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THE MEANINGS AND USES OF COUNTERTRANSFERENCE

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I

Freud describes transference as both the greatest danger and the best tool for analytic work. He refers to the work of making the repressed past conscious. Besides these two implied meanings of transference, Freud gives it a third meaning: it is in the transference that the analysand may relive the past under better conditions and in this way rectify pathological decisions and destinies. Likewise three meanings of countertransference may be differentiated. It too may be the greatest danger and at the same time an important tool for understanding, an assistance to the analyst in his function as interpreter. Moreover, it affects the analyst's behavior; it interferes with his action as object of the patient's re-experience in that new fragment of life that is the analytic situation, in which the patient should meet with greater understanding and objectivity than he found in the reality or fantasy of his childhood.

What have present-day writers to say about the problem of countertransference?[1]

Lorand *(16)* writes mainly about the dangers of countertransference for analytic work. He also points out the importance of taking countertransference reactions into account, for they may indicate some important subject to be worked through with the patient. He emphasizes the necessity of the analyst being always aware of his countertransference, and discusses specific problems such as the conscious desire to heal, the relief analysis may afford the analyst from his own problems, and narcissism and the interference of personal motives in clinical purposes.

Read at a meeting of the Argentine Psychoanalytic Association in May 1953.

[1] I confine myself in what follows to papers published since 1946. I have referred to a previous bibliography in another paper *(17)*.

He also emphasizes the fact that these problems of countertransference concern not only the candidate but also the experienced analyst.

Winnicott *(24)* is specifically concerned with 'objective and justified hatred' in countertransference, particularly in the treatment of psychotics. He considers how the analyst should manage this emotion: should he, for example, bear his hatred in silence or communicate it to the analysand? Thus Winnicott is concerned with a particular countertransference reaction insofar as it affects the behavior of the analyst, who is the analysand's object in his re-experience of childhood.

Heimann *(11)* deals with countertransference as a tool for understanding the analysand. The 'basic assumption is that the analyst's unconscious understands that of his patient. This rapport on the deep level comes to the surface in the form of feelings which the analyst notices in response to his patient, in his countertransference.' This emotional response of the analyst is frequently closer to the psychological state of the patient than is the analyst's conscious judgment thereof.

Little *(15)* discusses countertransference as a disturbance to understanding and interpretation and as it influences the analyst's behavior with decisive effect upon the patient's re-experience of his childhood. She stresses the analyst's tendency to repeat the behavior of the patient's parents and to satisfy certain needs of his own, not those of the analysand. Little emphasizes that one must admit one's countertransference to the analysand and interpret it, and must do so not only in regard to 'objective' countertransference reactions (Winnicott) but also to 'subjective' ones.

Annie Reich *(21)* is chiefly interested in countertransference as a source of disturbances in analysis. She clarifies the concept of countertransference and differentiates two types: 'countertransference in the proper sense' and 'the analyst's using the analysis for acting out purposes'. She investigates the causes of these phenomena, and seeks to understand the conditions that lead to good, excellent, or poor results in analytic activity.

Gitelson *(10)* distinguishes between the analyst's 'reactions to the patient as a whole' (the analyst's 'transferences') and the analyst's 'reactions to partial aspects of the patient' (the analyst's 'countertransferences'). He is concerned also with the problems of intrusion of countertransference into the analytic situation, and states that, in general, when such intrusion occurs the countertransference should be dealt with by analyst and patient working together, thus agreeing with Little.

Weigert *(23)* favors analysis of countertransference insofar as it intrudes into the analytic situation, and she advises, in advanced stages of treatment, less reserve in the analyst's behavior and more spontaneous display of countertransference.

In the first of my own two papers on countertransference *(17)*, I discussed countertransference as a danger to analytic work. After analyzing the resistances that still seem to impede investigation of countertransference, I attempted to show without reserve how œdipal and preœdipal conflicts as well as paranoid, depressive, manic, and other processes persist in the 'countertransference neurosis' and how they interfere with the analyst's understanding, interpretation, and behavior. My remarks applied to 'direct' and 'indirect' countertransference.[2]

In my second paper *(18)*, I described the use of countertransference experiences for understanding psychological problems, especially transference problems, of the analysand. In my principal points I agreed with Heimann *(11)*, and emphasized the following suggestions. 1. Countertransference reactions of great intensity, even pathological ones, should also serve as tools. 2. Countertransference is the expression of the analyst's identification with the internal objects of the analysand, as well as with his id and ego, and may be used as such. 3. Countertransference reactions have specific characteristics (specific contents, anxieties, and mechanisms) from which we may draw conclusions about

[2] This differentiation accords in essentials with Annie Reich's two types of countertransference. I would add, however, that also when the analyst uses the analysis for his own acting out (what I have termed 'indirect' countertransference), the analysand represents an object to the analyst (a 'subtransferred' object), not merely a 'tool'.

the specific character of the psychological happenings in the patient.

The present paper is intended to amplify my remarks on countertransference as a tool for understanding the mental processes of the patient (including especially his transference reactions),—their content, their mechanisms, and their intensities. Awareness of countertransference helps one to understand what should be interpreted and when. This paper will also consider the influence of countertransference upon the analyst's behavior toward the analysand,—behavior that affects decisively the position of the analyst as object of the re-experience of childhood, thus affecting the process of cure.

Let us first consider briefly countertransference in the history of psychoanalysis. We meet with a strange fact and a striking contrast. The discovery by Freud *(7)* of countertransference and its great importance in therapeutic work gave rise to the institution of didactic analysis which became the basis and center of psychoanalytic training. Yet countertransference received little scientific consideration over the next forty years. Only during the last few years has the situation changed, rather suddenly, and countertransference become a subject examined frequently and with thoroughness. How is one to explain this initial recognition, this neglect, and this recent change? Is there not reason to question the success of didactic analysis in fulfilling its function if this very problem, the discovery of which led to the creation of didactic analysis, has had so little scientific elaboration?

These questions are clearly important, and those who have personally witnessed a great part of the development of psychoanalysis in the last forty years have the best right to answer them.[3] I will suggest but one explanation.

The lack of scientific investigation of countertransference must be due to rejection by analysts of their own countertransferences,—a rejection that represents unresolved struggles with

[3] Michael Balint *(2)* considers a similar problem, the scarcity of papers on the system of psychoanalytic training. Investigation of this problem leads him to several interesting remarks on the relationship between didactic analysts and candidates. (See footnote 5.)

their own primitive anxiety and guilt. These struggles are closely connected with those infantile ideals that survive because of deficiencies in the didactic analysis of just those transference problems that later affect the analyst's countertransference. These deficiencies in the didactic analysis are in turn partly due to countertransference problems insufficiently solved in the didactic analyst, as I shall show later. Thus we are in a vicious circle; but we can see where a breach must be made. We must begin by revision of our feelings about our own countertransference and try to overcome our own infantile ideals more thoroughly, accepting more fully the fact that we are still children and neurotics even when we are adults and analysts. Only in this way—by better overcoming our rejection of countertransference—can we achieve the same result in candidates.

The insufficient dissolution of these idealizations and underlying anxieties and guilt feelings leads to special difficulties when the child becomes an adult and the analysand an analyst, for the analyst unconsciously requires of himself that he be fully identified with these ideals. I think that it is at least partly for this reason that the œdipus complex of the child toward its parents, and of the patient toward his analyst, has been so much more fully considered than that of the parents toward their children and of the analyst toward the analysand. For the same basic reason transference has been dealt with much more than countertransference.

The fact that countertransference conflicts determine the deficiencies in the analysis of transference becomes clear if we recall that transference is the expression of the internal object relations; for understanding of transference will depend on the analyst's capacity to identify himself both with the analysand's impulses and defenses, and with his internal objects, and to be conscious of these identifications. This ability in the analyst will in turn depend upon the degree to which he accepts his countertransference, for his countertransference is likewise based on identification with the patient's id and ego and his internal objects. One might also say that transference is the ex-

pression of the patient's relations with the fantasied and real countertransference of the analyst. For just as countertransference is the psychological response to the analysand's real and imaginary transferences, so also is transference the response to the analyst's imaginary and real countertransferences. Analysis of the patient's fantasies about countertransference, which in the widest sense constitute the causes and consequences of the transferences, is an essential part of the analysis of the transferences. Perception of the patient's fantasies regarding countertransference will depend in turn upon the degree to which the analyst himself perceives his countertransference processes,—on the continuity and depth of his conscious contact with himself.

To summarize, the repression of countertransference (and other pathological fates that it may meet) necessarily leads to deficiencies in the analysis of transference, which in turn lead to the repression and other mishandling of countertransference as soon as the candidate becomes an analyst. It is a heritage from generation to generation, similar to the heritage of idealizations and denials concerning the imagoes of the parents, which continue working even when the child becomes a father or mother. The child's mythology is prolonged in the mythology of the analytic situation,[4] the analyst himself being partially subject to it and collaborating unconsciously in its maintenance in the candidate.

Before illustrating these statements, let us briefly consider one of those ideals in its specifically psychoanalytic expression: the ideal of the analyst's objectivity. No one, of course, denies the existence of subjective factors in the analyst and of countertransference in itself; but there seems to exist an important difference between what is generally acknowledged in practice and the real state of affairs. The first distortion of truth in 'the myth of the analytic situation' is that analysis is an interaction between a sick person and a healthy one. The truth is that it is an interaction between two personalities, in both of which the ego is under pressure from the id, the superego, and the external

[4] Little *(15)* speaks, for instance, of the 'myth of the impersonal analyst'.

world; each personality has its internal and external dependences, anxieties, and pathological defenses; each is also a child with its internal parents; and each of these whole personalities—that of the analysand and that of the analyst—responds to every event of the analytic situation.[5] Besides these similarities between the personalities of analyst and analysand, there also exist differences, and one of these is in 'objectivity'. The analyst's objectivity consists mainly in a certain attitude toward his own subjectivity and countertransference. The neurotic (obsessive) ideal of objectivity leads to repression and blocking of subjectivity and so to the apparent fulfilment of the myth of the 'analyst without anxiety or anger'. The other neurotic extreme is that of 'drowning' in the countertransference. True objectivity is based upon a form of internal division that enables the analyst to make himself (his own countertransference and subjectivity) the object of his continuous observation and analysis. This position also enables him to be relatively 'objective' toward the analysand.

II

The term countertransference has been given various meanings. They may be summarized by the statement that for some authors countertransference includes everything that arises in the analyst as psychological response to the analysand, whereas for others not all this should be called countertransference. Some,

[5] It is important to be aware of this 'equality' because there is otherwise great danger that certain remnants of the 'patriarchal order' will contaminate the analytic situation. The dearth of scientific study of countertransference is an expression of a 'social inequality' in the analyst-analysand society and points to the need for 'social reform'; this can come about only through a greater awareness of countertransference. For as long as we repress, for instance, our wish to dominate the analysand neurotically (and we do wish this in one part of our personality), we cannot free him from his neurotic dependence, and as long as we repress our neurotic dependence upon him (and we do in part depend on him), we cannot free him from the need of dominating us neurotically.

Michael Balint *(2)* compares the atmosphere of psychoanalytic training with the initiation ceremonies of primitives and emphasizes the existence of superego 'intropressure' (Ferenczi) which no candidate can easily withstand.

for example, prefer to reserve the term for what is infantile in the relationship of the analyst with his analysand, while others make different limitations (Annie Reich [21] and Gitelson [10]). Hence efforts to differentiate from each other certain of the complex phenomena of countertransference lead to confusion or to unproductive discussions of terminology. Freud invented the term countertransference in evident analogy to transference, which he defined as reimpressions or re-editions of childhood experiences, including greater or lesser modifications of the original experience. Hence one frequently uses the term transference for the totality of the psychological attitude of the analysand toward the analyst. We know, to be sure, that real external qualities of the analytic situation in general and of the analyst in particular have important influence on the relationship of the analysand with the analyst, but we also know that all these present factors are experienced according to the past and the fantasy,—according, that is to say, to a transference predisposition. As determinants of the transference neurosis and, in general, of the psychological situation of the analysand toward the analyst, we have both the transference predisposition and the present real and especially analytic experiences, the transference in its diverse expressions being the resultant of these two factors.

Analogously, in the analyst there are the countertransference predisposition and the present real, and especially analytic, experiences; and the countertransference is the resultant. It is precisely this fusion of present and past, the continuous and intimate connection of reality and fantasy, of external and internal, conscious and unconscious, that demands a concept embracing the totality of the analyst's psychological response, and renders it advisable, at the same time, to keep for this totality of response the accustomed term 'countertransference'. Where it is necessary for greater clarity one might speak of 'total countertransference' and then differentiate and separate within it one aspect or another. One of its aspects consists precisely in *what is transferred* in countertransference; this is the part that originates in an earlier time and that is especially the infantile and primitive

part within total countertransference. Another of these aspects —closely connected with the previous one—is *what is neurotic* in countertransference; its main characteristics are the unreal anxiety and the pathological defenses. Under certain circumstances one may also speak of a countertransference neurosis *(15, 17)*.

To clarify better the concept of countertransference, one might start from the question of what happens, in general terms, in the analyst in his relationship with the patient. The first answer might be: everything happens that *can* happen in one personality faced with another. But this says so much that it says hardly anything. We take a step forward by bearing in mind that in the analyst there is a tendency that normally predominates in his relationship with the patient: it is the tendency pertaining to his function of being an analyst, that of understanding what is happening in the patient. Together with this tendency there exist toward the patient virtually all the other possible tendencies, fears, and other feelings that one person may have toward another. The intention to understand creates a certain predisposition, a predisposition to identify oneself with the analysand, which is the basis of comprehension. The analyst may achieve this aim by identifying his ego with the patient's ego or, to put it more clearly although with a certain terminological inexactitude, by identifying each part of his personality with the corresponding psychological part in the patient—his id with the patient's id, his ego with the ego, his superego with the superego, accepting these identifications in his consciousness. But this does not always happen, nor is it all that happens. Apart from these identifications, which might be called *concordant* (or *homologous) identifications,* there exist also highly important identifications of the analyst's ego with the patient's internal objects, for example, with the superego. Adapting an expression from Helene Deutsch, they might be called *complementary identifications.*[6] We will consider these two kinds of identifica-

[6] Helene Deutsch *(4)* speaks of the 'complementary position' when she refers to the analyst's identifications with the object imagoes.

tion and their destinies later. Here we may add the following notes.

1. The concordant identification is based on introjection and projection, or, in other terms, on the resonance of the exterior in the interior, on recognition of what belongs to another as one's own ('this part of you is I') and on the equation of what is one's own with what belongs to another ('this part of me is you'). The processes inherent in the complementary identifications are the same, but they refer to the patient's objects. The greater the conflicts between the parts of the analyst's personality, the greater are his difficulties in carrying out the concordant identifications in their entirety.

2. The complementary identifications are produced by the fact that the patient treats the analyst as an internal (projected) object, and in consequence the analyst feels treated as such; that is, he identifies himself with this object. The complementary identifications are closely connected with the destiny of the concordant identifications: it seems that to the degree to which the analyst fails in the concordant identifications and rejects them, certain complementary identifications become intensified. It is clear that rejection of a part or tendency in the analyst himself, —his aggressiveness, for instance,—may lead to a rejection of the patient's aggressiveness (whereby this concordant identification fails) and that such a situation leads to a greater complementary identification with the patient's rejecting object, toward which this aggressive impulse is directed.

3. Current usage applies the term 'countertransference' to the complementary identifications only; that is to say, to those psychological processes in the analyst by which, because he feels treated as and partially identifies himself with an internal object of the patient, the patient becomes an internal (projected) object of the analyst. Usually excluded from the concept countertransference are the concordant identifications,—those psychological contents that arise in the analyst by reason of the empathy achieved with the patient and that really reflect and reproduce the latter's psychological contents. Perhaps it would be best to

follow this usage, but there are some circumstances that make it unwise to do so. In the first place, some authors include the concordant identifications in the concept of countertransference. One is thus faced with the choice of entering upon a terminological discussion or of accepting the term in this wider sense. I think that for various reasons the wider sense is to be preferred. If one considers that the analyst's concordant identifications (his 'understandings') are a sort of reproduction of his own past processes, especially of his own infancy, and that this reproduction or re-experience is carried out as response to stimuli from the patient, one will be more ready to include the concordant identifications in the concept of countertransference. Moreover, the concordant identifications are closely connected with the complementary ones (and thus with 'countertransference' in the popular sense), and this fact renders advisable a differentiation but not a total separation of the terms. Finally, it should be borne in mind that the disposition to empathy,—that is, to concordant identification,—springs largely from the sublimated positive countertransference, which likewise relates empathy with countertransference in the wider sense. All this suggests, then, the acceptance of countertransference as the totality of the analyst's psychological response to the patient. If we accept this broad definition of countertransference, the difference between its two aspects mentioned above must still be defined. On the one hand we have the analyst as subject and the patient as object of knowledge, which in a certain sense annuls the 'object relationship', properly speaking; and there arises in its stead the approximate union or identity between the subject's and the object's parts (experiences, impulses, defenses). The aggregate of the processes pertaining to that union might be designated, where necessary, 'concordant countertransference'. On the other hand we have an object relationship very like many others, a real 'transference' in which the analyst 'repeats' previous experiences, the patient representing internal objects of the analyst. The aggregate of these experiences, which also exist always and

continually, might be termed 'complementary countertransference'.[7]

A brief example may be opportune here. Consider a patient who threatens the analyst with suicide. In such situations there sometimes occurs rejection of the concordant identifications by the analyst and an intensification of his identification with the threatened object. The anxiety that such a threat can cause the analyst may lead to various reactions or defense mechanisms within him,—for instance, annoyance with the patient. This—his anxiety and annoyance—would be contents of the 'complementary countertransference'. The perception of his annoyance may, in turn, originate guilt feelings in the analyst and these lead to desires for reparation and to intensification of the 'concordant' identification and 'concordant' countertransference.

Moreover, these two aspects of 'total countertransference' have their analogy in transference. Sublimated positive transference is the main and indispensable motive force for the patient's work; it does not in itself constitute a technical problem. Transference becomes a 'subject', according to Freud's words, mainly when 'it becomes resistance', when, because of resistance, it has become sexual or negative *(8, 9)*. Analogously, sublimated positive countertransference is the main and indispensable motive force in the analyst's work (disposing him to the continued concordant identification), and also countertransference becomes a technical problem or 'subject' mainly when it becomes sexual or negative. And this occurs (to an intense degree) principally as a resistance,—in this case, the analyst's,—that is to say, as counter-resistance.

This leads to the problem of the dynamics of countertransference. We may already discern that the three factors designated by Freud as determinant in the dynamics of transference (the impulse to repeat infantile clichés of experience, the libidinal need, and resistance) are also decisive for the dynamics of countertransference. I shall return to this later.

[7] In view of the close connection between these two aspects of countertransference, this differentiation is somewhat artificial. Its introduction is justifiable only considering the above-mentioned circumstances.

III

Every transference situation provokes a countertransference situation, which arises out of the analyst's identification of himself with the analysand's (internal) objects (this is the 'complementary countertransference'). These countertransference situations may be repressed or emotionally blocked but probably they cannot be avoided; certainly they should not be avoided if full understanding is to be achieved. These countertransference reactions are governed by the laws of the general and individual unconscious. Among these the law of talion is especially important. Thus, for example, every positive transference situation is answered by a positive countertransference; to every negative transference there responds, in one part of the analyst, a negative countertransference. It is of great importance that the analyst be conscious of this law, for awareness of it is fundamental to avoid 'drowning' in the countertransference. If he is not aware of it he will not be able to avoid entering into the vicious circle of the analysand's neurosis, which will hinder or even prevent the work of therapy.

A simplified example: if the patient's neurosis centers round a conflict with his introjected father, he will project the latter upon the analyst and treat him as his father; the analyst will feel treated as such,—he will feel treated badly,—and he will react internally, in a part of his personality, in accordance with the treatment he receives. If he fails to be aware of this reaction, his behavior will inevitably be affected by it, and he will renew the situations that, to a greater or lesser degree, helped to establish the analysand's neurosis. Hence it is of the greatest importance that the analyst develop within himself an ego observer of his countertransference reactions, which are, naturally, continuous. Perception of these countertransference reactions will help him to become conscious of the continuous transference situations of the patient and interpret them rather than be unconsciously ruled by these reactions, as not seldom happens. A well-known example is the 'revengeful silence' of the analyst. If the analyst is unaware of these reactions there is danger that the patient will

have to repeat, in his transference experience, the vicious circle brought about by the projection and introjection of 'bad objects' (in reality neurotic ones) and the consequent pathological anxieties and defenses; but transference interpretations made possible by the analyst's awareness of his countertransference experience make it possible to open important breaches in this vicious circle.

To return to the previous example: if the analyst is conscious of what the projection of the father-imago upon him provokes in his own countertransference, he can more easily make the patient conscious of this projection and the consequent mechanisms. Interpretation of these mechanisms will show the patient that the present reality is not identical with his inner perceptions (for, if it were, the analyst would not interpret and otherwise act as an analyst); the patient then introjects a reality better than his inner world. This sort of rectification does not take place when the analyst is under the sway of his unconscious countertransference.

Let us consider some applications of these principles. To return to the question of what the analyst does during the session and what happens within him, one might reply, at first thought, that the analyst listens. But this is not completely true: he listens most of the time, or wishes to listen, but is not invariably doing so. Ferenczi *(6)* refers to this fact and expresses the opinion that the analyst's distractability is of little importance, for the patient at such moments must certainly be in resistance. Ferenczi's remark (which dates from the year 1918) sounds like an echo from the era when the analyst was mainly interested in the repressed *impulses,* because now that we attempt to analyze resistance, the patient's manifestations of resistance are as significant as any other of his productions. At any rate, Ferenczi here refers to a countertransference response and deduces from it the analysand's psychological situation. He says '. . . we have unconsciously reacted to the emptiness and futility of the associations given at this moment with the withdrawal of the conscious charge'. The situation might be described as one of mutual withdrawal. The analyst's withdrawal is a response to the analy-

sand's withdrawal,—which, however, is a response to an imagined or real psychological position of the analyst. If we have withdrawn,—if we are not listening but are thinking of something else,—we may utilize this event in the service of the analysis like any other information we acquire. And the guilt we may feel over such a withdrawal is just as utilizable analytically as any other countertransference reaction. Ferenczi's next words, 'the danger of the doctor's falling asleep . . . need not be regarded as grave because we awake at the first occurrence of any importance for the treatment', are clearly intended to placate this guilt. But better than to allay the analyst's guilt would be to use it to promote the analysis,—and indeed so to use the guilt would be the best way of alleviating it. In fact, we encounter here a cardinal problem of the relation between transference and countertransference, and of the therapeutic process in general. For the analyst's withdrawal is only an example of how the unconscious of one person responds to the unconscious of another. This response seems in part to be governed, insofar as we identify ourselves with the unconscious objects of the analysand, by the law of talion; and, insofar as this law unconsciously influences the analyst, there is danger of a vicious circle of reactions between them, for the analysand also responds 'talionically' in his turn, and so on without end.

Looking more closely, we see that the 'talionic response' or 'identification with the aggressor' (the frustrating patient) is a complex process. Such a psychological process in the analyst usually starts with a feeling of displeasure or of some anxiety as a response to this aggression (frustration) and, because of this feeling, the analyst identifies himself with the 'aggressor'. By the term 'aggressor' we must designate not only the patient but also some internal object of the analyst (especially his own superego or an internal persecutor) now projected upon the patient. This identification with the aggressor, or persecutor, causes a feeling of guilt; probably it always does so, although awareness of the guilt may be repressed. For what happens is, on a small scale, a process of melancholia, just as Freud described it: the object has to some degree abandoned us; we identify ourselves with the

lost object;[8] and then we accuse the introjected 'bad' object,—in other words, we have guilt feelings. This may be sensed in Ferenczi's remark quoted above, in which mechanisms are at work designed to protect the analyst against these guilt feelings: denial of guilt ('the danger is not grave') and a certain accusation against the analysand for the 'emptiness' and 'futility' of his associations. In this way a vicious circle—a kind of paranoid ping-pong—has entered into the analytic situation.[9]

Two situations of frequent occurrence illustrate both the complementary and the concordant identifications and the vicious circle these situations may cause.

1. One transference situation of regular occurrence consists in the patient's seeing in the analyst his own superego. The analyst identifies himself with the id and ego of the patient and with the patient's dependence upon his superego; and he also identifies himself with this same superego,—a situation in which the patient places him,—and experiences in this way the domination of the superego over the patient's ego. The relation of the ego to the superego is, at bottom, a depressive and paranoid situation; the relation of the superego to the ego is, on the same plane, a manic one insofar as this term may be used to designate the dominating, controlling, and accusing attitude of the superego toward the ego. In this sense we may say, broadly speaking, that to a 'depressive-paranoid' transference in the analysand there corresponds—as regards the complementary identification—a 'manic' countertransference in the analyst. This, in turn, may entail various fears and guilt feelings, to which I shall refer later.[10]

[8] It is a partial abandonment and it is a threat of abandonment. The obj that threatens to abandon us and the persecutor are basically the same.

[9] The process described by Ferenczi has an even deeper meaning. The 'emptiness' and 'futility' of the associations express the empty, futile, dead part of the analysand; they characterize a depressive situation in which the analysand is alone and abandoned by his objects, just as has happened in the analytic situation.

[10] Cesio *(3)* demonstrates in a case report the principal countertransference reactions that arose in the course of the psychoanalytic treatment, pointing out especially the analyst's partial identifications with objects of the patient's superego.

2. When the patient, in defense against this situation, identifies himself with the superego, he may place the analyst in the situation of the dependent and incriminated ego. The analyst will not only identify himself with this position of the patient; he will also experience the situation with the content the patient gives it: he will feel subjugated and accused, and may react to some degree with anxiety and guilt. To a 'manic' transference situation (of the type called 'mania for reproaching') there corresponds, then,—as regards the complementary identification,—a 'depressive-paranoid' countertransference situation.

The analyst will normally experience these situations with only a part of his being, leaving another part free to take note of them in a way suitable for the treatment. Perception of such a countertransference situation by the analyst and his understanding of it as a psychological response to a certain transference situation will enable him the better to grasp the transference at the precise moment when it is active. It is precisely these situations and the analyst's behavior regarding them, and in particular his interpretations of them, that are of decisive importance for the process of therapy, for they are the moments when the vicious circle within which the neurotic habitually moves,—by projecting his inner world outside and reintrojecting this same world,—is or is not interrupted. Moreover, at these decisive points the vicious circle may be re-enforced by the analyst, if he is unaware of having entered it.

A brief example: an analysand repeats with the analyst his 'neurosis of failure', closing himself up to every interpretation or repressing it at once, reproaching the analyst for the uselessness of the analysis, foreseeing nothing better in the future, continually declaring his complete indifference to everything. The analyst interprets the patient's position toward him, and its origins, in its various aspects. He shows the patient his defense against the danger of becoming too dependent, of being abandoned, or being tricked, or of suffering counteraggression by the analyst, if he abandons his armor and indifference toward the analyst. He interprets to the patient his projection of bad internal objects and his subsequent sado-masochistic behavior

in the transference; his need of punishment; his triumph and 'masochistic revenge' against the transferred parents; his defense against the 'depressive position' by means of schizoid, paranoid, and manic defenses (Melanie Klein); and he interprets the patient's rejection of a bond which in the unconscious has a homosexual significance. But it may happen that all these interpretations, in spite of being directed to the central resistance and connected with the transference situation, suffer the same fate for the same reasons: they fall into the 'whirl in a void' *(Leerlauf)* of the 'neurosis of failure'. Now the decisive moments arrive. The analyst, subdued by the patient's resistance, may begin to feel anxious over the possibility of failure and feel angry with the patient. When this occurs in the analyst, the patient feels it coming, for his own 'aggressiveness' and other reactions have provoked it; consequently he fears the analyst's anger. If the analyst, threatened by failure, or to put it more precisely threatened by his own superego or by his own archaic objects which have found an *'agent provocateur'* in the patient, acts under the influence of these internal objects and of his paranoid and depressive anxieties, the patient again finds himself confronting a reality like that of his real or fantasied childhood experiences and like that of his inner world; and so the vicious circle continues and may even be re-enforced. But if the analyst grasps the importance of this situation, if, through his own anxiety or anger, he comprehends what is happening in the analysand, and if he overcomes, thanks to the new insight, his negative feelings and interprets what has happened in the analysand, being now in this new positive countertransference situation, then he may have made a breach—be it large or small—in the vicious circle.[11]

IV

We have considered thus far the relation of transference and countertransference in the analytic process. Now let us look more closely into the phenomena of countertransference. Countertransference experiences may be divided into two classes. One

[11] See Chap. V, example 8.

might be designated 'countertransference thoughts'; the other 'countertransference positions'. The example just cited may serve as illustration of this latter class; the essence of this example lies in the fact that the analyst feels anxiety and is angry with the analysand,—that is to say, he is in a certain countertransference 'position'. As an example of the other class we may take the following.

At the start of a session an analysand wishes to pay his fees. He gives the analyst a thousand peso note and asks for change. The analyst happens to have his money in another room and goes out to fetch it, leaving the thousand pesos upon his desk. During the time between leaving and returning, the fantasy occurs to him that the analysand will take back the money and say that the analyst took it away with him. On his return he finds the thousand pesos where he had left it. When the account has been settled, the analysand lies down and tells the analyst that when he was left alone he had fantasies of keeping the money, of kissing the note goodbye, and so on. The analyst's fantasy was based upon what he already knew of the patient, who in previous sessions had expressed a strong disinclination to pay his fees. The identity of the analyst's fantasy and the patient's fantasy of keeping the money may be explained as springing from a connection between the two unconsciouses, a connection that might be regarded as a 'psychological symbiosis' between the two personalities. To the analysand's wish to take money from him (already expressed on previous occasions), the analyst reacts by identifying himself both with this desire and with the object toward which the desire is directed; hence arises his fantasy of being robbed. For these identifications to come about there must evidently exist a potential identity. One may presume that every possible psychological constellation in the patient also exists in the analyst, and the constellation that corresponds to the patient's is brought into play in the analyst. A symbiosis results, and now in the analyst spontaneously occur thoughts corresponding to the psychological constellation in the patient.

