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Agoraphobia And Emptiness: Theoretical Considerations From A Psychoanalytic Perspective

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A thesis submitted in partial fulfillment of the requirements for the Doctor of Philosophy degree in Theory and Criticism

Agoraphobia and Emptiness: Theoretical Considerations From A Psychoanalytic Perspective

(a Monograph)

by

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of the requirements for the degree of
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Abstract

Milrod (2007) identifies persistent emptiness in agoraphobia patients whose symptoms of anxiety and avoidance have remitted. Through an analysis of the available theoretical and clinical literature on agoraphobia, the psychological experience of emptiness, and the development of the ego, I argue that agoraphobia is not an anxiety about "open spaces" but, rather, about the boundaries between spaces. In agoraphobia, there is a pathological persistence of the psychological processes of normal ego development. Recognition of the usefulness of agoraphobic anxieties in the development of ego boundaries may help to identify the point at which they persist beyond usefulness and into pathology, both theoretically and clinically. Following Winnicott (1951, 1969), I argue that the analytic frame – the setting of the analysis – has the potential to become a transitional object for the analysand. The agoraphobic's opportunity for new experiences with a transitional object – if it can survive her destruction of it – allows the frame to be used in the development of the ego's boundaries.

Milrod suggests that a deficient Reflective Function (RF) may explain the persistent emptiness she identifies in agoraphobia patients. Though Milrod's patients may indeed have a weak RF, I argue that assertions of emptiness in the clinical situation cannot be causally attributed to this deficiency. Further, I contend that these patients' assertions *and* experiences of emptiness can be better explained by the presence of traumatic and unmourned losses. I propose several explanations for why agoraphobia patients, in particular, defend unconsciously against mourning. I argue that a clinical emphasis on interpreting the transference may lead to an impasse in the relief of this emptiness insofar as it may impede the development of free association. I contend that the agoraphobic requires the freedom to be incoherent, afforded in the psychoanalytic clinic via the distinctive method of free association, in order to define for herself the boundaries of self and other, and to recognize in action – or, more precisely, in words; in the act of putting it all into words – the limits of her affective life. Specifically, these boundaries limit the agoraphobic's fears of destruction of the object and annihilation of the ego.

Keywords

Agoraphobia; panic disorder; emptiness; Milrod; psychoanalysis; anxiety; narrative; free association; analytic frame; analytic setting; therapeutic frame; ego development; agora-claustrophobic anxieties

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Introduction

They that live in fear are never free, resolute, secure, merry, but in continual pain…No greater misery, no rack, no torture like unto it.

(Burton 1621; qtd. in Snaith 1968, p. 673)

Agoraphobia is commonly described as a morbid fear of open spaces. Psychiatrically, it is defined according to two predominant symptoms: anxiety and avoidance. Research with American populations finds a 12-month prevalence of 2.7% (American Psychiatric Association 1995) and a lifetime prevalence of almost 5% (Kessler et al. 2006). In Canada, 12-month and lifetime prevalence rates are 1.6% and 3.7%, respectively (Government of Canada 2006). In moderate to severe cases of agoraphobia – which affects an estimated 86% of sufferers (Kessler et al. 2006) – individuals may become entirely or largely housebound. Along with severity, agoraphobia is also associated with impairment (interfering with home management, work, social life, and personal relationships) and comorbidity with other mental disorders (including other anxiety disorders, mood disorders, and substance use disorders). These statistics indicate that agoraphobia presents a significant social problem. While almost all sufferers seek out and respond to some level of treatment, relapse is common after treatment ends (see, for example, Wiborg & Dahl 1996; Kessler et al. 2006).

Relapse may be so common because of a third, more pernicious, symptom that Milrod, one of the foremost contemporary theorists of agoraphobia,[1] has recently identified – "persistent emptiness":

> Although the flagrant symptoms of agoraphobia and accompanying panic remit fairly readily with these treatments [CBT and pharmacotherapy], from the perspective of clinical psychoanalysis some of these patients' underlying inner constriction is striking. This constriction affects ability to think independently and to lead emotionally full and intellectually broad and stimulating internal lives. This

[1] Milrod, along with colleagues, is one of the foremost innovators of outcome studies for panic focused psychodynamic psychotherapy. Milrod et al.'s (1997) manual, *Panic-Focused Psychodynamic Psychotherapy*, is recognized as a landmark achievement in the integration of psychodynamic approaches with CBT and pharmacotherapy (Gassner 2004, p. 229). Milrod has led or participated in numerous studies and individual psychoanalytic treatments of patients with panic disorder and agoraphobia (e.g., Klein et al. 2003; Milrod 1995; Milrod et al. 1996; Milrod 1998; Milrod et al. 2000; Milrod et al. 2001; Milrod et al. 2007; Rudden et al. 2003; Rudden et al. 2006).

> problem persists long after agoraphobic symptom remission. The overt difficulty that these patients experience in venturing out of their magically designated safe space in the real world, punctuated by overwhelming anxiety, parallels a difficulty they often have in looking inward, reflecting on their lives or feelings, or permitting themselves to experience their feelings at all. (Milrod 2007, pp. 1008-1009)

Milrod's experience as a psychiatrist who works with a predominately psychodynamic model has led to her familiarity with the advantages and limitations of both the psychiatric and the psychoanalytic paradigms. It is from the psychoanalytic perspective that Milrod notes the emergence of this persistent symptom in agoraphobia patients.[2] She refers to this phenomenon variously within her article as "emptiness" (p. 1007), "inner constriction" (p. 1008), "internal vacancy" (p. 1009), and "subjective sense of incompleteness" (p. 1010) without remarking on the very different meanings of each of these terms. The complexities of the subjective phenomenological[3] experiences of this emptiness are evident from the connotations of these various terms: emptiness implies a nothingness and a complete absence; constriction implies an intense anxiety; and, incompleteness implies a something missing along with the presence of something else. The nature of these "somethings" remains undefined, which results in the sense of unease that is often emptiness's affective companion. All of these meanings accord with Milrod's descriptions of her patients' experiences at certain moments; however, Milrod's use of these various terms without clarification obscures her intended meaning, which remains unclear throughout the article; or, rather, the complexity of the phenomenon she encounters in her patients remains to be explicated. At the same time, my reading of her article, which focuses on the meanings of patients' assertions of emptiness, reveals incompatibilities in Milrod's arguments that undermine her suggestion that her patients' persistent emptiness can be attributed to a developmental deficit in the form of a weak reflective function. Milrod's finding of persistent emptiness in agoraphobia patients has

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[2] This phenomenon of emptiness is anticipated, though not elaborated, in Morgan's important overview on the history of agoraphobia: "the impression conveyed by the phobic personality is of emptiness" (2003, p. 191). Morgan also notes the relevance of traumatic loss in some phobic patients (p. 196).

[3] By phenomenological, here and elsewhere, I mean the subjective physiological and psychological experiences of agoraphobia. I distinguish the phenomenological from the symptomatological, which I take to refer, at least implicitly, to diagnostics; I maintain this distinction to indicate that the phenomenological exceeds the symptomatological and that it remains, necessarily, beyond our ability to fully articulate an objective definition of psychical experiences, in general, and of agoraphobia, in particular.

important implications for the successful treatment of the disorder long-term, namely, the need to address this emptiness in patients for whom panic symptoms have remitted. In this thesis, I critique Milrod's explanation for the persistent emptiness and propose an alternative explanation with clinical implications. I also provide the theoretical foundations for my critique, and provide an analysis of the theoretical implications of this emptiness in agoraphobia patients specifically and in the development of psychical reality generally.

0.1. The Universalities in Agoraphobia and Emptiness

There are two broad issues in establishing the framework for this thesis. The first issue concerns the relevance of gender in agoraphobia. This first issue bleeds into the second, which concerns the wide array of theoretical paradigms within which agoraphobia has been considered. Much of the extra-psychoanalytic literature on agoraphobia – psychiatric, sociological, psychotherapeutic, attachment, and cultural geographic – focuses on the gender variance, namely, that agoraphobia is diagnosed in women much more frequently than in men. Ultimately, I suggest that the universal experiences of anxiety that are part of ego development and psychical reality tend to be overlooked in favour of explanations of agoraphobia that emphasize this gender variance.[4] In this thesis, I focus on the unconscious elements of agoraphobia. Thus, while my thinking on agoraphobia has been influenced by arguments from a range of disciplines, my arguments strongly depend on the psychoanalytic literature on agoraphobia and emptiness.

Prior to World War I, agoraphobia was predominantly diagnosed in male patients. Currently, it is diagnosed much more frequently in female patients. Statistically, the percentage of women in research populations of at least 25 agoraphobics varies between 63% and 95%. (Bekker 1996, p. 129; see also Chambless & Mason 1986). There are two main perspectives on this gender variance in agoraphobia. They can be summarized

[4] Rey, a psychoanalyst, argues that, although more overt in women, the "claustro-agoraphobic syndrome [...] is basic to both sexes; only certain manifestations of it are different" (1994, p. 9). I do not disagree with those who argue that the differences between these manifestations are significant; however, the focus of this thesis is what is, in Rey's words, "basic to both sexes." I consider Rey's work in detail in Chapter Two.

briefly as follows: agoraphobia is a “women’s syndrome”; it is both diagnosed and occurs in females almost to the exclusion of males because of the socio-cultural conditions in which we live. This perspective is exemplified by Seidenberg and DeCrow, who argue that agoraphobia is “a paradigm for the historical intimidation and oppression of women” (1983, p. 6). This misunderstanding, I suggest, of the psychological nature of agoraphobia leads Seidenberg and DeCrow to – in my view, the rather absurd – conclusion that people suffering from agoraphobia “have come to terms with their own sense of pride by not setting foot on land that is deemed alien and hostile” (p. 7). Carter provides a succinct critique of this perspective: “this approach seems to attribute to agoraphobia sufferers an insight they don’t have. It risks discounting the suffering, the actual, chronically debilitating unease” (2002, p. 209).

The second perspective on the gender variance in agoraphobia emphasizes that the rate of diagnosis likely does not correspond to the rate of incidence. Bekker, for example, in a review of the clinical psychology literature on agoraphobia and gender, critiques the status quo of accepting agoraphobia as a “women’s syndrome” and argues that the prevalence of diagnosis does not equal the prevalence of the disorder. The gap between diagnosis and incidence, if it exists, has several explanations, most involving diagnostic sex bias and/or socio-cultural etiological sex bias. These biases mean that agoraphobia is diagnosed more in women because diagnosticians expect to find it in women, and/or that the prevalence of the disorder is affected by socially constructed differences between the sexes (namely, gender bias). Bekker suggests that men are more likely than women to abuse alcohol to cope with severe anxiety, a hypothesis supported by the high rate of co-morbid agoraphobia and/or social phobia among patients treated for alcoholism, a higher rate of which are male (1996, pp. 130-131). As Bekker indicates, the rates of anxiety-reducing substance abuse other than alcohol are not known. Although there has been much research on this gender variance in agoraphobia since Bekker’s review (see, for example, Foot & Koszycki 2004; McLean & Anderson 2009; Starcevic et al. 2007), the statistics and concerns remain relatively unchanged. McLean and Anderson, for example, find support for Bekker’s suggestion of a socio-cultural etiological sex bias, concluding that “gender differences at each level of analysis are likely moderated by socialization processes that prescribe gender-specific expectations regarding the expression of anxiety and the acceptable means of coping with anxiety" (2009, p. 503).

Reuter (2007a, 2007b) considers the contemporary prevalence of female agoraphobics in a Foucauldian analysis, addressing the problematic socio-cultural (psychiatric) narrative that has developed around the physiological symptoms of agoraphobia (including tachycardia, chest pain, shortness of breath, etc.). Reuter critiques the "normalizing" diagnostic criteria as a tool for ideological social order. She points out that, along with the development of a psychiatric diagnosis, for many social theorists agoraphobia became a metaphor for the alienation and social estrangement of modern urban space.[5] Reuter supports her critique of psychiatric methods as socially and culturally determined with an analysis of other cultural shifts that coincided with World War I. There is no doubt that cultural expectations of women shifted from the late nineteenth century – when it was considered inappropriate for (bourgeois) women to leave the house unaccompanied ("unchaperoned") – to the late twentieth century when, as Reuter puts it, "what was previously considered normal bourgeois behaviour […] became something to see as pathological" (2007a, p. 250). Women's resistance to the "freedom" to move about in public spheres unaccompanied, Reuter argues, may account for part of this shift. Reuter also suggests that the advent of "shell shock," or war neurosis, as a (masculine) diagnosis may have predominantly replaced agoraphobia as a diagnosis for men with anxiety disorders. Reuter's critique, then, accounts for both a diagnostic sex bias and a socio-cultural etiological sex bias.

Much of the recent research on agoraphobia uses a framework of attachment theory. Attachment theory proposes an evolutionary system of security based on proximity and accessibility of care providers during development. A care provider that is consistently available serves as a "secure base" (Bowlby 1988) for the child and repeated experiences of availability result in a secure attachment. An inconsistently responsive

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[5] See especially Reuter 2007b, pp. 28-31. Reuter refers to Simmel's argument that the modern city and its various assaults on the individual in the form of "nervous stimulation" required the construction of a protective "inner barrier" (see Simmel 1950). Reuter notes Benjamin's addition of an external barrier in the form of the home as a bourgeois private refuge (see Benjamin 1978). See also Carter (2002), who argues that agoraphobia is a "realistic anxiety" of the expanse of modern urban space.

secure base results in an insecure attachment, either avoidant or anxious-ambivalent. Attachment researchers have investigated the relationship between agoraphobia and an anxious-ambivalent attachment style; findings suggest that anxious-ambivalent attachment is a risk factor for agoraphobia, but not exclusively. That is, anxious-ambivalent attachment is a risk factor for a number of mental disorders in adulthood. De Ruiter and van Ijzendoorn (1992) provide a review of this research; they also point to several studies that suggest that early traumatic events (including death of a parent and parental divorce) were related to the development of adult agoraphobia (de Ruiter & van Ijzendoorn 1992, p. 377; see Tweed et al. 1989 and Faravelli et al. 1985). By contrast, Fleischer-Mann (1995) finds that early traumatic events are not more common in agoraphobics than in a control group of non-agoraphobics but that these events were perceived more negatively by agoraphobics. Influenced by the development of the fourth category of disorganized attachment that specifically concerns an individual's response to loss and trauma, Iddiols (2005) suggests that agoraphobia may follow from disorganized attachment rather than from an organized anxious-ambivalent attachment. I discuss the significance of traumatic events in agoraphobia in Chapter Three, but, as I am specifically concerned with the unconscious aspects of agoraphobia that lead to experiences of persistent emptiness, I do not consider in any detail the research on agoraphobia from an attachment perspective, which is more applicable in research on the cognitive and behavioural aspects of agoraphobia (see, for example, Liotti 1991; Sable 1994).

Social and cultural geographers with psychotherapeutic practices, notably Bankey (2004), Bondi (2005), and Davidson (2000, 2001, 2003), consider the implications for agoraphobia and space anxieties in psychotherapy. Davidson (especially 2000, 2001) considers with a creative and astute analysis the ways in which cultural femininities shape women's experiences of themselves, their bodies, and others. There are important first-person accounts of the lived experiences of agoraphobia sufferers in many of these works, including also Capps and Ochs (1995) and McWatters (2013). Orr (2006) provides an account of her own experiences of agoraphobia. These personal narratives are integral to our broader conceptualizations of agoraphobia insofar as, as McWatters emphasizes, theorizations about the social, cultural, and political dimensions of agoraphobia must account for the agoraphobic's *suffering*.

In this thesis, I do not refute that agoraphobia, as currently diagnostically defined, occurs more commonly in women than in men. The focus of this thesis is not, however, an interrogation of agoraphobia's diagnostic criteria, nor the sex variance in its occurrence. While the development of psychiatric narratives is certainly an interesting question, it is also not the focus of this thesis. I am particularly concerned with the phenomenon – symptom – of persistent emptiness Milrod (2007) has identified in agoraphobia patients whose symptoms of anxiety and avoidance have remitted. In this thesis, I assume the validity of psychoanalysis as both a distinctive method in the alleviation of mental suffering and as a framework for understanding the nature of mental life. Unlike some projects (e.g., Busch & Milrod 2013; Busch et al. 2009; Milrod 1995; Milrod et al. 1997; Milrod et al. 2007), this thesis is not concerned with demonstrating the efficacy of psychoanalysis or psychodynamic psychotherapy in treating panic disorder and agoraphobia; nor is it concerned with arguing what constitutes psychoanalysis proper, or discounting particular treatments because they are *not* psychoanalysis. Rather, in this thesis, I consider what Milrod's (2007) finding of persistent emptiness in agoraphobia patients for whom symptoms of anxiety and avoidance have remitted can add to our understanding of the nature of agoraphobia. I argue that agoraphobic anxieties, the development of the ego, and the experience of emptiness are all inextricably connected to the agoraphobic's particular uses of language. Although I do not wish to engage in the debate of what constitutes psychoanalysis, I do argue that specific elements of the psychoanalytic process are more efficacious in the relief of the agoraphobic's persistent emptiness than others, namely, the fundamental rule: the analysand's free associations and the analyst's evenly hovering attention. This argument follows from the theoretical and clinical additions I offer in this thesis to the understanding of agoraphobia, the significance of emptiness and agoraphobic anxieties in the development of the ego, *and* the particular way agoraphobia patients use language – more specifically, narrative – as part of their experience of agoraphobia.

0.2. Overview

I begin this thesis with theoretical considerations of agoraphobia in Chapters One and Two in order to lay the foundations for the more clinical developments in Chapters Three and Four. Broadly, I begin with a conceptual overview of agoraphobia, and then turn to an analysis of agoraphobic anxieties and the experience of emptiness in the development of the ego and psychical reality. I then engage directly with Milrod's (2007) article, using the theoretical arguments of the first two chapters to critique her conclusion that a developmental deficit in the form of a weak reflective function can explain agoraphobia patients' persistent emptiness. Finally, I suggest a clinical counterpoint to Milrod's emphasis on interpreting the transference relationship within the psychoanalytic setting and return to the fundamental psychoanalytic emphasis on language.

More specifically, in Chapter One I provide an analysis of the conceptualization of agoraphobia, including its historical development, psychiatric delineations, and psychoanalytic contributions. I review arguments about the "phobia" aspect of agoraphobia, which indicate the theoretical and phenomenological distinctions between agoraphobia and simple (aka: simple, true, discrete, or specific) phobias. This distinction illuminates the nature of the disorder and clarifies both its profound disabling effect on sufferers and its chronicity. The use of the term "phobia" to describe the disorder is contentious in part because the fear is not, as originally described (and the psychiatric definition notwithstanding), of an object (or space) that can be avoided, but, following Weiss, a "mental registration of structural disorganization" (Compton 1992, p. 409). I then review arguments about agoraphobia's phobic object, to which "agora" is meant to refer and I offer my own theoretical description of the unconscious motivation of the anxiety embodied in patients with agoraphobia. Informed by Milrod's (2007) addition to the clinical picture of agoraphobia of persistent emptiness beyond the remittance of the overt symptoms of anxiety and avoidance, I argue that agoraphobia involves a profound anxiety about the boundaries *between* spaces, both physical and psychical. This anxiety is fuelled – if not caused – by the inability to symbolize (or, more specifically, to engage in the creative process of symbolization[6]). The agoraphobic's difficulty in putting her feelings into words contributes, I argue, to the persistent emptiness Milrod describes. To name is to define, and thus to delimit. Without the experience of these limits, the very thought of engaging in life is overwhelming.

In Chapter Two, I expand on the issue of psychical space. Specifically, I address the question of what is internal and what is external, the anxieties fuelled by the navigation of these separated spaces, and, especially, the agoraphobic's anxiety of navigating between them – of crossing the threshold, so to speak – via an elucidation of the development and functions of the ego. Following Freud and the psychoanalytic tradition, I argue that the distinction between "normal" and "pathological" is a matter of degree. In agoraphobia, there is a pathological persistence of the psychological processes of normal ego development. Recognition of the usefulness of agoraphobic anxieties in the development of ego boundaries may help identify the point at which they persist beyond usefulness and into pathology, both theoretically and clinically. From an original unity, in which no ego exists, the ego comes into being by distinguishing an internal reality from

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[6] In this thesis, I use the term "symbolization" in reference to the phobic "object" of agoraphobia; specifically, I argue that agoraphobia indicates a fear of *symbolization*. While I anticipate that the meaning of this argument will be clarified through the detailed arguments of this thesis, it is necessary to clarify here what I mean by "symbolization." My sense of symbolization is intimately connected to the concept of the transitional object (Winnicott 1951, 1959, 1969) and to Lacan's notion of the symbolic order (Lacan 1988, 1958/2006b, 2006d, 2006j). In this thesis, I refer to the individual engaging in the creative process of symbolization; it requires the prior existence of an object (via Winnicott) or a linguistic symbol (via Lacan), and it also requires the ability to create anew this previously existing object or symbol. The paradox of these two simultaneous acts – the finding and the creating – is integral to an individual's sense of living his or her *own* life. I am primarily referring to the use of language as a system of symbols. Engaging in a process of symbolization, here, simply means putting one's thoughts and feelings into words; however, the simplicity of this statement belies the extraordinary difficulty of the task. My use of the term symbolization is connected to, but distinct from, much of the psychoanalytic literature on symbolism, which tends to focus on objects as symbols of repressed ideas (whether conscious or unconscious, i.e., in dreams) or on symbolic thinking (or symbolic equation) as what is more commonly referred to now as concrete thinking, where the symbol is taken to *be* the object rather than understood as referring to the object. Often, according to this literature, the function of symbol formation is to substitute for the loss of the child's "primary" objects, the maternal and paternal part objects. We can see the connection between this understanding of symbolism and my use of the term symbolization, which merely requires an extrapolation of the sense of "symbol" from an object to a word. As I note above, this extrapolation – for me – follows primarily from the work of Winnicott and Lacan. For some notable examples within the psychoanalytic literature on symbolism, see: Jones (1918); Klein (1923, 1930); Fenichel (1946); and, Milner (1952).

an external reality. For the agoraphobic, I suggest that something has gone awry in this process of creative differentiation. The agoraphobic is not able to take for granted the distinction between internal and external, and therefore cannot experience shared reality as *illusion*. This illusion of shared reality is necessary for the creative uses of language. Following Winnicott (1951, 1969), I argue that the analytic frame – the setting of the analysis – has the potential to become a transitional object for the analysand. The agoraphobic's opportunity for new experiences with a transitional object – if it can survive her destruction of it – allows the frame to be used in the development of the ego's boundaries, which can thereby be creatively inhabited, with all of the risks and rewards of human vulnerability.

In Chapter Three, I argue that assertions of emptiness in the analytic situation indicate the unconscious presence of strongly warded-off emotional or cognitive experiences. The nature of these experiences must be explored with each patient, as they will naturally vary among individuals. Specifically, however, the subjective experience of emptiness in agoraphobia patients commonly indicates the presence of significant losses that have yet to be mourned. I propose several explanations as to why agoraphobia patients, in particular, defend against mourning. Further, I argue that a structural emptiness exists in all individuals along with the pathological emptiness evident in certain patients. Pathological emptiness, I argue, is a complex defense organization that masks overwhelming unconscious material; for the agoraphobia patient, pathological emptiness is a defense against one's own aggressivity and the painful experience of overwhelming loss. Structural emptiness, on the other hand, and as Winnicott argues, is the basis for all learning; it is an aspect of the psychical apparatus that allows for the possibility of new thoughts, feelings, and experiences. An understanding of structural emptiness does not elucidate the particular meaning of pathological emptiness, but it does provide a technical counterpoint to the therapeutic emphasis on the transference relationship. Structural emptiness is a consequence of entering into a language system; by following the psychoanalytic method of free association and abiding by the fundamental psychoanalytic rule – the pact between the analysand and the analyst of complete candor and complete discretion respectively – the analytic couple can make use of this structural emptiness in order to elucidate the individual meaning(s) of pathological emptiness.

In Chapter Four, I explore agoraphobia and the uses of language in the psychoanalytic setting. Specifically, I consider three main themes: coherence as resistance; the analyst's over-reliance on interpreting the transference as an impediment to the development of free and freer associations; and, the concept of *Nachträglichkeit* and the logic of the unconscious. These themes are all connected to the concepts of psychoanalytic truth and psychical reality, which provide the frame within which I develop my arguments. There is little consensus on what constitutes psychoanalytic truth. As I am here concerned with psychical coherence – and, relatedly, psychical reality – I follow Faimberg's concept of psychic truths, which "are the consequence of the psychic work resulting from the demands of reality that are fashioned by the unconscious wish and the unconscious fantasy" (1997, p. 449). This definition is consistent with my arguments in Chapter Two, namely, that psychical reality is created through the ego's mediation of external reality; both the facts of external reality and the ego's mediation – or, better, modification – of those facts is clinically pertinent. Indeed, it is precisely the ego's modification of external reality that is the concern of psychoanalytic work and is the realm of that work's influence.

I argue that the tasks of trying to be coherent and trying to say everything involve different processes and therefore have different results; likewise, the task of listening differs between trying to make sense of what is being said and waiting to see what sense emerges. It is not that incoherence in itself is preferable to coherence, but that when coherence is *demanded*, fewer feelings and thoughts are possible; when incoherence is tolerated, new and unanticipated feelings and thoughts can develop. The agoraphobic is unable to tolerate incoherence: she either produces narratives that are too coherent or she produces empty narratives. The agoraphobic suffers from a restricted unconscious freedom in addition to the restrictions she places on her freedom of mobility. Following Bollas (1995), I argue that there are two aspects of mental health: the ability to construct coherent narratives and the freedom to explore the feelings that precede coherence. The agoraphobic, I suggest, uses narrative to stave off the overwhelming emotions that accompany incoherence. An analytic emphasis on interpreting the transference colludes with the agoraphobic's ego in the resistance of incoherence, inhibiting the development of free association. Focusing on narrative coherence forecloses the emergence of the unconscious in the gaps revealed by language, gaps which must emerge in order for new thoughts and feelings to be possible. The psychoanalytic invitation “try to say everything” provides the space for these gaps to emerge and the opportunity to explore them.

Chapter One: The Concept of Agoraphobia

The dictionary definition of agoraphobia depends on the literal significance of its parts; that is, agoraphobia is defined as the fear of open spaces: from the Greek *agora*, meaning "an assembly; hence, the place of assembly, especially the marketplace"; and, *phobia*, meaning "fear" ("Agoraphobia" 2014). However, the theoretical understanding of both elements of the psychological disorder "agoraphobia" – *agora* and *phobia* – is contentious. It is evident from agoraphobia's theoretical and conceptual history that the nature of the disorder still eludes our understanding. In this chapter, I first provide an overview of the conceptualization of agoraphobia, including its historical development, psychiatric delineations, and psychoanalytic contributions. I then review arguments about the question of the "phobia" aspect of agoraphobia, which indicate the theoretical and phenomenological distinctions between agoraphobia and simple (aka: simple, true, discrete, or specific) phobias. This distinction illuminates the nature of the disorder and clarifies both its profound disabling effect on sufferers and its chronicity (that is, resistance to long-term efficacious treatment). The use of the term "phobia" to describe the disorder is contentious in part because the fear is not, as originally described (and the psychiatric definition notwithstanding), of an object (or space) that can be avoided, but, following Weiss, a "mental registration of structural disorganization" (Compton 1992, p. 409). I then review arguments about agoraphobia's phobic object, to which "agora" is meant to refer (if not describe) and I offer my own theoretical description of the unconscious motivation of the anxiety embodied in patients with agoraphobia. Informed by Milrod's (2007) addition to the clinical picture of agoraphobia of persistent emptiness beyond the remittance of the overt symptoms of anxiety and avoidance, I argue that agoraphobia involves a profound anxiety about the boundaries *between* spaces, both physical and psychical. This anxiety is fuelled – if not caused – by the inability to symbolize (to engage in the process of symbolization). This difficulty, I argue, contributes to the persistent emptiness Milrod describes.

1.1. Definitions: Historical, Psychiatric, and Psychoanalytic

For several years patients have repeatedly come to me with the peculiar complaint that it is impossible for them to go into open spaces and down certain streets, and because of this fear their freedom of movement is disturbed. They yearned for an explanation of the nature of their affliction, and I believed I could form the word agoraphobia (from the Greek "agora"), dread of outside places, for it.

(Westphal 1871; qtd. in Boyd & Crump 1991, p. 80)

The term *agoraphobia* was first coined in 1871[7] by Westphal, a neurologist and psychiatrist, to describe three male patients for whom the experience, or contemplation, of walking through certain streets was accompanied by a "dread of anxiety" (p. 12; qtd. in Snaith 1968, p. 673). Westphal reports that his patients indicated "that they might be laughed at or considered to be insane due to the peculiarity of the matter" and that they had "no idea what cause[d] the fear, as if it were *a fear of fear*" (Westphal 1871/1988, p. 59; p. 62; my emphasis). Their "fear of fear" seemed to be accentuated by the fear of being perceived as insane, or otherwise embarrassed.[8]

Snaith, in his study "A Clinical Investigation of Phobias" (1968), draws attention to Benedikt's article, "*Über Platzschwindel*," published in 1870, in which Benedikt suggests the term *Platzschwindel*, meaning "dizziness in public places," for the symptomatological experience Westphal describes. Although the medical community adopted "agoraphobia" as the preferred term, Snaith suggests that the connotations of each are significant and that *Platzschwindel* may more accurately describe the experience of agoraphobia:

[7] For a review of historical references to "irrational fears" causing extraordinary anxiety and avoidance prior to the development of a medical description of phobias, see Snaith, who includes, among others, Hippocrates as having noted the presence of what we would now call phobias (1968, p. 673). Knapp references Errera's historical review of the concept of phobia and also indicates Hippocrates's treatment of phobic patients (1988, p. 37). The disorder, then, profoundly predates its nomination.

[8] Mr. P, Westphal's third patient, "is simultaneously frightened by the thought that his condition could attract attention" (1871/1988, pp. 70-71). This patient also reports fear in crossing the Dirschauer Bridge: "during the times he had to cross it, a great feeling of anxiety overcame him, combined with the fear that he could become insane and would jump over the bridge during such a condition. When asked, however, if he had the urge to do so, he denied it vehemently" (pp. 71-72). This vehement denial points to unconscious factors, which I address in detail in Chapters Two and Three.

> The word *Platzschwindel* places stress upon the somatic and autonomic accompaniments of the symptom at the expense of the psychic experience; and indeed, direct questioning of these patients often reveals that unpleasant somatic sensations may be a great deal more distressing than the psychic experience of anxiety. (1968, p. 673)

However, Westphal specifically addresses Benedikt's article and dismisses the proposed *Platzschwindel* precisely because the experiences of his own patients could not be described as dizziness or vertigo, but anxiety. Westphal emphasizes the distinction between a physical (specifically, ocular) impairment, which Benedikt suggests, and a cerebral (psychological) cause, which Westphal emphatically favours. At Westphal's request, each of his patients underwent an independent ophthalmological examination, which revealed no evidence of ocular impairment that would cause such dizziness, thus supporting his conclusions (1871/1988, pp. 74-79).[9] Furthermore, distinguishing between the psychic and the somatic experiences of anxiety, as Snaith attempts, may be impossible.[10] Indeed, attempting to distinguish between the psychic and the somatic is one of the ongoing central issues in theorizing and treating agoraphobia. Although Westphal chose the term "agoraphobia," he indicated that the term was "not entirely exhaustive," given that the fear was "related to certain other situations" (1871/1988, p. 59) in addition to walking through certain streets. Indeed, opposed to the common-place and initial conception of agoraphobia as a "fear of open spaces," perpetuated in part by the literal translation of the word, the actual symptomatology of the disorder as currently understood refers to a ranging severity of anxiety reactions concerning space.

The "other" anxiety reaction concerning space, claustrophobia, was introduced sometime between 1878 and 1879. Its precise origin is contested, but credit is accorded to Ball and his article, "On Claustrophobia" (1879) ("Claustrophobia" 2014). However, Westphal refers to claustrophobic anxieties in his patients, beginning "as soon as they were together with many people in closed rooms" (1871/1988, p. 74). A contemporary

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[9] The first complete English translation of *Die Agoraphobie* was not published until 1988, so it is possible that Snaith was not familiar with this aspect of Westphal's article; it is not cited in his study.

[10] Studies of psychosomatic processes, and the mutual effects of so-called psychological and physical well-being or illness, are sharply on the rise, especially in the field of psychoneuroimmunology. See, for example, Karren, Smith, and Gordon (2013).

commentator, Webber (1872), supported Westphal's use of the term agoraphobia if its definition included what is now called claustrophobia: insofar as "agora means not only a market place, but also an assembly of people, the term agoraphobia would seem appropriate for the dread of crossing a square, or dread of being in a crowded room" (qtd. in Knapp 1988, p. 31). White, an American contemporary, suggested that agoraphobia and clithrophobia – a form of claustrophobia specifically referring to a morbid fear of being locked in – be considered in the same category, "as in both cases the characteristic symptom is that the patient cannot by any means form an accurate conception of his surroundings" (1884, p. 1140).

These early speculations on agoraphobia eventually gave way to the standardized definitions effected by the American Psychiatric Association (APA) via their compilation of the *Diagnostics and Statistical Manual of Mental Disorders* (*DSM*), first published in 1952.[11] The *DSM-IV-TR* (4th edition, text revision) provides the psychiatric definition – or, "diagnostic features" – of agoraphobia:

> The essential feature of Agoraphobia is anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having a Panic Attack [separately defined] or panic-like symptoms. […] The anxiety typically leads to a pervasive avoidance of a variety of situations that may include being alone outside the home or being home alone; being in a crowd of people; traveling in an automobile, bus, or airplane; or being on a bridge or in an elevator. (APA 2000, p. 395)

There are some changes in the recently published fifth edition of the manual (*DSM*-5, APA 2013) in the criteria and description for agoraphobia. Notably, in *DSM-IV-TR*, within the main category of Anxiety Disorders, there are three codable disorders[12]: Panic Disorder Without Agoraphobia; Panic Disorder With Agoraphobia; and, Agoraphobia Without History of Panic Disorder. Neither Agoraphobia nor Panic Attack, though delineated, is considered codable outside of these three diagnoses. In *DSM-5*, panic

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[11] For a critique of the development of the *DSM* and, in particular, the diagnostic criteria for agoraphobia, see Reuter (2007b) (especially Chapter 5, pp. 95-160). For a history of the classification of panic disorders from Freud to (at the time, forthcoming) *DSM-IV* (1994), see Frances et al. (1993).

[12] Codable disorders are discrete diagnosable conditions, as opposed to delineated symptoms; the symptoms, defined, contribute to the diagnosis, but are not diagnoses in and of themselves.

disorder and agoraphobia are unlinked: panic disorder and agoraphobia are separate diagnoses with separate criteria. In panic disorder, the fear or anxiety is about the panic attacks themselves; the phobic object in agoraphobia is considered to be “a variety of situations” (APA 2013, p. 219).

In *DSM-IV-TR* (APA 2000), there are three specific criteria for agoraphobia: briefly, anxiety typically about situations that include being outside the home alone (Criterion A); avoidance of the anxiety situations, which may include enduring the situation in the presence of the phobic companion (Criterion B); and, Criteria A and B are not better accounted for by another mental disorder (Criterion C).[13] In *DSM-5*, there are more – and more specific – criteria for agoraphobia: intense fear or anxiety triggered by the real or anticipated exposure to variety of situations (Criterion A); upon exposure, thoughts that something terrible might happen (Criterion B); fear or anxiety occurs upon nearly every exposure (Criterion C); the feared situations are actively avoided (Criterion D); fear or anxiety is out of proportion to the actual danger posed by the situations (Criterion E); fear or anxiety is persistent (Criterion F); and, it causes clinically significant distress or impairment in social, occupational, or other areas of functioning (Criterion G) (APA 2013, pp. 218-219). A significant addition to the *DSM-5* is the note that either real *or anticipated* exposure to the phobic situation can cause marked anxiety. Evident in these criteria is the limited or absent capacity of the agoraphobic to locate a specific phobic object, despite the delineation of five specific agoraphobic situations (I describe these situations below, in *Agora-*).

The underlying phenomenological experiences of the agoraphobic are generalized within the psychoanalytic literature beyond the diagnostic criteria used psychiatrically. Frances and Dunn, practicing psychoanalysts, describe the clinical situation of agoraphobia patients as follows: “patients suffering from these space phobias have a disturbing degree of background anxiety punctuated by attacks of panic when they leave a safe space” (1975, p. 435). Capps and Ochs suggest that “avoidance in response to this

[13] Some examples regarding Criterion C: Specific Phobia might better account for avoidance limited to a single situation like elevators; Obsessive-Compulsive Disorder might better account for avoidance of dirt in someone with an obsession about contamination; or, Posttraumatic Stress Disorder might better account for avoidance of stimuli associated with a severe stressor.

fear is the central feature of agoraphobia" (1995, p. 3). Agoraphobia is the other side of claustrophobia and its onset, as Westphal and his contemporaries noted, is often a response to a claustrophobic panic. Paradoxically, "agoraphobic persons often describe feeling trapped by an ever-present threat of panic and their belief that they cannot risk leaving safe havens such as home" (Capps & Ochs 1995, p. 3).[14] The co-presence of agoraphobic and claustrophobic fears in individuals diagnosed as agoraphobic continues to be noted today: "multiple and seemingly incompatible fears (closed places and open spaces) are regularly found in agoraphobic patients" (Compton 1992, p. 405).[15] Bion, within the psychoanalytic tradition, describes this limitation of the psychiatric delineation of agoraphobia:

> If a patient presenting such symptoms is investigated psycho-analytically we find an extremely complex personality; this in itself is of no significance but for the fact, relevant to this discussion, *that I am soon unable to use the term agoraphobia in a way that is meaningful*: the conjunction is not of the elements that first appeared to compose it nor are they constant. I need to continue using this term, and with it the term 'claustrophobia.' [...] In analysis it appears that the patient has terrible feelings when he is in open spaces or if he feels shut in. (1965, p. 123; emphasis added)[16]

One of the difficulties in understanding and delineating the specific characteristics of agoraphobia is the wide variety of experiences agoraphobia sufferers describe. The motivation of the *DSM* is precisely to be as specific as possible about the diagnostic criteria for psychological disorders. Its authority, however, is belied by its constant revisions and new editions. It has practical uses, but is theoretically limited. The psychiatric definition also does not include the important characteristic of a high degree

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[14] Two agoraphobia sufferers describe their experiences: "I was never housebound, but I did find the world was getting smaller"; and, perhaps more typically, "I wouldn't go outside the door. I wouldn't even go to the backdoor to empty the bin" (Davidson 2000, p. 33).

[15] For a clinical example, see Matte-Blanco (1940), who presents a case vignette from the psychoanalysis of a patient with severe agoraphobia and claustrophobia.

[16] Ferro, a contemporary Italian psychoanalyst practicing in the Bionian tradition, indicates this same diagnostic hesitation. Although he makes an initial and basic diagnosis of agoraphobia and claustrophobia in his patient, "Carla," he generally "avoid[s] in-depth diagnosis, for fear of imposing an excessively rigid pattern on the material observed and its elaboration" (1996, p. 997). Ferro acknowledges the risk of operating according to any established diagnostic framework without an awareness of the reductionist structure it implicitly imposes on complex realities.

of free-floating anxiety,[17] which likely contributes to the "variety" of "situations" that form the phobic object, as well as the disorder's chronicity.

Weiss contributes the important observation that "agoraphobia often develops at a particular phase in [the patient's] life when he is required to take a step forward in the direction of independence" (1935, p. 65). Weiss explains its onset as follows: "If he succumbs to agoraphobia at such a time it indicates that his capacity for adapting himself to reality has broken down before his necessity for emancipating himself" (1935, p. 65). A step towards independence would also be – consciously or unconsciously – perceived as a step away from the family of origin, which the agoraphobic might perceive as an act of aggression against her family (primarily, in most cases, her mother). Compton (1992) draws attention to this observation, though Weiss himself did not emphasize its relevance, and points to Ruddick's (1961) similar observations that the onset of agoraphobia in his three case studies was related to marriage and parenthood. Jackel (1966) offers several clinical examples of patients (not frankly agoraphobic[18]) who, upon interruptions to the analytic treatment (for example, notification of summer vacation or the need to cancel a session), expressed a conscious or unconscious (namely, in dreams or symptoms) wish for a child. He interprets this wish for a child as the conscious representation of the unconscious wish to have someone who would not (be able to) leave the patient; this wish is a defense against the pain of separation, and of separateness. Jackel suggests that this wish derives from the pre-oedipal narcissistic wish "to establish a mother-child relationship in which the patient is both mother and (by identification) child"; thereby, the patient "can never be deserted and […] is never alone" (1966, p. 733).[19] Milrod develops this theme by exploring the pregnancy fantasies of two panic patients, suggesting similarly that these fantasies become "important dynamic organizers

[17] "Background anxiety" has also been identified as "general," "free-floating," and "pessimistic expectant" anxiety and refers to patients' level of anxiety when they are in their "safe space." These terms are used interchangeably to refer to an individual's level of anxiety when he or she is *not* confronted with the phobic object: for an agoraphobic, his or her anxiety while at home in a "safe space."

[18] That is to say, these patients would not be diagnosed with agoraphobia. However, and as I argue in Chapter Two, agora-claustrophobic anxieties are part of each individual's psychical structure; therefore, in circumstances that threaten the defenses against these anxieties, agoraphobic moments arise. For patients who are frankly agoraphobic, I mean that agora-claustrophobic anxieties are not primarily unconscious structures, but predominate and are conscious influences in their psychic lives.

[19] Jackel reports this wish in both male and female patients.

of their panic experience [...] because of the way they permit the avoidance of real, painful separations by means of a fantasy restitution, and foster regression through identification with the baby" (1998, p. 675).[20] There seems to be an unconscious paradox: a step towards apparent independence, such as marriage or parenthood, can also be a narcissistic step away from autonomy.[21]

1.2. *-phobia*

With this general description of the agoraphobic experience in mind, I turn to the meanings of agoraphobia's specific aspects, namely "phobia" and "agora." Snaith (1968) provides a study comparing the symptomatology of patients suffering primarily from agoraphobia with that of patients suffering primarily from "other" phobias (that is, more discrete and circumscribed fears, such as thunderstorms, eating in public, spiders, etc.[22]). For the purposes of his study, Snaith considers patients "agoraphobic" if their most prominent fears are of leaving home and being in the open.[23] His findings suggest that

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[20] Milrod (1998) discusses the presence of pregnancy fantasies in both male and female patients. Davidson (2001) explores the connection between pregnancy and agoraphobia from a different perspective, emphasizing the bodily aspects and instability of bodily boundaries of both. All (15) of the agoraphobic women Davidson interviews had experienced pregnancy and most of them linked the experience of pregnancy and the onset or increase in their agoraphobic anxieties (p. 291). Further, it is not just the experience of pregnancy but also the subsequent responsibility of caring for an entirely dependent infant that appears to be connected to agoraphobic anxieties.

[21] Others have suggested that the marriage *relationship* is the significant precipitating factor, rather than the marriage event, though Arindell (1987) finds no support for this hypothesis. I suggest that the relationship is not *irrelevant* insofar as all dependency (which agoraphobia can surely be described as) is mutually enacted. In this vein, see Symonds (1971). I discuss this element of dependency in more detail in Chapter Three in my critique of a clinical emphasis on interpreting the transference.

[22] Perhaps following the diagnostic codes of the *DSM*, Snaith includes fear of crowded places in the category of discrete phobias. By contrast, and following many theoretical and clinical descriptions, I argue that such a fear is intimately connected to agoraphobia.

[23] Snaith excludes from his study those patients suffering primarily from schizophrenic or depressive psychotic illnesses. The exclusion of such patients from so-called scientific studies of mental disorders is required in order to arrive at any statistically significant results; this exclusion reduces the complexity of phenomena being studied, necessarily, for the study's purposes, but also significantly limits our understanding of the complexities of mental life. Milrod's (2007) finding of persistent emptiness in agoraphobia patients for whom panic symptoms have remitted connects agoraphobia, psychiatrically defined, and agora-claustrophobic anxieties, psychoanalytically delineated, with a range of other disorders, including borderline disorders (see, for example, Fonagy 1991; Kumin 1978, LaFarge 1989; and, Singer

agoraphobia is significantly different from discrete phobias and are highlighted by Frances and Dunn: agoraphobia is "more gradually developed, more generalized, less demonstrably related to conditioning, more resistant to treatment and more likely to involve extensive character pathology [than specific phobias]" (Frances & Dunn 1975, p. 435). Agoraphobia is distinguished, then, from what might be called *true* phobias, insofar as its characteristics are so distinct from the shared characteristics of specific phobias. Snaith argues, in fact, that the agoraphobic's high level of generalized anxiety[24] "is directly responsible for the occurrence of the uncommon fears of the agoraphobic constellation" (1968, p. 692). Paradoxically, avoidance is one of agoraphobia's central features and yet there is no object to avoid. This paradox distinguishes agoraphobia from the simple phobias and partly accounts for the suffering it causes. A discrete phobia, ironically, provides relief from anxiety by circumscribing it to a particular object that *can* be avoided. The object-less nature of agoraphobia induces its own specific kind of anxiety, which searches, so to speak, for an object in the attempt to define and limit it. Hence, "the onset of a state of generalized anxiety tends to increase the patient's sensitivity to all common fears" (Snaith 1968, p. 692).[25]

Phillips (1993), writing on phobia, conflates discrete phobias (or, phobias generally speaking) with agoraphobia; in so doing, he unwittingly provides us with some ideas about the particular nature of agoraphobia. Phillips makes three points about phobias that do *not* pertain to agoraphobia: 1) "one can only become phobic by believing

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1977a, 1977b), psychotic disorders (see, for example, Ellonen-Jéquier 2009), and, as Rey (1994) demonstrates, in psychical states between borderline and psychotic. Likewise, many descriptions of borderline and psychotic patients' psychological complexes include agora-claustrophobic anxieties.

[24] Again, the agoraphobic's high level of generalized anxiety distinguishes agoraphobia from specific phobias; individuals suffering from specific phobias tend to experience very low anxiety as long as their phobic object is not present. If, for example, a person suffers from arachnophobia (fear of spiders), he or she may have a panic attack when confronted with a spider but is not likely to be anxious otherwise. An agoraphobic individual may have a panic attack when he or she leaves the house, but will also tend to have significant levels of anxiety at home, in their "safe space." See also infra note 17.

[25] Cf. Phillips, who provides a different comparison of the relative comfort offered by phobic objects: "A phobic situation, broadly speaking, one can choose to avoid, but a phobic object can turn up unexpectedly" (1993, p. 19). Nevertheless, his suggestion that "a person who imagines that his hate could turn up at any moment, like an unwanted guest – who has to live in a state of continual internal vigilance to ensure that he will always be fair – might choose an object rather than a situation" (p. 19) coincides with my argument that agoraphobia might follow precisely from this inability to "choose an object."

that there are an external and an internal world that are discrete" (p. 24); 2) "it is part of the developmental project to find a phobia, to localize the impossible in oneself elsewhere" (p. 25); and, 3) "if one can tolerate some of one's badness – meaning recognize it as yours – then one can take some of the fear out of the world" (p. 25). None of these three points describe the agoraphobic's experience, which tells us three important qualities of the agoraphobic's psychical reality: 1) she does not, on a profound level, believe in discrete internal and external worlds; 2) she has not been able, developmentally, to find a specific phobia; the impossible, therefore, remains (internally) unlocalized; and 3) she is unable to recognize and tolerate her own "badness," and is therefore unable to take any of the fear out of the world.

The developmental issues we can tease out of Phillips's description of phobias is evident in Freud's *Analysis of a Phobia in a Five-Year-Old Boy* (1909), the case of "Little Hans," which, I argue, can be read as a description of Hans's struggle to *achieve* a phobia.[26] Freud identifies Hans's anxiety as a phobia – with the phobic object as the horse, that a horse will bite him, and of the street – but specifically chooses not to consider it a case of agoraphobia; Friedman, by contrast, refers to Hans precisely as an example of a case of agoraphobia (1985, p. 529), as does Morgan (2003, p. 181). This diagnostic discrepancy is partly explained by the ongoing uncertainty, both theoretically and clinically, about the distinctions between agoraphobia and discrete phobias. Further, I suggest that Hans is struggling, through the course of the analysis, to achieve a specific phobia and avoid the more pervasive and disabling experience of agoraphobia. Rather than detail a complete analysis of this case study, I wish to draw out the distinction between true phobias and agoraphobia via the development of Hans's symptoms: Hans's father writes to Freud, concerned about his son's fear of being bitten by a horse in the

[26] Midgely (2006) provides an analysis of the theoretical and clinical issues in Freud's analysis of Little Hans, as well as the subsequent analyses of Little Hans by Freud himself (who revisited the case in 1926's *Inhibitions, Symptoms and Anxiety*), Klein, Bowlby, and Lacan. Midgley indicates the primary theoretical concerns of Klein's, Bowlby's, and Lacan's re-readings of Little Hans – primitive anxieties, separation anxiety due to real attachment experiences, and anxiety about Little Hans's movement from imaginary oedipal triangulation (mother-child-phallus) to symbolic oedipal quaternity (mother-child-phallus-symbolic father) and argues that the case of Little Hans, with all of its re-readings, provides a framework for understanding how psychoanalytic theory has changed and developed – without, of course, providing any sort of "truth" about the development of Little Hans's (agora)phobia. See Chapter Four, below, for my discussion of historical, narrative, and psychical truths.

street. Freud connects the onset of Hans's anxiety with an increased affection for his mother, which Hans represses; thereby, this (perhaps overwhelming) affection is expressed as anxiety. The primary meaning of Hans's dislike of streets, prior to fixating on the horse as the phobic object, is, Freud suggests, that he missed his mother and preferred to be near her. When Hans was upset, his mother would comfort him; this comfort reinforces the unconscious association between the repression of his desires (which cause anxiety) and satisfaction (his mother comforts him when he is anxious); in Freud's words, "his affection for his mother triumphantly achieved its aim" (1909, pp. 139-140). However, a pathological anxiety ensued, when the attainment of his longed-for object (his mother) did not extinguish his anxiety of the street. As Freud emphasizes in his discussion of the case, "his anxiety was no longer reconvertible into longing" (p. 114).[27] Thus, the anxiety must find an object, which, for Hans, became the horse. Yet, what might have been a simple phobia was somehow compounded into an anxiety neurosis more closely resembling agoraphobia.

The phobic object, which is a substitution for reality, covers up, so to speak, the loss of reality – the mother as object of desire – in the two-phase development of the neurosis.[28] Because of Han's ambivalence towards his father – that is, the co-occurrence of affection and hostility – his wish for intimacy with his mother is transformed into fear, and the original wish is repressed. Freud describes this ambivalence and its effect on the phobia's development:

> Hans's anxiety had two constituents: there was the fear *of* his father [a result of Hans's libidinal desire for his mother, which his father thwarted] and fear *for* his father. The former was derived from his hostility towards his father [for

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[27] I expand on the relation between anxiety and longing, loss, and emptiness in Chapter Three. For now, I will say that longing is a very painful state, perhaps more painful, or less bearable, than anxiety, for there is nothing to do to relieve it. Anxiety is relieved by repression or, in the case of phobias, by avoidance. In agoraphobia, there seems to be no relief of anxiety *or* of longing, compounding the suffering this disorder causes.

[28] Freud describes this process in "The Loss of Reality in Neurosis and Psychosis." Briefly, "the ego, in the service of reality, sets about the repression of an instinctual impulse. This, however, is not yet the neurosis itself. The neurosis consists rather in the processes which provide a compensation for the portion of the id that has been damaged – that is to say, in the reaction against the repression and in the failure of the repression" (1924, pp. 185-187). Repression is never complete and unqualified: this *failure* of repression, not repression itself, results in neurosis.

> preventing the satisfaction of his libidinal desire for his mother], and the latter from the conflict between his affection, which was exaggerated at this point by way of compensation, and his hostility. (1909, p. 45)

The movement of the analysis demonstrates the diffusion of anxiety, which begins with no known cause (but is actually due to the – always incomplete – repression of a forbidden libidinal desire for the mother), to the phobic object, horses (which is explained by Hans's experiences of horses combined with his phantasies about them and about his father[29]), and then to a fear of going out into the street (where a horse might be encountered any time). As the analysis progresses, the connection is made between the anxiety-instigating scene with the horse, who fell down and "made a row with his feet" (p. 50), and Hans's own habit of stamping his feet when he is angry; that is, he is anxious about his own aggressive impulses as much as his libidinal ones; or, better, he is afraid of the interplay between the two.[30] His identification with the horse is supported by an account of playing "at horses" with some other children, when they would take turns pretending to be the horse (pp. 58-59). There are times when Hans is afraid a horse will come into his room and bite him, indicating the internal source of the fear and the diminishing "safe space," as he realizes he cannot escape from his psychical reality.

