The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: http://www.tandfonline.com/loi/upaq20

The Working Alliance and the Transference Neurosis

Ralph R. Greenson

To cite this article: Ralph R. Greenson (1965) The Working Alliance and the Transference Neurosis, The Psychoanalytic Quarterly, 34:2, 155-181, DOI: 10.1080/21674086.1965.11926343

To link to this article: https://doi.org/10.1080/21674086.1965.11926343

THE WORKING ALLIANCE AND THE TRANSFERENCE NEUROSIS

BY RALPH R. GREENSON, M.D. (LOS ANGELES)

The clinical material on which this presentation is based is derived from patients who developed unexpected difficulties in the course of psychoanalytic therapy. Some of these patients had undergone one or more analyses with other analysts; others were patients of mine who returned for further analysis. In this group there were patients who were unable to get beyond the preliminary phases of analysis. Even after several years of analysis they were not really 'in analysis'. Others seemed interminable; there was a marked discrepancy between the copiousness of insight and the paucity of change. The clinical syndromes these cases manifested were heterogeneous in diagnostic category, ego functions, or dynamics of personality. The key to understanding the essential pathology as well as the therapeutic stalemate was in the failure of the patient to develop a reliable working relation with the analyst. In each case the patient was either unable to establish or maintain a durable working alliance with the analyst and the analyst neglected this fact, pursuing instead the analysis of other transference phenomena. This error in technique was observable in psychoanalysts with a wide range of clinical experience and I recognized the same shortcoming in myself when I resumed analysis with patients previously treated.

In working with these seemingly unanalyzable or interminable patients I became impressed by the importance of separating the patient's reactions to the analyst into two distinct categories: the transference neurosis and the working alliance. Actually this classification is neither complete nor precise. However, this dif-

Presented before the Cleveland Psychoanalytic Society, May 1964. An earlier version was presented before the Los Angeles Psychoanalytic Society, May 1963.

From the Department of Psychiatry, University of California School of Medicine, Los Angeles.

ferentiation helps make it possible to give equal attention to two essentially different transference reactions.

My clinical experiences in regard to the working alliance were enhanced and clarified by Elizabeth Zetzel in Current Concepts of Transference *(32)*. In that essay she introduced the term 'therapeutic alliance' and indicated how important she considered it by demonstrating that one could differentiate between the classical psychoanalysts and the British school by whether they handled or ignored this aspect of the transference. Leo Stone *(31)* gave further insight and fresh impetus in my attempts to clarify and formulate the problem of the working alliance and its relation to other transference phenomena.

The concept of a working alliance is an old one in both psychiatric and psychoanalytic literature. It has been described under a variety of labels but, except for Zetzel and Stone, it either has been considered of secondary importance or has not been clearly separated from other transference reactions. It is the contention of this paper that the working alliance is as essential for psychoanalytic therapy as the transference neurosis. For successful psychoanalytic treatment a patient must be able to develop a full-blown transference neurosis and also to establish and maintain a reliable working alliance. The working alliance deserves to be recognized as a full and equal partner in the patient-therapist relationship.

DEFINITION OF TERMS

Transference is the experiencing of feelings, drives, attitudes, fantasies, and defenses toward a person in the present which are inappropriate to that person and are a repetition, a displacement of reactions originating in regard to significant persons of early childhood *(4, 6, 11)*. I emphasize that for a reaction to be considered transference it must have two characteristics: it must be a repetition of the past and it must be inappropriate to the present.

During analysis several transference phenomena can be distinguished. In the early phases we see usually sporadic, tran-

sient reactions, aptly called 'floating' transference reactions by Glover *(17)*. Freud described more enduring transference phenomena which develop when the transference situation is properly handled. Then all the patient's neurotic symptoms are replaced by a neurosis in the transference relation of which he can be cured by therapeutic work. 'It is a new edition of the old disease' *(9, 11)*. I would modify this concept and say that the transference neurosis is in effect when the analyst and the analysis become the central concern in the patient's life. The transference neurosis includes more than the infantile neurosis; the patient also relives the later editions and variations of his original neurosis. The 'floating' transference phenomena ordinarily do not belong to the transference neurosis. However, for simplification, the phrase, transference neurosis, here refers to the more regressive and inappropriate transference reactions.

