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The analytic state of consciousness as a form of play and a foundational transference[1]

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The analytic state of consciousness *is a particular regressive altered state in the patient characterized by an increased sensitivity and reactivity to impressions arising from both the inner world and the analyst, a heightened sense of dependence and vulnerability, a permeability of boundaries in regard to the analyst, and a shift toward functioning on the basis of omnipotent fantasy in the analytic relationship. These changes are accompanied by a feeling of realness of one's psychic reality, but without any true loss of reality testing. Based on an analysis of the structure of play, this state can itself be understood as a kind of play; it serves as a* foundational transference *underlying more specific transference manifestations; and it is central to the analytic process. Over time, in response to physical aspects of the analytic setting, its safety, the analyst's emotional accompaniment, and a generally restrained analytic stance (an issue I discuss in some detail), it emerges in a more developed form that promotes symbolization and ownership of aspects of self, greater emotional presence, and a deeper sense of meaning in one's experience. Additionally, the concept of the analytic state of consciousness provides a new look at the role of abstinence and frustration in analytic process.*

Key words: abstinence, analytic restraint, analytic state of consciousness, foundational transference, play, symbolization

Prelude: Ferenczi's explorations of the analytic state of consciousness

I begin my exploration of the analytic state of consciousness with an intriguing statement unearthed from a century-old paper by Sándor Ferenczi:[2] "*We may treat a neurotic any way we like, [but] he always treats himself psychotherapeutically, that is to say, with transferences*" (Ferenczi, 1909, p. 55, original in italics).

Ferenczi was saying in that paper that analytic patients – and here I universalize Ferenczi's "neurotic" to include analytic patients in general, since I think the analytic setting typically elicits this – place themselves in a kind of hypnotic state: transference, Ferenczi suggested, *is* a hypnotic state,

[1]An early version of this paper was presented at the Conferenczi 09 Conference, Buenos Aires, Argentina, October 2009.

[2]Ferenczi credited Freud with this statement.

involving a heightened openness to influence. In the sentence quoted, Ferenczi was saying that patients seeking their own cure naturally create an altered experience of reality based on regressive fantasies and characterized by a highly receptive state of consciousness coupled with a dependent relationship to the analyst. Patients in this state are *eager* to introject and identify with the analyst and to be influenced by him, based, Ferenczi believed, upon feelings ultimately rooted in the patient's relationship to his parents of childhood.

Ferenczi's comment was not an appreciation of the value of patients doing this but a warning to analysts not to acquiesce in the patient's misguided "self-taught attempts … to cure himself" (1909, p. 55). Indeed, the long trajectory of Ferenczi's work can be read as his struggle with the need, and value, for patients to live out regressive, wish-fulfilling, omnipotent fantasies in analytic sessions. But after many years battling against patients' seeking out such states,[3] Ferenczi slowly came to recognize how difficult it is for them to renounce living on the basis of omnipotent fantasies, and the extent to which analysts must temporarily allow patients their comforting illusions and regressive states without interference, if patients are ultimately to risk letting these go.

The idea that the analytic situation naturally evokes a particular altered state of consciousness has been further developed, and with greater appreciation, both by Ferenczi in his later work and by his successors, as I will discuss. By the late 1920s, Ferenczi was explicit about the need for analysts to welcome patients' regressive states. One of his great clinical elaborations of this viewpoint was his 1931 paper *Child-analysis in the analysis of adults*, where, like his other papers from that period, he likened the analyst to an indulgent parent. Here, he described analytic treatment as a form of playing: the patient enters an altered state, a play reality where regressive fantasies determine the game – a game the analyst must not spoil.

In its most basic form, this altered state, as I understand it, reflects a heightened sense of need and vulnerability, even permeability, and also, paradoxically, the workings of the patient's reactivated sense of omnipotence, perhaps even before it resolves itself into a self-object transference with a particular form[4] – all of which inhere in regressive experience.

How can we best conceptualize the state of consciousness that patients instinctively seek in an analytic setting? And if we accept the idea that patients have a correct intuitive sense that this state is healing, what valuable or even essential therapeutic role does it play? And further, what can we do, and what must we avoid doing, in order to protect and foster such a state?

To anticipate where I am going, I propose that play is the deep structure of the state of consciousness that drives analytic process.

[3]Ferenczi's disapproval of giving in to a patient's omnipotent fantasies, already expressed in his early paper, *Introjection and transference* (1909), continued for more than another decade and a half: Ferenczi's 'active technique' experiments of the late 1910s and first half of the 1920s (e.g. Ferenczi, 1919, 1920, 1925) involved his development of a technique to frustrate patients' efforts to hold onto gratifying omnipotent fantasies in a way that he saw as undermining their treatment.

[4]See Kohut's (1971) description of the different self–object transferences whose form is based on whether grandiosity is owned or projected.

Is this altered state of consciousness healing? The role of the analyst's restrained stance

But, first, a basic assumption underlies the importance of this line of inquiry – that the special state that patients in analysis naturally seek out does in fact underlie analytic process and progress and should therefore be protected and nurtured. Is it correct to assume that patients' quest for this state reflects an intuitive wisdom and that finding it will move them toward cure?

Life outside the consulting room often suggests that the opposite is true. People are drawn to all kinds of self-defeating solutions to anxieties and conflicts – what Lacan (1979) called imaginary solutions, that is, concretized attempts to replace unmanageable reality with wish-fulfilling fantasy: is precisely the danger Ferenczi warned against in his 1909 paper. And certainly this can happen in analytic treatment: patients may cling to the pleasure principle and avoid the renunciation, pain and anxiety demanded by facing certain realities – in Lacan's terms, they avoid symbolizing and thus coming to terms with their conflicts and dilemmas, and instead take an imaginary way out.

Nevertheless, in line with more recent writers I will mention, I believe that certain elements of the analytic situation make it more likely that the patient's instinctive shift into an altered state of consciousness – triggered by the analytic situation itself – is generally constructive. In addition to certain physical aspects of the situation, including the couch and a general ambience conducive to this state, these elements include, most notably, 'analytic neutrality', as I understand it: the analyst's high level of acceptance of all aspects of the patient[5] – or, more accurately, his always-less-than-perfect *attempt* to do this. A neutral attitude reflects "neither indifference nor absence of love-hate, but persistent renunciation of involvement", in Loewald's (1971, p. 63) words: a disciplined self-restraint by the analyst, in an effort to be open to as much as possible in the patient.

The analyst's neutrality is paired with a reserve or reticence in communicating about himself – something akin to 'analytic anonymity', but not absolute: a *preference* in approaching the analytic situation, and one which must be exercised flexibly or perhaps even temporarily set aside to some extent, depending on the patient and the clinical moment. The restraint in the analyst's attitude that results from adopting this kind of neutral and reticent stance results in a paradox regarding the intersubjectivity of the analytic situation: the analyst is very much personally present for the patient while at the same time keeping himself in the background.[6]

[5]See Chused's (1982) definition of analytic neutrality as a genuinely felt "nonjudgmental willingness to listen and learn" (p. 3) – an attitude that requires some degree of capacity to reflect upon and master one's own conflicts as they arise in listening to the patient. This description of neutrality is also echoed in Borgogno's (2009, unpublished) concept of 'the introjective analyst': an analyst who actively resists the impulse to interpret or otherwise intervene in a premature way, but rather tries to hold to a state in which he can take in as fully as possible the patient's suffering and struggles.

[6]Relational objections to the idea that the analyst can minimize his influence will be dealt with in the final section of this paper.

Traditionally, anonymity – which, I think, is more helpfully thought of as the analyst's reserve or reticence – in combination with neutrality, and the heightened need and activation in the patient that results, are seen as inviting the patient's fantasy longings to structure the void left by the relative absence of signposts as to what the analyst wants, expects, or feels.