I discuss these developmental aspects of agoraphobia, and the complex relation of internal and external realities, in detail in Chapter Two, but they are also relevant to the particularly agoraphobic phenomenon of the "phobic companion" (Frances & Dunn 1975, p. 435).[31] Freud suggests that he would have identified Hans's phobia as agoraphobia except that he does not present with the symptom of the phobic companion; that is, his anxiety about horses – which is exacerbated while he is in the street as it is more likely he will there encounter a horse – is not entirely relieved by the presence of his mother, who would otherwise have been considered the phobic companion. However, Freud perhaps overstates this characteristic of agoraphobia, suggesting that locomotion "can *always* be

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[29] I detail in Chapters Two and Four the ways in which the development of psychical reality is a consequence of the interdependence of historical, or real, experiences and unconscious fantasy.

[30] I will note here that Hans most often stamps his feet in anger when he must stop playing in order to use the bathroom, or "lumf," as Hans says (Freud 1909, p. 54; p. 95). Furthermore, Hans's father indicates the difficulty Hans has always had with his stools, requiring frequent aperients (laxatives) and enemas. Later in the analysis, the connection is made between "lumfs" and the birth of Hans's little sister.

[31] The phobic companion is *DSM-IV*'s Criterion B for a diagnosis of agoraphobia. See also Deutsch (1929).

easily performed" with the phobic companion (1909, p. 115; my emphases).[32] Even at the earliest stages of agoraphobia's conception, Westphal notes this phenomenon, indicating that his patients "experienced great comfort from the companionship of men or even an inanimate object, such as a vehicle or a cane" (1871/1988, p. 12; qtd. in Snaith 1968, p. 673). Frances and Dunn clarify the centrality of the phobic companion to experiences of agoraphobia, which is an alternative protective measure that fluctuates along with the degree of necessary avoidance. Some agoraphobics are "afraid to go out of the house at all"[33]; others can leave the house with their phobic companion (who can variously be only one particular person, or almost any other person); sometimes a sort of safety object is employed to tolerate feared situations, which might include a cane or vehicle (as Westphal indicates of his patients), or "carts, kittens, and dark glasses" (Compton 1992, p. 409). The phobic companion, a consistent – though not universal – aspect of agoraphobia, is unique among phobic disorders; the relief the phobic companion offers to the agoraphobic individual further suggests that this is no simple phobia. The task of disambiguating the fear of the external world from the fear of leaving the supposed safety of the home, and the fear of being alone (without the companion) from the fear of others is a formidable one, again pointing to the complex relation of internal and external realities, a relation with which the agoraphobic struggles.

Freud describes the behaviour of a man with agoraphobia as that of "a small child" insofar as a child is taught to avoid the dangers of the street unaccompanied by an adult and the agoraphobic patient "will in fact be saved from his anxiety if we accompany him across the square" (1917, p. 400). Freud makes the same distinction as Snaith regarding the specificity of "phobias," which are psychically bound and symbolically attached to particular objects or situations, and anxiety neurosis, which is characterized by "free floating anxiety" and a "tendency to an expectation of evil" (p. 398). However, in contrast to Snaith's later findings, Freud includes agoraphobia in the group of specific (and, he finds, inexplicable) phobias. Freud suggests, in fact, that "people whose whole

[32] Fenichel argues that the phobic companion is not an essential feature of agoraphobia, occurring only variably (1944, pp. 314-315).

[33] Frances and Dunn suggest that, for these housebound agoraphobics, the house itself has become their phobic companion (1975, p. 438).

existence is restricted by agoraphobia may be entirely free from pessimistic expectant anxiety" (p. 400).[34] He seems to have made the common error of considering the specific phobia rather than addressing the general anxiety experience.

Agoraphobia's unique character, in comparison to true (that is, discrete and specific) phobias, supports Snaith's argument that the use of the term "agoraphobia" is, at best, inaccurate and, at worst, misleading resulting in errors in both the conceptualization and treatment of the disorder.

1.3. *Agora-*

Fear itself cannot be wrong, even if it is difficult to find out where it fits.

(Phillips 1993, p. 13)

DSM-5 lists the following five "situations" as specifically agoraphobic: 1) using public transportation (e.g., automobiles, buses, trains, ships, planes); 2) being in open spaces (e.g., parking lots, marketplaces, bridges); 3) being in enclosed spaces (e.g., shops, theaters, cinemas); 4) standing in line or being in a crowd; and, 5) being outside of the home alone (APA 2013, p. 217). These examples are "not exhaustive" (p. 218), but at least two of them must cause marked anxiety in any one patient for a diagnosis of agoraphobia.[35] This attempt to list the various, and often conflicting, agoraphobic fears points to the historical contention surrounding it and also indicates the difficulty in theorizing it.

Freud defines agoraphobia as the "anxiety to walk along a street or cross a square in his own familiar home-town" (1917, p. 399) and identifies the phobic object as "the square" or the "open street." The phobic object, according to early psychoanalytic theorizing (including those of Abraham 1913/1979, Deutsch 1929, Fenichel 1944, and

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[34] Although Deutsch follows the Freudian paradigm otherwise, she suggests that agoraphobic patients "must always have a tendency to anxiety, which breaks out under certain conditions associated with the street" (1929, p. 69).

[35] I note the inclusion of claustrophobia ("being in enclosed spaces") as one of the agoraphobic situations. In *DSM-IV-TR*, claustrophobia is coded as a simple phobia but it is excluded entirely (as a distinct disorder) from *DSM-5*.

Freud 1909, 1917, among others), is a symbolic substitution for conflicting instinctual demands, the manifestation of repressed desires. The temptation of the street arises out of the danger of, and desire for, a sexual relationship characterized by prostitution, as well as a "danger to exhibitionistic impulses" (Deutsch 1929, p. 69). It is considered a derivative of castration anxiety. In the same vein, Freud indicates that the agoraphobic's anxiety of being left alone is ultimately "an endeavour to avoid the temptation to engage in solitary masturbation" (1926, p. 128). Compton (1992), in a contemporary review of the psychoanalytic understanding of agoraphobia, indicates the ongoing issue of identifying the content of agoraphobic anxieties given the variety of fears agoraphobia patients articulate (for example: going crazy, losing control, wide streets, narrow streets, stores, bridges, tunnels, open spaces, closed spaces, etc.). Furthermore, the content of agoraphobic anxieties are not always explored in the literature, at times identified only as "street fear" (Compton 1992, p. 413).

Freud makes a particular point in *Inhibitions, Symptoms and Anxiety* (1926) about defining the symptom of a neurosis: in the case of Little Hans, it may have seemed obvious that the symptom from which Hans suffered was a fear of horses; however, Freud emphasizes the importance of the unconscious specificity of the symptom, which leads to the identification of the fear that a horse was going to bite him. The "nucleus" of the symptom, however, is still further repressed. The neurotic character of Little Hans's phobia is defined by the displacement of his fear of his father onto a horse (Freud 1909, p. 103). The repression of the specific meaning of the fear is part of the work of the neurosis as it removes the content of the fear from consciousness and replaces it with an "undefined phobia in which only the anxiety and its object" appear (p. 101). In the case of agoraphobia, we must be careful to avoid overstating our knowledge of the symptom, which has been indicated, but perhaps not emphasized (as I have suggested above) in the literature. Rather than a "fear of sexual temptations" (invariably connected to castration anxiety) (Freud 1909, p. 109), Deutsch suggests a more profound and disturbing experience: "a genuine dread of death"; or, "put into words, […the feeling that] 'I shall suddenly die'" (1929, p. 51). The displacement of the fear from an unconscious fear of death onto a "variety of situations" is not surprising and, as with Little Hans's phobia, the *displacement* is the symptom.[36]

Compton, referring to Weiss's extensive discussion on agoraphobia in *Agoraphobia in the Light of Ego Psychology* (1964), suggests that the fear of an internal danger is the paradigmatic characteristic of agoraphobia. The perception of this "internal danger" *precedes* the overwhelming anxiety and includes: "a profound sense of being ill, loss of feeling of identity (depersonalization, loss of 'ego feeling'), derealisation, dizziness, fainting sensations, loss of orientation" (Compton 1992, p. 408) and amounts to "an unbearable feeling of ill-being" (Weiss 1964, p. 3; qtd. in Compton 1992, p. 408). Weiss's characterization of agoraphobic anxieties does not exclude Deutsch's similar characterization, "a genuine dread of death" (Deutsch 1929, p. 51), though Weiss adds that "it is an actual process of destruction, emanating from the patient's own death-instinct" (1935, p. 81). To emphasize, this "dread of death" is a far cry from the common-place notion, and literal definition, of agoraphobia as a fear of open spaces, and also has quite different implications than both the *DSM-IV* and *DSM-5,* and current clinical understanding as a fear of leaving a safe space. These various fears may actually characterize agoraphobia insofar as they may be part of the conscious phobic "object," but they do not approach the nucleus of the anxiety.[37] Weiss is the first theorist to suggest that the agoraphobic's feeling of ill-being is "a direct mental registration of structural disorganization, rather than representing a meaning" (Compton 1992, p. 409). Specifically, rather than a symbolic fear, agoraphobia indicates the fear of symbolization itself.[38] The persistent emptiness Milrod (2007) describes, along with the agoraphobic's inability to limit her anxiety by locating a specific phobic object, are indicative of this inhibition of symbolization. To anticipate briefly my arguments to follow in Chapter Two, agoraphobic anxieties are more accurately described as residing in the boundaries of spaces, both internal and external, and are related to Klein's (1940) theories of

[36] Displacement, generally, refers to "a shifting hither and thither of various affects and conflicts" (Katan 1951, p. 43). Katan provides a clinical example of the role of displacement in agoraphobia.

[37] If we consider the case of Little Hans, we can say that he truly was afraid of horses, but horses became the phobic object to account for his startling anxiety in order to avoid the heart of his fear, his own internal desires and, thus, of punishment for his desires in the form of castration.

[38] Snaith notes that agoraphobic "fears" do not depend on the mechanism of symbolism, as true phobias do (1968, p. 692).

primitive anxieties and Winnicott's (1974) theory of the fear of breakdown. The agoraphobic is unable to creatively inhabit the spaces *between* and, instead, defends against all of the vulnerability and possibility inherent in them.

Davidson argues that "agoraphobia can be characterized as a disorder that problematizes sufferers' experiences of bodily boundaries" (2000, p.31). Based partly on individual interviews and self-help group discussions, Davidson draws attention to two important issues: the first, which I discuss above, is that the agoraphobic experience often includes claustrophobic anxieties; and, secondly, that the anxiety about "space" has more to do with *other people* in the space than the space itself.[39] Davidson's description of the agoraphobics' boundaries includes both physical and psychical space, explicating agoraphobics' very distressing experience of derealization, or depersonalization. I agree with Davidson's thesis, and similarly argue that agoraphobia is not merely an anxiety about space but more specifically about the boundaries between spaces, including the boundaries between psychical spaces. This focus on the boundaries between spaces follows from the qualities of agoraphobia that distinguish it from true phobias and, further, from Milrod's (2007) finding of persistent emptiness in agoraphobia patients for whom symptoms of anxiety and avoidance have remitted.[40]

Agoraphobia confounds absolutely the boundary between inside and outside. Although it may seem a simple question of what is external and what is internal, the agoraphobic is not able to take this separation for granted. The ill-defined boundary between spaces, both physical and psychical, leads to the constant anxiety of the confrontation between self and other, forcing the agoraphobic to diminish her external world[41] and also, as Milrod (2007) indicates, the freedom she experiences in her internal,

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[39] Cf., for example, Carter (2002), who argues that agoraphobia is a "realistic anxiety" caused by the expanse of modern urban space.

[40] I address Milrod's (2007) article in detail in Chapter Three.

[41] This diminution is partly explained by the theory of reinforcement, which, as Snaith explains, leads to the strengthening of the phobic person's fears "every time he escapes from the situation he dreads" (1968, p. 680). Furthermore, anxiety exacerbates this reinforcement, indicating that "a patient is more likely to form conditioned fear responses ('phobias') if he is already suffering from an anxiety state" (Snaith 1968, p. 680). See also Katan 1951, p. 45: "She fought her anxiety by far-reaching, self-imposed restrictions, gradually gave up her profession and her social life, until finally the anxiety attacks also befell her within the confines of her home, so that she felt dislodged from her last refuge and, at last, came into analysis."

or psychical, world. This is not to say that the agoraphobic entirely lacks a sense of externality and internality, or that she lacks the ability to differentiate between her own self and others. What the agoraphobic (unconsciously) lacks, then, more precisely than the boundary between self and other, is a sense of what belongs to the self and what does not, and thus of the limits of the self. There persists a confusion of what it means to be individuated, hence agora-claustrophobic anxieties' forceful irruption around the events of marriage and (impending) parenthood, and the phenomenon of the phobic companion. For the agoraphobic, this confusion does not result in (frank[42]) paranoia – although paranoid expectations are evident – but in a sense of helplessness and an unconscious refusal to become independent.[43] As Freud states, a person with agoraphobia resembles, in some way, "a small child" (1917, p. 400), a description which accords both with Milrod's sense of her patient, Deborah, and with Deborah's description of herself (2007, p. 1012). The shrinking external world increases the claustrophobic impingement of the internal world from which the agoraphobic cannot escape, fuelling an ever-tightening spiral of avoidance. As I argue in Chapter Four, the analytic method of free association affords the agoraphobic patient the opportunity to risk exploring the boundaries of her world, which leads to more established boundaries and also to the development of the capacity to creatively inhabit the emptiness of the spaces between, "out of which all new things emerge" (Winnicott 1974, p. 106).

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[42] As above (see infra note 18), *frank* refers to an overarching mode of being in the world and is opposed to the paranoia that is part of each individual's psychic development that occasionally emerges in moments of particular stress, but also is part of the unconscious psychic structure: blatant, rather than underlying, paranoia.

[43] Frances and Dunn draw attention to the similar psychical processes at work in agoraphobia and paranoia: "The defences involved in phobia and paranoia – repression and denial, projection, symbolization and avoidance – are essentially the same. Both patients externalize internal conflicts, find the world diffusely threatening and avoid. The more purely phobic individual, however, has a safe place and a safe object relationship, a haven in a frightening world. The more paranoid person has no safe place or person and is more ambivalent and distrustful about attachment to any possible source of dependency gratification. It follows that the paranoid's symptoms drive people away rather than capture a partner. It is as if the paranoid's fears of dependency and/or dedifferentiation render him unable to project out of the dyad the dangerous hostile impulses" (1975, p. 437). I have two comments on Frances and Dunn's comparison: firstly, I suggest that they overstate the safety of the agoraphobic's "safe place"; secondly, and of more relevance here, I suggest that, unlike true phobias, agoraphobia results from a *failure* of symbolization. I agree that the difference between these two disorders likely develops due to the state of the individual's aggressivity, which, as I discuss in Chapter Three, is predominately repressed in the agoraphobia patient. For the paranoid individual, rage is likely more conscious than in the agoraphobic.

1.4. Conclusion

Agoraphobia is not, then, a phobia as traditionally understood. It is distinguished from simple, or discrete, phobias by the sufferer's high levels of background anxiety, the phenomenon of the phobic companion, and by the nature of the phobic "object," which resists description, both clinically and phenomenologically. The adoption and retention of the term "agoraphobia" is significant because it influences theoretical formulations and has implications for treatment.[44] For example, Seidenberg and DeCrow's (1983) politico-sociological argument is derived from the claim that the object of agoraphobia anxieties is the marketplace. John Bowlby, by contrast, suggests that "*all* workers now agree [that] the central symptom of the condition under scrutiny [agoraphobia] is fear of leaving home" (1973, p. 299; my emphasis). Of course, Bowlby's views on agoraphobia, derived from attachment theory, depend on this symptom.[45] It is clear that Bowlby overstates the level of consensus on this issue. The tension between the etymology of the term – and definitions that follow the etymology, including clinical descriptions that take its definition for granted – and the subjective experiences of the disorder create a conflict in the theoretical understanding of agoraphobia. Accepting the etymological significance of "agoraphobia" as exhaustively descriptive of the phenomenological experiences of the disorder, or even as a basis for an argument concerning the nature of the disorder, is clearly a misrepresentation of the situation, leading to errors in both the conceptualization and treatment of the disorder.

[44] Boyd and Crump (1991) also draw attention to the manner in which terminology has likely influenced theoretical, conceptual, and clinical developments in understanding agoraphobia.

[45] However, Bowlby is one of the few theorists to emphasize the relation between agoraphobia and depression (or "bereavement"), which I take up in Chapter Three. Although Compton (1992) points to Bergler's (1935) important observation of the association between agoraphobia and depression, he implies that this association has been integrated into the psychoanalytic literature. Furthermore, Compton suggests that the "alternation of depressive states with anxiety states is so regular that it should be included as a descriptor of the agoraphobic syndrome" (1992, p. 415). However, while some analysts write of alternating depression and agoraphobia, there is no consistent indication in the subsequent analytic literature that depression is part of the agoraphobic syndrome. Mention of depressive symptoms in agoraphobia patients are, when indicated, noted only in passing, without any analysis of the meaning between them.

Chapter Two: Realities: Internal, External, and Intermediary

In Chapter One, I argued that agoraphobia is distinguished from discrete phobias in part due to the nature of the phobic object. In discrete phobias, the phobic object is easily identified, limited, and determined on the basis of symbolization and conditioning. In agoraphobia, by contrast, the phobic object is ambiguous; it resists description, both clinically and phenomenologically. Rather than a fear of 'open spaces' or a 'variety of situations,' I suggested that agoraphobic anxieties are more accurately described as manifesting in the boundaries between spaces, both internal and external. The agoraphobic's anxiety at the frontiers of space – in the internal as much as in the external world – indicates, as many others have argued,[46] issues with separation-individuation or, in Lacan's terms, the transition from the "spectral-I" to the "social-I" (2006f, p. 79). Mahler indicates the importance of the threshold in the normal process of individuation, noting the toddler's arrest and return to mother upon first reaching the threshold, then a significant pause and assessment before crossing the threshold, and, finally, an eager preference for the other playroom, "which had so much more diversification" (1975/2000, p. 27). For the agoraphobic, as Phillips describes, "[t]he threshold between this one moment and the next is aversive" (1993, p. 14). The agoraphobic never arrives at the normal toddler's eager preference for "so much more diversification," preferring the safely limited and relatively known space of the original 'playroom.'[47]

In this chapter, I expand on the question of what is internal and what is external, the anxieties fuelled by the navigation of these separated spaces, and, especially, the agoraphobic's anxiety of navigating between them – of crossing the threshold, so to speak – via an elucidation of the development and functions of the ego. Following Freud

[46] See, for example: Bowlby (1973); Fairbairn (1941, 1952); Fonagy (1991); Frances and Dunn (1975); Guntrip (1961); Rey (1994); and, Sable (1994).

[47] Rey describes the schizophrenic's double-bind of claustro-agoraphobic-philia, where the aversive threshold is the only space inhabitable, as both 'inside' and 'outside' are overwhelming. There is no escape from one's own internal reality: "One [schizoid patient] dreamt that he was quite happy inside mother. He then felt he wanted to find out about outside, so he got out and started enjoying himself sexually and also doing aggressive things. He then became anxious as he felt some people might be angry with him, and that he was outside in the open and unprotected. So he got back inside mother. Unfortunately, he realized that it was not much safer because he could do things to his mother from inside that would put him in danger just the same" (1994, p. 26).

and the psychoanalytic tradition, I argue that the distinction between "normal" and "pathological" is a matter of degree. In agoraphobia, there is a pathological persistence of the psychological processes of normal ego development. Recognition of the usefulness of agoraphobic anxieties in the development of ego boundaries may help identify the point at which they persist beyond usefulness and into pathology, both theoretically and clinically.

From an original unity, in which no ego exists as such, the ego comes into being by distinguishing an internal reality from an external reality. For the agoraphobic, I suggest that something has gone awry in this process of creative differentiation. The agoraphobic is not able to take for granted the distinction between internal and external, and therefore cannot experience shared reality as *illusion*. This illusion of shared reality is necessary for the creative uses of language.[48] Following Winnicott (1951, 1969), I argue that the analytic frame – the setting of the analysis – has the potential to become a transitional object for the analysand. The agoraphobic's opportunity for new experiences with a transitional object – if it can survive her destruction of it – allows the frame to be used in the development of the ego's boundaries, which can thereby be creatively inhabited, with all of the risks and rewards of human vulnerability.

2.1. In/Sanity

The distinction between nervous health and neurosis is [...] reduced to a practical question and is decided by the outcome – by whether the subject is left with a sufficient amount of capacity for enjoyment and of efficiency.

(Freud 1917, p. 457)

There is, from the psychoanalytic perspective, only a tenuous divide between sanity and insanity – or, health and pathology. This divide is at the same time, as Freud discovers and reiterates, also a relative correspondence; that is to say, the same psychical processes

[48] I consider the agoraphobic's (pathological) uses of language resulting from this absence of illusion in Chapter Four. Briefly, I argue that without this illusion, the agoraphobic is unable to tolerate incoherence: she either produces narratives that are too coherent or she produces empty narratives.

are evident in both healthy and pathological individuals.[49] Rather than a difference in kind, pathology occurs when "the logical processes underlying 'normal' human experiences [...] degenerate into symptoms" (Kristeva 2001, p. 8). Winnicott reminds us that "every detail of the insane person's insanity" points to a universal phenomenon, even though not every individual is overwhelmed by their underlying insanity (1974, p. 103). Klein indicates the fluidity between the normal and the neurotic, suggesting "that in all human beings at some time or other neurotic anxiety has been present in a greater or less[er] degree" (1923, p. 79). Within the psychoanalytic paradigm, the pathological is, in fact, prior to the normal. The priority of the pathological is evident in the normal development of the infant, which proceeds from pathological (excessive) process to mature psychic (dynamic) structure.

Frances and Dunn imply the priority of the pathological in their parenthetical addition of "the normal infant" to their description of the agoraphobic's psychic process:

> The agoraphobic (and the normal infant) protects the integrity of the bond to the partner (mother) by projecting what is threatening to that bond out of the dyad and on to the outside world. The dyad is preserved and its boundaries delimited at the expense of the creation of a frightening outside world. (1975, p. 437)

The agoraphobic's aggressive impulses are threatening to the dyad's cohesion. The agoraphobic's feelings of hate, rage, and an unconscious wish to destroy the partner (or, phobic companion) are projected into the external world; thus, experiences of the outside world are sacrificed to maintain the (phantasy[50]) dyad. Projection, as Frances and Dunn indicate, is a necessary part of healthy ego development; the inability to project hostility outward results in paranoia. However, the extent to which the agoraphobic adult projects

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[49] Freud discusses the relative correspondence of neurotic mental life and normal mental life in a number of places. For example: "no sharp line can be drawn between 'neurotic' and 'normal' people – whether children or adults – [and] our conception of 'disease' is a purely practical one" (1909, pp. 145-146). And: "it is not scientifically feasible to draw a line of demarcation between what is psychically normal and abnormal; so that that distinction, in spite of its practical importance, possesses only a conventional value" (1938, p. 195).

[50] While "fantasy" refers to conscious mental processes, like daydreams, and suggests a degree of conscious fictionalization, "phantasy" refers to primarily *unconscious* mental content, which may or may not become conscious.

is pathological.[51] As I argued in Chapter One, the agoraphobic is unable to recognize and tolerate her own “badness” – namely, her own aggressive impulses – and is therefore unable to take any of the fear out of the world.

Writing on emptiness, Kumin includes a comparison between the schizoid patient and the infant similar to the comparison Frances and Dunn make between the agoraphobic and the infant:

> It is thus that experiences of emptiness, *for the schizoid patient as well as for the infant*, are essential stages in the ultimate constitution of self in the world. The loss of the mother by the infant through repetitive experiences of cold, hunger, frustration and separation, which must be experienced by the infant as excruciating emptiness and annihilation, is a necessary precursor of introjections of the maternal imago and the development of internalized object relations, which strengthen the process of separation-individuation and the formation of the self. (1978, p. 214; my emphasis)

Evident in schizoid patients, the experience of emptiness is essential to ego development. The experience of emptiness is thus essential to all individuals, including the agoraphobic. The excessive projection of the agoraphobic, when ‘relieved’ of her symptoms, reveals, as Milrod (2007) finds, a persistent emptiness,[52] which we can posit is a result of an excessive splitting of the self similar to the emptiness of the schizoid patient.

Recalling Klein’s primary positions (paranoid-schizoid and depressive), the agoraphobic has been unable to move successfully through the paranoid-schizoid position and is therefore unable to develop the capacity for relating in new non-anxious ways. The paranoid-schizoid position is characterized by splitting and persecutory anxieties.[53] For

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[51] Kristeva describes the pathological and normal manifestations of projection: “On the one hand, projective identification describes pathological states, particularly states of manic-depressive psychosis or psychosomatic illness. On the other hand, however, the endless game of projection and introjection constitutes what Florence Guignard calls a veritable ‘psychic exhalation’ because its underpinnings reveal a sort of normalcy, even universality” (2001, pp. 70-71).

[52] I explore this phenomenon of emptiness, in both its pathological and developmental facets, in detail in Chapter Three.

[53] The mechanism of “splitting” referred to here as a fundamental aspect of the paranoid-schizoid position is anticipated by Freud in his short discussion of fetishism: “there is a *splitting of the ego*” in all psychoses as well as the neuroses. The behaviour of fetishists is “simultaneously expressing two contrary premises.

the infant, the breast becomes a "bad" object because of the (inevitable) experience of deprivation; further, "the baby projects its own aggression" on to it (Klein 1940, p. 262).[54] The infant's projection of his own aggression causes the bad objects to become also dangerous, as "persecutors who [the baby] feels will devour…" him (p. 262). These dangerous objects cause "quite little children [to] pass through anxiety-situations (and react to them with defence-mechanisms), the content of which is comparable to that of the psychoses of adults" (p. 262). When the infant reaches the developmental stage where he is able to integrate the good and bad objects – that is, when total rather than partial incorporation of the object occurs – he realizes that the bad breast that he has attacked and destroyed in phantasy is the same good breast that has loved him and that he has loved; he is thus beset by depressive anxiety. The depressive position is characterized by the guilt resulting from ambivalence, followed by feelings of regret, remorse, and the wish for reparation. The movement from the paranoid-schizoid position to the depressive position is in itself threatening. In the former, the infant fears annihilation; but, in the latter, the infant fears that he has destroyed his good object. The possibility of the loss of the good object is terrifying. This terror is especially salient from the perspective of the paranoid-schizoid position, where the good object protects against the threat of the bad object. If the good object is destroyed, the threat of the bad object is overwhelming.[55]

These earliest object-relations set the stage for adult experiences. Although the paranoid-schizoid position precedes the depressive position developmentally, both are primary positions and neither is ever 'overcome,' psychically speaking. In health, both positions remain active in psychic life and as the infant grows into an adult, she vacillates

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On the one hand they are disavowing the fact of their perception – the fact that they saw no penis in the female genitals; and on the other hand they are recognizing the fact that females have no penis and are drawing the correct conclusions from it [that they, too, could be castrated]. The two attitudes persist side by side throughout their lives without influencing each other. Here is what may rightly be called a splitting of the ego" (1938, pp. 202-203; original emphasis).

[54] Kristeva adds that the infant projects not only his aggression but "bits of the baby [himself] as well (his organs – the mouth, the anus, and so forth – as well as his bodily products)" (2001, p. 63).

[55] Scott (1981) writes on the development of a zest for life when we can have faith in our ability to mourn. I understand him to mean that we develop an enthusiasm for life when we have faith that we will not be annihilated by our bad objects once we have destroyed our good objects; rather, we will 'humanize' our bad objects by destroying our good objects, which have, in fact, been limiting our experience of life. I discuss this further in Chapter Three.

between them. In health, the individual develops more kinds of relating than persecutory and depressive anxieties, although various object relations and traumatic experiences will inspire these anxieties anew. Klein chooses the term "position" to emphasize the association between the child's early developmental anxieties and the adult's psychoses (Klein 1940, pp. 275-276, ft.). For the agoraphobic, the entire outside world becomes the "bad," and therefore dangerous, object. The agoraphobic has not been able to integrate the good and bad objects; thus, the bad object – namely, the outside world – remains both dangerous and terrifying. She fears the outside world as it threatens the integrity of her ego with the possibility of annihilation.[56] She is also terrified of destroying her good internal objects with her aggressive impulses, which would leave her vulnerable to the threat of her bad internal objects. Following Fairbairn (1941, 1952) and Guntrip (1961), I argue that insofar as agora-claustrophobic anxieties are a necessary structuring experience for the development of the infant's psychic life, they are not pathological[57]; however, the inability to move beyond primitive anxieties in adulthood becomes pathological. As a corollary to the movement from pathological to normal, I suggest we can also construct the inverse movement, from a "normal" experience of agora-claustrophobic anxieties that occur, for example, as part of the mourning process, which I describe in Chapter Three, towards a better understanding of what might go wrong in that process that becomes pathological.

Rey (1994) develops the implications of the structuring aspects of agoraphobic and claustrophobic anxieties, which he calls "claustro-agoraphobia." He identifies the pervasive and yet hidden claustro-agoraphobic anxieties in his work with

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[56] Many researchers have noted a common experience of annihilation anxiety among patients with agoraphobia, borderline, and psychotic disorders. See, for example: Hurvich (1989); Hurvich et al. (1993); and, Levin & Hurvich (1995).

[57] In her clinical illustrations of Rey's claustro-agoraphobic syndrome, Catan draws attention to Fairbairn's and Guntrip's recognition of agora-claustrophobic anxieties in normal development, "originating," as she notes, "in the phase of 'transitional' or 'quasi-independence', between infantile and mature dependence. […F]ailure to separate and develop age-appropriately as a distinct individual drives the child back into a state of secondary infantile dependence, a re-identification with the maternal object and a longing to return to the security of a merged, undifferentiated state – the 'safe inside policy'. While enabling a regressive escape from the demands of maturity and independence, such dwelling in safe-seeming maternal space remains inherently vulnerable to the threat of annihilation as an individual" (2011, p. 244). See also infra note 58.

schizophrenics.[58] This identification also points to the limits of diagnostic categories, insofar as Rey's psychoanalytic work with patients with schizophrenia "reveal claustro-agoraphobic basic fears not in the least evident when their behaviour is assessed from a purely phenomenological psychiatric approach" (1994, p. 21). As Milrod (2007) finds with her agoraphobia patients, the psychiatric diagnosis does not approach the nucleus of a very painful and persistent disturbance. The similarities and differences between the claustro-agoraphobia of 'schizoid' patients and that of 'agoraphobic' patients remain to be elucidated but are beyond the scope of my thesis[59]; however, several connections are instructive here. Firstly, Rey argues that "the emergence of depression, as well as a developing capacity to think and experience mourning and reparation" (1994, p. 85) was extremely useful for these patients; secondly, that "claustro-agoraphobia-philia not only concerns objects and their domains but also words and their domains" (p. 2); and, thirdly, he argues for an extension of "the claustro-agoraphobic syndrome from a specific syndrome to a basic universal organization of the personality" (p. 24). As I argue in Chapter Three, the persistent emptiness Milrod (2007) identifies in her patients indicates the presence of traumatic and unmourned losses; as with Rey's patients, I suggest that the "emergence of depression" (in the sense of the depressive position and the affects associated with facing and mourning loss[60]) would be extremely useful for Milrod's

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[58] Fairbairn notes this same claustro-agoraphobic feature of schizoid patients, connecting it to the conflict of both a desperation for and an extraordinary reluctance to move beyond infantile dependence: "During the course of analysis, such an individual [a schizoid patient] provides the most striking evidence between an extreme reluctance to abandon infantile dependence and a desperate longing to renounce it; […] the patient, like a timid mouse, alternately creep[s] out of the shelter of his hole to peep at the world of outer objects and then beat[s] a hasty retreat" (1941, p. 261). Fairbairn continues with the following description, particularly resonant of the agoraphobic's dilemma: "In the absence of such evidence [that he is loved by his parents and that his parents accept his love] his relationship to his objects is fraught with too much anxiety over separation to enable him to renounce the attitude of infantile dependence" (p. 261).

[59] I might only tentatively suggest here that agoraphobia is a defense against a further breakdown towards schizophrenia. This suggestion accords with LaFarge (1989), who suggests that the empty states of her borderline patients are a consequence of a severe strain on the borderline organization of the personality, and are a defense against further regression to a psychotic state.

[60] I repeat here and in Chapter Three Steiner's important note about the use of the word "depression" and the distinction between the depressive position and depressive illness: "It is confusing that the word *depression* has been applied both to the state that accompanies mourning and to that which results from the defences mounted against mourning. The path that leads towards facing the loss, and mourning it, is associated with painful depressive feelings, involving guilt, regret, remorse, and a wish to make reparation. These feelings were thought by Klein [1952] to represent the depressive position and are very different

patients. As I argue in Chapter Four, the method of free association particular to psychoanalysis is called for to aid agoraphobia patients in the relief of their emptiness insofar as it affords them the freedom to approach words (and thus affects) previously anxiously avoided. And, as I argue in this chapter, the psychical apparatus is inherently neurotic and agoraphobic anxieties, specifically, are both necessary and pathological, but they are not inevitably pathological. Agora-claustrophobic anxieties are a necessary structuring experience for the development of the infant's psychic life. Recognition of the usefulness of these anxieties helps to identify the point at which they persist beyond usefulness and into pathology, both theoretically and clinically.[61] The developmental and the clinical thus overlap insofar as *something* gone astray in the developmental project is manifested in the clinic as symptom.

2.2. The Development and Functions of the Ego

The boundaries between ego and external reality develop out of an original state where, psychologically, there are no boundaries and therefore there is no distinction between the two.

(Loewald 1951, p. 14)

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from those observed in depressive illness. Although mixed states are common, severe depressive illness or melancholia results from defences against loss and hence against all those feelings associated with the depressive position. The clinically depressed patient is likely to suffer anxiety and persecution, to harbour grievance, and to deploy manic and obsessional defences that aid in denying the reality of the loss" (2011, p. 151). I discuss mourning and melancholia in agoraphobia patients in Chapter Three.

[61] Further similarities between Rey's and Milrod's patients are evident in Rey's descriptions of his patients' experiences of emptiness. Rey writes of one patient: "One remarkable example [of pathological splitting] was a man who suffered from the worst claustro-agoraphobic syndrome I have ever come across. He complained of hypochondriacal sensations in his body, and although very intelligent was amazingly devoid of phantasies. On a very rare occasion, he remembered one dream of himself with a sort of bubble coming out of his mouth. It was like the bubbles in children's comics that contain the words that people in the drawings are speaking. However, the bubble was empty; there were no words in it" (1994, p. 143). Of another schizophrenic patient, Eva, he writes: "She always discussed the same subject – of not being able to receive from her mother what she was missing. At first it was mainly that the giving part of mother was giving nothing good, which was causing a kind of emptiness inside her that was characterized by something negative" (p. 158).

2.2.i. Creative Differentiation

The question of what is external and what is internal is deceptively simple. The challenge emerges upon recognition that one cannot assume a shared reality; frequently, pathological thinking is apparent in a mistaken assumption about the existence of a shared *internal* reality. As we will see, however, there is little theoretical agreement upon what is meant by internal and what is meant by external. Freud suggests that what is truly external and truly internal can only be theoretically posited:

> The unconscious is the true psychical reality; in its innermost nature it is as much unknown to us as the reality of the external world, and it is as incompletely presented by the data of consciousness as is the external world by the communications by our sense organs. (1900, p. 613)

For all that, internal and external are no less *real*, and each brings its own significant weight to bear on the individual's experience of the self in the world.[62]

The ego's primary "task" is "self-preservation" (Freud 1938, p. 145). This task depends on the ego's capacity to mediate between internal and external excitations:

> As regards *external* events, it performs that task by becoming aware of stimuli, by storing up experiences about them (in the memory), by avoiding excessively strong stimuli (through flight), by dealing with moderate stimuli (through adaptation) and finally by learning to bring about expedient changes in the external world to its own advantage (through activity). As regards *internal* events, in relation to the id, it performs that task by gaining control over the demands of the instincts, by deciding whether they are to be allowed satisfaction, by postponing that satisfaction to times and circumstances favourable in the external world or by suppressing their excitations entirely. (Freud 1938, pp. 145-146)

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[62] Hallucination is one phenomenon that arises from confusion between internal and external, specifically, when "internal reality succeeds in passing for external reality" (Green 1999, p. 170). I do not discuss hallucination here, as it is beyond the scope of my thesis. I briefly consider negative hallucination, where an external stimulus is not perceived in internal reality, in Chapter Three. For some thoughts on hallucination as a psychical process, see Bion (1958, 1965), De Monchaux (1962), and Garma (1946, 1969). Ferro offers this useful insight, which supports my argument that the analyst can function as a transitional object for the analysand: "The discriminating function of the analyst, for the patient, seems to me to be that of precursor of the formation (activation) of the 'contact barrier,' which enables him or her to distinguish between conscious and unconscious, between external and internal reality" (1993, p. 390).

The ego is a portion of the id that has *adapted* to the pressures of external reality and, in that adaptation, comes into conflict with itself, to which it must also adapt. The ego develops through conflicts: firstly, between the id and the world; and, secondly, through conflicting instinctual demands. Instinctual demands only come into conflict with one another once the ego begins to accommodate the pressures of the external world. The ego is a process that structures the individual's id experiences (instinctual impulses) and external experiences. It is the fact of the ego's organization and the ego's capacity to make judgements (about, for example, danger-situations) that allows (or causes) the ego to produce anxiety. So, although the id cannot *have*, so to speak, anxiety, "it very often happens that processes take place or begin to take place in the id which cause the ego to produce anxiety" (Freud 1926, p. 140), *viz*., a conflict of libidinal impulses, or a conflict between a libidinal impulse and the demands of reality. The ego is also, as Lacan (1988) argues, one among many of the subject's internal objects. The contact between the ego and the subject's other internal objects is equally as fraught for the agoraphobic as the spaces between the ego and the world. The conflict that gives rise to, or motivates, anxiety, is thus located at the points of contact between the ego and the world, and the ego and its objects. It is important to note that, as I argue, the agoraphobic "object" of anxiety is this contact, which occurs in the spaces between self and other.

The construction of the ego's boundaries involves, as Rey describes, the creation of internal and external spaces, as well as personal and universal spaces:

> [T]he infant, by taking in and putting out 'objects' from his body, has also created an internal space inside himself bounded by his body surface. The other boundary is the boundary between his personal space and the universal space created by the displacement of himself and of his objects. (1994, p. 167)

The ego distinguishes internal from external in a process of creative differentiation. That is, the process involves both identification of what is internal and what is external and the creation of a uniquely individual internal reality at the same time. This task is vital, for the inability to do so leads to the ego's own annihilation. The agoraphobic has only a tentative ability to distinguish internal from external, mine from not-mine. Significantly, her anxiety is not a mere fear of open spaces but a signal of the realistic danger of annihilation if this tentative ability disintegrates. Anxiety about the ego's vulnerability as it is constituted as both subjective process and object in the world mobilizes agoraphobic panic.

The ego must define itself against the world, but it must also locate itself as an object in the world. Lacan emphasizes the impossibility of this task insofar as the ego "fragment[s]" the subject (1988, p. 177). The impossibility of this task – the ego's task to both define and locate itself – is the central problematic of psychoanalysis. The nature of psychical reality is thus of critical importance to psychoanalytic work. It is no wonder, then, that the nature of psychical reality has been much debated.[63] And yet, as Lacan points out, the term that has been taken for granted – namely, "reality" – is used "in such a careless way" (1997, p. 36).[64] Zachrisson (2013), a contemporary psychoanalyst working in the tradition of object relations, suggests that much of the theoretical confusion surrounding the nature of reality stems from an imprecise use of the term "object."[65] He suggests three terms to clarify different types of object relations: "internal object" to refer to the more traditional notion of the object in object relations, which is to say, the object as it exists in psychical reality distinct from external reality; "actual other" to refer to another subject when the otherness of that subject is recognized; and, "external object" to refer to the projection of an internal object onto an individual in external reality. This third term carries with it the greatest possibility for confusion, as it is the *externalization of an internal object*. The otherness of the "actual other" is not recognized insofar as its qualities are assumed; curiosity is not possible, as the "external object" is already known, so to speak (Zachrisson 2013, p. 261). These terms always refer to the

[63] Much of this debate has focused on the use of the term "phantasy." For a seminal explication of the development of the term "phantasy" and its relevance in psychic life, see Isaacs (1948). For both Klein and Lacan, as Leader points out, phantasy is "that which organizes one's reality, rather than that which is opposed to it" (1999, p. 93). Parsons argues that external reality can be used defensively to avoid attending to psychical reality; in such cases, "the analyst must work all the harder to hold a position within psychic reality, knowing that that is where analytic work is done" (2000, p. 173). I return to the question of psychical reality in Chapter Four.

[64] Rey also notes that, in the analysis of borderline and psychotic patients, the assumption of external reality (and the external object) as given "is wrong" (1994, p. 35).

[65] Although Zachrisson frames his article in terms of internal and external realities *in general*, his clinical example is of a man whose character is marked by separation anxiety and the inhibition of aggression. These characteristics are also found in those patients who might be, in different clinical settings, diagnosed with agoraphobia, thus indicating that the question of reality is particularly relevant in patients with these characterological disturbances.

object relations of a particular subject, so that two individuals' object relations are never the same. This basic point bears repeating: even when one is referring to an "actual other," it is only ever more or less free from the influence of internal objects; thus, the "actual other" of one subject never corresponds exactly to an "actual other" of a second subject even when the relations are with the same third subject. Zachrisson's explanation of the term "actual other" brings us back to Lacan: "every object relation can only be infected with a fundamental uncertainty by it" (1988, p. 169). Lacan employs his trademark dramatic flair to counter the ego's pressure to cover up this "fundamental uncertainty," which is so hard to bear consciously. I emphasize this important point: within a relationship between two "actual others," there is always a fundamental discord based on the impossibility of an unmediated experience of the other.

There is no possibility of an unmediated experience of the other; there is only a *mediated* experience of the other. This mediated experience depends on the determination of internal and external, which is required for an individual to have an object relation with, in Zachrisson's terms, an "actual other." Without this determination, all object relations can only be with external objects, which are, as we recall, projections of internal objects onto individuals in the external world. As we also recall, projection dominates the agoraphobic's psychical processes; she is unable, therefore, to have an experience of an actual other or an experience of an actual other *world*, a world of curiosity and possibility.

There is an original instinctual impulse to (r)eject all that the ego judges bad and to introject everything that is good: "What is bad, what is alien to the ego and what is external are, to begin with, identical" (Freud 1925b, p. 237).[66] Firstly, the ego judges whether a thing is good or bad. If the ego judges a thing to be good, then it is internalized;

[66] Fairbairn prefers the terms "satisfying" and "unsatisfying" objects to "good" and "bad" objects (1944, p. 83). He argues that the unsatisfying object is internalized prior to any other in order for the infant to bring it under his control; the infant internalizes the satisfying object to help manipulate the unsatisfying object. Fairbairn indicates two aspects of the unsatisfying object: the desired, alluring aspect and the frustrating aspect. It is bad, or unsatisfying, precisely because it contains both of these two aspects. The infant has internalized the unsatisfying object to attempt to bring it under his control but in doing so has transformed an external conflict into an internal one. Fairbairn suggests that the infant deals with this internal conflict utilizing aggression in the service of repression.

it becomes an object in psychical reality. If the ego judges a thing to be bad, than it is rejected from the internal world. Secondly, the ego must judge the *reality* of the good internal objects; the ego must judge if each internal object also exists in the external world. Freud writes: "It is, we see, once more a question of *external* and *internal*. What is unreal, merely a presentation and subjective, is only internal; what is real is also there *outside*" (1925b, p. 237; original emphasis). The ability to move beyond the first judgement, of whether a thing is good (and therefore to be introjected) or bad (and therefore to be ejected), to the second judgement of whether a thing is real, is a developmental accomplishment based on intellectual activity; or, rather, based on the mutual cooperation of affective and intellectual capacities. The "precondition" for this development – the ability to determine the objective reality of an object; the *refinding* of the internal object in the external world – "is that objects shall have been lost which once brought real satisfaction" (Freud 1925b, p. 238). Loss, then, is the precondition for the development of the capacity for reality-testing, which is basic to the ego's ability to differentiate between internal and external in the process of creative differentiation.

As I develop in Chapter Three, there are two possible responses to any kind of loss: mourning or defending against mourning. Defending against mourning includes denying the very fact of loss. There is a difference between the loss of an object in Freud's sense here – in the process of reality-testing during which the object can be *refound* in external reality – and the loss of an object in the sense of death – in which the object cannot be refound as it no longer exists in external reality – only insofar as the mourning called for in response to the latter is based on the developmental process of the former. There is not a difference in kind, as even if in the process of development a child's object is lost in external reality, it can be refound if the loss of the object is talked about by others. The object itself is not refound in external reality, but the fact of the object's existence in external reality is reaffirmed insofar as others acknowledge the real loss of the object. I explicate this significance for the agoraphobic in Chapter Three and, further, argue that it cannot just be loss that leads to the development of this capacity; *mourning* one's losses – suffering one's losses – is required. The agoraphobic's basic limitation in this ability to differentiate between internal and external indicates her need for a greater capacity for mourning.[67] A greater capacity for mourning leads, in turn, to a more secure sense of what is internal and what is external.

Loss of the external object, then, is one precondition for this process of creative differentiation; as we will now see, destruction of the internal object is another. Echoing and expanding on Freud's formulation of negation, Winnicott emphasizes the movement of the destructive drive, which "creates the quality of externality" (1951, p. 93). As I detail below in my discussion of transitional objects, the internal object must be destroyed, in phantasy; if the external object survives, the individual gains a greater sense of what is internal and what is external, and consequently a greater capacity for object use. Ogden indicates the persistence of this process of destructive creation:

> Externality is not created once and for all by a single act of 'destruction' (renunciation) of the internal object. The pull of the primitive tie to the internal object must be consistently resisted. In psychological terms, the internal object must be constantly destroyed in unconscious fantasy, thus continually making room for the rediscovery of the external object. (1986, pp. 199-200)

If the individual is unable to mobilize her aggression, unconsciously, to destroy the internal object, the question of what is internal and what is external must be continually confronted without resolution. The resolution would not be, as Ogden points out, a singular act of renunciation; but the repeated acts of renunciation lead to an unconscious faith in the internal versus the external. The distinction, and the fact of a distinction, can be taken for granted. The inability to effectuate this renunciation is profoundly disabling, as the object can then never be *used*. Winnicott distinguishes between object-relating and object-use in these terms of internal and external realities insofar as object-relating, as Winnicott understands it, "is an experience of the subject that can be described in terms of the subject as an isolate" (1969, p. 712). In Zachrisson's terms, as described above, object-relating concerns an internal object or, perhaps, an external object. Object-use, on

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[67] Reeder, in an article on Lacan's concept of symbolic castration and *das Ding*, comments on Freud's words: "Freud's train of thought here seems to imply that a primordial loss appears in conjunction with the symbolic function of representations: *the object is lost when the child begins to form thoughts independent of its immediate perception of the surrounding world*" (2012, p. 38; original emphasis). Loss and the capacity to symbolize thus go hand-in-hand; an inhibition of symbolization and unmourned losses are thus also expected to occur coextensively. I discuss the implications of this point in Chapter Three.

the other hand, requires that the object "be real in the sense of being part of shared reality, not a bundle of projections" (Winnicott 1969, p. 712).[68] In Zachrisson's terms, object-use requires that the object in question be an "actual other"; that is, that the otherness of the object is recognized.

If the distinction and the relation between inner and outer realities – variously termed internal and external, subjective and objective, psychical and *real* – appear nebulous, it is, as Hämäläinen (2009) suggests, perhaps unavoidable. Hämäläinen brings to the foreground of our attention the difficulty, both terminological and conceptual, of evaluating 'objective' reality insofar as it is impossible to observe beyond our subjective reality. Returning to Freud's declaration that our "innermost nature [...] is as much unknown to us as the reality of the external world" (1900, p. 613), Hämäläinen provides this reminder:

> This distinction, in which a situation is observed either externally or internally, is, however, only clear in a theoretical sense. In practice and at the level of the experiential world it is more ambiguous, due precisely to the impossibility of observing another from inside and the impossibility of being objective with regard to one's own boundary either. Nor is external perception of another objective, because we cannot with certainty say, for instance, where the boundary of another's illusion lies because our own experience is also subjective. (2009, p. 1286)

Hämäläinen argues that we rest on our understanding of what constitutes internal and external without examining too closely what we mean by these terms because to do so would be, in Winnicottian terms, to question the paradox that sustains our illusion of shared reality. Winnicott refers to shared reality as the third area of experience and suggests that it is characterized by the same paradox as the transitional object: the infant creates the transitional object and the object existed waiting to be created by the infant. To ask the question, is it created or is it found, destroys the paradox necessary to sustain it as a transitional object. As with the transitional object, the question of whether shared

[68] I return to Winnicott's concept of a capacity for object-use below in relation to transitional phenomena and the analytic frame. For now, I remain with the question of internal and external realities and the ego's process of creative differentiation.

reality is created or found must not be asked. The illusion of shared reality, as Hämäläinen notes, depends on this paradox:

> A consequence of separateness is that individuals do not actually share an experiential world nor, as a result, do we share any area where we would know for certain that we share an other's experience. And yet we need the illusion of a shared world, and in everyday life this illusion is not necessarily challenged. (2009, p. 1281)

I amend Hämäläinen's statement slightly: we share an experiential world but it is not the same world for each individual. In health, we share the illusion of a more or less similar shared experience. In order to sustain this necessary illusion, there needs to be some space and time in which, as Milner states, "it will not be necessary for self-preservation's sake to distinguish clearly between inner and outer, self and not-self" (1952, p. 192). Paradoxically, the agoraphobic needs the opportunity to develop this necessary illusion of a shared world. She needs the illusion *as* illusion instead of as terrifying reality, which will only become possible once she has a clearer sense of what is internal and what is external. As I argue below, the agoraphobic needs a new experience of a transitional object that can survive her destruction of it and thus demonstrate the non-correspondence between internal and external objects; the analytic setting, including the frame and the analytic stance maintained by the analyst, can potentially become this transitional object.

2.2.ii. Original Unity

There is neither world nor ego, psychologically speaking, for the newborn infant. Loewald (1951) addresses the development of the complicated relationships between the ego and the world and the ego and its objects by returning to the theoretical "original unity." As we will see, the agoraphobic attempts to preserve this unity, which is, as I explain below, the ego's phantasy of unity, at the expense of more experiences – more pain and more joy – in the outside world. In Mahler's terms, as I refer to above, the agoraphobic is developmentally stuck, so to speak, at the threshold between the infant room with the mother and the toddler room, "which ha[s] so much more diversification" (1975/2000, p. 27). As Mahler suggests, "[s]tanding on the threshold would seem to be the perfect symbolization of conflicting wishes – the wish to enter the toddler world away from the mother and the pull to remain with mother in the infant room" (1975/2000, p. 96). The agoraphobic shies away from the threshold and from diversification, as she is not confident that she can survive all that she may encounter; likewise, she is not confident that she will be able to return to the mother in the infant room if she finds that the toddler room – the outside world – proves overwhelming. The agoraphobic fears that her preference for the outside world will destroy the mother; indeed, it will, insofar as their dyad will become more complex, altered permanently by the increasing diversification of experiences. She does not have the experience of the mother surviving destruction, the experience of which, as I have noted, would demonstrate for her the non-correspondence between the internal and external worlds. I consider this process in detail below in my discussion of transitional objects.

To begin with, Loewald argues, the ego and the outer world are undifferentiated: "The relatedness between ego and reality, or objects, does not develop from an originally unrelated co-existence of two separate entities which come into contact with each other, but on the contrary from a unitary whole which differentiates into distinct parts" (1951, p. 14). It is not that the yet-to-be ego experiences a unity with the environment; rather, everything belongs to the ego. There is not a world in which or to which the ego belongs, but a world that belongs to the ego. The only way we can know the world is via the ego's relation to it; therefore, from the ego's perspective, the ego precedes the world. The difference between these two belongings, so to speak, is apparent in the fantasy of omnipotence that characterizes the early stages of the child's psychic life: because the world belongs to the ego, or, to be more accurate, because the infant perceives everything external to her as her own creation, the infant or young child believes in her omnipotent[69] control over the world.[70] Thus, the young child – and the agoraphobic – unconsciously

[69] Ogden's definition of "reality" (as part of a reality-fantasy dialectic) indicates the significance of this original state out of which reality and fantasy develop: "The term *reality* is used here to refer to that which is experienced as outside of the realm of the subject's omnipotence" (1986, p. 216).