In fantasies of the type just described and in the example of

the analyst angry with his patient, we are dealing with identifications with the id, with the ego, and with the objects of the analysand; in both cases, then, it is a matter of countertransference reactions. However, there is an important difference between one situation and the other, and this difference does not seem to lie only in the emotional intensity. Before elucidating this difference, I should like to emphasize that the countertransference reaction that appears in the last example (the fantasy about the thousand pesos) should also be used as a means to further the analysis. It is, moreover, a typical example of those 'spontaneous thoughts' to which Freud and others refer in advising the analyst to keep his attention 'floating' and in stressing the importance of these thoughts for understanding the patient. The countertransference reactions exemplified by the story of the thousand pesos are characterized by the fact that they threaten no danger to the analyst's objective attitude of observer. Here the danger is rather that the analyst will not pay sufficient attention to these thoughts or will fail to use them for understanding and interpretation. The patient's corresponding ideas are not always conscious, nor are they always communicated as they were in the example cited. But from his own countertransference 'thoughts' and feelings the analyst may guess what is repressed or rejected. It is important to recall once more our usage of the term 'countertransference', for many writers, perhaps the majority, mean by it not these thoughts of the analyst but rather that other class of reactions, the 'countertransference positions'. This is one reason why it is useful to differentiate these two kinds of reaction.

The outstanding difference between the two lies in the degree to which the ego is involved in the experience. In one case the reactions are experienced as thoughts, free associations, or fantasies, with no great emotional intensity and frequently as if they were somewhat foreign to the ego. In the other case, the analyst's ego is involved in the countertransference experience, and the experience is felt by him with greater intensity and as true reality, and there is danger of his 'drowning' in this experi-

ence. In the former example of the analyst who gets angry because of the analysand's resistances, the analysand is felt as really bad by one part of the analyst ('countertransference position'), although the latter does not express his anger. Now these two kinds of countertransference reaction differ, I believe, because they have different origins. The reaction experienced by the analyst as thought or fantasy arises from the existence of an *analogous situation* in the analysand,—that is, from his readiness in perceiving and communicating his inner situation (as happens in the case of the thousand pesos),—whereas the reaction experienced with great intensity, even as reality, by the analyst arises from *acting out* by the analysand (as in the case of the 'neurosis of failure'). Undoubtedly there is also in the analyst himself a factor that helps to determine this difference. The analyst has, it seems, two ways of responding. He may respond to some situations by *perceiving* his reactions, while to others he responds by *acting out* (alloplastically or autoplastically). Which type of response occurs in the analyst depends partly on his own neurosis, on his inclination to anxiety, on his defense mechanisms, and especially on his tendencies to repeat (act out) instead of making conscious. Here we encounter a factor that determines the dynamics of countertransference. It is the one Freud emphasized as determining the special intensity of transference in analysis, and it is also responsible for the special intensity of countertransference.

Let us consider for a moment the dynamics of countertransference. The great intensity of certain countertransference reactions is to be explained by the existence in the analyst of pathological defenses against the increase of archaic anxieties and unresolved inner conflicts. Transference, I believe, becomes intense not only because it serves as a resistance to remembering, as Freud says, but also because it serves as a defense against a danger within the transference experience itself. In other words, the 'transference resistance' is frequently a repetition of defenses that must be intensified lest a catastrophe be repeated in transference *(20)*. The same is true of countertransference. It is

clear that these catastrophes are related to becoming aware of certain aspects of one's own instincts. Take, for instance, the analyst who becomes anxious and inwardly angry over the intense masochism of the analysand within the analytic situation. Such masochism frequently rouses old paranoid and depressive anxieties and guilt feelings in the analyst, who, faced with the aggression directed by the patient against his own ego, and faced with the effects of this aggression, finds himself in his unconscious confronted anew with his early crimes. It is often just these childhood conflicts of the analyst, with their aggression, that led him into this profession in which he tries to repair the objects of the aggression and to overcome or deny his guilt. Because of the patient's strong masochism, this defense, which consists of the analyst's therapeutic action, fails and the analyst is threatened with the return of the catastrophe, the encounter with the destroyed object. In this way the intensity of the 'negative countertransference' (the anger with the patient) usually increases because of the failure of the countertransference defense (the therapeutic action) and the analyst's subsequent increase of anxiety over a catastrophe in the countertransference experience (the destruction of the object).

This example also illustrates another aspect of the dynamics of countertransference. In a previous paper *(20)*, I showed that the 'abolition of rejection'[12] in analysis determines the dynamics of transference and, in particular, the intensity of the transference of the 'rejecting' internal objects (in the first place, of the superego). The 'abolition of rejection' begins with the communication of 'spontaneous' thoughts. The analyst, however, makes no such communication to the analysand, and here we have an important difference between his situation and that of the analysand and between the dynamics of transference and those of countertransference. However, this difference is not so great as might be at first supposed, for two reasons: first, because

[12] By 'abolition of rejection' I mean adherence by the analysand to the fundamental rule that all his thoughts are to be expressed without selection or rejection.

it is not necessary that the free associations be *expressed* for projections and transferences to take place, and second, because the analyst communicates certain associations of a personal nature even when he does not seem to do so. These communications begin, one might say, with the plate on the front door that says *Psychoanalyst* or *Doctor*. What motive (in terms of the unconscious) would the analyst have for wanting to cure if it were not he that made the patient ill? In this way the patient is already, simply by being a patient, the creditor, the accuser, the 'superego' of the analyst; and the analyst is his debtor.

V

The examples that follow illustrate the various kinds, meanings, and uses of countertransference reaction. First are described situations in which the countertransference is of too little intensity to drag the analyst's ego along with it; next, some situations in which the intense countertransference reaction intensely involves the ego; and finally, some examples in which the repression of countertransference prevents comprehension of the analysand's situation at the critical moment.

1. A woman patient asks the analyst whether it is true that another analyst named N has become separated from his wife and married again. In the associations that follow she refers repeatedly to N's first wife. The idea occurs to the analyst that the patient would also like to know who N's second wife is and that she probably wonders whether the second wife was a patient of N. The analyst further supposes that his patient (considering her present transference situation) is wondering whether her own analyst might not also separate from his wife and marry her. In accordance with this suspicion but taking care not to suggest anything, the analyst asks whether she is thinking anything about N's second wife. The analysand answers, laughing, 'Yes, I was wondering whether she was not one of his patients'. Analysis of the analyst's psychological situation showed that his 'spontaneous thought' was possible because his identification with the patient in his œdipal desires was not blocked by repression, and

also because he himself countertransferred his own positive œdipal impulses, accepted by his conscious, upon the patient.

This example shows how, in the analyst's 'spontaneous thoughts',—which enable him to attain a deeper understanding,—there intervenes not only the sublimated positive countertransference that permits his identification with the id and the ego of the patient but also the (apparently absent) 'complementary countertransference',—that is, his identification with the internal objects that the patient transfers and the acceptance in his conscious of his own infantile object relations with the patient.

2. In the following example the 'spontaneous thoughts', which are manifestly dependent upon the countertransference situation, constitute the guide to understanding.

A woman candidate associates about a scientific meeting at the Psychoanalytic Institute, the first she had attended. While she is associating, it occurs to the analyst that he, unlike most of the other didactic analysts, did not participate in the discussion. He feels somewhat vexed, he thinks that the analysand must have noticed this, and he perceives in himself some fear that she consequently regards him as inferior. He realizes that he would prefer that she not think this and not mention the occurrence; for this very reason, he points out to the analysand that she is rejecting thoughts concerning him in relation to the meeting. The analysand's reaction shows the importance of this interpretation. She exclaims in surprise: 'Of course, I almost forgot to tell you'. She then produces many associations related to transference which she had previously rejected for reasons corresponding to the countertransference rejection of these same ideas by the analyst. The example shows the importance of observation of countertransference as a technical tool; it also shows a relation between a transference resistance and a countertransference resistance.

3. On shaking hands at the beginning of the session the analyst, noticing that the patient is depressed, experiences a slight sense of guilt. The analyst at once thinks of the last session, in which he frustrated the patient. He knows where the

depression comes from, even before the patient's associations lead him to the same conclusion. Observation of the countertransference ideas, *before* and *after* the sessions, may also be an important guide for the analyst in understanding the patient's analytic situation. For instance, if a feeling of annoyance before entering the consulting room is a countertransference response to the patient's aggressive or domineering behavior, the annoyance may enable the analyst to understand beforehand the patient's anxiety which, at the most superficial layer, is fear of the analyst's anger provoked by the patient's behavior. Another instance occurs in the analyst who, before entering his consulting room, perceives a feeling of guilt over being late; he realizes that he often keeps this analysand waiting and that it is the analysand's pronounced masochistic submission that especially prompts him to this frustrating behavior. In other words, the analyst responds to the strong repression of aggression in the patient by doing what he pleases and abusing the patient's neurosis. But this very temptation that the analyst feels and yields to in his behavior, and the fleeting guilt feelings he experiences for this reason, can serve as a guide for him to comprehend the analysand's transference situation.

4. The following example from analytic literature likewise shows how the countertransference situation makes it possible to understand the patient's analytic situation in a way decisive for the whole subsequent course of the treatment. It is interesting to remark that the author seems unaware that the fortunate understanding is due to an unconscious grasp of the countertransference situation. I refer to the 'case with manifest inferiority feelings' published by Wilhelm Reich *(22)*. After showing how, for a long period, no interpretation achieved any success or any modification of the patient's analytic situation, Reich writes: 'I then interpreted to him his inferiority feelings toward me; at first this was unsuccessful but after I had persistently shown him his conduct for several days, he presented some communications referring to his tremendous envy not of me but of other men, to whom he also felt inferior. And then there

emerged in me, like a lightning flash, the idea that his repeated complaints could mean only this: "The analysis has no effect upon me,—it is no good, the analyst is inferior and impotent and can achieve nothing with me". The complaints were to be understood partly as triumph and partly as reproaches to the analyst.' If we inquire into the origin of this 'lightning idea' of Reich, the reply must be, theoretically, that it arose from identification with those impulses in the analysand or from identification with one of his internal objects. The description of the event, however, leaves little room for doubt that the latter, the 'complementary countertransference', was the source of Reich's intuition,—that this lightning understanding arose from his own feeling of impotence, defeat, and guilt over the failure of treatment.

5. Now a case in which repression of the countertransference prevented the analyst from understanding the transference situation, while his later becoming conscious of the countertransference was precisely what brought this understanding.

For several days a patient had suffered from intense anxiety and stomach-ache. The analyst does not understand the situation until she asks the patient when it first began. He answers that it goes back to a moment when he bitterly criticized her for certain behavior, and adds that he has noticed that she has been rather depressed of late. What the patient says hits the nail on the head. The analyst has in truth felt somewhat depressed because of this aggression in the patient. But she has repressed her aggression against the patient that underlay her depression and has repressed awareness that the patient would also think, consciously or unconsciously, of the effect of his criticism. The patient was conscious of this and therefore connected his own anxieties and symptoms with the analyst's depression. In other words, the analyst scotomatized the connection between the patient's anxiety and pain and the aggression (criticism) perpetrated against her. This scotomatization of the transference situation was due to repression of the countertransference, for the aggression that the patient suspected in the analyst, and to

which he responded with anxiety and gastric pains (self-aggression in anticipation) existed not only in his fantasy but also in the analyst's actual countertransference feelings.

The danger of the countertransference being repressed is naturally the greater the more these countertransference reactions are rejected by the ego ideal or the superego. To take, for instance, the case of a patient with an almost complete lack of 'respect' for the analyst, it may happen that the analyst's narcissism is wounded and he reacts inwardly with some degree of annoyance. If he represses this annoyance because it ill accords with the demands of his ego ideal, he deprives himself of an important guide in understanding the patient's transference; for the patient seeks to deny the distance between his internal (idealized) objects and his ego by means of his manic mechanisms, trying to compensate his inferiority feelings by behavior 'as between equals' (in reality inverting this situation with the idealized objects by identification with them) and defending himself in this way against conflict situations of the greatest importance. In like manner, sexual excitement in the analyst may point to a hidden seductive behavior and erotomanic fantasies in the analysand as well as to the situations underlying these. Repression of such countertransference reactions may prevent access to the appropriate technique. What is advisable, for instance, when the patient exhibits this sort of hypomanic behavior is not merely analytic 'tolerance' (which may be intensified by guilt feeling over the countertransference reactions), but, as the first step, making the patient conscious of the countertransference reactions of his *own* internal objects, such as the superego. For just as the analyst reacted with annoyance to the almost total 'lack of respect' in the patient, so also do the patient's internal objects; for in the patient's behavior there is aggressiveness against these internal objects which the patient once experienced as superior and as rejecting. In more general terms, I should say that patients with certain hypomanic defenses tend to regard their conduct as 'natural' and 'spontaneous' and the analyst as 'tolerant' and 'understanding', repressing at the

same time the rejecting and intolerant objects latently projected upon the analyst. If the analyst does not repress his deeper reactions to the analysand's associations and behavior, they will afford him an excellent guide for showing the patient these same repressed objects of his and the relationship in which he stands toward them.

6. In analysis we must take into account the *total* countertransference as well as the total transference. I refer, in particular, to the importance of paying attention not only to what has existed and is repeated but also to what has never existed (or has existed only as a hope),—that is to say, to the new and specifically analytic factors in the situations of analysand and analyst. Outstanding among these are the real new characteristics of this object (of analyst or of analysand), the patient-doctor situation (the intention to be cured or to cure, to be restored or to restore), and the situation created by psychoanalytic thought and feeling (as, for instance, the situation created by the fundamental rule, that original permission and invitation, the basic expression of a specific atmosphere of tolerance and freedom).

Let us illustrate briefly what is meant by 'total transference'. During a psychoanalytic session, the associations of a man, under treatment by a woman analyst, concern his relations with women. He tells of the frustrations and rejection he has endured, and his inability to form relationships with women of culture. There appear sadistic and debasing tendencies toward women. It is clear that the patient is transferring his frustrating and rejecting imagoes upon the analyst, and from these has arisen his mistrust of her. The patient is actually expressing both his fear of being rejected by the analyst on account of his sadism (deeper: his fear of destroying her and of her retaliation) and, at bottom, his fear of being frustrated by her,—a situation that in the distant past gave rise to this sadism. Such an interpretation would be a faithful reflection of the transference situation properly speaking. But in the total analytic situation there is something more. Evidently the patient needs and is seeking

something through the session as such. What is it? What is this specific present factor, what is this prospective aspect, so to speak, of the transference situation? The answer is virtually contained in the interpretation given above: the analysand seeks to connect himself with an object emotionally and libidinally, the previous sessions having awakened his feelings and somewhat disrupted his armor; indirectly he is asking the analyst whether he may indeed place his trust in her, whether he may surrender himself without running the risk of suffering what he has suffered before. The first interpretation refers to the transference only as a repetition of what has once existed; the latter, more complete interpretation refers to what has existed and also to what has never existed and is hoped for anew from the analytic experience.

Now let us study an example that refers to both the total transference and total countertransference situations. The illustration is once again drawn from Wilhelm Reich *(22)*. The analysis has long centered around the analysand's smile, the sole analyzable expression, according to Reich, that remained after cessation of all the communications and actions with which the analysand had begun treatment. Among these actions at the start had been some that Reich interpreted as provocations (for instance, a gesture aimed at the analyst's head). It is plain that Reich was guided in this interpretation by what he had felt in countertransference. But what Reich perceived in this way was only a part of what had happened within him; for apart from the fright and annoyance (which, even if only to a slight degree, he must have felt), there was a reaction of his ego to these feelings, a wish to control and dominate them, imposed by his 'analytic conscience'. For Reich had given the analysand to understand that there is a great deal of freedom and tolerance in the analytic situation and it was this spirit of tolerance that made Reich respond to these 'provocations' with nothing but an interpretation. What the analysand aimed at doing was to test whether such tolerance really existed in the analyst. Reich himself later gave him this interpretation, and this interpretation

had a far more positive effect than the first. Consideration of the total countertransference situation (the feeling of being provoked, *and* the 'analytic conscience' which determined the fate of this feeling) might have been from the first a guide in apprehending the total transference situation, which consisted in aggressiveness, in the original mistrust, *and* in the ray of confidence, the new hope which the liberality of the fundamental rule had awakened in him.

7. I have referred above to the fact that the transference, insofar as it is determined by the infantile situations and archaic objects of the patient, provokes in the unconscious of the analyst infantile situations and an intensified vibration of archaic objects of his own. I wish now to present another example that shows how the analyst, not being conscious of such countertransference responses, may make the patient feel exposed once again to an archaic object (the vicious circle) and how, in spite of his having some understanding of what is happening in the patient, the analyst is prevented from giving an adequate interpretation.

During her first analytic session, a woman patient talks about how hot it is and other matters which to the analyst (a woman candidate) seem insignificant. She says to the patient that very likely the patient dares not talk about herself. Although the analysand was indeed talking about herself (even when saying how hot it was), the interpretation was, in essence, correct, for it was directed to the central conflict of the moment. But it was badly formulated, and this was so partly because of the countertransference situation. For the analyst's 'you dare not' was a criticism, and it sprang from the analyst's feeling of being frustrated in a desire; this desire must have been that the patient overcome her resistance. If the analyst had not felt this irritation or if she had been conscious of the neurotic nature of her internal reaction of anxiety and annoyance, she would have sought to understand why the patient 'dared not' and would have told her. In that case the lack of courage that the analyst

pointed out to the patient would have proved to be a natural response within a dangerous object relationship.

Pursuing the analyst's line of thought and leaving aside other possible interpretations, we may suppose that she would then have said to the analysand that something in the analytic situation (in the relationship between patient and analyst) had caused her fear and made her thoughts turn aside from what meant much to her to what meant little. This interpretation would have differed from the one she gave the patient in two points: first, the interpretation given did not express the object relationship that led to the 'not daring' and, second, it coincided in its formulation with superego judgments, which should be avoided as far as possible.[13] Superego judgment was not avoided in this case because the analyst was identified in countertransference with the analysand's superego without being conscious of the identification; had she been conscious of it, she would have interpreted, for example, the feared aggression from the superego (projected upon the analyst) and would not have carried it out by means of the interpretation. It appears that the 'interpretation of tendencies' without considering the total object relationship is to be traced, among other causes, to repression by the analyst of one aspect of his countertransference, his identification with the analysand's internal objects.

Later in the same session, the patient, feeling that she is being criticized, censures herself for her habit of speaking rather incoherently. She says her mother often remarks upon it, and then she criticizes her mother for not listening, as a rule, to what she says. The analyst understands that these statements relate to the analytic situation and asks her: 'Why do you think I'm not listening to you?' The patient replies that she is sure the analyst is listening to her.

What has happened? The patient's mistrust clashes with the

[13] If the interpretations coincide with the analysand's superego judgments, the analyst is confused with the superego, sometimes with good reason. Superego judgments must be shown to the analysand but, as far as possible, one should refrain from uttering them.

analyst's desire for the patient's confidence; therefore the analyst does not analyze the situation. She cannot say to the patient, 'No, I will listen to you, trust me', but she suggests it with her question. Once again interference by the uncontrolled countertransference (the desire that the patient should have no resistance) converts good understanding into a deficient interpretation. Such happenings are important, especially if they occur often. And they are likely to do so, for such interpretations spring from a certain state of the analyst and this state is partly unconscious. What makes these happenings so important is the fact that the analysand's unconscious is fully aware of the analyst's unconscious desires. Therefore the patient once again faces an object that, as in this case, wishes to force or lure the patient into rejecting his mistrust and that unconsciously seeks to satisfy its own desires or allay its own anxieties rather than to understand and satisfy the therapeutic need of the patient.

All this we infer from the reactions of the patient, who submits to the analyst's suggestion, telling the analyst that she trusts her and so denying an aspect of her internal reality. She submits to the previous criticism of her cowardice and then, apparently, 'overcomes' the resistance, while in reality everything is going on unchanged. It cannot be otherwise, for the analysand is aware of the analyst's neurotic wish and her transference is determined by that awareness. To a certain degree, the analysand finds herself once again, in the actual analytic situation, confronting her internal or external infantile reality and to this same degree will repeat her old defenses and will have no valid reason for really overcoming her resistances, however much the analyst may try to convince her of her tolerance and understanding. This she will achieve only by offering better interpretations in which her neurosis does not so greatly interfere.

8. The following more detailed example demonstrates: (a) the talion law in the relationship of analyst and analysand; (b) how awareness of the countertransference reaction indicates what is happening in the transference and what at the moment is of the greatest significance; (c) what interpretation is most

suitable to make a breach in the vicious circle; and (d) how the later associations show that this end has been achieved, even if only in part—for the same defenses return and once again the countertransference points out the interpretation the analysand needs.

We will consider the most important occurrences in one session. An analysand who suffers chiefly from an intense emotional inhibition and from a 'disconnection' in all his object relationships begins the session by saying that he feels completely disconnected from the analyst. He speaks with difficulty as if he were overcoming a great resistance, and always in an unchanging tone of voice which seems in no way to reflect his instincts and feelings. Yet the countertransference response to the content of his associations (or, rather, of his narrative, for he exercises a rigid control over his ideas) does change from time to time. At a certain point the analyst feels a slight irritation. This is when the patient, a physician, tells him how, in conversation with another physician, he sharply criticized analysts for their passivity (they give little and cure little), for their high fees, and for their tendency to dominate their patients. The patient's statements and his behavior meant several things. It was clear, in the first place, that these accusations, though couched in general terms and with reference to other analysts, were directed against his own analyst; the patient had become the analyst's superego. This situation in the patient represents a defense against his own accusing superego, projected upon the analyst. It is a form of identification with the internal persecutors that leads to inversion of the feared situation. It is, in other words, a transitory 'mania for reproaching' as defense against a paranoid-depressive situation in which the superego persecutes the patient with reproaches and threatens him with abandonment. Together with this identification with the superego, there occurs projection of a part of the 'bad ego', and of the id, upon the analyst. The passivity (the mere receptiveness, the inability to make reparation), the selfish exploitation, and the domination he ascribes to the analyst are 'bad

tendencies' of his own for which he fears reproach and abandonment by the analyst. At a lower stratum, this 'bad ego' consists of 'bad objects' with which the patient had identified himself as a defense against their persecution.

We already see that it would be premature to interpret this deeper situation; the patient will first have to face his 'bad ego': he will have to pass in transference through the paranoid-depressive situation in which he feels threatened by the superego-analyst. But even so we are still unsure of the interpretation to be given, for what the patient said and did has even at the surface still further meanings. The criticism he made to the other physician about analysts has the significance of rebellion, vengeance, and provocation; and, perhaps, of seeking for punishment as well as of finding out how much freedom the analyst allows, and simultaneously of subjugating and controlling this dangerous object, the analyst.

The analyst's countertransference reaction made clear to the analyst which of all these interpretations was most strongly indicated, for the countertransference reaction was the living response to the transference situation at that moment. The analyst felt (in accordance with the law of talion) a little anxious and angry at the aggression he suffered from the patient, and we may suppose that the patient in his unconscious or conscious fantasy sensed this annoyance in the internal object toward which his protesting behavior was directed, and that he reacted to this annoyance with anxiety. The 'disconnection' he spoke of in his first utterance must have been in relation to this anxiety, since it was because of this 'disconnection' that the analysand perceived no danger and felt no anxiety. By the patient's projection of that internal object the analyst is to the patient a tyrant who demands complete submission and forbids any protest. The transgression of this prohibition (the patient's protest expressed to his friend, the physician) must seem to the analyst—in the patient's fantasy—to be unfaithfulness, and must be responded to by the analyst with anger and emotional abandonment; we deduce this from the countertransference experi-

ence. In order to reconcile the analyst and to win him back, the patient accepts his anger or punishment and suffers from stomach-ache;—this he tells in his associations but without connecting the two experiences. His depression today is to be explained by this guilt feeling and, secondarily, by the object loss resulting from his increased 'disconnection'.

The analyst explains, in his interpretation, the meaning of the 'disconnection'. In reply the patient says that the previous day he recalled his conversation with that physician and that it did indeed cause him anxiety. After a brief pause he adds: 'and just now the thought came to me, well . . . and what am I to do with that?' The analyst perceived that these words once again slightly annoyed him. We can understand why. The patient's first reaction to the interpretation (he reacted by recalling his anxiety over his protest) had brought the analyst nearer to satisfying his desire to remove the patient's detachment. The patient's recollection of his anxiety had been at least one forward step, for he thus admitted a connection that he usually denied or repressed. But his next words frustrated the analyst once again, for they signified: 'that is of no use to me, nothing has changed'. Once again the countertransference reaction pointed out to the analyst the occurrence of a critical moment in the transference, and that here was the opportunity to interpret. At this moment also, in the patient's unconscious fantasy, must have occurred a reaction of anger from the internal object,—just as actually happened in the analyst,—to which the interpretation must be aimed. The patient's anxiety must have arisen from just this fantasy. His anxiety,—and with it his detachment,—could be diminished only by replacing that fantasied anger by an understanding of the patient's need to defend himself through that denial ('well . . . what am I to do with that?'). In reality the analyst, besides feeling annoyed, had understood that the patient had to protest and rebel, close himself up and 'disconnect' himself once again, deny and prevent any influence, because if the analyst should prove to be useful the patient would fall into intense dependence, just because of this

usefulness and because the patient would be indebted to him. The interpretation increased this danger, for the patient felt it to be true. Because of the analyst's tyranny,—his dominating, exploiting, sadistic character,—this dependence had to be prevented.

The analyst by awareness of his countertransference understood the patient's anxiety and interpreted it to him. The following associations showed that this interpretation had also been accurate.

The patient said shortly afterward that his depression had passed off, and this admission was a sign of progress because the patient was admitting that there was something good about the analyst. The next associations, moreover, permitted a more profound analysis of his transference neurosis, for the patient now revealed a deeper stratum. His underlying dependence became clear. Hitherto the interpretation had been confined to the guilt feelings and anxiety that accompanied his defenses (rebellion, denial, and others) against this very dependence. The associations referred to the fact that a mutual friend of the patient and of the analyst had a few days before told him that the analyst was going away on holiday that night and that this session would therefore be his last. In this way the patient admits the emotional importance the analyst possesses for him, a thing he always used to deny. We understand now also that his protest against analysts had been determined beforehand by the imminent danger of being forsaken by his analyst. When, just before the end of the session, the analyst explains that the information the friend gave him is false, the patient expresses anger with his friend and recalls how the friend has been trying lately to make him jealous of the analyst. Thus does the patient admit his jealousy of the analyst, although he displaces his anger onto the friend who roused his anxiety.

What has happened? And how is it to be explained?

The analyst's expected journey represented, in the unconscious of the patient, abandonment by internal objects necessary to him. This danger was countered by an identification with

the aggressor; the threat of aggression (abandonment by the analyst) was countered by aggression (the patient's protest against analysts). His own aggression caused the patient to fear counteraggression or abandonment by the analyst. This anxiety remained unconscious but the analyst was able to deduce it from the counteraggression he perceived in his countertransference. If he had not interpreted the patient's transference situation, or if in his interpretation he had included any criticism of the patient's insistent and continuous rejection of the analyst or of his obstinate denial of any bond with the analyst, the patient would have remained in the vicious circle between his basic fear of abandonment and his defensive identification with the persecutor (with the object that abandons); he would have continued in the vicious circle of his neurosis. But the interpretation, which showed him the analyst's understanding of his conduct and of the underlying anxiety, changed (at least for that moment) the image of the analyst as persecutor. Hence the patient could give up his defensive identification with this image and could admit his dependence (the underlying stratum), his need for the analyst, and his jealousy.

And now once again in this new situation countertransference will show the content and origin of the anxiety that swiftly drives the analysand back to repetition of the defense mechanism he had just abandoned (which may be identification with the persecutor, emotional blocking, or something else). And once again interpretation of this new danger is the only means of breaking the vicious circle. If we consider the nature of the relationship that existed for months before the emotional surrender that occurred in this session, if we consider the paranoid situation that existed in the transference and countertransference (expressed in the patient by his intense characterological resistances and in the analyst by his annoyance),—if we consider all this background to the session just described, we understand that the analyst enjoys, in the patient's surrender, a manic triumph, to be followed of course by depressive and paranoid anxieties, compassion toward the patient, desires for repara-

tion, and other sequelae. It is just these guilt feelings caused in the analyst by his manic feelings that may lead to his failure adequately to interpret the situation. The danger the patient fears is that he will become a helpless victim of the object's (the analyst's) sadism,—of that same sadism the analyst senses in his 'manic' satisfaction over dominating and defeating the bad object with which the patient was defensively identified. The perception of this 'manic' countertransference reaction indicates what the present transference situation is and what should be interpreted.

If there were nothing else in the analyst's psychological situation but this manic reaction, the patient would have no alternative but must make use of the same old defense mechanisms that essentially constitute his neurosis. In more general terms, we should have to admit that the negative therapeutic reaction is an adequate transference reaction in the patient to an imagined or real negative countertransference in the analyst.[14] But even where such a negative countertransference really exists, it is a part only of the analyst's psychological response. For the law of talion is not the sole determinant of the responses of the unconscious; and, moreover, the conscious also plays a part in the analyst's psychological responses. As to the unconscious, there is of course a tendency to repair, which may even create a disposition to 'return good for evil'. This tendency to repair is in reality a wish to remedy, albeit upon a displaced object, whatever evil one may have thought or done. And as to the conscious, there is, first, the fact that the analyst's own analysis has made his ego stronger than it was before so that the intensities of his anxieties and his further countertransference reactions are usually diminished; second, the analyst has some capacity to observe this countertransference, to 'get out of it', to stand outside and regard it objectively; and third, the analyst's knowledge of psychology also acts within and upon his psychological response. The knowledge, for instance, that behind the negative transference and the resistances lies simply thwarted love, helps

[14] *Cf.* Little *(15, p. 34).*

the analyst to respond with love to this possibility of loving, to this nucleus in the patient however deeply it be buried beneath hate and fear.

9. The analyst should avoid, as far as possible, making interpretations in terms that coincide with those of the moral superego.[15] This danger is increased by the unconscious identification of the analyst with the patient's internal objects and, in particular, with his superego. In the example just cited, the patient, in conversation with his friend, criticized the conduct of analysts. In so doing he assumed the role of superego toward an internal object which he projected upon the analyst. The analyst identified himself with this projected object and reacted with unconscious anxiety and with annoyance to the accusation. He inwardly reproached the patient for his conduct and there was danger that something of this reproach (in which the analyst in his turn identified himself with the conduct of the patient as superego) might filter into his interpretation, which would then perpetuate the patient's neurotic vicious circle. But the problem is wider than this. Certain psychoanalytic terminology is likely to re-enforce the patient's confusion of the analyst with the superego. For instance 'narcissism', 'passivity', and 'bribery of the superego' are terms we should not use literally or in paraphrase in treatment without careful reflection, just because they increase the danger that the patient will confuse the imago of the analyst with that of his superego. For greater clarity two situations may be differentiated theoretically. In one, only the patient experiences these or like terms as criticism, because of his conflict between ego and superego, and the analyst is free of this critical feeling. In the other, the analyst also regards certain character traits with moral intolerance; he feels censorious, as if he were indeed a superego. Something of this attitude probably always exists, for the analyst identifies himself with the objects that the patient 'mistreats' (by his 'narcissism', or 'passivity', or 'bribery of the superego'). But even if the analyst had totally

[15] Something similar, although not connected with countertransference, is emphasized by Fairbairn (*5*).

solved his own struggles against these same tendencies and hence remained free from countertransference conflict with the corresponding tendencies in the patient, it would be preferable to point out to the patient the several conflicts between his tendencies and his superego, and not run the risk of making it more difficult for the patient to differentiate between the judgment of his own superego and the analyst's comprehension of these same tendencies through the use of a terminology that precisely lends itself to confusing these two positions.