But more to my point, and even more basic to the workings of analytic treatment, I believe, is the idea that the analyst's hanging back, trying to subordinate his feelings and play down the details of his own person "impel[s] the patient to understand himself in his involvement instead of concentrating exclusively, albeit unconsciously, on the object" (Loewald, 1971, p. 63). That is, a reticent stance helps the patient's inner fantasy life – his psychic reality – come to life and feel real, to some extent, in the outer reality of the analytic sessions, while at the same time supporting in the patient some sense that, paradoxically, these experiences are also a personal expression. Poland (1984) states this succinctly: the analyst's neutrality "is a major contribution the analyst utilizes to sustain and nurture the patient's observing ego in the presence of the transference" (p. 285). Or, from a somewhat different perspective, a restrained approach supports the patient's experience of the analytic setting as transitional (Winnicott, 1971) or play space, as I will discuss below.

It may now be clearer why I see a flexible tendency toward reticence by the analyst as preferable to a more unbending anonymity: consistent with a broad swathe of contemporary analytic opinion, I think that helping the patient toward a certain state of consciousness is more important than facilitating his projections onto the analyst. The former, as I see it, is aided by a more flexible reticence and the latter by stricter anonymity; the former must take priority when these goals conflict.

Beyond the analyst's self-restraint, his awareness of and attentiveness to the vicissitudes of this state of consciousness guide him implicitly, in his silences and comments, to facilitate the emergence of this state in the patient.

One of the implicit skills of analytic work is balancing: (1) the self-restrained attitude of neutrality and reticence that invites a deepening of the analytic state of consciousness in the patient, (2) an exploratory mindset which may culminate in interpretation, and (3) the at-least-implicit acknowledgment of, and perhaps active work with, the intersubjective factors present in every analysis. Briefly, I see a quieter, self-restrained, 'holding' attitude as the analyst's baseline position; this supports the safety in the vulnerable analytic setting that allows the patient to look within and move toward symbolizing previously poorly linked aspects of experience (I discuss the role of safety, below). To the extent that an adequate degree of safety exists, exploration of more anxiety-laden areas of experience can move into the foreground, though with the analyst always keeping a finger on the pulse of the patient's feelings of security; and while a benign intersubjective connection quietly undergirds the safety of the holding environment, at times when too much safety is lost (often triggered by a tactless or disturbing communication by the analyst), the analyst's self-containment *may* need to give way to his allowing a more mutual, active exploration of intersubjective factors as a means to re-establish safety.

I will expand upon the value and limitations of a restrained analytic stance in my discussion of the controversy regarding analytic expressiveness, at the end of this paper. But first I will explore more basic issues related to the analytic state of consciousness, including other facilitating conditions, aspects of the state itself, and its effects.

Object-relational considerations

Before delving into the nature of the altered state of consciousness that allows the analytic situation to exert its influence, I want to address what I see as the object-relational precondition of this state: an experience of basic safety or holding by the analyst and the analytic situation, which allows the patient to place himself in a position of heightened vulnerability toward the analyst and frees him to pay greater attention to his own inner processes – shifts that entail some feeling of risk. To emphasize its fundamentally object-relational nature, and because I see it as more basic than, and undergirding, the patient's specific object-related and even selfobject transferences, I suggest that the analytic state of consciousness serves as a *foundational transference*.

An adequate sense of safety may simply exist for a patient at a given time, or else the analyst may need to act in some way that supports this sense when it is lacking. Ferenczi, in his *Child-analysis in the analysis of adults*, found a lovely metaphor to capture an important aspect of an analytic stance that both provides this safety and invites the analytic state of consciousness:

> The analyst's behavior is thus rather like that of an affectionate mother, who will not go to bed at night until she has talked over with the child all his current troubles, large and small, fears, bad intentions, and scruples of conscience, and has set them at rest. By this means we can induce the patient to abandon himself to all the early phases of passive object-love, in which – just like a real child on the point of sleep – he will murmur things which give us insight into his dream-world.
>
> (Ferenczi, 1931, p. 137)

I believe that this maternal 'holding' aspect of the analytic stance must find its shape within the gravitational field of analytic self-restraint that I have described.

Ferenczi's mother–child metaphor can be understood as a description of the analytic frame, or a particular variation of it – not simply a protective set of rules, but an object relationship that may be thought of as a benign game in which patient and analyst each has her assigned role; the 'game' has implicit rules and functions as a protective structure for the treatment. I suggest that in each analytic treatment, a particular, unique frame develops – an implicit, benign, intersubjective 'game' unconsciously constructed mainly on the basis of the patient's unconscious fantasies; specifically, the game reflects the patient's reassuring regressive wishes – transformations of his regressive anxieties. But, due to inherent identificatory processes in the analytic relationship (Racker, 1968), the game is also shaped with the analyst's unconscious cooperation. The reassuring alterations in the patient's unconscious anxieties

are based upon omnipotent thinking – negating one's helplessness by taking the active role and reworking the world to one's liking – and reflect the workings of characteristics of play such as self-assertion, reversal of scenarios and roles, exaggeration of certain elements, and so on, as I will discuss. These elements of play allow the patient to feel greater control over anxiety-evoking fantasies and create a positive shift in affective tone.

The frame's purpose is twofold. First, it provides adequate reassurance about the patient's unconscious anxieties so she can feel safe enough to turn her gaze inward with the sense that her anxious fantasies are indeed fantasies and not real – that the analyst is not a threat who must be monitored and managed. This safety allows a productive analytic state of consciousness to develop. And the frame's resonance with the patient's fantasies helps to bring these fantasies into focus in the intrapsychic play promoted by the analytic state of consciousness (cf. Briggs, 1992).

On occasion the analyst may be pressed to collude in some gross way that threatens to make the patient's regressive fantasy too real and thus retraumatizing, destroying the necessary intersubjective play space of the treatment – a move that the analyst must resist, as Ferenczi (1931) noted in a passage I will cite shortly.

The analytic state of consciousness as a form of play

Moving to the state of consciousness itself: Ferenczi's early observation that analytic patients are in a regressed, quasi-hypnotized state marked by vulnerability and openness to influence and rooted in wish-fulfilling fantasies blossomed, in his 1931 *Child-analysis* paper, into the idea that analytic patients are, in a sense, in a state of play.[7]

[7]While play is often thought of as a physical activity, there is a strong basis for seeing certain mental activities and states, too, as forms of play. The natural history of play in children shows that with increasing age a progressive dissimilarity can be accommodated between the play object and the real object it represents – what researchers call "decontextualization" (Smith, 2005, p. 181). Additionally, with age play actions tend to become increasingly abbreviated, schematized, condensed, or incomplete, compared with the real thing, so that play actions become symbols or signifiers of other actions (Piaget, 1962). This progression characteristically culminates in complete 'interiorisation' of the symbol (Piaget, 1962). Ultimately, play often becomes a mental activity taking the form of daydreaming and private fantasy (Singer, 1995) – an observation echoed by psychoanalyst Eugene J. Mahon (1993), who said that "Play has become *internalized* as the action-oriented childish mind grows up" (p. 175, italics in original). Another analyst, Russell Meares (1993), has discussed the similarities between children's play and adults being "lost in thought" (p. 6). It may be that mental rather than physical play predominates in adult humans.

Beyond this, play is associated with specific mental states. Researchers on play with animals and children have observed that play is characterized by moderately increased states of arousal and alertness, often accompanied by subjective pleasure but sometimes with other emotions activated (see, for example, Burghardt, 2005, pp. 19, 138–40, 155; Millar, 1968, pp. 45, 94; Sutton-Smith, 1997, p. 174), and have understood play as reflecting a particular attitude (Millar, 1968, p. 20; Schwartzman, 1982; Sutton-Smith, 1997). Its allusions to functional behavior are paradoxical (Schwartzman, 1982) – e.g. a play bite both is and is not what it represents – and are detached from their usual emotions, allowing animals to experiment with new behaviors without anxiety (Eibl-Eibesfeldt, 1982). Play exists in the subjunctive mode (Singer, 1995) in a reality implicitly acknowledged not to exist. A duality of consciousness is intrinsic to play: as scholars from various fields have regularly observed, the sense of reality in play is colored by what psychoanalysts call the pleasure principle and primary process thinking, while at the same time containing a greater awareness of and perspective on self (Meares, 1993) – what Winnicott (1971) termed a 'transitional' state, which I will discuss shortly.

