revolution, a fairly passive individual, mostly reactive to his environment and therefore, hardly accountable to his interiority and his mind" (p. 212).

Both from personal experience and knowledge of the 'sabra' character, this reviewer, like many other readers, will find the above conclusive remarks by the author somewhat contradictory. In effect, the image of new Zionist man comes across as far from passive. One could wonder whether Rolnik might mislead the reader, since he may have meant that the new Zionist man was and is 'passive' in terms of introspection but not in terms of reacting and taking 'realistic' initiative towards the external environment.

Confirming what he terms 'passive', Rolnik suggests that the analytic theories that gained most popularity in Israel are those he calls 'trauma-centric'. He concludes that 'such theorizing tends to portray the patient as a passive template on which the atrocities or the shortcomings of his significant others are inscribed, rather than as an active agent' (p. 213). He is quite critical of the psychoanalytic tendency in Israel to attribute psychological disturbance to external factors rather than internal forces. Linking this to political life, he says, Israel tends to blame external threats and not assume enough internal responsibility. He suggests that it is a challenge for psychoanalysis in Israel to help translate external realities into meaningful psychic reality.

To sum up, the book is both engaging and well researched. However, since the chosen style of writing is historical rather than psychoanalytic, the author often goes from one fact to another and at times reads like a collection and accumulation of facts and stories, losing its argument along the path. It would have gained greatly by formulating its thinking more formally, for instance through the division of chapters into sections and subheadings following a development of thought and argument. This formal aspect of the book can make it difficult to identify its aims, though this may be because the topic itself raises more questions than answers.

For the non-specialist reader, the interest of the book will lie mainly in the history of the European psychoanalytic movement before and after World War II, and serve as a good reference resource for both historians and psychoanalysts.

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***Taking the transference, reaching towards dreams: Clinical studies in the intermediate area***

by **M. Gerard Fromm**
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Gerard Fromm has written a clinically wise and engaging book that explicates the implications and applications of Winnicott's thinking to work with

 

our most disturbed patients. The title, *Taking the transference*, embodies Fromm's core thesis: the analyst must be able to 'take', that is, tolerate and hold, the intense transference feelings that very ill patients bring to the consulting room.

This is a deeply phenomenological, non-polemical book, rich with complex case illustrations and thickened with Fromm's creative use of theory. It will engage a range of readers, from beginning therapists struggling with their most disturbed patients, to seasoned clinicians interested in expanding the relevance of Winnicottian ideas to borderline and psychotic patients.

Much of Fromm's clinical material is taken from patients seen at the Austen Riggs Center in Massachusetts. Riggs is an unusual – and impressive – treatment setting. In an open (non-coercive) therapeutic community, very disturbed patients receive treatment in individual psychoanalytic psychotherapy along with other community-based modalities.

Many of the patients Fromm describes would be diagnosed as borderline or psychotic. But Fromm challenges the usefulness of these categories and formulates clinical dynamics outside them. Fromm uses detailed case material to illustrate how the therapist can help very ill patients work through the kind of deep transference involvement that we more typically associate with intensive on-the-couch psychoanalytic treatment of neurotic patients. Implicitly, Fromm challenges those readers committed to ideas of 'analyzability' to rethink these categories.

Each of the 13 chapters takes up a different clinical/theoretical issue. Two explicitly discuss (and challenge) aspects of standard diagnosis – "What does borderline mean" (Chapter 2) and "Psychosis, trauma, and the speechless content" (Chapter 10). While issues of technique are central throughout the book, two chapters focus on Fromm's 'technical' clinical position. Chapter 9, "Taking the transference", describes the therapeutic efficacy of holding or containing negative transference. Chapter 12, "Interpretation in psychoanalysis" might have better been titled (or subtitled) 'the clinical limits of interpretation with more disturbed patients'. Fromm echoes Winnicott's conviction that interpretation actually may prevent deep change in work with patients who are very ill. Other chapters address such issues as transitional relatedness, disturbances of the self, the hope embedded in the experience of hopelessness, creative activity and dreaming. A final chapter describes the Austen Riggs Center and its function as an overarching holding environment.