[70] An understanding of the fact of the child's earliest fantasies of omnipotence is vitally important to the development of many psychoanalytic ideas. As early as 1926, Ferenczi emphasizes the movement from omnipotence to conditional potency paralleling the movement from the pleasure principle to the reality principle: "before it has assumed its first disappointments a child believes itself to be unconditionally

believes that her aggressive impulses are powerful enough to destroy the world. As Winnicott will emphasize, the presence of the mother's breast, which satisfies the infant's hunger, helps to maintain the fantasy of wholeness; the absence of the mother's breast, necessarily repeated over time because in reality it cannot always be present, leads to the concurrent development of an ego and a world against which the ego defines itself.

Loewald expands on Freud's characterization of the ego as "a coherent organization of mental processes" (1923, p. 17). He argues that the essential organizing function of the ego is to maintain the original unity – which is always already lost in order for the ego to exist – "on more and more complex levels of differentiation and objectivation of reality" (1951, p. 14). Unity refers to the phantasy of the original libidinal relationship with the mother; although the unity is not entirely fantastical, it is the *ego's* phantasy insofar as the ego does not exist prior to the fragmentation of that unity. The ego's essential defensive function is not against a threatening reality, but from the threat of reality's loss, which is to say, the loss of differentiation from the original unity. The threat of reality's loss encroaches from two positions: the paternal castration threat of being cut off from objects and the maternal womb threat of engulfment, of boundary loss between ego and reality. The ego can be annihilated either by being cut off from the world or by being reabsorbed into its unity. If each threat is as strong as the other, the ego is protected from both insofar as the one protects the ego from the other. The psychic struggle against these threats continues through normal oedipal development, and constitutes an ongoing process of maintaining both individuation and object relations.

Lacan (2006f) revisits the question of an original unity – which he will describe as belonging to the imaginary dimension – via his concept of the mirror stage; he describes the earliest formation of the ego as the infant's response to his mirror image.[71] To reiterate, the agoraphobic is stuck somewhere between this original unity and the development of a differentiated ego. Her experience of the world, then, *reflects* the

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omnipotent, and further […] it clings to this feeling of omnipotence, even when the effectiveness of its power in the fulfillment of its wishes is bound up with the observance of certain conditions" (p. 312).

[71] Lacan (2006f) refers to the analytic term "imago" to designate the series of unconscious identifications that constitute the ego. Lacan's argument here is that the individual's (unconscious) assumption of various imagos is based on the specular image, namely, what is reflected.

qualities of the imaginary dimension: the imaginary precedes the mirror stage (and, as we will see, the symbolic). Fink describes the qualities of the imaginary dimension:

> Prior to the advent of the symbolic, the delimitation of myself (ego) is not clear; there is no essential barrier between what I call me and what I call you (ego′), because I perceive and construct who I am only on the basis of what I see in you, and I perceive and construct you only on the basis of my own self-perception and self-construction. (2005, p. 560)

The imaginary relation depends on what is seen; hence, the *imag*inary: emphasis on "image." The self is apprehended via the image of the other; the other is *seen* as a self, like my self, but not my self; that is, the other is not radically *other* from the self, only more or less similar to the self. Fink argues that, for Lacan, this otherness is constituted by size: the other is either bigger and stronger or smaller and weaker than the self.[72] Size is fundamentally linked to aggression insofar as the imaginary relation is used to ascertain the threat of the other or the possibility of being the other's aggressor: "The question here seems to be that of domination or submission: Either the other is a threat to oneself or is not, but there is no *recognition* of the other as possibly operating on altogether different principles than one's own" (Fink 1995, p. 554). Fink emphasizes the lack of limits in the realm of the imaginary; there are no limits to the threat posed by the other's aggression towards oneself and no limit to the damage the self can do to the other: "There are no innate limits here to what can be done in the course of the struggle for survival" (1995, p. 557). And it *is* a question of survival. The agoraphobic does not have a secure sense of the limits between herself and her objects, her self and the world. The agoraphobic experiences the threats of the imaginary dimension in their unlimited state, unimpeded by the symbolic order (which I return to below). Her survival, therefore, is always in question.

Strikingly, the agoraphobic is not able to rest in "the mirage of a unity" (Lacan 1988, p. 169); instead, the threat of unity – namely, ego annihilation – is always looming.

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[72] In his discussion of Little Hans's analysis, Freud remarks: "The ego is always the standard by which one measures the external world; one learns to understand it by means of a constant comparison with oneself" (1909, p. 107). Little Hans expresses this standard by his concerned comparison of the horse's "widdler" with his own, and of his own with his parents'.

As I note above, Lacan reiterates the necessary discord between objects (including the ego as one of the subject's objects) that the subject masks with illusions of unity:

> This disarray, this fragmentedness, this fundamental discordance, this essential lack of adaptation, this anarchy, which opens up every possibility of displacement, that is of error, is characteristic of the instinctual life of man […]. If the object is only ever graspable as a mirage, the mirage of a unity which can never be grasped again on the imaginary level, every object relation can only be infected with a fundamental uncertainty by it. (1988, p. 169)

In so many words, Lacan returns to Milner's proposition: that the individual needs to be able to rest, so to speak, in the "mirage of a unity." To reiterate: the existence of the ego depends on differentiation; at the same time, the ego needs to be able to take this differentiation for granted so that it is not always necessary – for the sake of the ego's survival – to be effectuating it. The question of survival can fade into the background of experience so that curiosity about the world can develop.

For Winnicott, the mother provides the infant's first mirror, reflecting back to the infant "an image of himself that accurately derives from his inner experience: if he is distressed, she soothes him, and in doing so provides him through a changed inner experience with a self that matches her own tranquility" (Bollas 1995, p. 241). This characterization of the infant's mirrored experience is starkly different from Lacan's, a difference that is reflected in their distinctive views on trauma (which I return to in Chapter Three; for now, I only point out that, for Winnicott, the "good-enough" mother is both ideal – in the sense of satisfying the infant's needs in the process of development – and also normal, in the sense of not being an unusual or outlying phenomenon. Trauma, for Winnicott, is not assumed.). Rather than disarray and fragmentation, Winnicott emphasizes the child's psychical processes within the mother-child dyad. For Winnicott, it is not that the infant experiences an original unity with the mother; rather, there is a single psychological entity comprised of the mother-infant unit. The mother experiences the original unity as much as the infant does. Winnicott describes this state, for the mother, as "primary maternal preoccupation" (1956, p. 304). Winnicott theorizes that the mother's preoccupation with her infant *creates* the phantasy of the original unity for the infant until the infant is developmentally mature enough to bear the frustrations of separation. Despite the differences, the mirror function for both Winnicott and Lacan provides the infant with the illusion of coherence. While Lacan concerns himself primarily with the paternal law, language, and symbolization (which I return to below), Winnicott emphasizes the importance of the maternal environment in which the infant/child develops. Ogden indicates the paradox that Winnicott postulates is the mother's role: "the mother must shield the infant from awareness of desire and separateness, *and* the mother must safeguard the infant's opportunity to experience desire and the accompanying knowledge of separateness" (1986, p. 175).[73] For Winnicott, the mother creates the illusion of unity; and, she gradually allows the infant to become aware of the fact that it is illusion. The satisfaction of this paradox is what Winnicott calls "good-enough mothering."[74] If we recall Mahler's description of the child poised to cross the threshold from the infant room to the toddler room, we can suggest that the agoraphobic's mother anxiously draws the toddler's attention to all of the potential dangers rather than confirming for the child that some combination of curiosity, eagerness, and caution is appropriate, with the assurance that mother will be waiting in the infant room if comfort is required. We can speculate that the agoraphobic mother has not, to repeat Ogden's words, "safeguard[ed] the infant's opportunity to experience desire and the accompanying knowledge of separateness" (1986, p. 175).

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[73] Green emphasizes the temporal dimensions of this process, which necessarily accompany the spatial considerations in the establishment of self and other. Referring to Winnicott's work, Green writes: "If the response [from the mother/object] is immediate, without delay, symbiotic omnipotence sets in, depriving the infant's ego of the possibility to say no to the object and therefore yes to itself. […] On the other hand, when the delay is too great, it is despair, stamped by the experience of pain, which makes one say no to everything (including oneself)" (1999, pp. 272-273). Milner also draws attention to the importance of the temporal aspects of this process: "I suggest that, if, through the pressure of unsatisfied need, the child has to become aware of his separate identity too soon or too continually, then either the illusion of union can be what Scott calls catastrophic chaos rather than cosmic bliss, or the illusion is given up and premature ego-development may occur; then separateness and the demands of necessity may be apparently accepted, but necessity becomes a cage rather than something to be co-operated with for the freeing of further powers" (1952, p. 192).

[74] Green (1999) and Kristeva (2001) draw attention to the fact that good-enough mothering is also bad-enough mothering.

2.2.iii. Trauma in the Process of Creative Differentiation

Freud insists "that the ego owes its origin as well as the most important of its acquired characteristics to its relation to the real external world" (1938, p. 201). In the development of neuroses, "demands from within, *no less than excitations from the external world,* operate as 'traumas,' particularly if they are met halfway by certain innate dispositions" (Freud 1938, p. 184; my emphasis). The development of neuroses *and* the development of the ego

> is made possible by hereditary disposition; but it can almost never be achieved without the additional help of upbringing, of parental influence, which, as a precursor of the super-ego, restricts the ego's activity by prohibitions and punishments, and encourages or compels the setting up of repressions. We must therefore not forget to include the influence of civilization among the determinants of neurosis. (Freud 1938, p. 185)

"The influence of civilization" includes parental influence and traumas from the external world. Traumas from the external world – real events, as it were – must not be neglected any more so than the neurotic traumas of phantasy. We can extrapolate and emphasize this important point: all trauma, like all object relations,[75] is both externally and internally effectuated. Trauma is a psychical event connected in some way to an external event; the nature of this connection may be contentious,[76] but the trauma itself necessarily involves both the external event and the psyche's response to that event.

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[75] See, for example, Opdal 2013, p. 3: "we must acknowledge that the object is related both to external and to internal reality."

[76] On trauma, Fairbairn writes: "Frustration of his desire to be loved and to have his love accepted is the greatest trauma that a child can experience; and indeed, it is the only trauma that really matters from a developmental standpoint" (1941, p. 261). Lacan disagrees, suggesting rather that "there is something originally, inaugurally, profoundly wounded in the human relation to the world" (1988, p. 167). Klein's position can be found between these two, as she argues that "the capacity for love and happiness which develops in the child is [not] in direct proportion to the amount of love afforded him" (1930, p. 336). If the individual has "little capacity to tolerate frustration, and if aggression, fears and feelings of guilt are very strong, then the actual shortcomings of the parents […] may become grossly exaggerated and distorted in the child's mind" (Klein 1930, p. 339). As I discuss in Chapter Three, I agree with Winnicott (following Fairbairn) that a failure of the maternal holding environment to provide a good-enough mothering experience for the mother-infant dyad surely leads to some level of trauma. At the same time, I agree with Lacan (and Freud, as above) that there is something "profoundly wounded" in the very fact of being a human in the world. Both levels of trauma, I contend, must be addressed.

As I describe above, the psychical structure is inherently neurotic – or, more accurately, it is initially comprised of psychotic processes. In the development of a mature psychical structure, the individual moves from pathological process to mature psychic (dynamic) structure. Part of that process is, as I also note above, the experience of emptiness. The psychical experience of emptiness is derived from the physical experience of hunger. The infant will necessarily experience hunger; the very experience of hunger's emptiness, no matter how temporary, is perceived as a deprivation. The experience of emptiness stimulates aggression and leads to the further development of the ego.

Winnicott refers to the need for emptiness prior to learning, which includes the potential for new experiences, and developing one's ego and new object relations; to wit, "[t]he basis of all learning (as well as of eating) is emptiness" (Winnicott 1974, p. 107). Without the experience of hunger (emptiness) and the resulting aggression, the individual is unable to experience satisfaction or love. When emptiness is defended against, and/or when *aggression* is repudiated, there are many consequences, one of which is the inability to achieve ambivalence and therefore, as I describe above, the inability to progress from the paranoid-schizoid position to the depressive position. The world turns monstrous and, as the agoraphobic shows us, intolerable. The ego's vulnerability, then, and the capacity to utilize that vulnerability for growth, is ironically repudiated in agoraphobia patients who are commonly characterized, and commonly characterize themselves, as childlike and unable to care for themselves in a manner appropriately corresponding to their actual age.[77]

For Winnicott, the infant experiences some level of trauma if the mother imposes on the infant the fact of his or her separateness before the infant is developmentally capable of bearing that reality, or if the mother forecloses the possibility of the infant's recognition of their separateness.[78] Winnicott suggests a distinction between trauma and "nothing happening when something might profitably have happened" (1974, p. 106). If

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[77] See, for example, Milrod (2007, pp. 1012, 1020).

[78] Ogden adds that there may be some "breaches in," rather than failures of, the facilitating environment, such as an infant's severe or chronic illness (2014, p. 210, n. 5).

"nothing" happened, then "emptiness needs to be experienced, and this emptiness belongs to the past, to the time before the degree of maturity had made it possible for emptiness to be experienced" (p. 106). For these patients, emptiness "turns up as a state that is feared, yet compulsively sought after" (1974, p. 106). Winnicott relates the experience of emptiness – as both feared and compulsively sought after – with the fear of breakdown in certain individuals. As a constituting experience, emptiness is related to primitive anxieties.[79] The term "breakdown" refers in the first instance to the failure of a defence organization; which is to say, it refers to a failure of the ego's functions. Recalling Loewald's explanation of the ego's organizing and defensive functions, "breakdown" refers to "a reversal of the individual's maturational process" (Winnicott 1974, p. 103). The two most relevant of the primitive anxieties Winnicott lists are a return to an unintegrated state and loss of the capacity to relate to objects, which Maizels (1985) understands as forming the basis of agoraphobic and claustrophobic anxieties.[80] Winnicott contends that psychotic illness is a defence organization in relation to a primitive anxiety, the fear of which is overwhelmingly unthinkable. This contention implicitly refers to Klein's concepts of the paranoid-schizoid and depressive positions, which are always already, or at least, in the first instance, psychotic anxieties. Subsequently, the defence-mechanisms that correspond to the infantile anxiety situations form, as Klein argues and I discuss above, "the basis of the most severe psychoses" (1940, p. 262). The anxiety is overwhelmingly unthinkable precisely because, Winnicott

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[79] Although Winnicott refers to these anxieties as "agonies" to impress upon us their painful profundity, I will maintain the more common terminology of anxiety without losing sight of the severity of the experience. Along with the infant's anxieties, Ogden adds the mother's inevitable narcissistic wounds of not knowing "what it is her baby needs and whether it is within the power of her personality to provide it even if she somehow could discover what he 'wants'" (1989, pp. 202- 203). Ogden's addition deepens our understanding of the connection between pregnancy (and/or impending parenthood) and the onset or exacerbation of agora-claustrophobic anxieties, which I discussed in Chapter One.

[80] Maizels (1985) proposes a model of psychological conflict based on two opposing tendencies: the first tendency, similar to Freud's conceptualization of the death instinct, moves toward non-conflict and is accompanied by the unconscious fantasy of a return to the mother's womb; the second tendency moves towards autonomy and the capacity to exert oneself in the overcoming of frustrations. He identifies agoraphobic and claustrophobic anxieties as the "two 'basic' anxieties" (p. 188) corresponding to these tendencies and offers a clinical example of a patient who exhibits the fluctuations between them, indicating an inability to tolerate either situation (either being protected in the womb or being independent of the womb) and therefore an inability to move freely between forays towards independence and moments of intimacy and comfort.

argues, it is the fear of a breakdown that has already been experienced.[81] The fear of breakdown refers to Loewald's original unbounded state, in which the ego did not exist because it had not yet differentiated itself from the world. In the sense that the ego was relatively undeveloped, the individual did not experience the breakdown in the past. The individual needs to experience intellectually what they are only affectively aware of in order to organize her realities. Winnicott refers to experiences that occur prior to the development of the ego, and, as such, no subject existed, so to speak, to *have* the experience (in order to organize it) (1974, p. 104).[82] I add to this description experiences for which the subject *has no words*. The problematic insufficiency of (some particular element of) language persists beyond ego development. Therefore, the subject may experience a debilitating anxiety perceived to be future-oriented but caused by a previous experience that the subject is unable to put into words. This argument is anticipated by Rivière: "The worst disasters have actually taken place; it is this truth that [the patient] will not allow analysis to make real, will not allow to be 'realized' by him or us" (1936, p. 312).[83] The agoraphobic's emptiness that Milrod (2007) describes suggests this possibility.

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[81] In Chapter Four, I discuss the relevance of this anxiety in the analytic situation via the concept of *Nachträglichkeit*. C. Winnicott provides a clinical example of Winnicott's theory of the fear of breakdown, linking her patient's unconscious fear of breakdown – which was inhibiting her capacity to function in the world – with the patient's early experiences of trauma. The patient relays a recurring dream relatively early in the analysis in which she is in a "*vast empty sandy space*" (1980, p. 352; original emphasis). This emptiness is linked to the patient's disavowal of a part of herself that is a terrified and utterly alone little child. Significantly, and as I explore in more detail in Chapter Four, the patient remarks of her relationship with her analyst: "'You don't press me into any kind of shape. You give me elbow room and space to move around in.'" Her analyst comments that she [the patient] "felt that the space included me [the analyst] – it was the space between [them], and this was different than emptiness – the emptiness of the desert" (p. 353).
[82] Ogden considers that Winnicott's (1974) article, likely written in the year before his death and posthumously published, is unfinished. Ogden works to clarify some of its ambiguities and, to that end, suggests that each of the primitive agonies that Winnicott lists "*is an agony only because it occurs in the absence of a good enough mother–infant bond*" (2014, p. 210; original emphasis).
[83] See also Freud 1914b, p. 151: "We have learnt that the patient repeats instead of remembering, and repeats under the condition of resistance"; and, Freud 1937, p. 268: "The transposing of material from a forgotten past on to the present or on to an expectation of the future is indeed a habitual occurrence in neurotics no less than in psychotics. Often enough, when a neurotic is led to an anxiety-state to expect the occurrence of some terrible event, he is in fact merely under the influence of a repressed memory (which is seeking to enter consciousness but cannot become conscious) that something which was at that time terrifying did really happen."

Winnicott's emphasis on the mother-infant dyad and the maternal holding environment indicate that he considers the effects of real experiences on psychical development. Winnicott's theory of the fear of breakdown, I suggest, can also refer to experiences for which the subject has no words, which leads to Lacan's clinical emphasis on the symbolic. As Bollas (1995) and Fink (2004) point out, this clinical emphasis requires the articulation of real traumatic experiences. Ogden implies this potential connection between Winnicott and Lacan, noting that "Winnicott points to a theory of the psychopathology of the symbolic function [...] that remains to be completed" (1986, p. 214).[84]

As I gesture towards above, the inauguration of the subject into the symbolic order – the development of the ego as object – divides the subject from himself: the "subject [is] fundamentally fragmented by this ego" (Lacan 1988, p. 177). The unconscious, "excluded from the system of the ego" (p. 58), comes into existence as the limitless drives of the imaginary are repressed. The unconscious, according to Lacan, "has the radical structure of language," which is to say that "a material operates in the unconscious according to certain laws, which are the same laws as those discovered in the study of natural languages [*langues*] – that is, languages [*langues*] that are or were actually spoken" (1958/2006b, p. 496).[85] The murderous, unbounded rage that exists in the imaginary register is limited by the internalization of the Law, the superego, *le nom du père* (the Name of the Father, the No of the Father) – which takes place as the individual enters into the symbolic register and becomes part of discourse, a part of the chain of signification. The symbolic intervenes in the murderous rage of the imaginary; the word intervenes in the image. As the symbolic introduces limits into the imaginary,

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[84] Luepnitz draws an explicit comparison between Winnicott and Lacan, suggesting that "Winnicott and the Middle Group [are] a corrective to Lacanian abstraction, and turning back to Lacan [is] a corrective to the absence of reflection on language in Winnicott" (2009, p. 962). Luepnitz indicates a further difference, the significance of which will become more evident in Chapter Three: "[f]or Winnicott, the central drama will turn around the infant's loss or feared loss of maternal connection. For Lacan, […] something even more profound is at stake – the lack built into subjectivity by the mere existence of the unconscious" (p. 964). See also infra note 76.

[85] See also Lacan 1997, p. 32: "We only grasp the unconscious finally when it is explicated, in that part of it which is articulated by passing into words. It is for this reason that we have the right – all the more so as the development of Freud's discovery will demonstrate – to recognize that the unconscious itself has in the end no other structure than the structure of language."

the boundaries of the ego are created. Speech draws attention to our vulnerability, as it can never be complete, never whole. As we speak, our words slip along the signifying chain, always missing the mark. And yet, speech relieves the vulnerabilities inherent in instinctual life:

> The power of naming objects structures the perception itself. The *percipi* of man can only be sustained within a zone of nomination. It is through nomination that man makes objects subsist with a certain consistence. […] Naming constitutes a pact, by which two subjects simultaneously come to an agreement to recognize the same object. (Lacan 1988, p. 169)

Lacan's formulations are instructive here, as the symbolic order is that which interrupts the imaginary and introduces limits, both to the ego as object of the subject and to the ego's attribution of limits to others.[86]

The agoraphobic's emptiness that replaces her symptoms of anxiety and avoidance, which Milrod (2007) describes, indicates her particular difficulty in, not just entering but, *inhabiting* the symbolic. The symbolic dimension is part of Winnicott's third area of (cultural, shared) experience and thus has the qualities of a transitional object, which I describe in detail below. Like all individuals, the agoraphobic is born into a language system, but she is unable to make it her own; she *finds* language, but does not create it. Of course, the agoraphobic is not the only type of patient for whom symbolization is fraught; it is, on the contrary, one of the features of psychoanalytic practice that the process of putting it all into words is resisted. However, the agoraphobic's specific complaint of emptiness upon remission of anxiety and avoidance indicates the need for the *analyst* to emphasize and encourage the use of symbolization via the psychoanalytic method of free association, which would thus stabilize the agoraphobia patient's psychical experience of limits: of her ego's limits and the limits of others.[87]

Lacan's development of the symbolic dimension and his clinical emphasis on language cannot be read as dismissing the effects of reality – Freud's "influence of

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[86] Similarly, Bacon suggests that "phobias may well arise in the absence of the name, or metaphor [of the father], in an attempt to make good the loss or absence" (2003, p. 158).
[87] I expand on this aspect of clinical technique in Chapter Four.

civilization" – on an individual's psychical reality. To the contrary, Lacan, as Bollas writes, specifically accounts for the real dimension and provides some thoughts with which to think through the question of internal and external realities clinically:

> The psychoanalytical insistence on the priority of the imagined – juxtaposed, if necessary, to the happened – is understandable, if regrettable. [...] Lacan, however, ascribes powerful influence to the real. It is there. It may evade representation but the fact is, reality happens to one, and there is a kind of categorical memory of its nature. So, according to Lacan, we do not remember the actual event that happened to us, because our perception of reality is disqualified by our own subjectivity – guided as it is by its imaginative capacity and the latent rules of the symbolic order – but we do recall the categorical moment, if one can put it that way. We recall that something happened from the real (not the imaginary or the symbolic) that profoundly affected us. (1995, pp. 103-104)[88]

Bollas continues:

> The analyst must return to the patient's presentation of his or her facts of life not because they bear some meta-truth in themselves that will displace the patient's projective constructions of an internal world, but because the patient is *entering the intrinsically traumatic in the process of analysis, unconsciously asking that the trauma of things done be addressed*. (1995, p. 113; original emphasis)

The nature of agoraphobia in particular, characterized by an unconscious confusion of self and other and the boundaries between, requires a theoretical perspective that takes into consideration real – that is, external – experiences and the patient's representation of these experiences. The patient represents her experiences primarily via language, which is, as Green articulates, both a perception and a representation: "it represents the relation between things and the relations of thought relations making it possible for the latter to be perceived" (1999, p. 197). In Lacan's words, the symbolic order (the order or dimension of natural – spoken – language) "preexists the infantile subject" and it is in "accordance with [this symbolic order that] he has to structure himself" (1958/2006b, p. 497). A clinical emphasis on language – as opposed to narrative, which implicitly *demands*

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[88] See also Freud 1914b, p. 149: "There is one special class of experiences of the utmost importance for which no memory can as a rule be recovered. These are experiences which occurred in very early childhood and were not understood at the time but which were subsequently understood and interpreted."

coherence[89] – provides the opportunity to consider the patient's perceptions, or real experiences, *and* representations, or phantasies. Lacan's emphasis on language, then, is a clinical one, and maintains the unconscious at the forefront of psychoanalytic practice.

The demands of the analytic situation pressure the ego to relinquish its familiar and neurotic organization in favour of a more painful but ultimately more satisfying mediation of internal and external pressures.[90] Resistance is a defence that arises, in particular, in response to these demands. Resistance is the work of the ego struggling to maintain its coherent and familiar self, to not admit conflicts into its being. As I argue in Chapter Four, the agoraphobic is *too* coherent; she is unable to tolerate incoherence, which thus restricts her unconscious freedom in addition to the restrictions she places on her freedom of mobility. For Lacan, resistance indicates the real dimension and provides evidence of its dominant quality: the real is "the domain of that which subsists outside of symbolization" (2006g, p. 324).[91] More pointedly, "*the real resists symbolization*" (Fink 2004, p. 172, n. 24; original emphasis). The subject does not resist; rather, the real resists. The real resists discourse, resists symbolization. The real *is* that which resists symbolization and, thus, resists the analytic process. Fink clarifies the qualities of the real, as Lacan conceives it, in terms of resistance in the clinical situation: "Lacan wants us to consider the idea that it is not the patient who is in any way willfully resisting the therapeutic process; rather, it is the very nature of the job that the patient is faced with that is fraught with resistance" (2004, p. 172, n. 24).[92] The real resists symbolization; but only through the symbolic dimension can the real be apprehended, again underscoring the

[89] In Chapter Four, I consider the movement between coherence and incoherence in psychical life.
[90] See Bion (1979) on the pain of living and Scott (1981), who amends Bion's account with his particular emphasis on mourning, and faith in our capacity to mourn as contributing to "making the best of this sad job" of life.
[91] See also, Lacan 2006g, p. 324: "*what did not come to light in the symbolic appears in the real*" (original emphasis).
[92] Fink describes resistance in relation to the imaginary: "Now the analysand cannot help but fall back into the imaginary realm of defenses and resistance when the real that she is trying to put into words (trauma and other experiences that have never before been articulated by the subject) resists symbolization" (2004, p. 25). Further: "The real that the analysand is up against always resists symbolization" (2004, p. 26). The real is that which resists symbolization, but the imaginary is the realm of resistance; that is, in the act of resistance and defending against the real, the analysand uses the imaginary, i.e., the ego. Lacan is not unique in identifying the ego as the agent of defenses; see, for the most prominent and influential example, A. Freud (1937/1966/1993).

clinical use of language (rather than, for example, a clinical focus on the therapeutic relationship as the mechanism of change). In Lacan's words: "we have no means of apprehending this real – on any level and not only on that of knowledge – except via the go-between of the symbolic" (1988, p. 97).[93] A clinical emphasis on coherence, as I argue in Chapter Four, is a kind of resistance to the analytic process insofar as it is complicit with the ego's struggle to maintain its familiar (neurotic and unsatisfying) coherence; an intolerance of incoherence impedes the work of analysis, which needs to include a destabilization (and subsequent re-ordering) of the ego's organization. For the agoraphobic, *something* has gone wrong in the process of ego development; I argue in Chapter Three that, for the agoraphobia patients Milrod (2007) describes, persistent emptiness indicates the presence of unmourned traumatic losses. As I suggest above in my description of the process of reality-testing, the fact of the lost object's existence in external reality is reaffirmed insofar as others acknowledge the real loss of the object. The analyst must, I argue, return to these real experiences of loss in order to address the agoraphobic's emptiness. Only when these real losses are symbolized will the agoraphobic be able to develop clearer boundaries between the internal and the external, and create the world that is waiting outside for her to find.

2.3. Transitional Phenomena and the Analytic Frame

Language, in my view, is the heir to the first transitional objects.

(Green 1975, p. 11)

As a particular element of shared reality, language is characterized by the paradox of the transitional object, which precedes it developmentally. The use of a transitional object – an external object that the infant does not yet fully recognize as belonging to external reality – is a necessary aspect of psychic development. As I gesture towards above on the question of internal and external realities, the infant both finds and creates the transitional

[93] See Miller on *extimité*, or "extimacy," a term Lacan uses to denote the real in the symbolic (1994, pp. 74-87). The term denotes, as Miller explicates, that that which is "most interior – [which is to say, that which is *intimate*] – has, in the analytic experience, the quality of exteriority" (p. 76). Further, "[e]xtimacy is not the contrary of intimacy. Extimacy says that the intimate is Other" (p. 76).

object; this object aids in the process of reality testing and creative differentiation. Ogden writes: the relationship with the transitional object is “a reflection of the development of the capacity to maintain a psychological dialectical process” (1986, p. 213). This dialectical process is paradoxical, referring to the movement between unity and individuation, or individuation within unity and unity with individuation. The transitional object is the hinge of this dialectic, of “separateness in unity, unity in separateness” (Ogden 1986, p. 212).

The transitional object, as hinge, attaches to the gap between the experiential – that is, external – world and the internal world. Green draws attention to this gap, noting that the emptiness localized in the “potential space between the self and the object” is “essential to psychic development” (1975, p. 18). This potential space depends on the vitality of the transitional object, which contains the paradox of interconnected separateness. As I note above, one does not ask the question of the child’s transitional object: did you find it or did you create it? To do so would destroy the illusion that covers up the paradox. I propose that the analytic frame has the potential to become a transitional object for the analysand.

The analytic frame is the setting of the analysis; it marks off the space – physical, temporal, and psychical – from everything outside of it. Aspects of the frame include, for example: the position of the couch and chair, the room in which the analysis takes place, the time at which a session starts, and its duration. The two participants – analyst and analysand – agree to an absence of physical contact and the payment of the analyst’s fee. Further, the analyst commits to maintaining confidentiality, the analysand agrees to try to say everything, and the analyst agrees to try to listen. The frame is a physical setting, a set of behavioural conventions, and a psychical space.[94] The qualities and aspects of the

[94] In a discussion on the analyst’s use of a home office, Maroda (2007) explicitly connects the analytic frame with the analyst’s boundaries, specifically the boundary the analyst maintains between analyst-as-professional and analyst-as-private individual. Although I disagree with much of Maroda’s argument, particularly her views on self-disclosure, she draws attention to the importance of the question of internal and external, or, more specifically, what belongs to the analyst and what belongs to the analysand. Again, the answers to these questions are not as straightforward as one might think. Indeed, as Bromberg argues, “it is only because the line between ‘personal’ and ‘professional’ is permeable rather than hard-edged that it is possible for the therapeutic relationship we call psychoanalysis to exist in the first place” (1998, p. 13).

frame have been the subject of much debate.[95] Discussions about the frame tend to connect it to the phenomenon of transference insofar as it is assumed that the frame demarcates a particular space distinct from outside of the analytic setting wherein the illusion of transference may develop.[96] Some analysts – for example, Busch (1995) and Opdal (2012) – consider the method of free association to be the distinguishing aspect of the analytic frame. I return to these considerations below.

I argue that the frame can be used in the creation of the ego's boundaries insofar as it offers the analysand the possibility of new experiences with a transitional object. When the individual has participated in the creation of his ego boundaries, the potential space between the self and the object can thereby be creatively inhabited, with all of the risks and rewards of human vulnerability. Green, following Winnicott, implies this possibility: "[Winnicott] supplements through verbalization the lack of maternal care in order to encourage the emergence of a relationship to the ego and to the object, until the moment is reached when the analyst can become a transitional object and the analytic space a potential place of play and field of illusion" (1975, p. 17). I add that the frame itself, and not just the analyst, can become a transitional object. For the agoraphobia patient, the analytic frame may be more *accessible*, so to speak, than the analyst in becoming a transitional object. The agoraphobic is already acutely aware of the significance of crossing the threshold between spaces. While each analysand requires a certain psychical dexterity in order to traverse the threshold from the outside world into the analytic room, to put oneself onto the couch as the analysand and accept the position of the seated, out-of-sight analyst, for the agoraphobic this crossing is particularly

[95] For a recent debate on the nature and function of the frame in psychoanalytic work, see: Bass Anthony (2007a, 2007b, 2008); Bromberg (2007); Federici-Nebbiosi (2007, 2008); Gabbard (2007); Hernández-Tubert (2008); Laor (2007); and, Tubert-Oklander (2008). Despite a number of clinical, theoretical, and pedagogical disagreements, the conclusions of this debate suggest a general consensus that the analytic frame is an integral aspect of psychoanalytic work that is co-created by analyst and patient, and that negotiations to the frame, whether initiated by the analyst or the patient, must be attended to as part of the analytic work, with particular attention to the unconscious meanings implicit in frame negotiations and associations thereof.

[96] See, for example, Freud (1913) and Milner (1952). Sabbadini (1989) also connects his discussion of the frame with the development of the transference, but he uniquely emphasizes the threshold experiences, arguing for the necessity of interpreting the events that occur immediately preceding and following an analytic session.

fraught. Like the distinction between internal and external realities, the agoraphobia patient cannot take the *integrity* of the analytic frame for granted. She may, however, be capable of *performing* “minor frame violations” (Holmes 1997, p. 244) to experiment with the developing frame and, along with the frame, her developing sense of her own capacities and limitations.[97]

In order for the analytic frame to become a transitional object for the analysand, it must survive the analysand’s destruction of it, just as, paradoxically, the child must destroy the object (in fantasy) and the object must survive its destruction. This destruction is part of the transition from object-relating to object-use. The object is valuable because it survives the subject’s destruction of it; now, having survived, it can be used. The object’s survival in external reality demonstrates to the individual the imperfect correspondence between internal and external; thereby, the distinction between internal and external becomes clearer.[98] The subject begins to be able “to live a life in the world of objects,” but at the same time must accept “the ongoing destruction in unconscious fantasy relative to object-relating” (Winnicott 1959, p. 90). The child creates and destroys the transitional object; the object exists prior to the child’s creation of it and survives the child’s destruction of it. This survival of destruction is an unconscious paradox but, on a conscious level, is clear and easily understood, as Winnicott clarifies that “to survive” means to “‘not retaliate’” (1969, p. 714).

Clinically, the analyst, analytic technique, and the analytic setting must all survive the analysand’s destruction. Fromm indicates the significance of this process for the establishment of usable boundaries:

> [T]he treatment environment must be tested and used fully and survive in a vital working way for the patient to finally and securely achieve these differentiations,

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[97] Ferro notes: “As Bleger (1966) writes, breaches of the setting *by the analyst* may ultimately be useful and inevitable, but can by no means be perpetrated on purpose” (1999/2006, p. 6; my emphasis). The analyst has the responsibility of maintaining the integrity of the analytic frame. Adler and Bachant describe this analytic asymmetry: “While it is the patient’s process, it is the analyst’s situation. In the organization of the analytic situation, it is always the analyst’s obligation to safeguard the analytic dyad from potentially disruptive intrusions, whether they arise from mounting pressures within the analytic situation or from the needs of an outside party” (1996, p. 1041).

[98] As Parsons argues, “what allows experience to be processed is the separation between the representation in psychic reality and the thing itself in literal reality” (2000, pp. 174-175).

> along with the shrinking to life-size, in Harry Stack Sullivan's phrase, so joyfully experienced upon being survived. This is the task of establishing real and helpful boundaries – boundaries that are not barriers but that establish "edges" for both interchange and contact. (1995, p. 242)

The "shrinking to life-size" describes, in Lacan's paradigm, the symbolic's intersection and interruption of the limitless imaginary. In Kleinian terms, the bad objects are no longer monstrous and the good objects no longer saintly, but all objects – including the ego as one of the subject's internal objects – are experienced as something more akin to 'human, all too human.' As Fromm indicates, contact between objects becomes possible without the risk of annihilation. There are vulnerabilities, of course, but they come to be anticipated as 'worth the risk,' as they say, rather than so anxiously avoided, as the housebound agoraphobic has needed to do.

Milner provides a clinical example of the destruction and survival of the object, and the way in which the patient is able to make use of it: "The repeated discovery that I went on being friendly and unhurt by him, in spite of the continual attacks on me, certainly played a very important part [in the mutative effects of the analysis]" (1952, p. 193). She links this effect directly to her patient's developing creativity, in Winnicott's sense:

> [W]hen I began to see and to interpret, as far as I could, that this use of me might be not only a defensive regression, but an essential recurrent phase in the development of a creative relation to the world, then the whole character of the analysis changed; the boy then gradually became able to allow the external object, represented by me, to exist in its own right. (1952, p. 194)

As I note above, Winnicott distinguishes between object-relating and object-use in these terms of internal and external realities. Object-relating, as Winnicott understands it, "is an experience of the subject that can be described in terms of the subject as an isolate" (1969, p. 712). Object-use, on the other hand, requires that the object "be real in the sense of being part of shared reality, not a bundle of projections" (p. 712). In this way, through the analysand's destruction of the frame and the frame's survival (including the analyst's ability to survive: as analyst, as maintaining an analytic stance), the frame can become something like a transitional object for the analysand. Further, as Rappaport suggests, the analysand's capacity for object-use will extend beyond the specific object that has 'survived' – in this case, the analytic frame – and will ideally include the analysand's own mind (1998, p. 378).[99]

Winnicott describes the fate of the child's transitional object and elaborates the meaning of the third area of experience. The first two areas of experience are psychic reality, to which internal objects belong, and external or objective reality. The third area of experience, which Winnicott associates with cultural life, "corresponds to the infant's transitional phenomena and […] actually derives from them" (1959, p. 57). The successful use of the transitional object is required for the third area of reality to be accessible to the mature individual. The transitional object is

> gradually allowed to be decathected, so that in the course of years it becomes not so much forgotten as relegated to limbo. […] In health the transitional object does not "go inside" nor does the feeling about it necessarily undergo repression. It is not forgotten and it is not mourned. It loses meaning and this is because the transitional phenomena have become diffused, have become spread out over the whole intermediate territory between "inner psychic reality" and "the external world as perceived by two persons in common", that is to say, over the whole cultural field. (1951, p. 5)

This third reality is defined by the same paradox characteristic of the infant's relation to the transitional object: "the transitional object is symbolical of the internal object which is kept alive by the alive mother's presence" (Winnicott 1951, p. 58). Paradoxically, an experience is both created by the individual and would have existed even if the individual did not. As opposed to internal objects, which do not require any sort of maintenance from external reality, transitional objects – the use of which becomes the capacity to enjoy cultural experiences – depend upon some play between inner and outer reality. This third area of experience, characterized in part by a shared illusion and also by the exchange of internal and external phenomena, supports the difficult task of keeping the

[99] Before this development, pseudo-debility, pseudo-stupidity, and/or pseudo-imbecility may be evident. Cohn describes pseudo-stupidity as an "inhibition, characterized by a generally (not focally) diminished curiosity, intellectual interest, and astuteness relative to one's potential" (1989, p. 132). Mahler suggests that pseudo-imbecility is a particularly effective way of "restoring or maintaining a secret libidinal rapport within the family" (1942, p. 149). It is often accompanied by a similar inhibition of affect. This phenomenon is connected to the capacity for mentalization, which I discuss in Chapter Three.

ego and its objects separate and connected; that is, keeping the ego alive within and against the world. The nebulous boundaries between the agoraphobic's inner and outer realities lead to her inability to inhabit Winnicott's third area of experience, and the inability to continually navigate the paradox of individuation and object relations. Lacan characterizes the symbolic dimension in the same way as Winnicott's shared reality and emphasizes this aspect of language: we are born into a discourse that we must learn to make our own, even as it shapes us beginning before we are born.[100] Again, as Green writes, "[l]anguage [...] is the heir to the first transitional objects" (1975, p. 11). The agoraphobic, unable to inhabit this space of creativity, is unable to engage with a process of symbolization – to bear the frustration of the absence of the thing in order to name it – leading to melancholia and the persistent emptiness Milrod (2007) identifies in her agoraphobia patients.[101]

Winnicott's conception of creativity is unique and is essential to his sense of "potential space." Creativity is possible only when the fear of annihilation is not too great; creativity is possible only when one's continuity of existence can be taken for granted. Creative living is the doing that comes out of being. It is distinguished from artistic creativity by the fact that "what we create is already there"; the creative aspect involves "the way we get at perception through conception and apperception" (Winnicott 1965, p. 52).[102] Kumin connects creativity in Winnicott's sense with the experience of emptiness, the transitional object, and the process of separation-individuation:

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[100] Rey also indicates language's "personal" and "universal" meanings. See Rey 1994, p. 185.

[101] Steiner conceptualizes a pathological kind of transitional space – a psychic retreat – out of which a patient must emerge for any progress to occur (1993, p. 41). Specifically, Steiner suggests that melancholia can be thought of as a psychic retreat away from the depressive position – that is, mourning: "If the patient can shift from melancholic denial towards facing reality, then it is mourning that he has to confront and work through" (2011, p. 15). Milrod's (2007) patients seem to have replaced their 'safe' physical space of the home, from which they feared to emerge, with the psychical space of emptiness that has, indeed, removed them from an area of experiencing, thus indicating, as I argue in Chapter Three, the need for mourning in order to emerge into the painful world of vulnerability, loss, and, of critical importance, potentiality.

[102] Winnicott perhaps overstates this distinction, as Milner's productive thoughts on the analytic frame, symbol formation, and the boundary between inner and outer realities are inspired by her artistic creativity, and the inhibition of her artistic expression. Her sense of the nature of intermediary spaces is inspired by her experiences as psychoanalyst and as artist. She writes, for example: "To be able to break down the barrier of space between self and other, yet at the same time to be able to maintain it, this seems to be the

> The transitional object, and its use at bedtime to help deal with the separation represented by sleep, may therefore be viewed as the first primordial work of art: created by the infant in ‘external reality’; symbolizing the mother, her holding and her breast; regressive, but in the service of the ego; ultimately an expression of the self and utilized in its own differentiation. The transitional object is the first artistic creation and it grows out of emptiness. (1978, p. 214)

The paradox of creativity, if we are sane, is that “we only create what we find” (Winnicott 1965, p. 53).

The analytic frame can become a transitional object for the analysand if it is able to, as I describe above, survive the analysand’s destruction of it. Busch, however, emphasizes the particularly *analytic* function of the frame, suggesting that the analytic frame is characterized “by the principle that *the analysand’s free associations are the primary data upon which the two participants base their understanding*” (1995, p. 453; original emphasis). Further, he argues, “the frame I believe it is necessary to establish is that it is the patient’s free associations that we will be analyzing, for the purpose of increasing freedom of thought and the capacity to see these thoughts as psychologically meaningful” (pp. 453-454). Opdal concurs with Busch’s view, arguing that the

> analyst's main task is not to understand everything, but to sustain the analytic setting. The analyst will support the continuous flow of associations in both the analysand's and the analyst's minds as well as the evolving experience of objects and others that may be staged in the analytic setting. (2012, p. 7)

The establishment of a firm analytic frame marks a different space from all that is uncontained by the frame. Paradoxically, this containment provides a safe space in which the analysand is given a greater degree of freedom, freedom with which to experiment and be creative, to play with the psychic material that has previously been only oppressive. The analytic frame, which marks the analytic space as that in which free association is the ‘rule’ that the analysand must follow, can survive if the analyst supports the analysand’s developments of free and freer associations.[103] The analyst must be aware

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paradox of creativity” (1950, p. 144). Artistic creativity and creative living might therefore both depend on the same psychological processes of finding and creating reality.

[103] R. Lowenstein argues that the analytic setting is part of the fundamental rule and helps to facilitate free association (1963, pp. 458-459). I investigate these elements of the analytic process – the fundamental rule

of, and beware of, her own resistance to the psychoanalytic process, be cognizant of the things she does not want to hear the analysand say. The analyst must maintain her *own* boundaries between internal and external in the onslaught of the analysand's – particularly the agoraphobic's – unconscious destruction of them.

In Chapter Four, I argue that it is necessary to follow the method of free association particular to psychoanalysis in order to effectively address the agoraphobic's persistent emptiness. Part of the efficacy of free association is, as Bollas articulates, its nature as "creative destruction" (1995, p. 53). Using the destructive drive in the service of creation parallels the creative differentiation at work in the construction of the ego's boundaries. Thus, establishing and maintaining the analytic frame in the sense that Busch describes – that is, as demarcating the analytic space as particular insofar as the analysand's free associations are the primary data of analysis – is particularly useful in countering the therapeutic emphasis on interpreting the transference, which, following Bollas (2013), can lead to the inhibition of the development of free association.

2.4. Conclusion

Agoraphobia is a problem of boundaries; it is the psychic defence against the insufficient capacity to experience the world with others without being consumed by them or destroying them, to share external reality while maintaining ego integrity. Rather than risk the loss of reality from the threat of a world that is too big, that threatens to overwhelm and engulf, the agoraphobic closes herself off from experiencing the world at all and in so doing loses herself regardless. Neither the world nor the self is wholly satisfying to the individual; one must learn to navigate the in-between and risk the disintegration of boundaries in order to establish them. The agoraphobic's threshold anxiety indicates a lack of clarity as to what is internal and what is external, which leads, paradoxically, to the absence of "the illusion of a shared world" (Hämäläinen 2009, p.

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and the method of free association – in detail in Chapter Four, as well as the relationship between the free associative process and the development of the transference.

1286). Instead of illusion, the agoraphobic experiences the shared world as terrifyingly real.

The agoraphobic patient is overwhelmed by her anxieties, but the correspondence between the psychical processes of the agoraphobic patient and the normally developing infant indicates that a developmental tool – namely, the transitional object – may be of use in the relief of the agoraphobic symptoms of anxiety and avoidance, and also in the development of a capacity for object-use, which would, I suggest, relieve the persistent emptiness Milrod (2007) identifies. Clinically, the analytic frame has the potential to become a transitional object for the analysand. Language (as both perception and representation), and the particularly psychoanalytic method of free association, is the means by which this potentiality can be realized. The possibility of new experiences with a transitional object – if it can survive the analysand's destruction of it – allows the frame to be used in the creation of the ego's boundaries. The non-correspondence between the unconscious destruction of the internal object and the survival of the external object creates and clarifies the individual's sense of internal versus external, which the agoraphobic has thus far been unable to take for granted. Once ego boundaries are established, the potential spaces between self and other, and between the ego and its objects, can thereby be creatively inhabited, with all of the risks and rewards of human vulnerability.

Chapter Three: Agoraphobia and Emptiness

In Chapter One, I argued that agoraphobia involves a profound anxiety about the boundaries *between* spaces, both physical and psychical. This anxiety is fuelled – if not caused – by the inability to symbolize (or, more specifically, to engage in the creative process of symbolization). In Chapter Two, I expanded on the nature of this anxiety and argued that the agoraphobic is not able to take for granted the distinction between internal and external, and therefore cannot experience shared reality as *illusion*. This illusion of shared reality is necessary for the creative uses of language. The arguments of both chapters are informed by Milrod's (2007) finding of persistent emptiness in agoraphobia patients whose symptoms of anxiety and avoidance have remitted. In this chapter, I consider Milrod's article in detail and provide an analysis of the meanings of emptiness in the psychoanalytic setting.

Standard psychiatric treatment of agoraphobia includes cognitive behavioural therapy (CBT) combined with pharmacotherapy. This treatment is often effective in the remission of overt agoraphobic symptoms.[104] However, the incidence of relapse is striking, with rates between 83% and 91% when medication is discontinued without prolonged maintenance treatment (Wiborg & Dahl, 1996). Milrod, one of the foremost contemporary theorists of agoraphobia, addresses this problem from a psychoanalytic perspective, presenting case material of agoraphobia patients who are technically in remission but experience a persistent psychic emptiness, which, she suggests, may contribute to agoraphobia's chronicity (Milrod 2007). Given the important implications of her finding of persistent emptiness in agoraphobia patients for the successful treatment of the disorder long-term, that is, the need to address this persistent emptiness in agoraphobia patients for whom panic symptoms have remitted, I critique Milrod's analysis of the persistent emptiness and propose an alternative explanation with clinical implications.[105]

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[104] I discuss the characteristic symptoms and various definitions of agoraphobia in Chapter One. Here, I am referring specifically to the *DSM* definition and the particular symptoms of high levels of anxiety and avoidance of the world outside a self-defined safe space.

[105] These findings have not otherwise been addressed in the literature. Strubbe and Vanheule (2014) provide a technical counterpoint to Milrod and colleagues Panic-Focused Psychodynamic Psychotherapy

In the first section, I consider the plurality of possible meanings of emptiness in the psychoanalytic clinic. This first section is composed of three subsections: in the first, I consider Milrod's suggestion that persistent emptiness may be indicative of a development deficit in the form of a weak reflective function. In the second subsection, I argue that assertions of emptiness in the analytic situation precisely indicate the unconscious presence of strongly warded-off emotional or cognitive experiences. The nature of these experiences must be explored with each patient, as they will naturally vary among individuals. The majority of the psychoanalytic literature on emptiness accords with Milrod's interpretation of unconscious rage. However, in the third subsection, I argue that the clinical material Milrod provides supports an alternative interpretation, namely, that the subjective experience of emptiness in agoraphobia patients commonly indicates the presence of significant losses that have yet to be mourned. In the second section, I provide an analysis of agoraphobic anxieties in the normal process of mourning. As part of this analysis, I propose several explanations as to why agoraphobia patients, in particular, defend against mourning. In the third section, I argue that a structural emptiness exists in all individuals along with the pathological emptiness evident in certain patients. Pathological emptiness, I argue, is a complex defense organization that masks overwhelming unconscious material; for the agoraphobia patient, pathological emptiness is a defense against one's own aggressivity and the painful experience of overwhelming loss. Structural emptiness, on the other hand, and as Winnicott argues,[106] is the basis for all learning; it is an aspect of the psychical apparatus that allows for the possibility of new thoughts, feelings, and experiences. An understanding of structural emptiness does not elucidate the particular meaning of pathological emptiness, but it does provide a technical counterpoint to the therapeutic emphasis on the transferential relationship. As I argued in Chapter Two, and below, structural emptiness is a

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(PFPP), offering an account of a Lacanian psychoanalysis of a panic patient, but they do not address the persistent emptiness Milrod (2007) identifies in agoraphobia patients. Reed (2009) refers to Milrod (2007) only obliquely in an article on Green's concept of the void; she does not consider agoraphobia, nor does she directly address the emptiness Milrod identifies.

[106] See Chapter Two for my analysis of Winnicott's arguments. Briefly, emptiness is a psychical response to hunger; hunger stimulates aggression, which is necessary for healthy ego development insofar as the self must reject all that does not belong to the self in order to establish the boundaries between self and other. Further, the experience of emptiness is the basis of all learning and of all new experiences.

consequence of entering into a language system; by following the psychoanalytic method of free association and abiding by the fundamental psychoanalytic rule – the pact between the analysand and the analyst of complete candor and complete discretion respectively – the analytic couple can make use of this structural emptiness in order to elucidate the individual meaning(s) of pathological emptiness.

3.1. Meanings of Emptiness

We are all familiar with the feeling of being "full of emptiness." Emptiness is positive, in sensation, just as darkness is felt as an actual thing, not the mere absence of light, whatever we may know. Darkness falls, like a curtain or a blanket. When the light comes, it drives away the darkness; and so on.

(Isaacs 1948, p. 88)

Milrod (2007) presents the case studies of two agoraphobia patients, Deborah and Rita. Deborah began treatment of twice-weekly psychodynamic psychotherapy at the age of twenty-one for panic disorder with severe agoraphobia. Although enrolled as a college student, she was unable to attend her classes due to the increasing severity of her symptoms. Anxiety began affecting her school attendance in junior high, though her main complaints were nausea and dizziness. Milrod's report indicates that Deborah's mother experienced severe separation anxiety when apart from her daughter and limited Deborah's social involvement in outings that would result in their separation. Deborah was an only child with "a childlike manner" and she "ascribed magical, omnipotent powers to her parents at times of heightened anxiety" (Milrod 2007, p. 1012). She "wound up repeatedly disappointed and furious if they too ran into difficulties managing practical problems" (p. 1012). Her agoraphobia remitted after eight months of treatment, after which emerged the quality of "emptiness." Rita began four-times-weekly psychoanalysis at the age of twenty-nine for worsening panic disorder and severe agoraphobia, despite increasingly aggressive pharmacotherapy and several attempts at CBT. Her anxiety and agoraphobia symptoms began at the age of eighteen. Following her first panic attack and a six-week period of being housebound, she was able to return to school with the aid of pharmaceutical intervention. She worked with her father and lived with her husband in her parents' home. Rita was terrified of being alone and arranged her time accordingly; any moment she was alone, even at work, she watched television to "help take her 'mind off stuff'" (p. 1016). She also exhibited claustrophobic anxieties, walking up and down twenty-two flights of stairs every day at work rather than taking the elevator. Rita was an only child, and her parents were "nearly absent" (p. 1016) during her childhood. Rita's mother had a phobia of being touched and Rita couldn't recall ever being embraced. Rita's history is quite different from Deborah's, though their experiences of emptiness are similar.