One might object that this confusion between the analyst and the superego neither can nor should be avoided, since it represents an essential part of the analysis of transference (of the externalization of internal situations) and since one cannot attain clarity except through confusion. That is true; this confusion cannot and should not be avoided, but we must remember that the confusion will also have to be resolved and that this will be all the more difficult the more the analyst is really identified in his experience with the analysand's superego and the more these identifications have influenced negatively his interpretations and conduct.

VI

In the examples presented we saw how to certain transference situations there correspond certain countertransference situations, and vice versa. To what transference situation does the analyst usually react with a particular countertransference? Study of this question would enable one, in practice, to deduce the transference situations from the countertransference reactions. Next we might ask, to what imago or conduct of the object,—to what imagined or real countertransference situation,—does the patient respond with a particular transference? Many aspects of these problems have been amply studied by psychoanalysis, but the specific problem of the relation of transference and countertransference in analysis has received little attention.

The subject is so broad that we can discuss only a few situations and those incompletely, restricting ourselves to certain

aspects. We must choose for discussion only the most important countertransference situations, those that most disturb the analyst's task and that clarify important points in the double neurosis, *la névrose à deux,* that arises in the analytic situation,—a neurosis usually of very different intensity in the two participants.

1. What is the significance of countertransference anxiety?

Countertransference anxiety may be described in general and simplified terms as being of depressive or paranoid character.[16] In depressive anxiety the inherent danger consists in having destroyed the analysand or made him ill. This anxiety may arise to a greater degree when the analyst faces the danger that the patient may commit suicide, and to a lesser degree when there is deterioration or danger of deterioration in the patient's state of health. But the patient's simple failure to improve and his suffering and depression may also provoke depressive anxieties in the analyst. These anxieties usually increase the desire to heal the patient.

In referring to paranoid anxieties it is important to differentiate between 'direct' and 'indirect' countertransference *(17).* In direct countertransference the anxieties are caused by danger of an intensification of aggression from the patient himself. In indirect countertransference the anxieties are caused by danger of aggression from third parties onto whom the analyst has made his own chief transferences,—for instance, the members of the analytic society, for the future of the analyst's object relationships with the society is in part determined by his professional performance. The feared aggression may take several forms, such as criticism, reproach, hatred, mockery, contempt, or bodily assault. In the unconscious it may be the danger of being killed or castrated or otherwise menaced in an archaic way.

The transference situations of the patient to which the de-

[16] See Klein *(12, 13).* The terms 'depressive', 'paranoid', and 'manic' are here used simply as descriptive terms. Thus, for example, 'paranoid anxieties' involve all the fantasies of being persecuted, independently of the libidinal phase or of the 'position' described by Klein. The following considerations are closely connected with my observations upon psychopathological stratification *(19).*

pressive anxieties of the analyst are a response are, above all, those in which the patient, through an increase in frustration[17] (or danger of frustration) and in the aggression that it evokes, turns the aggression against himself. We are dealing, on one plane, with situations in which the patient defends himself against a paranoid fear of retaliation by anticipating this danger, by carrying out himself and against himself part of the aggression feared from the object transferred onto the analyst, and threatening to carry it out still further. In this psychological sense it is really the analyst who attacks and destroys the patient; and the analyst's depressive anxiety corresponds to this psychological reality. In other words, the countertransference depressive anxiety arises, above all, as a response to the patient's 'masochistic defense',—which at the same time represents a revenge ('masochistic revenge'),—and as a response to the danger of its continuing. On another plane this turning of the aggression against himself is carried out by the patient because of his own depressive anxieties; he turns it against himself in order to protect himself against re-experiencing the destruction of the objects and to protect these from his own aggression.

The paranoid anxiety in 'direct' countertransference is a reaction to the danger arising from various aggressive attitudes of the patient himself. The analysis of these attitudes shows that they are themselves defenses against, or reactions to, certain aggressive imagoes; and these reactions and defenses are governed by the law of talion or else, analogously to this, by identification with the persecutor. The reproach, contempt, abandonment, bodily assault,—all these attitudes of menace or aggression in the patient that give rise to countertransference paranoid anxieties,—are responses to (or anticipations of) equivalent attitudes of the transferred object.

The paranoid anxieties in 'indirect' countertransference are

[17] By the term 'frustration' I always refer to the subjective experience and not to the objective facts. This inner experience is determined by a complementary series at one end of which is primary and secondary masochism and at the other end the actual frustrating happenings.

of a more complex nature since the danger for the analyst originates in a third party. The patient's transference situations that provoke the aggression of this 'third party' against the analyst may be of various sorts. In most cases, we are dealing with transference situations (masochistic or aggressive) similar to those that provoke the 'direct' countertransference anxieties previously described.

The common denominator of all the various attitudes of patients that provoke anxiety in the analyst is to be found, I believe, in the mechanism of 'identification with the persecutor'; the experience of being liberated from the persecutor and of triumphing over him, implied in this identification, suggests our designating this mechanism as a manic one. This mechanism may also exist where the manifest picture in the patient is quite the opposite, namely in certain depressive states; for the manic conduct may be directed either toward a projected object or toward an introjected object, it may be carried out alloplastically or autoplastically. The 'identification with the persecutor' may even exist in suicide, inasmuch as this is a 'mockery' of the fantasied or real persecutors, by anticipating the intentions of the persecutors and by one doing to oneself what they wanted to do; this 'mockery' is the manic aspect of suicide. The 'identification with the persecutor' in the patient is, then, a defense against an object felt as sadistic that tends to make the patient the victim of a manic feast; and this defense is carried out either through the introjection of the persecutor in the ego, turning the analyst into the object of the 'manic tendencies', or through the introjection of the persecutor in the superego, taking the ego as the object of its manic trend. Let us illustrate.

An analysand decides to take a pleasure trip to Europe. He experiences this as a victory over the analyst both because he will free himself from the analyst for two months and because he can afford this trip whereas the analyst cannot. He then begins to be anxious lest the analyst seek revenge for the patient's triumph. The patient anticipates this aggression by becoming unwell, developing fever and the first symptoms of influenza.

The analyst feels slight anxiety because of this illness and fears, recalling certain previous experiences, a deterioration in the state of health of the patient, who still however continues to come to the sessions. Up to this point, the situation in the transference and countertransference is as follows. The patient is in a manic relation to the analyst, and he has anxieties of preponderantly paranoid type. The analyst senses some irritation over the abandonment and some envy of the patient's great wealth (feelings ascribed by the patient in his paranoid anxieties to the analyst); but at the same time the analyst feels satisfaction at the analysand's real progress which finds expression in the very fact that the trip is possible and that the patient has decided to make it. The analyst perceives a wish in part of his personality to bind the patient to himself and use the patient for his own needs. In having this wish he resembles the patient's mother, and he is aware that he is in reality identified with the domineering and vindictive object with which the patient identifies him. Hence the patient's illness seems, to the analyst's unconscious, a result of the analyst's own wish, and the analyst therefore experiences depressive (and paranoid) anxieties.

What object imago leads the patient to this manic situation? It is precisely this same imago of a tyrannical and sadistic mother, to whom the patient's frustrations constitute a manic feast. It is against these 'manic tendencies' in the object that the patient defends himself, first by identification (introjection of the persecutor in the ego, which manifests itself in the manic experience in his decision to take a trip) and then by using a masochistic defense to escape vengeance.

In brief, the analyst's depressive (and paranoid) anxiety is his emotional response to the patient's illness; and the patient's illness is itself a masochistic defense against the object's vindictive persecution. This masochistic defense also contains a manic mechanism in that it derides, controls, and dominates the analyst's aggression. In the stratum underlying this we find the patient in a paranoid situation in face of the vindictive persecution by the analyst,—a fantasy which coincides with the analyst's

secret irritation. Beneath this paranoid situation, and causing it, is an inverse situation: the patient is enjoying a manic triumph (his liberation from the analyst by going on a trip), but the analyst is in a paranoid situation (he is in danger of being defeated and abandoned). And, finally, beneath this we find a situation in which the patient is subjected to an object imago that wants to make of him the victim of its aggressive tendencies, but this time not in order to take revenge for intentions or attitudes in the patient, but merely to satisfy its own sadism,—an imago that originates directly from the original sufferings of the subject.

In this way, the analyst was able to deduce from each of his countertransference sensations a certain transference situation; the analyst's fear of deterioration in the patient's health enabled him to perceive the patient's need to satisfy the avenger and to control and restrain him, partially inverting (through the illness) the roles of victimizer and victim, thus alleviating his guilt feeling and causing the analyst to feel some of the guilt. The analyst's irritation over the patient's trip enabled him to see the patient's need to free himself from a dominating and sadistic object, to see the patient's guilt feelings caused by these tendencies, and also to see his fear of the analyst's revenge. By his feeling of triumph the analyst was able to detect the anxiety and depression caused in the patient by his dependence upon this frustrating, yet indispensable, object. And each of these transference situations indicated to the analyst the patient's object imagoes,—the fantasied or real countertransference situations that determined the transference situations.

2. What is the meaning of countertransference aggression?

In the preceding pages, we have seen that the analyst may experience, besides countertransference anxiety, annoyance, rejection, desire for vengeance, hatred, and other emotions. What are the origin and meaning of these emotions?

Countertransference aggression usually arises in the face of frustration (or danger of frustration) of desires which may superficially be differentiated into 'direct' and 'indirect'. Both direct

and indirect desires are principally wishes to get libido or affection. The patient is the chief object of direct desires in the analyst, who wishes to be accepted and loved by him. The object of the indirect desires of the analyst may be, for example, other analysts from whom he wishes to get recognition or admiration through his successful work with his patients, using the latter as means to this end *(17)*. This aim to get love has, in general terms, two origins: an instinctual origin (the primitive need of union with the object) and an origin of a defensive nature (the need of neutralizing, overcoming, or denying the rejections and other dangers originating from the internal objects, in particular from the superego). The frustrations may be differentiated, descriptively, into those of active type and those of passive type. Among the active frustrations is direct aggression by the patient, his mockery, deceit, and active rejection. To the analyst, active frustration means exposure to a predominantly 'bad' object; the patient may become, for example, the analyst's superego which says to him 'you are bad'. Examples of frustration of passive type are passive rejection, withdrawal, partial abandonment, and other defenses against the bond with and dependence on the analyst. These signify frustrations of the analyst's need of union with the object.

In summary, we may say that countertransference aggression usually arises when there is frustration of the analyst's desires that spring from Eros, both those arising from his 'original' instinctive and affective drives and those arising from his need of neutralizing or annulling his own Thanatos (or the action of his internal 'bad objects') directed against the ego or against the external world. Owing partly to the analyst's own neurosis (and also to certain characteristics of analysis itself) these desires of Eros sometimes acquire the unconscious aim of bringing the patient to a state of dependence. Hence countertransference aggression may be provoked by the rejection of this dependence by the patient who rejects any bond with the analyst and refuses to surrender to him, showing this refusal by silence, denial, secretiveness, repression, blocking, or mockery.

Next we must establish what it is that induces the patient to behave in this way, to frustrate the analyst, to withdraw from him, to attack him. If we know this we shall know what we have to interpret when countertransference aggression arises in us, being able to deduce from the countertransference the transference situation and its cause. This cause is a fantasied countertransference situation or, more precisely, some actual or feared bad conduct from the projected object. Experience shows that, in somewhat general terms, this bad or threatening conduct of the object is usually an equivalent of the conduct of the patient (to which the analyst has reacted internally with aggression). We also understand why this is so: the patient's conduct springs from that most primitive of reactions, the talion reaction, or from the defense by means of identification with the persecutor or aggressor. In some cases it is quite simple: the analysand withdraws from us, rejects us, abandons us, or derides us when he fears or suffers the same or an equivalent treatment from us. In other cases it is more complex, the immediate identification with the aggressor being replaced by another identification that is less direct. To exemplify: a woman patient, upon learning that the analyst is going on holiday, remains silent a long while; she withdraws, through her silence, as a talion response to the analyst's withdrawal. Deeper analysis shows that the analyst's holiday is, to the patient, equivalent to the primal scene; and this is equivalent to destruction of her as a woman, and her immediate response must be a similar attack against the analyst. This aggressive (castrating) impulse is rejected and the result, her silence, is a compromise between her hostility and its rejection; it is a transformed identification with the persecutor.

To sum up: (a) The countertransference reactions of aggression (or of its equivalent) occur in response to transference situations in which the patient frustrates certain desires of the analyst. These frustrations are equivalent to abandonment or aggression which the patient carries out or with which he threatens the analyst, and they place the analyst, at first, in a depressive or paranoid situation. The patient's defense is in one

aspect equivalent to a manic situation, for he is freeing himself from a persecutor.[18] (b) This transference situation is the defense against certain object imagoes. There may be an object that persecutes the subject sadistically, vindictively, or morally, or an object that the patient defends from his own destructiveness by an attack against his own ego *(19)*; in these, the patient attacks,—as Freud and Abraham have shown in the analysis of melancholia and suicide,—at the same time the internal object and the external object (the analyst). (c) The analyst who is placed by the alloplastic or autoplastic attacks of the patient in a paranoid or depressive situation sometimes defends himself against these attacks by using the same identification with the aggressor or persecutor as the patient used. Then the analyst virtually becomes the persecutor, and to this the patient (insofar as he presupposes such a reaction from his internal and projected object) responds with anxiety. This anxiety and its origin is nearest to consciousness, and is therefore the first thing to interpret.

3. Countertransference guilt feelings are an important source of countertransference anxiety; the analyst fears his 'moral conscience'. Thus, for instance, a serious deterioration in the condition of the patient may cause the analyst to suffer reproach by his own superego, and also cause him to fear punishment. When such guilt feelings occur, the superego of the analyst is usually projected upon the patient or upon a third person, the analyst being the guilty ego. The accuser is the one who is attacked, the victim of the analyst. The analyst is the accused; he is charged with being the victimizer. It is therefore the analyst who must suffer anxiety over his object, and dependence upon it.

As in other countertransference situations, the analyst's guilt

[18] This 'mania' may be of 'superego type', as for instance 'mania for reproaching' (identification with the persecuting moral superego) which also occurs in many depressive and masochistic states. It may also be of a 'pre-superego type' (belonging to planes underlying that of moral guilt) as occurs for instance in certain erotomanias, for erotic mockery is identification with the object that castrates by frustrating genitally *(19)*.

feeling may have either real causes or fantasied causes, or a mixture of the two. A real cause exists in the analyst who has neurotic negative feelings that exercise some influence over his behavior, leading him, for example, to interpret with aggressiveness or to behave in a submissive, seductive, or unnecessarily frustrating way. But guilt feelings may also arise in the analyst over, for instance, intense submissiveness in the patient even though the analyst had not driven the patient into such conduct by his procedure. Or he may feel guilty when the analysand becomes depressed or ill, although his therapeutic procedure was right and proper according to his own conscience. In such cases, the countertransference guilt feelings are evoked not by what procedure he has actually used but by his awareness of what he might have done in view of his latent disposition. In other words, the analyst identifies himself in fantasy with a bad internal object of the patient and he feels guilty for what he has provoked in this role,—illness, depression, masochism, suffering, failure. The imago of the patient then becomes fused with the analyst's internal objects which the analyst had, in the past, wanted (and perhaps managed) to frustrate, make suffer, dominate, or destroy. Now he wishes to repair them. When this reparation fails, he reacts as if he had hurt them. The true cause of the guilt feelings is the neurotic, predominantly sado-masochistic tendencies that may reappear in countertransference; the analyst therefore quite rightly entertains certain doubts and uncertainties about his ability to control them completely and to keep them entirely removed from his procedure.

The transference situation to which the analyst is likely to react with guilt feelings is then, in the first place, a masochistic trend in the patient, which may be either of a 'defensive' (secondary) or of a 'basic' (primary) nature. If it is defensive we know it to be a rejection of sadism by means of its 'turning against the ego'; the principal object imago that imposes this masochistic defense is a retaliatory imago. If it is basic ('primary masochism') the object imago is 'simply' sadistic, a reflex of the pains ('frustrations') originally suffered by the patient. The

analyst's guilt feelings refer to his own sadistic tendencies. He may feel as if he himself had provoked the patient's masochism. The patient is subjugated by a 'bad' object so that it seems as if the analyst had satisfied his aggressiveness; now the analyst is exposed in his turn to the accusations of his superego. In short, the superficial situation is that the patient is now the superego, and the analyst the ego who must suffer the accusation; the analyst is in a depressive-paranoid situation, whereas the patient is, from one point of view, in a 'manic' situation (showing, for example, 'mania for reproaching'). But on a deeper plane the situation is the reverse: the analyst is in a 'manic' situation (acting as a vindictive, dominating, or 'simply' sadistic imago), and the patient is in a depressive-paranoid situation *(19)*.

4. Besides the anxiety, hatred, and guilt feelings in countertransference, there are a number of other countertransference situations that may also be decisive points in the course of analytic treatment, both because they may influence the analyst's work and because the analysis of the transference situations that provoke such countertransference situations may represent the central problem of treatment, clarification of which may be indispensable if the analyst is to exert any therapeutic influence upon the patient.

Let us consider briefly only two of these situations. One is the countertransference boredom or somnolence already mentioned which of course assumes great importance only when it occurs often. Boredom and somnolence are usually unconscious talion responses in the analyst to a withdrawal or affective abandonment by the patient. This withdrawal has diverse origins and natures; but it has specific characteristics, for not every kind of withdrawal by the patient produces boredom in the analyst. One of these characteristics seems to be that the patient withdraws without going away, he takes his emotional departure from the analyst while yet remaining with him; there is as a rule no danger of the patient's taking flight. This *partial* withdrawal or abandonment expresses itself superficially in intellectualization (emotional blocking), in increased control, some-

times in monotony in the way of speaking, or in similar devices. The analyst has at these times the sensation of being excluded and of being impotent to guide the course of the sessions. It seems that the analysand tries in this way to avoid a latent and dreaded dependence upon the analyst. This dependence is, at the surface, his dependence upon his moral superego, and at a deeper level it is dependence upon other internal objects which are in part persecutors and in part persecuted. These objects must *not* be projected upon the analyst; the latent and internal relations with them must not be made present and externalized. This danger is avoided through various mechanisms, ranging from 'conscious' control and selection of the patient's communications to depersonalization, and from emotional blocking[19] to total repression of any transference relation; it is this rejection of such dangers and the avoidance and mastery of anxiety by means of these mechanisms that lead to the withdrawal to which the analyst may react with boredom or somnolence.

Countertransference anxiety and guilt feelings also frequently cause a tendency to countertransference submissiveness, which is important from two points of view: both for its possible influence upon the analyst's understanding, behavior, and technique, and for what it may teach us about the patient's transference situation. This tendency to submissiveness will lead the analyst to avoid frustrating the patient and will even cause the analyst to pamper him. The analyst's tendency to avoid frustration and tension will express itself in a search for rapid pacification of the transference situations, by prompt 'reduction' of the transference to infantile situations, for example, or by rapid reconstruction of the 'good', 'real' imago of the analyst.[20] The analyst who feels subjugated by the patient feels angry, and the

[19] This emotional blocking and, in particular, the blocking of aggression seems to be the cause of the 'absence of danger' for the analyst (the fact that the analysand does not run away or otherwise jeopardize the analysis), which seems to be one of the conditions for occurrence of countertransference boredom.

[20] Wilhelm Reich *(22)* stressed the frequent tendency in analysts to avoid negative transference. The countertransference situation just described is one of the situations underlying that tendency.

patient, intuitively perceiving this anger, is afraid of his revenge. The transference situation that leads the patient to dominate and subjugate the analyst by a hidden or manifest threat seems analogous to the transference situation that leads the analyst to feel anxious and guilty. The various ways in which the analyst reacts to his anxieties,—in one case with an attitude of submission, in another case with inner recrimination,—is also related to the transference attitude of the patient. My observations seem to indicate that the greater the disposition to real aggressive *action* in the analysand, the more the analyst tends to submission.

VII

Before closing, let us consider briefly two doubtful points. How much confidence should we place in countertransference as a guide to understanding the patient? And how useful or how harmful is it to communicate to the patient a countertransference reaction? As to the first question, I think it certainly a mistake to find in countertransference reactions an oracle, with blind faith to expect of them the pure truth about the psychological situations of the analysand. It is plain that our unconscious is a very personal 'receiver' and 'transmitter' and we must reckon with frequent distortions of objective reality. But it is also true that our unconscious is nevertheless 'the best we have of its kind'. His own analysis and some analytic experience enables the analyst, as a rule, to be conscious of this personal factor and know his 'personal equation'. According to my experience, the danger of exaggerated faith in the messages of one's own unconscious is, even when they refer to very 'personal' reactions, less than the danger of repressing them and denying them any objective value.

I have sometimes begun a supervisory hour by asking the candidate how he has felt toward the patient that week or what he has experienced during the sessions, and the candidate has answered, for instance, that he was bored, or that he felt anxious because he had the impression that the patient wanted to abandon the analysis. On other occasions I have myself noticed an-

noyance or anxiety in the candidate relative to the patient. These countertransference responses have at times indicated to me in advance the central problem of the treatment at whatever stage it had reached; and this supposition has usually been verified by detailed analysis of the material presented in the supervisory hour. When these countertransference reactions were very intense they of course referred to unsolved problems in the candidate, and his reactions were distorted echoes of the objective situation. But even without such 'intensity' we must always reckon with certain distortions. One candidate, for instance, reacted for a time with slight annoyance whenever his analysands were much occupied with their childhood. The candidate had the idea that only analysis of transference could further the treatment. In reality he also had a wish that the analysands concern themselves with him. But the candidate was able by analyzing this situation quickly to revive his interest in the childhood situations of the analysands, and he could also see that his annoyance, in spite of its neurotic character, had pointed out to him the rejection of certain transference situations in some analysands.

Whatever the analyst experiences emotionally, his reactions always bear some relation to processes in the patient. Even the most neurotic countertransference ideas arise only in response to certain patients and to certain situations of these patients, and they can, in consequence, indicate something about the patients and their situations. To cite one last example: a candidate, at the beginning of a session (and before the analysand, a woman, had spoken), had the idea that she was about to draw a revolver and shoot at him; he felt an impulse to sit in his chair in a defensive position. He readily recognized the paranoid character of this idea, for the patient was far from likely to behave in such a way. Yet it was soon clear that his reaction was in a certain sense appropriate; the analysand spontaneously remarked that she intended to give him 'a kick in the penis'. On other occasions when the candidate had the same idea, this patient was fantasying that she was the victim of persecution; in this case also the analyst's reaction was, in a way, appropriate,

for the patient's fantasy of being persecuted was the consequence and the cause of the patient's sadistic impulses toward the transferred object.

On the other hand, one must critically examine the *deductions* one makes from perception of one's own countertransference. For example, the fact that the analyst feels angry does not simply mean (as is sometimes said) that the patient wishes to make him angry. It may mean rather that the patient has a transference feeling of guilt. What has been said above concerning countertransference aggression is relevant here.

The second question,—whether the analyst should or should not 'communicate' or 'interpret' aspects of his countertransference to the analysand,—cannot be considered fully here.[21] Much depends, of course, upon what, when, how, to whom, for what purpose, and in what conditions the analyst speaks about his countertransference. It is probable that the purposes sought by communicating the countertransference might often (but not always) be better attained by other means. The principal other means is analysis of the patient's fantasies about the analyst's countertransference (and of the related transferences) sufficient to show the patient the truth (the reality of the countertransferences of his inner and outer objects); and with this must also be analyzed the doubts, negations, and other defenses against the truth, intuitively perceived, until they have been overcome. But there are also situations in which communication of the countertransference is of value for the subsequent course of the treatment. Without doubt, this aspect of the use of countertransference is of great interest; we need an extensive and detailed study of the inherent problems of communication of countertransference. Much more experience and study of countertransference needs to be recorded.

[21] Alice Balint *(1)*, Winnicott *(24)*, and others favor communicating to the patient (and further analyzing) certain countertransference situations. Heimann *(11)* is among those that oppose doing so. Libermann *(14)* describes how, in the treatment of a psychotic woman, communication of the countertransference played a very important part. The analyst freely associated upon unconscious manifestations of countertransference which the patient pointed out to him.

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THE ROLE OF NARCISSISM IN MORAL MASOCHISM

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Masochism has been identified clinically in three forms, as a sexual perversion, or a neurosis, or a character disorder. It poses many clinical and theoretical problems, such as the existence of a death instinct, the unconscious sense of guilt (need for punishment), and the need to fail. The need to fail often produces negative therapeutic reactions among patients. Because of its apparent negation of the pleasure principle and the self-preservative function of the ego, it strikes the casual observer as peculiarly ego alien.

Freud's study of The Economic Problem in Masochism (1924) opened the way for investigation of the manifestations, dynamics, and economics involved *(6)*. He divided masochism into three forms: 1, erotogenic: a condition which arouses sexual excitation; 2, feminine: in which men seek submission to being bound, beaten, defiled or degraded, which unconsciously represents the man's distorted acting out of what he considers the feminine sexual role of being castrated, forced into sexual submission, and giving birth; 3, moral: a sense of guilt that is for the most part unconscious. Early psychoanalytic efforts to understand masochism emphasized its libidinal aspects. Recently, attention has been directed to the defensive functions of masochism and the attempt to maintain object relationships through masochism *(2, 9, 10, 12)*. Oral deprivation has been considered particularly important in the genesis of masochism by Jekels and Bergler *(11)*. Eidelberg *(4)* paid special attention to narcissistic mortification which is defended by masochism. Brenman *(3)* comments on the incompleteness of our understanding of masochism and suggests that it be considered as a complex configuration specifically designed not to encompass primarily an unconscious need for punishment, but to maintain a balance between primitive libidinal and aggressive drives and defensive and adaptive measures.

CASE I

A thirty-one-year-old unmarried woman was the natural child of a couple who ultimately eloped and married against the wishes of the paternal grandmother. The husband was promptly disowned for marrying below his station. When the patient was two years old, her parents separated and she was given to her paternal grandmother who later adopted her. The patient related that her mother would read magazines and leave her hungry, wet, and crying until her father came home. This was probably based on stories from her grandmother. Her mother visited her once about a year after her placement with the grandmother and then was not heard from again. The relationship with the grandmother was a very close one, the little girl being coddled and taken everywhere by her grandmother. During the child's latency and adolescence she attempted to rebel against her grandmother's efforts to maintain the closeness of their relationship. The child's rebellious outbursts were followed by tremendous feelings of guilt and tearful reconciliations. When she was six years old her father again married someone below his 'social class'. When she was ten years old, her father died of intestinal cancer. He had visited her from time to time until she was about nine years old.

Her grandmother died when the patient was twenty-one years old. Consciously, she felt considerable relief since the responsibilities of the care of her grandmother during the terminal phase of her illness were very burdensome. At the age of twenty-six, she had an affair with a man of forty-five who treated her so badly that she was practically always in tears. Shortly after terminating this relationship she began an affair with a man of her own age. At the outset she was 'wary of revealing herself' and 'kept it gay', afraid of showing her interest in him to the extent of not answering his letters and failing to keep an appointment with him. Later, he took her to visit his family but 'was cold to her' and told her that he feared she would fall in love with him. Tearfully, she described: 'I cried. I'm sure he enjoyed that very

much. I realized then I didn't even like him. It tore me to pieces. I always thought nobody could possibly love me anyway, but didn't want it confirmed.' Similar instances of being abused and rejected were successively experienced in relationships with her employers. In the transference, a sequence of initial anxious expectation of 'being made a fool of', timid confessions of erotic interest, followed by angry denials and bitter, tearful disappointment ending in frigid contempt, was repeated over and over again.

The patient's castration complex was intense. She related it to an incident at the age of four when she tried to urinate standing, in imitation of a little boy. He also stimulated her genitals, and she had an orgasm followed by great fear and guilt. She was later rejected by this boy. She linked this experience to her feelings of social inferiority for which she blamed men. Her œdipal disappointment and sense of rejection were thus, as Fenichel *(5)* and others have noted, patterned on the pregenital antecedents of oral deprivation, abandonment by a neglectful mother, and the narcissistic injuries of feeling helpless and castrated. Her reaction was to develop tremendous hatred of men with very strong castrative impulses accompanied by great guilt and fear. She would arrange to be rejected and the renewed disappointment and narcissistic injury would lead to her repeated avowals that she would never again let a man make a fool of her. Unconsciously, this was a repetitive acting out of her experience with the little boy. Crying represented a displacement of urinating like the boy; it was also an appeal for comfort and love from her grandmother. As Freud stated, 'the real situations are in fact only a kind of make-believe performance of the fantasies'.

In recapitulating the early development of the instinctual drives in this patient, it could be seen that the oral and phallic exhibitionistic strivings were particularly marked. The strong oral attachment to the grandmother was frequently expressed in dreams:

> I was afraid I would be delayed coming here. People were on a terrace; they ignored me. Water was coming up higher all

around. I climbed up on a brick wall, holding on to a chimney; I felt secure there.

The preceding night she had been in a theater and had 'bumped up against women who felt soft'. She commented that she never liked dancing with girls because of their breasts. Her grandmother had had big breasts. The chimney in the dream represented the grandmother's breasts where she felt secure. Wishes to suck, bite, and incorporate occurred in dreams and fantasies. The grandmother had stimulated her anal eroticism by the insertion of suppositories and by a considerable interest in all of the child's bathroom activities which later included menstruation. Her general cutaneous eroticism was heightened by the grandmother's frequent fondling, petting, and bathing.

The phallic fixation revolved around the memory of mutual exhibition and being genitally stimulated by the little boy. Many fantasies contained the wish to be able to display a penis. The wish to have the male undress her and expose her was later directed toward her father. It was strongly defended by the conscious fear of being humiliated by having the man see or touch her genitals and discover how she was 'made'. During latency, she had fantasies of being undressed, of exposing her breasts, and having them fondled: clearly a breast-penis equation.

Subsequently, these fantasies became more masochistic. This trend was aided by her grandmother who repeated to her all the local gossip of marital discord, and incidents of rape reported in the newspapers. The girl had fantasies of being torn to pieces, cut and split apart. These were linked to fantasies of prostitution, of becoming pregnant and being abandoned by the man. The identification with her mother and her father's second wife played an important part here. Fantasies of oral impregnation accompanied by oral castrative wishes expressed the wish for a child which was equated with a penis.