While Fromm grounds his thinking mainly in Winnicott, he is not theoretically rigid and also references a diverse set of writers. Aside from Winnicott, Fromm leans most heavily on Lacan and Erikson; however, the reader will find references from classical writing, Kleinian, Interpersonal and relational literatures as well. These references reflects Fromm's deep understanding; they are not 'tossed out' willy nilly, but enrich and complicate his theoretical perspective.

His is a decidedly non-dogmatic position: Fromm does not take up the theoretical clashes among theories, but instead usefully invokes different ideas to illustrate the underlying dynamics of the moment. While it may offend a reader who strenuously objects to one or another theory or seeks a

 

cross-theoretical comparison, I found it refreshing to encounter a clinician more interested in what works in the therapeutic encounter – and why – than in political/theoretical arguments that require us to take sides.

Because Winnicott's writing was so evocative, poetic, and rarely concrete, many of his concepts lend themselves to multiple interpretations, readings or 'misreadings'. I suspect that Winnicott would not have minded this. Thus, while I resonate with much of Fromm's Winnicott, I occasionally encountered a clash where Fromm seemed to know a somewhat different Winnicott from the one I had fashioned for myself. For example, in Chapter 7 ("Illusion and desire"), Fromm describes the work of a French analyst who remained "relatively inactive and often very silent during these three years" (p. 94). Following a concerning period of disturbance, Fromm notes that "the analyst's act of holding these warning signs in mind across long stretches of time is precisely what Winnicott meant by a holding environment" (p. 96). I found myself surprised to hear that Fromm viewed this as precisely what Winnicott meant. My own reading of Winnicott has led me to understand holding quite differently, as a process located firmly in the analyst's emotional activity vis-à-vis the patient – activity that results in *the patient's conscious experience of the analyst as a protective presence*. I cannot think of an instance in which Winnicott felt that he held a patient outside the arena of regression to an (object-related) dependence and so I have trouble stretching this clinical example of work by a Lacanian to the Winnicottian holding metaphor. Fromm might well reply that this patient unconsciously did feel protected by the analyst's silence and this seems plausible; nevertheless, I associate this vignette with a decidedly non-Winnicottian approach. My point here is not that Fromm is wrong or that I am correct, but rather that his discussion of Winnicott's writing will itself stimulate discussion.

Although Fromm does not take up these differences of opinion or challenge other perspectives, there is one exception: in Chapter 12 ("Interpretation in psychoanalysis"), he directly but playfully critiques Winnicott's (1989) handling of the 'orange dream'. Winnicott actively interpreted a patient's dream, apparently ignoring his own belief that the analyst's interpretation could spoil the work. Fromm suggests that Winnicott's interpretation reflected his countertransference (aggressive) response to the patient's aggression. But rather than criticizing Winnicott's clinical work or pointing to this discrepancy between theory and practice, Fromm offers us a creative re-reading: noting that the patient made good use of the interpretation, Fromm suggests that she was able temporarily to tolerate the analyst's shift to the position of an outsider, someone who resided beyond the arena of the subjective object. Other readers (myself included) may wonder whether Winnicott inadvertently breached his own theory by failing to allow the patient to 'create' meaning out of the dream or instead demonstrated his willingness to tolerate paradox and contradiction.

Chapter 2, "What does borderline mean" illustrates Fromm's overall approach. He views "borderline" as a useless empty signifier that mainly reflects the clinician's subjective experience of the patient. Fromm takes a relational (and Winnicottian) perspective when he declares, "I am

 

suggesting that there is no such thing as a "borderline" patient, only a couple interacting in a paradigmatically borderline way" (p. 26). Integrating Winnicott and Lacan, Fromm locates what has been called borderline pathology in the arena between unintegration and integration (in Winnicott's sense), while also underscoring the therapist's investment in the Imaginary (Lacan) as the therapist tries to manage her own countertransference response.