Milrod's description of emptiness includes both an emotional and an intellectual aspect. She defines the clinical phenomenon that she observes in her agoraphobia patients as an "inner constriction" that "affects [their] ability to think independently and to lead emotionally full and intellectually broad and stimulating internal lives" (2007, pp. 1008-1009). Milrod refers to the phenomenon variously within her article as "emptiness" (p. 1007), "inner constriction" (p. 1008), "internal vacancy" (p. 1009), and "subjective sense of incompleteness" (p. 1010) without remarking on the very different meanings of each of these terms. The complexities of the subjective phenomenological experiences of this emptiness are evident from the connotations of these various terms: emptiness implies a nothingness and a complete absence; constriction implies an intense anxiety; and, incompleteness implies a something missing along with the presence of something else. All of these meanings accord with Milrod's descriptions of her patients' experiences at certain moments; however, Milrod's use of these various terms without clarification obscures her intended meaning, which remains unclear throughout the article; or, rather, the complexity of the phenomenon she encounters in her patients remains to be explicated.

Milrod argues that it is necessary to determine clinically (and individually) whether the manifestation of emptiness in analysis is strictly defensive (evident in the transference) or whether the patient does not have the capacity for thinking about her own feelings.[107] Milrod points to Levy's (1984) excellent article on emptiness as a reminder to

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[107] Bion makes a similar distinction regarding types of pathology, summarized by Ferro: "As we know, Bion distinguishes two types of pathology. The first and more serious concerns a deficiency of the α

distinguish between these two interpretations of emptiness; however, her emphasis on maintaining this distinction overshadows the multiplicity of meanings a single patient's experience of emptiness may encompass. I return to Levy's article in order to emphasize a different point, namely, that emptiness is neither straightforward nor simple. That is, emptiness in the analytic situation "differs from patient to patient both in how it feels and in its particular *dynamic meaning*" (Levy 1984, p. 388; my emphasis). Singer makes a similar point: the state of emptiness "reflects a spectrum of meanings at one and the same time" (1977a, p. 460). As with most expressions encountered in the course of an analysis, the specific meaning or meanings of emptiness must be explored with each patient and within the context of the analytic situation and the particular analytic moment. Emptiness includes the patient's statements of feeling empty and the subjective experience of that feeling (for the patient and for the analyst, who may approach some experience of the patient's emptiness in various ways, including, for example, through the countertransference). It bears repeating that the meanings of emptiness cannot be assumed to be fixed.[108]

function, in which the inability to transform β into α elements is lacking, so that the former are evacuated, giving rise to hallucinatory and psychosomatic disorders, characteropathies, etc.; while the second, in which the α function is unimpaired, is observed when the apparatus for thinking thoughts is incapable of 'handling' or using these thoughts" (2002, p. 67). See Wilde (2003) for her important analysis of the relationship between agoraphobia, and the α [alpha] function.

[108] The common fantasy that meaning is stable and shared often results in striking miscommunications, a particularly dangerous interference in the analytic process. This fantasy exists in Lacan's *imaginary* dimension, or register. Fink describes the nature of this potential interference: "In the imaginary register, I am focused on what I believe the other person is saying and trying to say as opposed to what the other is actually saying. Insofar as I operate in the imaginary register, I cannot hear a slip of the tongue, because I immediately correct it in my mind with what *I* believe the other meant to say. I do not really need to hear the other speak, because I think I already know what he is going to say, believing that I comprehend his point of view even before I hear it" (2010, p. 266). Or, in Lacan's words: "the unconscious shuts down insofar as the analyst no longer 'supports speech [*porte la parole*],' because he already knows or thinks he knows what speech has to say" (1955/2006j, p. 297). Bion makes this same point, arguing that the analyst must suspend his memory, desire, and understanding in order for analytic work to be possible (1984, pp. 143-145, 151). The capacity to tolerate the presence of emptiness is directly related to the capacity to tolerate the movement between coherence and incoherence; I expand on this point in Chapter Four. For now, let me emphasize the complexity of emptiness's meanings, which is also evident in Levy's enumeration of emptiness's multifacedness: "[e]mptiness may appear as a complaint of feeling empty, as a fear of being empty, or as a belief that someone else is empty. Emptiness may appear along with feelings of depression, boredom, rage, restlessness, unreality, or may be felt as the entirety of experience, precluding

Milrod's priority and, in my view, the success of her article, is the identification of this emptiness in agoraphobia patients. Secondarily, she offers a number of potential suggestions to explain this phenomenon. At times, it is difficult to distinguish between Milrod's descriptions of the phenomenon and her explanations for it. The first explanation I discern is the possibility of a developmental deficit in the form of a weak reflective function (RF).[109] Milrod and I agree that RF, as I detail below, refers to the ability to conceive of mental states in one's own and in others' minds, as well as to conceive of the otherness of others' mental states. However, there is the possibility of inferring from the phrase "developmental deficit" the sense that these patients' experiences and assertions of emptiness indicate an *actual* emptiness. For example, Milrod writes: "These patients cannot go out by themselves. The question is, can they think for themselves either, and if not, why not?" (2007, p. 1011). I caution against this interpretation of pathological emptiness as it risks, as I argue below, perpetuating the deeper elements of agoraphobia. Glucksman (2000), for example, makes the distinction between defense and deficit in patients with affect dysregulation. His clinical report, however, is of a single patient exhibiting both types of affect dysregulation, indicating the defensive aspect of any kind of "deficit." While the term "developmental disturbance" is surely apt, and we can speak of "deficits of self-representation," it is, I suggest, both imprecise and misleading to speak of a developmental deficit. I argue, contrary to Milrod, that the agoraphobic's persistent emptiness neither indicates an actual emptiness nor can it be explained by a "developmental deficit" in the form of a weak RF. Further, I contend that Milrod seems to conflate RF with conscious introspection. I am not suggesting that these patients do not have a weak RF. I am suggesting, rather, that these patients'

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any other feeling" (1984, p. 388). Even if the experience of emptiness "preclud[es] any other feeling," there are always feelings about the emptiness, including, for example, frustration, fear, and/or pride.

[109] In Rudden et al. (2003), which Milrod co-authored, the authors imply that they agree with Kessler, who argues against "reductionistic 'deficit theories' for panic disorder" (1996, p. 1001). It appears, then, that Milrod favors a 'deficit theory' for the emptiness she finds in agoraphobia patients but not as a theory of panic disorder itself. Rudden et al. (2003) is not cited in Milrod (2007), and clarification of this apparent complication is not provided. Further, Milrod argues that panic-focused psychodynamic psychotherapy (PFPP) with a focus on strengthening RF is an effective treatment for panic disorder; thus, according to her view, an increase in RF is associated with a decrease in panic symptoms. However, it is not clear how, in her view, a weak RF explains the persistent emptiness apparent beyond the agoraphobic symptoms of anxiety and avoidance, which have presumably been alleviated by an increase in RF.

assertions of emptiness in the analytic session cannot be explained by appeal to the RF in either Milrod's use of the term or in the sense Fonagy (1991) originally uses it (which I explicate below). The second explanation Milrod presents for her patients' persistent emptiness is the repression of overwhelming affects, specifically rage.[110] Milrod's identification of repressed rage hiding behind emptiness accords with much of the literature and I do not disagree with her interpretations of repressed rage. However, I offer an alternative analysis of patients' experiences and assertions of emptiness based on the clinical material Milrod provides: I argue that the phenomenon of emptiness Milrod identifies can be better explained by the presence of traumatic and unmourned losses.

Green's theories of the negative are useful and, as of yet, underemployed in understanding the clinical phenomenon of emptiness, which – diversely conceived – is a well-noted phenomenon. The negative, as Kernberg writes in his introduction to Green's work, "exceeds by far the death drive, but also includes the expression of the death drive as an ever present, intrinsic and unavoidable aspect of all object relations" (1999, p. xiv). Importantly, Green identifies the work of the negative not only in what he calls the aggressive expressions of the death drive (expressed directly as attacks on self or other) but also in what he calls the destructive aspect of it. This "disobjectalising" function of the death drive is characterized by a withdrawal of investment: "Destruction without aggression can be expressed in a radical withdrawal from objects, or in a tendency to eliminate the very self as an agency searching for satisfaction" (Kernberg 1999, p. xv). However, as I discuss in more detail below, the negative, according to Green's theorizations, is not fundamentally pathological; rather, the pathological expression of the negative is only a "'negativisitic' vicissitude of a potentially creative negative which suffering, rage and impotence have distorted and transformed into psychical paralysis" (Green 1999, p. 5). This description allows us to connect Green's concept of the negative with Winnicott's sense of emptiness as the basis of all learning and all new experiences.

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[110] Milrod also asks: "From a more behavioral perspective, is it simply that it is only people with no interest in self-reflection, no curiosity about themselves or the rest of life, who can tolerate the restrictions engendered by agoraphobia?" (2007, p. 1009). However, she does not appear to consider this as a viable suggestion and does not provide any further reflection on the possibility.

Green's theorizations are relevant here for two reasons: firstly, he draws attention to the structural aspects of the negative and, thus, emptiness. That is, the negative is an integral aspect of the ego, not ever only a deficit or a defense. I discuss this element in detail below, in Section 3.3. Secondly, Green articulates the connection between the negative and melancholia, and identifies melancholia as a particular instance in which emptiness – or, the negative – becomes something else, or rather, takes on a different, more pervasive character. I discuss this element in Section 3.1.iii. Briefly, in melancholia, the negative acquires a greater complexity, to wit:

> We are in an all-too-present world of suffering resulting from loss, but the one who is suffering cannot know either what he is suffering from or what has caused his suffering. The more the suffering presents itself as an excess of internal presence caused by the absence of the lost object, manifesting itself by a psychic pain, the less the ego knows the nature of this suffering (the hate which is underlying it) and that of the object which causes it. (Green 1999, pp. 53-54)

The absence of a lost object, then, can become more present than any original presence. This excessive presence of an absence characterizes melancholia and also, I suggest, the persistent emptiness Milrod (2007) describes in her agoraphobia patients.

3.1.i. Emptiness as Deficit

As I indicate above, Milrod suggests that agoraphobics' restricted exploration of the external world is paralleled by an equally challenged exploration of the inner world, of "reflecting on their lives or feelings, or permitting themselves to experience their feelings at all" (2007, p. 1009).[111] Milrod utilizes the concept of mentalization, which Fonagy introduces and defines as "the capacity to conceive of conscious and unconscious mental

[111] Bodin (1996) anticipates much of Milrod's argument and provides a clinical example of a patient suffering from "claustra agoraphobia" who used practical or physical activities, and an inhibition of her mentalizing capacities, as a psychic retreat from overwhelming emotional situations. Although Bodin suggests that Miss P's increasing ability to mentalize effectuated her decrease in panic symptoms, he also describes her painful realization that her father had sexually abused her. Although Bodin does not offer details of this aspect of the analysis, some mourning is implied, as the realization "made her see herself as an orphan" (p. 187). Bodin also notes the patient's movement from the paranoid-schizoid position to the depressive position, again implying the work of mourning in the progress of the analysis and the alleviation of the patient's panic symptoms.

states in oneself and others" (Fonagy 1991, p. 641), as one way of thinking about her patients' inner constriction. Milrod argues that the emptiness she observes in her agoraphobia patients might indicate an inhibition of the operationalized form of mentalization, that is, a weak RF (pp. 1009, 1011). She suggests that this persistent emptiness, like an inhibition of the RF, is indicative of a profound inability to relate to others. Her argument that her agoraphobia patients' persistent emptiness is connected to a deficient RF is consistent with her findings (with colleagues) in a pilot study, "Reflective Functioning in Panic Disorder Patients" (Rudden et al. 2006), which supported the following hypothesis (based on clinical observations): "panic disorder patients use defenses involving 'not knowing' to defend themselves against the highly charged and conflicted affective states connected with their symptoms" (p. 1342). Significantly, despite the inferences Milrod draws, this study did not show that a higher RF was associated with any significant change in panic symptoms (Rudden et al. 2006, p. 1342), which suggests that what is "not known" is something other than unconscious emotional/impulse conflicts. That is, despite Milrod's (2007) suggestion that her patients experience emptiness as a symptom of a deficient or inhibited RF – in other words, an inability to mentalize – the significance of real events that may have contributed to a limited RF (and thus led to her patients' experiences of emptiness) is not explored. This possibility is also not suggested by Rudden et al. (2006). I argue that the analysand's assertions of emptiness in the psychoanalytic setting are always, at least in part, defensive. The *experience* of emptiness is, in fact, a developmental achievement, and may be used either defensively or productively, as I argue in more detail below.

I return to Fonagy's initial conceptualization of mentalization in order to clarify what the term is meant to refer to, and to indicate its limited applicability in Milrod's (2007) patients. I argue that appealing to the concept of mentalization, or the capacity for RF, as an *explanation* for assertions of emptiness assumes a causal relationship between the two where only a correspondence can be shown; that is, do these patients experience, or assert, feelings of emptiness *because* they have a deficient RF or does the concept of RF merely describe, and not explain, the pathological experience of emptiness? Fonagy

(1991) links the "capacity to *mentalize*"[112] with the capacity for symbolization, although he prefers the specificity of the concept of mentalization given the wide array of meanings related to symbolization in the psychoanalytic literature.[113] However, despite this terminological manoeuvre, mentalization and symbolization are conceptually linked; that is, mentalization is a process of representation, with significant consequences for the individual's experiences of self and other. Without this capacity, the separation of self and other (or self and object) is constantly threatened (Fonagy 1991, p. 642). The tenuousness of this separation, or boundary (as I argued in Chapter One), is a fundamental aspect in agoraphobia. Furthermore, the representation of affect, as idea, "is crucial in the achievement of control of overwhelming affect" (Fonagy 1991, p. 642). The inability to *idealize*, or represent affects mentally, of both self and other, consequently means that "affect in others can be appreciated only through direct experiencing via emotional resonance" (p. 642). That is, for those with an inability, or limited ability, to mentalize, affective experiences of others are knowable only through an elision of the divide between self and other. This affective experience is easily overwhelming. The subjective experience of emptiness can be used as a defence against the overwhelming experience of an other's affective life *because* the boundary between self and other is only, if at all, nebulously conceived. The agoraphobic asserts her own emptiness in order to avoid being overwhelmed by her own emotional reality (specifically, her unconscious rage and/or unresolved loss) and, because of her inability to distinguish between her own emotional reality and that of her objects, to defend against being overwhelmed by others' emotional states. I am not, then, suggesting that Milrod's (2007) patients do not exhibit a weak or inhibited RF; I am suggesting, on the one hand, that assertions of emptiness cannot be *explained by* an inhibition of the RF and, on the other hand, that assertions of

[112] The concept of mentalizing, though introduced and elaborated by Fonagy, is evident in the early work of Ferenczi (1926). Ferenczi introduces the term *psychophobia* to describe the inhibition of what Fonagy will later call mentalization. Psychophobia is a regression to a "purely materialistic phase, characterized by excessive (perhaps even entire) projection (Ferenczi 1926, p. 318). For Ferenczi, negation, as a capacity for differentiation, is connected with autonomy. The ability to conceive of mental states in others' minds, as well as the otherness of others' mental states, is a critical component of the mentalizing faculty. Negation and the capacity to tolerate one's own aggressivity are thus intimately linked with the reflective function.
[113] I discussed symbolization in the psychoanalytic literature briefly in Chapter Two. In this thesis, my use of the term symbolization refers to the use of language as a system of symbols. Engaging in a process of symbolization, then, simply means putting one's thoughts and feelings into words. See also infra note 6.

emptiness do not indicate a developmental deficit. As I indicate above, it is, in my view, more accurate and productive to describe this psychical phenomenon as a "developmental disturbance" in the form of a "deficit of self-representation."

Fonagy and Target suggest that the psychological impetus for the development of RF is as follows: "By attributing mental states to others, children make people's behaviour *meaningful* and predictable" (1997, pp. 679-680; original emphasis). The capacity does not depend on a particularly high level of intellectual activity; rather, the emphasis is on behaviour rather than cognition. Fonagy and Target emphasize that the point "is *not* that the individual should be able to articulate this [knowledge] theoretically" (1997, p. 680; original emphasis). Further, they distinguish RF from the conscious act of introspection: "Introspection or self-reflection is quite different from reflective function as the latter is an automatic procedure, unconsciously invoked in interpreting human action" (p. 681). The intellectual gains Milrod identifies in her patient, Rita, as indicative of an improved RF, then, are not consistent with Fonagy and Target's development of the concept. Milrod indicates that Rita "was able to see that Laura [her daughter] was in part expressing despair about the emotional and physical distance her mother seemed to require from her, and she also recognized that she herself must have been in a similar emotional situation with her own mother"; Milrod suggests that this recognition "demonstrates considerable improvement in reflective capacity" (2007, p. 1020). However, Milrod appears to be conflating reflective capacity with conscious introspection, and mistakenly characterizing the cognitive and intellectual gains Rita has made as unconscious emotional knowledge. Milrod indicates the limits of Rita's gain as a conscious development insofar as "this understanding did not alter Rita's need to distance herself from Laura and her emotional demands, nor did it make her more empathic with her daughter's distress" (2007, p. 1020). Again, despite Milrod's characterization of this intellectual understanding as a gain in reflective capacity, it lacks the unconscious dimension by which that capacity is defined. The limited development of RF is likely connected, in my opinion, to the relationship of Rita and Deborah to their phobic companions (often mothers), whose behaviour was "routinely self-absorbed or thoughtless and controlling toward them" (p. 1021). Although Milrod indicates, and I agree, that this "parental input" cannot be considered the sole etiological factor in the development of agoraphobia, this thoughtless behaviour could be (and ought to be) considered a key element in the patients' inhibition of their RF. The relevance of parental treatment of these patients as objects rather than as thinking and feeling individuals clearly affects the patients' own sense of themselves as thinking and feeling individuals. I suggest, then, that the development of agoraphobia and the development, or inhibition, of RF follow two independent courses. This suggestion is supported by much of the research on RF in individuals with, for example, borderline personality disorder (see, for example, Levy et al. 2006). It is also supported by Graf (2009), the results of which determined that the capacity for reflective functioning is not related to the severity of an individual's agoraphobia.

Fonagy (1991) indicates that the inhibition of the RF (mentalization) is in itself a defensive function, even as it prohibits the development of more mature defensive functions such as repression. This point is sometimes lost in subsequent discussions of mentalization (which is now a popular concept in contemporary circles). To emphasize, then: mentalization is a capacity that depends on particular environmental factors in order to develop interrelationally; *and*, the inhibition of mentalization is also a relatively primitive defense brought about by psychic trauma. These two factors are undoubtedly related insofar as the psychic trauma that the inhibition of mentalization responds to is most likely not uncommonly the failure in some way of the facilitating environment to provide the necessary factors for the safe development of the mentalizing capacity: to *practice* mentalizing. This connection is suggested by Fonagy's presentation of some case material of a borderline patient, Mr. S,[114] marked by an inhibition of his mentalizing capacity and also by severe abuse suffered at the hands of his father and a severely depressive and intermittently suicidal mother.[115]

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[114] Mr. S's referring psychotherapist characterized him as narcissistic, schizoid, and prone to intellectualizing affective life. Fonagy notes his "transient psychotic-like episodes" (1991, p. 642). Again, I emphasize the complexities of psychic life and the co-existence of schizoid, psychotic, neurotic, and normal elements. While Fonagy develops the concept of mentalization through his work with borderline patients, he clarifies his own use of the term "borderline" as more descriptive, in distinction to the psychiatric diagnosis.

[115] As becomes increasingly clear to Fonagy through the course of the analysis, this patient's "experience of his mental self as empty, his experience of me [Fonagy] as non-human and his apparent inability to conceive of my [Fonagy's] mental state to a degree that might permit communication could be understood

Fonagy details the defensive aspect of the inhibition of the mentalizing capacity, arguing that, at least in the case of borderline functioning, [116] the inhibition of mentalization is "self-imposed and partial" (1991, p. 651). Even in the context of RF, then, the assertion of a psychic emptiness ought never to be taken as a purely descriptive manoeuvre; the subjective experience of emptiness does not indicate an absolute emptiness, but rather an inhibition of the awareness of *aliveness* due in part to an incomplete (or malformed; perverted) sense of the other in the self and the self in the other. Singer offers some clinical vignettes of borderline patients which support this argument and from which he similarly concludes: "behind the defensive scotoma or erasure, was the unacceptable and painful sensations rather than a structural defect" (1977a , p. 465).[117] The significance of emptiness thus exceeds reflective functioning's definitional reach. While a limited capacity to reflect on one's own mental state, and on thinking and feeling more generally, likely results in an experience of emptiness, the agoraphobic's experience of persistent emptiness is not sufficiently explained by a

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as *an inhibition of and defence against* conceiving of his own or his objects' mental functioning" (1991, p. 647; emphasis added). Again, a limited reflective function is already indicative of a defensive inhibition, even as it also indicates some inability to mentalize.

[116] Connections between Fonagy's description of his borderline patient and the persistent emptiness Milrod describes in her agoraphobia patients are evident. Fonagy writes of his experiences with his Mr. S: "It was not just his expressionless voice and matter-of-fact, harsh way of speaking but also the content of his utterances that left me with a *sense of emptiness* which I gradually realized was an echo of something that Mr. S experienced" (1991, p. 644; my emphasis). Following a "bad" dream of "*a bureau with many drawers*" which "*should be full, yet* […] *were empty*," Fonagy interprets Mr. S's "fear of finding only emptiness in himself and me [Fonagy]" and his fear that his relationship with Fonagy, experienced as an intimacy, "might replace his [the patient's] emptiness in a way that threatened to make him feel entrapped and suffocated" (p. 644; original emphasis). Fonagy describes this movement between the fear of a vast, isolating emptiness and the fear of a suffocating intimacy as "claustra-agoraphobic shuttling" (p. 644, n. 1), again underscoring the connections between the type of borderline patient/behaviour Fonagy uses to exemplify the concept of mentalization and the anxieties of the agoraphobia patients discussed here. Fonagy suggests that, given the patient's inability to mentalize, "analytic self-reflection could only yield to him a nameless dread of *mental emptiness*" (p. 644; my italics). Milrod also notes her patients' dread of their own emptiness, further suggesting that this emptiness is not a pure emptiness, but is rather an emptiness replete with affective meaning. Significantly, and perhaps a notable distinction between the experiences of borderline and agoraphobic patients, Fonagy's patient seemed to experience his emptiness as "a background against which the rest of the analysis took place" rather than as "a peremptory response to anxiety" (p. 644).

[117] See Kohut (1971) for an example of an argument for the deficiency state of emptiness. Similar to Milrod, he argues that an empty state occurs due to the failure to internalize the idealized object at a particular stage of development due to experiences of disappointments, frustrations, and absences.

deficiency in reflective functioning. Further, while agoraphobia patients exhibit an inhibited RF, it is not their assertions of emptiness that tell us so.

Here, Green's (1999) concept of negative hallucination[118] may be instructive. Referring specifically to work with borderline patients,[119] Green draws our attention to particular moments when the analysand fails to understand the analyst's words, or fails to recognize her own words when the analyst's reminds her of them: he identifies such moments as involving a "psychical agnosia"[120] (1999, p. 175), a term that, in my view, encompasses the existence of psychical material and the analysand's inability to access it. While this inability may correspond to a weak or underdeveloped RF, there is no confusion about an analysand's assertions of emptiness being taken as fact.

Milrod suggests a possible meaning of emptiness in the clinical situation that is particular to the agoraphobic: "fears of the unsafe external world reflect and mirror an inner fear of the internal world, or of thinking and intense emotions" (2007, p. 1010). The implication of Milrod's argument is that the overt symptoms by which agoraphobia is defined conceal the covert aspect of this pathology; external space is anxiously avoided as a projection of anxieties about internal (that is, psychical) space, including one's impulses and object relations. The implication of this suggestion supports my argument

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[118] Green distinguishes between repression – "employed against the internal processes of drives, affects, and representations" – and negative hallucination, effectuated against either internal or external perceptions, and cautions against confusing perceptions and representations (1999, p. 194). As I indicated in Chapter Two, language is both a representation and a perception (we find it and we create it): "it represents the relation between things and the relations of thought relations making it possible for the latter to be perceived" (Green 1999, p. 197). Language's doubled nature as both perception and representation leads Green to distinguish "the silence of an absence of speech" and the silence "of the formation of words as tools for thinking" (p. 197). This latter silence characterizes negative hallucination and may be linked to Bion's concept of the alpha function, or the absence of the capacity to think thoughts and to make experiences (beta elements) meaningful. See also infra note 107.

[119] Green links negative hallucination to alexithymia and psychosomatosis without much elaboration (1999, p. 174); the kernel that connects them is the inability to symbolize, or nominate, unconscious affects and thus *to have* them.

[120] Freud (1891) introduced the term "agnosia" to describe a neurological disturbance in the recognition of objects. Contemporary neuropsychology distinguishes many types of agnosia, which can affect visual, tactile, or auditory objects. Despite its symptoms, agnosia is not a disorder of the senses. Rather, for those with agnosia, a normal part of their life "has somehow been stripped of its meaning" (Teuber 1968, p. 293). See also Heilman and Valenstein (2011). Green's suggestion of "psychical agnosia" precisely implies the individual's inability to recognize or process words of psychical and emotional significance.

that the concept of RF cannot be utilized to explain the agoraphobic's persistent emptiness and, more specifically, that the inhibition of RF is always to some degree defensive. That is, emptiness does not only involve the incapacity for self-reflection, but indicates a defense against what reflection reveals. The outside world still exists, even if the agoraphobic never ventures beyond the threshold of her self-defined safe space; likewise, the inner world is never "empty," though it may remain unexplored.

3.1.ii. Emptiness as Defense

The patient's declaration of emptiness in analysis indicates a paradox: while it serves a defensive function, it also draws attention to the repression of unbearable or forbidden thoughts and feelings. Klein argues that "certain manifestations of very acute anxiety and the specific defence mechanisms against this anxiety (*particularly an increase in denial of psychic reality*) indicate that an internal situation predominates at the time" (1940, p. 365, n. 1; my emphasis). Although Klein is not referring to agoraphobia or emptiness in particular, the relevance is clear: emptiness can be seen as a defence mechanism against very acute anxiety insofar as it involves "an increase in denial of psychic reality." The very declaration of this emptiness points to the fact of an overwhelming internal situation. The expression of emptiness "becomes in this sense *the conscious experience* of the absence of warded-off wishes along with their associated fantasies" (Levy 1984, p. 389; my emphasis). Emptiness is related to negation[121] insofar as "a positive assertion that something is not there is required to maintain repression" (Levy 1984, p. 389). Negation is "already a lifting of the repression, though not, of course, an acceptance of what is repressed" (Freud 1925b, p. 236). The same psychical movement is apparent in complaints of emptiness: there is *something* identified as emptiness, though the affective content (or the historical reality) of that something, of the emptiness, remains repressed.

[121] See Chapter Two for my discussion of the intellectual function of negation and its role in the development of a sense of self distinct from the world. Insofar as the individual uses negation as a mediator between external reality and psychical reality, it relates analogously to assertions of emptiness: that which is denied must first be unconsciously understood to exist. This denial must be treated appropriately, as a marker of a significant unconscious presence. Negation is a specific, and relatively sophisticated, psychical process that may be considered a manifestation of Green's concept of the negative.

As Freud observed, “we never discover a ‘no’ in the unconscious and […] recognition of the unconscious on the part of the ego is expressed in a negative formula” (1925b, p. 239). Therefore, the assertion “I am empty” already indicates the presence of something unconscious. Levy emphasizes this critical point regarding experiences of emptiness: assertions of emptiness may not always be predominantly defensive, but they are never only descriptive; that is, the analysand’s assertions of emptiness cannot be taken as accurately and comprehensively describing her inner world, however “empty” she may feel. A patient can express the subjective feeling of emptiness, but, as indicated above, the subjective feeling of emptiness is the conscious experience of unconscious material: the manifestation of latent meaning: “emptiness, despite its conscious assertion of the absence of something, portrayed in spacial and bodily terms, always consists of more or less specific latent mental content which, when brought to light, helps delineate and clarify the mental activity [...] represented by emptiness” (Levy 1984, p. 396; internal reference omitted).[122]

Emptiness is also related to negation insofar as meaning is established by discrimination or exclusion, a necessarily aggressive repudiation. The patient might experience an emptiness that indicates an inability to exclude, to aggressively repel otherness; emptiness, then, may also be a ‘too much,’ which one can think of as an emptiness of ‘self-ness.’ Ellonen-Jéquier (2009) aptly explores the potential *fullness* of asserted emptiness in a psychotic patient. Specifically, the analysis progressed significantly when Ellonen-Jéquier interpreted to her patient how much work went into her (the patient’s) creation of nothingness or emptiness. Prior to this interpretation, the patient had thought she was, in actuality, “deficient in certain [intellectual] areas” (p. 849). Echoing Levy’s statement of caution, Ellonen-Jéquier emphasizes that the ego is doing a significant amount of work in the creation of emptiness. She writes:

> I was able not to fall into the trap of believing that there was a *real* emptiness or that some aspects were *actually* missing; the danger would have been to think, for

[122] I do not disagree with Levy’s point that *assertions* of emptiness always refer to unconscious psychical content; however, I add that the experience of emptiness is also constitutive of psychical life. Emptiness is structurally related to incoherence, which is one aspect of unconscious activity. I explore this connection between emptiness, incoherence, and psychical life below and further in Chapter Four.

> example, that her ego had to be strengthened[123] – whereas, in fact, her ego was already powerful and highly active, although in a particular manner. Believing that something was actually deficient would have entailed going along with the patient's defence mechanisms. (p. 864; original emphasis)

Even if a patient's subjective experience indicates, for example, a low capacity for reflection, it would be a mistake to believe that the patient's assertion of emptiness is indicative of an actual, unconscious absence. Furthermore, as Levy also indicates, the temptation and the mistake would be "to view emptiness as the *state of things* for a person, as patients often aggressively insist upon," which would "deprive the patient of the opportunity to 'fill in' his awareness of his always active inner life" (1984, p. 396; original emphasis). Ellonen-Jéquier also "emphasized her [the patient's] destructiveness" (2009, p. 847), engaging with the patient's aggressive wishes and phantasies in relation to emptiness. The patient's destructiveness was evident in the manner in which she "suppress[ed] all space between meanings" (p. 862) and "was gradually making me [the analyst] into almost nothing – I felt paralysed, I had no ideas, no feelings when I was with her" (p. 847). Transformation only became possible through the analyst's interpretation of the work that the patient put into the creation of emptiness, or nothingness, in herself and in the analytic relationship. The patient was eventually able to express the effect of these interpretations: because the analyst "hadn't tried to fill up any gaps," the patient was able to see "that her feeling of emptiness was the outcome of the work she was doing inside herself" (p. 849).

Milrod indicates the defensive aspects of her patients' persistent emptiness, noting that Deborah's "emptiness had a partially defensive quality" (2007, p. 1015) and that Rita's "inability to think" was an "enormous resistance" to their analytic work (p. 1020). Despite Milrod's emphasis on the need to differentiate between emptiness as a defense and emptiness as a deficit, it is evident that these two meanings might occur at different

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[123] Although Freud refers to strengthening a weakened ego (1940, pp. 180-181), it is clear that the term "strength" must refer to the ego's original function, "to meet the demands raised by its three dependent relations – to reality, to the id and to the super-ego – and nevertheless at the same time to preserve its own organization and maintain its own autonomy" (1940, p. 172). A "weakened" ego, then, is not the same as a deficient ego. The work of analysis, *if* it can be said to strengthen the ego, must refer to re-organizing the ego's efforts, which are *overworked* by the demands of the neurosis.

times, or simultaneously, in the same patient.[124] Indeed, Eigen argues that these two elements are "profoundly linked" (1993, p. 216).[125] The defensive activity of declarations of emptiness emerges out of a "destructive hate," which we can also characterize as rage, anger, or the work of the death drive. I draw attention to Eigen in order to again emphasize the insufficiency of the 'deficit theory' of emptiness and in order to highlight the importance of unconscious affects in the clinical assertion of emptiness, specifically rage. Milrod highlights her patients' unconscious rage, noting Deborah's "rage at her mother's controlling anxiety and chronic depression" and her "unconscious death wishes toward her mother" (2007, p. 1012); Milrod suggests that Deborah's anxiety is in fact "fuelled by her rage at her mother" (p. 1013). Rita's analysis focused at times on "her overwhelming rage at her parents" (p. 1018) and, "after years," Rita "had a growing understanding that her excessive anxiety about being apart from her parents was connected to her long-standing unconscious murderous rage at them" (p. 1019). Similarly, Singer indicates that the conscious experience of emptiness may occur "over fear of one's murderous, rageful impulses […], so that rather than feel full of evil and power, one feels weak, useless and empty" (1977a, p. 463). Ironically, fear of one's own hostility leads to the destruction, via defense, of one's powerful (and useful) aggressiveness. As a corollary, the pleasure, or gratification, patients' exhibit in their own emptiness, particularly within the analytic context where emptiness becomes resistance to the analytic work, further indicates the work of the death drive. LaFarge (1989),[126] Levy (1984),[127] and Ellonen-Jéquier (2009)[128] highlight the gratifying aspect of emptiness, further supporting my argument that assertions of emptiness can neither be taken at face

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[124] See, for example, Glucksman (2000).

[125] Eigen (1993) provides a brief discussion of a vignette Bion offers of a psychotic patient. He comments on the impossibility of knowing whether the patient's "lack of discipline, his inability or refusal to conform to the rules of discourse" stems from "destructive hate" or a "deficiency." This impossibility, he argues, "suggests how profoundly linked these two elements are" (p. 216).

[126] LaFarge suggests that the defensive function of emptiness is, in particular, a defense against "aggressive object relations," noting the "interplay of such empty states with aggressive fantasies" (1989, p. 986). She emphasizes "the highly deviant aspects of these states" (p. 994).

[127] Levy cautions analysts against the temptation of "joining the empty patient" in the maintenance of "ultimately pathological *gratifications*" (1984, p. 403; my emphasis).

[128] "In the analysis of psychotic patients, I have always noted the hidden pleasure they take in the emptiness that they create – forcing the other person to go looking for them – a pleasure that is mixed with feelings of revenge and persecution" (Ellonen-Jéquier 2009, p. 859).

value, that is, as indicating an actual emptiness, nor explained as a "developmental deficit."

LaFarge (1989) argues that the experience of emptiness is, in fact, a developmental achievement. Following Isaacs, to whom I allude in the epigraph at the beginning of this chapter, LaFarge writes: "empty states are not a normal experience of early childhood. The young child does not see absence or darkness as empty, but fills the empty space with negative feelings and fears" (1989, p. 992). In Isaacs's words, "the absence of satisfaction is felt as a positive evil. Loss, dissatisfaction or deprivation are felt in sensation to be positive, painful experiences" (1948, p. 88). LaFarge also highlights Winnicott's (1974) idea of the fear of breakdown[129] and emphasizes that "the child's ability to maintain the idea of an absence, without filling the empty space, [is] a developmental accomplishment" (1989, p. 992). That is to say, the developmental deficit would be an *inability* to experience emptiness. These are two different but related points: the subjective experience of emptiness is not a naturally occurring state, but must be learned. Emptiness may be used as a defence or it may be experienced as a potentiality to new experiences; in either case, it is a complex state, indicating a relatively high degree of psychical development. *Assertions* of emptiness in the analytic space are thus distinguished from the experience of emptiness.

We might better understand the agoraphobic's persistent emptiness if we think not of her emptiness as being *revealed*, but of the affective content of her psychic reality being emptied. She 'empties' herself of anxiety, but is then unable to experience much feeling at all. LaFarge describes this phenomenon of *emptying* in severely ill borderline patients and notes that her patient's "emergence from her 'empty' state was accompanied by anxiety" (1989, p. 983). The exchange, so to speak, between emptiness and anxiety is also evident in Ellonen-Jéquier's patient, for whom the discovery of "all kinds of aspects of life" were met with "tremendous happiness, of course, but also a great deal of anxiety" (2009, p. 851). While this patient seems to have been able to fill her emptiness with more feelings and the capacity to bear more of the happiness and sadness that life brings,

[129] I explore Winnicott's idea of the fear of breakdown and primitive anxieties in Chapter Two on the development of the ego. I connect this idea to the concept of *Nachträglichkeit* and the use of language in the psychoanalytic situation in Chapter Four.

Milrod's (2007) patients seem to have exchanged their intense anxiety for a life emptied of emotional experiences.[130] At the same time, there are many hints in Milrod's descriptions of both Deborah and Rita that suggest an on-going intense anxiety. Deborah, Milrod reports, "became anxious about the expectation of thinking and talking about her thoughts and feelings in therapy" (2007, p. 1014). While Milrod suggests that Deborah's emotional life was now "free of anxiety" (p. 1015), she goes on to describe Deborah's "underlying terror of depression and her deep terror of being unable to be different, or to be separate from her mother" (p. 1016). After years of psychoanalysis, Rita was able to move out of her parents' house with her husband and have a child with him; however, despite saying that she "loved her daughter," Rita "found it difficult to spend much time with her" and found her daughter's expressions of emotional needs "'somewhat sickening'" (p. 1020). Rita continued to experience a "terror of asserting herself at all" (p. 1018). Both Rita and Deborah "remained unable to tolerate intimacy, intense emotions, or very much thinking" (p. 1021). Despite the remission of their *agoraphobic* anxiety, it is evident that both Rita's and Deborah's emotional lives are greatly coloured by a profound anxiety concerning the limits of their selves, the limits of their emotional effects, and the limits of their rage.

The subjective experience of persistent emptiness in agoraphobia patients beyond the remittance of their overt symptoms shares some qualities of the experience of emptiness in psychotic, narcissistic, schizoid, and borderline patients discussed by other analysts' case reports. This subjective experience of emptiness is primarily defensive, and arguments that it indicates a developmental deficit are unconvincing; rather, assertions of conscious emptiness are a form of negation that specifically indicate the intensity of an unconscious emotional experience. Although for some patients the feeling of emptiness itself causes a profound anxiety, for others the emergence from an empty state increases the level of anxiety. Analyses of the subjective experience of emptiness in patients

[130] Singer suggests, however, that in borderline patients, an increased sense of emptiness is associated with increased anxiety, connected to the quality of their emptiness that includes the dissolution of the self. The affective experiences associated with persecutory internal objects is preferable to their absence, which is experienced as a loss of the self (not a part of the self that can be mourned, but a loss of the self's essence, so to speak) (1977b, p. 476). The loss of self is accompanied by an increase in anxiety, hence the great potential for suicide that Singer identifies.

suffering from a range of disorders include an emphasis on the patients' unconscious rage and aggressivity, particularly towards (ambivalently) loved objects. Although one of the primary affects emptiness defends against is murderous rage, or any aggressive impulse, grief is another affect that requires particular attention but is infrequently recognized in the literature. As I discuss below, the relationship between emptiness and melancholia suggests that, for Milrod's patients at least,[131] the loss of agoraphobic anxieties results in feelings of emptiness when traumatic losses are not mourned. One of these losses particular to agoraphobia patients is the unconscious tie to the phobic companion. In the next section, I explore the relationship between loss and anxiety, and experiences of emptiness in agoraphobia patients for whom significant losses have not yet been mourned.

3.1.iii. Melancholia: Emptiness and Anxiety

The connection between experiences of emptiness and melancholia is especially relevant in agoraphobia patients. A contemporary respondent to Westphal's early article on agoraphobia draws this connection: "the case seems essentially a form of mental depression in certain faculties […] closely allied to what is called simple melancholia" (White 1884, p. 1141).[132] In a letter to Fleiss, Freud mentions briefly: "Melancholia appears in typical combination with severe anxiety" (1985/1895, p. 98). Freud also adds a short addendum to *Inhibitions, Symptoms and Anxiety* (1926) in an attempt to ask some of the very difficult questions surrounding psychological responses to loss. Namely, he asks: "when does separation from an object produce anxiety, when does it produce mourning and when does it produce, it may be, only pain?" (p. 169). Although Freud suggests that the answers to this question continue to elude him, he offers one point that may be of help to us here: "When there is physical pain, a high degree of what may be termed narcissistic cathexis of the painful place occurs. This cathexis continues to

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[131] Milrod indicates that the case studies she provides are more typical than exceptional in her many years of experience (2007, p. 1022). Bodin (1996) provides another discussion of a patient with "claustra agoraphobia" who uses coherence and "the silencing method" (1996, p. 181) as defenses against overwhelming affect (connected to discordant ideas). See infra note 111.

[132] I discussed the history of the concept of agoraphobia in detail in Chapter One.

increase and tends, as it were, *to empty the ego*" (p. 171; my emphasis). An unbearable level of pain – whether physical or psychical, I contend – is accompanied by a kind of emptiness, a protective emptying of the ego, though what exactly the meaning of that emptiness is Freud never says.[133] In her influential article on agoraphobia, Deutsch also indicates some relationship between the two pathological states: "The process [of phobias] reminds us of melancholia. There the object is introjected and its fate – the threat of death and the reaction of anxiety in the imperilled ego – is through the destructive instinct inflicted on the subject's own ego" (1929, p. 68).[134]

Despite these early, though brief, acknowledgements of the relevance of melancholia in understanding agoraphobia (and necessarily vice versa), the relationship between agoraphobia and melancholia has not, as of yet, been developed in the psychoanalytic literature.[135] As Rudden et al. (2003) indicate, major depression is often comorbid with panic disorder. This comorbidity assumes, or follows from, a psychiatric diagnostic mode. The literature on both depression and panic disorder focuses on unconscious conflicts, particularly on guilt over aggression (which, in depression, is turned against the self). The need for mourning traumatic losses in patients with depression is not commonly discussed. Bowlby (1969, 1973, 1980) draws attention to the connections between attachment and separation, anxiety, and loss. The second volume in Bowlby's trilogy focuses on anxiety and the third on depression, indicating – as Bowlby

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[133] We also note that grief is a complicated process: more than the sadness resulting from a loss, grief includes *suffering* the loss and, as Klein (1940) writes, doing the painful work of rebuilding the internal world bereft of the lost object. Klein, in fact, offers this solution to Freud's question as to why mourning is so painful: "[t]he pain experienced in the slow process of testing reality in the work of mourning thus seems to be partly due to the necessity, not only to renew the links to the external world and thus continuously to re-experience the loss, but at the same time and by means of this to rebuild with anguish the inner world, which is felt to be in danger of deteriorating and collapsing" (1940, p. 354). Although Freud seemed not to understand why mourning is so painful, the fact that it is indeed very painful work cannot be overstated. In melancholia, the bereft individual attempts to avoid suffering the loss which she has endured. Of course, in order to avoid suffering a loss, we must never have had it (the lost object) in the first place: an ultimately untenable paradox that the melancholic attempts to inhabit.

[134] I will not go into detail here about the process Deutsch describes, as I have done so in Chapter One. My point here is to emphasize the connection between the development of phobias (including agoraphobia, which is the main subject of Deutsch's article) and melancholia.

[135] One exception to this absence in the literature is Bion, who describes the impairment of mourning and, consequently, symbolization, in claustrophobia (and agoraphobia), which he considers to be a result of an intolerance of frustration (1962a, 1965). See Willoughby (2001) for a Bionian analysis of claustrophobia.

and others theorize elsewhere – the assumed progression of separation: from protest, to yearning and searching (anxiety), and, finally, to detachment (melancholia). The more complex relationship between anxiety and mourning (beyond melancholia or depression) is not developed,[136] although Rey briefly notes of schizoid patients exhibiting claustro-agoraphobia: “What was extremely useful to the patients was [...] a developing capacity to think and experience mourning and reparation” (1994, p. 85). In the psychiatric literature, the connection between anxiety and depression is more elaborated, insofar as low dosages of some antidepressants offer relief to many patients who suffer from panic attacks.[137] However, the question of why anxiety may be relieved for some individuals with antidepressants is not addressed.[138]

In this subsection, I consider the connections between the agoraphobic’s persistent emptiness and melancholia. I argue that the agoraphobic, having finally escaped, so to speak, the maddening cycle of anxiety and avoidance, situates herself in a new cycle of avoiding grief and mourning (and the specific anxiety that mourning includes) by immersing herself in emptiness, or, in other words, by emptying herself of as much emotional content as possible. Above, I argued that assertions of emptiness in the analytic situation are not to be taken literally; that is, that the subjective feeling of emptiness is the conscious experience of an unconscious *something*. The nature of that something necessarily varies from patient to patient, and from moment to moment. I also argued, in agreement with Milrod, that one of the affects likely to be repressed and hidden behind an

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[136] There are two articles in the psychoanalytic literature on the relationship between claustrophobia and depression. Gehl notes: “In frequent, rather dramatic episodes in treatment, interpretations have succeeded in greatly lessening the phobic anxiety only to find a melancholic state replacing it. At other times a state of depression has been relieved, only to find a claustrophobia making its appearance” (1964, p. 312). Asch argues that both claustrophobia and depression are specific reactions to the threatened loss of an object; he suggests that “the clinical picture of claustrophobia appears in place of depression when there is threatened object loss in an ego that has developed a propensity for displacement and avoidance” (1966, p. 728). I argue that melancholia (that is, depression, or defences against mourning) is particularly strong in the agoraphobic patient precisely because of this “propensity for […] avoidance.”
[137] See, for example, Mitte (2005).
[138] For examples within the psychiatric literature on the co-morbidity of panic disorder and depression, or agoraphobia and depression, see Breier et al. (1984), Kessler et al. (1998), Marchand et al. (1994), Starcevic et al. (1992), and Westenberg (1998). Rudden et al. (1996) provide an overview of this literature, concluding similarly that the psychological meanings of this comorbidity are largely unexplored in the psychiatric literature.

emptiness is the patient's aggressivity and murderous rage. Here, I argue that another affect likely to be replaced by an emptiness particularly relevant to agoraphobia patients is loss, either the real loss of a loved object or the loss of the fantasies upon which the agoraphobic anxieties were maintained; perhaps, of course, both of these kinds of losses are present in any particular patient.

Before moving on to an examination of melancholia in agoraphobia patients, I bring our attention to some more terminological complications. Steiner offers an important note about the psychological terminology for the various processes involved in mourning:

> It is confusing that the word *depression* has been applied both to the state that accompanies mourning and to that which results from the defences mounted against mourning. The path that leads towards facing the loss, and mourning it, is associated with painful depressive feelings, involving guilt, regret, remorse, and a wish to make reparation. These feelings were thought by Klein [1952] to represent the depressive position and are very different from those observed in depressive illness. Although mixed states are common, severe depressive illness or melancholia results from defences against loss and hence against all those feelings associated with the depressive position. The clinically depressed patient is likely to suffer anxiety and persecution, to harbour grievance, and to deploy manic and obsessional defences that aid in denying the reality of the loss. (2011, p. 151)

Clinical depression is caused, not by loss itself, but by the avoidance of grief in the face of loss. As Steiner notes, "mixed states are common"; indeed, during a state of acute mourning there will almost necessarily be moments of pathological depression (melancholia). In the psychiatric mode, these moments are not diagnosed as depression because the duration of the state is an integral aspect of the definition. However, we expect that those individuals doing the work of mourning will occasionally vacillate between mourning and melancholia, that is, between mourning and defending against mourning.

Freud offers the following symptomatological description of melancholia: it includes "a profoundly painful dejection, cessation of interest in the outside world, *loss of the capacity to love*, inhibition of all activity, and a lowering of the self-regarding feelings to a degree that finds utterance in self-reproaches and self-revilings, and culminates in a delusional expectation of punishment" (1917, p. 244; my emphasis). We quickly note the similar experiences of emptiness in agoraphobia patients whose overt symptoms have remitted. To reiterate what I have described above in more detail, Milrod's (2007) patients demonstrate an inability to tolerate intimacy and seem to reject their own loving aspects.[139]

In more detail, we recall those differences Freud notes between the normal process of mourning and its pathological counterpart, melancholia:

> Where the exciting causes are different one can recognize that there is a loss of a more ideal kind. The object has not perhaps actually died, but has been lost as an object of love […] [M]elancholia is in some way related to an object-loss which is withdrawn from consciousness, in contradistinction to mourning, in which there is nothing about the loss that is unconscious.[140] (1917, p. 245)

The unconscious aspect of the loss is particularly relevant in agoraphobia, where it frequently appears that the object lost, or *one of* the lost objects, is the tie between the patient and the phobic companion. Frances and Dunn describe the nature of this tie in detail, indicating three distinct levels: "the psychotic symbiotic, the narcissistic, and the differentiated dependent" (1975, p. 438). The first level, the psychotic symbiotic, implies a complete lack of self-object differentiation. The second type exists on a higher level of differentiation and includes an "intense narcissistic investment in the other" (p. 438) resulting in a degree of impaired self-object differentiation and self-object constancy. As long as the object (i.e., the phobic companion[141]) is present, a stable self constancy is

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[139] Green writes on the negative in the case of melancholia: "it seems to know nothing about the way it has negativised itself in order to replace the lost object, losing its capacity for recognition and awareness, sacrificing the love it has for itself and the pleasure which it can draw from its own image" (1999, p. 54).

[140] I disagree on a small point with Freud's description of mourning: I suggest that even if the actual loss is consciously recognized, there will always be aspects of that loss that are unconscious. I do not know that we can ever be fully conscious of the losses we have suffered. As Klein writes, the "poignancy of the actual loss of a loved person is, in my view, greatly increased by the mourner's unconscious phantasies of having lost his *internal* 'good' objects as well" (1940, p. 353). That is, the unconscious phantasies ("phantasies" instead of fantasies already implies their unconscious nature) concern the loved, internalized object even if the reality of the loss of the loved person is entirely conscious.

[141] It is important to note that, when the phobic companion is another *person* (as opposed to a phobic object like those described in the Introduction: a cane, a pet, a house, etc.), the tie implies a mutual dependency, though the dependency may be more unconscious in the partner not exhibiting traditional agoraphobic symptoms.

possible. The third type predominates when there is a high level of dependency, but clear self-object separateness is maintained. Agoraphobia can be present on any of these three levels of differentiation, but for those patients with either the psychotic symbiotic or narcissistic tie to the phobic companion, “the real or symbolic loss of the phobic partner is experienced as a loss of part of the self – a threat to self constancy” (p. 438). This “threat to self constancy” is described clearly in the accounts of borderline and psychotic patients exhibiting agora-claustrophobic anxieties indicated above, but is also hinted at in Milrod’s patients (2007, pp. 1014, 1019).

The agoraphobia patient’s fantasies surrounding the phobic companion – for example, his or her ability to keep the patient safe – must be confronted with the reality of the phobic companion’s helplessness, as well as the patient’s own helplessness, in order for the symptoms of anxiety and avoidance to be addressed. The loss of this fantasy, a fantasy which was experienced as part of the self, leads to a melancholic feeling of emptiness. Levy makes a similar point: “confusion secondary to difficulties in the separation-individuation process may contribute to the experience of the self as empty” (1984, p. 392). It seems likely that the agoraphobic’s difficulties in the process of individuation lead to a particular experience of melancholia subsequent to the loss of the psychic connection to the phobic companion following remission of overt symptoms which served to maintain the fantasy of symbiosis. Milrod indicates this ongoing difficulty with her patient, Rita: “Likely her desperate need to define herself in keeping with and as being linked to one of her parents had been substituted in part by her relationship with me” (2007, p. 1020). Despite the remission of Rita’s overt agoraphobic symptoms, she has not been able to relieve herself of the need for a symbiotic tie with another. A similar development occurred between Milrod and her patient, Deborah, who “began to feel as though she and I [Milrod] were fused” (p. 1014). Again, this development became more salient in the analysis after the remission of Deborah’s overt agoraphobia symptoms.

Returning to Freud, we find a further distinction between mourning and melancholia: the melancholic suffers “an extraordinary diminution in his self-regard” (1917, p. 246). Freud’s astute explanation involves the ambivalence towards a love object, an ambivalence with which we are now familiar: “the self-reproaches are reproaches against a loved object which have been shifted away from it on to the patient’s own ego” (p. 248). In melancholia, “countless separate struggles are carried on over the object, in which hate and love contend with each other; the one seeks to detach the libido from the object, the other to maintain this position of the libido against assault” (p. 256). The agoraphobic is unable to feel anything but emptiness because of the refusal to mourn the reality of her losses, a process which includes learning to tolerate her ambivalent feelings toward her phobic companion. Because the agoraphobic is unable to fully and functionally differentiate between self and other, the loss of the other cannot be mourned; thus, the ego remains bereft.