She would imagine that she was married, was pregnant every year, and was nursing a baby as her husband drove their car. Clad in beautiful nightdresses and robes, she was very attractive. She dreamed:

> I bit into a piece of fudge; the outside was hard and good; then the inside poured out. I felt uncomfortable and wanted to hide it. Then I was with Aunt D who talked in a constrained, polite way. I said she had a nice house but that the front and back opened on a street; other houses are back to back.

Her first association was to an embarrassing and painful menstrual experience connected with the aunt. Further associations, however, led to her great fear of taking a penis in her mouth.

> In another dream she was going with J, a man, to buy some flowers for M, a woman, who was going to England. The man was going to get gladioli which she hated, but he was in charge. 'Then', she said, 'I was at the florist wearing a cotton dress with a full skirt that was covered with blood. I had to take care of that without letting J know. I tried to find the ladies' room. I grabbed a woman to ask her. I put a shawl, which grandmother had used as a stole, around me. I found myself back with M and J and I felt like a little girl.'

Feeling like a little girl was as she had felt during her two love affairs. The shawl was connected with her grandmother's possessiveness and prying curiosity which had enraged her.

As a defense against the positive œdipal wishes, this patient sought, by demonstrating that she was castrated and suffering, to be loved, fed, comforted and taken care of. After describing a married woman whose husband mistreated his wife, she reported the following dream:

> My friend had lost her job. Her husband tried to comfort her. She was crying. I then tried to call Jean (another friend). She was working next to me. I hadn't realized she was so near.

'I don't know', she commented, 'why I want to cling to the idea that men mistreat women'. The dream gave the answer that she clung to women for comfort and protection from abandonment. In another dream she was with a woman, a friend from childhood:

> My feet were in the gutter. A car ran over the big toe of my right foot—not badly. I kept my feet there and a car did it

> harder, really injuring me. I was pleased. It didn't hurt. I was physically injured but not suffering. I went home to show it to grandmother. I thought she was going to be angry because I had left her. I wanted to go to the hospital, thinking if I showed her I had been hurt she would not be angry.

The first part of the dream was a denial of her fears of being sexually injured. She was also fearful that her grandmother would be angry with her if she became sexually interested in a man, and would disown her as she had the child's father. In being castrated and clinging to the woman, she unconsciously became the woman's phallus, as indicated by the following dream: 'I was holding a little bird. I gave it to Jean who was on a pedestal.' To this her association was that she was Jean's 'stooge'.

These fantasies were combined in a rather elaborate way to provide a mixture of masochistic sexual gratification without forfeiting the infantile oral gratification to which she clung. To begin with, the man degraded and humiliated her according to her distorted conception of genital sexuality as an assault. When in the transference she said she had not understood something which was then explained, she nevertheless felt that I was irritated and was saying 'Don't be so stupid'. She shed some tears and fantasied that she said, 'You're so mean to me'. All this was pleasurable to her. During the same hour, she reported what she described as a 'horrible dream'.

> She was removing some blood-soaked tampons. Then she was with some woman. Two men were talking to each other, one holding a small pad and wearing some sort of hearing device. The other man, in a grey suit, was whispering; he couldn't talk. Suddenly, his voice became loud. He wanted to celebrate and asked, 'Will someone have a drink with me?'. She felt very sympathetic and decided to comply if nobody else would. Then a little, plain, grey-haired old lady said, 'I will have a drink with you'.

The man with the pad was identified as the analyst, the other man as the dreamer. The dream indicated that her genital desires were becoming stronger, thus intensifying the struggle

with her superego which permitted only disguised masochistic gratifications or regressions to oral satisfactions. After the man degraded and humiliated her, her superego relented and permitted restoration of her early relation with her grandmother.

The following day she reported a dream after tearfully telling me she had felt very foolish the day before.

> You were talking to someone else. I was inside the door lying on the floor. Not noticing me, you had one foot up in the air and put the other foot down, stepping on me.

Her feelings of hopelessness now were similar to those she had had during the two times she had had affairs and felt hopeless. She believed I was like her grandmother who had felt the others were right. She decided that there were some things she would not tell me about her boss until I had admitted that he had behaved abominably. In this way, she felt she would be cleared of responsibility. In the past, this procedure also provided the grandmother with the sexual pleasure of hearing about the mistreatment of the patient, as the grandmother had stimulated her as a child by recounting such stories about others. She not only identified herself with her grandmother, but felt that her body, including her genitals belonged to her grandmother. The following dream illustrates this:

> She is inside an elevator. Grandmother's patchwork is on the seats. People come in and sit on it. Men, one of whom she recognizes, put their dirty feet on it.

She is reminded of early screen memories regarding sexual curiosity. Parts of her body belonged to her grandmother and were not for the patient to touch or for men to soil.

In summary, as a result of severe early deprivation, this patient had subsequently strongly dependent attachments to a mother substitute, marked feelings of castration, and an easily injured narcissism. She experienced her œdipal disappointment as an overwhelming rejection, a repetition of the earlier neglect by her mother. Her response was to repeat, in masochistic fash-

ion, the disappointment and rejection by men and to regress defensively to her relationship with a protective woman, represented by her grandmother.

CASE II

A second patient was a forty-five-year-old woman who was the second child with three brothers. Her feelings about her brothers were epitomized by her remark, 'I told mother that she made one mistake when I was born'. Her hostility toward her younger brother was very great and she subsequently displaced much of this to her own three children, all boys.

Her relation to her father, a professional man, was ambivalent although she was really much attached to him and admired him. From adolescence she had bitter arguments with him and expressed violent hatred of him. She identified herself with his intellectuality and imitated him in her anxious, overprotective, rigidly controlling attitudes toward her children, commenting that she was doing with them what her father had done with her in warning them about possible accidents, worrying if they were not home exactly on time, making the simplest decisions and choices for them. She was constantly talking and frequently shouting at them. She talked a great deal about them with feelings of pride, possessiveness, concern and guilt about her behavior toward them, which she frequently recognized as being sadistic.

During her years in college she was awarded fellowships, and she established a close protected relationship with the chairman of the department of the subject in which she majored and which she later taught. She was considered to be aggressively masculine in her manner and relatives commented on her resemblance to her father. She did not marry until after her father's death when she was thirty-two years old. The year preceding his death she had managed to take an apartment for herself, a move which her father opposed vigorously and which her family said contributed to his death. Ostensibly she married the first man she met after

her father's death, but this man made it clear from the outset that his work took precedence over everything else, thus duplicating the situation with her hardworking, overconscientious father.

Between her fourth and fifth years, she had her tonsils removed. Her father 'fooled' her by bringing in two men who forcibly restrained her while the operation was performed. This early trauma established a great fear of being attacked from behind. When her husband approached her sexually in this manner, she would first be very angry, then become motionless and inert.

This woman suffered from severe osteoarthritis of her knees from which her father had also suffered. She disregarded medical advice to limit her activities and use braces or crutches for support, although she often complained of excruciating pain and, at times, limped badly. Although greatly concerned with her appearance, she dressed in what she termed 'sloppy' clothes. Her masochism was further evidenced by her failure to complete the thesis which was the last requirement for her doctorate. This was a repetitive compulsion. She would take a course, do well in the work, be advised that she showed promise and aptitude in the subject, and then drop it completely. 'I would go up to the end', she said, 'and then it was like taking a sledge hammer to destroy it'. She severely criticized herself for her mistakes in handling her children and blamed herself for causing their emotional difficulties, especially those of her oldest son.

She was closely attached to her mother whom she invited to live with her after the father's death. The mother continued to do the shopping, cooking, and entertaining until, after several years of analysis, the patient was able to maintain her own household and have her mother live elsewhere. The patient was demanding, jealous, and resentful of her mother. She envied her mother's charm, activity, and competence.

This woman's defense against her erotic attachment to her father was to establish a strong identification with him. Her phallic fixation was a severe narcissistic injury which made her

keenly aware of her physical appearance, and her castrative competitive feelings toward men made her feel guilty and anxious. When her father died she made amends by marrying a man like him to whom she felt subjugated. An additional mode of reparation and reaction-formation was a masochistic compulsion to fail in her competitive intellectual (phallic) strivings. Her ambivalent attachment to her mother was defensively regressive.

CASE III

The third patient, a man of twenty-four, a borderline psychotic, intellectually superior, sought analysis because of failure in his studies in college. He was the middle child, with a brother two years older and a sister four years younger. He remembered himself as having been a quiet child, inclined to play alone and fantasy a great deal. He had always been afraid of his father, a successful financier who had very little time for his children. He described his mother as artistic and gentle. He was closely attached to her and identified himself strongly with her in contrast to his father and his brother who were 'doers without imagination and sensitivity'.

From early childhood he rolled his head in bed with fantasies of being a marching, conquering hero. Masturbatory fantasies were about women being tortured by being dipped in feces, being hit, or having explosions in their genitals. Unconsciously, he identified with these women, occasionally smeared himself with feces, and once inserted a firecracker in his anus and exploded it.

The birth of his sister was experienced by him as a tremendous rejection because the mother was so fond of the little girl. He believed she had wanted a girl instead of him. Added to the injury was the fact that during her pregnancy his mother left several times to take care of her mother who had had a series of 'strokes'. He and his brother were taken care of by a strict and severe governess; although seething with rage, he remained docile. Latency was a relatively happy period for him. Separations

from home to go to camp and later to boarding school were very painful and depressing. He pleaded to return home but was persuaded to stick it out. He did well in his studies although he found it hard to concentrate. His mother developed severe hypertension when he was twelve years old. She became progressively worse, had an operation, became weak, confused and childish in her behavior, and died when he was sixteen years old. The next year the patient entered college, and did very well although with great effort. To his surprise, he was awarded a prize in English. The following year he failed and had to leave college.

This man suffered from marked feelings of physical inferiority because he was fat and flabby. He was much concerned and very critical about his appearance being unsightly and unattractive. From this he retreated into day dreaming. His disappointment at the birth of his sister was a rejection not only of his maleness but of his wish to be like his mother. His reaction against his aggression was to become even more passive and to strengthen his feminine identification with passive masochistic fantasies underlying manifest sadistic ones.

THE ROLE OF NARCISSISM

The first case was a woman moderately pleasing in looks. She placed special emphasis on clothes, on her appearance, and how she impressed people. It was possible to demonstrate that her feelings of being ugly or unattractive were usually a reflection of feelings of castration, and that these feelings were more intense just preceding menstruation.

The second woman was concerned with the appearance of her hair, her breasts, her face, and most especially her legs which were affected by a deforming chronic arthritis. She felt acutely self-conscious about her gait and was intensely envious of women with straight legs. Her childhood ideal had been to be a brilliant and beautiful actress. She worried about the possibility that her fingers and shoulders would become arthritic.

The male patient was greatly preoccupied with his appearance, especially with being overweight. He made unsuccessful efforts to diet because he reacted to any frustration or disappointment with compulsive eating. He was particularly interested in his bearing, and moved with a ponderous stiffness. He was impressed with his high forehead which was further heightened by his receding hairline. Frequently, he commented about the clothes he was wearing, particularly when they were not very clean as was often the case. Hypochondriacal concern was expressed about his stomach in the form of burning sensations, fullness, and flatulence. He was acutely anxious about a nonspecific urethritis, and was excessively worried about recurrent skin eruptions.

The early object relations and subsequent object choices of these patients are of interest. The first was very strongly attached to her grandmother who, in turn, felt very close to the little girl. The grandmother took great pride in the child's neatness, bathing her until the girl became adolescent and was infuriated at the grandmother's attempts to continue this practice. The grandmother took great pleasure in telling her friends that the girl was 'not boy crazy'. The girl was very devoted to her grandmother, would telephone to tell her where she was, and later give a detailed account of what she had been doing during absences of even a few hours. She felt compelled to tell the grandmother details about 'dates' and parties even though she knew her grandmother would make her feel 'awful'. There were repeated quarrels and tearful reconciliations.

This woman attached great importance to her grandmother's social position, and was very proud of her father's physical attractiveness to women. She chose men on the basis of their physical appearance (narcissistic types) and became quickly infatuated and soon disillusioned. Of a man in whom she became momentarily interested during a party, she remarked, 'He served his purpose: someone I was interested in so I could enjoy the party'. She unconsciously evaluated the man simply as an appendage to her damaged body image, or herself as an appendage to the man,

because she had felt herself serving only as an instrument for the gratification of her grandmother's needs. She likewise felt her grandmother had no existence apart from her.

The second patient particularly admired her father's intellect. He encouraged the girl's intellectual interests in every way, including sending her abroad to study. 'Father', she said, 'made up his mind when I was born: "A girl", he is reported to have said, "should be a teacher".' He disapproved of her relationships with young men. He would engage her beaux in serious conversations and by this and other maneuvers succeeded in driving them away. He frightened her with stories of rape, concluding with the maxim: 'Inside the house you are safe'. Her stated reaction, 'Father practically made a man out of me', indicated her father's success in suppressing her femininity. The unconscious idea that being a woman is the equivalent of being castrated, whereas remaining a little girl is safely remaining the paternal phallus, is suggested if not directly expressed, and acted out in her reaction to motherhood by her inability to complete the thesis for her doctorate. Her anxious concern and tremendous convictions of guilt that she had damaged her children, particularly her oldest boy, stemmed directly from associations in which this boy represented her damaged phallus. Her male objects represented her narcissistic masculine ideal of herself. One, with whom she had a romance, was a handsome young man who was vain and dependent. The relationship was terminated under the pressure of his mother's objections. Her impulsive marriage, soon after the death of her father, was to a man who had little capacity for mature object relationships. That he utilized his work as a rationalization for his neglect of her was the cause of many quarrels between them. Sexual relations with her husband frightened her and she avoided them. Despite her unhappiness, she was terrified of being abandoned by him although he provided little more than the income with which to maintain the home. The patient sought friendships with women whom she admired and envied, and felt terribly hurt and angry when they could not show the unflagging interest in her that she sought

from them. At times she would acknowledge, 'What bothers me is that I am so interested only in myself'. Another time she declared, 'I don't recognize any self. I have to "latch on" to other people—do what they do or others do—as if there were no such thing as what I do.' Here is quite openly stated the blurring of ego boundaries and the merging of her psychic representation of herself with a child or a friend, as she had been with her father *(10)*. She was often told that she was just like her father, a remark that would enrage her in later years.

The third patient had a great admiration for his mother's artistic sensitivity and her popularity. He recalled that she would read him stories of the heroic feats of legendary characters, and he imagined himself as a conquering hero, accompanying the fantasies with rolling of his head from side to side. The birth of his sister proved to him that his mother wanted a girl instead of him; later it also destroyed for him the fantasy that his mother was too pure to have sexual relations with his father. All this was an avoidance of his rivalry with his father whom he feared and envied. The father was reserved and prudish, and their arguments led him to the conviction that his father was stupid and unimaginative. The father naturally preferred the older brother who was aggressive and energetic. Toward his friends, the patient maintained a distant and critical attitude, a good deal of his time with them being spent in telling them about his difficulties and asking them for advice which he disregarded. His interest in women was primarily sexual and intended to demonstrate his potency. With the prostitutes he picked up in bars, he was unsuccessful, feeling disgusted and frightened. When later in treatment he achieved a physical potency in such relationships, they were without much pleasure. He was afraid of any total involvement with a woman and broke the relationship whenever he felt she was becoming too interested in him.

It can be seen from the above descriptions that these patients were primarily interested in themselves—their appearances, their physical conditions, how they looked or sounded to others—and

their relationships with others were governed by their attempts to gratify such narcissistic needs.

In Freud's paper, On Narcissism: An Introduction (1914), he states:

'A person may love:

(1) According to the narcissistic type:
  (a) What he is himself (actually himself).
  (b) What he once was.
  (c) What he would like to be.
  (d) Someone who was once part of himself.

(2) According to the anaclitic type:
  (a) The woman who tends.
  (b) The man who protects; . . . .'

The patients here described were loved or felt loved predominantly according to their narcissistic fixations and the resultant strivings.[1]

During their early years these patients' body attributes and ego functions were made to serve the parental narcissistic and partial instinctual drives. Their successes were therefore not their own but their parents' achievements, and they were robbed of the ego gratifications that might otherwise have been derived from being encouraged to accomplish something for themselves.

Nunberg *(13)* described a masochistic patient who stated, 'My mother always decided for me what I should do'. Menaker *(12,* p. 211*)* described her patient's relationship with her mother: 'She had been the possession, the extension, the tool of her mother

[1] Hartmann *(9)* calls attention to the fact that the concept of narcissism requires further definition and synchronization with more recent psychoanalytic concepts. Freud described narcissism as the cathexis of the ego with libidinal energies. If this is extended to include aggressive energies, then the closeness of the tendency of the individual to inflict pain on himself (masochism) and the tendency to love himself (narcissism in the earlier sense) becomes apparent metapsychologically as well as clinically.

from the beginning of life'. The consequence for many children so conditioned is that failure and defeat become triumph in childhood, and a repetitive compulsion in adult life. Such a reaction is expressed in the transference when a patient (Case III) declares, 'You are trying to cure me; you want me to get better'; which may be paraphrased: 'You are seeking to get the credit for making me well; not for my benefit!'. Unconsciously, therefore, this spiteful narcissistic defiance is a self-injurious contest for power which contributes substantially to a negative therapeutic reaction in such cases. The parents of the first two cases demanded that the child gratify its instinctual needs in accordance with their determination which excluded genital maturity.

These observations do not minimize the importance of aggression in the genesis of masochism. The significance of the guilt evoked by intense aggression toward the parents and the part that this plays in the need to fail are sufficiently well known.

DISCUSSION

Part of the child's primary narcissism is ordinarily gradually transformed into object love and contributes to the formation of an ego ideal *(7)*. The renunciation of complete narcissism occurs when the child is loved by mature adults in accordance with the child's needs *(8)*. If, however, the child is made to serve the highly narcissistic needs of the parental objects, the child regresses to its own narcissistic satisfactions whenever the object becomes disappointing, i.e., cathexis of the object is interfered with.

From earliest childhood these patients had reason to feel they were instruments of their parents' narcissistic needs. Such relationships lead to defective development of the ego, abnormally dependent (symbiotic) parental ties, and strong oral fixations or regressions. Under conditions of actual or threatened loss, introjection of the object takes place, with a merging of the images of self and the ambivalent object.

The œdipal disappointment is felt both as a narcissistic and oral trauma with feelings of loss, helplessness, and rage. The tremendous access of aggression threatens the ego with destruction of the object representations. The combination of the heavy investment of narcissistic libidinal cathexis with the weakness of the ego prevents adequate neutralization of aggression, leading to regression. Renewed introjections of the object occur, followed by regressive splitting of the object and the ego representations, accompanied by defusion of feelings of love and hate, aggression and submission. The object representations and ego representations are split into 1, the idealized, good parent-child with all of the love and aggression embodied in the superego; 2, the bad parent-child with all of the hatred and devaluation directed toward it as the object embodied in the ego. As the superego becomes more aggressive and sadistic, the ego becomes correspondingly submissive and masochistic. In this manner, the child-parent relationship is regressively restored.

In resolving the œdipal conflict, the child resorts passively not only to the same methods it employed to resolve pregenital conflicts *(5)* but, in an active way, also what it has experienced as the object of the parental narcissistic and sadistic attitudes toward it.

What follows in the world of reality consists of a repetitive compulsion to repeat the original narcissistic trauma of disappointment, rejection, and humiliation. It is progressively experienced, however, with increasing conviction as a result of the unconscious connivance of the individual. It becomes also a source of a sense of power and gratification, rather than of helplessness, as it becomes the fulfilment—for want of a better one—of his own libidinized masochistic fantasy. The last process, the externalization, is analogous to the secondary efforts at recovery designed to lead the libido back toward an object *(7)*. The sequence may thus be summarized schematically: 1, imposition of narcissistic and oral attachments followed by 2, exaggerated disappointment with feelings of helplessness, loss, rage, and sadomasochistic fantasies, leading to 3, endopsychic restoration

of the object relationships through introjection with splitting, and 4, externalization of the fantasy with efforts through repetition to master the trauma and to restore the lost object. Viewed in the light of the foregoing, the acting out of these fantasies in masochistic behavior may be considered to be, in part, a defense against the traumatic feelings of loss, helplessness, annihilation, or castration.

It may be noted that the dynamic formulations for masochism are, to some extent, the same as those for depression: introjection of the object and a regressive splitting of the object and self-representations into the idealized good parent-child with all of the love and aggression embodied in the superego and the bad parent-child with all of the hatred and devaluation directed toward it as the object embodied in the ego *(10)*. Clinically, all three of these patients had periods of depression; possibly their masochism helped to avert even more severe depression.[2] It is possible that masochism may occupy a mid-position between depression and paranoia. When the ego employs more introjection, the masochist becomes more depressed; if the mechanism is more projective, he will become more paranoid. This does not mean that the only difference between depression and paranoia is the greater degree of introjection or projection as defense mechanisms.

SUMMARY

Excerpts from the analysis of three patients are presented to illustrate some genetic, dynamic, and economic aspects of narcissism in the genesis of moral masochism. They were children of a narcissistic parent or parents to whom they became ambivalently, helplessly dependent. The child's body attributes, ego functions,

[2] A patient described by Brenman *(3)* as a masochistic 'court jester' began to make suicidal attempts when she became more seriously ill and developed paranoid attitudes. Bak *(1)* describes the projection of sadism as the fourth step of defense: 'It is the paranoid mechanism proper and it is a restitution'. In my own formulations, masochism externalizes the fantasy of being mistreated. What I think *partially* differentiates the masochist from the paranoiac is the degree of projection.

and instinctual drives were in the service of the parental narcissism and immature instinctual drives. They were unable to differentiate the boundaries of their own egos from the influences of the important parent. Œdipal disappointment was dealt with in the same manner as the pregenital trauma of separation or loss—by introjection of the object and regressive splitting of object and self-representations with defusion of libidinal and aggressive feelings. The superego became the sadistic idealized parent-child while the ego became the hated devalued parent-child. In this endopsychic manner, the child-parent relationship is regressively restored. Masochistic relationships in adult life are repetitive re-enactments of such childhood experiences and fantasies in which the patient has the illusion that he actively controls the situations which he once passively endured.

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Penelope's Character

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PENELOPE'S CHARACTER

BY GEORGE DEVEREUX, PH.D. (NEW YORK)

It is well known that even so early a literary critic as Aristarchus[1] rejected lines 218-224 of the XXIII Book of the Odyssey because to him they seemed out of place. This view is echoed so consistently even by modern scholars that W. D. H. Rouse omitted these lines from his recent, and otherwise excellent, English translation of the Odyssey.

The lines that have been challenged occur in the following context. Penelope halfheartedly pretends to accept the true identity of Odysseus, but tests him once more by instructing Euryclea to move their bed. At this point, Odysseus, according to Rouse, speaks for the first time impulsively, and explodes in anger over the possibility that someone may have cut down the olive tree which was one of the bedposts, thus altering the bed and making it movable. The fact that the bed was originally not movable was a secret between Odysseus and Penelope.[2]

It is hardly necessary to stress that Odysseus' anger over the possibility that someone may have tampered with his marriage bed—his first impulsive outburst of feeling in the entire Odyssey —must be interpreted, *lato sensu*, as signifying a suspicion of infidelity. This incident explains Penelope's earlier, cryptic remark to Telemachus that she would certainly recognize the real Odysseus because he and she had certain secrets which no one else knew—a transparent enough allusion to the secrets of the parental bedchamber, carefully hidden from the son.

Odysseus' outburst convinces Penelope of his identity. She

An application of psychoanalysis to the philological problem of lines 218-224 of Book XXIII of the Odyssey.

1 Aristarchus of Samothrace: Greek grammarian and critic who died about 150 B.C.

2 Compare in this context (Book XXI) the scene where Odysseus examines his great bow, fearing that worms may have gotten into it. Note also, in Book XXII, that Laertes' shield was covered with mold and dirt, and that it was coming apart at the seams.

rushes to him, embraces him, and asks him to show himself full of understanding for her reluctance to recognize him at once. She carefully explains that her heart was frozen all these years because she feared being deceived by some impostor pretending to be him; in other words, to protect her chastity and marital fidelity she had to numb her heart. In the world's literature, one could scarcely find a more explicit description of a reaction-formation against the sexual desire which would tempt a lonely woman to accept an impostor as her husband.[3]

It is at this point that the lines disputed by literary critics since the time of Aristarchus occur. Penelope states that it is in this manner that the first unhappiness of her married life came about. She declares that it was not Helen's own imagination which caused her to invent the tragic folly of having an affair with Paris. It was a god who tempted her to go astray. Helen would not have done it had she known that the Achaian warriors would in the end take her back to Sparta. The allegedly questionable lines end at this point. Penelope then declares that she has been convinced of Odysseus' identity by his obvious knowledge of the secrets of their bed, which is a euphemism for his awareness of their sexual habits.

Contrary to the traditional view, it is our thesis that these lines are a stroke of genius on the part of Homer and occur at just the right place and in the most effective manner. The 'higher criticism' of professors of philology in this—and perhaps in many other instances—is understandable only in terms of their prejudices and preconceptions which prevent them from grasping the full scope and intuitive perception of the creative writer.

The allegedly questionable lines do not, as a matter of fact, seem to fit the context only if one presupposes that Homer in-

[3] Compare the case of Bertrande, wife of the French peasant Martin Guerre, who, after her husband went off to the wars and did not return, accepted 'in good faith' an impostor as her real husband, and did not begin to suspect him until she became pregnant by him, that is, only after he had gratified her sexual needs. This is an authentic instance which was recently made into an opera by William Bergsma.

tended Penelope to be strictly an incarnation of wifely perfection—as indeed he seems to do in his formal utterances. The psychologist poet Homer, however, sensed that Penelope was a woman with all the needs and notions of her kind. He therefore chose, with consummate skill and taste, to present another aspect of Penelope in a wholly different manner by citing the derogatory remarks of some 'obviously prejudiced persons', by means of a dream, and by a device of the plot which revolves around Penelope's failure and reluctance to recognize Odysseus. Let us examine Homer's three devices for describing the hidden aspect of the supposedly ideal wife, Penelope, in detail.

When the suitors are publicly challenged for their misbehavior (Book II), the chief suitor declares to the people of Ithaca that Penelope herself is at fault. She has, he says, subtly induced many men to become her suitors so as to acquire fame—as indeed she succeeded in doing. Let us now note in passing that it is the name, Clytaemnestra, and not the name, Penelope, which means 'famous for her suitors'; yet it was not Clytaemnestra—who was satisfied with giving herself to one ambitious lover—but chaste Penelope who became famous for her many suitors; 'chaste Penelope' whom the Odyssey supposedly describes as the polar opposite of Clytaemnestra—or so classicists tell us. But does the Odyssey actually define Penelope as the genuine opposite of Clytaemnestra? In Book XI of the Odyssey, in that 'Naukya' which some classicists also view as a possible interpolation since they can see no reason for its content or its place in the plot, the shade of the murdered Agamemnon speaks ill of all women, which of course is understandable. He also warns Odysseus against trusting even the chaste Penelope too far, though he pays her some dubious and purely *pro forma* compliments. The philologists ask us to disregard these utterances as being expressions of an understandably biased Agamemnon's posthumous misogyny.

Let us comply with these appeals to our credulity, and let us disregard the suitor's accusations and Agamemnon's barbed compliments. Let us assume that these two sets of statements cast

light not upon Penelope's character, but upon the personality of the suitor, whose attitude can be colloquially described as 'sour grapes', and upon the personality of the angry and embittered shade of Agamemnon. Let us also assume that Telemachus' strange coldness toward his mother—his readiness to see her married to someone else, provided that she first returns to her father's roof, renouncing her claim to Odysseus' estate—is due to his Hamletlike ambivalence, rooted in his œdipus complex. Like Hamlet, he is incapable of punishing the suitors, because he unconsciously identifies himself with them.

Let us turn instead to the plot itself, to the second indirect and brilliant literary device which Homer used for highlighting Penelope's real character and ambivalence. We will choose at random two incidents, both of which are motivated by the deepest layers of the unconscious.

The Odyssey reports (Book XIX) that Penelope dreamed her geese were destroyed by an eagle; this caused her to cry in the dream. Professor Dodds, in his magnificent work,[4] states that this dream has been generally held to be 'out of character' and a 'blemish' in the psychological plot of the Odyssey. Since Professor Dodds is too psychologically sensitive a scholar to be misled by such statements, he tried to interpret this dream as representing an 'inversion of affect'. His perceptiveness in recognizing that this dream had to make sense and his attempt to get at the real meaning and literary function of this dream (instead of parroting the 'truism' that it is 'inappropriate') by appealing to psychoanalysis deserve the highest praise. Indeed, as the mathematician, Georg Cantor, pointed out, it is more important to ask a question correctly, than it is to solve it. Professor Dodds identified the problem and suggested that the psychoanalytic frame of reference should be used in solving it.

Penelope's dream cannot, however, represent an inversion of affect, since such an inversion of affect in dreams occurs only when the wish is ego dystonic and contrary to the accepted cul-

[4] Dodds, E. R.: *The Greeks and the Irrational.* Berkeley: University of California Press, 1951.

tural norm. Obviously the chaste Penelope could be expected to rejoice over the destruction of the geese—specifically stated to represent the suitors—by the eagle, which is specifically equated with Odysseus; therefore her tears cannot represent an inversion of affect, but must represent real affect.[5] In fact, it is hard to understand how literary critics could have overlooked the obvious fact that a rapidly aging woman, denied for some twenty years the pleasures of sex and the company and support of a husband, would inevitably be unconsciously flattered by the attentions of young and highly eligible suitors, which is precisely what the chief suitor accuses her of in public. We therefore believe that Penelope cried over her geese for the simple reason that unconsciously she enjoyed being courted though the suitors were probably more interested in inheriting Odysseus' kingship by marrying his widow, than in her fading charms.[6]

The second element of the plot to be considered is Penelope's tardiness and overt reluctance in recognizing Odysseus. She justifies this in the passage preceding the lines questioned by Aristarchus and his successors as a means of protecting herself against the risk (or does she mean the temptation?) of acknowledging a clever impostor as her long lost husband. This extraordinarily honest explanation is psychologically authentic but not sufficiently explicit in that it does not account for her unconscious hostility toward Odysseus. He went off to Troy to fight about another woman's adultery and left his wife at home, sexually unsatisfied, so that, save for the fact that she had already given birth to Telemachus, she remained for twenty years unfulfilled as a mother and wife. Why, then, should not her hostility, combined with a reaction-formation against persisting sexual temptation, account for the fact that Penelope, the person

[5] It is noteworthy that this dream appears to be the only dream in Homer which is interpreted symbolically.