What does this mean? Winnicott (1971), a kindred spirit to Ferenczi who famously also saw analytic treatment as a kind of play, understood play to reflect what he called 'transitional space', where fantasy and reality coexist and interpenetrate and a child is never asked whether his experience is real. The child endows some aspect of the outside world with illusory, or personal, meaning and also uses the real world to enrich his subjective experience. The duality of play is thus essential in the child's developmentally crucial twin projects of establishing the outer world as a familiar, meaningful, welcoming place, and finding a self that feels solid, integrated, and authentic and desires to engage the world.

Empirical research and scholarly thinking about play from fields other than psychoanalysis similarly emphasize the special nature of play reality (e.g. Huizinga, 1955; Smith, 2005; Sutton-Smith, 1997). Huizinga (1955), a cultural historian, called play reality "a world of its own …. There things have a different physiognomy from the one they wear in 'ordinary life', and are bound by ties other than those of logic and causality" (p. 119). Like the analytic state of consciousness, the laws of play, which reflect omnipotent thinking and can disregard logic and the reality principle, are those of the pleasure principle – but in the service of the ego: ultimately, play enriches the experience of reality and supports adaptation.[8]

The duality of consciousness that characterizes play also captures an aspect of the analytic state of consciousness: despite play reality *feeling* like it is real and important – to the child playing superman and to the analytic patient – this special reality coexists comfortably with ordinary reality and is not confused with it; when a true play state of consciousness is present, child and patient do not generally allow their inner worlds to make serious claims on outer reality. For example, while a patient may press his demands on the analyst, he also *more or less* understands the boundaries required to maintain transitionality – both by respecting the analytic frame and in more subtle ways – and limits his claims on the analyst.

Compare these ideas with Freud's famous earlier statement about "transference as a playground", a "definite field" in which the compulsion to repeat

> is allowed to expand in almost complete freedom. … Provided only that the patient shows compliance enough to respect the necessary conditions of the analysis, we regularly succeed in giving all the symptoms of the illness a new transference meaning and in replacing his ordinary neurosis by a 'transference-neurosis'… . The transference thus creates an intermediate region between illness and real life through which the transition from the one to the other is made. … It is a piece of real experience, but one which has been made possible by especially favourable conditions, and it is of a provisional nature.
>
> (Freud, 1914, p. 154)

[8]Play research suggests that play fosters learning, innovative thinking, flexibility in problem-solving, exploratory behavior, the establishment and maintenance of social roles and bonds, the capacity to symbolize one's experience, the capacity for restraint, and the capacity to act (see brief review in Frankel, 2011).

Winnicott (1960a) introduced the idea that a 'holding environment' is necessary to contain the vulnerable transitional play state and protect it from impingement by the outside world. Similarly, empirical play researchers (e.g. Bateson, 2005; Lorenz, 1971; Smith, 2005) also emphasize that play requires conditions of safety, and Huizinga (1955) proposed, based on his historical research, that play exists only within some kind of time-and-space boundary – a 'magic circle' – that separates it from ordinary reality.

In his *Child-analysis* paper, Ferenczi stressed the importance of the analyst protecting the play space – even from the patient, if necessary:

> Adult patients … should be free to behave in analysis like naughty (i.e. uncontrolled) children, but if the adult himself falls into the mistake with which he sometimes charges us, that is to say, if he drops his role in the game and sets himself to act out infantile reality in terms of adult behavior, it must be shown to him that it is he who is spoiling the game. And we must manage, though it is often hard work, to make him confine the kind and extent of his behaviour within the limits of that of a child.
>
> (1931, p. 132)

Calling it "hard work", as analysts know, can be an understatement.

Sutton-Smith (1997), a leading play theorist, has proposed ideas about play that also apply to the analytic state of consciousness and that bring us even closer to seeing the analytic state of consciousness as a play state. Addressing the question of the adaptive functions of play, Sutton-Smith has suggested that the constant internal play of the brain – "the ceaseless inner talking that is like fantasy" (p. 60) – serves to keep the brain labile so it does not "rigidify in terms of its prior specific adaptive successes. Sustaining its motivation for generality could be seen as the price [*sic*] of eternal alertness" (p. 61). Play can thus be thought of as

> a self-rewarding process that keeps this holistic capacity [i.e. an unremitting search for new and better adaptations] in a state of alertness. Dreams [referring to the constant fantasy activity of the brain] exist to amuse the brain into continued labile alertness.
>
> (p. 62)

This line of thought suggests to Sutton-Smith that play fosters maximum adaptability – certainly a goal of analytic therapy. Freud's (1920) thinking adds here that this labile alertness can also keep a person vigilant against potential traumatic situations. For our immediate purposes, Sutton-Smith, with his concept of labile alertness, has identified an aspect of play, or really two interrelated aspects – keeping one's mind in a state of alertness or activation, and keeping one's thinking free to form new, unexpected, creative links and associations – that are central to the analytic state of consciousness and that foster new forms of experiencing oneself (cf. Freud's strikingly similar term "mobile attention" (1900, p. 102) for the state of consciousness that the analytic situation induces in the patient).

At this point I briefly note some characteristics of play which have been identified in empirical research with animals and children, and which are

surprisingly relevant, as I will soon elaborate, to understanding the play that takes place in psychoanalytic treatment. These characteristics include fragmentation of behavior sequences found in ordinary reality, emphasizing certain elements by repeating or exaggerating them and by re-ordering behavioral sequences, and in other ways feeling free to rearrange roles, relationships, and rules that exist in ordinary reality (cf. Fagen, 1981, chap. 2). These characteristics reflect play's basic attitude of freedom and self-assertion that Groos (1898, 1901) captured in his apt phrase "joy in being a cause".

Aspects of the play state of consciousness that appear quickly and those that may develop over time

Certain rudimentary aspects of the analytic state of consciousness that suggest a play process appear early in treatment, while a more evolved state that indisputably deserves to be called play may develop over time. Clinical observations suggest that the rudimentary state contains several aspects. The patient's *increased sensitivity* includes an increase in being aware of and affected by fragmentary impressions from deeper layers of one's psyche, a greater *sensitivity and reactivity* to large and small details of the analyst's behavior, and a feeling of increased *vulnerability*. In keeping with this increased sense of permeability of boundaries between patient and analyst, the patient moves toward a *greater reliance on identificatory and introjective modes of relating to the analyst* (see Fairbairn, 1952, and see below) – a regressive shift that reflects the patient's increased *functioning on the basis of omnipotent fantasies*. Whether the patient assigns the more obviously omnipotent role to himself or the analyst, the common thread of omnipotence is the patient's wish to be central in the analyst's thoughts and a sense of entitlement to have the analyst as he wants. These wishes generally reflect a reparative fantasy – thus, even at this early stage, the patient is starting to bring a scenario or intersubjective game into the analytic relationship: another proto-element of play. The flipside of the patient's omnipotence is a *dependency* on and receptiveness to influence by the analyst, upon whose behavior the patient's sense of security, stability, and well-being feel like it depends.

Do the aspects or facets of the rudimentary state of consciousness add up to a state of play? I think they do, but in an embryonic way. The patient's experience of reality has started to 'come apart', to fragment in a way that brings certain elements to greater awareness and salience. This fragmentation and exaggeration of certain elements of reality – basic characteristics of play, as noted – are accompanied by the benign heightened alertness and the lability of attentional focus that Sutton-Smith (1997) described as the mental attitude of play, and arise in consequence of the protected, special reality of analysis: the play frame that provides enough safety to allow the increased risk and vulnerability that this 'coming apart' requires. The special, safe, non-intrusive, responsive reality that the analytic setting offers also implicitly invites the patient to relax her ego boundaries and impose her omnipotent fantasy scenario onto the actual interpersonal situation.