Extending his discussion beyond the study of individual patient dynamics, Fromm consistently underscores the phenomenology of the therapist's experience with borderline patients. This emphasis also finds expression in his discussion of psychosis (Chapter 10), where he considers its social dimension.

Moving fluidly between theory and case material, Fromm attributes clinical impasse to a "pathology of relatedness" (p. 5). The clinician's task is to offer a usable therapeutic medium and set the frame in order to create a transitional, potentially transformative setting. Fromm leans on many Winnicottian ideas here. He views the therapeutic holding environment as essential with these very disturbed patients. Because they are highly vulnerable to indications of the therapist's separateness that disrupt the experience of transitional relatedness, the therapist's role will be to hold, or "take the transference", a phrase used by Symington (1986). "Taking the transference" requires that the therapist contain (hold) the patient's aggression largely without using interpretation to manage it (or, I'd add, to manage herself). Fromm especially emphasizes the clinically mutative movement from object relating to object usage. His thesis resonates with my own work on holding hate in a clinical trajectory with object usage as a goal (Slochower, 2006).

From Fromm's perspective, the patient needs to work through anger with a therapist who contains more than she interprets. Addressing therapist and patient's separate experiences of each other, Fromm describes how the therapist's clinical shift can move the treatment. Fromm does not explore explicit work around the re-enacted element – that is, the ways in which certain dynamics are co-created and might be usefully unpacked to mutative effect. However, his working assumption is that the dyad is always implicated in the patient's pathology.

With Winnicott, Fromm notes that therapeutic roadblocks (like maternal ones) emerge from the therapist's – rather than the patient's – failures. Emphasizing the limits of the therapist's authority and omniscience, Fromm points to her participation in moments of impasse. He focuses less than Winnicott (e.g. 1956) on the mutative impact of the patient's capacity to make use of the therapist's failures, and more on the therapist's function as a reparative, resilient object.

This Winnicottian sensibility also informs his perspective on dreaming: it is *dreaming the dream* rather than interpreting the dream that is therapeutic. The analyst's task is to grasp "something of the range of the implicit possibilities the patient may be formulating in the dream about himself … the process … and the setting" (p. 167). Following this theme, Fromm underscores the therapist's function as a medium to the patient's process and

 

reminds us how much integrative work takes place during silent clinical periods (Winnicott, 1958).

Fromm's central clinical thesis is a familiar one to those who know Winnicott's work or that of clinicians influenced by him. The review of Winnicottian concepts will be very familiar to the senior clinician but will be extremely useful to the therapist in training. I am not, however, suggesting that *Taking the transference* is a book for beginners: Fromm gives us much more than a review of Winnicott by creatively integrating these concepts within a larger theoretical umbrella and applying them to a group of patients far more troubled than those we analysts typically encounter in the consulting room. In so doing, Fromm expands and deepens the reach and meaning of the Winnicottian trope.

This wise and seasoned analyst has written a fascinating clinical integration that extends Winnicottian themes to work with very disturbed patients. Across chapters we encounter Fromm's sensitivity and sophisticated capacity to use the 'right' theory in the 'right' moment. He shows himself to be neither rigid nor infinitely flexible (since the latter position runs the risk of sidestepping patients' aggression). He has filled in some of the clinical gaps left by Winnicott whose incredibly evocative papers used illustrative vignettes but rarely explicated ideas in detailed clinical case studies.

While the chapters build on each other, each also can be read on its own. Had I been the editor, I would have asked Fromm to begin (rather than end) the book with the discussion of Austen Riggs. The considerable therapeutic power of this very unusual community is a fascinating backdrop to Fromm's thinking and the source of most of his clinical examples. I also would have liked to hear more about how Fromm's own experience there altered his thinking and clinical work. Perhaps this will be his next book.

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