that looking at me would be too aggressive."

"Yes," she said with conviction. "I think it's more that. The sound of your voice got me excited."

I said, "It felt like an invitation, a joining: you *could* look at me."

"Yes," she said emphatically, and then she fell silent. After a moment she explained, "I'm in trouble. I just detached from you."

So we had come full circle. I had used my identification with my supervisor not to notice what seemed now to have been the true source of my patient's erotic excitement—that it had been elicited by my comment, not my absence—and in so doing I had once again dismissed the excitement itself, thus confirming her sense that I avoided her erotic attachment to me, as if it were only serving earlier aims. But as I "found" her with my acknowledgment that it was my comment that had excited her, she pulled back defensively into a more passive and detached position. Together and sequentially we thus both avoided the erotic component of the interaction between us.

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One could argue, of course, that both interventions spoke to a part of what was going on—the first one, which felt prompted by my supervisor's voice, and the second one, which seemed to be my own. Or perhaps that my detachment was indeed the salient moment, and that with my second approach I was actualizing her erotic fantasy as a way of bringing us back together. In any given moment we do not know what may become clearer over time. Regardless of one's perspective on this particular interaction, however, we can see that there is a subtle dance of engagement and disengagement being played out between analyst and patient, in which my identificatory figures are standing on the sidelines, looking on, waiting for an invitation, but in no way responsible for the dance itself.

You may have noticed that, as in some of the other clinical moments in this paper, I "find" the patient here only after I have silenced my supervisory voice ("my supervisor no longer on my mind and with no conscious substitute"). While to some this may demonstrate that such voices are primarily interferences, there are other ways to understand this phenomenon. One would be that after reaching for help in my uncertainty, once I bring my former supervisor into the room, that presence so alters my own inner state that I can go it alone more easily, hear my patient more clearly, and, in so doing, find my own voice. Another would be that silencing my supervisor reflects

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the need for a kind of analytic “parricide” (Cooper 2001), in Loewald’s (1978) terms, so as to throw off the supervisory yoke and achieve a fuller intimacy with the patient. These are not mutually exclusive explanations.

VIGNETTE 4: BEING CORRECTED BY THE PATIENT

Patients have various ways of telling us when our identifications are too rigidly held, if those very identifications do not prevent us from hearing them. From time to time, for example, with patients who have profound resistance to engagement in the transference, I find myself paying selective attention to the aggressive aspects of that resistance, a focus on aggression that I associate with a number of more recent influences on my work. It can be an important source of a patient’s lack of engagement, but it is never the whole story.

A patient I used to see, a lawyer in his late thirties, had been in analysis for a number of years. Recently he had begun acknowledging the anxiety, shame, and fury that lay behind his avoidance of me, something he expressed by frequent lateness and missed hours. One day in response to my persistent inquiry about his behavior he said, “I used to think I was coming here wearing a magic suit that was invulnerable. Today I was walking with my jacket open. I like to disappear, almost like being invisible. The enemy wouldn’t be able to find me.” I felt a surge of affection and protectiveness toward him, as I had at other moments recently. Toward the end of the hour I reminded him that we would not be seeing each other the following week; he was going to be away for a few days, after which I would be too. He had forgotten that I was also leaving.

The following day he did not show up and did not call. When he came for his next hour, several minutes early, he said that his lateness and absence bothered him. Specifically he was bothered that even though we had talked about it, he continued to do it. But he did not sound bothered, at least not deeply; he sounded as if he were trying to engage me in an intellectual argument. The thought of a moment with a former supervisor flashed across my mind, and I suggested that perhaps it didn’t bother him *that* much. We discussed his experience of being controlled, and as the hour went on I said that he seemed intent on proving that my comments had no effect on him; perhaps he heard my words themselves as instruments of control. He responded,

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“Actually I hate being observed.” But then he added, “If this is such an angry gesture, not coming in, why don’t I feel it?” I said, again with my former supervisor in mind, that even if he wasn’t feeling it, he seemed to be *behaving* it. The hour continued in this familiar struggle, which felt more tolerable to me than those states in which he used to remain remote and absent.

In retrospect, many barely conscious figures of identification supported me in my persistence, some telling me to stay with it, others suggesting what the issue was, or what to say. My comment about his hearing my words as instruments of control felt like my own voice, however, and I added, “You pretend this is all of no consequence, that it has no meaning to you at all.”

Then my patient disarmed me. “What if I say it has so much meaning that I was scared? I was. I spent the whole day trying to get here. When I’m in that state there’s no way to get out of it.” I was moved. As the hour went on, he began to knit together his fear, his anger, his realization of how important I had become to him, and how upset he was that he had forgotten I would be away. Then he returned again to his fear of being controlled. “I don’t feel like being accountable to anyone,” he said.

