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Being, doing, and play: A theoretical and clinical exploration

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Abstract

This paper explores the metonymy of the following aphorism, delivered by Winnicott in a 1967 lecture: “From being comes doing, but there can be no *do* before *be*.” (1970, p. 25, emphasis in original). This aphorism has been little discussed or explored in the literature, but Winnicott articulated similar ideas in his more academic papers (e.g., 1965, 1970). These similar communications about *being* and *doing* will be examined alongside more contemporary thinking about the ideas to which Winnicott alludes in this aphorism; works by Benjamin (1988) and Akhtar (2000) in particular will be brought to bear on the subject. Two case studies will then be discussed, in order to examine the clinical implications of the theoretical discussion. Ultimately, such exploration will substantiate the claim that, through the metonymy of *being* and *doing*, Winnicott was alluding to a “statement of human nature” that he published just 3 years later (1970, p. 2). Winnicott’s own concept of *play* will then be posited as a critical, third element comprising “the life of a human being,” which will serve to situate the discussion within a contemporary, relational framework (1970, p. 2).

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Chapter 1

Introduction

In a talk given to the Royal Medico-Psychological Association in 1967, Winnicott delivered this evocative aphorism: “From being comes doing, but there can be no *do* before *be*.” (1970, p. 25, emphasis in original). The compelling metonymy of this line has been little discussed or explored in the literature. Perhaps this is because Winnicott delivered the line in one of his less-academic publications. Despite this informal context, the line is delivered in trademark Winnicottian style, which Ogden (1986) describes as involving “deceptively simple, highly evocative metaphorical language” (p. 206). The line’s ostensible simplicity make it an evocative line indeed; it seems to invite us more thoroughly to investigate Winnicott’s thinking about *being* and *doing*.

This paper attempts to respond to that invitation. Moreover, it attempts to avoid what Ogden (1986) notes as a common effect of Winnicott’s use of language: namely, a sense of being admired but ultimately “insulated from systematic exploration, modification, and extension” (p. 206). Accordingly, this paper attempts to explore and to extend Winnicott’s communication about *being* and *doing*. Specifically, the metonymy of “being” and “doing” will be unpacked, contextualized relationally, and extended to the clinical situation. It will also be an attempt at synthesis, integrating the ideas contained within Winnicott’s aphorism with the ideas of Benjamin (1988) and Akhtar (2000), and with Winnicott’s own ideas about play, transitional objects, and transitional space.

Being:Doing :: Female:Male?

The first place we might turn to in exploring this aphorism about *being* and *doing* is to Winnicott's more academic communications of this idea. He penned a similar line in Chapter 4 of *Playing and Reality*: "After being – doing and being done to. But first, being" (1970, p. 85). In this same chapter, Winnicott introduces the idea of "male and female elements," and associates them with the verbal nouns of being and doing: "The object-relating of the male element *does* while the female element (in males and females) *is*" (p. 81, emphasis in original).

It seems clear, then, that Winnicott associates *being* with a relational style characteristic of the female gender, and *doing* with a relational style characteristic of male gender. What these gendered relational styles are presumed to be is still unclear, however. Moreover, such ossified, even prescriptive categorization may well be considered problematic. Recent dialogue about the vicissitudes and the performativity of gender (e.g., Butler, 1995; Phillips, 1995) provide a compelling rationale for such concern. If Winnicott's thinking about being and doing is grounded in a problematic politics of sex, gender, and power, does the entire constellation of thought lose its merit? Gerson (2004) has read such criticism into Winnicott.

However, one of the field's preeminent feminist thinkers has interpreted Winnicott's seemingly sexist associations in a more positive light: Benjamin (1988) asserts that, "If feminists are not to ignore the importance of the body in shaping our mental representations, they must read [metaphors of spatial, anatomical representation] differently. Winnicott offered the beginning of such a different reading." (p. 127). This is to say that when Winnicott (1970) writes that "the pure female element establishes … the experience of *being*" (p. 80), Benjamin bears female bodily imagery (viz. yonic and uterine imagery) in mind. Because such imagery involves

containment to a considerable degree, she concludes that Winnicott uses *being* metonymically, to stand in for "the capacity to develop an inside, to be a container" – in short, for "the ability to hold oneself," to feel that one is an authentically alive *self* (Winnicott, 1988, p. 127-128).

Benjamin (1988) also interprets Winnicott's association of *doing* with "the male element," though not through the use of physical imagery. Instead, she substantiates her interpretation with findings from an infant observation study: "Fathers play with infants differs from mothers: it is more stimulating and novel, less soothing and accurately tuned" (Yogman, 1982, as cited in Benjamin, 1988, p. 102). Through this study, Benjamin reifies Winnicott's "male element" as the active, exciting interaction of fathers, and active, exciting interaction thus becomes the substance of the Winnicottian metonymy *doing*. Benjamin also asserts that "the father is perceived as representing the outside world," adding an element of *alterity* to what we can hear in Winnicott's *doing*, just as she added a holding of the internal *self* to what we can hear in his *being* (p. 100).