The term, working alliance, is used in preference to diverse terms others have employed for designating the relatively non-neurotic, rational rapport which the patient has with his analyst. It is this reasonable and purposeful part of the feelings the patient has for the analyst that makes for the working alliance. The label, working alliance, was selected because it emphasizes its outstanding function: it centers on the patient's ability to work in the analytic situation. Terms like the 'therapeutic alliance' *(32)*, the 'rational transference' *(2)*, and the 'mature transference' *(31)* refer to similar concepts. The designation, working alliance, however, has the advantage of stressing the vital elements: the patient's capacity to work purposefully in the treatment situation. It can be seen at its clearest when a patient, in the throes of an intense transference neurosis, can yet maintain an effective working relationship with the analyst.

The reliable core of the working alliance is formed by the patient's motivation to overcome his illness, his conscious and rational willingness to coöperate, and his ability to follow the instructions and insights of his analyst. The actual alliance is formed essentially between the patient's reasonable ego and the analyst's analyzing ego *(29)*. The medium that makes this

possible is the patient's partial identification with the analyst's approach as he attempts to understand the patient's behavior.

The working alliance comes to the fore in the analytic situation in the same way as the patient's reasonable ego: the observing, analyzing ego is split off from his experiencing ego *(30)*. The analyst's interventions separate the working attitudes from the neurotic transference phenomena just as his interventions split off the reasonable ego from the irrational one. These two sets of phenomena are parallel and express analogous psychic events from different points of reference. Patients who cannot split off a reasonable, observing ego will not be able to maintain a working relation and vice versa.

This differentiation between transference neurosis and working alliance, however, is not absolute since the working alliance may contain elements of the infantile neurosis which eventually will require analysis. For example, the patient may work well temporarily in order to gain the analyst's love, and this ultimately will lead to strong resistances; or the overvaluation of the analyst's character and ability may also serve the working alliance well in the beginning of the analysis, only to become a source of strong resistance later. Not only can the transference neurosis invade the working alliance but the working alliance itself can be misused defensively to ward off the more regressive transference phenomena. Despite these intermixtures, the separation of the patient's reactions to the analyst into these two groupings, transference neurosis and working alliance, seems to have clinical and technical value.

SURVEY OF THE LITERATURE

Freud spoke of the friendly and affectionate aspects of the transference which are admissible to consciousness and which are 'the vehicle of success in psychoanalysis . . .' *(6,* p. 105*)*. Of rapport he wrote: 'It remains the first aim of the treatment to attach him [the patient] to it and to the person of the doctor. To ensure this, nothing need be done but to give him time. If one exhibits a serious interest in him, carefully clears away the re-

sistances that crop up at the beginning and avoids making certain mistakes, he will of himself form such at attachment. . . . It is certainly possible to forfeit this first success if from the start one takes up any standpoint other than one of sympathetic understanding' *(8,* pp. 139-140*).*

Sterba *(30)* wrote about the patient's identification with the analyst which leads to the patient's concern with the work they have to accomplish in common—but he gave this aspect of the transference no special designation. Fenichel *(2,* p. 27*)* described the 'rational transference' as an aim-inhibited positive transference which is necessary for analysis. Elizabeth Zetzel's emphasis on the importance of the 'therapeutic alliance' was discussed above. Loewald's paper on the therapeutic action of psychoanalysis is a penetrating and sensitive study of the different kinds of relations the patient develops toward the analyst during psychoanalysis *(23).* Some of his ideas are directly concerned with what I call the working alliance. Leo Stone devotes himself to the complexities in the relation between analyst and patient. He refers to the 'mature transference' which he believed to be: (a) in opposition to the 'primordial transference' reactions and (b) essential for a successful analysis *(31,* p. 106*).*

The Symposium on Curative Factors in Psychoanalysis presented before the Twenty-second Congress of the International Psychoanalytical Association (1962) contained many references to the special transference reactions that make for a therapeutic alliance and also some discussion of the analyst's contribution to the 'good' analytic situation. Gitelson *(16)* spoke of the rapport on which we depend in the beginning of analysis and which eventuates in transference. He stressed the necessity for the analyst to present himself as a good object and as an auxiliary ego. Myerson *(25),* Nacht *(26),* Segal *(27),* Kuiper *(22),* Garma *(13),* King *(21),* and Heimann *(20)* took issue with him on one or another aspect of his approach. In some measure the disagreement seems to be due to failure to distinguish clearly between the working alliance and the more regressive transference phenomena.

This brief and incomplete survey reveals that many analysts, including Freud, recognized that in psychoanalytic treatment another kind of relation to the analyst is necessary besides the more regressive transference reactions.