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In this hour my patient tells me in effect that I have it wrong, that I am focusing too single-mindedly on his aggression, that his story, like all such stories, is not only about anger but also about love. This was Semrad’s message as well. As a first-year resident I had a patient with a manic psychosis and a florid erotic transference. Her fixation on me seemed to fuel her manic excitement, and I had been given the conventional wisdom that exploring this aspect of the transference would only make things worse. But she was still tearing up the ward, and in some desperation we presented her to Dr. Semrad. She calmed as she spoke with him about her feelings for me, and afterward I asked him if I, too, should talk with her about her erotic excitement. To the consternation of the nursing staff, he answered without hesitation, “You should talk about love wherever you find it.”

Here my lawyerly patient is, in fact, reminding me about the nature of conflict, that it is always a mixture of aggressive and loving wishes. What allows him to tell me this? This is a man who does his best work in the midst of an argument. Notice that my initial stance enacts just such an argument, and when he tells me I’ve got it wrong it is both an acknowledgment *to* me and a triumph *over* me. In this hour

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my identifications both facilitate and obstruct the work. In forcefully pursuing his aggressive motives I am recreating with him a familiar sadomasochistic object tie, honed by him over many years of familial interaction.

The following hour, however, there emerged a new awareness of his internal objects and a new approach to them. Normally contemptuous of himself as a child, he said, "If I could go back there and find myself I would hug me and kiss me and tell me it's all right." And then he looked at the other side, "But what if that little boy wouldn't want to talk to me. Maybe I would strangle him." This, then, was the internal drama we had been playing out together in both its frustrating and its loving aspects, which he was now making his own. His fantasy of how he might treat himself with love—and perhaps frustration—was a new creation, at least new to the analysis, and for the first time suggested a way out of the old sadomasochistic interaction.

Perhaps you feel that my irritation with my patient in this hour was excessive. There is no doubt that such moments occur. Identifications fuel both loving and not-so-loving behaviors. What to say about the less loving ones? Grete Bibring (1954) observes that candidates are destined to live out their negative identifications with their analysts when they first begin treating patients. She compares it to the moment when children become parents and visit the "unsolved aggressive and guilt-ridden aspects of the relationship" with their own parents on their child. Thus the candidate does to the patient what he "did not want to have done to himself by his training analyst" (p. 172).

There are certain expressions of negative countertransference—a particular silence, an ironic tone, a laugh perhaps—when I feel I am transmitting an aspect of my own experience as a patient. I find that such moments are prompted in part by our patients and tell us about the patient's transference and object relations, as do any such countertransferential moments, but, as with more positive moments, the form they take is shaped by our own identifications. For those of us who have had more than one analysis, there may be several models from which to choose, and the more negative identifications may reside with one of our analysts rather than another. I believe that we internalize the total interaction with our analyst as we experienced it, including our experience of his or her countertransference. Certain aspects of our analyst's negative countertransference may fit seamlessly with our own self-critical tendencies with the result that later, when patients stir our

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own annoyance, we may visit upon them what we have inherited from prior experience. There are, of course, many dynamic reasons that analysts may recreate with their patients the more aggressive, competitive, and guilt-ridden identifications with their own analysts. You will note that the mechanisms to which I am alluding, including the use of projection and identification with the aggressor, are similar to the dynamics of child abuse. It is a reminder that the analyst's identifications modify his or her conscience for ill as well as for good, and that this effect may echo through succeeding generations.

VIGNETTE 5: INTO THE DARK

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Let me give you a final example of how the appearance of identificatory figures may reflect the inner lives of both patient and analyst. A patient arrives, breathless from emphysema and visibly anxious. She sits on the couch and says, "I need water. Don't lock it." I leave both doors open, and I think, "Don't lock it? What does she mean?" We have explored her curiosity about what goes on behind locked doors both in the transference and in her own childhood recollections for many years. This does not seem to be the point of urgency at the moment.

I ask, "Don't lock it?" Ignoring my question, she goes and gets water and sits again on the couch, drinking it. I know this woman is afraid of being both locked *out* and locked *in*, and that her fear of confinement has recently reached near panic proportions due to her illness. At this moment she seems afraid I might lock her in my room. I say again, "You wanted me not to lock it?"

Reacting to my question as if I am trying to lock her in with my words, she says, again breathlessly and anxiously, "I don't know whether you lock it or not." I think of a moment with a consultant who taught me about the fear of the claustrum. He would have found this fantasy in the patient's words. Can I interpret it in her actions? It is an odd question for me to ask myself. I have become quite used to following this woman's actions as one would a sequence of associations and interpreting them in kind, as with child patients. In fact, I have come to feel that it is one of the things that I do relatively well, an intervention that usually feels like my own voice. Here, faced with her terror and her helplessness, you hear me reach for supervisory support and, briefly, my self-critical doubt.