To summarize what has been said so far, Winnicott (1970) associated *being* with a female element and *doing* with a male element. Such gendered associations are the extent of Winnicott's explication of these metonymic terms, however, and the field has done little to interpret this metonymy.[1] Benjamin (1988) unpacked this metonymy, interpreting *being* as a matter of containment/holding of the self (through an analysis of the physical imagery of Winnicott's "female element") and she interpreted *doing* as a matter of exciting alterity (through observation

[1] The concept of *being* has received more attention than *doing* (e.g., Green, 2010), but both terms remain relatively unexplored. A comparison of *being* and *having* is more common in Lacanian discourse. Others might find the notion of *being* itself to be fallacious – "There is only *doing*," they might claim, "in that personality and selfhood are meaningless terms outside of active relations with others." Perhaps *becoming* might be argued to be a more accurate linguistic placeholder.
As with any psychic material, multiple, valid interpretations are possible or even inevitable. Accordingly, I do not question to the validity of any of these objections, and present them simply as thoughts for future consideration.

of fathers' interactions with infants). These interpretations are helpful in that they clarify Winnicott's "deceptively simple, highly evocative" language (Ogden, 1986, p. 206). However, these interpretations retain the problematically gender-bound circumscription of Winnicott's original communications. An interpretation that can account for the way in which a capacity for [a held, contained, inner-sense of *being* in one's self] can come from male caregivers, and for the way in which a capacity for [active, excitatory, externally-oriented *doing* with others] can come from female caregivers, is needed.

Chapter 2

A Relational Focus

Being:Doing :: Homepathic:Disruptive

Akhtar (2000) cites a child observation study (Herzog, 1984) about the relational styles of caregivers, which closely resembles the study (Yogman, 1982) that Benjamin (1988) used in her discussion of relational styles. Like the study cited by Benjamin, Herzog observed a marked difference in the way mothers and fathers tend to relate with children. He identified these two relational styles as homeostatic and disruptive attunement. *Homeostatic attunement* is defined as the caregiver *joining the toddler* in her or his play. This type of relating was more commonly observed in mothers. *Disruptive attunement*, on the other hand, is defined as interaction in which the caregiver cajoles the toddler into *joining the caregiver* in a new activity. This was more commonly observed in fathers.

These observations, even more than the observations cited by Benjamin, allow us to enrich Winnicott's discourse on *being* and *doing*. Winnicott spoke of *being* as corresponding to female object-relating, and Herzog's study identifies homeostatic attunement as the characteristic female/maternal interaction. This pairing allows us to understand *being*, and secure selfhood, as facilitated by *homeostatic attunement*, rather than as something provided specifically or exclusively by mothers.[2] Likewise, Herzog's study finds that disruptive attunement provides important contrast to homeostatic attunement. We can thus understand *doing* – healthy

[2] Perhaps "selfhood" is not a meaningful concept, as argued by Lacan, Mitchell (1991), and many eastern thinkers from Hindu and Buddhist traditions, among others. I will not take up such discussion in this paper, and will instead simply note that "a sense of self experiences as real" (Mitchell, 1991, p. 114) seems to be a solid point from which to discuss matters involving what might be called a "self" or "the self."

engagement with alterity – not as something specifically associated with male caregivers, but as a faculty facilitated by interactions that provide *disruptive attunement*.

The language that Herzog used – "homeostatic" and "disruptive"– is significant because it highlights not the gender of the caregiver, but the manner of interaction. Akhtar's (2000) presentation of Herzog's study is significant in that it expands this discussion outside of caregiving interaction and brings it to bear on a discussion of modes of clinical intervention; homeostatic and disruptive attunement are seen as relational positions that a clinician (regardless of gender or sex) can take. The benefits of this broader, more relational conceptualization will be expanded upon in the discussion of clinical material that will conclude this paper.

At this time, I will present an informal observation of homeostatic and disruptive attunement, which I chanced upon while preparing this paper. I hope that doing so will demonstrate how our understanding of Winnicott's *being* and *doing* is enriched by a more relationally oriented perspective:

> I was hiking out in the Columbia River Gorge months ago when, at one point in the trail, the densely-wooded hillside opened out into an expansive view of the eponymous gorge. At this point, I heard a young child strapped to his mother's back exclaim, "Mommy, Daddy, look at the hole!" For a moment, both his parents were puzzled and asked the boy to clarify what "hole" he was referring to. Then it dawned on them that, with the word "hole," the boy was referring to the vast gorge that had come into view. The boy's mother was quick to accommodate to his language/perception, affirming that it was indeed a big "hole." [She was exampling homeostatic attunement, *joining in with* the toddler.] The boy's father, on the other

> hand, took a different tack: he explained in a firm voice that the "hole" in question was actually a "gorge." [The father was exampling disruptive attunement, obliging the boy to *join him* in something new – in this case, identifying linguistic and geographic distinctions.]

In reflecting on this vignette, the gender of either parent is unimportant. What is worthy of note is the function of each parents' interaction, that is, the way in which selfhood and *being* are shored up by homeostatic attunement (which the mother, in this case, happened to provide), while active *doing* – engagement with alterity – is encouraged by disruptive attunement (which the father here happened to provide).