Milrod hints at the relevance of loss and mourning. For instance, she writes: “The loss of a phobic companion is experienced as the catastrophic loss of a part of the object/self symbiotic union” (2007, p. 1011). However, Milrod does not suggest a connection between the inner constriction her patients experience and the need to mourn this “catastrophic loss.” The complexities of mourning are overlooked, evident in the very brief mention of “a later focus” in the analysis with Milrod’s patient, Deborah, which “involved her deeply and secretly mourning the sudden death of a cherished older cousin, Marcy, who was killed in a car crash two months before the onset of Deborah’s somatic symptoms and agoraphobia at the age of thirteen” (p. 1012). I question the nature of Deborah’s “mourning” insofar as it seems more likely that this loss, rendered secret, was never truly mourned at all, rather than “deeply” mourned, as Milrod suggests. Instead of exploring this sudden death as another, earlier “catastrophic loss,” Milrod connects the death of this cousin to Deborah’s “unconscious death wishes toward her mother” (p. 1012). I am not suggesting that Milrod is mistaken in this interpretation; rather, I am suggesting that there is potentially also an issue of unresolved mourning – that is, melancholia – in Deborah’s ongoing and persistent feelings of emptiness and that Deborah’s “unconscious death wishes” contribute to this unresolved mourning.[142]

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[142] Dunn, in his commentary on Milrod (2007), offers a pertinent description of a sequence from one of his own patients, Charlotte, a nineteen-year-old woman who suffered from agoraphobia and, in particular, a travel phobia: when she was seven, Charlotte’s “best friend Annie was run over by a truck,” an “incident” which Charlotte “quickly forgot” (2007, p. 1030). Dunn’s description of the sessions focusing on this loss,

Gassner (2004) suggests that the role of conflict over impulse expression and unconscious fantasy is over-emphasized in clinical reports of patients with panic disorder and/or agoraphobia, insofar as this emphasis has led to the neglect of the impact of development trauma. Gassner indicates examples of parental illness or death, parental substance abuse, and physical, sexual, or emotional child abuse (pp. 223-224). I add to these examples, as evidenced in Milrod's and Dunn's case reports, the early traumatic loss of a childhood friend.[143] As Gassner indicates, the trauma of loss is compounded when a parental figure is unavailable to help the patient grieve or, further, prevents mourning by denying the severity of the loss:

> A significant aspect of the childhood trauma is that the parent(s) are unavailable to offer their child sustained, emotionally attuned, and reality-oriented help, the kind of responsiveness that would facilitate their child's capacity to process and master the intense emotions and associated disturbing convictions that these real-life ordeals inevitably generate. (p. 223)

The combination, then, of developmental trauma and the absence of a supportive parental figure for the mourning process contribute to the traumatic effects of a childhood event. Both of these elements are evident in Milrod's and Dunn's patients.

Milrod describes other melancholic features of her patients' emotional lives. These features evidently contribute to Deborah's ongoing emptiness in particular. Milrod quotes Deborah: "My whole life has been about these symptoms that are just…gone. There's nothing there, and it makes me upset. It's not worse than the panic, but it's a

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and the accompanying injunction from Charlotte's mother against mourning, draws out the relevance of melancholic factors in agoraphobia. Dunn interprets that "Charlotte must have sensed that her mother wanted Charlotte not to think about the accident or to have any feelings about it," an impossible wish given that Charlotte, who in fact witnessed the accident, "must have been filled with frightful images" (p. 1030). Dunn provides this segment to support his (and Milrod's) hypothesis that "certain patterns of pathological parenting play a role in the genesis of agoraphobia" (p. 1032). Again, I do not disagree with his assessment. However, he fails to emphasize the relation between melancholia (the refusal to mourn – based partly, perhaps, on an injunction against mourning) and his patient's feeling "bored and empty" (p. 1030).

[143] See also Bonomi (2003), Boulanger (2005), Brown (2005), Tarantelli (2003), and Torsti (2000), all of whom "emphasize that traumatized patients have generally impaired symbolizing capacities or that they defensively avoid symbolization [...]. That is, not only do they have trouble remembering their trauma, experiencing it, and integrating its meaning in their lives, but their very capacity to remember, to experience, and to integrate is impaired or its use defensively avoided" (Rosegrant 2010, p. 503).

weird feeling" (2007, p. 1014). Milrod interprets that "giving up her [Deborah's] anxiety symptoms seemed to represent a loss to her, and also a sad separation from her mother" (p. 1014), but there is no indication that this loss has been worked through. Indeed, Milrod's choice of words, that the absence of Deborah's anxiety symptoms "*seemed* to *represent* a loss," implicitly denies or devalues the reality of this loss. Instead, the loss of her mother-fusion was substituted with an analyst-fusion (p. 1014). There is a tension between Deborah's experience of "nothing there" and the feelings that accompany that "nothing." That is, there cannot be an absolute nothingness if there is also a "weird feeling." There is an absence, surely, a something missing that had always been there previously, but there is not literally "nothing." As indicated above, the expression of a nothingness is the conscious manifestation of an unconscious something, even if it is not apparent what that unconscious something signifies.

Problematically, Milrod suggests that, with her agoraphobic symptoms in remission, Deborah's emotional life was "now free of anxiety" (2007, p. 1015). However, Milrod then writes that "psychotherapeutic focus on her boredom[144] and superficiality consistently invoked both her *underlying terror of depression* and her *deep terror* of being unable to be different, or to be separate from her mother" (p. 1016; my emphases). I do not know if Milrod is implicitly suggesting a distinction between anxiety and terror, but it seems as though Deborah has repressed her anxiety in order to function and that she has not sufficiently worked through the repressed material at the root of her anxiety. Her

[144] Phillips considers the experience of boredom and emptiness in childhood development: "In the muffled, sometimes irritable confusion of boredom the child is reaching to a recurrent sense of emptiness out of which his real desire can crystallize. But to begin with, of course, the child needs the adult to hold, and to hold to, the experience – that is, to recognize it as such, rather than to sabotage it by distraction" (1993, p. 69). According to the clinical reports of Fenichel (1934/1953) and Greenson (1953), emptiness and boredom are often encountered together. Milrod also indicates the co-occurrence of emptiness and boredom in her two clinical case studies (2007, pp. 1014, 1016, 1017, 1020). Writing on boredom, Fenichel and Greenson both emphasize its defensive function, particularly the defense against unacceptable instinctual wishes. Boredom may be a "screen for rage" (Phillips 1993, p. 76), as Milrod implies is the case in her patients, and also may indicate the repression of traumatic events. Greenson indicates of his patient: "It quickly became clear that in the bored state the affects connected to the traumatic events were repressed" (1953, p. 10). Weiss notes: "A sense of boredom and impatience often precedes a patient's first anxiety-attack" (1935, p. 69).

"terror of depression" is particularly striking, given that the description of her ongoing emptiness depicts a melancholic state. The recognition that mourning is called for would perhaps relieve some of her terror of depression as well as some of her depressive symptoms.

3.2. Emptiness and Agoraphobic Anxieties in Mourning

No one ever told me that grief felt so like fear. I am not afraid but the sensation is like being afraid. The same fluttering in the stomach, the same restlessness, the yawning. I keep on swallowing.

(Lewis 1961, p. 1)

Emptiness in patients for whom overt symptoms of agoraphobia have remitted may potentially indicate the presence of losses which have not yet been sufficiently mourned. At the same time, agoraphobic anxieties may also appear during the process of so-called normal mourning. Klein identifies this phenomenon quite clearly, stating that "[i]n normal mourning early psychotic anxieties are reactivated" (1940, p. 354). However, there are very few examples in the psychoanalytic literature of agoraphobic anxieties during the process of mourning. Klein provides one of the very few descriptions of this process, clearly articulating the emergence of agoraphobic anxieties (although she does not identify them specifically as such). "Mrs A" is mourning the sudden death of her young son:

> After a few weeks of mourning, for instance, Mrs A went for a walk with a friend through the familiar streets, in an attempt to re-establish old bonds. She suddenly realized that the number of people in the street seemed overwhelming, the houses strange and the sunshine artificial and unreal. She had to retreat to a quiet restaurant. But there she felt as if the ceiling were coming down, and the people in the place became vague and blurred. *Her own house suddenly seemed the only secure place in the world*. (p. 361; my emphasis)

Klein provides one explanation for the sudden onset of agoraphobic anxieties during a period of mourning, suggesting that the "frightening indifference of these people was reflected from her internal objects, who in her mind had turned into a multitude of 'bad' persecuting objects" (p. 361). That is, because the 'good' internal objects had not yet been firmly re-established, persecutory anxiety predominated. As we know, the absence of love is felt as hate; the indifference of the crowds, ignorant of her loss and her vulnerable state, were experienced as hateful and destructive. Klein continues: "The external world was felt to be artificial and unreal, because real trust in inner goodness had temporarily gone" (p. 361). The relationship between internal reality and external reality is the key consideration in the evaluation of these anxieties: the "chaos" of the internal world results in a hostile and frightening external world. In my words, following the arguments of the previous chapters, the limits of the self and of the other have suddenly become unstable.[145] Whether the threat comes from inside oneself or from the surrounding people is unclear to the mourner; it is, rather, the collision of the two that is so frightening. Hence, the solitary safety of one's own home is sought.

Mrs A provides a counter-example of mourning to the melancholic responses of Milrod's and Dunn's patients. Klein describes the complicated and painful mourning process Mrs A both endures and must actively participate in, as the loss of the loved person is accompanied by the loss of the protective function of the 'good' internal objects; 'bad' (persecutory, punishing, annihilating) objects predominate for a time. As the reality of the loss becomes internalized, 'good' objects can be re-established and 'bad' objects become less powerful. In Klein's words:

> Mrs A, who at an earlier stage of her mourning had to some extent felt that her loss was inflicted on her by revengeful parents, could now in phantasy experience the sympathy of these parents (dead long since), their desire to support and to help her. She felt that they also suffered a severe loss and shared her grief, as they would have done had they lived. In her internal world harshness and suspicion had diminished, and sorrow had increased. (1940, p. 359)

Milrod's and Dunn's agoraphobia patients do not have the internal good parents with whom to share their grief. Even if it is true in reality that the parents suffered a great loss, they were not able to share their grief and therefore share their sympathy. These historical

[145] See also Davidson (2001, p. 294): "In the face of bereavement, for example, one feels utterly impotent. The profound experience of loss can seem to alter the shape of one's family relations and life-world, forcing the subject to negotiate new spaces, or gaps in their lives where, previously, there were none."

facts impede the patients' own mourning processes, leading to severe melancholia and feelings of emptiness. The emptiness refers not only to the lost loved persons, but also to the absence of the good internal objects with whom they could share their sorrow and by whom they could be comforted. Reiterating Fonagy's arguments about the development of the mentalizing capacity, we see that "disavowal should not be confused with absence, it is tantamount to an inhibition, which is permitted by the incomplete development of the capacity in the first place" (1991, p. 651). I emphasize this important point: the incomplete internalization of 'good' objects leads to the inhibition of mourning insofar as mourning the loss of the loved person would also necessitate mourning the absence of the 'good,' sympathetic objects with whom one could share his or her grief. In the examples of Milrod's and Dunn's patients, mourning would require recognizing both the severity and painful nature of the traumatic childhood losses, and also mourning the painful absence of parents with whom the burden of those losses could be shared.[146] I emphasize that this 'painful absence' is a presence; that is, it is the presence of a painful absence. Assertions of emptiness signify the very presence of this painful absence.

The transference relationship between Milrod and her patients helps to alleviate some overt agoraphobic symptoms, but also perpetuates the deeper elements of the disorder by acting as a substitute for the parental relationship.[147] Milrod theorizes that

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[146] I detail the theoretical relevance of loss and mourning in the process of ego development in Chapter Two, especially pp. 43-44.

[147] The dependence on the analyst is another consonant element between Fonagy's description of borderline functioning and Milrod's description of her agoraphobic patients. As Fonagy writes, "the desperate dependence borderline patients manifest in the transference [...] may well concern their difficulty in maintaining analytic understanding as a functioning mental entity" (1991, p. 651; internal reference omitted). Milrod's patients are unable to keep her alive in their minds outside of the analytic sessions; or rather, the analytic process is only alive in the moment and disappears from mental reach as soon as it is over (2007, p. 1019). This dependence, Fonagy argues, relates to the analysand's use of the analyst's mentalizing capacity, the relinquishing of which "inevitably bring[s] with it a fear of disintegration" insofar as the analysand is unable to maintain a representation of his or her own "coherent and mature identity" (1991, p. 652). Fonagy reports that Mr. S's "sense of emptiness" referred to his inability to "conceive of himself as a person with various feelings and thoughts in the past and present" (p. 645). His various rages at Fonagy expressed an inability to tolerate the experience of his analyst thinking about him, since he was unable to think about himself and therefore to conceive of himself as a person about whom one could think; rather, he had to "conceive of his life as something which cannot be thought or felt about" (p. 645). Fonagy connects this emptiness to Mr. S's early traumas, which "must have included a profound identification with the thoughtless state of the original abusers [his father and mother]" (p. 645). As a protective function, the inhibition of his mentalizing capacity was threatened by the developing analytic relationship, which incited

agoraphobia patients are unable "to function psychically for themselves without an external ego to guide them" (2007, p. 1023), and appears to put herself, as analyst, in the position of the guiding external ego. Although she argues that it is the patients who "unconsciously turn their psychoanalyst into the object they require in order to feel secure and complete" (p. 1023), she offers no indication that the analyst might be problematically complicit in becoming their patients' required object. The problem, as Lacan articulates it, is clear: "If the intersubjective relationship in analysis is, indeed, conceptualized as that of a dyad of individuals, it can only be based on the unity of a perpetuated vital dependency" (1955/2006j, p. 288). That is, interpretations emphasizing the transference relationship, especially when formulated with the basic assumption that the analyst must be the agoraphobic's guiding external ego (as Milrod implies), indicate and perpetuate the analyst's dependency on the analysand as much as vice versa. Both Fonagy (1991) and Steiner (1993) note their patients' painful experience of an increasing awareness of the analyst's independence. This experience is one which Deborah and Rita have refused, leading to the denial of their own independence as well, further restricting the process of separation-individuation.

Klein provides a vital distinction between kinds of dependence that clarifies the unconscious significance of the agoraphobic's dependence on her analyst, and its relation to mourning:

> The pining for the lost loved object also implies dependence on it, but dependence of a kind which becomes an incentive to reparation and preservation of the object. It is creative because it is dominated by love, while the dependence based on persecution and hatred is sterile and destructive. (1940, p. 360)

The agoraphobia patient, particularly one no longer suffering from the overt symptoms of anxiety and avoidance, has learned that she is pathologically dependent on her phobic companion and that, to be 'well,' she must learn to be more independent, to not rely on others for her sense of self. She has learned these things, and they are true, but she must

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the incredible terror of an increased capacity to mentalize: "I said that he was just as frightened of mental aliveness in himself as in me; that the sadness inside him when he missed me was sometimes so unpleasant that it was easier to kill the thinking part of both of us than face the pain of experiencing the end of the session that he valued" (p. 647).

also learn more dependence, a good kind of dependence that allows her to mourn her losses and to internalize 'good' objects: a kind of dependence that is "dominated by love" rather than persecution and hatred.[148]

There are many and complex reasons, then, for why the work of mourning might be especially difficult for patients suffering from agoraphobia. As Lewis (1961) describes, grief feels startlingly like fear. For agoraphobia patients whose overt symptoms have remitted, the fear of their return (relapse is notably common in agoraphobia cases) might readily scare off, so to speak, the patient from suffering her losses, a process which would require the fear-like experience of grief. Not only does grief *feel* like fear, even normal mourning can stimulate the emergence of agoraphobic anxieties in particular. This emergence is due to the primitive nature of agoraphobic anxieties and also due to the nature of loss, which, in its essence, threatens to tear us apart.[149] Secondly, the losses of the phobic companion, in fantasy, and of the agoraphobic anxiety itself, are difficult to recognize *as* losses that need to be mourned. Interpretations that aim at the analysand's unconscious conflicts without acknowledging the depth and reality of these losses delay their necessary mourning. Thirdly, for the agoraphobic, mourning traumatic losses from childhood would require acknowledging how painful those losses are and how overwhelmingly alone she has been with her pain. Not only must the losses to death be mourned, but the absence of 'good' internal objects to whom one can turn to in grief must also be mourned. Finally, the agoraphobic has never known the kind of dependence "dominated by love" (Klein 1940, p. 360). Instead, she has been both pathologically dependent and devastatingly alone. Like the feelings of fear that come with grief, the feelings of dependence also present particular challenges to the agoraphobic patient.

It is clear that agoraphobia is not reducible to a single cause, or to any one of the single paradigms of theoretical understanding currently available. Gassner articulates this point, which has serious implications for theoretical and clinical work with agoraphobia: "Panic attacks and agoraphobic symptoms are clearly a multidetermined psychological disorder, and like other symptoms, there are undoubtedly many pathways to these

[148] Fairbairn (1944, 1963) refers to the "anti-libidinous ego," which attaches to the rejecting object and which itself rejects and hates all dependence.
[149] Taylor and Rachman (1991) argue that sadness, like fear, is itself an aversive state.

manifestations of psychopathology" (2004, p. 224). Treatment plans that emphasize the diagnostic criteria for agoraphobia and, as it were, treat the symptoms of the disorder (such as CBT combined with pharmacotherapy), tend to result in some short-term positive effects but long-term ineffectiveness. Psychoanalytic psychotherapy that focuses on the transference seems to provide some long-term effectiveness against the recurrence of anxiety and avoidance, but also appears to reach an impasse if the transference relationship continues to be emphasized (as seen in Milrod 2007). At this point, we may inquire if perhaps the transference has become, as Freud originally thought it was, an obstacle to the progress of the analysis. What is beyond the ego of the analysand? How can we get beyond the transference, an egoic phenomenon, in order to relieve a persistent "inner constriction"? We must return to the fundamental rule of psychoanalysis and the pursuit, however impossible, of putting all of one's thoughts and feelings into words. I address these questions, along with the unconscious function of incoherence, in Chapter Four. For now, I remain with the meanings of emptiness. In the next section, I argue that the agoraphobic's persistent emptiness is a pathological manifestation of a structural emptiness that is central to psychic life. Out of this structural emptiness, all new things emerge.

3.3. Structural Emptiness

Is there not a danger of overfilling the psychic space, when one should be helping to form the positive cathexis of the empty space?

(Green 1975, p. 17)

Green distinguishes what he calls "the no of the ego, the no of the super-ego and the no of the id" (1999, p. 269). He argues that the drives are expressions of the "no of the id," an argument that is particularly relevant in the establishment of the boundaries and limits of the self. He writes:

> Expelling what is bad allows for the creation of an internal space in which the ego as an organisation can come into being, setting up an order founded on the formation of links related to experiences of satisfaction. This organisation

> facilitates recognition of the object as separate in the space of the not-ego as well as the reunion with it. (p. 272)

The work of the negative is apparent prior to the differentiation of the ego from the id in the process of expulsion by which the ego is organized.[150] This process indicates the "no of the id." This process also indicates that the vulnerable moment exists at the frontiers of the self; and, in the process of establishing what belongs to the ego and what the ego will exclude from itself, there must be room for emptiness.[151] I follow Green's argument that the work of the negative "extends to the agencies of the psychical apparatus as a whole" (1999, p. 269). That is, the negative is a *structural* aspect of psychical life. I argue that the agoraphobic's persistent emptiness is a manifestation of Green's pathological negative; however, the point of the structural emptiness is a technical one – how do we make use of structural emptiness in the treatment of persistent, pathological emptiness? I argue that structural emptiness reveals itself in the gaps created by language; following the psychoanalytic rule, 'try to say everything,' encourages the foray into more of these gaps so that the agoraphobic's persistent emptiness may be overcome, replaced with all kinds of feelings as well as an enjoyment of her structural emptiness out of which all new things emerge.

As I described in Chapter Two, the experience of emptiness is necessary for healthy ego development. Emptiness is the psychical representation of physical hunger, both of which stimulate aggression. The ego must use this aggression to repudiate the other and the external world in order to establish itself differentiated from the world. Without the experience of emptiness (hunger) and the resulting aggressivity, the individual is able to experience neither satisfaction nor love, but only frustration and a limited kind of gratification. Winnicott identifies emptiness as a constitutive experience,

[150] I described the details of this process and the relevance of agora-claustrophobic anxieties in ego development in Chapter Two.
[151] On the potentiality and vulnerability at the boundaries of the self, see also Milner: "...the basic identifications which make it possible to find new objects, to find the familiar in the unfamiliar, require an ability to tolerate a temporary loss of sense of self, a temporary giving up of the discriminating ego which stands apart and tries to see things objectively and rationally and without emotional coloring" (1952, p. 189); and, Kumin, on schizoid emptiness: "Emptiness has become a fact of ego structure and the ego feeling will reside chiefly at the external ego boundaries, separated by a libidinal gulf from the developing self representations" (1978, p. 212).

arguing that the "basis of all learning (as well as of eating) is emptiness. But if emptiness was not experienced as such at the beginning, then it turns up as a state that is feared, yet compulsively sought after" (1974, p. 107). Similarly, and as I quoted above in Chapter Two, Kumin writes:

> It is thus that experiences of emptiness, for the schizoid patient as well as for the infant, are essential stages in the ultimate constitution of self in the world. The loss of the mother by the infant through repetitive experiences of cold, hunger, frustration and separation, which must be experienced by the infant as excruciating emptiness and annihilation, is a necessary precursor of introjections of the maternal imago and the development of internalized object relations, which strengthen the process of separation-individuation and the formation of the self. (1978, p. 214)

Grotstein, writing on the vicissitudes of nothingness, also indicates the structural manifestations of emptiness: "Nothingness, similarly, may be primary or secondary. In its primary sense it is the matrix or 'ether' of primary meaningless and is the emptiness which must be experienced in order for meaningful experience to be realized" (1990, p. 268). In Green's words: "The dimension of absence, essential to psychic development, finds its place in the potential space between the self and the object" (1975, p. 18). LaFarge (1989), in her arguments against the deficit theory of empty states, refers to these descriptions of structural emptiness: the experience of emptiness is required for healthy ego development and is also a developmental *achievement*. To understand emptiness as a development achievement, we might also think of a different but similar example: the developmental achievement of the capacity for anticipation. If the individual has developed the capacity for anticipation, some painful experiences can be endured in order to achieve a greater satisfaction. If there is no capacity for anticipation, and therefore no tolerance for painful or frustrating experiences, there can be only a very limited, immediate kind of gratification. If there is no capacity to tolerate or *enjoy* emptiness, then there can be no room for creativity, no possibility for the emergence of new thoughts or feelings. As Winnicott argues, "*only out of non-existence can existence start*" (1974, p. 107; emphasis in original). This opening to new experience is the "positive element" of emptiness that is neither deficit nor defence. Emptiness, then, is not simply a deficiency, nor is it only related to the ego and its mechanisms of defence, but is a structural aspect of the psychical apparatus.

Strongly related to ignorance, or not-knowing, the capacity to tolerate emptiness, like the capacity to tolerate one's ignorance, is a necessary step towards the enjoyment of a full life. If these states of emptiness, ignorance,[152] and silence[153] are defended against, nothing new can emerge. Scott writes of "wooing" the unknown, "since from it all new good, as well as, bad and sad states, will come" (1981, p. 577). The ability to "woo the unknown" and love our ignorance depends on our faith in our capacity to mourn our losses: "With mourning, the realization emerges that a new beginning becomes possible" (p. 574).[154] As I argue above, the agoraphobic's pathological emptiness indicates the *presence* of losses not yet mourned. The agoraphobic defends against painful mourning and, in doing so, closes herself off to new experiences. Without faith in her capacity to mourn, the risk of more loss is too great. As Scott argues, "[w]e must accept the risks of new development leading to new opportunities and new zest, knowing that the more we risk the more we may lose" (pp. 574-575). The agoraphobic, with so many losses not yet mourned, is not able to take these risks.

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[152] See, for example, Lacan: "Indeed, the analyst cannot follow this path unless he recognizes in his own knowledge the symptom of his own ignorance, in the properly analytic sense that the symptom is the return of the repressed in a compromise [formation] and that repression, here as elsewhere, constitutes the censorship of truth. Ignorance must not, in fact, be understood here as an absence of knowledge but, just as much as love and hate, as a passion for being – for it can, like them, be a path by which being forms. […] The positive fruit of the revelation of ignorance is nonknowledge, which is not a negation of knowledge but rather its most elaborate form" (1955/2006j, p. 297). Bion makes the distinction between K (knowledge) and –K (minus knowledge): –K is neither ignorance nor nonknowledge; indeed, K "covers everything the individual knows and does not know" (1992, p. 182). –K is associated with "nameless terror" and involves envy's destructiveness; rather than indicating nonknowledge, –K involves an attack on knowledge. I expand on the relevance of ignorance in Chapter Four; for now, I indicate its importance and its relation to structural emptiness.

[153] I explore the relation between speech and silence, and the importance for both in the analytic situation, below and also in Chapter Four. Free association is, I argue, the vehicle in analysis by which the meanings of both speech and silence can be apprehended.

[154] See also, Scott: "Our knowledge is finite, but our ignorance is infinite. Consequently, we can be frustrated by our ignorance or we can progress to being disappointed by our ignorance and also to learning to mourn the loss of our omnipotent beliefs. Possibly, eventually, we can learn to love and woo our ignorance, from which all new things will come" (1988, p. 88). See also infra note 55.

The “unconscious fear of not knowing” (Ogden 1989, p. 195) is an important psychological construct in the analyses of patients who have tremendous difficulties creating and occupying their own potential space (which, as I argued in Chapter Two, the agoraphobic does). This unconscious fear develops from an inability to know what one feels and, therefore, “who, if anyone, [one] is” (Ogden 1989, p. 195). In response to the fear of *not* knowing, the individual creates the illusion “that he is able to generate thoughts and feelings, wishes and fears that feel like his own”; as illusion, this defense “further alienates the individual from himself” (Ogden 1989, p. 195). Ogden refers to these illusions as “misrecognitions,” and distinguishes this defense from the more extreme cases of alienation encountered in alexithymia, states of non-experience, and disaffected states; rather, Ogden describes patients “who are able to experience the beginnings of feelings of confusion, emptiness, despair, and panic, as well as being able to mobilize defenses against these incipient feelings” (p. 196). The agoraphobia patients discussed above fit Ogden’s description, alternately using panic and emptiness to defend against the fear of not knowing, which is ultimately a fear of the unknown and of what might emerge out of the spaces between knowing. In Milrod’s words, there is a “core lack of structure in the self-representation” (2007, p. 1023) of these patients.

Ogden highlights Lacan’s emphasis on the *méconnaissance* of the ego, and the problematic (though inescapable) introduction of the symbolic (namely, language) into our self-knowledge.[155] Alienation is not just an effect of symbolization as such, but also depends on the nature of the symbol as something that predates the individual: “we do not create the symbols we use; we inherit them” (Ogden 1989, p. 197). Thus, we engage in the (necessary) illusion of self-expression; it is only possible to *misname* our experiences. At the same time, as Winnicott (and others, including Lacan) argues, we make the symbols we have inherited our own. Like the transitional object, which had to have existed before we can make use of it, and which we are able to make use of only as we create it anew, we are born into a language system: it exists long before we begin to

[155] See also Reeder on Lacan’s “symbolic castration”: “the acquisition of language establishes a splitting and division within the subject. But, what has been lost in symbolic castration is not so much the breast or even this or that person -- what is at stake is a *severance from the immediate reality of experience* in a process that reaches its height when the subject has become well-anchored in the realm of language to represent its world” (2012, pp. 38-39).

speak (to use it) and before we are even born. And yet, even as we can only misname our experiences, our use of language makes it something that it never was before, something new and uniquely our own. This paradoxical relation to the self is determined by the nature of language; it institutes a structural emptiness within every individual's psychical apparatus. This structural emptiness has the quality of chinks in a suit of armour: as breaks or gaps in the integrity of the armour, chinks are both areas of vulnerability and necessary spaces that allow for movement. The armour can be inhabited by a body that requires movement only insofar as its chinks provide openings and spaces between the various pieces of the suit. If language is the suit of armour, gaps in the integrity – that is to say, wholeness or absolute coherence – of language allow it to be inhabited by an individual; the individual can use language only insofar as s/he can take advantage of the chinks, the structural emptiness, that is, the spaces where coherency falters.

Wilson, via the analyses of several obsessional narcissistic patients, investigates the doubled meaning of "the nothing that is a source of fear and the nothing that is a source of help" (2006a, p. 398). The former, "the nothing that is a source of fear," is described above in the sections on pathological emptiness, and grief and agoraphobia; the latter, "the nothing that is a source of help," refers to what I am calling structural emptiness. Like Wilson, I refer to Lacan because his notion of lack occupies a central position in his theories of subjectivity and psychical life. In Chapter Two, I discussed the centrality of lack in the constitution of the subject. Here, I am concerned with the manifestation of lack in the analytic situation and its connection to the agoraphobic's persistent emptiness. In particular, I emphasize lack's function within language in order to identify the transformative limitations of interpreting the transference particularly for agoraphobia patients who appear to be stuck within their subjective experiences of emptiness. Wilson takes up the question, empirically derived, of why the analyst's *mistakes* are often transformative. Following Lacan, Wilson argues that the "*analyst's missing the patient, on a fundamental level, is an evocation of nothing or lack*" (2006a, p. 401; original emphasis). That is, when the analyst *misses* the patient, or the analyst's interpretation misses the mark, there is a space opened between them out of which the patient can find something new about his or her own self. Wilson clearly articulates that both the analyst and the analysand must learn to tolerate lack in order for the analytic process to unfold. Lack is essential to analysis and is essential to the very "nature of meaning" (p. 402). Although the analyst's mistakes are particularly obvious 'evocations' of lack, "[t]here is always a limit or a lacking in any statement, even if the statement suggests an excess of meanings" (p. 402). Thus, the analyst's mistakes are not the only instances of lack irrupting in the analysis. It, lack, is always there in the inevitably incomplete encounters between people. Wilson argues that a capacity to "explore this inevitable missing" in both the analyst and the analysand contributes to the analytic work, insofar as this "missing" creates an "interpretive space" (p. 402).[156] Curiosity about this space provides opportunities for new thoughts and feelings. The problem arises when the meanings of this space are foreclosed, whether by the analyst's embarrassment about making a mistake, the analyst's narcissistic desire to make a clever interpretation, or the analysand's anxiety about what the analyst does not know. Wilson summarizes: "The structure of the subject and the structure of things meaningful both rest on a space created by lacking" (p. 406).

In the cases of the agoraphobia patients discussed above we can say that the anxiety and avoidance – as well as all of the fantasies that go along with one's identity as an individual with agoraphobia – concealed any meaningful encounter with lack, and therefore any encounter with the creation of meaning. Once overt agoraphobic symptoms have remitted, the emptiness out of which everything new appears is terrifyingly revealed:

> When the components of the fantasy appear, the lack that supports and is hidden by the fantasy can be 'seen,' or experienced. This experience is the experience of nothing, and more precisely that nothing which supports what one thinks, where one is, what one feels. It is an experience of confusion, of utter not knowing. One can see then what one has used, psychically, to prop oneself up, so to speak. (Wilson 2006a, p. 417).

The agoraphobic's loss of her anxiety and other phobic symptoms entails a significant encounter with the "utter not knowing" of who she is. Her experience of emptiness, then,

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[156] See also Faimberg (1996, 1997) on "listening to listening." I discuss this clinical technique further in Chapter Four.

is not at all surprising. However, insofar as her emptiness gets in the way of her lack, so to speak, it remains a pathological phenomenon.

Goldberg, in his commentary on Wilson (2006a), suggests (as critique) that "when a patient reaches a point of missing or of misunderstanding, it is not an invitation to settle for some sort of compromise; instead it is an opening to the pursuit of a more positive accomplishment" (2006, p. 432). Yes; the "opening" is exactly the point. I cannot speak for Wilson but, in my reading of his article, this opening is also part of his point. Although I am not as optimistic, perhaps, as Goldberg appears to be in the analyst's (or the analysand's) capacity to *arrive* at what might be called "a more positive accomplishment," the "opening" and the "pursuit" is the goal of analysis. Lack, or emptiness, when it can be tolerated, provides this necessary opening towards something "more" – if it is to be more "positive," well, that will always remain to be seen. In his "Response to Commentaries," Wilson emphasizes this essential point: "an assumption of lack and the capacity to act follow one from the other" (2006b, p. 459). The meaning of this statement is perhaps clarified if re-formulated in its negative version: the denial of lack and the incapacity to act follow one from the other. That is, if lack, or structural emptiness, is defended against, there is no opening for new experiences, and no freedom to explore one's internal and external worlds.

Reed's commentary on Wilson (2006a) provides an important hesitation: "in Wilson's paper there is an underlying rhetorical legerdemain that equates lack with missing the patient and missing the patient with good analytic practice. It is this current in Wilson's paper that makes me uneasy" (2006, p. 451). Further, she writes:

> Techniques appropriate for the normal negative, for patients who can express affect and ideation together in the chain of signifiers characteristic of neurosis, are not necessarily helpful for Green's pathologically negative patients. It is a question of letting space between analyst and patient evolve, but of allowing just enough so that the patient's frustration does not take on the flavor of the original trauma. (p. 454)

Wilson's important work on the clinical use of lack (or what I have called structural emptiness, and Green has called the normal negative) as the structuring element in the constitution of the subject and of meaningfulness is hampered by his clinical example, which provides evidence, rather, of pathological emptiness. Wilson indicates that Evan[157] endured severe maternal deprivation very early in his infancy; it is possible that Evan's losses must be recognized, analytically, and worked through before it is possible for him to approach the profundity of his subjective lack.

In Chapter Two, I gestured towards the importance of all of emptiness's meanings via Luepnitz, who indicates the most significant difference between Winnicott and Lacan: "For Winnicott, the central drama will turn around the infant's loss or feared loss of maternal connection. For Lacan, while loss is obviously important, something even more profound is at stake – the lack built into subjectivity by the mere existence of the unconscious" (2009, p. 964). Analyses of loss and mourning encounter a limit, a barrier to a deeper experience, if the centrality of lack is never articulated; at the same time, we cannot approach the profundity of subjective lack if there is a loss, real or phantasied, in the way. As Green provocatively writes in his work on negative hallucination, "[p]leasure arises from its roots in need. Desire is a pivotal concept for one cannot overlook the fact that it is the satisfaction of need which sets it in motion" (1999, p. 183). That is, without the satisfaction of need, desire (and thus lack) is *unmotivated*, so to speak. The analyst, however, can make use of lack insofar as it is part of language and insofar as language is the analytic medium. Lack irrupts in the analysand's speech in many and various forms, including slips of the tongue, silences, and bodily gestures[158]; by drawing attention to these moments of potential meaning-making, the analyst utilizes the structural nature of lack without overwhelming the analysand with its profundity. These little incoherencies are also manifestations of lack, or emptiness, and the capacity to explore these gaps in coherence encourages the analysand to greater explorations of his subjective experiences.

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[157] In order to protect his patients' anonymity, Wilson constructs a patient composite, which he nominates Evan, comprised of details drawn from several patients.

[158] See also Lacan 1998, p. 234: "Desire always becomes manifest at the joint of speech, where it makes its appearance, its sudden emergence, its surge forwards. Desire emerges just as it becomes embodied in speech, it emerges with symbolism."

3.4. Conclusion

In Chapter One, I discussed the distinctions between agoraphobia and "true," or discrete, phobias. One of the main distinctions involves the nature of the phobic object: in discrete phobias, the phobic object is specifically identified and the phobia can be said to be a displacement of an unconscious fear onto the phobic object. In the case of Little Hans, which I offered as an early example, Hans's unconscious fear of his father was displaced onto the horse and became the conscious fear that the horse would bite him. The phobic object, then, becomes a symbol of the unconscious fear. In agoraphobia, the precise nature of the phobic object is contentious. Agoraphobia, I argued, is not only the anxiety about space but, more specifically, the boundaries between spaces, including the spaces between the self and the world and the ego and its objects. As I argued in Chapter Two, agoraphobia signals an individual's inability to create secure boundaries between the self and others, and also to creatively inhabit the spaces between the self and others (and the self and its objects). It develops out of an inability to delimit affects via symbolization, leading to, in Deutsch's words, "a genuine dread of death" (1929, p. 51) or in Bion's phrase, "a nameless dread" (1962a, p. 309). For patients with agoraphobia, particularly evident in those patients whose overt symptoms have remitted, the gaps inherent in language and in the meaning-making process of putting it all into words are defensively avoided. This avoidance mimics the agoraphobic's avoidance of the external world, which, as I argue, is fundamentally an avoidance of intermediary spaces. These spaces, like the gaps in language, are avoided because the agoraphobic does not know what will emerge out of them.

Language inevitably fails to be wholly satisfying insofar as representation definitively encounters the gap between the sign and that which the sign attempts to signify; therefore, language, I argue, structures an emptiness that is central to psychic reality: the gap that always remains between what is said and what is. There is always something left behind, something that falls out during our attempts to express meaning. It leaves a gap, an emptiness, a silence, an ignorance. While in health, this emptiness is effectively a potentiality, an opening to (unconscious) experience, for the agoraphobic this emptiness is a barricade to experience. That is, rather than experiencing the emptiness as a potential space wherein something productive might happen, the ‘something’ that ‘might happen’ – which, for the agoraphobic, is either an overwhelming ‘already-happened’ or a ‘nothing happening’ where something might have productively happened – is defended against by filling the emptiness with a blankness, like putting psychic locks on emotional doors and then experiencing them as impenetrable walls. Therefore, the freedom to be incoherent affords the agoraphobic the opportunity to experience her intrinsic emptiness as a potential space wherein something productive might happen rather than as a barricade to experience or as an emptiness that needs to be filled. In the next chapter, I argue that a therapeutic emphasis on narrative coherence displaces the focus from unconscious truth to a good story. The tasks of trying to be coherent and trying to say everything involve different processes and therefore have different results; likewise, the task of listening differs between trying to make sense of what is being said and waiting to see what sense emerges. It is not that incoherence in itself is preferable to coherence, but that when coherence is *demanded*, fewer feelings and thoughts are possible; when incoherence is tolerated, new and unanticipated feelings and thoughts can develop. Coherence, then, cannot be taken to dictate the process of psychoanalysis, or as its ultimate aim. I develop these arguments in the next chapter on the use and function of language in the psychoanalytic situation.

Chapter Four: In/Coherence

In Chapter Three, I discussed the phenomenon of emptiness Milrod (2007) identifies in patients whose agoraphobic symptoms of anxiety and avoidance have remitted. Milrod's discussion of the clinical case studies she presents emphasizes the transference relationship and implies (as she argues elsewhere: see Milrod et al. 2000, 2001, 2007) that it is this particular element of psychoanalysis that distinguishes it from the temporary effects of the psychiatric treatment of agoraphobia. However, the limitations of this emphasis are evident in Milrod's assessment of one of her patients' progress: "Likely her desperate need to define herself in keeping with and as being linked to one of her parents had been substituted in part by her relationship with me" (2007, p. 1020). The substitutive relationship with the analyst allows for higher everyday 'functioning,'[159] but it fails to relieve the patient's psychic emptiness. In light of the failure of interpreting the transference to effect change in patients' experiences of pathological emptiness, I argue that the fundamental rule of psychoanalysis – what Bollas (2013) calls the Freudian Pair: the freely associating analysand and the evenly suspended analyst – is the most important element in psychoanalysis generally, and in the psychoanalysis of patients with agoraphobia specifically.

As I argued in Chapter One, agoraphobia indicates a failure to symbolize – and, thus, to limit – the anxiety that results from the repression of libidinal and aggressive drives. Rather than the symbolic fear of a specific phobia, agoraphobia indicates the fear of symbolization itself.[160] The persistent emptiness Milrod (2007) describes, along with the agoraphobic's inability to limit her anxiety by locating a specific phobic object, is indicative of this inhibition of symbolization. As I argued in Chapter Two, the agoraphobic "object" of anxiety is intermediary spaces, which can be understood to include all of what Winnicott calls the third area of experience. As I developed in Chapter Two, this third area of (shared) experience develops from the diffusion of the transitional

[159] For example, this patient's psychiatrically delineated agoraphobic symptoms of anxiety and avoidance remitted. She was able to move out of her parents' house and into her own apartment with her husband (Milrod 2007, p. 1020).

[160] As I described in Chapter One, agoraphobia is "more gradually developed, more generalized, less demonstrably related to conditioning, more resistant to treatment and more likely to involve extensive character pathology [than specific phobias]" (Frances & Dunn 1975, p. 435).

object and, following Green (1975), includes the use of language. In order to alleviate the agoraphobic's persistent emptiness, the agoraphobic needs to be able to learn to use language creatively. The creative use of language is only possible when the agoraphobic's fear of destruction (of the object) or fear of annihilation (of the ego) is not too great. There are two problematic uses the agoraphobic makes of language: the first is indicated above and is symptomatic of her inability to symbolize, namely, to limit feelings by putting them into words. This problem may only become evident once, as Milrod (2007) shows, anxiety and avoidance recede to reveal the agoraphobic's persistent emptiness. The second problem involves a particular reliance on specific narratives to defend against the gaps in language which, as I described in Chapter Three, emerge out of the subject's structural emptiness. I argue that the agoraphobic's use of language in this latter way is characteristic of a repetition compulsion, distinct from the more familiar behavioural repetition compulsion in which individuals re-enact troubling relationships and traumatic events.[161] This second problem may be more apparent in frankly agoraphobic patients – that is, individuals currently beset by the anxiety and avoidance by which the disorder is psychiatrically defined – than in patients for whom these symptoms have remitted. Free association addresses both of these problems, providing the agoraphobic with the opportunity to experience her structural emptiness as a potential space wherein something productive might happen instead of as a barricade to experience or as an emptiness that needs to be filled.

I argue that the tasks of trying to be coherent and trying to say everything involve different processes and therefore have different results; likewise, the task of listening differs between trying to make sense of what is being said and waiting to see what sense emerges. It is not that incoherence in itself is preferable to coherence, but that when

[161] For some early conceptualizations of the repetition compulsion, see Freud (1914b, 1920) and Kubie (1939). Loewald makes a distinction between active and passive repetition, and suggests that the "compulsion to repeat unconscious conflicts, wishes, experiences, passively is due primarily to their having remained under repression, that is not exposed to the influence of the organizing activity of the ego" (1971, p. 61). The agoraphobic's conscious repetition of her narratives belies the simplicity of this distinction, but also suggests the possibility that *something* in the agoraphobic's unconscious remains repressed, unacknowledged, or unsaid. For a recent addition to the literature, see Künstlicher (2010), in which the connection between the repetition compulsion and the phenomenon of *Nachträglichkeit* is demonstrated, though not made explicit. I discuss this connection further in section 4.4.

coherence is *demanded*, fewer feelings and thoughts are possible; when incoherence is tolerated, new and unanticipated feelings and thoughts can develop. The agoraphobic is unable to tolerate incoherence: she either produces narratives that are too coherent or she produces empty narratives. The agoraphobic suffers from a restricted unconscious freedom in addition to the restrictions she places on her freedom of mobility. Following Bollas, I argue that there are two aspects of mental health: the ability to construct coherent narratives and the freedom to explore the feelings that precede coherence.[162] The agoraphobic, I suggest, uses narrative to stave off the overwhelming emotions that accompany incoherence. An analytic emphasis on interpreting the transference colludes with the agoraphobic's ego in the resistance of incoherence, inhibiting the development of free association. Focusing on narrative coherence forecloses the emergence of the unconscious in the gaps revealed by language, gaps which must emerge in order for new thoughts and feelings to be possible. The invitation 'try to say everything'[163] provides the space for these gaps to emerge and the opportunity to explore them.

In this chapter, I explore agoraphobia and the uses of language in the psychoanalytic setting through three main themes: coherence as resistance; the analyst's over-reliance on interpreting the transference as an impediment to the development of free and freer associations; and, the concept of *Nachträglichkeit* and the logic of the unconscious.[164] These themes are all connected to the concepts of psychoanalytic truth

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[162] Some patients exhibit a problematic lack of coherence. The inability to cohere can be related to a plethora of possible traumas and presents a different kind of psychic dilemma that is beyond the scope of this thesis. As Loewenstein indicates, and as I argued in Chapter Two, the "illusion of unity and identity […] is an absolute necessity for being in this world that is less than harmonious (1994, p. 730). I do not think any of the theorists I consider here disagree that narrative is an important aspect of psychical life. The disagreement revolves around how one uses narrative analytically and where a patient's narrative comes from. Here, I focus on the agoraphobic's inability to explore the gaps in conscious experience, which is to say, the inability to use the experience of incoherence (and emptiness) creatively.

[163] As I explore below, the articulation of the fundamental rule takes many forms. I note here the historical shift from Freud's authoritarian insistence on free association to contemporary analysts' "gentle exhortation" (Lichtenberg & Galler 1987, p. 63), evident in such phraseology as "try to say everything." See also Busch 1994, pp. 364-365: "Lichtenberg and Galler's characterization of the tone of the guidelines given to patients as 'gentle exhortation' (p. 63**)** captures a current dilemma for many analysts. The strident nature of Freud's view of the method of free association seems alien, thus the 'gentle' component. Yet we still believe it necessary to 'exhort' our patients to hold back as little as possible."

[164] I refer to unconscious "logic" in the Freudian tradition. See, for example, Bollas (2013), Bradby (1920), Freud (1900, 1915), Green (1986), and Melnick (2000). See especially Matte Blanco (1959, 1973/2005,

and psychical reality, which provide the frame within which I develop my arguments. There is little consensus on what constitutes psychoanalytic truth. As I am here concerned with psychical coherence – and, relatedly, psychical reality – I follow Faimberg's concept of psychic truths, which "are the consequence of the psychic work resulting from the demands of reality that are fashioned by the unconscious wish and the unconscious fantasy" (1997, p. 449). This definition is consistent with my arguments in Chapter Two, namely, that psychical reality is created through the ego's mediation of external reality; both the facts of external reality and the ego's mediation – or, better, modification – of those facts is clinically pertinent. Indeed, it is precisely the ego's modification of external reality that is the concern of psychoanalytic work and is the realm of that work's influence.

4.1. Psychoanalytic Truth and Psychical Reality

"Go ahead and lie."

(Stern 1966, p. 144)

The question of psychical coherence is intimately connected to the question of psychical reality. In Chapter Two, I addressed the question of 'realities' along one line of thought, arguing that the agoraphobic is not able to take for granted the distinction between internal reality and external reality, and therefore cannot experience shared reality as *illusion*. Psychical reality refers to internal reality, which is formed in a process of creative differentiation; the process involves both identification of what is internal and what is external, and the creation of a uniquely individual internal reality at the same time. I developed these ideas in detail in Chapter Two. However, there is much more that

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1975, 1988) for an elaboration of the "symmetrical" or "anaclitic" logic of the unconscious, which is contrasted with – in fact, defined against – the asymmetrical logic of conscious thought. Matte Blanco's term "bi-logic" (1975) refers to the admixture of these two logics which forms most thought. The qualities of unconscious logic include: displacement; condensation; timelessness; the confusion of (inner) fantasy with (outward) reality; the absence of negation; and, the principle of non-contradiction (Freud 1915; Matte Blanco 1975, 1988). In this chapter, I am primarily concerned with the quality of timelessness – as displayed in the phenomenon of *Nachträglichkeit* – and its implication for the psychoanalytic treatment of agoraphobia.

has been said and much that remains to be said on the question of reality in psychoanalysis. At the same time, this question of psychical reality cannot be entirely extricated from psychoanalytic considerations of truth. As recent publications indicate, the natures of truth (Mills 2014) and of psychical reality (Rosegrant 2010) are entirely unresolved in the psychoanalytic literature, both clinically and theoretically. Some distinguish between “historical truth” and “material truth” (e.g., Avenburg & Guiter 1957; Freud 1937); “narrative truth” and “historical truth” (e.g., Spence 1982a and Shengold 1985); “psychical reality” and “historical truth” (e.g., Schimek 1975); “narrative truth” and “theoretical truth” (e.g., Spence 1982b); “poetical truth” and “scientific truth” (e.g., Toynbee 1949). Truth is also variously distinguished from illusion, fantasy, lies, and error. Rather than belabour these various distinctions, I draw attention to a few critical points. The first point is quite simply that the questions of truth and of reality remain open. Mills, referring specifically to truth, summarizes this state:

> Psychoanalysis has no formal theory of truth. When analysts speak of truth, they are often referring to empirical matters, such as patients’ statements or disclosures that correspond to events in the real world, historical facts, recollection from memory versus construction via fantasy, sincere first-person narratives, and how truth is revealed or concealed in the analytic encounter. A close inspection of the psychoanalytic contributions on the question and meaning of truth is almost exclusively centered on clinical phenomena, while a genuinely unique philosophical theory peculiar to psychoanalysis remains unrealized. (2014, p. 268)

Although the question of truth is unresolved, this is not to say that there are no arguments about the nature of truth in psychoanalysis; that is to say, while the question of truth may be unresolved – like many, if not most, psychoanalytic concepts – as a psychoanalytic principle, there are a finite number of specific arguments concerning the nature of truth in psychoanalysis. Most of these arguments concern the competing clinical relevance of narrative truth (that is, a “good story”) and historical truth (that is, “what *really* happened”). As I will argue below, following Faimberg (1997), neither of these exclusive options is clinically satisfying as each ignores the complexity of psychical reality.

Hanly (1990, 2009) explicates the three philosophical theories of truth: correspondence, coherence, and the pragmatic.[165] Although these theories have traditionally been opposed one to the others, Hanly importantly argues that they can function together psychoanalytically, that is to say, clinically.[166] To this end, he implicitly moves from considering each one as a philosophical theory of truth to considering each one as a criterion for truth clinically. Briefly, the coherence theory of truth "requires logical consistency (non-contradiction) and explanatory completeness" (Hanly 2009, p. 364). Ultimately, Hanly argues that clinical "[a]rguments based only on a criterion of coherence over-value logical consistency which while necessary is not sufficient as a criterion [for truth]" (2009, p. 365). While Hanly emphasizes an over-valuation of logical consistency, I point to the overvaluation of *narrative* consistency, which is more relevant clinically in the work of narrative-oriented psychoanalysts. Generally speaking, the narrativists privilege the coherence theory of truth over the correspondence theory, which requires that a proposition find its match in external reality. They argue that, working psychoanalytically, the material reality of the patient's clinical discourse cannot be verified by any external source. Partly, the private nature of psychoanalytic work is responsible for this impossibility.[167] The narrativists also express concern over the analyst's supposedly authoritarian access to truth – as if there could be one absolute Truth – for those analysts subscribing to the correspondence theory. However, as Hanly argues, in the context of clinical psychoanalysis (as in the empirical sciences), "[c]orrespondence

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[165] Cf. Muniz de Rezende (Lewkowicz & Flechner 2005), who distinguishes types of truth according to discipline: in formal sciences, truth requires coherence; in empirical sciences, it needs correspondence; in human sciences, it calls for symbolic consensus. Symbolic consensus is based on Blumer's (1962/1969) symbolic interactionism in the discipline of sociology and is similar to critical pragmatism in its clinical significance. See also infra note 166.

[166] In the history of psychoanalysis, the debate between correspondence and coherence is reflected in the longstanding debate on psychoanalysis as science or art; popular perspective has shifted from defending psychoanalysis as a science to holding that psychoanalysis is both art *and* science. See, for example, Bowlby (1979), Dugan (2010), French (1958), and Slochower (1964). Despite the consensus of popular opinion, the debate continues, and continues to develop greater complexity as findings from other fields (especially developmental psychology and neuroscience) are taken into account.