[6] Sir James G. Frazer, discussing the transmission of royal powers in Alba Longa and in early Greece, suggests that royal powers were transmitted not to the son, but to the husband of the widowed queen, or else to the husband of the king's daughter.

with the most cogent reasons for being ambivalent toward Odysseus, is the last and most reluctant person to recognize him? By contrast, the faithful dog, Argos, is the only one to recognize him spontaneously, and this faithful dog dies of joy (Book XVII). It is interesting, if one examines the difficulties which Odysseus' absence caused to various persons, to note that he is recognized by various persons in an increasing order of reasons for ambivalence toward him: first, the faithful swineherd Eumaeus; second, Laertes; third, Telemachus; fourth, Eurycleа; then the suitors (who fear him); and finally, at long last, the reluctant Penelope. The point is too obvious to require further comment. It suggests, however, that psychoanalytic studies of *fausse reconnaissance* can be supplemented by equally impressive examples of *fausse nonreconnaissance*.

The preceding considerations force us to conclude that Penelope is frozen emotionally as a result of her attempts to ward off constant temptation, and that she is far from unambivalently happy either over Odysseus' long absence or his long delayed return.

Once our resistance to this psychological reality is overcome—and Homer forces us to do so—the lengthy plot element of nonrecognition is not only plausible but psychologically imperative. If this point is rejected, the whole concealment, disguise, and failure of recognition ceases to be magnificent literature and profound poetic intuition, and becomes the shabby rigmarole of arbitrary disguises and mistaken identities which abounds in second-rate romantic dramas. In Homer, disguise and nonrecognition have inherent psychological plausibility. In routine, uninspired romantic plots such elements are introduced solely to create artificial synthetic effects.

It is well worth mentioning in this context that the other great 'disguise' plot in Homer also involves Odysseus—in the Iliad (Book X)—and is, like the disguise plot in the Odyssey, replete with psychological verities.[7]

[7] The Iliad, Book X, reports that Diomedes and Odysseus approached the Trojan camp as spies. Enroute they heard Dolon, a Trojan spy, approach, whereupon they lay down among the corpses and pretended to be dead, the better to

As regards Odysseus' disguise in the Odyssey, it is, in itself, prima-facie evidence that our thesis regarding Penelope's real character is correct. If Odysseus had not halfway agreed with Agamemnon's ambiguous praise of Penelope, which is hedged about with many reservations, he would not have disguised himself in the first place; furthermore, he would have revealed his true identity to Penelope at once.

Let us now return to our point of departure which is that the lines challenged by Aristarchus and his successors are not only not out of place but are extremely significant and relevant in the precise context in which they appear. Penelope has stated that she is protecting herself against the possibility of yielding to an impostor. She then refers to Helen of Sparta and Troy and 'inexplicably' comes to her defense, alleging that Helen did not *will* her adultery but was led astray by a god. At first blush it seems strange indeed that Penelope, who had more reasons for resenting the war of which Helen was the direct cause than had almost any other woman in Greece, should come to her defense and express a theory about Helen's motivation which no one else mentions. The conclusion is forced upon us that Penelope, ostensibly speaking about Helen, is actually justifying her innermost thoughts, temptations, and wishes, though not her deliberate actions. Her defense of Helen is, moreover, a reproach to Odysseus. She says in effect: 'Had I deceived you, as Helen deceived Menelaus, I, too, would not have been guilty; I would have been misled by a god'.

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ambush him. The Odyssey, Book IV, reports that Odysseus later caused himself to be scourged and entered Troy disguised as an abused runaway slave. Helen alone recognized him, despite his disguise and denials. She invited him to her apartments, bathed and anointed him, and swore not to betray his plans since she now felt a captive of Troy. Strangely enough Helen's mother-in-law Hecabe, who also knew of his presence, did not betray him either. Helen's recognition of Odysseus in his wretched disguise, her hospitable treatment of the spy, etc. are the exact opposite of Penelope's nonrecognition of Odysseus, whom she did not bathe or anoint. On the other hand, the shielding of traitorous Helen by her mother-in-law Hecabe is the exact parallel to Anticlea's failure to mention the suitors to her son Odysseus (Odyssey, Book XI). The psychological nexus between this disguise episode and the disguised homecoming of Odysseus is obvious.

In another communication[8] it was proposed that what the Greeks called 'Fate' was actually the character structure of the individuals described. Penelope's recourse to a god, in this context, is a justification of her instinctual needs for which she has no reason to feel guilty. Penelope's statement implies: 'You could as easily have been cuckolded as Menelaus, had the psychological climate been different'. She is telling Odysseus that he has no right to resent her tardiness in recognizing him; that her determined resistance to the suitors deserves a better reward; that, had she not persevered, she might have yielded to some impostor.

The plot and the psychology of the protagonists in this context demand something of this kind, and Homer satisfied this demand by means of seven lines of tremendous psychological scope. The questioning of these lines by the 'higher criticism' leads one to wonder how many classical texts have been mutilated for equally spurious reasons, i.e., because of the psychological scotomata of philologists to complex psychological overtones in great literary works. Clemenceau is said to have declared that war was too important a matter to entrust to generals. The 'inappropriateness' of seven marvelously appropriate lines in Homer inclines one to suggest—somewhat ungraciously—that the critical explanation of great literature may perhaps be too important a matter to be entrusted to philologists.

The preceding conclusions were reached solely by means of a psychoanalytic study of the text of the Odyssey itself. Such interpretations are often rejected on the grounds that psychoanalysts ignore cultural differences and therefore tend to attribute a 'modern psychology' to some ancient personage. Hence, it seemed desirable to ascertain whether the Greeks themselves were also dogmatic about Penelope's fidelity and whether modern classicists, *not* interested in psychoanalytic problems, ever reached similar conclusions about Penelope's behavior.

[8] Devereux, George: *Why Œdipus Killed Laius.* Int. J. Psa., XXXIV, 1953, pp. 132-141.

A scrutiny of the literature revealed the existence of an archaic Greek myth, according to which Penelope was the mother of the God Pan by *all* the suitors,[9] which indicates that the Greeks themselves had doubts about Penelope's proverbial chastity. As for modern classicists, the antianalytic Graves,[10] who is interested primarily in the survival of the cult of the Mother Goddess and of matriarchy in Greece, and, secondarily, in proving that the Odyssey was written by the girl Nausicaä, also concluded that Penelope was not a chaste wife. He cites, in support of his thesis, Penelope's coquetry toward the suitors (Book XVIII), her extorting tribute from them, and her marked preference for Amphinomus of Dulichium (Book XVI). He also points out that Odysseus killed the suitors before revealing himself to Penelope and suggests that Odysseus' mother Anticlea was apparently aware of Penelope's conduct, since she did not mention the suitors in talking to Odysseus (Book XI).

The convergence of our psychoanalytic inferences, archaic Greek myths, and the conclusions of an antianalytic student of the history of Greek culture, not only strengthens our conclusions, but once more shows the universal and culturally neutral validity of psychoanalysis.

SUMMARY

Certain lines of Book XXIII of the Odyssey are regarded by the 'higher criticism', beginning with Aristarchus, as being interpolations which do not belong in the text. The opinion is here presented that Homer included these lines because they have a very pointed psychological significance for understanding Penelope's behavior on the return of Odysseus. The questioning of these lines leads one to wonder to what extent other classical texts may have been mutilated for equally spurious reasons by philologists.

[9] The most easily accessible summary of this myth is to be found in Graves, Robert: *The Greek Myths*. 2 Volumes. Baltimore: Penguin Books, 1955. *Cf.* especially Vol. I, p. 101 and Vol. II, p. 375.

[10] *Ibid.*

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Teaching and Learning of Psychoanalytic Psychiatry in Medical School

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TEACHING AND LEARNING OF PSYCHOANALYTIC PSYCHIATRY IN MEDICAL SCHOOL

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I

Since the end of the second World War, an increasing number of psychoanalysts have become professors of psychiatry in an increasing number of medical colleges in this country by virtue of the time and interest they have devoted to psychiatry and by reason of their interest in graduate and undergraduate medical education. As the president of the American Psychoanalytic Association, Dr. William Barrett stated recently, every art or science in the Western World which has demonstrated its validity, effectiveness, and usefulness to society has eventually been admitted to the curriculum of the universities—as has psychiatry increasingly for many decades. The recent gradual increase in the number of psychoanalysts on the faculties of colleges of medicine is not only evidence that the fruit of Freud's genius is progressively being recognized as an addition to the storehouse of knowledge and of useful skills; it may also be a sign that psychoanalysis is entering upon another phase of its development and of its more thorough integration with other relevant sciences of human behavior, particularly with psychiatry—despite the doubts and fears which still exist of dilution and distortion of Freud's basic contribution, or of deviation from orthodox psychoanalysis.

The eager, youthful enthusiasm of freshmen and sophomores in medical school can be a powerful stimulus and challenge to instructors to re-examine their pedagogical techniques, and attempt experiments in ways of increasing the participation of more students as the most effective way of their acquiring the skills they desire. The introduction of the actual life situations

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of patients earlier and earlier in the medical curriculum is becoming more and more widespread in medical colleges *(9,* cf. especially Chap. 4, pp. 41-61*)* as one means toward this goal.

Opportunities for exploring the emotional aspects of illness of all patients by students under the guidance of psychiatrists trained in psychoanalytic concepts, and of psychoanalysts, are becoming an influence that can reduce the 'cadaver-psychology' *(8)* to which the impersonal basic science curriculum of the traditional first two years of medical education has contributed. The variety of such teaching experiments now in progress, increasing in tempo, extent and thoroughness, and being progressively refined, raises the hope that more general practitioners and specialists may in the future be better practitioners of what is coming to be known as integrated or comprehensive medicine. Earlier attention by such practitioners to the initial stages of those disorders, which have come to be called psychosomatic disorders, is but one excellent example of an understanding which might provide some measure of solution to the problem of widespread untreated neurosis. In addition to such work as they themselves may be better able to do with patients, they may be more effective both in referrals to psychiatric specialists, and in collaborative work with psychiatrists for the benefit of more patients *(1, 2).*

The number of psychiatric specialists is increasing as a result of both the increased interest of medical students in psychiatry, in part a consequence of improvements in undergraduate psychiatric curricula, and the increased opportunities for graduate training. The general caliber of applicants for training in psychiatry is improving as a result of the higher standards of graduate training programs in the last twenty years, and there is considerable basis for hope that both will continue to improve, in no small measure as a result of the increase among teaching staffs of formally trained psychoanalysts. Grants from private foundations, and federal and state aid—as well as the interest of the profession itself in the problems of mental health in the community —are resulting progressively in training able specialists for teach-

ing. This is especially evidenced by greater interest in psychodynamics and in psychotherapy on the part of trainees as well as teachers, *(10,* cf. especially Chaps. 2 and 3, pp. 49-61*)*. Some of the applicants for training in dynamic psychiatry and in psychoanalysis today are more thoroughly and more broadly prepared in their premedical and medical graduate years in more modern basic biological, psychological, and psychiatric concepts and disciplines. Probably a larger proportion of graduates in specialty training programs, some of them undergoing psychoanalytic training, continue to remain members of the medical faculty in at least part-time clinical appointments in which they contribute to the teaching of undergraduate and graduate students, and sometimes participate in research with patients they might not often see in private practice.

The comprehensive and psychotherapeutic study of all degrees of psychopathology by medical and graduate students under close supervision by an analytically trained or oriented faculty provides a richer experience for all concerned. A psychoanalytic psychotherapy can thus be developed for understanding and treating the psychotic, the 'borderline' conditions, and the psychopathic or impulsive disorders. Closer refinement of the essential elements of the psychotherapeutic process will be inevitable, and further development of the understanding of ego psychology which Freud anticipated would come from closer study of the narcissistic disorders. The psychiatrists with the broadest, if not the most intensive, clinical experience with the severer instances of narcissistic neuroses are those who have been attending psychiatrists in mental hospitals—which are also training and research centers—in contrast to the experience of the many psychoanalysts which has been largely confined to analysis of the transference neuroses.

Both of these groups can meet in such training centers even more often than at present for both the training of the psychiatrists of the future and some collaborative effort in psychotherapeutic research, and thus pool their special experience. The psychiatrists of the future will then have more balanced train-

ing. Therapeutics of *both* the narcissistic *and* transference disorders may be then still further developed. As has happened in other branches of medicine, all this may also contribute to improved therapy and care for more people with mental disorder—another hope of Freud, expressed in his paper of 1919 under the title Turnings in the Ways of Psychoanalytic Therapy.

The emphasis in some undergraduate curricula in which students observe a variety of patients is first, on contact with the entire family of the patient throughout his treatment; second, on the constant close correlation between didactic presentation and clinical demonstration and experience; third, on obtaining direct psychotherapeutic experience under individual supervision and discussion in small groups; fourth, on extending such teaching throughout all four, or at least three, years of medical school *(18)*. This provides for the direct study of psychopathology, and the environment and the intimate personal relationships in which it is developed.

Child psychiatrists, in particular, know the importance of the influence of details of the intimate attitudes of parents and siblings, upon the development of the individual during his most impressionable years. The experience gained in the training of psychiatrists with such emphasis on supervision and on the influence of the family leads one to expect excellent results from this method in undergraduate teaching *(10,* cf. Chap. 7, p. 101*)*. The longer and more intensive contact between student and teacher in individual supervision, reminiscent of the apprenticeship method of medical training, promotes identification of the student with his teacher as an essential step in the development of his own skill. Under these circumstances, the importance of the qualities of the teacher as a practical therapist is given much greater emphasis than in classroom instruction in principles or in amphitheater demonstrations of clinical entities. The opportunity for the student to discuss his impressions, his reactions to the patient's behavior—especially in individual supervision—is a challenge to the teacher to formulate his clinical skill and acumen in terms which assist the student in overcoming his own difficulties in understanding the deeper realities of human con-

flict. In this process, depending upon his aptitude, the student acquires a varying degree of awareness of the repressed, unconscious aspects of the patient's symptoms and motivations. He may even begin to become aware of similar processes in himself.

Somewhere in the training of medical men it might be useful to introduce to them some data about various aspects of group life, of pregenital and genital sexuality *(4)*, of aggressive-submissive tendencies and of the occurrence of conflict, of regression and fixation, both among mammalia, especially among gregarious primates *(11)*, and among various human groups from cross-cultural or anthropological studies *(7)*. Eventually, of course, such material belongs somewhere in the premedical years during basic biological studies, perhaps especially in the form of motion picture films, as well as by readings and lectures. Such material might well supplement the emphasis on comparative anatomy with comparative psychology. There is available some information *(11)* gathered in the field, especially about the gregarious animals, which is almost a replica of Freud's primal horde described in his Totem and Taboo *(5)*. An interesting teaching experiment would be to emphasize thus the general biological foundations of human behavior and some of the sources of human conflict.

All these opportunities, hopes, and promises are, of course, not without problems, difficulties, and even possible dangers. The hopes and promises implicit for theoretical, psychotherapeutic, and psychoanalytic development will undoubtedly be fulfilled in smaller measure, and more slowly in some respects than in others. In just which respect the greatest and most rapid developments will occur cannot be precisely foreseen. From experiences in the past nine years at Langley Porter Clinic *(14, 15, 16, 17)*, it is possible, nevertheless, to venture a few predictions. Teachers periodically will become discouraged as the inevitable resistances of patients, students, and some colleagues appear and persist in various forms. Untoward reactions in the therapy of some patients will occur *(3)* when the impatience of inexperienced students, or of some members of the faculty, presses too much and too soon upon the essential defenses of a patient be-

fore he acquires sufficient integration. Beyond this, or as part of all this, the basic truth of twenty centuries of medical wisdom and over half a century of psychoanalytic experience may again dawn on all the faculty: the student therapist, the student physician must first heal himself. It will again be confirmed that for the most thorough psychotherapeutic skill to emerge in every aspirant to its acquisition, he himself must first, in one or another way, penetrate back again—at least, in some measure—to his own basic biology, to his primary narcissism, through the acquired, socialized, overlying disgust and aversion to it, and guilt about any distortions of it.

There has not been much discussion of the way or ways in which the student psychotherapist may be helped directly by his teachers to gain such self-awareness (short of being psychoanalyzed) toward resolution of conflicts about his earliest pregenital libidinal drives—which is of the first importance in therapy of narcissistic disorders. The problem here concerns the undergraduate student in medical school, or while he is a resident in psychiatric training. Whether individual supervisory sessions, further developed and refined, will become established as the method of choice is uncertain. Recent experiments in this direction at Langley Porter Clinic and in many other training clinics both for adult patients and for children suggest this possibility *(6, 12, 14, 19)*. How discouragements may be reduced, how failures may be circumvented, will be the subject of many discussions among the pioneers working in this sector of the frontier of psychoanalytic psychiatry.

II

With these developments in mind, it is not too difficult to outline what one set of ideal competences in psychiatry of a graduating senior from a school of medicine could be[1] although it

[1] Dr. Ward Darley, President of the University of Colorado, acting as moderator of a Symposium on Teaching Psychiatry in Medical School, proposed that the panelists consider two questions: just what should be the competences of the graduating senior; what might be the best way of organizing a teaching program that would result in imparting these competences?

may be difficult to obtain general agreement about them. It is perhaps too much to expect any great probability very soon of assembling and retaining a sufficiently large and sufficiently competent faculty capable of working together, which would so organize a teaching program that it might have some chance of imparting these competences to even a recognizable fraction of an entire graduating class. This outline is consequently no more than concisely topical, and is not to be assumed to be anything but idealistic.

The competences of a graduating senior in psychiatry are those which we all hope a good physician might have at the beginning of his fifth year in medicine. They, therefore, include such grounding in the basic sciences, as applied to human disease and to disorder of functioning, that the young physician is ready to begin to study with his patient the nature of the complexity of external and personal factors that determine the illness, so that it becomes progressively clearer to both.

To obtain his doctorate in medicine, the student will have learned to obtain the history of a patient's present and past illnesses and to have acquired skills in physical diagnosis, supplemented by clinical observation and the evaluation of special laboratory tests. To attain the competences in psychiatry being discussed, he needs to learn, in addition, the skill of interviewing patients to elicit in detail the minutiae of a personal life experience by practice and precept.

Under the term *interviewing* is included a fairly well integrated skill to obtain an impression not only of the illness, but also of the person who complains of it. Although this is by now in psychiatric and general medical circles a truism, nevertheless an effective interview with a patient would: (a) not obstruct a patient's impulse to tell of his illness fully, and yet would obtain all the essential facts of a complete medical history; (b) help the patient overcome any of his reluctance or anxieties about telling his story as he may; (c) reveal as much of the entire complex of the physiologic disturbance as possible, and also the essential facts of the patient's current life situation, and the chronological

relation of the illness to any recent specific changes in it; (d) obtain a sufficiently adequate outline of the patient's total biography to get some impression of the relative balance of ego integration and psychopathology, and to place the current illness in this perspective.

All this requires that the young physician have a sufficient grasp both of psychodynamics and some basic operational skill in elementary psychotherapeutic procedures. This rudimentary psychotherapeutic skill necessarily includes some degree of objectivity with regard to the phenomena of transference. These competences also imply the ability to discriminate positively in some measure, not merely by exclusion of organic disease, between the psychosomatic reactions and nonneurotic processes; and to estimate the degree of psychopathology with a fair amount of accuracy. They imply, too, some knowledge and skill of referring patients to agencies best equipped to serve the needs of the individual, or to psychiatric specialists, and how to collaborate with them when necessary.

How much background information such a young physician needs to assimilate from greater study of the humanities in premedical years, from study of the basic clinical, theoretical, and historical knowledge of psychiatry—that is, of varieties of psychiatric illness characteristic of various age groups, of the dynamics of family life, of somatic and pharmacological therapies and the pathological physiology and biochemistry of reactions to stress *(13)*,—from study of data available from sociology and anthropology, from cross-cultural studies, and from comparative psychology—how much of such background information he needs for the qualifications outlined awaits comparison of results from various pedagogical experiments *(9,* cf. Chaps. 4, 5, and 6, pp. 41-103*)* now in progress in various schools of medicine.

It seems unlikely that any medical or psychiatric faculty can impart these proficiencies if the student does not bring to the learning situation certain particular capabilities. It is not enough that the student on admission to medical school bring an intelligence trained in systematic, orderly habits of work and

daily living, a love of learning, and a deep and integrated motivation for the study and practice of medicine. He may find learning psychiatry either difficult or impossible in any program of teaching unless he has also an aptitude that is derived from his early and later experiences which enables him without prejudice to be perceptive, tolerant, sympathetic but objective toward all varieties and degrees of distortion of human experience—his own and, therefore, that of others.

But even if he is possessed of such qualities of personality—or a good measure of all of them—then the entire medical faculty, and not only the teachers in the department of psychiatry, need to exemplify the same simple human attitudes in their most precisely scientific application of knowledge to the illnesses of all patients. Then, whatever specifically psychiatric, technical skills he may be taught and may learn in the psychiatric courses will solidify his unconscious, spontaneous identification with such human and humane practitioners of the healing art. Then, it may matter somewhat less to how much or to how little didactic presentation of the facts of psychiatry he is exposed. It may matter more how much opportunity he has to observe, in small groups or individually, the skilled psychiatric teacher interview patients, and to practice such interviewing himself, first under observation, and later under supervision—again in small groups or individually. It may be even more important that he have the opportunity to follow a few patients for a fairly long period of time in many consecutive interviewing sessions—perhaps in at least three of his four years of medical school—always under supervision, preferably individually and with the same supervisor for each patient.

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BOOK REVIEWS

PSYCHOANALYSIS AND PSYCHOTHERAPY. DEVELOPMENTS IN THEORY, TECHNIQUE, AND TRAINING. By Franz Alexander, M.D. New York: W. W. Norton & Co., Inc., 1956. 299 pp.

In his latest book, dedicated to the memory of Freud, Alexander presents his own and related psychoanalytic contributions of the last two decades. The form, however, is that of a comprehensive text, and the content ranges, with varying degrees of thoroughness, over the whole field, historical and current, suggested by the title. The book is, in general, characterized by its conspicuously modest interpretations of the author's own contributions, its measured attitude toward past criticisms, and its elaborate and considered arguments in defense of certain of the author's ideas. However, unless the process of attenuation, circumspection, and conservative reservation is to be construed as tantamount to depriving the proposals of mutative significance, one must deal in certain important references with essentially the same debatable issues which have consumed much space and time in the past.

While Alexander's keen and pervasive awareness of the limitations (and the failures) of the traditional psychoanalytic method is no doubt founded on certain observed clinical occurrences, one must recognize that his over-all orientation toward the method and its potentialities, whatever the origin of this orientation, is a special one. He appears to see it as one of many possible applications of psychoanalytic knowledge, one which has acquired a certain traditional prestige, rather than as a painstakingly forged instrument of unique power and rationale, deeply related to every known element in the body of science which he unreservedly esteems. The latter relationship he appears to value for its historical contribution; the research interest he criticizes as a current motivation vitiating therapeutic effectiveness. (If Ferenczi and Rank did have a basis for this criticism at the time of their monograph, one wonders how many analysts would agree that Alexander has reason for postulating this as an interfering motive in the therapeutic work of competent contemporaries.) In any case, this view of the conservative method lends itself readily to cliché conceptions such as the 'principle of flexibility'. Who does *not* believe in 'flexibility'? A surgeon can use a scalpel in many ways, for a great variety of surgical ill-

nesses; he can use its point, its cutting edge, even its handle. However, it must remain a scalpel, necessary and precise in its form. Furthermore, a surgeon is not devaluated because he deals largely with surgical illnesses (apropos of the monotonous and specious complaint that analysts select patients to suit their method!). Most analysts, quite aware of the limitations and contraindications of their method, are more impressed with what it *can* do than what it can *not* do. They prefer to use their basic well-tested instrument in a variety of flexible applications, and to continue to learn more about it, perhaps modify it gradually, than to turn to an amorphous mass of conceptual molten iron to forge a new instrument for each case. They are justly cautious about hurried extrapolations. Right or wrong, this conservative view cannot be ignored. Alexander is especially concerned that the 'middle period' of the analysis is often unduly prolonged because the analyst, in his putative search for pregenital material, often fails to distinguish between regressive evasion (of the incest conflict) and the need to resolve or master a genuine early fixation to a traumatic conflict. This is a legitimate criticism of certain individual efforts; it is not a valid criticism of a method or of a group orientation. In relation to fixed frequency of hours, a typical bête noire, is this something which, in itself, fosters 'regressive evasion' and pathological 'dependency', or is this type of transference neurosis usually a reflection of the patient's essential psychopathology, requiring a reasonable degree of transference experience verification and working through in the analysis, as do other important latent transferences? In Alexander's refreshing rejection of the glib tendency to place the responsibility for failure invariably on the patient, he appears only to reverse the direction of the traditional error. In any case, the remedies for the errors and failures, putatively due to traditional methods, are the more effective interpretation of regressive evasion in relation to the current situation, and the well-known specific technical precepts dealing with quantitative factors. It is specified, in line with the general mood of the text, that the latter are intended as additional methods, not substitutes, for interpretation.

The 'principle of flexibility' is thought to solve the problem of the great number and variety of clinical problems which do not lend themselves to traditional analysis. While most would feel that traditional analysis is far wider in its applications than Alexander

believes, few would disagree that many illnesses come outside its optimum indications, and only a rare analyst would not agree that it is an important obligation of psychoanalysis to contribute to the development of other rational psychotherapeutic methods. The scientific reasons for preferring, where possible, to maintain terminological distinctions have often been argued; this is not the place to repeat such arguments. It may be mentioned that a common body of knowledge does not of itself render methods identical; nor do comparable good results; nor do certain external resemblances. Regarding the inner psychological processes—not enough is as yet definitely known.

Alexander's remarks about the importance of discerning variations in the required depth of analysis (or interpretative intervention), the matter of circumscribed conflicts, the importance of studying scientifically the 'rapid' cures, and the scientific importance of the divergences between the theoretical model of technique and actual psychoanalytic practice do point, without question, to certain crucial and fertile issues of the future, for psychoanalysis and for other psychotherapies. One demurs only to the suggestion that we are now ready for important innovations in basic psychoanalytic method derived from impressions gained in these spheres.

In reviewing the development of psychoanalytic technique, Alexander finds Two Main Trends: Emotional Experience—Ego Analysis. He makes clear his own current belief in the preponderant therapeutic importance of transference emotional experience. 'At the same time recognizing and experiencing this discrepancy between the transference situation and the actual patient-therapist relationship is what I call the "corrective emotional experience".' This is thought 'more important even than interpretations which but spell out in words what the patient feels'. He would regard himself as differing from Freud only in the use of his own explicit term. The 'corrective emotional experience' is thought to serve as a natural challenge to the ego to find a new solution to old conflicts. In seeking to establish the fundamental position of this principle, Alexander suggests that the importance of the diminished *intensity* of transference experience compared to the actual experience of the past, and the comparative maturity of the ego re-experiencing infantile conflict have been emphasized, with corresponding neglect of the crucial role of the *difference* between the past and the thera-

peutic situation. We may state at the outset that many would not accept the fact that this sense of difference is the decisive therapeutic factor in analysis. That it is a necessary condition for the complicated processes which follow is self-evident. In his acknowledgment that recall of the past as such has some perplexing therapeutic value, Alexander appears to ignore the fact that unresolved infantile conflicts can only be disavowed or modified as such if the patient becomes aware of them in their infantile context, whether through direct recall or sound reconstruction. That they may be subject to other forms of therapeutic modification is quite true; and this may well be the case in transferences dealt with on an exclusively current basis. It is a matter of incidental interest that Alexander, who experienced some perplexity on this score in 1925, speaks, without reservation, of Ferenczi and Rank as if they proposed to ignore the past utterly, in a technical sense. Actually, while their preponderant emphasis on current emotional experience as the indispensable and anterior phenomenon is quite clear, they *repeatedly* emphasize the need to restore the past (largely through reconstruction) before a genuine analysis can have been consummated, i.e., to substitute remembering for the repetition compulsion as expressed in the transference.

Alexander's principal explicit technical recommendations in this text are: variation in frequency of hours, planned interruptions of treatment, and 'control of the interpersonal climate of treatment'. The latter is proposed by Alexander, following a lengthy preliminary discussion, with a few case illustrations. He specifies that this is not the 'playing of a role'. Nevertheless, it is rooted in the idea of being 'different' in attitude from the decisive historical personage who dominates the transference, to the extent that the 'corrective emotional experience' is sharpened. A major argument for the specific 'climate' is the fact that analysts' personalities vary and inevitably impinge on the transference situation, both in the real and countertransference sense, so that the complete neutrality of the analyst is only a theoretical fiction. Instead of subscribing to the purely 'negative' prescription that the analyst analyze and master his *interfering* countertransferences, or accepting Tower's interesting suggestion of a specific countertransference neurosis for each case, Alexander, in a tour de force of logic, recommends that the variety of human attitudes present in analysts be bent to specific

attitudes toward their patients, while at the same time believing that the classical analytic attitude is impossible of attainment.

The methods of variation of frequency and planned interruptions do, of course, contain the seeds of a quantitative *reductio ad absurdum*. Furthermore, the temptation to substitute a xylophonic simplicity of method for the orchestra of psychoanalytic interpretative nuances is already adumbrated not only by Alexander's difficulty in understanding the special role which Bibring assigns to interpretation in the hierarchy of techniques utilized in psychoanalysis, but even more by his implied suggestion that it requires more resourcefulness to vary the frequency of hours than to conceive, time, and express an alternative and effective interpretation. As adjunctive devices, for final resort, when interpretation may in certain instances be overwhelmed by the economic and dynamic elements of the neurosis as integrated in the psychoanalytic situation, many analysts have used and do use one or another form or variant of these methods. They do not, in themselves, contravene basic psychoanalytic principles; and they are, of course, legitimate subjects for further exploration as to effectiveness.

In the matter of the specific planned 'interpersonal climates', however, the reviewer must enter unreserved and deep disagreement as to the basic principles involved. In the first case, in which Alexander showed his impatience and finally admitted his disike (unlike the patient's father), the general inference which the author draws is not justified. The reviewer, for example, has often discussed a case where momentary 'loss of patience' terrified a patient, struck her as *identical* with a critical early experience with her father—and provided a dramatically favorable turning point in the analysis. Problems of communication, of the meaning of tangible dramatization, of specific needs of certain personalities cannot be so readily simplified and generalized. In the second case, which includes an everyday type of countertransference error, one must ask whether adequate management of the countertransference, with realistic adjustment of the fee, would not have accomplished all that was accomplished by transfer to a 'tough' colleague (or the hypothetical arbitrary adoption of attitudes resembling his).