But at this phase, the fragments of experience that come into the patient's view may still feel somewhat persecutory and the patient may feel beset by them, uncomfortable and anxious. These fragmentary impressions remain relatively unsymbolized: isolated sense impressions that, to a great extent, have yet to acquire meaning (cf. Freedman, 1985). Similarly, psychological distance from one's sense of omnipotence and entitlement – a clear sense of a separate reality in which these phenomena are felt to be real-but-not-real – has not yet developed,[9] creating a situation that lacks resiliency and can easily be disrupted, perhaps irreparably, by an indelicate or tactless response by the therapist; in other words, there is a marked narcissistic vulnerability. In brief, while *structural elements* of play are present and evolving, there is not yet a *sense* of play.

My impression is that, in the more rudimentary state of play, the patient's increased sensitivity, vulnerability, and reactivity, and her reliance on more identificatory modes of relating, are likely to influence the analyst on an implicit level to shift toward an enhanced responsiveness to and identification with the patient. In turn, the patient may sense and be drawn into identifying with the analyst's heightened emotional involvement in the patient's experience and his greater interest in and attentiveness to the details of the patient's inner mental processes. The analyst's emotional accompaniment also brings to life the intersubjective matrix that gives form to the treatment's particular frame, which can be thought of as a kind of 'game' that resonates with, and amplifies, the patient's inner experience.

Additionally, the frame may facilitate an evolution toward a fully developed play state of consciousness by maximizing the key condition of safety. Related to this, components of the analytic setting and implicit aspects of analytic process, including the setting's separateness and protectedness from outside reality, its sameness over time, and the analyst's restraint, sensitivity and responsiveness – all elements of a holding environment – also contribute to safety. A sense of safety is further reinforced, hopefully, by a deep emotional accompaniment on the part of the analyst, which intrinsically disconfirms patients' disturbing narcissistic anxieties as they attach themselves to the analyst – the patient's belief and fear that she is not truly held in mind by him or will be emotionally abandoned (see Bach, 1994, 2006) – allowing a shift away from vigilance directed at the analyst and toward a greater focus on one's inner experiences. However, an analyst *may* need to become more active if a particular patient, at a particular moment, needs an active, concrete kind of reassurance that the analyst is emotionally present.

These elements of safety allow previously excluded, discordant elements of consciousness – excluded because of anxiety – to emerge into the patient's awareness and to draw her deeper into the exploration of what comes to feel like an increasingly multidimensional and absorbing inner environment, thus facilitating the attitude of approach characteristic of play.

The progression from the rudimentary to the fully developed play state is likely to have ups and downs, and the more developed play state may be vulnerable to regression to the more rudimentary state at certain times even

[9]Cf. Fonagy and Target's (1996) idea of psychic equivalence.

after it has been achieved. And, with some patients, the facilitating elements provided by the analytic setting and process will not be adequate to establish a sense of safety.

The more fully developed state of play that can arise in response to the safety, emotional responsiveness and restraint of the analytic situation includes an *increased feeling of freedom*, a *playful attitude*, and a *greater approach orientation*, rather than anxiety, in the patient in regard to what she becomes aware of in her mind. The patient feels more like the mover and doer and engages her perceptions in a more active and creative way, treating them as objects to manipulate and 'get into'. The question now on the table is the one identified by Hutt (1970) as central to play: 'What can *I* do with this object?': Groos's (1898, 1901) 'joy in being a cause'. The patient's state of 'labile alertness' becomes more pleasurable and opportunistic, constantly seeking experimentation and a deeper exploration of the details of her experience from ever-new angles.

The more evolved state of play also includes a more securely established, and security-generating, special reality. In contrast to the more rudimentary state, this more evolved state reflects a more organized inner fantasy that is felt and treated as real while also being better differentiated from ordinary reality. The specific transferences that develop out of the play state of consciousness, in its function as a foundational transference, become more workable – an object of genuine analytic interest to the patient – rather than simply defensive against an analyst whom the patient feels is essentially dangerous.

In consequence of the patient's greater active engagement of his inner world, he is better able to symbolize his experience, as Freedman and his colleagues (Freedman, 1985; Freedman and Russell, 2003; Freedman, Hurvich, and Ward, 2011) describe this process,[10] to exercise a *greater synthetic activity* of the ego that fosters the linkage of the patient's various newly-cathected, but isolated, perceptual impressions and leads to a sense of meaning and to insight and self-understanding. As part of this process, the patient gains a helpful observational perspective on his perceptions, thoughts and feelings that supports *owning* his inner experience as an expression of himself rather than simply as a reaction to other people.

The play state of consciousness that develops in psychoanalytic treatment *amplifies* selected aspects of the patient's experience. This amplification is facilitated by the characteristics inherent in play to which I have already briefly alluded. The following list of characteristics is derived from research on play in animals and children (e.g. cf. Fagen, 1981, chap. 2, and see above) but has been adapted to play as it occurs in adult psychoanalytic treatment, both in the associative process and in the patient's transference engagement of the analyst. These characteristics involve the transformation of inner and outer reality through such methods as fragmentation and disordering of sequences of external events and mental and motor acts, mixing behaviors from different motivational systems, exaggeration and repetition of selected elements of inner or outer reality, flexibility, reversal of the roles and

[10]Cf. Bucci's (1994) concept of referential activity.

relationships that exist in enduring inner fantasies or in outer reality, and creating special rules based on omnipotent wishes rather than on the rules of logic, ordinary reality, or persecutory fantasies. These and similar characteristics of play mentally highlight problematic aspects of someone's experience in a manageable way so they can be probed and explored from different angles, tested, and rearranged, resulting in new ways of perceiving, thinking about, and experiencing oneself and one's world. This process of amplification through play is the substance of the process of symbolization.

Play as a model for the analytic state of consciousness: Implications for the concept of abstinence and the role of frustration in analytic process

Sutton-Smith's ideas about the labile alertness that characterizes play focus us on the nature of the activation of the patient's mind that occurs in analytic treatment, and this points us to a reconsideration of the concept of abstinence. Abstinence, based in Freud's economic perspective, describes an analytic stance that seeks to maintain a certain level of frustration of drive-related transference wishes in the patient – a frustration which Freud (1915, 1919) saw as providing a necessary motivation for the patient to do the work of treatment. More contemporary definitions, however, still keep the tie to frustration, even as they shift the emphasis to how the analyst's abstinence functions in the service of neutrality and fosters regression to deeper levels of meanings (Poland, 1984), supports safety, containment and reflection (Hurst, 1996), and helps achieve a therapeutically useful tension between isolation and self-preoccupation, on the one hand, and involvement with the analyst, on the other (Fox, 1984; and see Killingmo, 1997; and Meissner, 1998).

The idea of frustration, or something like it, does capture something important about a therapeutically facilitating activated state of consciousness in the patient: the element of self-containment by the patient. But it leaves out the elements that Sutton-Smith described as the mental state during play: an enhanced lability, mobility, and flexibility in thought processes, and a heightened alertness to these processes. In addition to these two aspects of the activated state found in mental play in general and in that of analytic patients in particular, I would add a third element: owning as a reflection of aspects of oneself the inner landscape that emerges into view as a result of this activation of attentional processes. Thinking of patients' target state of consciousness mainly in terms of frustration may take analysts' attention away from these other important aspects they are trying to foster, and thus can mislead them into a level of emotional constraint, in pursuit of an abstinent stance, that may be counterproductive (cf. Fox, 1984; Killingmo, 1997). As discussed earlier, I prefer the more flexible term *restraint* to describe the analyst's recommended stance.