The example helps bring these relational functions into focus. In the mother's homeostatic response ("Yes, that is a big hole isn't it?"), the message that the child may receive is something like, *I see you and confirm you in the self that you are, just as you are right now*. The child is offered an experience of "continuity of being" (Winnicott, 1965, p. 54), and need do nothing in response but go-on-being. In the father's disruptive response ("That's not a hole, that's a gorge!"), the child is confronted with something outside himself and has the option of engaging with new material in an active way. Engaging with this new material would involve the child actively engaging his own cognitive processes. Responding to such attunement might also include active acknowledgement of what confronts him, maybe in the form of a question (e.g., "What's a gorge?").

We can imagine how differences in such factors as temperament, caregiver(s), and social and developmental history would impact a child's (or a patient's) pulling for or receiving these different relational/attunement functions. The case studies that conclude this paper will examine

this point to some degree. For now, the most significant observations to be made are to the links created above, between [*being*, homeostatic attunement, and the shoring up of the *self*,] and [*doing*, disruptive attunement, and engagement with *alterity*]. This linking is significant because, in using these links to unpack Winnicott's metonymy, we have an immediate grasp of the relational dynamics at hand, without having to stretch the connotations of "the male/female element" to the situation.

Winnicott no doubt meant to contextualize *being* and *doing* as modes of relating. However, his sole explicit communication about these terms was as the correlates of male and female elements, upon which he did not elaborate. And unfortunately, although Benjamin (1988) engages in an enlightening discussion of the subject, her discussion remains excessively correlated with a gendered situation. Thus, Akhtar's (2000) paper – which presents the non-gendered language of homeostatic vs. disruptive attunement in a manner that parallel's Winnicott's phrasing ("From being comes doing …") – helps us read *being* and *doing* as relational functions with significant clinical relevance.

Being:Doing:Play

Before proceeding with clinical discussion, the concept of *play* needs to be brought into this discourse. *Play*, and the corresponding concepts of transitional space and transitional objects, were central to Winnicott's thinking. Accordingly, our exploration of Winnicottian thinking benefits from considering *being* and *doing* in conjunction with *play*.

Winnicott understood *play* to be of critical importance because he viewed it as the "third part of the life of a human being," in a tripartite "statement of human nature" that he put forward in the opening pages of *Playing and Reality* (Winnicott, 1970, p. 2). He does not use the word

"play" at this preliminary point in his exposition – here he uses the word "*experiencing*" (p. 2, emphasis in original). However, his descriptions of *experiencing* as an "intermediate area between the subjective and the objectively perceived," straddling "inner reality and external life" correspond to his later elaborations upon the concept of play as "not inside ... nor … outside" (p. 2-3; p. 41). As for the other two parts of "the life of a human being," Winnicott speaks of (a) "inner reality" and (b) "interpersonal" – that is, external – reality as comprising the other two parts of human nature, on either side of the "intermediate" space of (c) *experiencing*/*play* (p. 2).

There is an interesting inconsistency to Winnicott's language about these three "parts of the life of a human being" It concerns his use of verbal nouns (adverbs), which Winnicott found particularly significant as evidenced by his frequent use of them (e.g., "hold*ing*," "dream*ing*, fantasy*ing*, and liv*ing*," "object-relat*ing*," etc.). So we may note with interest that in this grand "statement of human nature," Winnnicott supplies verbal nouns – "experienc*ing*" and later "play*ing*" – to denote "the third part of the life of a human being." But he does not supply verbal nouns for either of the other two parts: "inner" and "external" reality.

I submit that (a) be*ing* and (b) do*ing* might well be read as the verbal nouns that correspond to the first two parts of Winnicott's "statement of human nature," that is, to (a) inner and (b) external reality. In other words, *being* can be read as the verb-al expression of a secure sense of inner reality, and *doing* can read as the verb-al expression of healthy engagement with external reality. We can, in short, posit *being* and *doing* as two of the three vital spaces in which Winnicott's saw personhood taking place.

Reading *being* and *doing* as central components of Winnicott's thinking about human nature suggests a way out of the sex-gender-power circumscription that Winnicott (1970) seems

to propose when his words are taken at face value (p. 81). Perhaps, like Akhtar (2000), he meant to introduce *being* and *doing* as relational functions which consolidate a sense of self or invite engagement with alterity, respectively. If this reading is possible from within Winnicott's oeuvre, then *being*, *doing*, and *play* can be read as a unified concept. This conception may have significant clinical relevance. I will discuss this reading and this possibility through two case studies.

Ms. B

Ms. B was what diagnosticians could call "clinically depressed." She almost never left the house except to meet with me. At these meetings, she was a heavy presence to sit with, as she spoke of dysthymia and lethargy in a weary tone. Her entry into the room matched the cadence of her voice: slow and resigned. Ms. B would sit upon the couch almost motionless, feet firmly planted in front of her, for the duration of the session. She spoke in discouraged, plaintive tones about the neglectful, abusive relationships she had experienced, first with her mother and then with multiple husbands. She had no father to speak of. Overall, Ms. B felt definitively present, but more as an immoveable rock than as a dynamic presence.

I soon began to feel frozen, turned to stone myself by these sessions. I felt I could not move, almost could not open my mouth. I began to cast about for any sort of active intervention that might counter the inexorable, gravitational pull Ms. B's mass was having on me. Some of this casting about took place in a group supervision session. The behest of this group's staunchly behavioral supervisor was enticing, so I began to introduce some behavioral activation in my work with Ms. B.