In following correct precepts, in doing what is technically appropriate at a given time, in assuming an attitude required by the particular medical specialty which he practices, the analyst does

assume a role, in the realistic sense that all adults assume specific adult occupational responsibilities. Whether this is carried out with greater or lesser ease, its impact cannot be 'artificial', in the sense that this must be true of the assumption of attitudes or the creation of climates which are to be measured against inherently noncomparable situations, i.e., the patient's early life with parents, siblings, and other intimates. An individual cannot seriously and consistently maintain a comparison between the behavior and attitudes of a professional expert whom he, in a sense, employs—and that of his mother or father or siblings in early childhood—unless he is very seriously ill. To the extent that transference illusion is an even more tenacious, contrapuntal, and pervasive phenomenon in the lives of 'normal' and neurotic people than it is commonly thought to be, it is possible that patients for varying periods subjectively compare the new good father, for example, with the old bad father, or the new 'tough' father with the old overindulgent father, instead of the present physician with an aspect of the original actual father whom they have engrafted on him. If so, the treatment situation must be so arranged that it can ultimately dissolve this illusion too! Any attitude not directly derived from or germane to the therapist's role is perforce 'less unlike' the patient's past experience than the classical analytic attitude, which, as Alexander explicitly recognizes, *is* different from all other human attitudes, past and present.

As for the nuances of analysts' personalities and the fact that they inevitably do play a subtle role in the analysis—if we eliminate personalities who hate their patients, or who seduce or exploit them, or otherwise betray the high essential responsibilities of the relationship—it is better that we continue to *try* to understand them than to coerce them prematurely to oversimplified technical recommendations. The same is true of the play of intuition, controlled by sound principles. Where occasional disturbing reactions arise in otherwise well-qualified analysts in relation to individual cases, self-analysis, or analysis by a colleague still seems best. In any case, if Alexander does not believe that most individuals can successfully adopt the standard 'analytic attitude', toward which their entire training is rationally directed, how will they fare with personal attitudes specifically prescribed for specific individuals? How does the patient's reality sense deal with the change from the pretransference

neurosis neutrality (which is admittedly necessary) to the tendentious attitude adopted after its establishment? In his combined 'role' as analyst, as physician, as friendly human being, there is a considerable reservoir of attitudes with which the analyst may appropriately and unaffectedly respond, to the degree *proved necessary* by the diseased ego with which he deals, without illusory or artificial historically specified 'oppositeness'. Otherwise, and indeed in most instances, he does better to adhere, to the best of his ability, to that tested technical attitude which alone permits a relatively uncontaminated transference neurosis to arise, and to be resolved.

Alexander feels that the relatively warm reception accorded to psychoanalysis in the United States has facilitated its diffusion throughout psychiatric thought and practice and has tended to render anachronistic the isolation of analysts from other psychiatrists, especially those who teach in universities. Both in methods of practice and in methods of teaching, Alexander feels that analysts perpetuate a tradition born in their bitter struggle for acceptance in Europe. He believes that the return to the university and the merger with general psychiatry are inevitable. He thinks that the questions are largely those of tempo, and he recognizes that these may vary in different situations. There is no question, however, of the author's enthusiasm for these trends. A long, able, and generally interesting discussion of the theoretical (and sometimes operational) continuum of psychoanalysis and other psychotherapies, as now practiced, leads inevitably to the conclusion that, in effect, all psychotherapists should receive basic psychoanalytic training, of which the keystone is personal analysis. This would then place the crucial problem in the sphere of selection, whose criteria are very soundly and lucidly discussed. The question of specialization in 'standard' psychoanalysis or other psychotherapeutic methods would then develop as a matter of individual inclination. With this general ideal formulation few analysts would disagree. However, it is recognized that the practical difficulties involved in this approach necessitate the current maintenance of separate training in psychoanalysis as a special technique, regardless of the auspices. This poses the problem of the kind and degree of theoretical psychoanalytic instruction to be offered to residents who are *not* candidates in psychoanalysis, specifically whether or not it should differ from that offered to candidates. This is one of the important ques-

tions addressed to representative teachers of psychiatry in a questionnaire. The chapters devoted to this inquiry deserve careful reading by psychoanalysts, for multiple reasons. Alexander's own *tendency* in this reference appears to be consistent with his general attitude favoring the dissolution of barriers wherever possible. In the face of practical observation of the grotesque interpretative habits of residents who have had lectures and seminars in theory, excerpted without extreme didactic care from the training context of practical experience, the reviewer would feel, as do some of Alexander's respondents, that methods of teaching the two groups must be different.

Alexander's historical reminiscenses covering the Berlin Institute are of course valuable and interesting; the same is inevitably true of his intimate knowledge of the history and the training methods of the Chicago Institute, however 'controversial' certain elements in the latter may be.

This book is readable, interesting, certainly always 'stimulating', but highly uneven in quality. In places, the good and exceedingly well-stated psychoanalytic common sense seems so obvious from the point of view of accepted good practice (for example, Two Forms of Regression and Their Therapeutic Implications) that one almost wonders to whom the message is addressed. In a few places, where some detail of refined psychoanalytic argument appears, as in the extended discussion of resistance analysis or the interesting if inevitably selective sallies into the actual content of ego psychology, the material is in itself usually well-put and decidedly worth-while, but inner connections and the relevance to main themes are not always clear. In general, Alexander's devotion to simplicity (explicitly stated in The Psychoanalysis of the Total Personality) tends to appear in this work as oversimplification, most conspicuous in the important theme of the 'corrective emotional experience', and the ancillary 'control of the interpersonal climate'. One wishes that the author's engaging geniality and tolerance toward intellectual adversaries were not vitiated by patronizingly 'understanding' argument via motive analysis (against which Alexander legitimately protests early in the book!). A footnote apology, implying that all other arguments have been invalidated, and that it remains only to explain their heat (on the other side, of course!), does not undo the effect.

To expound the limitations, shortcomings, and failures of classical psychoanalytic technique, to call for the development of new methods, to emphasize the public health need for the treatment of incipient cases, is indeed an important function in the analytic world, and in this connection many join with Alexander and acknowledge his important role. The great expense in time and money of the 'classical' procedure (which the author does not elaborate) is a source of deep concern to many analysts, no less than to the public at large. To many, this is an even more pressing motive for developing modifications and derivative procedures than the problems of intrinsic clinical effectiveness or applicability. To confuse the two issues can obscure scientific realities, and rather retard than accelerate advance. Alexander's recent contributions to this advance are stimulating, always at least of heuristic value; their intrinsic or substantive merits remain debatable, or at least *sub judice*. His enthusiasm, vigor, persuasiveness, optimism, the general *direction* of his strivings are usually admirable. This is true whether he deals with new psychotherapeutic techniques, the need for maintaining a genuinely scientific spirit, or the wish to establish psychoanalytic training in the university. Such enthusiasm, however, may also color one's views of formidable realities. The chapter on Psychoanalysis in Western Culture, which is in general well considered and interestingly written, reflects in one or two places this excessive optimism. It may not be irrelevant (however right or wrong the author may be) that Alexander who once fully accepted the idea of the death instinct, and even recently at least discussed it as a philosophical formulation, no longer even mentions it seriously—in a chapter which deals extensively with the crisis of western man, a crisis whose social events surely threaten even more than 'to extinguish his individuality'. The occasional looseness of argument, excessive facility, lapse in strict textual accuracy, and the more frequent oversimplification, to which enthusiasm may perhaps contribute, are also less laudable than the author's ultimate purposes. They enjoin very careful discrimination in reading, and laborious after-reflection on what has been read. With such injunctions in mind, all analysts can read this interesting book with profit.

LEO STONE (NEW YORK)

NEW DIRECTIONS IN PSYCHOANALYSIS. The Significance of Infant Conflict in the Pattern of Adult Behavior. Edited by Melanie Klein, Paula Heimann, and R. E. Money-Kyrle. New York: Basic Books, Inc. 1955. 534 pp.

This collection of articles is the most recent presentation of the thought of a significant group of psychoanalysts whose views are widely divergent from those of most other analysts. Divergent views in a science serve the valuable function of forcing a reader to consider his own theoretical orientation and to compare points of agreement and disagreement.

The use of the term 'new' in a title raises the question: new in relation to what? In this book the question is: are the contributions new in relation to earlier works of the authors or new in relation to other psychoanalytic writings? It is apparent that the authors intend the latter. We would then have reason to expect a clear exposition of the historical development of psychoanalytic theory and the support by clinical evidence of the direction taken by the investigators. This would call for a statement of Freud's theories, the theories of others, and the studied comparison of these to the new theories proposed by the authors. I do not believe this book meets these requirements. It restates the views of Melanie Klein and her followers, but adds no new evidence to bring conviction of their value.

These views have in the past been subjected to exhaustive critical examination especially in a paper by Glover[1] and one by Bibring.[2] A recent study of Kleinian theories by Zetzel[3] attempts a comparison of these theories with those of Hartmann, Kris, and Loewenstein.

It is very striking that in this book there is an almost total lack of consideration of any other points of view. It is as if the authors believe that they have established a position which is beyond criticism, and which needs only to be stated. One therefore misses a sense of

[1] Glover, Edward: Examination of the Klein System of Child Psychology. In: *The Psychoanalytic Study of the Child, Vol. I.* New York: International Universities Press, 1945. (This paper is based on discussions in the British Psychoanalytic Society which took place in 1943-1944.)

[2] Bibring, Edward: *The So-called English School of Psychoanalysis.* This QUARTERLY, XVI, 1947.

[3] Zetzel, Elizabeth R.: An Approach to the Relation Between Concept and Content in Psychoanalytic Theory. (With special reference to the work of Melanie Klein and her followers.) In: *The Psychoanalytic Study of the Child, Vol. XI.* New York: International Universities Press, 1956.

contact and relationship with other streams of psychoanalytic thought. How for instance could Hanna Segal in a list of writers on psychoanalysis and art omit the name of Ernst Kris?

The book is divided into two sections, one devoted to clinical psychoanalysis, and the other to applied psychoanalysis. Ten of the twenty papers have been published elsewhere, chiefly in the International Journal of Psychoanalysis. It is not possible to deal with all the questions that this book raises in the mind of the reader. It will serve our purpose here to deal specifically with only a few examples which force attention: the nature of interpretations, the concept of unconscious fantasy, the early structuring of superego, and the nature of anxiety.

Melanie Klein contributes two new papers to the book: one, in the clinical section, The Psychoanalytic Play Technique: Its History and Significance; the other in the section on applied psychoanalysis, On Identification. The second is an exegesis of a French novel, If I Were You by Julian Green, which is used to illustrate the author's theories on introjection and identification. The first of these papers offers a clear description of Mrs. Klein's technique. At one point, however, this clarity does not hold, and that is the question of the timing of interpretations. This in turn is tied up with the Kleinian theory of fantasy, and offers a good example of the fact that practice and theory cannot be separated.

The impression that one gets from reading Melanie Klein's chapter, and even more from the different case reports by other authors in the book is that deep interpretations are made very early, and with an immediacy that suggests 'wild analysis'. This is not a new observation, and it is to be noted that Melanie Klein defended herself against the same criticism in 1927 when, in response to a comment by Anna Freud, she said, 'I should never attempt any such "wild" symbolic interpretations of children's play'.[4] But it is difficult to accept this denial as one reads Mrs. Klein's case reports and those of the other authors in the book. Here, for example, is the report by Lois Munro of her interpretations given to a three-year-old patient in the first week of an analysis: 'The interpretations which I gave him during this complex phase of play were that Little Col, the pig, was the greedy part of himself, which wanted to get inside me, stand-

[4] Klein, Melanie: *Contributions to Psychoanalysis, 1921-1945*. London: Hogarth Press, 1948, p. 160.

ing for his parents, to eat us and our contents. He then felt we were inside him threatening to devour him. This made him very frightened so that he had, by putting part of himself into the ball, to keep himself safe by running away. At the same time he felt that the parents he had eaten were in bits and should be put together. This he tried to do in three ways; by feeding them with roast beef, by putting the two "bits of Munro"—the Red Lady and the Christmas tree—on to my lap, and by sweeping all the toys off the table on to my lap. He also felt he was in bits and wanted to put himself together inside himself. This he showed when he insisted on picking up the marbles, putting them in their bag and holding it against his stomach.' Although I quote this passage out of context, without giving the details of the case, the quotation in my opinion does illustrate the type of interpretation and the timing chosen by the author.

There is throughout the book an emphasis on the importance of verbal interpretations, even with very young children and schizophrenics. The authors in each instance claim that they word their interpretations according to the child's understanding but it is not clear how this is done. It seems rather that the interpretations are complex beyond a child's capacity to conceptualize them. Does this kind of interpretation result in integrative changes in the psychic structure, or does it produce increased resistances and a compliant flight into health? Other critics have noted a confusion in Kleinian writings between unconscious and preconscious thought processes, and the wording of many interpretations described in the book suggest preconscious generalized elaboration of complex concepts rather than the specific reconstruction of infantile events which Freud emphasized as the aim of psychoanalytic interpretation.

The Kleinian approach to interpretation is based on the Kleinian theory of fantasy, and especially on the assumption that the most primitive psychic activities, even in the young infant, consist of unconscious fantasies. Paula Heimann says, 'We attribute unconscious fantasies to the infant from the beginning of his life'. It is maintained that the fantasy precedes the psychic mechanism. For example, 'introjection develops from the infant's unconscious fantasy of incorporating the mother's breast' and, 'conversely, the mechanism of projection develops from the fantasy of expelling an object'. We might assume that there is only a difference of definition involved in this concept of early fantasy which differs so markedly

from the more widely accepted idea that mentation of the new-born infant is unformed, nonconceptualized, consisting essentially of response to stimuli, and the immediate discharge of tension in accordance with the primary process. But the authors state very clearly their theory that even in earliest infancy the child is capable of complex concepts. Quoting again from Paula Heimann, we read, 'In the second half of the first year, however, genital stirrings gain in strength, and the wish for genital gratifications includes the wish to receive and give a child. In our observation a child of eleven months is not only capable of feeling rival hatred and jealousy of a baby brother or sister, as Freud described, but the child himself desires the baby and envies his mother. His jealousy is double-edged.'

This is no mere difference of terminology. Here is a highly elaborated theory which assumes a complexity of thought in an infant that runs counter to an impressive volume of highly sophisticated observations not only from psychoanalytic but also from psychological studies as, for example, Piaget's studies of the development of psychic functioning. Although the authors state that these concepts in the infant are nonverbal, they do not make clear how they are manifested. To this reviewer there seems to be a swift erasure of a number of basic theoretical concepts including the differentiation of unconscious and preconscious mentation, primary and secondary thought processes, memory, and the developmental factors in ego and superego formation. There are many unsolved problems in this area, and Kleinian thought has offered much to the elucidation of related phenomena such as symbolism, but these are to be found in the reports dealing with older children and adults, and not in the theories of the fantasy of the new-born infant.

Particularly interesting and stimulating is a paper by Marion Milner, The Role of Illusion in Symbol Formation, in which she demonstrates the role of imagination, symbol formation, and artistic creation in the therapeutic process, and the significance of illusion as a step toward reality and the development of object relationships.

Perhaps the boldest of the Kleinian theories is the operation of the superego and of the œdipal complex in earliest infancy. This theory requires the prior assumption of unconscious fantasy activity in the first months of life for which there is no objective evidence. The question whether certain clinical phenomena of early infancy should be designated as 'structured ego and superego' or as fore-

runners of ego and superego may appear to be only a matter of semantic difference; but there should be a basis of agreement on definition as to whether one uses the terms ego and superego to refer to systems, entities, or to groups of functions. At times the authors discuss specific functions but at other times they speak of ego and superego as congenital entities. There is a great danger (and the Kleinian school is not alone in courting it) of creating concepts as established facts and manipulating these concepts as one would algebraic symbols with the assumption that the rearrangement of these symbols constitutes an explanation or solution of a problem.

Ego and superego are abstract terms to denote groups of functions and only the latter are demonstrable and available to clinical observation. This has been repeatedly indicated by Freud and others, but it is a distinction not made in this book. To support the theories proposed by Melanie Klein the authors of this book give a number of case reports which are striking for their detail and clarity of presentation. Interesting as these cases are, it must be remembered that they do not prove a theory. A case report may illustrate the plausibility of a theory, and it may strengthen the theory by demonstrating its usefulness in clinical application. If the clinical evidence does not run counter to a theory, the latter may be retained. The question is whether the Kleinian theories actually give an understanding of clinical phenomena that alternative theories do not.

The acceptance of Kleinian theory requires giving up of a number of concepts which have proved their usefulness in clinical work. An example is the theory of anxiety elaborated by Freud in 1926. The concept of the Kleinian group that anxiety arises out of the death instinct does not clarify the clinical problems presented by anxiety, and it by-passes the theory of anxiety as an ego response and a signal of danger. One finds throughout the book the confusing adjectival approach to anxiety which is to be found in the writings of Freud prior to 1926. In this approach we read of 'psychotic anxiety', 'depressive anxiety', or 'persecutory-paranoid anxiety'. Does Mrs. Klein refer to 'psychotic anxiety', for instance, to indicate the manifestation of anxiety in psychotic patients, or does she postulate that there is a specific form of anxiety characteristic of psychosis and to be found only in psychotic patients? If it is the former, the writing is labored and inexact; if it is the latter, we have a startling and interesting concept that should be substantiated. The Kleinian theory

of anxiety differs from Freud's in the emphasis on fear of death as the most significant basis of anxiety. Klein agrees with Freud that fear of castration is the leading anxiety of the male. The question she raises takes us back to the confusion between unconscious and preconscious mentation; the question in this instance is whether one can assume that the infant has the capacity to conceptualize death.

This book gives no promise of resolving the divergences of opinion between the Kleinian psychology and psychoanalysis. When we are asked to replace a framework of theory which, though admittedly imperfect and in constant revision, serves to clarify clinical experience by other theories, it is the task of the proponents of the new theories to prove their greater value, not merely to assert them. There is in the Kleinian approach the prospect of Bacon's 'distemper of learning', the stage of 'contentious learning', of 'vain altercations', the stalemate of assertion and reassertion. Only if the emphasis is shifted to the examination of facts, to careful attention to the other person's argument, and the willingness to put one's theories to the test of clinical usefulness is there hope for a resolution of differences.

DAVID BERES (NEW YORK)

INTEGRATING SOCIOLOGICAL AND PSYCHOANALYTIC CONCEPTS. AN EXPLORATION IN CHILD PSYCHOTHERAPY. By Otto Pollak. New York: Russell Sage Foundation, 1956. 284 pp.

This book is the second publication resulting from a joint project begun in 1949 by the Russell Sage Foundation and the Jewish Board of Guardians to explore areas and ways in which social science thinking could be applied in child guidance practice and research. While the first book, Social Science and Psychotherapy for Children, introduced the possible contributions of sociology to the practice in a psychoanalytically oriented child guidance clinic, this second volume is a follow-up report by Dr. Pollak and his collaborators based on two years of practice testing of this liaison project. The author incorporated four social science concepts into the practice of child guidance: family orientation, social interaction, social roles, and culture conflict. He was able to prove the usefulness of these four concepts or theorems.

In regard to the concept of family orientation he considered that the traditional emphasis on the mother-child relationship is a

potential source of serious omission in diagnosis and therapy, and suggested that the grandmother, the siblings, and even the baby-sitter should be included in the orientation, but put particular stress on 'introducing the father into the framework of clinical concern and visualizing him as a legitimate and sometimes essential recipient of child welfare focused family therapy'. To stress the essential unity of the family and to focus on a family diagnosis he objected to the traditional practice of dividing cases between individual therapists and insisted that all members of one family should be treated by one therapist. Thus, the concept of family orientation helped to shift orientation from the focusing on the child to focusing on the total family and the welfare of the child. The concept of social interaction developed from taking into account the multiple interlocking relationships within the family and between family members and extrafamilial personnel. It helped to explain why a patient is not free to utilize therapeutic gains and why if one member of the family improves another one is likely to get worse. Professional and semiprofessional people, with whom the child or one of the parents were in treatment previously, were recognized as negative forces so far as the treatment of the child was concerned. The concept of social role proved to be helpful in a way the author had not foreseen. It was considerably easier to base a family diagnosis on role analysis than on data relative to intrapsychic mechanisms, so that 'the concept furnished a tool of as yet hardly visualized promise'. An important source of resistance of the client against treatment was discovered in the culture conflict between the social worker and the client. The patient would need clarity as to the nature and the probable course of the treatment that was planned, while the worker showed the tendency to answer a question with a question, typical of the professional subculture of social work. This, however, was felt as a disapproval by the patient.

The old concept of 'family balance' which is referred to in casework and psychiatric literature had to be discarded as insufficiently clear. Using the social science terms of association and dissociation, the author explains that 'unless the adjustive process between the spouses is associative and the process of child development leads from dependency to a measure of independence, that is, dissociative, family balance is unlikely to occur'. Dr. Pollak disregards here that there is always family balance, even though a neurotic or psy-

chotic balance, and that by the very process of social interaction pathological adjustment within the family is continually restored. However, he is absolutely right if he means that only if there is a good relationship between the parents is the child enabled to achieve a measure of emancipation. The author had to deal with the question whether the social science concepts proposed for integration into the body of theory underlying child guidance practice were really needed. Doubts were expressed by members of the team and it was felt that social casework always embraced the whole family. However, the author discovered that there was a divergence between theory and practice and that the workers, under the influence of psychoanalysis, were fascinated by concepts of greater specificity, such as the œdipus complex, reaction-formation, infantilization, etc., so that they neglected the broader concept of 'person in the situation' and forgot their real professional heritage, consisting of an emphasis on the family as a totality.

The rest of the first and the whole second chapter of the book deals with four case histories, which were worked out very lucidly with respect to the diagnoses (psychodynamics) of each parent and each child. By trying to simplify the multiple interaction patterns, a family diagnosis was arrived at and a treatment plan formulated. It consisted of helping the parents to an understanding of their own self-involvement in the handling of the child, and of helping the children, whose development had been arrested, to achieve the degree of dissociation from their parents appropriate to their ages. Great effort was exerted to prepare the child for clinic contact or, in other words, to remove the resistance of one or both parents against treatment of the child, especially when the child was referred by the school or another agency. There was also in one case the resistance of a nonmedical psychotherapist and in another case the resistance of the family physician which had to be overcome. The parents shrewdly utilized the professional person's resistance for their own resistances, which they expressed with the expectation that the child would outgrow its difficulties and that exposing the child to psychotherapy would stamp it with the stigma of insanity. Finally, the real fears were verbalized when the parents declared that the clinic would alienate the children from their parents. Dr. Pollak could have guided the reader even further and interpreted these resistances as resulting from the parents' fear of losing con-

trol over the children who had been exploited as scapegoats and as objects of vicarious gratifications. The family physician in a very arrogant manner simply refused to give up control. The psychotherapist, a woman, who had treated consecutively first the mother for one year and then the father for two years, expressed the opinion that the child needed no help if both parents could achieve a resolution of their conflicts. Of course, she had hardly touched the mother's defensive system and the father was still receiving some supportive therapy from her, therefore she was in no position to arouse hopes for a resolution of the parents' conflicts. However, one cannot deny the correctness of her statement in general terms, implying that a child's behavior disturbance, genetically caused by pathological needs of the parents, would disappear if the parents' need for the child's disturbance would be removed.

The fourth case which was particularly devoted to the demonstration of conflicting and incompatible social roles played by each member of the family is the most fascinating case report. Dr. Pollak had not foreseen, as he states previously, that the concept of social roles would prove to be so useful. It can also be associated with the phenomenon of separation anxiety as a motivating factor for incompatible role playing. In the first case, the mother by her poor housekeeping did not really frustrate the father, as the author believed, but by her ineffectiveness and spite provoked him, as infantile women always do, to play the role of her domineering and nagging mother. The parents did not frustrate each other's need for closeness, which was alien to them, but coöperated in a pathological sense to secure distance from each other, again for the purpose of overcoming the anxiety of separation from their parents, who had always been distant to each other. The mother's father is described as distant and withdrawn, and the father's father had preferred suicide to closeness with his wife. Peter's difficulties also had not developed accidentally but the mother had imposed them on him unconsciously to gratify her need for a mother. Then she was her own nagging mother, the boy's grandmother, while he represented herself as a girl. Thus, multiple interaction patterns can be unified under one common denominator: separation anxiety in reference to the grandparent.

Part III is entirely devoted to an investigation of the divergence between theory and practice in social work relative to the dynamic

importance of the father. A review of the literature proved that astonishingly little had been written about 'pop'. Somehow he had managed to remain in the background. Mary Richmond's warning, in her classic, Social Diagnosis, not to overlook the man of the family, had not been heeded. In practice the father was forgotten or not discovered and in theory he continued to be mentioned by some and not by others. The importance of both parents was stressed in theory but in practice it was concentrated on the mother-child relationship. Some authors even suggested the exclusive importance of the mother-child relationship. Considering the importance of the concepts of œdipal involvement and sibling rivalry in psychoanalysis, this appears puzzling indeed. Dr. Pollak gives the following reasons: favoring the principle of similarity, therapists are more likely to consider together concepts of the same quality, such as mother and child, than concepts of different quality, the child and his family. There is also a tendency for singularization of pluralities, the parent instead of the parents. Dichotomization of unequal, and therefore in their combination unmanageable, concepts is abandoned in favor of an assumption of singularity in parental influence. The author does not consider the bisexuality of the parent from the viewpoint of the child. He also wonders about the dichotomy of individual and environmental therapy, sometimes reformulated as direct and indirect therapy, and attacks indirect therapy as ineffective. He enumerates all the possible reasons responsible for singling out the mothers for therapy: there is first of all social convention, according to which the task of child care is assigned to the mother. In child guidance practice 'maternal child care' and 'determination of personality' have been declared synonymous, though classical psychoanalytic thinking should have suggested the opposite. The majority of social workers and child therapists are female and therefore have a preference for similarity in the clients. Many of these therapists because of their feministic tendencies even hate men. Sexual material is likely to come up in interviews and again is more easily discussed between members of the same gender. There are also unresolved œdipal conflicts of some workers and the wish to create better mothers than the workers' own mothers had been, which makes it more desirable to them to see mothers exclusively. The fathers are having difficulties in visiting the clinic because of the interference with their working hours. Last but not least if a

hypothesis once has been established it is not going to be abandoned easily but rather re-enforced.

To correct some misunderstandings I wish to add that turning the question back to the patient is a method of Rogers' nondirective therapy. Seeing a patient for less than three weekly hours cannot be called psychoanalysis. A patient starting analysis is informed explicitly that many of his questions will not be answered because the analyst might not know the answer, or he might know but the patient might not be able to utilize this knowledge yet, or the patient might know the answer himself. While in social work the emphasis is first on the total family and then becomes more concentrated on the mother-child relationship, the reverse process seems to have taken place in psychoanalysis: the emphasis first on the father and the œdipus complex and then more on the mother and the negative œdipus constellation. In a patriarchal or pioneer society, children increase the power of the father, but in an urban and more matriarchal society children often serve only the narcissism of a frigid mother and her desire to keep the husband away. Treatment of the total family is certainly an ideal solution to child psychotherapy, but economic problems have to be considered and indirect treatment of the family members who cannot be reached directly is still better than no therapy.

ERNEST A. RAPPAPORT (CHICAGO)

ERINNERUNGEN AN SIGMUND FREUD (Memories of Sigmund Freud). By Ludwig Binswanger. Berne, Switzerland: A. Francke AG Verlag, 1956. 120 pp.

Ludwig Binswanger's Memories of Sigmund Freud is a document of a rare friendship between two men who felt drawn to each other from the first moment they met. Their friendship lasted until Freud's death,—more than thirty years. This is the more remarkable as scientifically they never were really in agreement. Even in the summing up speech that Binswanger delivered at the celebration of Freud's eightieth birthday, he challenged the work of his great 'master and model'.

Binswanger's book, with its most interesting letters, presents a precious addition to the image of Freud. Binswanger's intention is not so much to throw light on Freud the scientist but on Freud in

his human qualities, on the man who in his opinion is still greatly misjudged.

Binswanger hesitated for a long time before he parted with the privacy of his relationship to Freud. A letter written by Freud in 1936 made Binswanger reluctant to publish the documents of their friendship. When he prepared his celebration speech and asked Freud's permission to use some recollections from their personal conversations or to quote some of his letters, Freud's reply was: 'I certainly don't want to influence you, what to say and what not to say; I don't want to ruin the pleasure of the task you have undertaken. But I should like to remind you of the situation and ask you not to give away the intimacies of our friendship to those strangers. We have been faithful to each other for a quarter of a century and have made no ado about it.'

It is fortunate that Binswanger eventually decided to publish his memories and a selection of their letters. There were five visits of Binswanger to Freud; one visit Freud paid to Binswanger in his home in Kreuzlingen (Switzerland) in 1912, when Binswanger was threatened by an ominous disease; and meetings at various psychoanalytic conventions. The main expression of their friendship, however, consists of a continuous correspondence.

Freud was fifty-one, Binswanger twenty-six years old, when they met for the first time. C. G. Jung—at that time Oberarzt in Burghölzli, Zürich—invited his young assistant to accompany him on his trip to Freud in Vienna. Binswanger, who comes from a family where psychiatry is tradition, was most eager to meet the creator of psychoanalysis in person. Freud took an immediate liking to Binswanger; an attitude of hope, disappointment, and love remains throughout their relationship. 'Like all fathers I am weak and blind and therefore proud of such a son. It is hard for me to reproach him', wrote Freud (May 1911), when he felt Binswanger was not positive enough in his acceptance of psychoanalysis and its propagation in Switzerland.

Even at the first meeting the nature of their relationship was understood—at least symbolically. Freud had asked his visitors to tell him their dreams on the first night in Vienna. The interpretation Freud gave Binswanger was prophetic and startling, and Freud still remembered it thirty years later: the dreamer wished to marry his eldest daughter and rejected this idea at the same time.

'I shall not marry into a house with such a shabby chandelier.'

Conflicts about psychoanalysis pervade Binswanger's whole life. He accepts the basic discoveries of psychoanalysis as the only method of understanding and treating neurosis. Yet he could never be satisfied with Freud's 'naturalism' (the shabby chandelier) and felt the need to grow beyond it, searching for higher philosophical concepts which he found in Husserl's phenomenology and Heidegger's ontology. Psychoanalysis remained for him the stimulus which caused him 'to submerge himself deeper and deeper into the problem of human existence' and its philosophical cognition. To Freud, however, philosophy as Binswanger sees it is pure speculation. He looked with some scepticism and irony at his young friend's needs: 'Has the philosophical devil finally got you in his clutches? Please, ease my mind.' But Freud respected Binswanger's intellectual development, and they remained friends. It was easier for Binswanger than for many of Freud's disciples, who were either smothered by the genius or rebelled against him and wanted to 'play pope themselves'. Binswanger writes: 'To be challenged by the great master and model could only confirm to me my own freedom'. The never changing loyalty of his friend made for an atmosphere in which Freud at times expressed himself casually and without reservation.

In 1911 Freud writes: 'It is certainly the task of the friend to drive away the gloomy thoughts which seize upon the aging by contradicting them. But I won't complain. Most of the time I believe anyhow that I have started something that will occupy mankind permanently; sometimes I become dissatisfied with the expansion and development of it, and slight doubts about the future come over me. Indeed, there is nothing for which man's organization makes him less fit than psychoanalysis.' In discussing the question under what conditions a traumatic experience precipitates a neurosis, Freud remarked: 'Constitution is everything'.