I suggest that the term *play state* is preferable to *frustration* to describe the facilitative mental state we hope for in the patient; this state is not a product of frustration, despite the fact that it may develop in response to the analyst's stance of self-restraint and requires a certain *self-containment*

by the patient in regard to keeping his mental contents in mind even when they stir up uncomfortable feelings, rather than somehow getting rid of them. Related to this, the idea of a play state – unlike frustration – captures the nature of the desired analytic state of consciousness even when transference demands are not pressing. The optimal play state to which I refer is the more fully developed one described above, including not only greater alertness to one's experience but, additionally, a sense of freedom and approach in regard to one's experience and an increased activation of one's symbolizing and synthesizing abilities. Freeing the development of a desirable analytic state of consciousness in the patient from the idea of the necessity that the analyst impose a state of frustration recasts and broadens the analyst's thinking about his technical choices, as I will elaborate in the section on technical implications.

The idea of the patient's *self-containment*, to my mind, avoids connotations of deprivation and self-denial; rather, it suggests a self-disciplined yet self-accepting act – an attitude of active 'holding' toward the contents of one's mind, in the sense of protecting and caring-for that characterize Winnicott's (1960a) use of this word – and conveys a tone of free choice. The term self-containment echoes the duality of pretend-play: both immersion in, and perspective on, one's experience. I think it is possible to speak of self-containment even at times when a patient is passionate and relatively unrestrained, as long as the boundary necessary to maintain the analytic play-space is not seriously breached. Indeed, along with the other aspects of play that I have discussed, I think that self-containment should be added to the list of qualities that characterize the analytic state of consciousness.

More on the effects of the play state of consciousness: Facilitating symbolization and fostering vitality, self-acceptance, and authenticity

Norbert Freedman and his colleagues (e.g. Freedman, 1985; Freedman and Russell, 2003; Freedman, Hurvich, and Ward, 2011) have written about how analytic treatment is inherently a process of symbolizing aspects of experience that had not been owned or accepted. Following their work, Frankel (1998) has shown how, in child therapy, the process of play in which the child gradually evolves roles and games – generally pleasurable games, despite their being based upon conflictual or frightening, excluded aspects of experience (cf. Sutton-Smith, 1997, p. 61) – is the very same process by which defensive modes of being loosen up, aspects of the child's experience come vividly into awareness, become symbolized, worked through in a full-bodied, experiential way, and owned. *It is the state of play, not simply a state of regression* – meaning the more developed form of the analytic state of consciousness – *that provides the medium along with the raw material for the process of symbolization*. In this state, immersion in fantasy is not a denial of difficult inner and outer realities, but a way – perhaps the only way – toward really accepting them. To use Lacan's terms: an imaginary approach becomes a vehicle for a symbolic resolution.

The alternative is what Winnicott (1960b) called living on the basis of a false-self organization – appearing to take in realities while really fending them off.

Similarly, Ferenczi (1933) had written earlier about 'identification with the aggressor' – as I see it, the opposite of play and of the genuine embrace of reality that play makes possible. Identification with the aggressor, in Ferenczi's original meaning of the term,[11] is a near-universal way of coping with trauma by instantaneously and without thinking, but in a highly attuned way, accommodating and mimicking what one senses is expected by the threatening other, in inner experience as well as behavior – even including taking the blame for being victimized – in order to placate the aggressor and survive. In the process, one loses the sense of authenticity, of goodness, even of self. Yet this 'playing along' can sometimes falsely appear to be genuine play. When identification with the aggressor takes hold in the analytic situation – as it often can in subtle ways (Frankel, 2002a) – the sense of freedom, agency, and playfulness that characterize the analytic state of consciousness at a more symbolizing, reflective level are stripped away from the patient's mental play, leaving the more primitive, anxious, reactive version, as discussed earlier: the anxiety-driven vigilant scanning of a person under siege. Seeing the important ways in which identification with the aggressor is the opposite of play (despite sometimes appearing similar) highlights how play opens the door to letting go of living on the basis of falseness and accommodation, and becoming able to live a life with greater self-acceptance and emotional presence and a deeper sense of meaning in one's experience.

In this light, one challenge for an analyst is to create conditions that permit the patient to loosen his grip on such self-robbing identifications and to begin to be able to play with reality – in his mind and in his way of engaging his analyst and the analytic situation – and not feel played with and persecuted by it, and powerlessly subject to it.

Other writers' conceptions of an analytic state of consciousness

Some analytic writers after Ferenczi have also emphasized the crucial role of an altered state of consciousness, generally linked to particular forms of transference:[12] Michael Bálint's (1968) work on regressive forms of object relationship and mental states into which the patient slips when narcissistic levels of the personality become activated in the analytic situation, and that may be central in the healing process; Kohut (1971, 1977, 1984), with his

[11]In contrast to Anna Freud's (1936) later, better known use of the term to mean making oneself *like* the frightening person, Ferenczi (1933), who first coined the term, was referring to an identification with what the frightening person *expects or requires* one to be – an identification with the object in the aggressor's mind rather than with his self. In Racker's (1968) language, this is a complementary rather than concordant identification with the adult's role; or, said differently, the child forms a concordant identification with the adult's experience, in which the child figures simply as an object, even for himself.

[12]See Antal Bokáy's (1998) exploration of the hypnotic element of the analytic situation in Ferenczi's writings.

concept of regressive selfobject transferences as experiences that the analyst must allow the patient, without interference, as the patient works through the narcissistically disturbed aspects of his personality. Notably, both ideas describe a state of consciousness linked to a particular role in a kind of intersubjective 'game' in which the analyst is also assigned a role.

Bertram Lewin (1954, 1955) discussed the relation of the patient's state of consciousness to hypnosis, sleep, and dream, and proposed that the analytic situation opens the door to the patient experiencing as true the narcissistic fantasies that otherwise feel true only when asleep. Indeed, Lewin (1954) directed his readers' attention back to an early comment of Freud's about the shift in consciousness that occurs during analytic treatment. In discussing free association in *The Interpretation of Dreams*, Freud (1900) referred to

> the establishment [in analytic treatment] of a psychical state, which in its distribution of psychical energy (that is, of mobile attention), bears some analogy to the state before falling asleep – and no doubt also to hypnosis. As we fall asleep, "involuntary ideas" emerge, owing to the relaxation of a certain deliberate (and no doubt also critical) activity which we allow to influence the course of our ideas when we are awake. … As the involuntary ideas emerge they change into visual and acoustic images … In the state used for the analysis of dreams and pathological ideas, the patient purposely and deliberately abandons this activity and employs the psychical energy thus saved (or a portion of it) in attentively following the involuntary thoughts which now emerge.
>
> (Freud, 1900, p. 102)

Lewin (1955) also referred back to what he called Rank's (1924) "tacit assumption that … the whole process of the analytic situation could be understood as if it were a dream" (p. 178).

Additionally, Lewin (1954) linked this state of consciousness to cure. A patient of his whose gastric ulcer healed itself during analysis without any other treatment was asked by the physician who examined her "what she had been doing for it. 'Oh', she said, 'I have been lying down for an hour every afternoon' " (p. 505). Lewin believed that his patient's joke reflected the reality that her "ulcer had been cured by 'lying down', by a form of therapy which enabled her to relive and understand infantile sleep" (p. 505) – that the altered state of consciousness induced by analytic treatment was itself healing.

Loewald contributed to this line of thought in two ways. First, he (Loewald, 1960) emphasized that transference involves not only the projection of preconscious imagos onto people in the outer world but also the transfer of instinctual, affective force from the unconscious onto these preconscious imagos, enriching the patient's associative processes and his attention to these processes – essentially, that an analytic transference heightens the patient's cathexis of his own associative processes and of the analyst; both these elements of the patient's consciousness are evoked by, and drive, the analytic process.