Just a few weeks into this kind of work, Ms. B began to experience stirrings of vital activity that went above and beyond any of the simple activities we had talked about her attempting. Entirely of her own accord, she proposed to her partner that they attend a showing of the exciting, visually stimulating movie *Gravity* in IMAX. She enjoyed herself immensely, and did not experience any of the agoraphobic panic she constantly defended against. The following weeks found Ms. B making plans to go to the mall or department store, and to clean her house, all of which she carried out to her great delight. It was astonishing. *Has she not only consolidated a stable sense of self*, I asked myself, *but also moved into good relations with the external world, all within a couple months? Is she, like the protagonist in* Gravity*, prepared to become untethered and to actively propel herself through the vast abyss all around her?*

However, Ms. B soon received a call from her mother's foster home informing her that her mother's health had taken a turn for the worse, and she likely only had a few weeks or months left to live. Following this news, all the movement that Ms. B was making into the outside world came to an abrupt halt. She became even more housebound than before. She now found herself rooted not just in the house but, for most hours of the day and night, in her armchair in front of the TV, food wrappers piling up all around her. As we talked about this new development, I learned that armchair-in-front-of-the-TV-all-day-and-all-night had been the customary position of Ms. B's mother, as well.

Discussion. There are, of course, numerous valid ways to read this case. As Mitchell (1998) reminds us, "Theories are not facts, observations, or descriptions – they are organizational schemes, ways of arranging and shaping facts, observations, and descriptions" (p. 15). With those words in mind, we might read this case through the organizational scheme of *being*, *doing*,

and *play*, to see what clinical relevance we may glean from this proposed interpretation of theory.

Winnicott described a sense of *being* as prerequisite to the active engagement with alterity that he spoke of through the metonymy of *doing* ("From being comes doing…"). Ms. B seemed capable only of *being*, and only tenuously at that. It was as if her sense of *being* was so insubstantial that she feared it would dissipate without the support of a holding, containing environment (e.g., the walls of her home or of my office). As long as she was receiving the homeostatic attunement (the messaging that she was safe and accepted just as she was) that these holding environments provided, she was secure. But it was as if she feared that, without walls to reinforce her *being*, she would be adrift in a vacuum, like the astronauts in *Gravity*.

As I began to introduce a new kind of relating in our sessions (i.e. disruptive attunement, the behavioral activation), Ms. B began to seem eager to engage with the outside world. She began to feel capable of propelling herself through the void, to some extent. Maybe this was the first time a significant attachment figure had invited her to *do* things – indeed, it is hard to imagine Ms. B's armchair-bound mother, or her controlling, abusive ex-husbands, engaging her with disruptive attunement. (They were, no doubt, *disruptive*, but disruption is far from disruptive *attunement*. Perhaps this suggests that disruption without attunement can trigger a need to find refuge in *being*.)

However, despite the disruptive attunement I provided (or whatever may have triggered Ms. B's surge of activity), the sudden and exciting nature of her newfound *doing* seemed to be more of a manic flight to health than a genuine discovery of a new relational pattern. It was not that she was beginning to explore a *playful* space between hypertrophied *being* and *doing*;

instead she had swung from one pole to another. No new space was created. For when Ms. B learned that she would soon be losing her mother, all of her movement collapsed back in on itself. We might venture that she was reverting to the hypertrophied homeostatic relational style, the *being*, that was all she had ever really known.

In short, we might say that Ms. B's fragile sense of self was excessively focused on *being*, to the detriment of all other modes of relating. She needed nearly constant homeostatic attunement, if only from inanimate objects, to cobble together a sense of going-on-being. One way that we might talk about certain depressions, then, is as a pathological excess of what Winnicott spoke of as *being*.

Mr. D

Mr. D could be said to have presented hypertrophy, or pathological excess, on the other end of the *being-doing* spectrum; his relating and his presentation were more exclusively focused with *doing*. Mr. D's hair was gray, but no other physical or behavioral characteristic belied his age. He seemed like a much younger man, biceps, quadriceps, and all. He strode into the room each week and sat himself firmly upon the couch, legs spread wide apart. He often kept his arms crooked rakishly, maybe roguishly, behind his head, or used them when speaking to carve bold, demonstrative strokes in the air. The strong physicality of his posture was accentuated by his frequently wearing shorts, a t-shirt, and open-toed shoes, even in cold weather.

Mr. D liked to talk about ideas that excited him. The manic quality of this presentation was reflected in his diagnosis of Bipolar Disorder, and in the medication he took for it. The ideas that excited Mr. D included quantum mechanics and other aspects of physics (e.g., the optical patent for which he still earned royalties), automobiles (e.g., his ingenious ability to keep an old

car going), or scenes from movies in which Gregory Peck and others acted heroic. Phallic imagery was also a common source of material for Mr. D: the World Trade Center towers, the obelisk in *2001: A Space Odyssey*, and Big Ben all made frequent appearances in his associations.

The memories that involved these phallic images often involved Mr. D's father, to whom Mr. D was very attached, and whom he idealized. Thus, stories about activities with his father – e.g., his father pushing him on a swing, or teaching him how to sail or install a TV antenna on the roof – could be included on the list of exciting ideas that Mr. D liked to talk about. Mr. D's mother, on the other hand, was so devalued in Mr. D's mind that she almost ceased to exist for him (or was annihilated by him). For example, Mr. D reported dreams which featured his father as a central figure and in which his mother "did not exist." He also reported that a college mentor once asked him if his mother was still living, because he spoke so frequently of his father but never mentioned his mother.