[167] One can also argue that the past no longer exists in material reality and cannot therefore be confirmed or refuted. See, for example, Russell (1921). In the past century, arguments in this vein have gained complexity. Faimberg (1997), for example, distinguishes material reality from historical truths. Correspondence, for Faimberg, refers not to the relationship between psychical reality and material reality (by which she refers to an apprehendable, objective, and external world), but to psychical reality and historical truth (by which she refers to past events).

can be evaluated without omniscience, without absolute knowledge and without certainty" (2009, pp. 366-367). Furthermore, correspondence "is not a question of absolute, automatic, intuitive certainty. It is a matter of accumulated evidence" (Hanly 2009, p. 367). Both the coherence and correspondence theories of truth lack the third element that Hanly identifies as essential to the clinical enterprise: critical pragmatism:

> An idea or theory is true, if, by means of a technology specified by it and coherent with it, the theory can be used to change the course of nature. It is this concept of pragmatism that we find at work in Freud's development of psychoanalytic theory and technique. In psychoanalysis the change in the course of nature we look for is the amelioration of neurotic disorders. The technique is the interpretation of free association and transferences in the analytic setup. The theories are about the causes of neuroses. (Hanly 2009, p. 368)

Hanly overstates the psychoanalytic consensus on all of these issues.[168] Nonetheless, his point regarding the clinical need for critical pragmatism as a criterion for truth is well-taken. As Jacobs (2002) also demonstrates, without the critical pragmatic element of truth, correspondence and coherence is clinically insufficient.[169]

Hanly vacillates between arguing about the truth value of a theory, suggesting that a *theory* is true if it fulfills these three criteria, and the truth of statements made clinically. Although one might think that, on questions of truth, there could be no distinguishing between theoretical and clinical truths, we must nevertheless do so. This distinction is

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[168] See Levy for a brief discussion, from the perspective of the editor of a leading psychoanalytic journal (*JAPA*), of "changing perspectives on the clinical role of interpretation" (2011, p. 1120) and other critical issues of dissension or contention among contemporary analysts. Kiersky and Fosshage also provide an editorial response to a case study with commentaries, noting "that something is missing in [this group of analysts], and that is the rigid, authoritarian analyst of the past who always knew more about the patient than she knew about herself" (2009, p. 355). Their response draws out the plurality of theoretical perspectives, which, of course, impacts each analyst's clinical work. See also Goldberg (2012), who addresses the plurality of clinical aims through an examination of clinical failures.

[169] See also Eigen (1983). Through the analysis of a dream from each of three patients, Eigen aptly demonstrates the limitations of coherence and correspondence. Referring to her dream, one patient succinctly describes her fear of the potential for "more" (more life, more experiences, more feelings): "'But what if I cross the ladder and the boat is empty?' [Eigen comments:] She apparently felt better off immersed in a fruitless or vicious circle with plenty of activity, if no real movement" (p. 215). Eigen's patient echoes one of Milrod's agoraphobic patients, who states: "'I'd prefer to live without any of this emotional intensity. […] What I like is to do things'" (Milrod 2007, p. 1021). Only with the addition of the criterion of pragmatism is, in Eigen's words, "genuine movement beyond the status quo" (p. 216) possible.

necessary precisely because of the nature of psychical reality. Here, I am not concerned with theoretical coherence, which, as Hanly points out, is a necessary but not sufficient condition for theoretical truth. I am concerned with truth in its relationship to psychical reality and psychical in/coherence.

Holmes, a leading figure in British psychodynamic psychiatry,[170] draws a conclusion on the significance of narrative coherence in attachment research, the psychoanalytic situation, and psychical reality: "It [attachment research] points to powerful links between the 'narrative truth' of the clinical situation and the 'historical truth' of the patient's actual biography" (1999, p. 56).[171] This conclusion is simply incorrect. As the Adult Attachment Interview manual clearly states, no assumption is made between reported and actual experiences (Main et al. 2002, p. 8). Furthermore, as I emphasized in Chapter Two, what is at stake in psychoanalysis is psychical reality. While the relationship between narrative truth and historical (or material) truth is certainly of

[170] Holmes has written extensively on attachment theory, narrative therapy, and psychoanalysis. See, for example, Holmes (1994, 1997, 1999, 2014) and Holmes and Slade (2013).

[171] The Adult Attachment Interview (AAI) is a semi-structured interview used as a psychological research measure of "adult state of mind with regards to attachment." In other words, the AAI attempts to reveal the nature of an individual's object relations using language as the medium between internal representations and behaviour. The AAI produces a transcript which is analyzed for the individual's discourse coherency about attachment experiences. The hallmark of a secure-autonomous speaker is precisely narrative coherence; in parallel, the various insecure states of mind with regard to attachment are characterized by different styles of incoherency. Coherence is defined according to the dyad; that is, coherence depends on the speaker *and* the listener, the text *and* the reader. Clinically, as Vaslamatzis (2007) demonstrates, the patient's degree of coherence is determined according to the analyst's understanding, or lack thereof, of the patient's speech. In adult attachment research, coherence is defined according to Grice's (1975) maxims of collaborative conversation: be truthful and have evidence for what you say; be succinct, yet complete; be perspicacious; and, be clear and orderly. The relevance of the AAI is due not only to its systematization of discourse analysis in terms of attachment status, but more importantly because of the link it demonstrates between language and behaviour. Specifically, a parent's state of mind as determined via discourse is strongly predictive of his or her child's attachment status, which is measured behaviourally through the Strange Situation Procedure (SSP). That is, a parent's state of mind with regards to attachment, measured via discourse analysis, is strongly correlated with his or her child's attachment style, measured behaviourally. The way a parent talks about his or her own attachment experiences corresponds, statistically, to the child's attachment behaviours towards that parent (see, for example, Main et al. 1985). Research with the AAI demonstrates that the ability to be coherent regarding attachment experiences is correlated with positive outcomes (see, for example, Karen 1998; Berlin, Cassidy & Appleyard 2008). Correlatively, incoherence, evidenced via the violation of these maxims, is associated with adverse outcomes both individually and intergenerationally (see, for example, van Ijzendoorn & Bakermans-Kranenburg 1997). For an example of the clinical application of the AAI in a psychotherapy patient, see Muscetta et al. (1999). See also Steele & Steele (2008).

interest, Holmes's suggestion that there might be a correspondence between them based on coherence conflates the philosophical distinction between the coherence theory of truth and the correspondence theory of truth and ignores the gamut of clinical literature arguing against this very claim (including Spence [1982a, 1982b], whom I discuss below). Furthermore, such a position displaces the focus of the clinic from unconscious (psychical) truth to a good story, which, as I describe below, is also the pitfall of the narrativists.

The chasm between narrative truth and historical truth is well articulated by Spence, a psychoanalyst who follows a narrativist approach:[172] "Narrative truth is confused with historical truth, and the very coherence of an account may lead us to [mistakenly] believe that we are making contact with an actual happening" (1982a, p. 27). And further:

> [T]he particular satisfaction that comes from good narrative fit should not be confused with the excitement of making a historical discovery; constructions should not be shaded into reconstructions, and the difference between the two kinds of truth statements should always be kept in mind. (1982a, p. 185)[173]

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[172] This "narrative approach" to psychoanalysis characterizes the work of, for example, Geha (e.g., 1993, 1996), Riceour (e.g., 1970/1977), and Schafer (e.g., 1987, 1996). Geha describes the extreme version of this narrative approach, fictionalism: "Fictionalism maintains that all aspects of human experience are creations of imagination, that mind-made realities constitute for human beings their sole realm of existence, and that it is only about these realms that anything at all can be known. No other knowable realities exist" (1993, p. 209). Further, Geha argues that "psychoanalysis is basically a fictional enterprise" (p. 210). To be clear, he does not intend this argument as a criticism of the psychoanalytic project; rather, he uses this argument to frame his criticisms of psychoanalytic "realism." Less extreme, Spence quotes Schafer on the analyst's role: to "help [analysands] transform these narrations into others that are more complete, coherent, convincing, and adaptively useful than those they have been accustomed to constructing" (Schafer 1980, p. 63; qtd. in Spence 1983, p. 460). Loewenstein (1991) provides a comparison of the narrative approach and the positivist scientific approach of the ego psychologists (e.g., Kohut 2011/1990; Hartmann 1939/1964a, 1964b) and criticizes the narrativists and the ego psychologists alike for constructing coherence as one of the pillars of psychoanalytic truth.

[173] Cf. Schimek: "What Freud (1899) said about conscious childhood memories – namely, that they are only memories 'relating to our childhood,' which do not simply re-emerge in the present, but are 'formed at that time' – should apply as well to the reconstruction of the past through the psychoanalytic process" (1975, p. 862); and Eickhoff, in his work on *Nachträglichkeit*, who also quotes Freud: "'Our childhood memories show us our earliest years not as they were but as they appeared at the later periods when the memories were aroused. In these periods of arousal, the childhood memories did not, as people are accustomed to say, *emerge*; they were *formed* at that time. And a number of motives, with no concern for

Succinctly, Spence emphasizes: “Narrative fit speaks to narrative truth; it says relatively little about historical truth” (1982a, p. 187). Even as Spence distinguishes between narrative truth and historical truth, he privileges narrative truth for the transformative effects it may have in the analytic setting: “narrative truth has a special significance in its own right and [...] *making contact with the actual past may be of far less significance than creating a coherent and consistent account of a particular set of events*” (1982a, p. 28; my emphasis). While the correspondence between narrative truth and historical truth may not be as close as Holmes suggests, the asymmetry between them may not be as radical as Spence argues.[174]

Avenburg and Guiter, following Freud’s use of “historical reality” to refer to the subjective experience and “material reality” to refer to that which may be confirmed by external sources,[175] suggest that

> the concept of truth includes different realities and, in analysis, is capable of resolving the opposition between internal and external by pointing precisely to those moments upon which such distinction between psychical reality and external reality was founded, the moment when both realities were one and the same, i.e. only one truth, a material truth which was then preserved as historical

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historical accuracy, had a part in forming them, as well as in the selection of the memories themselves’” (Freud 1899, p. 322; original italics; qtd. in Eickhoff 2006, p. 1457).

[174] Fitzpatrick Hanly provides an assessment of the current status of narrative in clinical psychoanalysis, suggesting that the “idea of a ‘narrative approach’ has come to mean that the history of the psyche of a patient is inaccessible and that what the analyst should aim to achieve in the process of the analysis is the co-construction of a ‘story’ agreed to by both analyst and patient. The psychoanalytic process constructs a fiction that is somehow helpful” (1996, p. 445). Referring to the clinical process (as opposed to theory), Fitzpatrick Hanly importantly argues that psychoanalytic discourse cannot be reduced to a narrative process without doing injustice to its integral aspects: “Disorganized, disconnected and fragmentary, with gaps whose content lie in the unconscious, and lacking any clear beginning-middle-end sequence, psychoanalytic ‘discourse’ has a unique status. To use the word ‘narrative’ (with its connotations of clear ‘beginning, middle, end sequence’ and ‘coherence’) for this special discourse can blur many distinct features of free association and can ignore the deeper structures of the psyche that are glimpsed through disjunctions in the associative process” (p. 451).

[175] It is interesting to note that the shift from contrasting historical reality with material reality to contrasting narrative truth with historical truth implicitly conceals the fictional aspects of any “history,” which is always already a subjective narrative construction of past events. Schimek traces this shift in Freud’s work, noting that “Freud started with the assumption that the analyst was unearthing unconscious memories of actual events, then only fantasies, then a psychical reality inherited from prehistoric events, and, finally, back to individual experiences that ‘did really happen’” (1975, p. 858). See Schimek (1987) for the further development of these arguments.

> truth in our subjectivity, separated from that other reality which is present, immediate and conventional. (1976, p. 17)

"Truth," then, brings us back to Chapter Two, the question of what is internal and what is external, and the process of reality-testing. As I suggest above, the question of truth is here of interest in its relation to coherence and the process of free association. As with the question of internal versus external, the question of truth is deceptively – impossibly – simple. The traditional philosophical notions of truth, established according to either correspondence or coherence, counters the work of free association in the psychoanalytic setting. As Stern suggests to one of his patients, "'Go ahead and lie'" (1966, p. 144). With this permission to deviate from the "truth," Stern encouraged the patient to "[make] up stories, creating material out of the spontaneous imaginative elements of his mind on the spur of the moment" (1966, p. 144).

I do not endeavour to construct a philosophical or metapsychological theory of truth. I wish only to indicate the impossibility of *arriving* at Truth, which is my second point here. Drawing attention to the truth of speech, Lacan states: "I always speak the truth. Not the whole truth, because there's no way, to say it all. Saying it all is literally impossible: words fail. Yet it's through this very impossibility that the truth holds onto the real" (1990, p. 3). This statement brings us back again to my arguments in Chapter Two. The real is that which resists. Narrative coherence indicates that the real remains outside of the story. As I argued in Chapter Three, the agoraphobic's persistent emptiness is better explained by the presence of traumatic and unmourned losses than by a deficient reflective function (as Milrod [2007] suggests). The historical reality of these losses must be given their due weight. Miller argues that, clinically, "what is said is not to be measured against what is" (1990, p. xxii). Further, the truth "is related to the real […] by the impossible-to-say" (Miller 1990, p. xxiii). A narrative's coherence, then, more likely indicates an altogether different relation to "historical reality" than the one Holmes suggests above. This impossibility ("saying it all"), like the "impossibility" of following the fundamental rule and the "impossibility" of analytic neutrality, does not entail that there is no use in the attempt. That is, the real *resists* symbolization, but one works at it and one gets better at saying more. There is always, as Faimberg notes (and I return to below), "an insistent residue" (1997, p. 449), but the more that can be said, the closer one is able to approximate truth: to approach psychical truth and account for the unconscious compromises between material reality and the mediating ego. As Bollas argues (and I developed in Chapter Two):

> The analyst must return to the patient's presentation of his or her facts of life not because they bear some meta-truth in themselves that will displace the patient's projective constructions of an internal world, but because the patient is *entering the intrinsically traumatic in the process of analysis, unconsciously asking that the trauma of things done be addressed*. (1995, p. 113; original emphasis)

The truth of the psychoanalytic process is this: that the patient is "unconsciously asking that the trauma" be recognized by someone other than herself. As I argued in Chapter Two, it is only once the loss is acknowledged in external reality that the patient – and especially, I argue, the agoraphobic – can begin to take for granted the distinction between internal and external.

4.2. Free Association, Coherence, and Resistance

Free association that reveals a coherent theme is already affected by anxiety, and the cohesion of ideas is a defence organization.

(Winnicott 1971, p. 55)

As I suggest above, the agoraphobic individual displays a kind of repetition compulsion of narratives. Frances and Dunn note that some "[agoraphobic] patients report repetitive ruminations or fantasies which they 'use' to protect them from frightening situations" (1975, p. 438).[176] Capps and Ochs (1995), Davidson (2000, 2001), and Hollway and Jefferson (2001) provide some data on the specific "repetitive ruminations" that agoraphobics use. Although Frances and Dunn suggest that the "repetitive ruminations or fantasies" protect agoraphobic individuals from frightening situations, Capps and Ochs importantly add that "agoraphobia is in part *kept alive* through [...] repeated psychological reconstructions of panic" (1995, p. 21; my emphasis). Capps and Ochs

[176] See also Parsons 2000, p. 41: "He spoke without emotion and his narrative technique obviously served to keep him affectively out of touch with what he was describing. Near the end of one session I commented on his organised way of presenting himself: perhaps it might be to try and ward of inner feelings of chaos."

perform a three-year case study on agoraphobia and discourse; Meg is the subject of this study. Through an analysis of Meg's discourse, Capps and Ochs demonstrate that agoraphobia is not only "kept alive" but continuously revivified and reinforced.[177] Davidson works with groups of agoraphobic women and suggests that "[e]ach individual has a different story to tell, and many continue to speculate and rework their narratives to the present day" (2001, p. 293). Unlike other psychological disorders, these individual stories *about* the disorder seem to be an integral aspect of the agoraphobic experience. Hollway and Jefferson consider the question of why these repetitive ruminations, which the agoraphobic often uses – consciously – in the aim of *understanding* her agoraphobic anxieties, are unsuccessful in relieving those anxieties. Hollway and Jefferson draw attention to the unconscious uses of narrative to, as Frances and Dunn indicate, "protect them from frightening situations," or, I add, to protect themselves from frightening feelings of, specifically, rage and grief.

Fink (2010) has argued that it is not necessary for a patient to understand the aetiology of her traumatic neuroses in order for the alleviation of her symptoms. On the contrary, understanding can be used, intellectually, to defend against overwhelming affects.[178] As I argued in Chapter Three, Milrod's patients exhibit an increased

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[177] I return to Capps and Ochs, and their case study of Meg, in Section 4.4.

[178] See also Grotstein: "Understanding is a myth, a falsehood – on its way to becoming a lie – and subverts transcending experience" (1981, p. 29). For a clinical example, see Jacobs 2012, p. 65. Although Jacobs's point is not that understanding is not necessary, or can even impede, analytic progress, he provides a clear clinical vignette of the limits of understanding. Indeed, like the agoraphobic patients I describe here, Jacobs's patient uses narrative – in this case, phrases previous of his analysts had used – to defend himself against overwhelming affect and true engagement with his unconscious, leading to little psychical transformation or growth: "He carried the analyst's words—he memorized phrases—with him like a magic talisman that he pulled out for use when needed. His defenses against true reliving and re-experiencing, both within and outside of the transference, remained unchanged" (2012, p. 65). See also p. 66: "Perhaps his intellectual grasp of the conflicts that lay behind his symptoms and many aspects of his character had increased, but this knowledge had not seemed to touch him." Although some (see, for example, Goldberg 2012, p. 162) have misread Fink (2010) as arguing against the analyst's understanding, it is clear Fink refers specifically to the *analysand's* understanding. At the same time, a therapeutic emphasis on understanding certainly distracts the analyst from his primary task of *listening*. Fink is not against understanding *as such* but, more specifically, he is cautioning against *using* understanding as a primary aim of psychoanalysis insofar as it interferes with psychical change: "Understanding what happened, why it happened, and how it changed is all well and good, as long as it does not get in the way of the change itself" (2010, p. 261). As Phillips phrases it, the "question is what we use *understanding* to do" (Holdengräber 2014; original emphasis).

intellectual understanding of their emotional lives; and yet, to reiterate, "this understanding did not alter Rita's need to distance herself from [her daughter] Laura and her emotional demands, nor did it make her more empathic with her daughter's distress" (Milrod 2007, p. 1020).

As I developed in Chapter Two, the ego is "a coherent organization of mental processes" (Freud 1923, p. 17). Resistance is a defence that arises in the clinical setting and is the work of the ego struggling to maintain its coherent and familiar self, to not admit conflicts into its being. Many theorists have written on the (false) lure of coherence. Stern connects truth and coherence, and importantly argues that a patient's strict adherence to "the truth" may interfere with his ability to free associate:

> [F]or some people, free-association is immoral, in accordance with their strict background of speaking only the truth and only what they are sure is the truth. [...For some, this means] that one has a responsibility to be sure that what is spoken corresponds to a rational, conscious estimate of truth. [...I]n order to speak along those lines, one must be coherent and accurate so that there is no question but that what is spoken is the truth. (1966, p. 143)

Meerloo similarly notes that "[w]hen patients talk continuously and coherently in the therapeutic session, they rarely associate freely" (1959, p. 76). Fink writes: "It is the analysand's ego that seeks to force his thoughts and speech to be coherent, whereas it is his 'free associations' (as unfree as they ultimately are, in a deeper sense) that allows us a glimpse of the repressed" (2007, p. 45). And, further:

> We do not assume that the analysand is of one mind – indeed, we assume that the analysand is inhabited by contradictory thoughts and desires, some conscious, some preconscious, and some unconscious – and *we certainly do not want to be complicit with the analysand's ego when it attempts to impose coherence and consistency on what comes out of the analysand's mouth*. (Fink 2007, p. 46; my emphasis)

To clarify: we do not assume that the analysand is "inhabited by contradictory thoughts and desires" because she is ill but because that is the very nature of subjectivity. As Loewenstein argues, by

> focusing on coherence […] the narrativists compromise Freud's insight that the subject is divided; that in the subject who says 'I' there is an 'otherness,' one that is erratic, everchanging, ambiguous, contradictory and, as Freud taught us in so many ways, defies coherence, certainty, and consistency. (1991, p. 11)

The coherence of statements regarding an individual's drives, thoughts, reflections, and desires must be distinguished from the coherence of statements regarding "facts," behaviours, or actions. I reiterate Fink's statement, bearing in mind this important distinction: "we assume that the analysand is inhabited by contradictory *thoughts and desires*" (2007, p. 46; emphasis added).

Winnicott develops a similar idea of coherence as defence: "free association that reveals a coherent theme is already affected by anxiety, and the cohesion of ideas is a defence organization" (1971, p. 55). The analyst's role is to support the emergence of incoherence or, perhaps, to bear the communication of nonsense. Winnicott warns against the dangers of being "a clever analyst" and of trying "to see order in chaos," which would force "the patient [to] leave the nonsense area because of hopelessness about communicating nonsense" (1971, p. 56). As I argued in Chapter Two, via Milner, the illusion of shared experience is only possible if there is a time when "it will not be necessary for self-preservation's sake to distinguish clearly between inner and outer, self and not-self" (1952, p. 192). If the analysand has to abandon her attempt to communicate nonsense, she also has to forsake this opportunity of relief from the conscious distinction between the internal and external worlds. As Winnicott writes, an "opportunity for rest has been missed because of the therapist's need to find sense where nonsense is" (1971, p. 56). As I also argued in Chapter Two, if the analyst can make room for the analysand's experience of this "opportunity for rest," the agoraphobic develops a greater sense of what is internal and what is external. When this distinction can be taken for granted, the third area of experience (shared reality) can be inhabited and language can be used creatively rather than only defensively.

Singer notes, "[m]any patients […] fear unlimited and unbounded free association, for that opens them up to infinity and psychological annihilation, since they cannot grasp or get hold of any continuity and coherence of their thought, and thus of themselves" (1977b, p. 475).[179] Although Singer is referring to borderline patients and their characteristic lack of a stable and coherent sense of self, his remark is equally applicable to agoraphobia patients. It is precisely a secure sense of the self separate from the other that the agoraphobic lacks and it is only through an exploration of the limits of the self via free association that the agoraphobic is able to establish the boundaries between self and other that will allow her to explore freely both her external and her internal worlds.

Green develops the connection between free association and the negative, which, as I argued in Chapter Three, manifests pathologically in agoraphobia patients as 'persistent emptiness': "Free association [...] is still the most prototypical expression of the negative. What does free association mean if not loosening the noose of the positive which constrains consciousness?" (1999, p. 37). I draw attention to Green's metaphor of the noose: even in the thought of a noose, one feels one's breath quickening and becoming shallow; the noose impinges the breath as the tyranny of the positive tightens around the agoraphobic, constricting her worlds, both internal and external. If the negative cannot be tolerated, the noose tightens. Approaching emptiness, or the open door, cannot be without its anxiety. If the analyst can encourage this exploration of space and freedom via free association, the analysand can contemplate and risk more feelings and more experiences (that is, more experiences in the internal and the external worlds).

As I described in Chapter Two, the ego is an essentially coherent organization of psychical reality. An adherence to coherence, which is the cause of the agoraphobic's suffering, interferes with destabilizing the ego's organization. In health, the ego need not adhere to its organization so rigidly, as evidenced in Green's additional description of the ego's functions: "The ego must chiefly be able to establish flexible connections, which alternately are going to be done, forming temporary hypotheses and conclusions, *and be undone*, in order to leave room for others who give a better representation of the situation" (1986, p. 20; my emphasis). In Bollas's terms, coherence is precisely not

[179] Lacan writes: "with the fundamental rule of psychoanalysis, the analyst is far from directing the subject toward full speech, or toward a coherent discourse – rather, the analyst leaves the subject free to have a go at it"; further, "this freedom is what the subject tolerates least easily" (1958/2006b, p. 535). See also Adler and Bachant: "Expressive freedom, like any freedom, is both a burden and an opportunity" (1996, p. 1024).

psychoanalysis's therapeutic goal; rather, the goal is to increase the analysand's freedom to free associate, to "crack up" the coherent narratives that the conscious mind is constantly writing. This dialectic movement between uniting disparate ideas and breaking up those unities is evidence of "unconscious freedom" (Bollas 1995, p. 3).[180] The agoraphobic, I suggest, uses narrative to stave off the overwhelming emotions that accompany incoherence. She uses narrative to resist the disorganization, the *undoing*, of the ego's connections.[181] The agoraphobic protects her neuroses to prevent a descent into psychosis.[182] As Green writes, "[r]esistance opposes the danger of disorganisation through a loss of control of speech and through speech which gives rise to a fear of madness" (1999, p. 270).

Bollas argues that the psychical processes involved in dream work also occur during waking life[183]: the movement between condensation and dissemination[184] is the

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[180] Rey – whose work I discussed in Chapter Two – also indicates that one aim of psychoanalytic treatment is "to increase freedom of choice" (1994, p. 32). Similarly, Meerloo states: "when a neurotic patient is really able to associate freely (in the psychoanalytic sense) he is, in effect, cured" (1959, p. 76). Milner makes a similar point: "as all analytic experience shows, it is when the patient becomes able to talk about all that he is aware of, when he *can* follow the analytic rule, then in fact he becomes able to relate himself more adequately to the world outside. As he becomes able to tolerate more fully the symbolic reality of the analytic relationship and the literal reality of libidinal satisfaction outside the frame of the session, then he becomes better (1952, p. 194).

[181] See also Wilson, who argues that the patient often consciously experiences her own moments of transformative insight as "the emergence of something alien within the self, usually of a drive-related, affective, and at times uncanny nature" (1998, p. 54). Wilson argues that the theoretical emphasis on the ego's integrative and narrativizing functions may impede our clinical understanding of these moments of insight.

[182] As I suggested, tentatively, in Chapter Two, it is possible that agoraphobia is a defense against a further breakdown towards schizophrenia. It is this breakdown that the agoraphobic fears and protects against. It is the analyst's responsibility to maintain the boundaries of the analysis to protect against an unlimited breakdown. See also, Adler and Bachant 1996, p. 1021: "Honoring the boundaries of this structure [the analytic situation] *serves to guarantee the safety* of both participants by channeling and absorbing the powerful psychological forces released by the psychoanalytic process. […F]ree association and analytic neutrality are the fundamental structural pillars of the psychoanalytic situation, *providing stability in the wake of the regressive* and progressive currents of the psychoanalytic process" (my emphases). I discuss Adler and Bachant's work further below.

[183] See also A. Freud (1937/1966/1993): "The dreamer's psychic state differs little from that of the patient during the analytic hour" (p. 15). The phenomenon of secondary revision refers to the "phenomenon of ordering, connecting and making [dreams] intelligible" (Breznitz 1971, p. 407). This phenomenon explicitly connects the psychical processes at work in dream and waking states. As Breznitz and Stein both argue, "[s]econdary revision […] is not confined to the sleeping state, but merges into waking and is the major contribution of waking thought to the final version of the dream" (Stein 1989, p. 70; see also

dialectic of the unconscious. The process “starts with a sequence of psychically intense experiences during the day, continues with the dream ‘event,’ followed by cracking up the dream contents through free association” (Bollas 1995, p. 3). Unconscious freedom is “found in the necessary opposition” between these two movements, each of which offers its own truths (p. 3). The aggressivity inherent in this process is clear: “Free association is creative destruction. […] It is essential to one’s personal freedom to break up lucid unities of thought, lest consciousness become a form of ideational incarceration” (Bollas 1995, p. 53). As I argued in Chapter Two, via Winnicott, aggressivity “creates the quality of externality” (Winnicott 1951, p. 93). It is precisely a sense of externality – or rather, a confident sense of what is internal versus what is external; and, hence, a sense of what belongs to the self, as well as the self’s limits – that the agoraphobic lacks. The agoraphobic, I suggest, is unable to mobilize her aggressivity in the service of this creative destruction.

As opposed to Bollas, who follows Freud (1900) in arguing that these two processes of uniting and “cracking up” are conversely related,[185] Spence (1982a) argues that there is too much conscious control over free association for that to be the case.[186] Specifically, Spence writes that the “partitioning” required for the dream’s articulation “introduces an element of conscious control into what is assumed to be a largely unconscious and automatic process”; furthermore, “the very fact of fragmentation does damage to the integrity of the dream” (Spence 1982a, p. 67). This last point takes us back

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Breznitz 1971, p. 407). Fitzpatrick Hanly notes that “[s]econdary revision brings it about that the more coherent is the telling of a dream the more distorted it may be and the more defended the patient against the latent content in which its meaning lies” (1996, p. 451). See also Bion’s (1962b) waking dream state, which, as Ferro (2005) discusses, broadens the dream work to include both sleeping dreams and waking dreams.

[184] “Dissemination” is Bollas’s term for the ‘cracking up’ process of free association. It helps move the dream work, traditionally associated with condensation and *displacement*, into waking life. I return to the logic of the unconscious below, which includes, for example, these processes of condensation and displacement, timelessness, and the absence of negation. See also infra note 164.

[185] When there is a moderate level of resistance, Freud writes, “the dreamer’s associations begin by diverging widely from the manifest elements, so that a great number of subjects and ranges of ideas are touched on, after which, a second series of associations quickly converge from these on to the dream-thoughts that are being looked for” (1923, p. 110).

[186] Many have noted that free association is not actually ‘free.’ See, for example: Busch (1995); Fink (2007); Freud (1925a); and, Scarfone (qtd. in McDermott 2003). See also infra note 202.

to Bollas's term "cracking up," which implies more than denies the aggressive nature of free association and the "damage" to the dream's integrity (whatever it is that "integrity" might mean in terms of a dream[187]) that Spence warns against. Consciousness can never be entirely absent from the work of analysis; to argue that free association is too conscious of a process implies, as a corollary, that consciousness is contrary to the work of analysis, or interferes with the work of analysis. Spence's argument is that how we choose to put our dreams into words affects our memory of them; on this point, we agree. Spence suggests, as a consequence of that argument, that there is something inherently limited about language and that attempting to put pictures into words is, inevitably, an impossible task. Again, I concur. However, I additionally argue, the words we choose to describe a dream image is as significant as the dream image itself. That process of selection is part of the analytic work: choosing to say some words and choosing not to say others even as we *try* to say it all. The *dream work* – not the dream – is most significant to the process of analysis,[188] which, as Aron indicates, is precisely Freud's argument:

> Freud believed that the narrative coherence of dreams argued against their being considered the product of random neurological processes. In clinical work with dreams, however, Freud argued that analysts "should disregard the apparent coherence between the dream's constituents as an unessential illusion" (1900, p. 449). [...D]reaming is both meaningful and motivated, but the meaning and motivation are to be found *not* in the manifest content, but in the dreamer's associations. (1989, p. 110)

Again, the dream's "apparent coherence" is a red herring and leads the analytic work away from the unconscious (Aron 1989, p. 114). Aron indicates that an analytic focus on the manifest content of dreams (namely, the narrative or the story rather than the details and their associations) is accompanied by either a movement away from, or a complete rejection of, the method of free association; furthermore, the abandonment of the free

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[187] As Stein indicates, "[m]ost of the dreams told to us are 'dreamlike,' full of contradictions and inconsistencies, mixed up in time and space, making little sense at first" (1989, p. 67)

[188] See also Faimberg 1997, p. 440: "In the session, for example, we interpret not a dream, which is an absent object, but the *account* of a dream, which forms part of the context of the history of the transference" (original emphasis). See also Lacan 2006i, pp. 393-394: "'Only the dream's elaboration interests us,' Freud says." See also Green (1975).

association method is often accompanied by a de-emphasis of the role of psychic conflict. Focusing on narrative coherence forecloses the emergence of the unconscious in the gaps revealed by language, gaps which must emerge in order for new thoughts and feelings to be possible.

To this end, Lacan argues that narrative coherence is antithetical to the work of analysis, which requires precisely, as I indicate above, a dismantling of coherence:

> Certainly, there is no question of restoring the chain of those reactions through the narrative, but the very moment in which the account is given can constitute a significant fragment of the chain, on condition that we demand that the patient provide the entire text and that *we free him from the chains of the narrative*. (2006a, p. 65; my emphasis)

Narrative coherence, rather than indicating an individual's state of psychological well-being or providing a therapeutic end-goal, can become a prison not unlike the agoraphobic's so-called safe space. What was once a retreat from the terrifying outside, the terrifying world of possibilities, becomes its own enclosure from which one cannot escape.

Stern suggests a connection between the process of free association and the state of original unity out of which the ego develops. This connection returns us again to the concerns of Chapter Two. He writes:

> On a certain primitive level of the unconscious, we might conjecture that free association represents the full reign of the polymorphous perverse activity of a child which at one time was all-pervasive and ego-syntonic. To achieve in psychoanalytic treatment the capacity for the optimum in free association means recapturing that childhood state when reality was almost indistinguishable from fantasy and differences were usually irrelevant. It means again attaining the feelings of that early period of our life when words, any words, were greeted like the first bloom of spring, and before the first frost of the fear of the social consequences of these words were felt. This was the pre-Oedipal period before the enormous filtering process began which has left so many people stifled of free expression or imagination and in a world with too sterile a sense of reality. (1966, p. 146)

Stern's comments, taken into consideration alongside Avenburg and Guiter (whom I reference above), allow us to connect psychoanalytic truth and free association. As I argued in Chapter Two, for the agoraphobic, something has gone awry in the process of creative differentiation, which is to say in the development of the ego out of an original unity. To return to, as Stern writes, "that childhood state" in phantasy provides the agoraphobic patient another opportunity to re-evaluate the relationship between internal and external realities "by pointing precisely to those moments upon which such distinctions between psychical reality and external reality was founded" (Avenburg & Guiter 1976, p. 17). The agoraphobic remains inhibited by "the fear of the social consequences of [...] words"; the analyst, then, and as I developed in Chapter Two, must encourage the development of the analysand's free associations by assuring her that the analyst will not be destroyed in external reality.[189]

4.3. Free Association and Transference

It is perfectly true that psychoanalysis, like other psychotherapeutic methods, employs the instrument of suggestion (or transference). But the difference is this: that in analysis it is not allowed to play the decisive part in determining the therapeutic results.

(Freud 1925a, p. 11)

As I indicate above, Milrod's (2007) discussion of the clinical case studies she presents emphasizes the transference relationship and implies (as she argues elsewhere: see Milrod et al. 2000, 2001, 2007) that it is this particular element of psychoanalysis that distinguishes it from the temporary effects of the psychiatric treatment of agoraphobia. I argue that the limitations of interpreting the transference in effecting change – particularly in relieving the agoraphobic's "persistent emptiness" – is evident in Milrod's (2007) description of her patient's progress. To reiterate, the substitutive relationship with the analyst allows for higher everyday functioning, but it fails to relieve the patient's

[189] See also Fink 2010, p. 272: "The neurotic is often afraid of the hostility that inhabits him, but if we face it openly, often he can too, and this opens the door to exploring it through speech, destroying neither himself nor others in the process."

psychic emptiness. While it is necessary to understand both the fundamental rule of psychoanalysis and the phenomenon of transference, the relation of the one to the other is equally important in the practice of psychoanalysis. Following Freud (1914a, 1925a), psychoanalysis is defined by the particular method of free association: free association is the method; transference is a tool.

There are two trends within the (scant[190]) literature on free association. The first (and historically earlier) trend, which assumes that the concept is familiar enough that it hardly bears repeating,[191] concerns exceptions to the fundamental rule. Laforgue (1937), for example, suggests a less strict adherence to the rule for those who obsessively attempt to follow the rule to the letter, with the inhibiting effect of not allowing any associations to develop; and, for those analysands who refuse to follow the rule, that their refusal be analyzed as a symptom rather than forced to comply.[192] The rule is a therapeutic rather than an orthodox one, which ought to be followed insofar as it does not impede the aims of analysis. Scott (1958) follows Laforgue's argument and provides his own version of the rule. Scott begins an analysis with, "Try to lie down and talk about anything and everything" (1958, p. 108). He suggests, however, that speech can become a defense against noise. Like Stern's patient, who needed permission to "lie," Scott indicates that

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[190] Mahoney (1979) provides a review of contributions to the psychoanalytic literature on free association. Although Kris suggests that the psychoanalytic literature on free association is "especially rich" (1982, p. ix), contemporary emphasis has shifted. A "Title" search on pep-web.org (Psychoanalytic Electronic Publishing) for "free association" returns 229 matches. 78 matches actually have "free association" in the title; the remaining 151 returns were published by Free Association Books, but are not concerned with the concept of free association. By contrast, a similar search for "transference" returns 1013 matches. Bollas notes this theoretical shift: "From Dora onwards the analytical literature reveals an increasing preoccupation with the Transference and correspondingly there is a dramatic decrease, not only in the literature on free association but, more tellingly, in the intellectual exploration of this division of function" [i.e., of "the free associating analysand and the evenly suspended analyst, a relation specifically designed to elicit unconscious lines of thought with the aim of discovering some of the latent mental contents"] (2013, p. 88; p. 85).

[191] Laforgue, for example, writes: "By the fundamental rule of psycho-analytic treatment we mean, *as you know*, the injunction which we give to our patients that, during the analytic hour, they are to tell us everything which comes into their minds and to conceal none of their thoughts, whatever they may be" (1937, p. 35; my emphasis).

[192] This force would clearly not serve the aims of analysis as contemporary analysts understand it, which is beyond the "revelation" or simple unearthing of unconscious material. And yet, this argument needed to be made; see infra note 163.

some patients may need permission to communicate extra-verbally – with sounds that are not quite yet speech – as he observed in some regressive patients. In these cases, he re-formulated the rule: "Try to talk, etc., and if you can't talk, try to make some kind of noise, and if you don't know what kind of noise to make just guess" (Scott 1958, p. 108). Scott points to the 'pre-verbal' infant, to whom a mother makes many sounds, both stimulating and comforting, that are not words and from whom babbling necessarily precedes speech. Noises can communicate something the analysand is not yet able to put into words. As I suggest above, there are times when the analyst must bear the analysand's nonsense.

The second, more recent, trend in the literature on free association concerns its centrality in the psychoanalytic session. Some (e.g., Adler & Bachant 1996; Bollas 2013; Busch 1995; Fink 2007; Kris 1983, 1992) consider that free association and the analyst's encouragement of free association (by way of, for example, "analytic neutrality") form the pillars of the psychoanalytic situation. Others (e.g., Hoffman 2006; Smith 2001, 2004) emphasize the relational aspects of the analysis. Although each side specifically disagrees with the other, both highlight words' powerful psychological effects. Hoffman, for example, writes: the "idea that words are a completely different category of 'action', protected by the sacrosanct rule of 'free association', denies the enormous power that words have in the construction of human experience" (2006, p. 59). For Hoffman, the enormous power that words have means that they must be moderated. The sentence quoted above is immediately preceded by: "No one would think twice about telling a patient who was starting to undress to keep his or her clothes on" (Hoffman 2006, p. 59). Hoffman implies that some words spoken out loud are akin to a patient undressing: in some sense inappropriate.[193] Adler and Bachant, from the opposing point of view, make a

[193] Hoffman provides the clinical example of a "patient who suddenly turns hostile" (2006, p. 57), responding to all of his [Hoffman's] interpretations with various sarcastic replies such as: "'If you say so' or 'I guess you know' or 'Whatever you say, Hoffman' or 'Sure, that must be it, sir! You're the boss'" (p. 56). Hoffman suggests the following might be an appropriate reply: "'You know you're being awfully rude. I want to understand what this is about, but I don't think I deserve to be treated this way, so I wish you'd find another way to express what you are feeling. In fact, I wish you would tell me more about what you are feeling more directly'" (p. 58). This suggestion is, of course, an interpretation that explicitly request further associations. Some analysts might suggest that it is precisely Hoffman's insistent "attempts to

similar point: “expressive freedom is not an unconditional privilege”; to the contrary, “there may be times when a patient engages in verbal acts which violate the safety or dignity of the therapist” (1996, pp. 1028-1029).[194] But, for those who privilege free association as the method particular to psychoanalysis, it is precisely the power of words that differentiates them from other kinds of “actions.” The transformative potential of psychoanalysis is *in* “the enormous power that words have in the construction of human experience.” As I state above, I argue in line with those who consider free association part of the fundamental rule, distinctive to the method of psychoanalysis. Given the agoraphobic’s problematic engagement with language and her limited ability to symbolize (that is, to put her feelings into words), an overemphasis on interpreting the transference to the detriment of the development of the analysand’s associations entrenches the relational aspects of the disorder. In order to break through this relational dilemma, the analyst must clear an appropriate space – an emptiness; a silence – to make room for the unconscious. Interpreting the transference repeats what the agoraphobic already knows and leaves no room for what neither the analyst nor the analysand have yet to discover of the analysand’s psychical reality. In light of this argument, I turn now to the specifics of the fundamental rule, including both free association and the analyst’s role in relation to the analysand’s free associations, variously conceived of as “evenly hovering attention” or “neutrality.”[195]

Lichtenberg and Galler (1987) conducted a survey, which asked analysts how they presented the fundamental rule to their analysands and what considerations led to their choice of initial guidelines. A number of respondents indicated that they did not

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interpret and *understand*” (Hoffman 2006, p. 58; my emphasis) that led to his patient’s trenchant hostility. If he could set aside the desire to understand, it might be more possible for the patient to say more about what he is feeling.

[194] I draw attention to the different connotations between Hoffman’s sense of inappropriate words and Adler and Bachant’s explicit concern for the analyst; unlike some straw-men arguments against “analytic neutrality” (which Adler and Bachant argue for), Adler and Bachant demonstrate a clear recognition of the analyst as a *person* involved in the progress of the analysis. See also infra note 195.

[195] I suggest that both “analytic neutrality” and the analyst’s “evenly hovering” or “evenly suspended” attention refer to the same analytic stance in relation to the analysand’s free associations. I refer specifically to Adler and Bachant’s explication of analytic neutrality, which includes three specific aspects: “neutrality with regard to conflict, neutrality with regard to sequence, and neutrality with regard to transference” (1996, p. 1021). Analytic neutrality, in this technical sense, “does not imply the eradication of the analyst as a person from the interaction” (1996, p. 1032). Clinically, analytic neutrality helps to maintain the analytic stance of evenly suspended attention and serves to encourage the analysand’s free associations.

make a point to articulate the fundamental rule to candidates (those patients training to be psychoanalysts themselves) or to so-called sophisticated patients who already knew what was expected of them (Lichtenberg & Galler 1987, p. 59). These analysts seem to have overlooked the rather basic point of psychoanalysis that saying something aloud has an effect; knowledge is not sufficient, nor can it be assumed. That is to say, it is not enough that an analysand *knows* what is expected in the psychoanalytic clinic, at least in part because the fundamental rule – distinct from the process of free association – is the "pact" to which Freud (1940, p. 174) and Lichtenberg and Galler (1987, p. 48) refer. The fundamental rule is an agreement that must be negotiated between the analyst and the analysand and not just 'understood': nothing 'goes without saying' in analysis! Something left unsaid is at least as significant as what is said aloud.[196] And, as Lichtenberg and Galler's survey makes clear, the formulation of the fundamental rule, and therefore the pact between analyst and analysand, is far from uniform.

The specific words one uses to describe the fundamental rule are, as I imply above, important. Freud, for example, provides this formulation:

> We tell the patient that without further reflection he should put himself into a condition of calm self-observation and that he must then communicate whatever results this introspection gives him - feelings, thoughts, reminiscences, in the order in which they appear to his mind. At the same time, we warn him expressly against yielding to any motive which would induce him to choose or exclude any of his thoughts as they arise, in whatever way the motive may be couched and however it may excuse him from telling us the thought: "that it is too unpleasant," or "too indiscreet" for him to tell; or "it is too unimportant," or "it does not belong here," "it is nonsensical." We impress upon him the fact that he must skim only across the surface of his consciousness and must drop the last vestige of a critical attitude toward that which he finds. (1920b, p. 130)[197]

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[196] See Lacan (2006a, 2006c). And see Dor 1985/1998, p. 152 for Lacan on "the said," "the half-said," and "the saying." See also Harari 2004, p. 76: "Lacan wanted to convey that the only thing truth can do is speak, that what we may attain of truth can be reached through speech, into whose bosom truth slips. Truth is said, but it is not fully said. […] In order for something to be said, something else must inevitably remain unsaid. This is where the register of the Real appears. Truth is real because it cannot be fully said."

[197] This passage is repeated almost verbatim in Freud 1923, p. 238, with the additional note: "It is uniformly found that precisely those ideas which provoke these last-mentioned reactions are of particular value in discovering the forgotten material." Bollas draws attention to this latter note (2013, pp. 86-87).

Lichtenberg and Galler describe the deceptive simplicity of the rule thusly: "Analytic patients are to put into words all their thoughts, feelings, and perceptions" (1987, p. 48). The entirety of Freud's version of the fundamental rule is *implicit* in Lichtenberg and Galler's formulation, but is certainly not explicit. Their description beyond this sentence explicates the effects of following this rule, but is not integral to the rule itself. The rule of psychoanalysis is not just that the analysand will follow the method of free association, but refers more precisely to the pact between the analyst and the analysand.[198] The second essential aspect of the fundamental rule, Bollas draws attention to Freud's description of the analytic role:

> The attitude which the analytic physician could most advantageously adopt [is] to surrender himself to his own unconscious mental activity, in a state of evenly suspended attention, to avoid so far as possible reflection and the construction of conscious expectations, not to try to fix anything he hear[s] particularly in his memory, and by these means to catch the drift of the patient's unconscious with his own unconscious. (Freud 1923, p. 239; qtd. in Bollas 2013, p. 86)

The fundamental rule of psychoanalysis, then, is the pact between the analysand and the analyst that each will fulfil their particular role in the analytic session. Bollas calls this fulfillment the "Freudian Pair," referring specifically to this division of function: the freely associating analysand who has the evenly suspended attention of the analyst.[199]

Milner, in her important work on symbolism, indicates something of the relationship between free association and the transference:

> The analytic rule that the patient shall try to put all that he is aware of into words does seem to me to imply a belief in the importance of symbolization for maturity as well as for infancy; it implies the recognition that words are in fact symbols by means of which the world is comprehended. Thus in the daily battle with our patients over the transference we are asking them to accept a symbolic relation to

[198] Only several writers (e.g., Mahoney [1979] and Kanzer [1972]) have noted the distinction between free association and the fundamental rule of psychoanalysis. Free association is the method of psychoanalysis and, as Kanzer notes, "predisposes to withdrawal and narcissistic states"; this method is complemented by the fundamental rule of psychoanalysis, the pact between analyst and analysand, which "involves a two-person relationship" (1972, p. 265).

[199] See also McDermott: "In the analytic situation, the evenly hovering attention of the analyst is as important as the analysand's free associations" (Hoffer; qtd. in McDermott 2003, p. 1349).

> the analyst instead of a literal one, to accept the symbolism of speech and talking about their wants rather than taking action to satisfy them directly. (1952, p. 194)

The transference influences the patient's free associations; the transference may even determine the patient's associations – or, more precisely, it may determine which of the patient's associations she is able, or not able, to articulate out loud. Lichtenberg and Galler suggest that the rule, insofar as they have expressed it here (as above), is "deceptive" since "all analysts know that no patient can or will be able to follow [it]" (1987, p. 48). Green expands on the "deceptive" element of the rule: the "fundamental rule of not filtering and not selecting is transgressed consciously and unconsciously" (1999, p. 270). Note, Green's negative formulation: *not* filtering and *not* selecting. Anna Freud clarifies the therapeutic value of both the rule and its transgressions: "what concerns us is not simply the enforcement of the fundamental rule of analysis for its own sake but the conflict to which this gives rise" (1937/1966/1993, p. 15).[200] Just as the analyst's mistakes often lead to transformation (namely, the possibility of new thoughts and new feelings),[201] the analysand's "transgressions" of the fundamental rule provide openings for further explorations. Adler and Bachant note that the conflict frequently concerns associations concerning the analyst: "the burdensome aspects [of expressive freedom] will come to the fore first as patients attempt, one way or another, to circumvent or circumscribe the radical implications of this invitation" (1996, p. 1024).[202] Thus, the relationship between free association and the transference is once again highlighted as method and interference/tool.

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[200] See also McDermott, who refers to Scarfone: "the principle of free association as he understands it is neither descriptive of what goes on in the session nor prescriptive of what can be turned on and off. He proposed that it may be an index showing that thinking is not free, a probe as to where resistance lies. In his view, free association is a challenge we artificially put to the patient to show how unfree associations are" (2003, p. 1355).

[201] See my discussion of Wilson on lack in Chapter Three. Faimberg (1997), whose work I discuss below in respect to the concept of *Nachträglichkeit*, considers misunderstanding – both the analyst's and the analysand's – to be an integral aspect of the psychoanalytic process that leads to the discovery of the analysand's psychic reality.

[202] See also Meerloo 1959, pp. 75-76: "What originally was called 'free' association appears to be not at all free; it is bound to numerous limitations and is modified in various ways. The flow of 'free association' is hampered by an infinite combination of feelings of shame, guilt, fear and hostile attitudes and unique inhibiting factors usually combined under the name resistance. The therapist plays an immediate role in the patient's form of censorship, even though apparently 'everything' may be said. The initial rapport and transference determines what the patient dares to say."

The movements between speech and silence in the clinic provide further evidence of the connection between free association and the transference. As I indicated in Chapter Three, emptiness and silence are analogous insofar as silence, like emptiness, can be used to defend against, for example, an unsayable truth. At the same time, silence can also be a pause between the insistence of speech, a pause that makes room for a new thought, a new word, or a new feeling. Silence may simply indicate a moment of rest; a lack of silence may indicate the impossibility of rest. The analyst's silence, Lacan writes, "implies speech, as we see in the expression 'to keep silent' which, speaking of the analyst's silence, means not only that he makes no noise but that he keeps quiet *instead of* responding" (1955/2006j, p. 291; original emphasis). Reik (1963/1968) discusses the analyst's silence – the analyst's *keeping silent* – and the effects this silence has on the analysand; the analysand interprets the analyst's silence in various ways according to his emotional state in that particular moment. The analyst's silence may be experienced as comforting or as persecuting, and all things in between:

> Slowly the analyst's silence changes its meaning for the patient. Something occurs to the patient which he does not want to tell, or whose telling is difficult for him. He talks further of other things, but what he is suppressing keeps forcing itself upon him and allows him to discuss other things only with difficulty; now he is silent like the analyst. It is as if the analyst's silence has spread to him, as if he has become infected with it. (Reik 1963/1968, p. 176)

The analyst's silence, then, encourages the analysand's "free" associations insofar as that which the analysand does not want to say becomes more and more insistent in his or her mind. If the analyst interrupts silence with speech, the analysand is able to respond to the analyst's comments rather than attend to that which he is attempting to suppress. This point, that the analysand interprets the analyst's silence in various ways according to his or her own fantasies, indicates the development of the transference. The transference, as a tool, may be used to encourage further free association, but the point of both the analyst's silence and any transference interpretations is to aid the analysand in saying more: saying difficult things more freely and saying new things that he or she has not previously been able to say aloud. Or, the analysand does not become "infected" with the analyst's silence and instead uses a wall of words to defend against silence. Reik writes: "In analysis we have become familiar enough with patients whose continuous speech has the sense of not saying precisely the most important things" (1963/1968, p. 183). That is, "people often speak because they cannot bear silence" (p. 184). If there is no silence, nothing new can emerge. Speech can be mobilized as a defence against everything that silence, as Reik says, "betrays" (p. 186). This relationship between silence and the development of the transference also indicates the relevance of structural emptiness, which is a necessary aspect of the process of the analysis and, specifically, in the development of free associations. Emptiness, as I detailed in Chapters Two and Three, is the basis of learning and of all new experiences.

Lacan describes the two conditions that constitute the free association of "'analytic experience'":

> [I]ts first condition is formulated in a law of non-omission, which promotes everything that "is self-explanatory," the everyday and the ordinary, to the status of interesting that is usually reserved for the remarkable; but it is incomplete without the second condition, the law of non-systematization, which, *positing incoherence as a condition of analytic experience*, presumes significant all the dross of mental life – not only the representations in which scholastic psychology sees only nonmeaning (dream scenarios, presentiments, daydreams, and confused or lucid delusions), but also the phenomena that are not even granted a civil status in it, so to speak, since they are altogether negative (slips of the tongue and bungled actions). (2006a, p. 66; my emphasis)[203]

Bollas argues that "the psychoanalyst's *preoccupation* with the Transference" causes the "suspension of the division of mental function central to the Freudian Pair" (2013, p. 88; my emphasis). Arguing in the tradition of Mahoney (1979) and Kanzer (1972) in distinguishing the method of free association from the fundamental rule of psychoanalysis, Bollas pays particular attention to the analyst's role as listening with evenly suspended attention in order to counter what he sees as a privileging of the conscious work of the analyst in interpreting the transference.[204] Bollas argues that the

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[203] See also Lacan 2006e, p. 462.