Second, Loewald (1971) conceived of the transference neurosis as a distinct shift in consciousness – an intensification of self-awareness specific

to analytic treatment and central to its therapeutic effect. Transference neurosis, in Loewald's words, is

> a creation of the analytic work done by analyst and patient, in which the old illness loses its autonomous and automatic character and becomes reactivated and comprehensible as a live responsive process and, as such, changing and changeable. New and different transference manifestations arise as signs of this new process. As promoted by the analyst, the transference neurosis is curative; as taking place in the patient, it is a healing process.
>
> (Loewald, 1971, p. 62)

These authors' various notions of the analytic shift in consciousness come from different perspectives, but in some ways they are different aspects of a single idea – that analytic process depends upon some kind of regressive shift in consciousness.

The intersubjective aspect of the analytic state of consciousness

Isakower (1992a) took this line of thinking further, bridging us to the intersubjective aspect of the analytic state of consciousness. Following Lewin, Isakower likened the patient's optimal state of consciousness to partial sleep and dreaming, a state in which thoughts become more visual and ambiguous and which provides the patient with greater access to his own unconscious processes. The analyst's "evenly hovering attention", a state of enhanced receptiveness in the analyst to more unconscious layers in himself and his patient – which Isakower called the 'analyzing instrument' – promotes a blurring of ego boundaries between patient and analyst that can result in "a near-identity of the quality of wakefulness in both the analyst and the analysand" (Isakower, 1992a, p. 207); Isakower saw this as facilitating the optimal state of consciousness in the patient.

Sheldon Bach's (1985, 1994, 2006) thinking about the state of consciousness of the narcissistically disordered patient in analytic treatment adds a dimension to understanding the intersubjective factors that promote an analytic state of consciousness – and not only in the treatment of narcissistic disorders. Bach speaks about the importance, in the treatment of such patients, of patient and analyst feeling merged or even, in some sense, in love with each other (Bach, 2006); the analyst's allowing this kind of interpenetration of affects and holding the patient in mind in such a deep way helps the patient feel more alive, become able to keep himself and others in mind in a more vital and stable way, improve his capacity to regulate his own affects, trust other people, and let go of rigid defenses that compensate for deficits in these areas. Bach's formula may apply to analytic treatment in general, to some degree, due to areas of faulty development in all analytic patients and the healing potential of this kind of intersubjective experience.

I think that the feelings of love that both patient and analyst may come to have for each other are to a significant extent a function of the intersubjective 'game' that underlies the analytic frame and reflect the roles prescribed by the game. This game is derived primarily from the patient's

pressing fantasies, modified in a way that reassures the patient about his anxieties, but also from the analyst's fantasy repertoire (Sandler, 1976). These feelings of love are facilitated by the safety inherent in the fact that the game comes to life most fully – especially for the analyst, due to the more limited role that the patient plays in the ecology of the analyst's life – mainly within the sequestered setting of analysis.

I understand as intrinsic to Bach's ideas about analytic love that, in an intensive analytic treatment, the analyst's state automatically shifts in concert with the patient's and contributes to the patient's shift. To some extent, this shift in the analyst's consciousness is involuntary. For instance, Freedman, Hurvich, and Ward (2011) and Bucci and Maskit (2007) have demonstrated that, when the patient's level of symbolization, or referential activity, increases, the therapist's level of these qualities of thinking follows.[13] And DiMascio, Boyd and Greenblatt (1957) have demonstrated that the greater the patient's subjective experience of tension, the higher the therapist's heart-rate is likely to be.

Additionally, I think I am in agreement with both Isakower (1992b) and Bach in my belief that the analyst's openness rather than resistance to this response in himself constitutes a receptivity, an acceptance, and an accompaniment in the patient's shift to an analytic state of consciousness and thus adds to the patient's sense of safety and the ease with which the patient can enter this state. Consistent with this, Freedman, Hurvich, and Ward (2011) have found that the patient's progress in symbolizing his experience is most likely to occur when the analyst is emotionally pulled in – a condition they call 'interactional synchrony', which I think can be understood as a kind of mutual identification.

In terms of play, the analyst's openness to his own identification with the patient as the patient shifts into a more playful mode of experience is crucial to the patient's continued ability to play, whether this takes some behavioral form of joining in with the patient's play or simply an inner responsiveness – an attentive, empathic emotional accompaniment that positions the analyst as an "environment mother" (Winnicott, 1963) and provides facilitating conditions for a more intrapsychic form of play in the patient.

I think I am also in agreement with Bach in suggesting that the patient's shift toward a play consciousness is best facilitated when the analyst's openness to his own responsive shift in consciousness is paired with the attitude of self-restraint I have described. Further, the patient's sense of the analyst's feelings of merger or love – often readily understood by the patient despite the analyst's restrained stance – directly addresses the patient's anxiety about being held in mind by the other person, which Bach sees as at the heart of narcissistic pathology; similarly, Ferenczi (1929a, 1933 and see Frankel, 2002b) thought of the lack of being loved and emotional abandonment as perhaps the most damaging traumas.

[13]However, Freedman and Ward have found that the reverse is not true – when the patient enters a desymbolizing mode, this does not predict that the therapist's symbolizing activity will decrease. In other words, the therapist may be able to hold on to his ability to reflect even while the patient has temporarily lost this ability.

While the analyst's state of consciousness is not my main focus, I want to stress its similarities to the analytic state of consciousness I have described in patients – notably including elements described by Sutton-Smith (1997) as central to the play state of consciousness, including: a lability, mobility or freedom in the focus of attention, a heightened sense of alertness to the vicissitudes of one's own state of consciousness, and (in the analyst's case) to the patient's states and to the interplay of states between patient and analyst. Psychoanalysts beginning with Freud, in his concept of evenly-suspended attention (Freud, 1912, p. 111), have described similar aspects of the analyst's consciousness. And later writers such as Heimann (1950), Tauber (1954), Racker (1968), Sandler (1976), Bromberg (1994), and Ogden (1994) have elaborated how the analyst's states of consciousness are not only intrinsically coordinated with those of the patient, but how the *roles* analysts may discover themselves feeling and even unwittingly enacting are responsive to (in present terms) the regressive 'games' their patients are playing.

Additionally, and certainly related to the analyst's role in these kinds of intersubjective games, a patient's shift into an altered state of consciousness is likely to evoke in the analyst an identification with the patient's mental state that may be part of a larger inner emotional involvement with the patient, perhaps even deserving the name "analytic love" (Bach, 2006). This high degree of identification draws the analyst into a more absorbing interest not only in *what* the patient is saying and thinking but in *how* the patient is working and struggling to express himself – in the various nonverbal aspects of his communication such as tone and coloration of voice, pauses, pacing, body movements, and so on, that provide windows to the nuances and moment-to-moment vicissitudes of the patient's experience of his own inner mental processes and that is generally of great interest to people as they listen to someone they love (cf. Steingart, 1995, on the analyst's love for the patient's psychic reality). As I have suggested earlier, this kind of loving interest by the therapist, even if only sensed by the patient, can lead to the patient's increased interest, perhaps loving interest, and certainly an increased sense of meaning, in his *own* experience.

Technical implications in terms of contemporary discussions of the analyst's expressiveness or restraint: Further thoughts

Despite this tradition in theorizing, I believe that the fundamental clinical role of the shift in consciousness in facilitating analytic process has neither been fully theorized nor adequately appreciated in clinical practice (and see Isakower, 1992a). The fact (if we accept it as such) of the fundamental *clinical* place of this state of consciousness, and the consequences of the potential failure to recognize this, have clear technical implications–most notably, the recommendation that the analyst adopt the restrained stance of neutrality and reticence, as I have already discussed. I return now to this issue in the context of the current-day discussion of analytic expressiveness. Space must be created for patients' excluded, regressive states to emerge in sessions, accompanied by a sense of at-least-provisional realness – without too much external reality to overshadow, organize, and suppress it. While a

more interactive, expressive stance can also enhance the reality feeling of the patient's fantasies, it may additionally damp down the patient's paradoxical awareness that, real as these experiences may feel, they are an expression of something from within himself.