For my part, I found all this at first to be very enjoyable; I felt myself getting caught up in the excitement with Mr. D. Though I tried to contain this countertransference, at least in my outward relating, I began to relish the opportunity to make interpretations through the medium of quantum mechanics, or of Gregory Peck's heroic moments in racecars or submarines. Soon, however, instead of leaning forward in my chair and gesticulating back at Mr. D when making an interpretation, I found myself more and more leaning back, folding my hands in my lap, and letting Mr. D *do* to his heart's content.

Discussion. The case of Mr. D can also be read through the lens of Winnicott's *being*, *doing*, and *play* – not because this is a definitive interpretation of the narrative, but to explore

what clinical relevance such a reading may hold. Like Ms. B, Mr. D's relating occurred primarily, seemingly almost exclusively, in just one of the three areas that Winnicott (1970) described as an essential part "of the life of the human being" (p. 2). His hypertrophied focus was on the area of *doing*, that is, with the area of "external life" that this paper has posited as the substance of Winnicott's *doing*.

Perhaps this hypertrophy reflected the relational patterns Mr. D had with his primary caregivers as a child. His father seemed to provide almost exclusively disruptive attunement – or those are, at least, the only sorts of memories Mr. D recalled of their relating. And neither his father nor his mother seemed to provide much in the way of homeostatic attunement, that is, with a sense that he was held and secure and that he need *do* nothing other than *go-on-being*. Mr. D's experience of receiving only disruptive attunement from his father and no other sort of attunement from either parent may have contributed to his preoccupation with phallic imagery and with *doing*. That is, perhaps the link between phallic imagery and *doing* is not that these concepts are intrinsically masculine, but that Mr. D associated both these concepts with his father, the only caregiver who seemed to attune to him.

Whatever the case, Mr. D's focus on *doing* had a countertransferential effect on me. The reader will remember that the weight of Ms. B's seemingly immobile presence – her staunch determination simply to *be* – led me to seek out ways of engaging her more actively, of attuning to her in a disruptive fashion. Mr. D's fierce drive to *do*, on the other hand, soon led me to respond by relating in a more laconic, homeostatic manner – that is, as I described above, leaning back and providing more empathy and holding than interpretation.

Gradually, in response to this homeostatic attunement, Mr. D began to develop more of a capacity to *be* with me, and with himself. He began, more and more, to pause and reflect on his feelings about a story he might recount, rather than rushing into the intellectual theorizing or philosophizing that was his wont. In short, he could *be* with how he felt, rather than rushing to *do* something about it. Perhaps most excitingly, we began sometimes to *play* with what might be at hand. That is, we could step back from Mr. D's verbose, active storytelling to *be* in the moment – and then we could move forward again, in a playful way: exploring possibilities, imagining or even experimenting with new ways of relating or perceiving, all without definitive or necessary conclusions.

In sum, we could say that Mr. D was focused on *doing* to the detriment of other modes of relating. He would, indeed, almost invariably interact with the external world as a parent might disruptively attune to a child: introducing new elements (e.g., his physics patent, or the conspiracy theory about which he was so passionate), and manipulating physicality in novel, exciting ways (e.g., stepping out to get the mail and walking a mile around the block, or MacGyvering a solution to an automotive problem). One way that we might talk about certain manic behavior, then, is as a pathological excess of *doing*.

Chapter 3

Conclusion

In summary, reading these cases through Winnicott's metonymy might lead us to partially interpret the two patients' narratives in the following way: Ms. B's mother and her numerous, abusive ex-husbands provided very little in the way of disruptive attunement, with its correlate of *doing*. Instead, the paucity of attunement that Ms. B did receive seemed much more unilaterally homeostatic. This could be said to have contributed to establishing a relational pattern that she extended into the present with her staunch determination simply to *be* and not to *do*. We might conjecture something similar about Mr. D's early experiences. The only significant positive interactions that Mr. D recalled were of disruptive attunement – of *doing*, of exciting, physical engagement with his father and the outside world. He did not seem to receive or internalize much homeostatic attunement. Perhaps this dynamic contributed to Mr. D's periods of manic *doing*, and his initial inability to *be* with himself or his experiences.

One might be tempted to read these cases along gender lines, like Winnicott originally proposed. Such a reading might venture the shorthand descriptions of *Ms. B had a preponderance of female "object-relating,"* and *Mr. D a preponderance of male "object-relating"* (Winnicott, 1970, p. 81). However, I submit that this would be an inaccurate reading of the situation, and an unfortunate one at that, because it would unnecessarily perpetuate problematic sex- or gender stereotypes. Ms. B's mother and Mr. D's father did seem to attune in more homeostatic and disruptive fashions, respectively, which is what Yogman's (1982) and

Herzog's (1984) observational studies found to be most common. However, Ms. B's mother (or other women in her life) could certainly have provided more disruptive attunement, fostering in Ms. B the capacity to *do* as well as to *be*. And Mr. D's father (or other men in his life) could have related to his son with more homeostatic attunement, fostering in Mr. D more of a capacity simply to *be*. In short, a person of any gender can relate in either homeostatic or disruptive ways; it is a person's manner of relating, not their gender, that can impact someone's capacity for *being*, *doing*, and *play*.