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Still struck by the improbable notion of locking a patient in, I say, "Do you think I lock the door to lock people out or lock them in?" She looks puzzled and continues drinking her water. I say finally, "I think you are afraid you will be locked in."

With a note of conviction and relief she says, "You're right," and she lies down. On the couch, she speaks of the terrible morale at the hospital; all the radiologists are leaving. Now I begin to hear the issue of confinement in displacement. And then she makes it immediate, "I'm starting to feel trapped in my life right now. I'm not sure what I want to do."

It is a convincing moment.

I say, "You are terrified of confinement whether by me, by your mother, or by your illness." As I say this I think briefly of another former supervisor, and a remark he made about Menninger's triad, interpretations that capture past, present, and transference. My comment and the memory that accompanies it help me feel in some command of this unstable, frightening situation.

She responds to it, "My mother spent an entire life being sick. I'm having a hard time with this."

I have a barely formed memory of yet another supervisory situation and of a patient who was terrified, as this woman is, of *becoming* her mother. I say, "You feel as if you are turning into your mother."

She says, "It is a terrifying thought."

In this sequence we are on familiar ground for her and for me. My thoughts of past supervisors, past moments of mastery, are all fleeting and not what is foremost in my mind. But as they pass through, they accompany me into this woman's horrifying fear of confinement and death and her urgent need for me. Her helplessness is contagious. I cannot change the course of her illness. Can I be of any use analytically? My supervisory voices, then, are revived here to support me in my anxiety about my patient, most of which is outside of my awareness. They are also responsive to her anxiety and to her desperate search for doctors who will help prevent her death from suffocation. And they guide me in an interpretive approach to her behavior.

But they have an earlier cast. In a previous publication (Smith 2000), I noted that this woman reminds me of my mother, her illness, her anxiety, her needs, and her erotic desires. The erotic component of the transference stirs my own oedipal anxiety in an attenuated, barely conscious form, and for brief moments I am a small boy unable to stem

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the tide of my patient's illness or take care of her overwhelming needs and wishes. Whereas in this hour my former supervisors come to mind, in another hour with her I might find myself intervening unexpectedly like my analyst, or I might think of my own father. Maybe one of them could help. Maybe one of them could manage this woman's needs and erotic desires. In other words there is a familiar oedipal anxiety and retreat.

The point I want to emphasize, however, is that having reached for my companions because of a shift in my own level of anxiety, when I bring them into the room my state shifts again, and I find I can hear my patient more attentively, less anxiously. Thus my thinking of them is not only a response to my patient's conflict; it also helps to sustain my analyzing function. The thoughts of past supervisors, then, like the thought of my analyst, all brief identificatory reinforcements, stem from my conscious and unconscious attention to my patient's concerns as well as from my anxiety raised by those concerns, and they seem both to calm me and to direct me back to the patient. Thus the thoughts I have and the actions I take are multiply determined by many aspects of the material and by my own conflict-stabilizing needs.

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Note again that the same identificatory revivals that serve to sustain my listening are direct responses to the specific nature of my patient's wishes and her conflict. In fact in this hour even my appealing to experts for help is impelled in part by her need to do the same; for her I am the expert from whom she seeks rescue, and she, too, characteristically retreats to various such figures in her mind for comfort. When she imagines herself without them, she says, "I don't know what I would do with the empty space."

I want to make it clear that I am not speaking here of my own consciously experienced anxiety in this hour. Like signal anxiety, the mechanisms I am describing for the most part keep my anxiety contained and out of awareness. They come to my mind here, as in the vignettes I have presented above, in response to challenges prompted by my patient's conflicts and by my own. They accompany me, as I accompany her, into the aloneness and terror of loss, abandonment, and death, and the self-critical doubts that accompany such states.

CONCLUSION

In this paper I have been reviewing the analyst's identifications with ambivalently held figures as an aspect of the countertransference, or,

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more broadly, of the analyst's conflictual engagement with the patient. I want to emphasize that this is not intended as a paper on technique, but rather as an exploration of the analyst's development and of a particular aspect of the analyst's mind at work. Analytic listening in all its forms is continuously responsive to both the patient's and the analyst's conflicts. Whether or not the analyst is conscious of it, his or her conflictual involvement leads the analyst at all times simultaneously toward and away from the patient, and it helps to sustain as well as interfere with his or her effectiveness.

The analyst's identifications are compromises, intended not only to educate but also to relieve the agonies of the work. They stem from mixtures of aloneness and loss, guilt and self-criticism, the seductive appeal of aggression, and the comfort of love. I hope to have shown how the analyst's identifications and idealizations modify over time but, never fully given up, remain as compromised responses to both the analyst's and the patient's conflicts in a dynamic reciprocal relationship with the patient's inner life.

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