A more expressive analytic stance may follow from Ferenczi's (1932 [1988]) experiments in 'mutual analysis'. However, Ferenczi was open and expressive with his patients, I believe, primarily because he felt it necessary in order to remove a sense of trauma – a sense often triggered by his own subtle dishonesty (what he termed "professional hypocrisy" [1933, p. 159]) and resonating with patients' early histories of having been lied to by parents about gross or subtle assaults against them. The analyst's and parents' dishonesty had been traumatic for these patients because it had led the patients to feel no one was really *with* them – they were left unbearably alone in their terrible suffering. Their response as children, their desperate way of trying to be *with* the parent, was to identify with the aggressor – to accommodate the parent in a self-negating, self-blaming way and detach from their own immediate experience. Ferenczi's self-disclosures were thus an antidote to the damage caused by dishonesty and traumatic aloneness – an acknowledgment of his own role and a validation of his patients' perceptions. Providing a sense of safety – in these cases via the analyst's honest disclosures – must take priority. But to the extent that a patient does, or comes to, feel safe, my line of thinking about the analytic state of consciousness suggests that the analyst should tend toward being self-effacing.

Openness and honesty are not the same thing. Being quiet is not inherently dishonest. If Ferenczi was correct in placing dishonesty as central to the traumatic effects of childhood abuse, it was his honesty, more than his openness, that mainly provided his patients with a sense of safety. Nevertheless, to the extent that a patient's narcissistic anxieties hold sway, the analyst's relative quietness may be hard for a patient to bear. As Bálint (1968) pointed out, patients under the spell of narcissistic anxieties feel they are mainly suffering from environmental deficiency rather than inner conflict, and may feel in urgent need of some kind of restitution from their environment – from the analyst. An analyst's quietness under such circumstances can feel abandoning, not constructive, though it may be difficult to discern at a given moment whether the primary basis for a patient's anxiety is deficit or inner conflict. An analyst should try to know how well a patient can tolerate the inner tension required by the analytic game of 'restrained analyst' – when this game furthers the patient's inner play and the analytic process, and when it feels abandoning and encourages pathological identification and shut-down.

Additionally, honesty is not always simple. Because of the inherent complexity and ambivalence of everyone's feelings – analysts' included – and because some of an analyst's feelings are necessarily unconscious, any attempt by an analyst to disclose his feelings to the patient *in a simple or conclusive way* is always incomplete, and thus never completely honest (cf. Greenberg, 1991; Hoffman, 1983). This is not to say that an analyst ought not to acknowledge his feelings openly with a patient *in a more complex, less authoritative way* – this has its place, I believe, especially when the analyst's countertransference has disturbed the patient and the patient feels he needs some

acknowledgement from the analyst in order to reestablish a minimum sense of safety and well-being. Ferenczi (1932 [1988], 1933), and, later, Kohut (1984) and Benjamin (2006), emphasized the importance of doing this, though complications may result – as Ferenczi (1932 [1988]) well understood.

Another argument for a more interactive analytic stance centers on the idea that greater personal expressiveness by the analyst helps the patient's inner life become more clearly expressed and more deeply felt, and thus ultimately makes it more possible for the patient to reflect on, symbolize, and understand it (e.g. Aron, 2006; Ehrenberg, 1984, 1996; Renik, 1993; Tauber, 1954). Closely related to this argument is the idea that the analyst's personal emotional involvement being evident to the patient, at least at certain times, may be a necessary element of therapeutic action (Boesky, 1990; Davies, 1994; Hoffman, 2009; Maroda, 2002; Skolnick, 2006). I believe that these lines of thinking can have merit – even to the point that a patient may sometimes *need* to live out a regressive fantasy with an analyst who is emotionally pulled in to this enactment – in order for the patient to have the best chance of working through his pressing inner conflicts. But this kind of mutual enactment also poses certain dangers: notably, it has the potential (1) to undermine the patient's ownership of what he expresses as reflecting the workings of his own mind rather than mainly being a function of the interaction between patient and analyst, with the additional possible consequence that the patient will feel his well-being depends upon the continuation of certain patterns of interaction with the analyst rather than their working through, and (2) in more extreme forms, to threaten the dependability of the most basic rules of the frame, which are necessary for analytic process (cf. Bálint, 1968). Therefore, to the extent that, either through self-reflection and self-analysis or through a patient's directly or obliquely stated observations, an analyst becomes aware of his own participation in such an enactment, he can gain some measure of control[14] and must temper his participation in the enactment with as much restraint as a patient can tolerate without withdrawing; and he must, of course, set a firm barrier against any expressiveness that could constitute a gross boundary violation (cf. discussion by Gabbard, 1995).

A different case for an interactive stance, albeit more limited, stems from the fact that the analyst inevitably has personal emotional responses toward the patient which are unavoidably communicated to and influence the patient (Aron, 1996; Hoffman, 1983; Levenson, 1972; Mitchell, 1988; Sandler, 1976) and is to a significant degree (at least occasionally) unaware of her own involvement. This leads the analyst to disavow her own influence, at least implicitly – a situation which may carry echoes for the patient of earlier self-protective denials by parents and which can reawaken traumatic feelings related to those denials. At such a moment, the analyst's openly acknowledging her own participation in the disturbing event, when the patient's direct or indirect communication has brought this to her attention, may help the patient work through and free himself from the disturbing

[14]See, for instance, Loewald's (1971) reference to the analyst's conscious effort at self-control with his phrase "persistent renunciation of involvement" (p. 63).

consequences of this and earlier similar situations by providing an experience with a new kind of object – less self-protective, more open and honest, more emotionally present (cf. Benjamin, 2006; Ferenczi, 1933; Frankel, 2002b; Jacobs, 1999; Mitchell, 1997, p. 267; Renik, 1993). In addition, this can help re-establish the patient's trust in the analyst.

I agree with this line of thinking, but I also think this argument can be pushed too far. For instance, Renik (1993) believes that the analyst cannot be in a position of even relative objectivity "*even for an instant*" (p. 560, italics in original), and proposes this as a rationale for a more freely expressive analytic technique where the analyst's potential unconscious counter-resistances can be more easily exposed. This argument, like some others that criticize more traditional technique, seems to me to be cast in extreme, black-and-white terms, and discourages more nuanced thinking about the issues involved – for instance, it implies that potential interferences (such as aspects of the analyst's reactions that are registered by the patient) that are quite manageable and even marginal for some patients and in some mental states (e.g. when narcissistic anxieties are not ascendant) are profoundly disruptive for all treatments always. Renik thus tends to throw out the essentially healthy baby of restrained technique with the bathwater of its potential pitfalls.

What about Winnicott's observation that "Children play more easily when the other person is able and free to be playful" (1971, pp. 44–5)? Ought not the analyst to be more actively engaged on this basis? Certainly, an analyst should aim for the ideal level of responsiveness that helps a particular patient at a particular moment both become able to play most productively and with the greatest sense of the play feeling real, and also own his play as an expression of himself. With some patients, a quieter approach is best; with others a more expressive one. The crucial variable seems to me to be the patient's sense of safety, which in turn, I believe, often depends on the patient's sense that he is not alone. One of Ferenczi's great insights was how being left alone in a vulnerable state – emotionally abandoned – is itself a trauma (Ferenczi, 1933; Frankel, 2002b). At moments when a patient has a pretty good grip on an internal sense of relationship to a good other, i.e. is less subject to narcissistic anxieties, the analyst may be able to remain relatively reticent and restrained; when not, he *may* need to be more interactive, to remind the patient that he is there.[15] (At times, certain patients cope with their narcissistic anxieties by requiring the analyst to be especially effaced rather than more active.[16]) Over time, as a patient internalizes the analyst as a good object in a more stable way, the analyst may become

[15]Cf. Killingmo's (1989) discussion of analysts choosing either an affirming or an exploratory tack, depending on whether a patient is functioning on primarily a deficit or a conflict level at that moment, and Frankel's (2006) related idea that an analyst's technical choices at any given time be based on the patient's 'diagnosis-of-the-moment'.