The effect of my interactions with Ms. B and Mr. D demonstrate this. It was surely not my male sex or gender that facilitated Ms. B's movement out from her self into the world. For my work with Mr. D – as the same, cis-male clinician – facilitated his making the opposite sort of shift that Ms. B did: slowing down instead of speeding up, moving inward instead of outward. It must, then, have been (among other factors) something about the position from which I was relating that induced these markedly different changes in Ms. B and Mr. D. Perhaps Ms. B's relational pattern seemed to shift as I responded to her homeostatic *being* with a disruptive invitation to *do*. And perhaps Mr. D began, gradually, to *do* less and *be* more as I responded not with the disruptive attunement that he pulled for but with the homeostatic attunement that he longed for. Even more felicitously, perhaps my oscillating between both relational positions with Mr. D contributed, over time, to his becoming more able to *play* with the innumerable ways in which he could relate to himself and to the world.

The idea of a clinician oscillating between different relational positions is felicitously discussed by Akhtar (2000) and by Bollas (1996). Both discussions are pursued with more

sophistication than I might hope to achieve in this paper.[3] So I will not say more about that technical aspect. Instead, what I will submit is that exploring such oscillation through the lens of Winnicott's "*being* and *doing*" is valuable because doing so allows us to bring the concept of *play* into the picture. When we see homeostatic attunement as fostering the stable, inner sense of self that Winnicott spoke about as *being* (or as the "true self"), and disruptive attunement as fostering the healthy engagement with alterity that he spoke about as *doing*, we locate the relational styles of a clinician on either side of the critical domain of *play*.

The concept of *play* has been perhaps the richest source of clinical wisdom to come from Winnicott's oeuvre. It is safe to say that I need not elaborate much on this well-discussed topic. Here then, is my brief discussion of the way in which I see Winnicott's *play* as enriching our discussion of the homeostatic *being* and disruptive *doing* between which clinicians may oscillate.

Final Thoughts on *Play*

At one point, Winnicott (1970) describes psychotherapy itself as "two people playing together" (p. 38). In giving this description, he adds that "where playing is not possible then the work done by the clinician is directed towards bringing the patient from a state of not being able to play into a state of being able to play" (p. 38). If we accept this presupposition, the oscillation that Akhtar and Bollas describe is, more than anything, a form of relating in which the clinician

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[3] For example, among other interesting points that these authors make, Bollas (1996) argues for preserving the allegorical use of "mother" and "father," instead of abstract terms such as "homeostatic" or "disruptive." Regarding his use of these terms he states:

> Am I not allegorizing where abstract terms would do us better? This may be so. But … if we think of the mother and the father we simultaneously evoke our own precise histories with these persons and their structures: shared in common among all people. So we are immediately part of our personal history and a universal order, as all of us have *our* mother and *our* father, and yet each of us participates in psychic orders that are properly listed under the name of the mother and the name of the father.

is trying to bring the patient into "a state of being able to play." Winnicott's work is replete with discussion of how important this work can be.

In short, what may be so vital about *play* is that it is a space in which a person may practice moving from *being* into *doing* and back again, without bearing the full weight of overdetermined reality. Games of all sorts – from the "playing house" of toddlers to the immersive role-playing games of adolescents and adults – seem to demonstrate this. Dreaming can also be seen as a vital, playful, rehearsing function in this way. And, of course, the psychoanalytic situation is vital in the same sense.

This discussion of a vital space [of *playing*, and of dreaming and analyzing etc.] between a polarity [of *being–doing*] may sound familiar to many readers. It may call to mind the discussion of finding thirds and deconstructing polarities/binaries that has been going on for over a decade now (e.g., Aron & Starr, 2013; Benjamin, 2004; Ogden, 1994). There is much to commend this perspective, and I submit that we might justifiably read this theory of *being–doing–play* against such a contemporary, relational background. The necessary oscillation between homeostatic empathy and disruptive interpretation takes on even more significance if we read this oscillation as an essentially revolutionary (Marxist-Hegelian) one – that is, one in which we are trying to find a *synthesis* between *thesis* and *antithesis*. Such a reading locates the *play*fulness of psychoanalytic work as the radical, revolutionary agent (the *synthesis* between the *thesis* of *being* and the *antithesis* of *doing*) that proponents of contemporary psychoanalysis might hope it to be.

To move from the safety and security of *being* into the risk and the adventure of *doing* is no small matter. It is scarier still to oscillate between these two positions, in a space of *play*. As

Akhtar (2000), Bollas (1996), and Benjamin (1988) all note, this kind of flexibility is required of us as clinicians, if we are to help patients further develop the liberating, revolutionary capacity for thirdness. So in returning to the Winnicottian metonymy whence this exploration began, we are now prepared to say that "…there can be no *do* before *be*," but *being* and *doing* alone do not comprise the full "life of a human being" (Winnicott, 1970, p. 2; Winnicott & Winnicott, 1986, p. 25). *Playing* is the vital, third space between *being* and *doing*, from which synthesis and liberation can happen.