[204] Fink (2007) criticizes short-term psychotherapy for its "normalizing" aims (implicit in concepts like "high functioning"). See especially Chapter 9 (pp. 206-230), "Non-normalizing Analysis," connected to his critique of transference interpretations existing in the realm of the imaginary. Fink notes the connection between an over-emphasis on transference interpretations and short-term psychotherapies (which Milrod's PFPP entails – usually 12 week clinical trials). One of the problems with "normalizing" therapeutic practices, focused on promoting "high functioning," is that it overlooks the deeper unconscious forces at

Transference need not interfere with the analytic process so long as free association is allowed to develop. Bollas repeats Lacan's emphasis on free association as constituting psychoanalysis and also draws our attention back to Freud's description of the analysand's position and function. Like Lacan, Bollas highlights the analytic value Freud places not so much on the ideas the analysand finds most disagreeable to say, but on the ideas that he deems "too unimportant" or "irrelevant to what is being looked for" (Freud 1923, p. 238; qtd. in Bollas 2013, p. 85). While the Transference might include material that the analysand finds particularly disagreeable to speak aloud, this need not interfere with the analytic process so long as the analysand continues in her function of free associating to other ideas: "Whatever wish, memory, or internal relation the patient may project on to the analyst – that is whatever content it reveals – does not shut down the mind that thinks it" (Bollas 2013, p. 89). Further, he writes:

> The patient might think that by not reporting a troubling idea he or she was not talking about what was really on the mind. However, that will only be true of the manifest content. The patient may not have been talking about what was consciously in mind but, as we know, the Freudian definition of what is on the self's mind is determined by the complexity of the unconscious – by all the interests occurring at any moment in psychic time driven by unconscious desires, memories, anxieties, curiosities, and so forth. (p. 90)[205]

While some (for example, Fonagy, in McDermott [2003]) believe that focus on one small part of an analytic session reveals the greater meaning of the whole, Bollas returns to Freud's description of the free associative process and reiterates Freud's theory of

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play. As I suggested in Chapter Three, Milrod's (2007) patients (Rita and Deborah) have become more "independent," but the kind of dependence situated in the realm of love is entirely absent from their psychic lives; in fact, that kind of dependence is now consciously avoided (even as they unconsciously strive towards it) just as previously any kind of independence was anxiously avoided. For another critique of "normalization" in psychoanalysis, see Molino & Ware (2001).

[205] Bollas emphasizes Freud's description of analytic communication occurring between the unconscious of the analyst and the unconscious of the analysand. Jacobs indicates that Isakower also emphasized this analytic communication: "Isakower's notion of the analytic instrument, with its emphasis on the coming together of two minds to create one instrument, the unconscious transmission of thought and feeling that takes place between patient and analyst, and the shift in levels of consciousness in both that makes possible the grasping of the unconscious, appealed to me as one of the most imaginative and creative ways of conceptualizing the kinds of communication that take place between patient and analyst. In his formulations, Isakower made an effort to extend and develop Freud's seminal idea that unconscious communication between the minds of patient and analyst is an inherent feature of analytic sessions." (2002, p. 17) Jacobs, too, explores this aspect of analytic experience. See also Jacobs (1983, 1987, 1992, 1993).

sequential contiguity: the *sequence* of one's associations reveals their unconscious relevance.[206] It is not, then, any single part of the analysand's associations that is significant but rather the sequence of associations:

> Unconscious thinking is not held in any single mental idea, but takes place as a logical process. It is revealed not in one narrative unit [...] but in the links between narrative units. In the caesura one finds the logical possibilities. It is exactly in and through these gaps that the logic of thought occurs which is never subordinate to the Transference. (Bollas 2013, pp. 90-91).[207]

Any theory, and any clinical work, that purports to take the unconscious as its object cannot, therefore, neglect these gaps, these experiences of emptiness, and these inevitable incoherencies – or, worse, attempt to fill them in.

The entirety of psychoanalysis as a practice and a methodology is founded on the power and force of speech, and the ambiguities and malleability of language. Lacan emphasizes this point: "the analyst is different in that he makes use of a function that is common to all men in a way that is not within everyone's grasp [*portée*] when he supports [*porte*] speech" (1955/2006j, p. 290). In the cases of Milrod's (2007) agoraphobia patients (discussed in Chapter Three), for whom interpreting the transference has led to some "higher-functioning," the point of the fundamental rule of psychoanalysis seems to have been lost, especially if the analyst takes protestations of emptiness as statements of fact. What does the emptiness hide? Is it anger, or grief? Is it something else entirely that neither the analyst nor the analysand will ever begin to approach if it is taken literally?[208] The meanings of emptiness necessarily vary among analysands, and therefore must be explored with each individual guided by the fundamental rule of

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[206] Bollas quotes Freud: "In a psychoanalysis one learns to interpret propinquity in time as representing connection in subject-matter. Two thoughts that occur in immediate sequence without any apparent connection are in fact part of a single unity which has to be discovered; in just the same way, if I write an '*a*' and a '*b*' in succession, they have to be pronounced as a single syllable '*ab*'" (Freud 1900, p. 247; qtd. in Bollas 2013, p. 18).

[207] Lacan also draws attention to this particularity of the psychoanalytic setting: "If we wish to recognize a reality that is proper to psychical reactions, we must not begin by choosing among them; we must begin by no longer choosing. In order to gauge their efficacy, we must respect their succession" (2006a, p. 65).

[208] I refer again to Ellonen-Jéquier's (2009) work with a psychotic patient, which I discussed in detail in Chapter Three. She writes: "I was able not to fall into the trap of believing that there was a *real* emptiness or that some aspects were *actually* missing" (p. 864; original emphasis).

psychoanalysis, the pact that the analysand will 'try to say everything' and the analyst will try to listen. The analyst cannot know what the analysand will say and cannot know what the emptiness hides. The analyst must learn to bear her own ignorance in order to discover the analysand's truth. As Loewenstein writes:

> [A] commitment to the pursuit of the Freudian unconscious entails a commitment to forego the temptation to supply our patients *or ourselves* with reductive but coherent histories. The curative effect of our praxis may be accounted for by its very refusal to offer the analysand yet another false sense of unity but rather increase the analysand's capacity to withstand the ambiguity, contradiction, and discontinuity that marks our present experience and our past. (1991, p. 26; emphasis added)

For the agoraphobia patient, in particular, who lacks a clear and stable sense of the boundaries between self and other, the process of trying to say everything can push the analysand up against her limits. The agoraphobia patient for whom emptiness covers over aggression will be able to experience the reality of her aggressive limits as she articulates her rage and destructiveness, putting it into words, and watching as everything around her does not, as she feared, fall apart.[209] The patient for whom emptiness covers over grief (which can, of course, be the same patient) will be able to experience the limits of her loss; that, although it feels as if she has lost a world (and, indeed, she has, as any significant loss renders us bereft, torn asunder, in its destruction of the illusion of shared space), she is capable of rebuilding an inner world around what she has lost, integrating her loss into her new world. This rebuilding, building anew, is only possible if the patient is given the opportunity to say it all aloud and only if the analyst is not too afraid of what emerges out of the patient's emptiness; that is, only if the analyst is not too afraid of being overwhelmed by the analysand's grief and/or aggressiveness.

As I argued in Chapter Two, following Busch (1995), the analyst must create the analytic frame with each patient, in part by communicating that the data produced by the analysand's free associations is the raw material upon which the analysis is based. Thus, the method of free association is utilized to produce a therapeutic frame distinctive to the

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[209] This is not to say that aggressivity is not dangerous, or that it is impotent. To the contrary, aggressivity's force must be utilized. The fear of aggressivity's danger renders it impotent. See also Eigen (2002) on the plurality, force, and dangers of rage.

psychoanalytic method. This frame, as I argued in Chapter Two, provides the analysand with some boundaries against which she may begin to define herself. Part of the process of putting it all into words is the re-transcription, so to speak, of past events: *Nachträglichkeit*, which, as I discuss in the following section, is a phenomenon based on speech that depends on the "timelessness" of the unconscious.

4.4. *Nachträglichkeit* and the Logic of the Unconscious

*The symbolic not only means an order which structures the ineffable and helpless world of infancy, but also an order which brings up to date the inarticulable infantile experience. That is the Freudian 'deferred action' [*Nachträglichkeit*] where what happens later reinterprets and shapes what had happened before. For Freud, as for Lacan, psychoanalysis is the reinterpreting and reordering of one's own history, one's own trauma and one's own destiny through the power of language. This is the heart of the psychoanalytic rite.*

(Benvenuto 1999, p. 30).

As I argue above, the agoraphobic's repetitive use of narrative resembles a repetition compulsion. Dahl parenthetically notes that the compulsion to repeat follows the same psychical mechanisms as the phenomenon of *Nachträglichkeit*[210]:

> *Nachträglichkeit* manifestly entails the action of a force, *analogous to that of the compulsion to repeat*, that seeks to symbolize the unfamiliarity and confusion of the original experience – whether as a real event that was not understood or as a diffuse primary-process scene – so that it can subsequently [*nachtraglich*], in accordance with the reality principle, be structured, thought, understood, and perhaps also mastered. (2010, p. 741; my emphasis)

Narrative is most commonly *contrasted* with a repetition compulsion.[211] However, as I argue above, for individuals with agoraphobia, the process of narrating and narrativizing

[210] For arguments connecting repetition compulsion and *Nachträglichkeit*, see also: Casoni (2002); Faimberg (2013); Marion (2012); and, Perelberg (2006, 2008).

[211] See, for example, Kliman, Rosenberg & Samples (2007). See also Bornstein 2012, p. 75: "…she was expressing herself partially through a repetition compulsion, not a narrative…." Bornstein correspondingly argues against free association. He argues that it is "impossible" for the patient to tell her story, not because we, as subjects, are too complex and conflicted to fit within the narrative of a "story," but because "she

their experiences seems to be a compulsive aspect of the disorder that serves to entrench the symptoms of anxiety and avoidance into the individuals' lived experiences. This use of narrative limits the agoraphobic's experience of the world as much as her physical avoidance of space does.

I refer above to Capps and Ochs, who argue that "agoraphobia is in part kept alive through [...] repeated psychological reconstructions of panic" (1995, p. 21). I turn now to the details of this three-year case study on language and agoraphobia. Capps and Ochs's case study of a principally housebound agoraphobic, "Meg," offers an example of the practical implications of the problem of persistent primitive anxieties[212] coupled with language. Meg uses narrative to keep her primitive anxieties alive, fearing what may happen if she were to venture out of her safe space without recognizing that what she fears most has already occurred. Meg's first experience of overwhelming panic is precipitated by a near-drowning experience: she is unable to breathe, literally engulfed by water. Throughout her narratives, including her defining moment of claustrophobic panic while stuck in a highway traffic jam, Meg's stories are peppered with references to needing to escape without knowing what she needs to escape from. It would be easy to suggest that all of Meg's agora-claustrophobic experiences are a retroactive defence against her childhood experience of near-drowning; that is, to suggest that Meg continues to relive that first anxiety in the attempt to psychically gain mastery over it. However, Meg not only recounts her *traumatic* anxiety experiences; she also reframes her autonomous and successful experiences into helpless, potentially anxiety-inducing ones. She (re-)frames her narratives in such a way as to cast herself as fundamentally prone to anxiety and worry, as a weak person overwhelmed by life rather than as a person who has suffered from anxiety in particular situations because of a limited set of experiences, with the potential for new and positive experiences.

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experiences fear of humiliation, rejection, and too much affect and understanding" (2012, p. 71). This "impossibility" leads him to abandon the pursuit of free association. Cf. Adler & Bachant (1996).

[212] See Chapter Two for my discussion of primitive anxieties and their relation to ego development. Briefly, I argued that insofar as agora-claustrophobic anxieties are a necessary structuring experience for the development of the infant's psychic life, they are not pathological; however, the inability to move beyond primitive anxieties in adulthood becomes pathological.

Nachträglichkeit is the term Freud uses to describe the temporal dimension, the delay, in the aetiology of neuroses.[213] Lacan (1988) argues that subsequent experiences filter into our past and into our memories so that what we experience next affects how we experience our past more than our past determines or even influences how we experience our future.[214] Meg utilizes this aspect of language in a pathological way, to de-structure her past and to reconstruct herself as helpless rather than masterful, ensnaring herself in a trap of impotent anxiety, the only way out of which is, paradoxically, increasingly overwhelming anxiety. Meg's problematic use of language does not centre on a lack of narrative coherence; rather, she uses narratives to limit her experiences of the world. Her narratives become walls that she builds around herself, more impenetrable than any physical walls could be. While it is clear that Meg's past anxiety experiences are affecting her future, it is also true that her memory – which she *rewrites* – of her past

[213] Freud writes: "I admit that this is the most delicate question in the whole domain of psycho-analysis. […] According to this view [that early childhood 'memories' are retrospective phantasies], wherever we seemed in analyses to see traces of the after-effects of an infantile impression […], we should rather have to assume that we were faced by the manifestation of some constitutional factor or of some disposition that had been phylogenetically maintained. On the contrary, no doubt has troubled me more […]. I was the first […] to recognize both the part played by phantasies in symptom-formation and also the 'retrospective phantasying' of late impressions into childhood and their sexualisation after the event" (Freud 1918, p. 103, ft.). He also mentions the "*deferred* effect" of a threat of castration in the case of Little Hans: "At the time it was made, when he was three and a half, this threat had no effect. […] It would be the most completely typical procedure if the threat of castration were to have a *deferred* effect, and if he were now, a year and a quarter later, oppressed by the fear of having to lose this precious piece of his ego" (1909, p. 35). Furthermore, Freud indicates the regularity of this deferral in the formation of neuroses: "In other cases of illness we can observe a similar deferred operation of commands and threats made in childhood, where the interval covers as many decades or more" (1909, p. 35). See also infra note 214.

[214] For example, Lacan writes: "It's not what happens afterwards which is modified, but everything which went before. We have a retroactive effect – *Nachträglichkeit*, as Freud calls it – specific to the structure of symbolic memory, in other words to the function of remembering" (1988, p. 185). While this is only one of the meanings implicit in Freud's use of the term, it has become the most salient of meanings (and effects) for French psychoanalysts, for which the French translation, *après-coup*, allows. Strachey's English translation of the term, deferred action, implies the opposite temporal movement: an original event becomes traumatic at a later, second event. This traumatic process is effected due to the biphasic nature of human sexual development. Freud uses the term most frequently in his discussion of Emma (1950/1895), letters to Fleiss (1985/1895), and the Wolf-Man case (1918). Regarding the aetiology of Emma's neurosis, Freud writes: "The change in puberty had made possible a different understanding of what was remembered. This case is typical of repression in hysteria. We invariably find that a memory is repressed which has only *nachträglich* become a trauma. The cause of this state of things is the retardation of puberty as compared with the rest of the individual's development" (1950/1895, p. 356). For more on the history of the concept of *Nachträglichkeit*, see Laplanche (1999), Laplanche & Pontalis (1967/1973), and Thomä & Cheshire (1991).

experiences is coloured by her expectation of future anxiety. Meg spends a great deal of her time sitting in her home retelling her panic narratives to herself; she becomes retroactively overwhelmed by her past experiences, even by experiences which were not at the time problematic. For example, when Meg recounts her pregnancy, she tells it in the present tense and emphasizes her helplessness: "I'm nine months preg--- almost nine months pregnant…I can't---If I *wanted* to leave I *couldn't*" (Capps & Ochs 1995, p. 62). Using language, Meg traps herself into her anxiety, reframing past successes as anxious experiences, fearing the impossibility of doing something she does not even want to do.

Via *Nachträglichkeit*, Lacan explicates (and complicates) the relation of speech and truth:

> [I]t is present speech that bears witness to the truth of this revelation in current reality and grounds it in the name of this reality. Now only speech bears witness in this reality to that portion of the powers of the past that has been thrust aside at each crossroads where an event has chosen. (2006c, pp. 212-213)[215]

It is not narrative that speaks the truth, but simply *speech* that speaks it. Truth is, as I imply above, mutable, depending on which *reality* we are concerned with. Historical – material – reality has one kind of truth; narrative truth corresponds to a different kind of reality. These truths and these realities are, however, interdependent elements. So, unlike Holmes, who suggests that narrative truth may reflect historical truth, and unlike Spence, who suggests that the two are completely distinct, Faimberg (2014) argues that, if we are listening, we are always surprised to discover in what *individual* ways these truths are intertwined in psychical reality. We are always surprised to discover something new about the psychical reality of an other. As I argued in Chapter Two, one can only be surprised by an other subject in this way if one recognizes the subject's *otherness* (Zachrisson's [2013] "actual other"), which is also to say that one can only be surprised by the other if one is open to being surprised and is able to tolerate not being "sure" about how history has been mediated by the other. Whatever knowledge one may have about history or material truth, the only access to psychic reality – an other's and even one's

[215] Freud, as Faimberg draws attention to, also connects language and psychical reality: "'Indications of discharge through speech are also in a certain sense indications of reality – but of thought-reality, not of external reality'" (Freud 1950, p. 373; qtd. in Faimberg 1997, p. 441).

own – is via this openness to being surprised. The phenomenon of *Nachträglichkeit* demonstrates that the nature of psychical reality demands a certain degree of incoherence in order for any event to have psychical effects. Clinically, then, and as I write above, when coherence is *demanded*, fewer feelings and thoughts are possible; when incoherence is tolerated, new and unanticipated feelings and thoughts can develop. When coherence is taken to be the aim of psychoanalysis, there is no room for the flashes of insight[216] that allow the agoraphobic to reexamine, unconsciously, the distinction between internal and external realities.

Faimberg argues that *Nachträglichkeit* "gives us a conceptual frame of unconscious psychic temporality with which to explore and understand how psychoanalysis produces psychic change" (2007, p. 1223). *Nachträglichkeit* includes the work of a dual-process: the first aspect is in the formation of neuroses; the second aspect is in the relief from neuroses. Faimberg's (2005) broader conceptualization of *Nachträglichkeit* emphasizes the complexities of the temporal dimension in the work of analysis, which is never merely a historical reconstruction, or re-ordering, and never purely a question of the here and now (that is, the transference relationship). Faimberg argues that this broader conceptualization – that is, not just at work in the development of the neurosis, but also characterizing the work of analysis – is implicit in Freud's work, even though he never articulates it explicitly.[217] Faimberg refers to Kardiner's (1977) exposition of his analysis with Freud, and an example of Freud's interpretation of one of his dreams. Freud interprets that a figure in Kardiner's dream "…was a projection into the future of what you actually feared in the past. What you feared was therefore not what was going to happen but *what actually had happened*, and which you not only forgot, *but feared to recall*" (Kardiner 1977, p. 55; qtd. in Faimberg 2005, p. 1230). Faimberg's analysis of this moment in Kardiner's analysis with Freud, as well as other moments in the analysis, supports her argument that Freud was working with a broader conceptualization of *Nachträglichkeit*. That is, Freud was not only interpreting the

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[216] See Wilson (1998).

[217] Some (see, for example, Sodré 1997) argue that British psychoanalysts utilize the concept of *Nachträglichkeit* without calling it such. This argument finds support in Winnicott's essay "Fear of Breakdown" (1974), (which I discussed in Chapter Two), and which details the process implied in the dual temporality of the German word without direct reference to the concept (in any translation).

material, but was also constructing[218] new meanings that did not previously exist for the analysand. There is a new connection made, based on relations of affect and meaning, between past and current experiences.[219] As I express above, this is the process by which Meg reconstructs her past experiences as coloured by anxiety; only this process, then, can be effective in the relief of Meg's agoraphobic symptoms and the emptiness that, we infer, her agoraphobic symptoms cover.

Thomä and Cheshire point out that this process of reconstruction is not a retroactive *causality*: it is unnecessarily confounding, they argue, to "contemplate revising our standard ideas about time-sequences and time-relationships ('temporality')" (1991, p. 413). Rather, the "causal *inter*-actions involved in *Nachträglichkeit* [take] place between the mutually *contemporary* contents of a storage-system" (Thomä & Cheshire 1991, p. 413; final emphasis added). As Freud states in a letter to Fliess, "the material present in the form of memory-traces [is] subjected from time to time to a *re-arrangement* in accordance with fresh circumstances – to a *re-transcription*" (1985/1896, p. 233; original emphasis). Put laconically, things happen over time; time is continuous, in some fashion or other, so things that happen in the past have an effect on present happenings and on possible futures; perhaps most importantly, they have an effect on our *experience* of the present and on our *experience* of the possibilities of the future. Our memory of things past is alterable, even though the past itself is inalterable[220]: we can add layers of meaning to our experiences and construct new meanings for experiences that were previously inassimilable. Our memory of the past – and the meaning we ascribe to past experiences – changes our way of experiencing the present and our present changes our way of anticipating the future. Our expectations for the future affect our way of experiencing in the present through relations of meaning and relations of affect. Meaning can be added, but not eradicated; that is, like a palimpsest, the unconscious records

[218] See also Freud 1937, pp. 258-259: "His [the analyst's] task is to make out what has been forgotten from the traces which it has left behind, or, more correctly, to *construct* it" (original emphasis).
[219] For Kardiner, the past experience is the unresponsiveness of his mother after she died while he was alone with her (at three years of age) and a subsequent childhood phobia of masks (Kardiner 1977, pp. 61-62; qtd. in Faimberg 2005, p. 1232). The current experience was a recurring dream of his own immobilized face reflected back at him in a mirror, and the distress and anxiety accompanying the dream.
[220] As Eickhoff writes, "*Nachträglichkeit* provides the memory, not the event, with traumatic significance" (2006, p. 1453).

meaning and any erasure leaves behind an imprint.[221] We cannot *unknow*, so to speak; we can only know more. The desire to unknow (which is impossible) prevents the acquisition of new knowledge, which is necessary to move beyond trauma. As I argued in Chapter Three, the agoraphobic's loss of her anxiety and other phobic symptoms entails a significant encounter with the "utter not knowing" of who she is. The unconscious fear of not knowing is complicated by this desire to (impossibly) unknow. The analyst *does not know* what the analysand cannot say, does not have words for, or is trying not to say; the analyst can only encourage the analysand, in various ways, to follow his or her associations and say *more* and, thus, to know more. Without incoherence, the interpretation of the transference can only be a repetition of what is already known.

Faimberg adds an important dimension to the psychoanalytic process beyond free association and evenly suspended attention that Bollas describes occurring between analyst and analysand, which she calls "decentred listening," or "listening to listening" (1997, p. 442).[222] The function of this additional dimension is precisely to create connections between psychic reality and historical truth using the phenomenon of *Nachträglichkeit*. Specifically, the concept of 'listening to listening' that Faimberg describes includes four aspects:

> (a) listening out for how the patient hears the analyst's interpretations or silences; (b) retroactively assigning meaning to the analyst's interpretations and silences on the basis of this listening to listening; (c) allowing the process of listening to listening to appear in the interpretation; and (d) ensuring that the patient can listen to the way the analyst listens to him so that he can become able to listen to himself: we shall then have two subjects whose listening is decentred. (1997, p. 442)[223]

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[221] For the most pertinent of Freud's essays concerning repetition, see Freud (1899, 1914b, 1919, 1920a, 1926). For some significant (post-Freudian) additions to the literature, see Bass Alan (2006), Felman (1982), Green (2003), Künstlicher (2010), and Loewald (1971). Lacan more or less replaces the concept of the repetition compulsion in his theorizations with the insistence of the signifying chain. See, for example, Lacan (2006d, 2006h); also, Lacan 1993, p. 242: "Repetition is fundamentally the insistence of speech."

[222] See Faimberg (1996) for her early formulation of "listening to listening" and Ferro (2002) for his clinical application of listening to the analysand's associations to his interpretations.

[223] Faimberg's description of this decentred listening recalls Busch's argument that the specificity of the analytic frame depends on communicating to the patient that the patient's free associations are the data upon which analytic understanding is based, which I discussed in Chapter Two.

As Faimberg explicates via a clinical vignette, the process of listening to listening indicates that the patient's "psychic reality is connected with a certain historical truth" (1997, p. 447). As I argued in Chapter Two, the nature of agoraphobia in particular, characterized by an unconscious confusion of self and other and the boundaries between, requires a theoretical perspective that takes into consideration real – namely, external – experiences and the patient's representation of these experiences. From this connection between perception and representation, Faimberg describes psychic truths, which "are the consequence of the psychic work resulting from the demands of reality that are fashioned by the unconscious wish and the unconscious fantasy" (1997, p. 449). In psychic truths, Faimberg argues, there is an "insistent residue, a dimension of the 'real'" (1997, p. 449) that remains. Again, as I argued in Chapter Two, the real resists symbolization; but only through the symbolic dimension can the real be apprehended, again underscoring the clinical use of language (rather than, for example, a clinical focus on the therapeutic relationship as the mechanism of change). Like Hanly, who suggests that "we are obliged to live with uncertainty" (2009, p. 371), Faimberg indicates the necessary capacity of the analyst to "listen from a position of not knowing" (1997, p. 450).[224] This (limited) uncertainty and not knowing is a partial guarantee that the "(re)construction of historical truths is not a mere intrusion of the analyst's theory" (Faimberg 1997, p. 450).[225]

[224] Winnicott (1971), Bion (1970, 1984), and Lacan (2006e, especially p. 471) also consider this capacity to linger in uncertainty to be an essential aspect of the analyst's function. See also infra note 108.

[225] Guralnik (2014a, 2014b) powerfully depicts the impact and insistence of historical reality in her case history of Nyx, a German woman whose parents were both children of Nazis. Guralnik's own parents were both children of Jewish Zionists who lost most of their family in the Holocaust. Guralnik writes: "Working psychoanalytically with this kind of background invite[d] the ongoing manufacturing of an illusion that we [were] simply two individuals, doing our own thing, and not subjects of history and nationhood. Yet this illusion was bound to crack under the weight of material seeking meaning" (2014a, p. 129). Although not every individual is directly bound to an event as historically significant as the Holocaust, every individual is part of History: a human history filled with all manner of real horrors often beyond imagining. As Faimberg writes in her commentary on Guralnik's article: "In the psychoanalytic process, we are trying to construct a time and a space to discover with surprise in *what way material reality has impinged in the psychic makeup of our patients*. In other words, for the particular situation at hand, we come to see how History has been *mediated*. In psychoanalysis, then, we discover in a fragmentary way, in a contradictory way, always with surprise, how History appears mediated by links between parents and grandparents in relation to the patient's psychic way of functioning as is (re)constructed in the history of the transference. This is so because the psychic makeup of the patient is made of all this" (2014, p. 157; original emphasis). Wolff, much earlier than Guralnik and largely against the grain of his contemporaries, argues similarly that "the patient's neurotic suffering in the present has its roots as much in the experience of social history as in

The concept of *Nachträglichkeit* is implicit, as Eickhoff (2006) and Faimberg (2005, 2007) argue, in Winnicott's ideas about the fear of breakdown. As I discussed in Chapter Two, the fear of breakdown is caused by and invokes primitive anxieties, which are overwhelming and unthinkable because the object of fear is a breakdown that has already happened. That is, Winnicott describes the complicated subjective experiences of time and trauma, wherein what is past causes a present anxiety about the future. In his discussion of primitive agonies, Winnicott refers to experiences that occur prior to the development of the ego, and, as such, no subject existed, so to speak, to *have* the experience (in order to organize it). As I argued in Chapter Two, experiences for which the subject *has no words* might also cause the (re-)emergence of primitive anxieties and contribute to an on-going fear of breakdown. That is, it might be that the problematic insufficiency of (some particular element of) language persists beyond ego development. Therefore, the subject may experience a debilitating anxiety perceived to be future-oriented but caused by a previous experience that the subject is unable to put into words.

Winnicott connects the fear of breakdown and primitive anxieties with the experience of emptiness. We are thus able to recognize the connections between the agoraphobic's experience of emptiness and her anxiety, as well as agoraphobic anxieties and psychic development, fear of one's own aggression, and the task of putting it all into words. As I argued in Chapter Two, the psychical experience of emptiness is derived from the physical experience of hunger. The infant will necessarily experience hunger; the very experience of hunger's emptiness, no matter how temporary, is perceived as a deprivation. The experience of emptiness stimulates aggression and leads to the further development of the ego. This emptiness is constitutive in ego development and is thus connected to the primitive anxieties that belong to the time before the ego properly existed. For the agoraphobic, *something* has gone wrong in the process of ego development; I argued in Chapter Three that, for the agoraphobia patients Milrod (2007) describes, persistent emptiness indicates the presence of unmourned traumatic losses. As I introduced in Chapter Two, the fact of the lost object's existence in external reality is

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the residues of infantile wishes and fantasies" (1988, p. 380). More emphatically, he argues that in order to "distinguish absurd from possible valid constructions, criteria of coherence and good fit in the 'narrative tradition' are unhelpful, if not meaningless" (p. 389).

only reaffirmed insofar as others acknowledge the real loss of that object. The analyst must return to these real experiences of loss in order to address the agoraphobic's emptiness. Only when these real losses are symbolized will the agoraphobic be able to develop clearer boundaries between the internal and the external, and create the world that is waiting outside for her to find.

The logic of the unconscious is different from the logic of the conscious mind, which corresponds more to what we might understand as a narrative logic.[226] In order to achieve the goals of psychoanalysis, to increase *unconscious* freedom, psychoanalytic work must follow the logic of the unconscious. Green describes the main characteristics of the unconscious:

> [I]t ignores time; it does not take negation into account; it operates by condensation and displacement; and it does not tolerate any expectation or delay. It succeeds in expressing itself by turning around the obstacles which would attempt to prevent it from making itself known; in other words, it permits our unconscious desires to experience a certain form of realization. (1986, p. 18)

Building on Green's first point, that one of the main characteristics of unconscious logic is that it "ignores time," Schubert writes:

> Every psychoanalysis contains contradictory relationships to time. The indefinite duration of the complete analysis and the monotonous rhythm of the recurrent sessions create in the analysand an illusory eternal time perspective. This is contrasted by the reality of the analytic contract, which is time-limited and entails separate analytic sessions with distinct time-frames. The timeless perspective stimulates regression and dependence, while the time-limited perspective requires development, process and the setting of goals. It is under these diametrically opposite conditions that the psychoanalytic work takes place. (2001, p. 93)

The phenomenon of *Nachträglichkeit* functions according to unconscious logic, specifically the temporal dimensions. Psychoanalytic work takes advantage of the

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[226] See Matte-Blanco (1988) for an elaboration of asymmetrical, symmetrical, and bi-logic. Asymmetrical logic is conventional and follows familiar principles of reasoning, including, for example, the concept of two-valued logic: either *A* or not *A* (either proposition *A* is true or it is not true). These principles do not hold according to symmetrical logic – the logic of the unconscious – whereby *A* can be both true and not true. Most thinking combines these two logics in what Matte-Blanco calls "bi-logic." See also infra note 164.

timeless nature of the unconscious, reproducing it in a sense with the “illusory eternal time perspective” and simultaneously creating a conflict with that perspective with the “reality” of the analytic frame. In order to effectuate unconscious change – that is, to increase unconscious freedom – analytic work must utilize the logic of the unconscious. Analytic work must follow the movement of the dream work, the movement of free association, and the movement between coherence, incoherence, and back again.

4.5. Conclusion

The fantasy inherent in the pursuit of coherence ignores and displaces the centrality of aggression in creative psychic life and in the freedom for that creativity, as well as denying the influence of the unconscious in psychic life. The exact (and exacting) repetition of specific narratives (like those of Meg) forecloses the possibilities of aggressivity and of creativity, which concurrently prevents the establishment of externality. Denying one’s own aggressive impulses is to imprison oneself in consciousness insofar as the limit of unconscious feelings has not been established. It is not that the unconscious becomes less influential in psychic life; rather, the agoraphobic ‘wards off,’ so to speak, the reality of the unconscious through repetitive narrative. The agoraphobic does not have the freedom to “crack up,” the freedom needed for and expressed in the free associative process of analysis. Again, the agoraphobic is able to cohere, but not to disseminate[227]; the agoraphobic is overwhelmed by the nature of the associations, the (passionate, intense) feelings experienced in the *freedom* of associating. This freedom is, as a number of authors have pointed out, both an opportunity and a burden.[228] Bollas refers to the overdetermined psychic moment as an intensity; the intensity of that moment is only recognized after the fact (*nachträglich*) through the second movement of the unconscious dialectic. The feelings that comprise that psychic intensity can be repressed if association is foreclosed, discouraged, or even not explicitly encouraged. Bollas writes, “[h]uman mental life does not have such a compositional unity to it, although narrative unities can be constructed about people’s lives. Instead,” he

[227] Disseminate refers to the “cracking up” of conscious and coherent intensities. See also infra note 184.
[228] See infra note 179.

argues, “we endure millions of psychic intensities in our life” (1995, p. 68). Mental life, then, involves the experience of psychic intensities and, in relative health, the “cracking up” of these intensities through discursive free association, as opposed to narrative coherence. The ability to free associate – to experience unconscious freedom – is requisite for developing a coherent narrative about life events that belongs to the individual’s psychic reality and not to some other reality.[229] The *feeling* comes first and then the thoughts about the feelings. In order to effectuate unconscious change, analysis must work with – not against – the logic of the unconscious, the logic of the dream, the logic of free association. In the psychoanalytic situation, the fundamental rule supersedes the demands of coherent narrative. As Bollas (1995) argues, the two processes are opposed: one cannot ‘say everything’ and construct a coherent narrative simultaneously. One aspect of psychoanalytic work, then, is creating a coherent narrative; but the other aspect, which is distinctive to psychoanalysis, is the invitation to 'say everything'. The *aim* of psychoanalysis is beyond either of these aspects: as Phillips argues, “the cure” psychoanalysis ideally offers is the cure *for* self-knowledge, not of self-knowledge; the cure *for* one’s “wish to know [one’s self] in that coherent, narrative way” (Holdengräber 2014). Via the movements between narrative and free association – coherence and incoherence – the analytic frame grows, so to speak and, I argue, along with the frame grows an accompanying sense of the boundary between self and other (in other words, a sense of one's limits). The experience of these limits is necessary for the agoraphobic to live in the world (so that she no longer feels she is risking the existence of the world, or of her self, by being in it, by engaging with it). Part of the psychoanalytic experience, with the invitation to “say everything,” is learning to negotiate the chiasmic gap between self and other; this experience is not available within the paradigm of narrative therapies or narrativist psychoanalysis. The structure of the frame, which the analysand participates in constructing and is able to experiment with destroying (because of the analytic rule), offers the possibility for the agoraphobic to experience new ways of relating to objects (including destructively). Once the agoraphobic has developed a faith in the distinction between self and other and between internal and external realities, she can begin to creatively inhabit the spaces between rather than anxiously avoid them.

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[229] See, for example, Faimberg (1981/2005b), Faimberg (1988/2010), and Faimberg and Corel (1990/2005).

5.0. Conclusion: To Calm Anxiety

A phobia, in other words, protects a person from his own curiosity.

(Phillips 1993, p. 14)

In this thesis, I have responded to Milrod's (2007) article, in which she describes a phenomenon of persistent emptiness in agoraphobia patients for whom the symptoms of anxiety and avoidance have remitted. Milrod's findings have important implications for the long-term efficacy of agoraphobia treatments, offering a possible explanation for the limited efficacy of standard treatments of CBT and pharmacotherapy. As I indicated in Chapter Three, her findings have not been addressed in the literature subsequently. Milrod's findings opened up an avenue to further our understanding of agoraphobia; in this thesis, I have used these findings to contribute to the theoretical understanding of agoraphobia and I have developed the clinical implications of these theoretical contributions.

I have attempted to explicate the complexity of the phenomenon Milrod encounters in her patients by connecting the agoraphobic's persistent emptiness with the pathological experience of emptiness well-noted in other disorders (e.g., Kumin 1978) and the structural phenomenon of emptiness experienced in the development of the ego. My explication of psychic emptiness supports an alternative interpretation of the clinical material Milrod provides counter to Milrod's suggestion that her patients' persistent emptiness can be attributed to a weak reflective function (RF). I suggested that assertions of emptiness in the analytic situation precisely indicate the unconscious presence of strongly warded-off emotional or cognitive experiences; specifically, the subjective experience of emptiness in agoraphobia patients commonly indicates the presence of significant losses that have yet to be mourned. I proposed several explanations as to why agoraphobia patients, in particular, defend against mourning.

At the same time, Milrod's findings contributed to my elucidation of the nature of agoraphobia and added to our, heretofore limited, understanding of agoraphobic anxieties in the process of ego development. The psychoanalytic paradigm of mental life uses an examination of psychical disorder to deduce the nature of all psychical processes, including pathological and 'normal' processes. The nature of agoraphobia, inflected with

Milrod's findings, offers an exemplary model of disorder to augment our understanding of both normal and pathological psychical processes. This augmented understanding, which includes the agoraphobic's pathological uses of language in the service of avoiding emotional experience, provides support for the argument that language is the fundamental tool of psychoanalytic treatment in the alleviation of mental suffering. Milrod's (2007) discussion of the clinical case studies she presents emphasizes the transference relationship and implies (as she argues elsewhere: see Milrod et al. 2000, 2001, 2007) that it is this particular element of psychoanalysis that distinguishes it from the temporary effects of other treatments of agoraphobia. However, the limitations of this emphasis are evident in her description of her patients' progress. As I argued in Chapter Three, the fact of structural emptiness provides a technical counterpoint to this emphasis on interpreting the transference as a means of addressing the agoraphobic's experience of persistent, pathological emptiness; likewise, as I argued in Chapter Four, the agoraphobic's pathological use of language – in producing narratives that are either too coherent or, alternatively, producing 'empty' narratives – can be countered through the fundamental rule of psychoanalysis. This rule, that the analysand 'try to say everything,' is sustained by the analyst's commitment to listening to what the analysand tries *not* to say in addition to what she is able to say.

I have suggested that the agoraphobia patient performs an emptying of the emotional valences of her psychical life in order to protect her ego from overwhelming affect, principally rage and/or grief. The banishing of such affect does not, however, result in an experience of calm. It is an anxious emptiness. We think of *calming* anxiety: one's task might be to calm one's own anxiety, or one might seek another to calm one's anxieties. Is calm the absence of anxiety? If anxiety, even in the form of an anxious emptiness, hides overwhelming affect, then it would follow than an absence of affect would result in calm. But this is not the case. Calm is filled with feelings, not absent them. Calm is the potential to feel all of the feelings one might have. Phillips suggests that a phobia "protects a person from his own curiosity," (1993, p. 14); we might thus think of curiosity as an antidote to the anxiety that phobias both hide and highlight. The guiding question might change from 'how does one relieve anxiety?' into 'how does one cultivate curiosity?'. Rather, these questions might be two sides of the same coin insofar as curiosity is not possible where there is too much anxiety and the true relief of anxiety makes room for curiosity. I believe the resolution of this paradox is connected to the movement between the paranoid-schizoid and depressive positions that I have described in Chapters Two and Three. That is to say, we are able to develop a zest for life when we begin to have faith in our capacity to mourn (Scott 1981); similarly, we are able to develop our curiosity when we have faith in our capacity to survive wherever it is our curiosity may lead us. While we may all be familiar with the proverb ‘curiosity killed the cat,’ the rejoinder is probably less familiar: ‘but satisfaction brought it back!’ That is to say, curiosity might be deadly but also worthwhile and, further, one might be able to survive the destruction that curiosity entails.

<u>5.1. Limitations of Current Project</u>

In this thesis, all of my clinical data is derived from the published clinical work of other psychoanalysts. There are two limitations that follow from this circumstance. The first, which I discuss in more detail below in my recommendations for further research, concerns the very issue of writing and reading clinical case studies. There is a well-noted impossibility of translating what occurs in the psychoanalytic session to the comparatively brief case study and, even more so, the case vignette. This impossibility has to do with the physical limitations of transcribing, describing, and analyzing an analysis that itself likely spanned (at least) hundreds of hours. The impossibility is compounded by the task of trying to account for the ineffable effects of the unconscious communication between analyst and analysand. As little as has been published on writing clinical material, even less has been written on commenting on them. There are a few preliminary warnings, so to speak, such as Samuels’ (2000) note that it never feels “easy” commenting on someone else’s clinical material: it is both a difficult task and the attempt results in no small amount of unease. For me, this unease follows not only from the attempt to comment and critique someone else’s clinical material, but from my own lack of clinical training and expertise. I have attempted to focus my commentary on clinical material on the theoretical discussion surrounding it, but, of course, the clinical implications are significant. I have attempted to draw out those implications without assuming the position of clinical surety that no one, and certainly not myself, can claim, and especially not regarding someone else's clinical work.

5.2. Questions for Further Research

There are a number of avenues for further research; some of these I have indicated throughout. Most urgently, a comparative investigation of the phenomenon of emptiness in agoraphobia, borderline, and psychotic patients is called for. One aspect of this comparative analysis would consider the various psychoanalytic concepts that might include a subjective feeling of emptiness, including Deutsch's (1942) "as if" personality, Winnicott's (1965) False Self, and McDougall's (1984) concept of "dis-affection." Importantly, this comparison could elucidate the meanings of emptiness in all patients and lead to more efficacious techniques for the alleviation of, what is for some, a very painful experience. Singer (1977b) has noted that borderline patients who experience both a feeling of emptiness and an acute fear of emptiness are at risk for suicide. It remains to be studied whether agoraphobia patients with persistent emptiness face the same risk.[230]

Secondly, there is an emerging sense in the literature of the complexity of psychical reality, and an emerging sense of the complex relationship between history and subjective experience. As I have made clear throughout this thesis, the realm of psychoanalytic influence is psychical reality. The question that remains to be explored further is: what of "history" needs to be taken into account in the analysis of psychical life? As I have indicated in Chapter Four, this question develops out of the work Wolff (1988) began on the influence of "social history" in the development of the neuroses and has most recently been considered by Guralnik (2014a). As commentary on Guralnik (2014a) clearly indicates (see: Bohleber 2014; Faimberg 2014; Wolff Bernstein 2014; and, Guralnik 2014b), there is a lack of consensus on what level of "history" interpretations in the psychoanalytic clinic are valid. The mutual influence of an

[230] Within a psychiatric framework, Bolton et al. (2008) have found that the presence of any anxiety disorder is an independent risk factor for suicide attempts.

individual's psychic functioning and social life is understood in only a very limited sense; the possibility for psychoanalytic work to address broader social problems thus remains underdeveloped. The need for such development is also indicated in the topic of one of the most recent issues of *Psychoanalytic Inquiry* 34(7), "Analytic Lives in a Wounded World," published in October 2014.

Thirdly, in working on this thesis, a question has presented itself to me that is tangentially connected to the questions of truth and psychical reality: what do we take for "truth" in reading case histories? In reading case histories, how do we interpret – and thus change – what we read? These questions have a lengthy history in the literature on interpretation and literary analysis, but have been rarely addressed in the psychoanalytic literature. Theoretical articles on writing case histories in psychoanalysis tend to address the question of patient confidentiality (see, for example, Aron 2000; Goldberg 1997). As an example of the complexity and clinical relevance of writing and commenting on case histories, I refer again to Guralnik (2014): Bohleber, in his commentary on Guralnik (2014a), is summarizing Nyx's (Guralnik's patient) history; he writes: "The patient is the fifth and last sibling; the third child died after eight weeks, while the fourth was a miscarriage" (Bohleber 2014, p. 146). Guralnik's original statement is as follows: "Nyx was the fifth child to be born. The two eldest siblings thrived, but the third died at eight weeks. Her mother got pregnant again, but a few weeks prior to her due date decided to lift a heavy table, which ultimately caused the baby to die in *utero*" (2014a, p. 130). Guralnik's paper is entitled "The dead baby," and so my mind was attuned to these issues, but I was struck by Bohleber's characterization of a (nearly?) full-term loss as a miscarriage. Even medically speaking (which is not concerned with the individual's subjective experience of the loss), any loss after 20 weeks gestation is classified as a stillbirth; only losses prior to 20 weeks gestation are classified as miscarriages. Further, I question with what certainty Guralnik can state that the baby died because of the mother's decision "to lift a heavy table." The connection between those two statements is not immediately apparent from a medical or physiological perspective. Given that much of Nyx's conscious suffering circles around her guilt at drinking during her pregnancy and her fears of having irreparably damaged her young daughter (despite what Guralnik reports of pediatricians' assurances of her normal development), an unconscious identification with a mother "responsible" for the death of her unborn child in this way may have compounded Nyx's own feelings of shame. Nevertheless, the "truth" of the "miscarriage" evades us; all one can do is remain aware of its evasions and attempt to account for the specific ways in which it slips out of our minds. Further research would approach the analysis of writing and reading case histories from the perspective of literary analysis and interpretation. Case histories with published commentaries would be particularly useful in this analysis. Michels (2000), Scharff (2000), and Coen (2000), with commentaries (Pulver 2000; Bernstein 2000; Rubovitz-Stein 2000; Szecsödy 2000; Tuckett 2000; Wilson 2000), begin to address these questions and note both the relative paucity of such discussions and the absolute imperative for them.

Bibliography

Abraham, K. (1979). On the psychogenesis of agoraphobia in children. In H. C. Abraham (Ed.). *Clinical papers and essays on psychoanalysis*, (pp. 42-43). (H. C. Abraham & D. R. Ellison, Trans.). London: Karnac. Published London: Hogarth, 1956; New York, NY: Basic Books, 1955. (Original work published 1913).

Adler, E., & Bachant, J. L. (1996). Free association and analytic neutrality: The basic structure of the psychoanalytic situation. *Journal of the American Psychoanalytic Association*, *44*, 1021-1046.

Agoraphobia, *n*. (2014). In *OED Online*. Retrieved from http://www.oed.com.proxy1.lib.uwo.ca/view/Entry/4119?redirectedFrom=agoraphobia.

American Psychiatric Association. (1995). *The diagnostic and statistical manual of mental disorders*, 4th ed. Washington, DC: American Psychiatric Association.

---. (2000). *The diagnostic and statistical manual of mental disorders*, 4th ed., text revision. (*DSM-IV-TR)*. Washington, DC: American Psychiatric Association.

---. (2013). *The diagnostic and statistical manual of mental disorders*, 5th ed. (*DSM-5)*. Washington, DC: American Psychiatric Association.

Aron, L. (1989). Dreams, narrative and the psychoanalytic method. *Contemporary Psychoanalysis*, *25*, 108-126.

---. (2000). Ethical considerations in the writing of psychoanalytic case histories. *Psychoanalytic Dialogues*, *10*, 231-245.

Arrindell, W. A. (1987). *Marital conflict and agoraphobia: Fact or fantasy?* Delft, The Netherlands: Eburon.

Asch, S. S. (1966). Claustrophobia and depression. *Journal of the American Psychoanalytic Association*, *14*, 711-729.

Avenburg, R., & Guiter, M. (1976). The concept of truth in psychoanalysis. *International Journal of Psycho-Analysis*, *57*, 11-18.

Bacon, R. (2003). Fathers and phobias: A possibly psychoanalytic point of view. In S. Morgan (Ed.), *Phobia: A reassessment* (pp. 157-177). London: Karnac.

Ball, B. (1879). On claustrophobia. *British Medical Journal*, *6 Sept*, 371.

Bankey, R. (2004). The agoraphobic condition. *Cultural Geographies*, *11*, 347-355.

Bass, A. [Alan]. (2006). *Interpretation and difference: The strangeness of care*. Stanford, CA: Stanford University Press.

Bass, A. [Anthony]. (2007a). When the frame doesn't fit the picture. *Psychoanalytic Dialogues*, *17*, 1–27.

---. (2007b). Framing further considerations: Reply to commentaries. *Psychoanalytic Dialogues*, *17*, 931–943.

---. (2008). A few more thoughts on the frame: Forms, functions, and meanings. *Psychoanalytic Dialogues*, *18*, 262–268.

Bekker, M. H. J. (1996). Agoraphobia and gender: A review. *Clinical Psychology Review*, *16*(2), 129-146.

Benjamin, W. (1978). *Reflections*. P. Demetz (Ed. & Trans.). Fort Washington, PA: Harcourt Brace Jovanovich.

Benvenuto, B. (1999). Once upon a time: The infant in Lacanian theory. In B. Burgoyne (Ed.), *The Klein-Lacan dialogues* (pp. 19-32). London: Rebus.

Berlin L. J., Cassidy J., & Appleyard, K. (2008). The influence of early attachments on other relationships. In J. Cassidy & P. R. Shaver (Eds.) *Handbook of attachment: Theory, research and clinical applications* (pp. 333–347). New York and London: Guilford Press.

Bernstein, S. B. (2000). Commentary. *Journal of the American Psychoanalytic Association*, *48*, 381-391.

Bion, W. R. (1958). On hallucination. *International Journal of Psycho-Analysis*, *39*, 341-349.

---. (1959). Attacks on linking. *International Journal of Psycho-Analysis*, *40*, 308-315.

---. (1962a). A theory of thinking. *International Journal of Psycho-Analysis*, *43*, 306-310.

---. (1962b). *Learning from experience*. London: Karnac Books, 1984.

---. (1965). *Transformations*. London: Heinemann.

---. (1967). *Second thoughts*. London: Karnac Books, 1984.

---. (1970). *Attention and interpretation*. London: Tavistock Publications. Reprinted London: Karnac Books, 1984.

---. (1979). Making the best of a bad job. *Bulletin British Psycho-Analytical Society, February 1979*. Reprinted in *Clinical seminars and other works* (pp. 321-331). London: Karnac Books, 1987, 1994].

---. (1992). *Cogitations*. F. Bion (Ed.). London: Karnac Books.

Blumer, H. (1962). Society as symbolic interaction. In A. M. Rose (Ed.), *Human behavior and social process: An interactionist approach* (pp. 179-192). Boston, MA: Houghton-Mifflin.

Bodin, G. (1996). Inhibiting the mentalizing capacities: A defence against anxiety in the interplay of the object and subject. *The Scandinavian Psychoanalytic Review*, *19*, 180-195.

Bohleber, W. (2014). How to come to terms with the shadows of the past in the treatment of third-generation patients: A commentary on Orna Guralnik's paper 'The dead baby'. *Psychoanalytic Dialogues*, *24*, 146-153.

Bollas, C. (1995). *Cracking up: The work of unconscious experience*. New York: Hill & Wang.

---. (2013). *The Freudian moment* (2nd ed.). London: Karnac.

Bolton, J. M., Cox, B. J., Afifi, T. O., Enns, M. W., Bienvenu, O. J., & Sareen, J. (2008). Anxiety disorders and risk for suicide attempts: Findings from the Baltimore epidemiologic catchment area follow-up study. *Depression and Anxiety*, *25*(6), 477-481.

Bondi, L. (2005). Making connections and thinking through emotions: Between geography and psychotherapy. *Transactions of the Institute of British Geographers, New Series, 30*, 433-488.

Bonomi, C. (2003). Between symbol and antisymbol: The meaning of trauma reconsidered. *International Forum of Psychoanalysis*, *12*, 17–21.

Bornstein, M. (2012). We could do much better with the clinical theory of psychoanalysis. *Psychoanalytic Inquiry*, *32*, 69–78.

Boulanger, G. (2005). From voyeur to witness: Recapturing symbolic function after massive psychic trauma. *Psychoanalytic Psychology*, *22*, 21–31.

Bowlby, J. (1969). *Attachment and loss: Attachment* (Vol. 1). London: The Hogarth Press and the Institute of Psycho-Analysis.

---. (1973). *Attachment and loss: Separation: Anxiety and anger* (Vol. 2). New York: Basic.

---. (1980). *Attachment and loss: Loss, sadness and depression* (Vol. 3). New York: Basic.

---. (1979). *The making and breaking of affectional Bonds*. London: Tavistock Publications.

---. (1988). *A secure base*. London: Routledge.

Boyd, J. H., & Crump, T. (1991). Westphal's agoraphobia. *Journal of Anxiety Disorders, 5*, 71-86.

Bradby, M. K. (1920). *The logic of the unconscious mind*. London: Oxford University Press.

Breier, A., Charney, D. S., & Heninger, G. R. (1984). Major depression in patients with agoraphobic and panic disorder. *Archive of General Psychiatry*, *41*, 1129-1135.

Breznitz, S. (1971). A critical note on secondary revision. *International Journal of Psycho-Analysis*, *52*, 407-412.

Bromberg, P. M. (1998). *Standing in the spaces: Essays on clinical process, trauma, and dissociation*. London: The Analytic Press.

---. (2007). The analytic moment doesn't fit analytic "technique": Commentary on Tony Bass's "When the frame doesn't fit the picture". *Psychoanalytic Dialogues*, *17,* 909–921.

Brown, L. J. (2005). The cognitive effects of trauma: Reversal of alpha function and the formation of a beta screen. *Psychoanalytic Quarterly*, *74*, 397–420.

Busch, F. (1994). Some ambiguities in the method of free association and their implications for technique. *Journal of the American Psychoanalytic Association*, *42*, 363-384.

---. (1995). Beginning a psychoanalytic treatment: Establishing an analytic frame. *Journal of the American Psychoanalytic Association*, *43,* 449-468.

---, & Milrod, B. (2013). Panic-focused psychodynamic psychotherapy – extended range. *Psychoanalytic Inquiry, 33*, 584-594.

--- ---, Rudden, M., Shapiro, T., Singer, M., Aronson, A., Roiphe, J. (1999a). Oedipal dynamics in panic disorder. *Journal of the American Psychoanalytic Association*, *47*, 773-790.

---, ---, & Singer, M. (1999b). Theory and technique of psychodynamic treatment of panic disorder. *Journal of Psychotherapy Practice & Research*, *8*, 234–242.

---, ---, & Sandberg, L. S. (2009). A study demonstrating efficacy of a psychoanalytic psychotherapy for panic disorder: Implications for psychoanalytic research, theory, and practice. *Journal of the American Psychoanalytic Association*, *57*, 131-148.