In 1929, after the death of Binswanger's twenty-year-old son, Freud wrote to him: 'We know that the acute grief after such a loss will subside. But one will remain unconsoled, will never find a substitute. Anything which might take its place, even if it does so completely, will remain something else. And really it is right that way. It is the only way to continue the love, from which one does not want to part.'

A reply to birthday greetings on his seventy-fifth anniversary said:

'Certainly, I have had many a good thing in my life, but altogether it has been hard. I was willing to love others [*andere lieb zu haben*], for example, you. But many made it impossible for me.'

When Binswanger delivered the speech at the celebration of Freud's eightieth birthday in Vienna, he discussed Freud's 'Naturalism' from his own philosophical point of view, and 'took him to account'. Freud's response was so characteristic, that it seems appropriate to conclude the review of Binswanger's valuable little book with this letter:

'My dear friend! A lovely surprise, your paper! Those who heard it and told me about it, were obviously unmoved; it must have been too difficult for them. Reading it, I enjoyed your beautiful diction, your erudition, the scope of your horizon, your tact in disagreeing. As you know, one can consume unlimited amounts of praise.

'Of course, I do not believe you. I have only dwelled on the groundfloor and in the basement of the building.—You claim, if one changes the viewpoint, one also sees an upper floor, where such distinguished guests as religion, art, etc., live. You are not the only one; most cultural specimens of the homo natura think the same. You are conservative in this respect, I am revolutionary. Had I another life to live I suppose I might assign a home in my humble little abode to those noble ones also. I have already found one for religion since I hit upon a category of "neurosis of mankind". But probably once again we do not see eye to eye, and only after centuries will our differences be settled.'

YELA LOWENFELD (NEW YORK)

MENTAL HEALTH AND INFANT DEVELOPMENT. Volume I—Papers and Discussion. 308 pp. Volume II—Case Histories. 289 pp. Edited by Kenneth Soddy, M.D. New York: Basic Books, Inc., 1956.

In 1952 The World Federation for Mental Health organized a seminar on Mental Health and Infant Development, at Chichester, Sussex. A teaching faculty of sixteen persons from Britain, France, and the United States presented lectures to a group of discussants from twenty-nine countries. Among the participants were psychiatrists, social workers, anthropologists, pediatricians, and others concerned with the welfare of children, all eminent in their professions and in their own countries. Volume One of these published proceedings of

the seminar contains, in abridged form, the lectures and discussions. Volume Two contains three groups of case histories from the United States, Britain, and France presented at the seminar. These case histories vary greatly in form and content. Some describe in detail both the subject's infancy and his later life into adulthood. Others describe infancy alone, or the childhood of a group,—the members, for example, of a French family of farmers. Most of these histories will be useful as subject matter for teachers of the development of children; some have exceptional importance because they illustrate the outcome in later life of certain traits and experiences of early childhood. The histories would have been more valuable if we had had more comments on them by the participants in the seminar. As it is, they constitute rich raw material from which the reader must largely draw his own conclusions.

Volume One is a remarkable compendium of what three countries can tell us about children: their psychosexual development in various cultures; their neuromuscular and intellectual growth; their education, and that of their parents; and the advancement of their welfare by the communities in which they live. Writers from France, Britain, and the United States compare children's life in those three countries, and others (including René Spitz, Jenny Aubry, and Anna Freud) describe the infant's relationships with those about it. In other sections the detrimental effects on children of social changes, and how they can be helped to master them, are discussed.

Most of these lectures are composed with charm and humor. They are vividly and simply expressed and are full of information. English and American workers with children usually find little variety in their reading, but there is variety here, both in the manner of presentation and the subject-matter. D. R. MacCalman, for example, quotes vivid descriptions of Scottish children in Scottish dialect; Anna Freud gives us an epigram reminiscent of Shaw (and not, I think, quite accurate): 'Children learn to quarrel from their parents and practice it on their siblings'. Really well written scientific discussion is so rare today that this volume would, if it had no other value, be important just because it presents a survey of the subject in a form so pleasant to read and so easy to follow. It is additionally valuable, however, because it raises questions we do not often think about. A French writer on children (Juliette Favez-Boutonnier), for example, points out some evidences of the parents' participation in

the œdipal drama,—a part of the picture often ignored in America. Many observations by British and French workers emphasize differences in the rearing of children in different social classes. These observations have a freshness to us because so much of the technical literature we read is written by fellow Americans, and it is a pleasure to see things differently, particularly through the eyes of French or Scottish observers.

The lectures appear to be comprehensive and authoritative. The volumes are attractively printed, and the first has an adequate index.

G. F.

PATTERNS OF MOTHERING. By Sylvia Brody, Ph.D. New York: International Universities Press, Inc., 1956. 446 pp.

Out of a neat and circumscribed research study of the presenting behavior of thirty-two mothers and their babies, derived from an overall sample of one hundred twenty-eight mothers, has grown a valuable source book of information on patterns of mothering. The excellence both of the literary style and of the clear grouping of a wide range of topics, makes it a model of presentation and easy assimilation. In brief, the desiderata for the ideal mother have been realized, as between Dr. Brody and her readers in need of easy access to recorded data. And, to continue the metaphor, the range of relevant literature provided is so wide as to be omnivorous. It does not stop at human patterns of mothering, no matter how primitive, but continues on into other species of the animal kingdom. This is very interesting but, although wide in scope, it seems to leave out some of the most important modern works and to include exemplification from old material, which could be misleading.

The modern work, which bears so closely on the examples provided and the author's discussion of the variations of maternal behavior within the same animal species, readily brings to mind such names as Tinbergen and Lorenz. While its attractiveness lies in the fact that it is largely concerned with the patterns of behavior of animals in conditions either of freedom or of its closest counterparts, as contrasted with the aberrant behavior of the laboratory animals of Masserman, or other confined creatures, e.g., the baboons and monkeys studied at close quarters by Zuckerman and quoted here, its importance is paramount.

Tinbergen and Lorenz, among other investigators, have shown that in a variety of creatures, of which birds of different species have been most closely studied, the first visual object associatively connected with the care of itself (sometimes incorrectly associated) becomes 'imprinted', not only as its first love object, but usually also as its last, i.e., its sole love object. If its love object is not of its own species, then its life pattern of instinctual object choice is radically changed, to the point that it may remain wholly unconcerned with its own species. It is now known that the characteristic song of a bird is not a matter of instinctual endowment, but must be individually learned. The importance of such findings cannot be overestimated, not only in the study of nonhuman animals, but also of human ones, especially in regard to such basic patterns as the repetition of mothering from one generation to another. In the case of the infant baboons studied at close quarters by Zuckerman on 'Monkey Hill', as it was called, in the London Zoo, there was not much likelihood of repetition of their maternal experiences, since only one survived out of the fourteen reported, a circumstance unlikely to be repeated in Nature.

The pattern of subprimate behavior quoted from Zuckerman's book largely concerned the tenacity with which the parents both held on to their dead infant yet, in the course of time, picked it over and possibly ate it, to the point of disappearance. Although Zuckerman is careful to refute any specific 'mothering' implications from this run of events, Dr. Brody links it with others, in rats and cats, in which the young may get eaten or crushed by their mothers. From these and related facts, she deduces that 'there is poor appreciation of the young as separate living beings'. In that case, rabbits should also have been emphasized as they notoriously eat their young, but in similarly abnormal conditions, usually because of fright from being prematurely viewed, plus confinement, or because of gross malnutrition. The fact is, as Zuckerman states explicitly elsewhere in the book, that both sexes of baboons and monkeys treat the body of a newly killed rat or sparrow as they would that of the dead young of their own species. It follows, therefore, that the example, as quoted, becomes dubious as a pattern of mothering. Perhaps it is not irrelevant to the theme of comparative behavior to state that the abnormal horrors and carnage, which eventuated from confining a number of baboons to the inescapable limits of 'Monkey

Hill', brought about such strong public protests that it had to be brought to an end many years ago.

Reverting to the human material which coöperated in the present study as a voluntary act, one can only admire the skill and celerity with which these finely etched, individual studies were made by a team. The time spent in actual observation of each mother with her baby was usually six hours, of which two were in the home. Much can be deduced within such a time span. The variations of handling and of affective response between the mother-infant couple, both good and bad, are enormous; and it would seem valid to draw psychopathological conclusions from them. However, an even wider gleaning from the psychoanalytic literature would be required in order faithfully to reflect its multidimensionality.

AUGUSTA BONNARD (LONDON)

BEING AND NOTHINGNESS. An Essay on Phenomenological Ontology. By Jean-Paul Sartre. Translated and with an introduction by Hazel E. Barnes. New York: Philosophical Library, 1956. 638 pp.

The famous book of Jean-Paul Sartre, *L'Être et le Néant,* now available in this excellent translation, may interest psychoanalysts for a variety of reasons. It is the fruit of a remarkable development in scientific thought concerning the human condition, known under the name its instigator, Edmund Husserl, gave it: phenomenology. Husserl (1859-1938), a close contemporary of Freud, mentions Brentano (whose lectures on philosophy Freud attended for some time) as one of his predecessors. Freud and Husserl, both investigating the human condition but from different angles, went completely independent ways, neither of them ever mentioning the other's name or work. Pure description of the data of consciousness is one of the fundamental ideas of Husserl's phenomenological method. Husserl wanted to start from all that is directly given, from what can immediately be seen and apprehended, still prior to all theoretical thinking. His plan seems in every way acceptable, yet it is a grave lesson that it proved workable only to a limited extent. The psychoanalyst is not surprised when qualified critics demonstrate that Husserl did not succeed in safeguarding his phenomenological descriptions from unconscious biases. However, there can

be no doubt that Husserl was a sincere seeker after universally valid truth, sharing the conviction that man must be regarded as a meaningful being in a meaningful reality, with an inner destiny which is considered essentially realizable. Of the conditions necessary to maintain such a view, the definite religious convictions, the definite moral judgments, and the stable social relations have disappeared; the standard of knowledge has perhaps been less affected. In spite of the enormous increase of knowledge, man has become more problematic to himself than ever. This is where the philosophy of existence comes in, questioning all earlier conceptions of man and posing again the agelong question, 'Who or what is man?'.

It did not escape Husserl that in human reality rational thinking is surrounded by a large expanse of more or less conscious elements which are emotional and not rational. His pupil, Heidegger, placed this irrationality in the center of his outlook on man. By some, e.g., Binswanger, Heidegger's work is considered of great importance for psychopathology because he posited the problem of human life more profoundly than had ever been done before. Freud once wrote, 'Life is not much, but it is all we have'. Compared with Heidegger's view of life, Freud's valuation should be called exceedingly optimistic. According to Heidegger, man tries to escape the disconsolate nature of his existence. He does not want to face the tragedy of being cast into a strange and hostile world of which, in his anguish, he fathoms the senselessness; yet he is always impelled to act, as he cannot help transcending himself into the future. Soundings should be made beyond or beneath our commonplace familiarity with the world and then it will appear that this familiarity covers an original foreignness of existence regarding the world. The uncanniness *(Unheimlichkeit)* of existence is escaped by the trusted absorption in the world. One point is worth mentioning. Heidegger does not mean to give a personal interpretation of existence, but a purely objective analysis. He has no doubt but that the result of his structural investigation applies to everybody. Starting from the analysis of his own existence he thinks he can designate the universal, which applies to every existence.

Sartre, taking his starting point from Heidegger, did not discover more joyful sides to human existence. Though he accuses Heidegger of desexualizing human existence in an indefensible way, and though Sartre proves himself to be sufficiently familiar with Eros,

his outlook on human existence is no whit more optimistic than Heidegger's. No less than Heidegger does Sartre regard man as the bearer of finitude and the deputy of the nothing. A few quotations may suffice: 'Man strives by nature after the impossible. . . . To be a man means trying to be God. . . . Man is like a donkey, running after a carrot fastened to the shaft of the cart he is drawing. . . . Man is a disease of being. . . . Without use. . . . Man is a useless passion.' These assertions are found in Sartre's work not as studiously cynical aphorisms or as witty whims; no,—he claims to be able to prove all of them irrefutably. For that purpose only one thing is needed,—we have to accept a definite premise. Sartre starts from the viewpoint that the only reality to which a defect, an incompleteness is attached, is the human reality. Man's struggle to undo this defect is doomed to perpetual failure. Sartre sharply contrasts the unconscious 'Being-in-itself' of all things and phenomena and the 'Being-for-itself' of consciousness. To the Being-in-itself Sartre attributes a far greater dignity. The In-itself is what it is, it has no bearing on anything but itself, incapable of the distinction of an inside and an outside, without connection with anything else, massive, solid and positive. In short it is what it is. Now the For-itself exactly is not what it is, but what has to be. Man's present being has meaning only in the light of the future toward which he projects himself. Sartre considers consciousness to be a Nothingness, but as such it is a revelation of Being. All consciousness is presence with and reflection of something it is not itself. It is nothing in respect to all the things it reflects and has in respect to these no independent existence at all. Consciousness *is,* but solely as a denial. It perpetually negates the In-itself by realizing inwardly that it is not the In-itself. In the view of Sartre, the appearance of the For-itself therefore is a fall, a self-degradation, a self-loss, a disintegration of the In-itself. Freud said of consciousness that it is not much, but it is all we have. Sartre calls it absolute, it is true, but then as a perfectly empty semblance. The consequence of this is that subjectivity is made a sheer not-being and that the apprehending of oneself, self-consciousness, becomes impossible.

With regard to this defeatist attitude toward human reality, one cannot avoid the suspicion that this doctrine is little else but the systematization and objectification of a purely personal reaction to life. Sartre too, as Heidegger does, believes in metaphysical moods

revealing universal structures of being. According to Sartre, man has not anguish, but he *is* essentially anguish, in the face of his unlimited possibilities, or in other words in the face of his freedom. This doctrine implies that the man who is aware of his freedom and who ascertains that it is he who gives sense to the world, would have to seize himself as pure anguish. That this occurs only rarely, Sartre ascribes to the flight from anguish. Man denies anguish, but he does so out of anguish. This is what Sartre calls 'bad faith'. He points out that in bad faith we are anguish to escape anguish, in the unity of the same consciousness. From this position Sartre develops a criticism of psychoanalytic views, to which I shall refer later on.

Sartre's expositions on man's corporality probably constitute the most important part of his phenomenological inquiries. He states that in the philosophical approach to the problem of the body, one's own body is often looked at as it appears to another. However, it should be seen first of all within the frame of the ontological order of the Being-for-itself. That means that the body is not in the first place a thing in the midst of the world, but is, on the contrary, a gateway for us to the things in the world. We are fixed in this world in a quite peculiar way: by our bodies and our sense organs. 'In every mood I feel, with everything I perceive, I experience the wide world, but at the same time my bodily presence in that world. The experience of the body-for-me may all at once turn into the experience of the body as a thing, for instance, if the spying eye of a stranger is suddenly known to be fixed upon me.' Sartre's observations about the body demonstrate that the order of Being-for-itself *(cogito)* and that of Being-in-itself (full being) are entirely dependent and interwoven. De Waelhens, in pointing this out, concludes that these theorems become unintelligible and untenable within the framework of Sartre's ontology, which never tires of stressing the irreconcilable antinomy between the In-itself and the For-itself.

Psychoanalysis made us familiar with the difficulties inherent in love relationships, but this did not lead to such a pessimistic evaluation of all human relations as Sartre preaches. Sartre looks upon all human relations as blind processes of tragic entanglements. 'The meeting with the other is essentially no enrichment of my world, but an encroachment on it, endangering me; it is a system revolving round a different axis from mine.' The recognition of the other as

a center of reference causes an 'internal hemorrhage of my world which bleeds in his direction'. The profoundest danger Sartre sees in the association with the Other is that 'he makes me into something I am, imposing on me a fixed invariable mode of being, which would involve the death of my possibilities'. As Malraux expressed it: each consciousness is the death of the other. This is especially apparent in the primary way of meeting which, according to Sartre, lies at the basis of every theory of the other, namely, the being discovered by the regarding eye, the 'Look'. Sartre only knows of the cold, loveless Look. 'The effect of the Look is that it nails me down, as it were on the spot, causes me to petrify into an object and lose control of myself. For that reason, shame, fear and pride are the original feelings with which I react to the meeting with the Other. Love in all its variants is an unrealizable postulate.'

A thorough understanding of psychoanalysis has not been acquired by Sartre. He hardly goes beyond the 'Introductory Lectures' and he preferably refers to Stekel. Sartre analyzes the attitude of bad faith in which man tries to conceal from himself a disagreeable truth, for instance the anguish he is. 'How is it possible to deceive oneself, for as a deceiver I am to know the truth that is masked from me as the one who is deceived.' To escape the difficulties of neither being able to deny, nor being able to understand bad faith, as Sartre says, the unconscious is gladly resorted to and, according to him, psychoanalytic censorship restores the duality of deceiver and deceived. But, Sartre argues, the censorship has to choose and in order to choose, it has to conceive of what can be chosen. He cannot imagine a form of knowing which would be ignorance of itself. According to him all knowing is consciousness of knowing. The censorship has to be conscious of itself. It must be consciousness of the tendency to repression, but calculated not to be consciousness of it. That is to say, the censorship must be in bad faith. The psychoanalytic doctrine of the repressed unconscious, the whole psychoanalytic theory of the neuroses, stands or falls with the possibility that man can know something not to know it and not know something to know it. No psychoanalyst will doubt that this possibility exists, that it forms part of the human condition. Already the phenomenon of the forgotten name, which nevertheless is 'on the tip of the tongue' is sufficient proof. The inability to recall the name is as a rule attended with the consciousness of knowing it all the same. As

soon as the right name is mentioned, we recognize it immediately. This commonplace phenomenon proves that man can know something not to know it and not know something to know it. Not anyone in his right mind will feel inclined to associate this common phenomenon with such a thing as bad faith. It is a curious fact that according to the theory of the phenomenologist, Sartre, this phenomenon is impossible. The reality of the phenomenon cannot be questioned, so that our doubt will have to be directed to Sartre's ontological premises. The not-knowing and yet knowing of a forgotten name contradicts both Sartre's postulate of the translucence of consciousness and that of the conscious unity of the psychic. The facts force us to recognize an unconscious unity of the psychic, even where the conscious unity is lacking. Such a statement is anathema to Sartre because it contradicts 'his peculiar concept of a free translucent consciousness' (Barnes), but nevertheless it expresses a fundamental aspect of the human condition. His untenable concept inspires Sartre to a somewhat amazing criticism of psychoanalytic theory. In his opinion, the rejection of the conscious unity of the psychic compelled Freud to presuppose everywhere a magic unity connecting phenomena at a distance across obstacles; his attempts to construct a real duality and even trinity are said only to have resulted in a verbal terminology. In the matter of bad faith Sartre reproaches psychoanalysis for replacing the duality of deceiver and deceived by that of the id and the ego, and for introducing into the deepest subjectivity the intersubjective structure of the *Mit-sein* (Being-with). I think Sartre is right in stating that psychoanalysis introduced the intersubjective structure of the *Mit-sein* into the deepest subjectivity, though it seems more correct to speak of 'discovered' instead of 'introduced'. But in doing so, Sartre reproaches Freud for one of his greatest discoveries. For as such we have to consider Freud's discovery that in the building up of the ego and superego, by the way of identifications, the intersubjective structure of the *Mit-sein* is really assimilated into the child's subjectivity.

Although to the psychoanalyst the conscious subject is the responsible executing agent of the total personality, he yet sees little reason to make the ideas of freedom, choice, and responsibility the central themes of his scientific communications. It might be said that by his method he approaches freedom from its opposite, i.e., bondage. The different ways in which this bondage presents itself,

he can very well describe in detail, but freedom remains elusive to him. One cannot turn a page of Being and Nothingness but to read the words freedom, responsibility, choice, free choice, etc. Sartre approaches man from a metaphysical ontology, that is to say, he starts from postulates concerning 'Being' about which, as appears from agelong experience, agreement could never be obtained, unlike empirical psychology, which applies methods of approach aiming at the obtaining of agreement. Setting out from the postulate that the nothing enters the world through human freedom, he concludes that freedom cannot possibly be distinguished from the being of human reality. Man is necessarily conscious of freedom, and he is either entirely and always free, or he is not free at all. In Sartre's opinion, the neurotic man too is free. It is his free choice of Being, his free project of himself that he is as he is. Being is choosing oneself. Connected with this is the fact that Sartre sometimes chooses examples for the purpose of illustrating freedom, which are somewhat amazing. A man who, on a path along an abyss, is assailed by masochistic or suicidal impulses, or a gambler who, in the gaming room, again succumbs to his passion for gambling in spite of a contrary intention, Sartre presents to us as illustrations of human freedom. The temperament or character too of a person is nothing but his free project. It goes without saying that Sartre will have none of psychic heredity; all that is just modern ideology. If psychoanalytic inquiry established one thing with certainty concerning man, it is the significance of earlier to earliest experiences of life for one's later fate. In view of these empirical findings, it is to be expected that it must be a difficult job for Sartre to make good his assertion that 'nothing happens to me but what is chosen'. He acquits himself of this task by a bold Copernican turn. 'If freedom', he writes, 'is the choice of a goal as a function of the past, the past only is what it is, with reference to the goal chosen. . . . It is the future that decides if the past is living or dead. . . . One can knock out the past by simply anticipating another future.' In this case the past collapses like a sandbag. This is possible 'because the only strength of the past flows to it from out of the future'. There is a grain of truth hidden in what Sartre says, but through his onesidedness it becomes an exaggerated untruth. What is lacking in Sartre is what Freud once called 'the great psychic labor' necessary for freeing oneself from the past.

On the foundation of his ontology Sartre erects a remarkable edifice, his sketch of an 'existential psychoanalysis'. What Sartre wants to get at is the 'unity of responsibility, lovable or detestable, blameworthy or praiseworthy, in short personal, the free unification'. Being means to everybody making oneself into a unity in the world. Sartre thinks he may ask biographers to describe the irreducible unification which, for instance, Flaubert *is*, the unification of an original project. The personality is only to be discovered in the initial project constituting it. Sartre thinks he can discover and unravel, by a comparison of the various empiric tendencies of a person, the fundamental project common to all these tendencies. It appears incompatible with this view that Sartre need not examine man empirically in order to learn what this fundamental project is. He starts by postulating that man is fundamentally a 'wish to be'. On ontological grounds he next proves that the fundamental project of human reality is that man is the being that projects to be God. The aims of psychoanalysis as an empiric science can only be limited and fragmentary as those of any empiric science. It cannot aspire to elucidate the 'mystery' man is, as Gabriel Marcel expresses it. Sartre's aspiration far surpasses the aim of psychoanalysis. If Sartre's projected 'method' could be thought realistic in the sense of 'truth-revealing', it is clear that with a sufficiently cleancut distinction of matters, a controversy between Sartre's endeavor and psychoanalysis can never arise. The latter need not oppose Sartre's endeavor. It contents itself with the modest part of a handmaid, although she will sometimes prove to be wiser than her master. I can pass over the points on which, according to Sartre, empiric and existential psychoanalysis correspond. He sees the latter too much as a philosophical theoretical doctrine, as can be expected from a philosopher without access to empirical evidence. This shows itself also in his misconception of the repressed unconscious. According to Sartre, Freud's psychoanalysis starts from the postulate of the existence of an unconscious psychism, which is essentially inaccessible to the intuition of the subject. He is unaware that this assertion is completely at variance with Freud's statement about the genesis of the repressed unconscious, that it has been essentially either conscious or *bewusstseinsfähig* (capable of being conscious), and that one of the fundamental features of Freud's doctrine is exactly that the repressed unconscious is ever pressing to become conscious.

One ought to guard oneself from judging the value of the phenomenological approach from Sartre's questionable assertions, of which I mentioned only a few. Although a master of phenomenological analysis, Sartre runs the risk of discrediting the phenomenological method by forcing the phenomenological data into the straight-jacket of his ontology.

The excellent introduction by the translator, Dr. Barnes, certainly will help many readers to understand Sartre's thinking.

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ABSTRACTS

International Journal of Psychoanalysis. XXXVII, 1956. (The Freud Centenary Number.)

Report on My Studies in Paris and Berlin (1886). Sigmund Freud. Pp. 2-7.

In this report to the Vienna Faculty of Medicine, on the completion of a 'Traveling Bursary', Freud describes his period of study at the Salpêtrière. He had originally intended to apply himself to problems of the cerebral atrophies and degenerations of childhood, but found the laboratory resources utterly unsatisfactory, in sharp contrast to the clinic conducted by Charcot. The clinical experience was valuable, but Freud was most stimulated by his scientific and personal acquaintance with Charcot, whom he admired without reservations. Freud believed that clinicians other than Charcot had less understanding of hysteria than did doctors in the Middle Ages. The recognition of hysteria in males was a major forward step, as was the concept of traumatic hysteria. He was deeply moved by his teacher's demonstrations of hypnosis, which he discusses at some length.

On the Psychical Mechanism of Hysterical Phenomena (1893). Josef Breuer and Sigmund Freud. Pp. 8-13.

This lecture, not previously published in English, was actually the work of Freud alone. After paying tribute to Charcot, he discusses the clinical and pathogenic characteristics of hysteria, demonstrating that 'common' hysteria (that not due to physical trauma) has the same pattern as traumatic hysteria (that due to physical trauma). 'Hysterical patients suffer from incompletely abreacted psychical traumas.' He explains the treatment of such cases as the re-experiencing of the psychic trauma in order to complete the emotional reaction to it, thus freeing the patient of the affect, hitherto 'strangulated', attached to the trauma.

On the Teaching of Psychoanalysis in Universities (1918). Sigmund Freud. Pp. 14-15.

Freud expressed the belief that analysts had little or no need for universities. But a grave fault in medical education was emphasis on the physical, with no regard for the psychogenic. Where psychiatry was taught, it was purely descriptive and therefore of little value for therapy. Universities could gain much by attention to analysis in the curriculum.

Memorandum on the Electrical Treatment of War Neurotics (1920). Sigmund Freud. Pp. 16-18.

This is Freud's report to the Austrian War Ministry, which was investigating rumors that soldiers with war neuroses had been brutally treated by army doctors. He first clarified the question whether 'war neurosis' has physical or

psychological causes, and pointed out its resemblance to the neuroses of peacetime resulting from unconscious conflict and ambivalence. Electrical stimulation was, in German hospitals, given with such violence that accidental deaths and suicides resulted. Such violent 'treatment' was intended to be even more unbearable than facing up to military duty. Essentially, it was a procedure directed to furthering the war rather than to helping the patient, and was of little or no therapeutic value.

The Inception of 'Totem and Taboo'. Ernest Jones. Pp. 34-35.

Freud was satisfied with very few of his writings. The three he liked best were the last chapter of The Interpretation of Dreams, the last chapter of Totem and Taboo, and his essay The Unconscious. All three were 'written at breakneck speed, sometimes in an almost dreamlike trance'. His enormous sense of elation on writing Totem and Taboo was soon replaced by doubt and misgiving, which proved to be totally subjective in origin. His anxieties were aroused by living through the excitement of killing and eating the father, a situation different from, and much more disturbing than, describing the œdipal problem of the *wish* to kill the father. His correspondence and discussions with Jones, Ferenczi, and Abraham succeeded in reassuring him.

Character and Neurosis. Herman Nunberg. Pp. 36-45.

Character, a synthesis of ego traits, habits, and attitudes, may be considered from various points of view: descriptive, genetic, structural, dynamic, economic, and libidinal. It is formed by the interplay of various constituent elements: fixated infantile experiences and transformed instinctual drives; interaction between id, ego, and superego; molding by the id and by the environment. Much has been written about 'character types', those within and those outside normal limits. One seldom, however, sees pure types. Different forces produce different types of character,—ambivalent, impulsive, inhibited, and others. Similar forces are at work in the formation of neurotic symptoms and of character. The difference between neurosis and character is that the neurotic conflict is still active, though often invisible, in neurosis, whereas it disappears in character. The difference between symptom neurosis and character neurosis is therefore not very significant. If repression fails, a character trait or habit may degenerate into a frank symptom. 'In other words, the character neurosis is, finally, a symptom neurosis.'

Phylogenetic vs. Ontogenetic Experience. Robert Fliess. Pp. 46-60.

Freud, like many of his followers, had great difficulty in accepting the role of phylogenesis although without it we cannot understand such phenomena as intense sibling rivalry in an only child or the fact that wood can be a symbol for mother. Using dreams, a passage from the analysis of Little Hans, and other data, Fliess examines this question and concludes that one must at times 'sup-

plement individual with collective experience, historic with prehistoric material', even if it is hard to imagine how phylogenetic vestiges can exist.

The Schreber Case. Franz Baumeyer. Pp. 61-74.

After the second World War, the author had opportunity to examine much of the original clinical records of Schreber kept at the institutions in which he was confined. He also amplified the record by data obtained from a living relative. The features of Schreber's several psychotic episodes are re-examined with special reference to his relationship with his wife, his father, the older jurists over whom he was appointed President of the Court, and others. These data supplement our knowledge of the conditions leading to the emergence of Schreber's homosexuality.

Freud's Repression Concept. A Survey and Attempted Clarification. Peter Madison. Pp. 75-81.

The concepts of repression, defense, and anxiety have become the core of modern analytic and psychiatric theory. The development of some ideas has been so complex, contradictory, and uneven as to make it most difficult to gain clear understanding. This is especially true of the 'repression-defense theory'. 'Defense' refers to all forms of ego protection against inner impulses perceived as dangerous. The term 'repression' is sometimes used with that same meaning. It is also used to mean the keeping of ideas from consciousness, through isolation, undoing, and reaction-formation, and in other ways. 'Repression' can also mean ego protection through emotional inhibition. Finally, it is sometimes applied to hysterical amnesia, forgetting. Sharper definition and usage of the word will contribute to clearer thinking and improved technique.

Freud's Writings on Art. Louis Fraiberg. Pp. 82-96.

Freud considered artists individuals with special aptitudes for assuaging the pain of an unconscious conflict by a temporary substitute gratification. Art achieves its psychic results by means of an adult form of fantasy-making or play. The artist is more sensitive to psychic stimuli than are most people, and better able to clothe his meaning in æsthetic form and symbols that veil the underlying instinctual impulses. Through his creation, the artist discharges enough tension to make his conflicts tolerable for a while. In seeking tranquility, the artist is not different from the scientist, the lawyer, or others. The social function of art lies in its establishing communication of mind with mind, psyche with psyche.

Dream and Vision. Some Remarks on Freud's Egyptian Bird Dream. Eva M. Rosenfeld. Pp. 97-105.

This dream is reviewed in some detail. It occurred when Freud was about eight, or perhaps later. Freud examined its œdipal and other implications in The Interpretation of Dreams. Rosenfeld discusses the symbolic value of this dream for understanding Freud.