[16]For instance, see Bálint's (1968) distinction between object-loving 'ocnophils' and space-loving 'philobats', Kohut's (1971) descriptions of the need to idealize as opposed to the need for mirroring, and Bach's (1994) discussion of masochistic versus sadistic strategies to control the object and deny anxieties about object loss; the second half of each of these pairs reflects an orientation in which the subject seeks to efface or subordinate the other person.

quieter in general. The analyst needs to find a balance between being actively present, when a patient needs this kind of help to feel adequately accompanied, while being restrained enough so as not to interfere with the patient's owning his emerging inner reality as a personal expression.

Related to the issue of analytic expressiveness, I think that a stance with a lot of active exploration or discussion as the norm engages the patient as an adult (cf. Bálint's [1968] idea that interpretation and even, at times, the very use of language reject a patient's regression and push the patient to an adult level of experience) and interferes with the patient's regression – an indispensable element in the foundational transference that I am suggesting is central in analytic change. Many advocates of an expressive stance by the analyst do in fact seem to believe that patients should be engaged primarily as adults (e.g. Renik, 1993; see also Bromberg, 1991; Mitchell, 1993, p. 145; Wolstein, 1988a, 1988b). To my way of thinking, that approach fails to appreciate the central place of the foundational transference, with its intrinsic regressive aspects, in the analytic process. When a patient can tolerate an analyst's restrained stance, I see this as the more desirable path.

To sum up: in order to protect the analytic state of consciousness, which I see as clinically essential, I am arguing against a *preference* for an interactive or disclosing analytic style, and am recommending an ever-present *inclination* toward restraint. However, where the actual line is drawn between an appropriate level of expressiveness and necessary restraint in any given clinical situation rests on each analyst's subjective judgment. In significant measure, it eludes quantification and is likely to vary in its actual application from one analyst to another and even from one treatment to another.

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Translations of summary

Der analytische Bewusstseinszustand als Form des Spiels und als Grundübertragung. Der analytische Bewusstseinszustand ist ein spezifischer, regressiver, veränderter Zustand des Patienten, für den eine erhöhte Sensibilität für und Reaktivität auf Eindrücke charakteristisch sind, die der inneren Welt entstammen oder vom Analytiker ausgehen; typische Merkmale sind überdies ein verstärktes Gefühl der Abhängigkeit und Verwundbarkeit und eine Durchlässigkeit der Grenzen gegenüber dem Analytiker sowie eine Verlagerung auf ein durch omnipotente Phantasie geprägtes Funktionieren in der analytischen Beziehung, das bewirkt, dass der Analysand, ohne die Fähigkeit zur Realitätsprüfung wirklich zu verlieren, seine psychische Realität für die Realität hält. Auf der Grundlage einer Analyse der Struktur des Spielens kann auch dieser Zustand als eine Art Spiel verstanden werden; er dient als Grundübertragung, die spezifischere Übertragungsmanifestationen fundiert; und er spielt im analytischen Prozess eine zentrale Rolle. In Reaktion auf die Sicherheit des analytischen Settings, die emotionale Begleitung durch den Analytiker und eine durch eine generelle Zurückgenommenheit charakterisierte analytische Haltung (ein Thema, das ich eingehend erläutere) nimmt dieser Zustand eine weiterentwickelte Form an, die der Symbolisierung ebenso zuträglich ist wie der Anerkennung von Aspekten des Selbst, einer verstärkten emotionalen Präsenz sowie einem vertieften Gefühl der Bedeutungshaltigkeit der eigenen Erfahrung. Das Konzept des analytischen Bewusstseinszustands ermöglicht einen neuen Blick auf die Rolle von Abstinenz und Frustration im analytischen Prozess.

El estado analítico de la consciencia como forma de juego y transferencia fundacional. El estado analítico de la consciencia es un estado alterado regresivo particular del o de la paciente, caracterizado por un aumento de la sensibilidad y de la reactividad a las impresiones que surgen tanto del mundo interno como del o de la analista, un sentido realzado de dependencia y vulnerabilidad y una permeabilidad de los límites entre paciente y analista, así como un pasaje hacia un funcionamiento en la relación analítica basado en la fantasía omnipotente, acompañado de una vivencia del carácter real de la propia realidad psíquica pero sin pérdida verdadera de la prueba de realidad. A partir de un análisis de la estructura del juego, este estado puede ser entendido como un tipo de juego en sí mismo. Sirve como transferencia fundacional que subyace a manifestaciones transferenciales más específicas, y es esencial para el proceso analítico. A través del tiempo – como respuesta a la seguridad del *setting* analítico, al acompañamiento afectivo del analista y a una actitud analítica moderada (una cuestión que analizaré en cierto detalle) – esta transferencia surge en una forma más elaborada que promueve la simbolización y la apropiación de aspectos del *self*, mayor presencia afectiva y una vivencia más profunda del significado de la propia experiencia. El concepto de estado analítico de consciencia brinda una nueva mirada sobre el papel de la abstinencia y la frustración en el proceso analítico.

L'état analytique de conscience comme une forme de jeu et de transfert fondateur. L'état analytique de conscience est un état modifié regressif particulier chez le patient caractérisé par une intensification de la sensitivité et de la réactivité aux impressions qui surgissent tant du monde intérieur que de l'analyste, un sentiment renforcé de dépendence et vulnérabilité et une perméabilité aux limites en ce qui concerne l'analyste, ainsi qu'un mouvement vers le fonctionnement sur la base de la fantaisie de toute-puissance dans la relation analytique, accompagnée par un sentiment de véritabilité en la réalité psychique propre, mais sans une vraie perte de la preuve de la réalité. Sur la base d'une analyse de la structure du jeu, cet état peut en soi être considéré comme une sorte de jeu; il sert comme un transfert fondateur sous-jacent dans des manifestations de transfert plus spécifiques, et ceci est central au processus analytique. Au cours du temps, en réponse à la sécurité du cadre analytique, l'accompagnement émotionnel de l'analyste et une position analytique contenue en général (un thème que je traite de façon un peu détaillée), une forme plus développée émerge, qui encourage la symbolisation et possession des aspects du soi, une présence émotionnelle plus importante, et un sentiment plus profond du sens de son expérience propre. Le concept de l'état analytique de conscience fournit une nouvelle perspective sur le rôle d'abstinence et de frustration dans le processus analytique.

Lo 'stato di coscienza analitica' come forma ludica e fondamento del transfert. Lo 'stato di coscienza analitica' è uno stato alterato del paziente, particolarmente regressivo e caratterizzato da una maggiore sensibilità e reattività alle impressioni: sia quelle che emergono dal proprio mondo interiore sia quelle provenienti dall'analista. Si tratta di un maggior senso di dipendenza e di vulnerabilità, di una maggiore permeabilità dei limiti rispetto all'analista; in questo stato si verifica inoltre un cambiamento della tendenza a funzionare nel rapporto analitico in base a fantasie di onnipotenza accompagnata da un senso di autenticità della propria realtà psichica, senza che si abbia nessuna vera perdita di contatto con l'esame di realtà. Sulla base di un'analisi della struttura del processo ludico, questo stato stesso può essere visto come una forma di gioco. Ha una funzione di transfert di base, che sottende a manifestazioni di transfert più specifiche e riveste un ruolo centrale nel processo analitico. Gradualmente, in risposta al senso di sicurezza procurato dal *setting* analitico, in risposta al sentirsi seguito a livello emotivo dall'analista, e al generale assetto di astinenza (una questione, quest'ultima, che esploro nel dettaglio), il paziente raggiunge una dimensione più definita di questo stato. A questo stadio si verifica una maggiore capacità di simbolizzazione, il riconoscimento di aspetti ripudiati del proprio sé e un maggior senso del significato della propria esistenza. Il concetto di 'stato di coscienza analitica' consente una nuova prospettiva sul ruolo dell'astinenza e della frustrazione nel processo analitico.

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