Capps, L., & Ochs, E. (1995). *Constructing panic: The discourse of agoraphobia*. Massachusetts: Harvard University Press.

Carter, P. (2002). *Repressed spaces: The poetics of agoraphobia*. London: Reaktion Books.

Casoni, D. (2002). 'Never twice without thrice': An outline for the understanding of traumatic neurosis. *International Journal of Psycho-Analysis*, *83*, 137-159.

Catan, L. (2011). Panic and flight: Claustro-agoraphobia in the consulting room. *British Journal of Psychotherapy*, *27*(3), 242-257.

Chambless, D. L., & Mason, J. (1986). Sex, sex-role stereotyping and agoraphobia. *Behaviour Research and Therapy*, *24*, 231-235.

Claustrophobia, *n*. (2014). In *OED Online*. Retrieved from http://www.oed.com.proxy1.lib.uwo.ca/view/Entry/33958?redirectedFrom=claustr claustr.

Coen, S. J. (2000). Why we need to write openly about our clinical cases. *Journal of the American Psychoanalytic Association*, *48*, 449-470.

Cohn, L. S. (1989). Pseudostupidity and analyzability. *Journal of the American Psychoanalytic Association*, *37*, 131-145.

Compton, A. (1992). The psychoanalytic view of phobias – part III: Agoraphobia and other phobias of adults. *Psychoanalytic Quarterly*, *61*, 400-425.

Dahl, G. (2010). The two time vectors of *Nachträglichkeit* in the development of ego organization: Significance of the concept for the symbolization of nameless traumas and anxieties. *International Journal of Psycho-Analysis*, *91*, 727-744.

Davidson, J. (2000). '… the world was getting smaller': Women, agoraphobia and bodily boundaries. *Area*, *32*(1), 31-40.

---. (2001). Pregnant pauses: Agoraphobic embodiment and the limits of (im)pregnability. *Gender, Place and Culture: A Journal of Feminist Geography*, *8*(3), 283-297.

---. (2003). *Phobic geographies: The phenomenology and spatiality of identity*. Aldershot: Ashgate.

De Monchaux, C. (1962). Thinking and negative hallucination. *International Journal of Psycho-Analysis*, *43*, 311-314.

Deutsch, H. (1929). The genesis of agoraphobia. *International Journal of Psycho-Analysis*, *10*, 51–69.

---. (1942). Some forms of emotional disturbance and their relationship to schizophrenia. *Psychoanalytic Quarterly*, *11*, 301-321.

Dor, J. (1998). *Introduction to the reading of Lacan: The unconscious structured like a language*. (S. Fairfield, Trans). New York, NY: Other Press, LLC. (Original work published 1985)

Dugan, L. (2010). *Towards a unified theory of mind: Psychoanalysis as art and science*. Durham, CT: Strategic Book Publishing.

Dunn, P. (2007). Emptiness in agoraphobic patients: Commentary on Milrod. *Journal of the American Psychoanalytic Association*, *55*, 1027-1032.

Eickhoff, F-W. (2006). On *Nachträglichkeit*: The modernity of an old concept. *International Journal of Psycho-Analysis*, *87*, 1453-1469.

Eigen, M. (1983). On time and dreams. *Psychoanalytic Review*, *70*, 211-220.

---. (1993). *The electrified tightrope*. London: Jason Aronson.

---. (2002). *Rage*. Middletown, CT: Wesleyan University Press.

Ellonen-Jéquier, M. (2009). Analysis of the creation of 'emptiness', of 'nothingness', in certain types of psychosis. *International Journal of Psycho-Analysis*, *90*, 843-866.

Faimberg, H. (1996). "Listening to listening". *International Journal of Psycho-Analysis*, *77*, 667-677.

---. (1997). Misunderstanding and psychic truths. *International Journal of Psycho-Analysis*, *78*, 439-451.

---. (2005a). *Aprés-coup*. *International Journal of Psycho-Analysis*, *86*, 1-6.

---. (2005b). The telescoping of generations: A genealogy of alienated identifications. In *The telescoping of generations: Listening to the narcissistic links between generations* (pp. 4–18). London: Routledge. (Original work published 1981)

---. (2007). A plea for a broader concept of *Nachträglichkeit*. *Psychoanalytic Quarterly*, *76*, 1221-1240.

---. (2010). Listening to the telescoping of generations. In D. Birksted-Breen, S. Flanders, & A. Gibeault (Eds.), *Reading French psychoanalysis* (pp. 10–13). London: Routledge. (Original work published 1988)

---. (2013). The ‘as-yet’ situation in Winnicott’s ‘Fragment of an analysis’: Your father ‘never did you the honor of’…*yet*. *The Psychoanalytic Quarterly*, *82*, 849-875.

---. (2014). The right to our own history: Paradoxical transference and the “friendly foreigner” commentary on Orna Guralnik paper. *Psychoanalytic Dialogues*, *24*, 154–162.

---, & Corel, A. (2005). Repetition and surprise: A clinical approach to the necessity of construction and its validation. In *The telescoping of generations: Listening to the narcissistic links between generations* (pp. 31–41). London: Routledge. (Original work published 1990)

Fairbairn, W.D. (1941). A revised psychopathology of the psychoses and psychoneuroses. In *Psychoanalytic Studies of the Personality* (pp. 28–58). London: Routledge and Kegan Paul, 1986.

---. (1944). Endopsychic structure considered in terms of object-relationships. *International Journal of Psycho-Analysis*, *25*, 70-92.

---. (1952). Psychoanalytic studies of the personality. London: Tavistock.

---. (1963). Synopsis of an object-relations theory of the personality. *The International Journal of Psychoanalysis*, *44*, 224-225

Faravelli, C., Webb, T., Ambonetti, A., Fonnesu, F., Jr Sessamgo, A. (1985). Prevalence of traumatic early life events in 31 agoraphobic patients with panic attacks. *American Journal of Psychiatry*, *142*, 1493-1494.

Federici-Nebbiosi, S. (2007). The wisdom of sharing a frame: Commentary on papers by Anthony Bass and Ilana Laor. *Psychoanalytic Dialogues*, *17*, 47-57.

---. (2008). Reply to “Expanding the frame” by Anthony Bass and to commentaries. *Psychoanalytic Dialogues*, *18*, 252-257.

Felman, S. (Ed). (1982). *Literature and psychoanalysis: The question of reading: Otherwise*. Baltimore: Johns Hopkins University Press.

Fenichel, O. (1934). On the psychology of boredom. In H. Fenichel & D, Rapaport (Eds.). *The collected papers of Otto Fenichel* (pp. 292-302). London: Routledge and Kegan Paul, 1953.

---. (1944). Remarks on the common phobias. *The Psychoanalytic Quarterly*, *13*, 313-326.

---. (1946). *The psychoanalytic theory of neurosis*. London: Kegan Paul, Trench, Tubner, & Co.

Ferenczi, S. (1926). The problem of acceptance of unpleasant ideas: Advances in knowledge of the sense of reality. *International Journal of Psycho-analysis*, *7*, 312-323.

Ferro, A. (1993). From hallucination to dream: From evacuation to the tolerability of pain in the analysis of a preadolescent. *Psychoanalytic Review*, *80*, 389-404.

---. (1996). Carla's panic attacks: Insight and transformation. *International Journal of Psycho-Analysis*, *77*, 997-1011.

---. (2002). Some implications of Bion's thought: The waking dream and narrative derivatives. *International Journal of Psycho-Analysis, 83,* 597–607.

---. (2005). Four sessions with Lisa. *International Journal of Psycho-Analysis*, *86*, 1247-1256.

---. (2006). *Psychoanalysis as therapy and story-telling*. (A. Ferro, Trans.). New York: Routledge. (Original work published 1999)

Fink, B. (1995). *The Lacanian subject: Between language and jouissance*. Princeton: Princeton University Press.

---. (2004). *Lacan to the letter: Reading Écrits closely*. Minneapolis: University of Minnesota Press.

---. (2005). Lacanian clinical practice. *The Psychoanalytic Review*, *92*(4), 553-579.

---. (2007). *Fundamentals of psychoanalytic technique: A Lacanian approach for practitioners*. New York, NY: W.W. Norton.

---. (2010). Against understanding. *Journal of the American Psychoanalytic Association*, *58*, 259-285.

Fitzpatrick Hanly, M. (1996). 'Narrative', now and then: A critical realist approach. *International Journal of Psycho-Analysis*, *77*, 445-457.

Fleischer-Mann, J. (1995). Exploration of attachment-separation, fear of death and separation anxiety in agoraphobia. Ph.D. diss., http://search.proquest.com/docview/618749577?accountid=15115 (accessed November 5, 2014).

Fonagy, P. (1991). Thinking about thinking: Some clinical and theoretical considerations in the treatment of a borderline patient. *International Journal of Psycho-Analysis*, *72*, 639-656.

---, & Target, M. (1997). Attachment and reflective function: Their role in self-organization. *Development and Psychopathology*, *9*, 679-700.

Foot, M. & Koszycki, D. (2004), Gender differences in anxiety-related traits in patients with panic disorder. *Depression and Anxiety*, *20*, 123–130. doi: 10.1002/da.20031

Frances, A., & Dunn, P. (1975). The attachment-autonomy conflict in agoraphobia. *The International Journal of Psycho-Analysis*, *56*, 435-439.

Frances, A., Miele, G. M., Widiger, T. A., Pincus, H. A., Manning, D., & Davis, W. W. (1993). The classification of panic disorders: From Freud to *DSM-IV*. *Journal of Psychiatric Research*, *27*. Suppl. 1, 3-10.

French, T. M. (1958). The art and science of psychoanalysis. *Journal of the American Psychoanalytic Association*, *6*, 197-214.

Freud, A. (1993). *The ego and the mechanisms of defence*. London: Karnac. (Original work published 1937; Revised edition published 1966.)

Freud, S. (1891). On aphasia. (E. Stengel, Trans.). New York, NY: International Universities Press, 1953.

---. (1899). Screen memories. In J. Strachey (Ed.). *Standard edition 3* (pp. 301-322). (J. Strachey, Trans.). London: Hogarth.

---. (1900). The interpretation of dreams. J. Strachey (Ed.). *Standard edition 4*. (J. Strachey, Trans.). London: Hogarth.

---. (1909). ‘Little Hans’. In J. Strachey (Ed.). *Standard edition 10* (pp. 3-152). (J. Strachey, Trans.). London: Hogarth.

---. (1913). Totem and taboo. In J. Strachey (Ed.). *Standard edition 13* (pp. 1-164). (J. Strachey, Trans.). London: Hogarth.

---. (1914a). On the history of the psycho-analytic movement. In J. Strachey (Ed.). *Standard edition 14* (pp. 1-66). (J. Strachey, Trans.). London: Hogarth.

---. (1914b). Remembering, repeating and working-through. In J. Strachey (Ed.). *Standard edition 12* (pp. 145-156). (J. Strachey, Trans.). London: Hogarth.

---. (1915). Mourning and melancholia. In J. Strachey (Ed.). *Standard edition 14* (pp. 237-258). (J. Strachey, Trans.). London: Hogarth.

---. (1917). Introductory lectures on psycho-analysis. J. Strachey (Ed.). *Standard edition 16*. (J. Strachey, Trans.). London: Hogarth.

---. (1918). An infantile neurosis. In J. Strachey (Ed.). *Standard edition 17* (pp. 1-124). (J. Strachey, Trans.). London: Hogarth.

---. (1919). The uncanny. In J. Strachey (Ed.). *Standard edition 17* (pp. 217-256). (J. Strachey, Trans.). London: Hogarth.

---. (1920a). *Beyond the pleasure principle*. J. Strachey (Ed.). *Standard edition 18*: (J. Strachey, Trans.). London: Hogarth.

---. (1920b). *A general introduction to psychoanalysis.* (G. S. Hall, Trans.). New York: Horace Liveright.

---. (1923). The ego and the id. In J. Strachey (Ed.). *Standard edition 19* (pp. 3-66). (J. Strachey, Trans.). London: Hogarth.

---. (1924). The loss of reality in neurosis and psychosis. In J. Strachey (Ed.). *Standard edition 19* (pp. 181-188). (J. Strachey, Trans.). London: Hogarth.

---. (1925a). An autobiographical study. In J. Strachey (Ed.). *Standard edition 20* (pp. 1-74). (J. Strachey, Trans.). London: Hogarth.

---. (1925b). Negation. In J. Strachey (Ed.). *Standard edition 19* (pp. 233-240). (J. Strachey, Trans.). London: Hogarth.

---. (1926). Inhibitions, symptoms and anxiety. In J. Strachey (Ed.). *Standard edition 20* (pp. 75-176). (J. Strachey, Trans.). London: Hogarth.

---. (1937). Constructions in analysis. In J. Strachey (Ed.). *Standard edition 23* (pp. 255-270). (J. Strachey, Trans.). London: Hogarth.

---. (1938). An outline of psycho-analysis. In J. Strachey (Ed.). *Standard edition 23* (pp. 139-208). (J. Strachey, Trans.). London: Hogarth.

---. (1940). An outline of psycho-analysis. *International Journal of Psycho-Analysis*, *21*, 27-84.

---. (1950). Project for a scientific psychology [1895]. In J. Strachey (Ed.). *Standard edition 1* (pp. 281-391). (J. Strachey, Trans.). London: Hogarth.

---. (1985). *The complete letters of Sigmund Freud to Wilhelm Fliess*. J. M. Masson (Ed.). (J. M. Masson, Trans.). London: Belknap Press of Harvard University Press.

Friedman, S. (1985). Implications of object-relations theory for the behavioral treatment of agoraphobia. *American Journal of Psychotherapy*, *39*, 525-540.

Fromm, M. G. (1995). What does borderline mean? *Psychoanalytic Psychology*, *12*, 233-245.

Gabbard. (2007). Flexibility of the frame revisited: Commentary on Tony Bass's “When the frame doesn't fit the picture.” *Psychoanalytic Dialogues*, *17*, 923-929.

Garma, A. (1946). The genesis of reality testing a general theory of hallucination. *Psychoanalytic Quarterly*, *15*, 161-174.

---. (1969). Present thoughts on Freud's theory of dream hallucination. *International Journal of Psycho-Analysis*, *50*, 485-494.

Gassner, S. (2004). The role of traumatic experience in panic disorder and agoraphobia. *Psychoanalytic Psychology*, *21*, 222-243.

Geha, R. E. (1993). Transferred fictions. *Psychoanalytic Dialogues*, *3*, 209-243.

---. (1996). Fictionalism and psychoanalyzed history. *Psychoanalytic Review*, *83*, 695-707.

Gehl, R. H. (1964). Depression and claustrophobia. *International Journal of Psycho-Analysis*, *45*, 312-323.

Glucksman, M.L. (2000). Affect dysregulation: Defense or deficit?. *Journal of the American Academy of Psychoanalysis*, *28*, 263-273.

Goldberg, A. (1997).Writing case histories. *International Journal of Psycho-Analysis*, *78*, 435–438.

---. (2006). A lament about lack: Commentary on Wilson. *Journal of the American Psychoanalytic Association*, *52*, 429-433.

---. (2012). *The analysis of failure: An investigation of failed cases in psychoanalysis and psychotherapy*. New York, NY: Routledge.

Government of Canada (2006). *The human face of mental health and mental illness in Canada*. Minister of Public Works and Government Services Canada. (Catalogue no.: HP5-19/2006E.) Retrieved from Statistics Canada website: http://www.statcan.gc.ca/pub/82-619-m/2012004/sections/sectionb-eng.htm

Graf, E. P. (2009). The relationship of reflective functioning and severity of agoraphobia in the outcome of a psychoanalytic psychotherapy for panic disorder. (Doctoral dissertation). Retrieved from ProQuest. <http://search.proquest.com/docview/304863143>

Green, A. (1975). The analyst, symbolization and absence in the analytic setting. *International Journal of Psycho-Analysis*, *56*, 1-22.

---. (1986). *On private madness*. Connecticut: International Universities Press.

---. (1999). *The work of the negative*. (A. Weller, Trans.). London: Free Association Books.

---. (2000). The central phobic position: a new formulation of the free association method. *International Journal of Psycho-Analysis*, *81*, 429-451.

---. (2003). *Diachrony in psychoanalysis*. (A. Weller, Trans.). London: Free Association Books.

Greenson, R. R. (1953). On boredom. *Journal of the American Psychoanalytic Association*, *1*, 7-21.

Grotstein, J. S. (1981). Wilfred R. Bion: The man, the psychoanalyst, the mystic: A perspective on his life and work. In J. S. Grotstein (Ed.). *Do I dare disturb the universe?* (pp. 1-35). Beverly Hills: Caesura Press.

---. (1990). Nothingness, meaninglessness, chaos, and the "black hole" I: The importance of nothingness, meaninglessness, and chaos in psychoanalysis. *Contemporary Psychoanalysis*, *26*, 257-290.

Guillermo, de la Parra C. (2002). The problem of distance or the claustro-agorophic dilemma. *Revista Chilena de Psicoanálisis*, *19*(2), 98-110.

Guntrip, H. (1961). *Personality structure and human interaction*. London: Hogarth.

Guralnik, O. (2014a). The dead baby. *Psychoanalytic Dialogue*, *24*, 129-145.

---. (2014b). History dislocated in a nightmare: Responses to commentaries. *Psychoanalytic Dialogue*, *24*, 167-174.

Hämäläinen, O. (2009). The relationship of the inner and the outer in psychoanalysis. *The International Journal of Psycho-Analysis*, *90*, 1277–1297.

---. (2013). Commentary on Zachrisson. *Psychoanalytic Study of the Child*, *67*, 275-278.

Hanly, C. (1990). The concept of truth in psychoanalysis. *The International Journal of Psycho-Analysis*, *71*, 375-383.

---. (2009). On truth and clinical psychoanalysis. *The International Journal of Psycho-Analysis*, *90*, 363–373.

Harari, R. (2004). *Lacan's four fundamental concepts of psychoanalysis: An introduction*. (J. Filc, Trans.). New York, NY: Other Press, LLC.

Hartmann, H. (1964a). *Ego psychology and the problem of adaptation*. (D. Rapaport, Trans.). New York, NY: International Universities Press. (Original work published 1939).

---. (1964b). *Essays on ego psychology*. New York, NY: International Universities Press.

Hazan, C., & Shaver, P. R. (1990). Love and work: An attachment-theoretical perspective. *Journal of Personality and Social Psychology*, *59*, 270-280.

Heilman, M. K. M., & Valenstein, E. (Eds.). (2011). *Clinical neuropsychology*. New York, NY: Oxford University Press.

Hernández-Tubert, R. (2008). Contribution to the discussion on the analytic frame. *Psychoanalytic Dialogues*, *18*, 248–251.

Hoffman, I. Z. (1998). *Ritual and spontaneity in the psychoanalytic process*. Hillsdale, NJ: Analytic Press.

---. (2006). The myths of free association and the potentials of the analytic relationship. *International Journal of Psycho-Analysis*, *87*, 43-61.

Holdengräber, P. (2014). Adam Phillips, the art of nonfiction no. 7. Interview. *The Paris Review* 208. http://www.theparisreview.org/interviews/6286/the-art-of-nonfiction-no-7-adam-phillips

Hollway, W. & Jefferson, T. (2000). *Doing qualitative research differently: Free association, narrative, and the interview method*. London/California/New Delhi: Sage Publications.

---. (2001). Free association, narrative analysis and the defended subject: The case of Ivy. *Narrative Inquiry*, *11*, 103-122.

Holmes, J. (1994). The clinical implications of attachment theory. *British Journal of Psychotherapy*, *11*, 62-76.

---. (1997). Attachment, autonomy, intimacy: Some clinical implications of attachment theory. *British Journal of Medical Psychology*, *70*, 231-248.

---. (1999). Defensive and creative uses of narrative in psychotherapy: An attachment perspective, In G. Roberts & J. Holmes (Eds.), *Healing stories* (pp. 49-66). Oxford: Oxford University Press.

---. (2014). *Attachment, psychiatry, psychotherapy, psychoanalysis: Selected papers of Jeremy Holmes*. London: Routledge.

---. & Slade, A. (2013). *Attachment theory*. Thousand Oaks, CA: Sage.

Hurvich, M. (1989). Traumatic moment, basic dangers and annihilation anxiety. *Psychoanalytic Psychology, 6,* 309-323.

Hurvich, M., Beneviste, P., Howard, J., & Connerty, S. (1993). The assessment of annihilation anxiety from projective tests. *Perceptual and Motor Skills*, *77,* 387-401.

Iddiols, T. J. (2005). Investigating personality and attachment variables in relation to panic disorder and agoraphobia. PhD diss., University of Toronto.

Isaacs, S. (1948). The nature and function of phantasy. *International Journal of Psychoanalysis*, *29*, 73-97.

Jackel, M. M. (1966). Interruptions during psychoanalytic treatment and the wish for a child. *Journal of the American Psychoanalytic Association*, *14*, 730-735.

Jacobs, T .J. (1983). The analyst and the patient's object world: notes on an aspect of countertransference. *Journal of the American Psychoanalytic Association*, *31*, 619-642.

---. (1987). Notes on the unknowable: Analytic secrets and the transference neurosis. *Psychoanalytic Inquiry*, *7*, 485-509.

---. (1992). Isakower's ideas of the analytic instrument and contemporary views of analytic listening. *Journal of Clinical Psychoanalysis*, *1*, 237-241.

---. (1993). The inner experiences of the analyst: Their contribution to the analytic process. *International Journal of Psycho-Analysis*, *74*, 7-14.

---. (2002). Secondary revision: On rethinking the analytic process and analytic technique. *Psychoanalytic Inquiry*, *22*, 3-28.

---. (2012). Travels with Charlie: On my long-standing affair with theory. *Psychoanalytic Inquiry*, *32*, 60–68.

Jones, E. (1918). The theory of symbolism. *British Journal of Psychology*, *9*(2), 181-229.

Kanzer, M. (1972). Superego aspects of free association and the fundamental rule. *Journal of the American Psychoanalytic Association*, *20,* 246-266.

Karen, R. (1998). *Becoming attached: first relationships and how they shape our capacity to love*. Oxford: Oxford University Press.

Karren, K., Smith, L., & Gordon, K. J. (2013). *Mind/body health: The effects of attitudes, emotions, and relationships* (5th ed.). San Francisco, CA: Benjamin Cummings.

Katan, A. (1951). The role of "displacement" in agoraphobia. (G. Kurth, Trans.). *International Journal of Psycho-Analysis, 32*, 41-50.

Kernberg, O. (1975). The subjective experience of emptiness. In *Borderline conditions and pathological narcissism* (pp. 213-224). New York: J. Aronson.

---. (1999). Introduction. In A. Green (Author), *The work of the negative*. (A. Weller, Trans.). London: Free Association Books.

Kessler R. J. (1996). Panic disorder and the retreat from meaning. *Journal of Clinical Psychoanalysis*, *5*, 505–528.

Kessler, R. C., Chiu, W. T., Jin, R., Ruscio, A. M., Shear, K., & Walters, E. E. (2006). The epidemiology of panic attacks, panic disorder, and agoraphobia in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 63*(4), 415-424.

Kessler, R. C., Stang, P. E., Wittchen, H. U., Ustun, T. B., Roy-Burne, P. P., & Walters, E. E. (1998). Lifetime panic-depression comorbidity in the National Comorbidity Survey. *Archives of General Psychiatry*, *55*(9), 801-808.

Kiersky, S. M., & Fosshage, J. L. (2009). Epilogue. *Psychoanalytic Inquiry*, *29*, 354-356.

Klein, C., Milrod, B. L., Busch, F. N., Levy, K. N., & Shapiro, T. (2003). A preliminary study of clinical process in relation to outcome in psychodynamic psychotherapy for panic disorder. *Psychoanalytic Inquiry*, *23*, 308-331.

Klein, M. (1923). The development of a child. *International Journal of Psycho-Analysis, 4*, 419-474.

---. (1930). The importance of symbol-formation in the development of the ego. In *Love, guilt and reparation and other works 1921-1945* (pp. 219-232). London: Free Press, 1988.

---. (1940). Mourning and its relation to manic-depressive states. In *Love, guilt and reparation and other works 1921-1945* (pp. 344-369). London: Free Press, 1988.

---. (1952). The mutual influences in the development of ego and id. *Psychoanalytic Study of the Child*, *7*, 51-53.

Kliman, G., Rosenberg, S. & Samples, G. (2007). Poster summaries II. Human development: Intersections with psychoanalytic perspectives: Facilitating effective coping in children following disasters: A psychoanalytically informed guided narrative intervention. *Journal of the American Psychoanalytic Association*, *55*, 279-282.

Knapp, T. J. (1988). Commentary. In *Westphal's "Die agoraphobie" with commentary* (pp. 1-58). Lanham, MD: University Press of America.

Kohut, H. (1971). *The analysis of the self: A systematic approach to the psychoanalytic treatment of narcissistic personality disorders*. New York, NY: International Universities Press.

---. (2011). *The search for the self: Selected writings of Heinz Kohut*. (Vols. 1-4). P. H. Ornstein (Ed.). London: Karnac. (Original work published by International Universities Press, 1990)

Kris, A. (1982). *Free association*. New Haven, CT: Yale University Press.

---. (1983). The analyst's conceptual freedom in the method of free association. *International Journal of Psycho-Analysis*, *64*, 407-411.

---. (1992). Interpretation and the method of free association. *Psychoanalytic Inquiry*, *12*, 208-224.

Kristeva, J. (2001). *Melanie Klein, or matricide as pain and creativity.* (R. Guberman, Trans.). New York, NY: Columbia University Press.

Kubie, L.S. (1939). A critical analysis of the concept of a repetition compulsion. *International Journal of Psycho-Analysis, 20*, 390-402.

Kumin, I. M. (1978). Emptiness and its relation to schizoid ego structure. *International Review of Psycho-Analysis*, *5*, 207-216.

Künstlicher, R. (2010). The constructive potential of the repetition compulsion: Oscillating between the standstill of the repetition compulsion and playing. *Scandinavian Psychoanalytic Review*, *33*, 13-22.

Lacan, J. (1988). *The seminar of Jacques Lacan, book II: The ego in Freud's theory and in the technique of psychoanalysis.* J-A. Miller (Ed.) New York, NY: Norton.

---. (1998a). *On feminine sexuality, The limits of love and knowledge, 1972-1973: Encore, the seminar of Jacques Lacan, book XX*. (B. Fink, Trans.). New York, NY: Norton.

---. (1998b). *The four fundamental concepts of psychoanalysis*. Trans. A. Sheridan. Ed. J-A. Miller. New York, NY: Norton.

---. (2006a). Beyond the "reality principle". In *Écrits* (pp. 58-74). (B. Fink, Trans.). New York, NY: Norton.

---. (2006b). The direction of the treatment and the principles of its power. In *Écrits* (pp. 489-542). (B. Fink, Trans.). New York, NY: Norton. (Original work published 1958)

---. (2006c). The function and field of speech and language in psychoanalysis. In *Écrits* (pp. 197-268). (B. Fink, Trans.). New York, NY: Norton.

---. (2006d). The instance of the letter in the unconscious. In *Écrits* (pp. 412-441). (B. Fink, Trans.). New York, NY: Norton.

---. (2006e). On a question prior to any possible treatment of psychosis. In *Écrits* (pp. 445-488). (B. Fink, Trans.). New York, NY: Norton.

---. (2006f). The mirror stage as formative of the *I* function. In *Écrits* (pp. 75-81). (B. Fink, Trans.). New York, NY: Norton.

---. (2006g). Response to Jean Hyppolite's commentary on Freud's "*Verneinung*". In *Écrits* (pp. 318-333). (B. Fink, Trans.). New York, NY: Norton.

---. (2006h). Seminar on "The purloined letter". In *Écrits* (pp. 6-48). (B. Fink, Trans.). New York, NY: Norton.

---. (2006i). The situation of psychoanalysis and the training of psychoanalysts in 1956. In *Écrits* (pp. 384-411). (B. Fink, Trans.). New York, NY: Norton.

---. (2006j). Variations on the standard treatment. In *Écrits* (pp. 269-302). (B. Fink, Trans.). New York, NY: Norton. (Original work published 1955)

---. (2007). *Book XVII: The other side of psychoanalysis*. (R. Grigg, Trans.). New York, NY: Norton.

LaFarge, L. (1989). Emptiness as defense in severe regressive states. *Journal of the American Psychoanalytic Association*, *37*, 965-995.

Laforgue, R. (1937). Exceptions to the fundamental rule of psycho-analysis. *International Journal of Psycho-Analysis*, *18*, 35-41.

Laor, I. (2007). The therapist, the patient, and the therapeutic setting: Mutual construction of the setting as a therapeutic factor. *Psychoanalytic Dialogues*, *17*, 29–46.

Laplanche, J. (1999). *Essays on otherness*. (J. Fletcher, Trans.). New York, NY: Routledge.

Laplanche, J., & Pontalis, J. B. (1973). *The language of psychoanalysis*. (D. Nicholson-Smith, Trans.). New York, NY: Norton. (Original work published 1967)

Leader, D. (1999). Phantasy in Klein and Lacan. In B. Burgoyne & M. Sullivan (Eds.). *The Klein-Lacan dialogues*. New York: Other Press.

Levin, R., & Hurvich, M. S. (1995). Nightmares and annihilation anxiety. *Psychoanalytic Psychology*, *12*(2), 247.

Levy, K. N., Meehan, K. B., Kelly, K. M., Reynoso, J. S., Weber, M., Clarkin, J. F., & Kernberg, O.F. (2006). Change in attachment patterns and reflective function in a randomized control trial of Transference Focused Psychotherapy for borderline personality disorder. *Journal of Consulting & Clinical Psychology*, *74*, 1027–1040.

Levy, S. T. (1984). Psychoanalytic perspectives on emptiness. *Journal of the American Psychoanalytic Association*, *32*, 387–404.

---. (2011). Lamentation of an aging warrior: *JAPA* 2003-2011. *Journal of the American Psychoanalytic Association*, *59*, 1119-1128.

Lewis, C. S. (1961). *A grief observed.* London: Faber & Faber.

Lewkowicz, S., & Flechner, S. (Eds.) (2005). *Truth, reality, and the psychoanalyst: Latin American contributions to psychoanalysis.* London: Karnac Books.

Lichtenberg, J. D., & Galler, F. B. (1987). The fundamental rule: A study of current usage. *Journal of the American Psychoanalytic Association*, *35*, 47-76.

Liotti, G. (1991). Insecure attachment and agoraphobia. In C. M. Parkes, J. Stevenson-Hinde, & P. Marris (Eds.), *Attachment across the life cycle* (pp. 216-233). New York: Tavistock/Routledge.

Loewald, H. (1951). Ego and reality. *The International Journal of Psycho-Analysis*, *32*, 10-18.

---. (1971). Some considerations on repetition and repetition compulsion. *The International Journal of Psycho-Analysis*, *52*, 59-66.

Loewenstein, E. A. (1991). Psychoanalytic life history: Is coherence, continuity, and aesthetic appeal necessary? *Psychoanalysis and Contemporary Thought*, *14*, 3-28.

---. (1994). Dissolving the myth of the unified self: The fate of the subject in Freudian analysis. *Psychoanalytic Quarterly*, *63*, 715-732.

Loewenstein, R. M. (1963). Some considerations on free association. *Journal of the American Psychoanalytic Association*, *11*, 451-472.

Luepnitz, D. A. (2009). Thinking in the space between Winnicott and Lacan. *International Journal of Psycho-Analysis*, *90*, 957-981.

Mahler, M. S. (1942). Pseudoimbecility: A magic cap of invisibility. *Psychoanalytic Quarterly*, *11*, 149-164.

---. (2000). *The psychological birth of the human infant: Symbiosis and individuation*. New York, NY: Basic Books. (Original work published 1975)

Mahoney, P. (1979). The boundaries of free association. *Psychoanalysis and Contemporary Thought*, *2*, 151-198.

Main, M., Kaplan, N. & Cassidy, J. (1985). Security in infancy, childhood, and adulthood: A move to the level of representation. *Monographs of the Society for Research in Child Development*, *50*(1/2), 66-104.

---, Goldwyn, R. & Hesse, E. (2002). Adult attachment interview manual. Unpublished manuscript, Department of Psychology, University of California at Berkeley.

Maizels, N. (1985). Self-envy, the womb and the nature of goodness. *International Journal of Psycho-analysis*, *66*, 185-192.

Marchand, A., Goupil, G., & Trudel, G. (1994). Fear and depression in patients with panic disorder and agoraphobia. *Scandinavian Journal of Behaviour Therapy, 23*, 87-95.

Marion, P. (2012). Some reflections on the unique time of *Nachträglichkeit* in theory and clinical practice. *International Journal of Psycho-analysis, 93*, 317-340.

Maroda, K. J. (2007). Ethical considerations of the home office. *Psychoanalytic Psychology*, *24*, 173–179.

Masson, J. M. (1985). *The assault on truth: Freud's suppression of the seduction theory*. New York: Penguin Books.

Matte-Blanco, I. (1940). Some reflections on psycho-dynamics. *International Journal of Psycho-Analysis*, *21*, 253-279.

---. (1959). Expression in symbolic logic of the characteristics of the system Ucs or the logic of the system Ucs. *International Journal of Psycho-Analysis, 40*, 1-5.

---. (1975). *The unconscious as infinite sets: An essay in bi-logic*. London: Duckworth.

---. (1988). *Thinking, feeling, and being: Clinical reflections on the fundamental antinomy of human beings and the world*. London: Routledge.

---. (2005). On the four antinomies of the death instinct. *International Journal of Psycho-Analysis, 86*, 1463-1476. (R. Carvalho, Trans.). (Original work published 1973: Le quattro antinomie dell'istinto di morte. In *Enciclopedia*, *73,* p. 447–456. Rome: Enciclopedia Italiana)

McDermott, V. A. (2003). Is free association still fundamental? *Journal of the American Psychoanalytic Association*, *51*, 1349-1356.

McDougall, J. (1984). The "dis-affected" patient: Reflections on affect pathology. *Psychoanalytic Quarterly*, *53*, 386-409.

McLean, C. P. & Anderson, E. R. (2009). Brave men and timid women? A review of the gender differences in fear and anxiety. *Clinical Psychology Review*, *29*, 496–505.

McWatters, M. R. (2013). The unworlding and worlding of agoraphobia. PhD. Diss., http://repositories.lib.utexas.edu/bitstream/handle/2152/21870/MCWATTERS-DISSERTATION-2013.pdf?sequence=1 (accessed December 7, 2014).

Meerloo, J. A. M. (1959). Psychoanalysis as an experiment in communication. *Psychoanalytic Review, 46A*, 75-89.

Melnick, B. A. (2000). Cold hard world\warm soft mommy: The unconscious logic of metaphor. *The Annual of Psychoanalysis*, *28*, 225-244.

Michels, R. (2000). The case history. *Journal of the American Psychoanalytic Association*, *48*, 355-375.

Midgley, N. (2006). Re-reading 'Little Hans': Freud's case study and the question of competing paradigms in psychoanalysis. *Journal of the American Psychoanalytic Association*, *54*, 537-559.

Miller, J. A. (1990). Microscopia: An introduction to the reading of *Television*. In J. Copjec (Ed.), *Television*. (xi-xxxii). (D. Hollier, Trans.). New York, NY and London: W.W. Norton.

---. (1994). Extimité. In M. Bracher, M. W. Alcorn, Jr., R. J. Corthell, & F. Massardier-Kenney (Eds.), *Lacanian theory of discourse: subject, structure, and society* (pp. 74-87).

---. (1999). “Did you say bizarre?” *Lacanian Ink*, *15*, 12.

Mills, J. (2014). Truth. *Journal of the American Psychoanalytic Association*, *62*, 267-293.

Milner, M. (1952). Aspects of symbolism in comprehension of the not-self. *International Journal of Psycho-Analysis, 33*, 181-194.

Milrod, B. (1995). The continued usefulness of psychoanalysis in the treatment armamentarium for panic disorder. *Journal of the American Psychoanalytic Association*, *43*, 151-162.

---. (1998). Unconscious pregnancy fantasies in patients with panic disorder. *Journal of the American Psychoanalytic Association*, *46*, 673–690.

---. (2007). Emptiness in agoraphobia patients. *Journal of the American Psycho-Analytic Association*, *55*, 1007-1026.

---, Busch, F., Hollander, E., Aronson, A., & Siever, L. (1996). A 23-year-old woman with panic disorder treated with psychodynamic psychotherapy. *American Journal of Psychiatry*, *153*, 698-703.

---, Busch, F., Cooper, A., & Shapiro, T. (1997). *Manual of panic-focused psychodynamic psychotherapy*. Washington, DC: American Psychiatric Press.

---, Busch, F., Leon, A., Aronson, A., Roiphe, J., Rudden, M., Singer, M., Shapiro, T., Goldman, H., Richter, D., & Shear, M.K. (2000). An open trial of psychodynamic psychotherapy for panic disorder: A pilot study. *American Journal of Psychiatry, 157*, 1878–1880.

---, ---, ---, ---, ---, ---, ---, ---, ---, ---, ---. (2001). A pilot open trial of brief psychodynamic psychotherapy for panic disorder. *Journal of Psychotherapy Practice & Research*, *10*, 239–272.

---, Leon, A., Busch, F., Rudden, M., Schwalberg, M., Clarkin, J.F., et al. (2007). The efficacy of psychoanalytic psychotherapy for panic disorder. *American Journal of Psychiatry*, *164*, 265–272.

Mitte, K. (2005). A meta-analysis of the efficacy of psycho- and pharmacotherapy in panic disorder with and without agoraphobia. *Journal of Affective Disorders*, *88*, 27-45.

Molino, A., & Ware, C. (Eds.). (2001). *Where Id was: Challenging normalization in psychoanalysis*. London and New York, NY: Continuum.

Morgan, S. (2003). The history of phobia: An overview of the development of ideas on the origins and meaning of agoraphobia. In S. Morgan (Ed.), *Phobia: A reassessment* (pp. 179-214). London, New York: Karnac.

Muscetta, S., Dazzi, N., Decoro, A., Ortu, F., & Speranza, A. M. (1999). 'States of mind with respect to attachment' and change in a psychotherapeutic relationship: A study of the coherence of transcript in a short-term psychotherapy with an adolescent. *Psychoanalytic Inquiry*, *19*, 885-921.

Muniz de Rezende, A. (2005). In S. Lewkowicz & S. Flechner (Eds.), *Truth, reality, and the psychoanalyst* (pp. 72-86). London: Karnac Books.

Ogden, T. H. (1986). *The matrix of the mind: Object Relations and the psychoanalytic dialogue*. New Jersey: Jason Aronson Inc.

---. (1989). *The primitive edge of experience*. New Jersey: Jason Aronson Inc.

---. (2004). This art of psychoanalysis: Dreaming undreamt dreams and interrupted cries. *International Journal of Psycho-Analysis, 85*, 857-877.

---. (2014). Fear of breakdown and the unlived life. *International Journal of Psycho-Analysis*, *95*, 205–223.

Opdal, L. C. (2012). The object and the other: a complex view. *The Scandinavian Psychoanalytic Review*, *35*, 2-8.

Orr, J. (2006). *Panic diaries: A genealogy of panic disorder*. Durham and London: Duke University Press.

Parsons, M. (2000). *The dove that returns, the dove that vanishes*. London and Philadelphia: Routledge.

Perelberg, R. J. (2006). The controversial discussions and *après-coup*. *International Journal of Psycho-Analysis*, *87*, 1199-1220.

---. (2008). *Time, space and phantasy*. London: Routledge

Phillips, A. (1993). *On kissing, tickling, and being bored: Psychoanalytic essays on the unexamined life*. Cambridge, Massachusetts: Harvard University Press.

Pulver, S. (2000). Commentary. *Journal of the American Psychoanalytic Association*, *48*, 376-381.

Rappaport, D. (1998). Destruction and gratitude. *Contemporary Psychoanalysis*, *34*(3), 369-378.

Reed, G. (2006). The reader's lack: Commentary on Wilson. *Journal of the American Psychoanalytic Association*, *52*, 447-456.

---. (2009). An empty mirror: Reflections on nonrepresentation. *The Psychoanalytic Quarterly*, *78*, 1-26.

Reeder, J. (2012). The empty core: Metapsychological reflections upon the lost object, an ethical order, and the inevitable void at the center of our existence. *Scandinavian Psychoanalytic Review*, *35*, 35-44.

Reik, T. (1968). The psychological meaning of silence. (K. M. Altman, Trans.). *Psychoanalytic Review*, *55*, 172-186. (Original work published 1963).

Reuter, S. Z. (2007a). Agoraphobia, social order, and psychiatric narrative. In V. Raoul (Ed.), *Unfitting stories: Narrative approaches to disease, disability, and trauma* (pp. 247-254). Waterloo, ON: Wilfred Laurier University Press.

---. (2007b). *Narrating social order: Agoraphobia and the politics of classification*. Toronto, ON: University of Toronto Press.

Rey, H. (1994). *Universals of psychoanalysis in the treatment of psychotic and borderline states*. London: Free Association Books.

Ricoeur, P. (1977). *Freud and philosophy*. (D. Savage, Trans.) New Haven, CT: Yale University Press. (Original work published 1970).

Rivière, J. (1936). A contribution to the analysis of the negative therapeutic reaction. *International Journal of Psycho-Analysis*, *17*, 304-320.

Rosegrant, J. (2010). Three psychoanalytic realities. *Psychoanalytic Psychology*, *27*, 492-512.

Rubovits-Seitz, P. (2000). Commentary. *Journal of the American Psychoanalytic Association*, *48*, 391-396.

Rudden, M., Busch, F.N., Milrod, B., Singer, M., Aronson, A., Roiphe, J., & Shapiro, T. (2003). Panic disorder and depression: A psychodynamic exploration of comorbidity. *International Journal of Psycho-Analysis*, *84*, 997-1015.

---. Milrod, B., Target, M., Ackerman, S., & Graf, E. (2006). Reflective functioning in panic disorder patients: A pilot study. *Journal of the American Psychoanalytic Association*, *54*, 1339-1343.

Ruddick, B. (1961). Agoraphobia. *International Journal of Psycho-Analysis*, *42*, 537-543.

Russell, B. (1921). *The analysis of mind*. London: George Allen and Unwin; New York: The Macmillan Company.

Sabbadini, A. (1989). Boundaries of timelessness. *International Journal of Psycho-Analysis*, *70*, 305-313.

Sable, P. (1994). Separation anxiety, attachment and agoraphobia. *Clinical Social Work Journal*, *22*, 369-383.

Samuels, A. (2000). Post-Jungian dialogues. *Psychoanalytic Dialogues, 10*, 403–426.

Schafer, R. (1987). Self-deception, defense, and narration. *Psychoanalysis and Contemporary Thought*, *10*, 319-346.

---. (1996). Authority, evidence, and knowledge in the psychoanalytic relationship. *Psychoanalytic Quarterly*, *65*, 236-253.

Scharff, J. S. (2000). On writing from clinical experience. *Journal of the American Psychoanalytic Association*, *48*, 421-447.

Schimek, J. G. (1975). The interpretations of the past: Childhood trauma, psychical reality, and historical truth. *Journal of the American Psychoanalytic Association*, *23*, 845-865.

---. (1987). Fact and fantasy in the seduction theory: A historical review. *Journal of the American Psychoanalytic Association*, *35*, 937-964.

Schubert, J. (2001). Between eternity and transience: On the significance of time in psychoanalysis. *Scandinavian Psychoanalytic Review*, *24*, 93-100.

Scott, W. C. M. (1958). Noise, speech and technique. *The International Journal of Psycho-Analysis*, *39*, 108.

---. (1981). The development of the analysands' and analysts' enthusiasm for the process of psychoanalysis. In J. Grotstein (Ed.), *Do I Dare Disturb the Universe?* (pp. 571-577). Beverly Hills: Caesura Press

---. (1984). Primitive mental states in clinical psychoanalysis. *Contemporary Psychoanalysis*, *20*, 458-464.

---. (1988). Repairing broken links between the unconscious, sleep and instinct and the conscious, waking and instinct. *Free Associations*, *1*(12), 84-91.

Seidenberg, R., & DeCrow, K. (1983). *Women who marry houses: Panic and protest in agoraphobia*. New York: McGraw-Hill Book Co.

Shengold, L. (1985). Narrative truth and historical truth. *Journal of the American Psychoanalytic Association*, *33S*, 239-244.

Simmel, G. (1950). *The sociology of Georg Simmel*. Trans. and Ed. K. Wolff. New York, NY: The Free Press, Macmillan.

Singer, M. (1977a). The experience of emptiness in narcissistic and borderline states: I. Deficiency and ego defect versus dynamic-defensive models. *International Review of Psycho-Analysis, 4*, 459-469.

---. (1977b). The experience of emptiness in narcissistic and borderline states: II. The struggle for a sense of self and the potential for suicide. *International Review of Psycho-Analysis, 4,* 471-479.

Slochower, H. (1964). Applied psychoanalysis: As a science and as an art. *American Imago*, *21*, 165-174.

Smith H. F. (2001). Obstacles to integration: Another look at why we talk past each other. *Psychoanalytic Psychology, 18,* 485–514.

---. (2004). The analyst's fantasy of the ideal patient. *Psychoanalytic Quarterly*, *73*, 627–658.

Snaith, R. P. (1968). A clinical investigation of phobias. *The British Journal of Psychiatry*, *114*, 673-698.

Sodré, I. (1997). Insight et après-coup [Insight and *après-coup*]. *Revue Francais Psychanalyse*, *61*, 1255–1262.

Spence, D. P. (1982a). *Narrative truth and historical truth: Meaning and interpretation in psychoanalysis*. New York: W. W. Norton.

---. (1982b). Narrative truth and theoretical truth. *Psychoanalytic Quarterly*, *51*, 43-69.

---. (1983). Narrative persuasion. *Psychoanalysis and Contemporary Thought*, *6*, 457-481.

Starcevic, V., Latas, M., Kolar, D., & Berle, D. (2007). Are there gender differences in catastrophic appraisals in panic disorder with agoraphobia? *Depression and Anxiety*, *24*(8), 545-552. doi:http://dx.doi.org/10.1002/da.20245

Starcevic, V., Uhlenhuth, E. H., Kellner, R., & Pathak, D. (1992). Patterns of comorbidity in panic disorder and agoraphobia. *Psychiatry Research*, *42*(2), 171-183.

Steele, H., & Steele, M. (Eds.). (2008). *Clinical application of the adult attachment interview*. New York: Guilford Press.

Stein, M. H. (1989). How dreams are told: Secondary revision—the critic, the editor, and the plagiarist. *Journal of the American Psychoanalytic Association*, *37*, 65-88.

Steiner, J. (1993). *Psychic retreats: Pathological organizations in psychotic, neurotic and borderline patients*. New York, NY: Routledge

---. (1994). Foreword. In J. Magagna (Ed.), *Universals of psychoanalysis in the treatment of psychotic and borderline states* (pp. ix-xx). London: Free Association Books.

---. (2011). *Seeing and being seen: Emerging from a psychic retreat*. New York, NY: Routledge.

Stern, H. R. (1966). The truth as a resistance to free-association. *Psychoanalytic Review*, *53*, 142-146.

Strubbe, G., & Vanheule, S. (2014). The subject in an uproar: A Lacanian perspective on panic disorder. *Journal of the American Psychoanalytic Association*, *62*, 237-266.

Symonds, A. (1971). Phobias after marriage. *American Journal of Psychoanalysis*, *31*, 144-152.

Szecsödy, I. (2000). Commentary. *Journal of the American Psychoanalytic Association*, *48*, 397-403.

Tarantelli, C. B. (2003). Life within death: Towards a metapsychology of catastrophic psychic trauma. *International Journal of Psycho-Analysis*, *84*, 915–928.

Taylor, G. J., & Bagby, R. M. (2013). Psychoanalysis and empirical research: The example of alexithymia. *Journal of the American Psychoanalytic Association, 61*, 99-133.

Taylor, S., & Rachman, S. J. (1991). Fear of sadness. *Journal of Anxiety Disorders*, *5*, 375-381.

Thomä, H., & Cheshire, N. (1991). Freud's *Nachträglichkeit* and Strachey's 'deferred action': Trauma, constructions and the direction of causality. *International Review of Psycho-Analysis*, *18*, 407-427.

Teuber, H. L. (1968). Alteration of perception and memory in man. In L. Weiskrantz (Ed.), *Analysis of behavioral change* (pp. 268-375). New York, NY: Harper.

Torsti, M. (2000). At the sources of the symbolization process: The psychoanalyst as an observer of early trauma. *Psychoanalytic Study of the Child*, *55*, 275–297.

Toynbee, A. J. (1949). Poetical truth and scientific truth in the light of history. *International Journal of Psycho-Analysis*, *30*, 143-152.

Tubert-Oklander, J. (2008). Contribution to the discussion on the analytic frame. *Psychoanalytic Dialogues*, *18*, 239–242.

Tuckett, D. (2000). Commentary. *Journal of the American Psychoanalytic Association*, *48*, 403-411.

Tweed, J. L., Schoenbach, V. J., George, L. K., & Blazer, D. G. (1989). The effects of childhood parental death and divorce on the six-month history of anxiety disorders. *British Journal of Psychiatry*, *154*, 823-828.

van IJzendoorn, M. H., & Bakersman-Kranenberg, M. J. (1996). Attachment representations in mothers, fathers, adolescents, and clinical groups: A meta-analytic search for normative data. *Journal of Consulting and Clinical Psychology*, *64*, 8-21.

Vaslamatzis, G. (2007) Keeping the analytic relationship alive: A clinical exploration into incoherence and lethargy. *Scandinavian Psychoanalytic Review*, *30*, 106-112.

Webber S. G. (1872). Agoraphobia. *Boston Medical and Surgical Journal*, *10*, 297-298.

Weiss, E. (1935). Agoraphobia and its relation to hysterical attacks and trauma. *International Journal of Psycho-Analysis*, *16*, 59-83.

Westenberg, H. G. M. (1998). Basic mechanisms of panic and depression: Are they separate? *European Neuropsychopharmacology*, *8*, Supp. 2, November 1998, S57-S58.

Westphal, C. F. O. (1988). *Die agoraphobie*. In *Westphal's 'Die Agoraphobie' with commentary* (pp. 59-92). (T. J. Knapp & M. T. Schumacher, Trans.). Lanham, MD: University Press of America. (Original work published 1871)

White, R. (1884). Agoraphobia. *The Lancet* December 27, 1884, 1140-1141.

Wiborg, I. M., & Dahl, A. A. (1996). Does brief dynamic psychotherapy reduce the relapse rate of panic disorder? *Archives of General Psychiatry*, *53*, 689–694.

Wilde, D. (2003). Phobias and primitive psychotic anxieties. In S. Morgan (Ed.), *Phobias: A reassessment* (pp. 133-156). London: Karnac.

Willoughby, R. (2001). "The dungeon of thyself": The claustrum as pathological container. *The International Journal of Psycho-Analysis*, *82*, 917-931.

Wilson, A. (2000). Commentary. *Journal of the American Psychoanalytic Association*, *48*, 411-417.

Wilson, M. (1998). Otherness within: Aspects of insight in psychoanalysis. *Psychoanalytic Quarterly, 67*, 54-77.

---. (2006a). ‘Nothing could be further from the truth’: The role of lack in the analytic process. *Journal of the American Psychoanalytic Association*, *54*, 397-421.

---. (2006b). Response to commentaries. *Journal of the American Psychoanalytic Association*, *54*, 457-462.

Winnicott, C. (1980). Fear of breakdown: A clinical example. *International Journal of Psycho-Analysis*, *61*, 351-357.

Winnicott, D. (1951). Transitional objects and transitional phenomena. In *Playing and reality* (pp. 1-25). London: Tavistock Publications, 1971.

---. (1956). Primary maternal preoccupation. In *Collected Papers, through paediatrics to psychoanalysis* (pp. 300-305). London: Tavistock Publications, 1958.

---. (1959). The fate of the transitional object. In *Psycho-analytic explorations* (pp. 53-58). Massachusetts: Harvard University Press, 1989.

---. (1965). The maturational processes and the facilitating environment: Studies in the theory of emotional development. *The International Psycho-Analytical Library*, *64*, 1-276. London: The Hogarth Press and the Institute of Psycho-Analysis.

---. (1969). The use of an object. *The International Psycho-Analytical Library*, *50*, 711-716. Republished in *Playing and reality* (pp. 86-94). London: Tavistock Publications, 1971.

---. (1971). *Playing and reality*. London: Tavistock Publications.

---. (1974). Fear of breakdown. *International Review of Psycho-Analysis*, *1*, 103-107.

Wolff, P. H. (1988). The real and the reconstructed past. *Psychoanalysis Contemporary Thought*, *11*, 379-414.

Wolff Bernstein, J. (2014). Dead babies: Response to Orna Guralnik’s paper. *Psychoanalytic Dialogues*, *24*, 163-166.

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