Freud and the Future. Thomas Mann. Pp. 106-115.

This speech was originally presented at the celebration of Freud's eightieth birthday in 1936. Mann stressed the close relation between creative writing and (analytic) science, referring to the 'pre-freudian' analytic perceptions and premonitions in Nietzsche, Novalis, Kierkegaard, and Schopenhauer. The bond between creative writing and science lies in love of truth and in understanding disease as an instrument of knowledge. Life, to the writer and to the analyst, is a succession, a moving in others' steps, an identification. One searches the past for patterns that provide the strength and skill to take a future step: life and living are a kind of reanimation of which myth and history provide many examples. Mann wondered, in fact, whether his talk on Freud and the Future might not better have been called Freud and the Myth.

JOSEPH LANDER

Psychoanalytic Review. XLIII, 1956.

Ego Movement and Identification. A. Chapman Isham. Pp. 1-17.

The author examines the problem of ego movement in the light of his linguistic definition of the ego as 'I'. Concluding that 'I move', and that the current psychoanalytic ego cannot move if defined in terms of functions and structures, he reviews the psychological concept of movement. He then presents a classification of movement. Out of this comes a definition of movement as a change in relationship between two objects, the ego usually being identified with one of these, the self. The identification of the ego with the self is called primary identification. This identification does not involve movement. Primary identification may be subdivided into three types: simple, introjective, and divided. These are exemplified. Besides primary identification there is perceptual identification which does involve ego movement. The paper concludes with a brief note on imitation as a form of identification.

AUTHOR'S ABSTRACT

Spasmodic Torticollis. William F. Murphy and Mignon Chasen. Pp. 18-30.

This condition responds poorly to the usual organic therapeutic measures, even to surgery by the most skilful. Psychotherapy and analysis have proved more effective. In the case described in this paper, the sector treatment method of Deutsch produced good results; reasons for the choice of organ, the past conflicts, the precipitating factors, and the current conflict could all be demonstrated.

A Note on Some Biologic Parallels Between Certain Innate Animal Behavior and Moral Masochism. Esther Menaker. Pp. 31-41.

The primary purpose of the instinctual life at all evolutionary levels seems clearly directed toward survival, though the complexities of man's psychic life tend at times to obscure this basic fact. Behavior patterns evolve as adaptive

mechanisms. Lorenz's work on birds, fish, and some animals stresses that their behavior patterns are as intrinsic to the individual as are his teeth or his claws. One such pattern among some species is the assumption of a role of utter submission when almost vanquished in mortal combat with a member of one's own species: under such conditions the victor, able and apparently ready to inflict the final killing blows, fails to do so, inhibits his aggression, and the wounded and beaten one is allowed to survive. Analogous behavior is seen in the assumption by infants of a submissive role which elicits new warmth from a mother who was previously relatively ungiving to a degree threatening psychic, and perhaps physical, survival. This psychic attitude of submissiveness is the forerunner of moral masochism.

Dream Analysis Within Dreams. Joseph Wilder. Pp. 42-56.

Such dreams should be viewed sceptically and with great caution, as they are sometimes used to mislead the dreamer or the analyst. In some cases the function of the dream within a dream is to turn unpleasant reality into a dream. The first part of a dream sequence in this type of dream 'is the important and original part'. The greatest value of this type of dream lies in its use in the analysis of transference and resistance. Dreams during analysis are strongly influenced by the analytic process.

Should Patients Be Presented in Person? Harold I. Lief. Pp. 57-67.

It is generally supposed that such presentation, in the psychiatric training of residents and others, frightens the patient and harms the therapeutic relationship. The author studied this question, comparing presentation of the patient to a group (residents, staff members) with presentation of the patient to a supervising psychiatrist only. From experience with forty-eight patients, he concludes that this procedure is safe and, in fact, at times decidedly advantageous. Curiously enough, the many patients presented to the group seem to derive direct help from the experience. This may occur because of the intensity of the emotional experience in such a presentation to a group, and the capacity of the therapist to utilize this intense emotional experience in subsequent work with the patients.

Psychotherapy of the Aged. Alvin I. Goldfarb. Pp. 68-81.

Experience of recent years tends to dissipate the pessimism surrounding such treatment, which is aimed at inducing changes in feeling, thinking, and acting. These changes enhance the opportunity for pleasure and 'success', thereby increasing self-esteem and dignity. For successful treatment, the patient must possess at least a minimal capacity for 'actions of mastery'. Granted such a capacity, one can offer even the aged an increased sense of status and a sense of purpose.

Clinical Observations on the Effect of Analytically Oriented Group Therapy and Group Supervision on the Therapist. Cornelius Beukenkamp. Pp. 82-90.

Transference reactions in group treatment are more intense than in the in-

dividual relationship with a therapist. Combined analysis of the primary parent-child (analyst and patient) relationship, and the family-sibling-society (patient in the group treatment experience) relationship, proved more than helpful. Such patients acted out less and developed a less disabling dependency on the therapist. This combined analysis 'appears to reach the totality of the personality structure, since it utilizes the various transferences in a realistic, meaningful manner'.

A Contribution to the Problem of Sado-Masochism. F. S. Friedenberg. Pp. 91-96.

As Freud pointed out, all psychological phenomena follow psychological prototypes. It is suggested that sadism psychologically re-enacts such early psychological processes as biting, processes that simultaneously serve self-preservation and the pleasure principle. The phase of dentition is prototypical for sado-masochism. The intensity of the feelings of that phase explains its frequent use as a fixation point. Regression reaches this phase because intensity of reaction is mistaken for pleasure.

Salome, The Turning Point in the Life of Oscar Wilde. Edmund Bergler. Pp. 97-103.

The male homosexual is a masochistically regressed individual with a unique and specific elaboration of the unconscious masochistic precœdipal conflict with the mother. Wilde's marriage was one of his unsuccessful attempts to escape this masochistic attachment to the image of the mother as a cruel, self-willed giantess. Having in Salome proved to himself that women are cruel, Wilde thereafter felt free to turn entirely to homosexuality. Evidence is adduced to demonstrate the powerful drive to destroy himself: he clearly paved the way for his ultimate doom by taking certain steps that must inevitably lead to it. When he once said, 'The burnt child *loves* the fire', he was talking about himself.

The Origins of Peter Pan. Marietta Karpe. Pp. 104-110.

When Barrie was almost seven, his thirteen-year-old brother David died suddenly. The mother never completely accepted that loss during the remaining twenty-nine years of her life, and James Barrie devoted a prodigious amount of energy and ingenuity throughout his childhood in an attempt to comfort his mother and replace the invincible dead rival, older and superior to him in every way. In the creation of Peter Pan, he achieved the victory by combining the figures of David, the dead boy (flying through the night in his nightgown) who never grew up; the mother (for the part of Peter is written for and has always been played by a woman); and the image of himself. Barrie's attitude toward his parents is revealed in various ways, among them his constant reference to his mother by her maiden name, and his portrayal of Captain Hook as a murderous monster, castrated, hating and sly: it was stipulated that the same actor play the parts of Mr. Darling and Captain Hook. The tremendous success of the play rests largely on its theme of eternal youth and immortality.

A Hypnoanalytic Exploration of the Psychopathology of Blushing and Erythrophobia. Jerome M. Schneck. Pp. 111-115.

Schneck's patient revealed many of the components described by Fenichel and others in erythrophobics: blushing as a sign of sexual excitement; conflicts about exhibitionism; fear of the discovery of masturbation; fear of sexual aggressive strivings; the idea of being judged by others supplanting the idea of sexual contact with others. For this patient, blushing took the place of sexual reaction and orgasm, the symptom beginning with the cessation of intercourse and the establishment of a new life involving much planning and control. Hypnosis enabled the therapist to break through the defensive barrier of isolation.

The 'I'm Damned if I Do, and Damned if I Don't' Technique. Edmund Bergler. Pp. 116-119.

Brief clinical descriptions illustrate the thesis that the psychic masochist pursues several goals: the proof that everyone is mean to him; the deeply repressed tendency always to be the victim of mistreatment; the more superficial search for an excuse to mollify a superego that objects to the unconscious gain from the 'pleasure in displeasure'. Such patients ingeniously create situations in which their 'victims' are trapped in a way that allows them no alternative to seeming to mistreat the masochist: hence the title of this paper.

JOSEPH LANDER

Psychiatric Quarterly. XXX, 1956.

Psychotherapeutic Evolution and Its Implications. L. C. Kolb. Pp. 579-597.

This excellent eighth annual Hutchings lecture summarizes the essential deviations from classical psychoanalytic technique in treatment of schizophrenia, manic-depressive psychosis, and the delinquency described by Johnson and Szurek. The initial transference relationship differs in these several conditions. These differences dictate modifications of technique and demand that the therapist have a personality different from that of the child's parent.

In the treatment of schizophrenics, patience, tolerance, and ready availability of the therapist are required. Communication must be established on the basis of the patient's private symbolizations. The therapist interprets these in relation to reality. He must be an active participant, free to disclose his feelings and the meaning of his actions. Full resolution of the schizophrenic process has so far not been achieved, and should not be attempted because it would produce some undesirable effects.

In treatment of manic-depressives, transference develops into a clinging dependency to a severely critical parent figure. Interviews should occur once or twice weekly. Interpretation should be elastic but firm, nondemanding, and active, but with cautious regard for the severe superegos of these patients. Delinquents who act out by identifying with the unconscious antisocial wishes of their parents require special caution in the therapist lest his passive or active

permissiveness lead to acting out. It may be necessary for the therapist to intervene actively to prevent this.

Yurok Shell Money and 'Pains': A Freudian Interpretation. S. H. Posinsky. Pp. 598-632.

The author is an anthropologist with understanding of psychoanalysis. He discusses the culture of the Yurok Indians of northwestern California. He notes a similarity between the dentalium shells (aboriginal money of the Yurok) and the *telogetl,* psychosomatic pains which are the primary manifestations of illness among them. Since the Yurok value things in terms of money, virtue is expected to result in wealth, and vice in these pains. The causes of the pains, recovered by the shaman, are fingerlike in shape and covered with blood and slime, suspiciously similar in appearance to the shell money. The author concludes that the shell money and the pains are respectively the positive and negative aspects of the introjected breast or penis. The symbolism is overdetermined by accretion of meaning from the other levels of psychosexual development. The culture seems to develop an anxious, compulsive, and highly ritualized society with a variable mixture of 'conversion hysteria', which is most pronounced among the shamans. The author finds the anal phase surprisingly unimportant in child rearing and in the adult character of the Yurok.

JOSEPH BIERNOFF

Psychosomatic Medicine. XVIII, 1956.

A Study of the Psychodynamics of Duodenal Ulcer Exacerbations: With Special Reference to Treatment and the Problem of 'Specificity'. Avery D. Weisman. Pp. 2-42.

Six male patients with exacerbations of chronic duodenal ulcer were studied exhaustively by psychoanalysis and psychoanalytic therapy in an effort to detect psychological factors concomitant with the disease. 'Ulcer symptoms recurred most often when the threat of depletion exceeded the promise of replenishment and the resulting angry protest was restrained. The ulcer exacerbation was associated with no single factor operating alone but required the integrated presence of the nuclear conflict, basic fear, special ego defenses, and ambivalent interpersonal relationships.' Specificity and its meaning are discussed.

Psychodynamic Significance of Seizure Content in Psychomotor Epilepsy. Arthur W. Epstein and Frank Ervin. Pp. 43-45.

Two patients with psychomotor epilepsy were seen for more than one hundred hours of psychotherapy. They illustrate the authors' thesis that the content of the psychosomatic seizure, like that of dreams and psychotic ideation, is dependent on past experiences and on the organization of the personality, and is characterized by patterns of organization resembling the primary process. The authors conclude: 'Seizures have an adaptive value representing miscarried attempts to dispel mounting psychological tension not immediately soluble in reality'.

Reaction of the Adrenal Cortex to Emotional Stress. Eugene L. Bliss, Claude J. Migeon, C. H. Hardin Branch, and Leo T. Samuels. Pp. 56-76.

The level of 17-hydroxycorticosteroids in the peripheral blood and in the urine is used in these studies as an index of the reaction of the adrenal cortex to emotional stress occurring in ordinary life and in experimental conditions. Emotional excitation caused consistent but modest increases of the steroids in the blood and urine, but these increases did not show the same magnitude as after administration of adrenocorticotropic hormone, Piromen, insulin, electroshock treatment, or moderate exercise.

Recurrent Urinary Retention Due to Emotional Factors. Report of a Case. George E. Williams and Adelaide M. Johnson. Pp. 77-80.

Intensive psychotherapy with a woman subject to recurrent urinary retention revealed that attitudes of parent figures toward the patient's urogenital functions had been highly pathological. These attitudes and the patient's reactions to them seemed to be primary and specific etiological factors. By using this knowledge, predictions could be made during therapy of approaching episodes of urinary retention. No generalizations are made about the psychological concomitants of unexplained urinary retention, but it is suggested that additional studies of this sort might be of value for understanding such cases.

Herpes Recurrens—Emotional Factors. Report of a Case. Paul Weichselbaum. Pp. 81-83.

Weichselbaum reports on an immature, highly suggestible man who was subject to herpes of the shaft of the penis after every marital coital act, although there was no such reaction to extramarital intercourse. Factors from the patient's history are presented to demonstrate the psychological roots and significance of the reaction.

Coexisting Organ Neuroses. A Clinical Study. Peter L. Giovacchini. Pp. 84-88.

The case histories of two patients, each with peptic ulcer and hypertension, are reported and discussed. It is asserted that organ neuroses occur together or in combination with one another more frequently than one might expect from reading psychiatric literature. In the two cases discussed 'the psychosomatic "formulas" that have been postulated by the Chicago Institute for Psychoanalysis seem to apply, . . . even though the entities were found in combination with one another'.

Evaluation of Results of Psychotherapy. Milton Rosenbaum, Jane Friedlander, and Stanley M. Kaplan. Pp. 113-132.

Descriptions of about two hundred ten out-patients and their treatment were supplied by resident psychiatrists, and the data thus obtained was subjected to

statistical analysis. The patients were thus divided into three main categories according to their relative improvement with psychotherapy. Approximately seventy percent of the patients showed considerable improvement. 'There was a significantly large number of fee-paying patients in the "much improved" group. These data failed to reveal a significant association between intelligence and education and improvement in therapy. The group of "much improved" patients had significantly better "childhood environments". Ability to develop interpersonal relations at the time therapy was started was significantly associated with improvement in therapy. Good sexual adjustment, high social station, and favorable financial status were significantly associated with "much improvement" in therapy. No significant associations could be established between pretreatment marital adjustment, work adjustment, insight, housing facilities, and improvement with treatment. Religious activity was associated to a significant level with lack of change with treatment.

'Improvement when it occurred was found mainly in marital and work adjustment and interpersonal relations. Housing, social stratum, and religious activity were influenced insignificantly by treatment.'

Psychological Significance of Visual Auras. Study of Three Cases With Brain Damage and Seizures. Aaron T. Beck and Thomas Guthrie. Pp. 133-142.

Visual auras in three patients with brain damage and seizures were studied by psychological testing, hypnosis, psychiatric interviews, and free associations. In two cases, the aura could be reproduced under hypnosis and underlying fantasies could be obtained. From these studies it is concluded that the visual aura is like the manifest content of a dream, and that visual aura is derived from underlying latent content by the mechanisms of plastic representation, condensation, symbolization, and distortion, just as occurs in the dream. 'The aura can no longer be considered as formed exclusively by a disturbance in a discrete portion of the cortex, but is to be regarded as a complex phenomenon resulting from the total integrative activity of the brain.'

EDWIN F. ALSTON

British Journal of Medical Psychology. XXIX, 1956.

Freud's Life and Work, an Appreciation of Ernest Jones's Biography. J. D. Sutherland. Pp. 77-81.

Sutherland congratulates Jones on producing this 'labor of love' without making it mere hero-worship. Jones was able to portray both Freud's genius and the irrational and psychoneurotic components in his love and hate. Sutherland points out how great was Freud's achievement in analyzing himself to the point of seeing the meaning of his own œdipus complex. He suggests that among the factors that enabled Freud to accomplish this were the particular structure of Freud's family; the fact that Freud was such a good dreamer; Freud's ability to use his relationship with Fliess in much the same manner as patients may use the transference; the death of Freud's father, which acted as a stimulus in the mobili-

zation of childhood feelings; his mother's ability to confirm many of Freud's own analytical recollections; and finally, Freud's ability to use his observation of the behavior of his own children.

Recent Developments in Psychoanalytical Theory. H. Guntrip. Pp. 82-99.

Guntrip points out that psychoanalytic theory has always been in a state of continuous development, but during Freud's lifetime virtually all the fundamentally new ideas came from Freud himself. Guntrip then offers a highly condensed critical review of the main aspects of psychoanalytic theory; of some of the modifications promulgated by Horney, Fromm, Sullivan, Klein, and Fairbairn; and, finally, an evaluation of some of these modifications. The author feels that the advocates of the 'culture pattern' theory have provided material of 'more descriptive importance . . . than explanatory value in idealogical depth'. Guntrip is more impressed with the work of Klein and Fairbairn, whose achievement has been 'in carrying the concept of object relationships into the investigation of the total psyche'. He believes that the most urgent task now confronting psychoanalysis is reinvestigation of the whole problem of psychotherapy in terms of the theory of object-relations, particularly with a view to understanding the part played by the relationship of analyst and patient as the real therapeutic factor.

Contributions to the Theory of Play. Elizabeth Kardos and Andrew Peto. Pp. 100-112.

The authors attempt a metapsychological description of play. They point out that all the characteristics of the primary process can be seen in children's play. In play, forbidden anxiety-producing impulses can be acted on without guilt or anxiety, and they can be used to bring external reality under control of the ego. The principal mechanism by which this can be achieved is denial of the forbidden impulses with the attendant anxiety and flooding of the self with libido. The many parallels between the characteristics of infantile sexuality and childhood play are emphasized. The basic model for play is what Kardos and Peto label 'primal play at the breast', where there is a denial of the bad aspects of the situation. The authors also discuss play in contrast to the phenomenon of depersonalization, which is described as the 'archaic patterns of losing objects' whereas play 'represents the effort of finding and integrating this object'.

Considerations Arising Out of the Schreber Case. W. Ronald D. Fairbairn. Pp. 113-127.

Fairbairn reviews some of the important literature on the Schreber case, including Schreber's own account of his illness, Freud's analysis, the theory of paranoia by which Freud explained Schreber's illness, and the recent contributions of Macalpine and Hunter. He points out that Freud produced his work on the Schreber case before he had fully formed his ideas of aggression and the ego, and that he never revised in the light of these newer ideas his theories based on the Schreber case. Fairbairn reformulates the dynamics in this case with emphasis

on the disintegration of the superego into internalized part objects and defensive projection of these internal persecutors onto the external world. He considers this explanation superior to one 'couched exclusively in terms of economics of libido'. He believes the rejection by the heterosexual parent more crucial for these individuals than the attachment to the homosexual parent. Fairbairn also stresses the significance of anal fixations in paranoia, since anal expulsion is a model for aggressive projection of bad internal objects. Finally, Fairbairn suggests that the conflict over the primal scene is the basic problem for Schreber. Horror of the primal scene is more basic than horror of incest, which is in fact derived from horror of the primal scene. 'Homosexuality represents for him a means of enjoying the excitement of the primal scene in a masturbatory manner, while denying the scene itself; and the horror of the primal scene is bound up with his sadistic attitude toward his mother as a monster of infidelity toward him,—his previously stressed hostility toward his father proving to be largely a displacement of his hatred of his mother.' Fairbairn argues that confusion over one's sexual identity is not due to any inherent bisexuality per se, but stems rather from the uncertainty as to one's identification in the primal scene. He gives a good deal of clinical evidence for these hypotheses.

Hinjra and Jiryan: Two Derivatives of Hindu Attitudes to Sexuality. George M. Carstairs. Pp. 128-138.

The author describes attitudes of certain high-caste Hindus in Northern India toward homosexuality and their rather widespread hypochondriacal preoccupation with spermatorrhea. He shows that the relation between local familial and cultural influences and the intrapsychic forces within the individual influence these attitudes.

A Case of an Unusual Impulse Disorder. C. K. Hofling and R. W. Minnehan. Pp. 150-161.

The authors describe a young man who sucked his own blood in a ritualistic way. The symptom is multidetermined, serving as reassurance against castration anxiety and against fear of starvation; a vehicle for attacking the introjected mother, as well as an identification with the dreaded mother; and finally it is a defense against regression to more blatant psychotic mechanisms.

Pleasure, Object and Libido. Michael Balint. Pp. 162-167.

Balint reviews Fairbairn's thesis that libido is object-seeking rather than pleasure-seeking. The author believes this thesis unjustifiable, inasmuch as pleasure-seeking and object-seeking tendencies seem 'equally important'. He also raises the question to what extent particular aspects of transference phenomena evinced in the course of analysis are produced by the analyst even when he follows so-called 'standard technique'.

EDWARD M. WEINSHEL

Revista de Psicoanálisis. XIII, 1956.

From the Inner to the Outer Objects. Internalization and Externalization. The Magnitudes of Identifications. Arnaldo Rascovsky. Pp. 103-117.

Rascovsky discusses development of the archaic and primitive relationship of ego and id. Initially the ego has a two-dimensional perception; this latter acquires four dimensions when it perceives the external object. During this development projection and identification are used constantly. These mechanisms allow for proper use of hostile impulses. The prenatal ego 'is in the position of the ego ideal . . . that is, of complete acceptance of any instinctual need'.

Obesity and Two Types of Feeding. Angel Garma. Pp. 153-159.

This brief communication compares the analytic findings in peptic ulcer with those in obesity. The obese person, like the patient with ulcer, eats 'infantile foods', such as purées, pastes, milk, and cheese, and soft and fattening foods. 'Genital' feeding, however, is based on meats and other foods that require hard chewing. Some popular sayings support this distinction. It is also evident in certain religious beliefs, such as the Jewish custom of not mixing meat dishes with dairy dishes, and in poetic expressions that show genitality equated with eating meat, whereas puddings, custards, and cheeses are infantile oral gratifications.

Denial in the Compulsive Eater and in the Obese. Leon Grinberg. Pp. 160-169.

Eating is related to the need for strength. The 'weak ego' seems weak in a physical as well as psychological sense. The compulsive eater may be diminishing his anxieties aroused by paranoid fantasies. His oral cannibalistic wishes are gratified and denied at the same time; it is as if the object were not really destroyed by the magic gesture of eating. It is neither incorporated nor lost. Obesity is the reverse of depression. Some persons are 'addicted' to certain foods. The nature of these foods is determined by the ideal imagoes of the 'addict'.

GABRIEL DE LA VEGA

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Meetings of the New York Psychoanalytic Society

John Donadeo

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NOTES

Dr. Howard B. Jefferson, President of Clark University, Worcester, Massachusetts, has announced that on September 21, 1957 at Clark University, a statue of Sigmund Freud is to be formally presented by The American Psychoanalytic Association to the University. Dr. Heinz Hartmann will represent the Association on this occasion, and Miss Anna Freud will be present at the ceremony. A scientific program may also be included.

Those wishing to attend should apply for tickets well in advance to Clark University, Department of Psychology, Worcester, Massachusetts, as it is anticipated that there will be a large attendance.

MISS ANNA FREUD will conduct seminars at the YOUTH GUIDANCE CENTER OF WORCESTER, MASSACHUSETTS, September 18, 19, and 20, 1957, on the occasion of the Center's thirty-fifth anniversary celebration. Dr. Joseph Weinreb, Director of the Center, will welcome the attendance of members of The American Psychoanalytic Association. Requests for admission to these seminars should be addressed to Dr. Joseph Weinreb, Director, Worcester Youth Guidance Center, 2 State Street, Worcester, Massachusetts.

MEETINGS OF THE NEW YORK PSYCHOANALYTIC SOCIETY

November 13, 1956. ON SOME VICISSITUDES OF INSIGHT IN PSYCHOANALYSIS. Ernst Kris, Ph.D.

Before proceeding to a detailed discussion of the specific problems presented in his paper, Dr. Kris first describes what he considers a distinct property of psychoanalysis: its character as a process with a progressive development over time in a definite direction; second, the twin character of theory and technique since the inception of Freud's work. The former constitutes the core of psychoanalysis, its therapeutic effectiveness and investigative value; the latter, through the interaction of theory and technique, constitutes the history of psychoanalysis. Dr. Kris then notes the special emphasis and increasing importance accorded the integrative (synthetic) functions of the ego in current psychoanalytic literature. As an illustration for the development of his topic, he chooses the 'good analytic hour' of which he says: 'Such an hour often does not begin propitiously but comes gradually into its own after ten or fifteen minutes with the recounting of a recent experience, connected or not with the previous session; then may come a dream with associations, and all begins to make sense. Sometimes memories from the recent or distant past, with varying degrees of affective charge, and often all that the analyst may have to say can be put into a question to which the patient does the summing up and arrives himself at the conclusions. Such hours seem as if

prepared in advance outside the patient's awareness and nothing in the patient's behavior at the start of the hour indicates it.'

It is in such hours that the integrative functions of the ego are most clearly observed. They cannot be merely the result of the tendency of the repressed to reach consciousness. It appears, rather, that the material comes 'prepared' outside awareness and confirms the view that all significant intellectual achievements are products of preconscious mentation. In explaining the dynamics of the good hour, Dr. Kris stresses not only the fact that it has an infantile prototype (id aspect of insight) but that the prototype also determines the state of the transference, which need not be positive for successful work in the analysis. The good hour is marked in a negative transference by a heavy atmosphere and a mood of scepticism and defeatism mirroring the reluctance attached to the original scene of which the good hour is a belated reflection. The work of the ego can thus proceed, whatever the transference reaction, providing there be transference of a certain intensity. The reorganization which takes place as the essence of the analytic process is a result of energies set free, and this is true of libidinous and aggressive energies, both of which have to be transformed, sublimated or, to choose a term intended for both, neutralized. The investment of the ego with neutralized energy as it comes about during analytic therapy may be to a considerable extent a precipitate of aggression, which energy then enables the ego to participate in analytic work leading to the experience of insight. Cognitive elements are merged with a particular 'assurance' leading to conviction or comprehension, making things 'concrete, three-dimensional', that is, referable to specific and archaic modes of experience representing the infantile prototype or id aspect of insight.

Certain vicissitudes of insight are then discussed in which neutralization of the energy used by the integrative functions of the ego is incomplete and when insight then is used for defense and resistance, in which case its potential for gratification must always be kept under scrutiny. The functions of the ego particularly referred to in this paper are three: the control of temporary and partial regression; the ability of the ego to observe itself and its own functions with some objectivity; control over the discharge of affects. The behavior of the patient during the good hour supplies the basis for demonstration of these functions which are discussed in detail. Dr. Kris adds that in spite of the extension of the range of analytic insight, there remains a core of the ego which tends to remain inaccessible, limiting the capacity and the range of its integrative function. Some unknown factors control the field and give new meaning to Freud's warning: we cannot guide patients in their synthesis; we can, by analytic work, prepare them for it.

Dr. Charles Brenner questioned whether in practice one must always scrutinize and analyze the function of integration of insight, especially if it does not function as resistance. He also asked if there were, in addition to oral and anal id components, scoptophilic, phallic and œdipal infantile prototypes of the experience of insight. Dr. David L. Rubinfine thought that the hallucinatory wish fulfilment would seem to be the infantile prototype or model of neutralization leading, through tension and deprivation, to feats of differentiation and structuralization.

He asked if the dreams reported in the good hours have any special characteristics. Dr. Martin Stein commented that something like a process of mourning may be at work in analysis, thus accounting for the atmosphere of negative transference in which the patient must not only renounce the infantile object and childish image of the self, but must eventually also give up his analyst. Dr. Rudolph Loewenstein called attention to the fact that the negative transference indicates as powerful a relationship as the positive one. He noted, too, the role of childhood games and fantasies as genetic prototypes of insight, citing as an example the playwright's efforts to diminish the reality testing of the audience by the induction of controlled regression. Dr. Jan Frank in viewing the vicissitudes of the good analytic hour questioned the 'anonymity' of the analyst in the gaining of insight by the patient. In the good hour, the 'preparation' of the material would seem to compare with problem-solving in dreams as described by Freud. Dr. Richard Frank also questioned the anonymity or the invisibility of the analyst in gaining insight. Dr. Jacob Arlow remarked that the shifting relationship between identification with the analyst and identification with the wishes and derivatives of childhood is a shift of cathexis and a much more dynamic expression toward understanding the process of analysis than the piecemeal introjection of the superego of the analyst.

Dr. Kris acknowledged the possibility that gratification through insight may be an unavoidable danger, but that this danger could be reduced when the gratifying and defensive aspects of insight are better elucidated. If some piece of insight produces a gratification that is more or less instinctual in nature, it would show itself as resistance. That there can be other than oral and anal infantile prototypes is covered by the general idea of the existence of prototypes. The comparison of insight with mourning is especially appropriate, since reviving memories means giving up secret possessions. As to dreams reported in the good hour, he feels that they do not have any special characteristics and refers to Freud's footnote about 'dreams from above and from below'. With reference to quantitative concepts relevant to neutralization, he emphasizes that this word designates the transformation of energy, that is, desexualization and 'deaggressivization'. The child's play, Dr. Kris believes, might have more to do with thinking and fantasy than with control of regression; but play contributes to control of regression by implementing the distinction between fantasy and reality. If this distinction is not accessible to the patient, analysis will not be effective.

JOHN DONADEO

The American Psychoanalytic Association, at its annual meeting in May 1957, conferred the first CHARLES FREDERICK MENNINGER AWARD on Dr. Charles Fisher. Dr. Fisher is a member of the staff of the Mount Sinai Hospital, New York, and a member of the New York Psychoanalytic Institute. The award was established a year ago by Dr. Karl A. Menninger and Dr. William C. Menninger of The Menninger Foundation as a memorial to their father who was the founder of The Menninger Sanitarium at Topeka, Kansas. Dr. Fisher received the award in recognition of experimental work on the role of primary modes of perception in dream formation. In a series of carefully controlled experiments he was able to

verify some of the basic theoretical principles originally postulated by Freud in his work on dreams. The work was carried on in the Department of Psychiatry of the Mount Sinai Hospital and was made possible through the assistance of the Foundations' Fund for Research in Psychiatry.

THE BRAZILIAN PSYCHOANALYTIC SOCIETY (São Paulo) elected in March 1957 the following officers for a period of two years. President: Dr. Adelheid Koch, Rua Maristella 16, São Paulo; Secretary: Henrique Julio Schlomann, Av. Vieira de Carvalho 197, Apt. 6 E, São Paulo; Treasurer: Lygia Alcatara Amaral, Rua Antonio Carlos 434, São Paulo.