References

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Phillips. (1995). Keeping it moving: Commentary on Judith Butler's "Melancholy gender—Refused identification." *Psychoanalytic Dialogues*, 165-180.

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Winnicott, D. (1970). *Playing and reality*. New York, NY: Basic Books.

Winnicott, D., & Winnicott, C. (1986). *Home is where we start from: Essays by a psychoanalyst*. New York, NY: Norton.

Appendix A

Curriculum Vitae

NATHAN HASKELL

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EDUCATION

Psy.D., Clinical Psychology (current GPA: 3.96) Anticipated: May 2017
George Fox University – APA Accredited –

M.A., Clinical Psychology (GPA: 3.98) May 2014
George Fox University – APA Accredited –

B.A., English Literature, magna cum laude (GPA: 3.89) June 2010
University of Portland
Outstanding English Major Award, Class of 2010

SUPERVISED CLINICAL EXPERIENCE

Pre-Doctoral Internship Aug. 2016 – Present
Norwich University, Northfield, VT

- Provided individual psychotherapy to students, faculty, and staff
- Responded to after-hours crisis calls and evaluated for suicidal/homicidal risk
- Coordinated care with infirmary, Student Affairs office, Academic Achievement Center, International Students Center, and Corps of Cadets
- Managed scheduling of individual caseload
- Conducted community outreach programs
- Wrote weekly progress notes and crisis response notes
- Conceptualized and presented cases for individual and group supervision, often with audio review of sessions as part of supervision

Practicum III – *(Inpatient Psychiatric Hospital)* Sep. 2015 – June 2016

Oregon State Hospital, Salem, OR

- Provided individual and group psychotherapy
- Provided psychological assessment, including Violence Risk Assessments and Short-Term Assessments of Risk and Treatability
- Participated in multidisciplinary case conferences with psychiatrists, nursing managers, case workers, clinical social workers, and other psychologists
- Coordinated care with Sex Offender Treatment Program team and Psychiatric Security Review Board
- Wrote weekly progress notes; reviewed notes and records from multidisciplinary team
- Conceptualized and presented cases for individual and group supervision

Practicum II – *(College Counseling Center)* Aug. 2014 – May 2015

Warner Pacific College, Portland, OR

- Provided individual psychotherapy and academic/career counseling
- Provided psychological assessment, wrote reports and diagnoses, and provided feedback to individuals
- Coordinated care with academic mentoring programs and residence life office
- Engaged in community outreach and academic mentoring
- Conducted intake assessments; formulated diagnoses and treatment plans
- Wrote intake reports and weekly progress notes
- Conceptualized and presented cases for individual and group supervision

Practicum I – *(Community Mental Health Center)* Aug. 2013 – Present

George Fox Behavioral Health Clinic, Newberg, OR

- Provided individual, group, and couples psychotherapy
- Provided psychological assessment, wrote reports and diagnoses, and provided feedback to individuals
- Coordinated care with medical clinics, court systems, and insurance companies
- Managed scheduling of individual caseload in conjunction with clinic waitlist
- Conducted intake assessments; formulated diagnoses and treatment plans
- Wrote intake reports, weekly progress notes, and termination summaries
- Conceptualized and presented cases for individual and group supervision, with video and audio review of sessions as part of supervision

Dream-Analysis Group Therapist Mar. – May 2015

George Fox University Psy.D. program, Newberg, OR

- Organized and facilitated a weekly dream-analysis group

Apr. – May 2012

Alliance Graduate School M.A. Counseling program, Manila, Philippines

- Co-facilitated a weekly dream-analysis group

Bibliotherapy Group Therapist Feb. – Apr. 2013

George Fox Behavioral Health Clinic, Newberg, OR

- Organized and co-facilitated a bibliotherapy/process group

Chronic Pain Group Therapist Nov. – Dec. 2013

George Fox Behavioral Health Clinic, Newberg, OR

- Organized and co-facilitated a psychoeducational/process group for individuals with chronic pain

Depression Group Supervisor Oct. – Nov. 2013

Nedley Depression Recovery Program, Newberg, OR

- Supervised depression group facilitators
- Received supervision of supervision from licensed clinical psychologist

Depression Group Facilitator Oct. – Nov. 2012

Nedley Depression Recovery Program, Newberg, OR

- Co-facilitated a psychoeducational depression management group
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Pre-Practicum Therapist Aug. – May 2012

George Fox University, Psy.D. program, Newberg, OR

- Provided individual psychotherapy to university undergraduates
- Conducted intake assessments; formulated diagnoses and treatment plans
- Wrote intake reports, weekly progress notes, and termination summaries
- Conceptualized and presented cases for individual and group supervision

Pre-Practicum Therapist Mar. – Apr. 2012

Ateneo de Manila University, Dept. of Counseling Psychology, Manila, Philippines

- Provided individual psychotherapy to a 29-year-old Filipino male
- Developed treatment plan; wrote case report and termination summary

RELATED CLINICAL & ACADEMIC EXPERIENCE

Panel Discussant Anticipated: Apr. 2016

- Invited to serve as a discussant on a live-supervision panel at 2016 Spring Meeting of APA Division 39 (Division of Psychoanalysis)
- Goal of panel was to discuss multicultural/diversity issues in psychoanalytic supervision

American Psychological Association Scholar Feb. 2015 – June 2016

APA Division 39 (Division of Psychoanalysis), Multicultural Committee

- Received monthly mentoring from local psychoanalytic psychotherapist
- Received $500 grant to attend 2015 Spring Meeting of APA Div. 39
- Received 12-month subscription to Psychoanalytic Electronic Publishing (PEP-Web) journal archive

Graduate-Level Instructor Aug. 2015

"The Contemporary Psychoanalytic Perspective"

Alliance Graduate School, Manila, Philippines

- Organized course content (based on psychoanalytic texts and journal articles) and developed syllabus
- Lectured, facilitated discussion, and led activities to promote engagement
- Graded assignments and papers

Conference Presenter Apr. 2015

Christian Association of Psychological Studies, International Conference

- Presented modified version of dissertation material

Program Consultant Jan. 2015 – May 2016

Clinical Advisory Committee, George Fox Univ. Psy.D. program

- Provided consultation about clinical training and didactic opportunities
- Advocated for the student body regarding clinical and academic concerns

Program Coordinator Oct. 2014 – May 2016

Doctoral Psychology Student Seminar Series

- Developed and co-coordinated an interscholastic series of seminars for doctoral psychology students, covering a wide range of relevant issues

Diversity Leadership Consultant Sep. 2014 – May 2016

Ubuntu Leadership Group, George Fox Univ. Psy.D. program

- Participated by invitation in a group that met to discuss leadership and other issues for psychologists of color

Peer Supervisor Sep. 2015 – May 2016

Clinical Foundations course, George Fox Univ. Psy.D. program

- Provided group and individual supervision to first-year Psy.D. students
- Reviewed video recordings of students' clinical work
- Provided feedback, in-vivo and on written assignments
- Facilitated group process regarding students' clinical development
- Received supervision of supervision from licensed clinical psychologist

Peer Supervisor

Jan. – May 2015

Psychodynamic Psychotherapy course, George Fox Univ. Psy.D. program

- Supervised second-year Psy.D. students in clinical lab group
- Facilitated discussion of students' clinical material
- Facilitated group process

Teaching Assistant

- *Contemporary Psychoanalytic Therapy* Fall 2015
- *Clinical Foundations* Fall 2015
- *Multicultural Psychotherapy* Spring 2015
- *Psychodynamic Psychotherapy* Spring 2016; Fall 2014
- *Psychology & Culture* (undergraduate course) Fall 2014
- *Integrative Approaches to Psychology & Psychotherapy* Spring 2014
- *Ethics for Psychologists* Fall 2013

- Developed and delivered lecture material
- Met and corresponded with students to provide assistance and clarification
- Graded assignments, mid-terms, and final exams
- Assisted professors with online grading system

Grant-Funded Researcher Jul. 2014

Richter Scholars Program, Manila, Philippines

- Gathered data for a self-proposed research project (award: $1,676)

Volunteer Therapist / Staff Member June – Dec. 2012

LifeChange Recovery Center, Manila, Philippines

(Residential treatment facility for patients with psychiatric disorders or addictions)

- Provided individual psychotherapy to patients (for disorders including schizophrenia, bipolar disorder, and methamphetamine addiction)
- Participated as milieu therapist; co-facilitated group-activities
- Wrote case reports and evaluated patients for release

SELECTED TRAININGS & WORKSHOPS

Bowen Family Systems Theory Symposium March 2017

Burlington, VT

Quarterly Psychological Case Conferences ("Clinical Moments") Jan. 2013 – May 2016

Oregon Psychoanalytic Center

American Psychological Association Division 39 Spring Meeting April 2016
Atlanta, GA
San Francisco, CA April 2015

Seminar Series on Michael Eigen's *The Psychotic Core* Sep. – Dec. 2015
Office of Robin Bagai, Psy.D.

Fundamentals of Psychoanalytic Psychotherapy Sep. – Jun. 2014
Oregon Psychoanalytic Center

DSM-5: Essential Changes in Form & Function Jan. 2014
Jeri Turgesen, Psy.D.
Mary Peterson, Ph.D., ABPP

NW Assessment Conference May 2013
Paul Green, Ph.D.
Mark Bondi, Ph.D.

Psychoanalytic Treatment Seminar Feb. – May 2013
Oregon Psychoanalytic Center

Motivational Interviewing Workshop Jan. 2013
Michael J. Fulop, Psy.D.

VOLUNTEER EXPERIENCE

S.U.N. (Schools Uniting Neighborhoods) Tutor Jan. – June 2010
Roosevelt High School, Portland, OR
- Provided after-school tutoring and mentorship to students with academic, behavioral, and/or psychosocial difficulties.

"Lunch Buddy" Sep. 2009 – June 2010
Clarendon-Portsmouth Elementary, Portland, OR
- Informally mentored children with behavioral issues.

S.M.A.R.T. (Start Making A Reader Today) Reader Sep. 2008 – June 2009
Clarendon-Portsmouth Elementary, Portland, OR
- Read books with children with behavioral and/or reading competency issues.

ADDITIONAL LANGUAGES SPOKEN

Fluent: **French**
Intermediate fluency: **Spanish**
Receptive skills only: **Filipino, German**

REFERENCES

Melvin Miller, Ph.D.
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