DEVELOPMENT OF THE WORKING ALLIANCE

ABERRATIONS

The first clinical examples show how the course of development of the working alliance deviated markedly from that of the usual psychoanalytic patient. The reason for proceeding this way stems from the fact that in the classical analytic patient the working alliance develops almost imperceptibly, relatively silently, and seemingly independently of any special activity on the part of the analyst. The irregular cases highlight different processes and procedures which take place almost invisibly in the usual analytic patient.

Some years ago an analyst from another city referred an intelligent middle-aged man who had had more than six years of previous analysis. Certain general conditions had improved but his original analyst believed the patient needed additional analysis because he was still unable to marry and was very lonely. From the beginning of the therapy I was struck by the fact that he was absolutely passive about recognizing and working with his resistances. It turned out that he expected them to be pointed out continuously as his previous analyst had done. It also impressed me that the moment I made some intervention he had an immediate response, although often incomprehensible. I discovered that he thought it his duty to reply immediately to every intervention since he believed it would be a sign of resistance, and therefore bad, to keep silent for a moment or so to mull over what had been said. Apparently his previous analyst had never recognized his fear of being silent as a resistance. In free association the patient searched actively for things to talk about and, if more than one idea occurred to him, he chose what seemed to be the item he thought I was looking for

without mentioning the multiple choices. When I requested information, he often answered by free association so that the result was bizarre. For example, when I asked him what his middle name was he answered: 'Raskolnikov', the first name that occurred to him. When I recovered my composure and questioned this he defended himself by saying that he thought he was supposed to free associate. I soon gained the impression that this man had never really established a working relation with his first analyst. He did not know what he was supposed to do in the analytic situation. He had been lying down in front of an analyst for many years, meekly submitting to what he imagined the previous analyst had demanded, constant and instant free association. Patient and analyst had been indulging in a caricature of psychoanalysis. True, the patient had developed some regressive transference reactions, some of which had been interpreted, but the lack of a consistent working alliance left the whole procedure amorphous, confused, and ineffectual.

Although I realized that the magnitude of the patient's problems could not be due solely or even mainly to the first analyst's technical shortcomings, I thought the patient ought to be given a fair opportunity to see whether he could work in an analytic situation. Besides, this clarification would also expose the patient's pathology more vividly. Therefore, in the first months of our work together, I carefully explained, whenever it seemed appropriate, the different tasks that psychoanalytic therapy requires of the patient. He reacted to this information as though it were all new to him and seemed eager to try to work in the way I described. However, it soon became clear that he could not just say what came to his mind, he felt compelled to find out what I was looking for. He could not keep silent and mull over what I said; he was afraid of the blank spaces, they signified some awful danger. If he were silent he might think; if he thought he might disagree with me, and to disagree was tantamount to killing me. His striking passivity and compliance were revealed as a form of ingratiation, covering up an

inner emptiness, an insatiable infantile hunger, and a terrible rage. In a period of six months it became clear that this man was a schizoid 'as if' character who could not bear the deprivations of classical psychoanalysis *(1)*. I therefore helped him obtain supportive psychotherapy with a woman therapist.

A woman I had previously analyzed for some four years resumed analysis after an interval of six years. We both knew when she had interrupted treatment that there was a great deal of unfinished analysis, but we agreed that an interval without analysis might clarify the unusual obscurities and difficulties we encountered in trying to achieve a better resolution of her highly ambivalent, complaining, clinging, sadomasochistic transference. I had suggested her going to another analyst, since, in general, I have found a change in analysts is more productive than a return to the old one. It usually offers new insights into the old transference reactions and adds new transference possibilities. However, for external reasons this was not feasible and I undertook the resumption of her analysis, although with some reservations.

In her first hours on the couch I was struck by the strange way the patient worked in the analysis. Then I quickly recalled that this had often happened in the past; it appeared more striking now since I was no longer accustomed to it; it seemed almost bizarre. After a certain moment in the hour the patient would speak almost incessantly; there would be disconnected sentences, part of a recital of a recent event, an occasional obscene phrase with no mention of its strangeness or that it was an obsessive thought, and then back to the recital of a past event. The patient seemed to be completely oblivious to her odd way of speaking and never spontaneously mentioned it. When I confronted her with this she at first seemed unknowing and then felt attacked.

I realized that in the previous analysis there had been many such hours or parts of hours whenever the patient was very anxious and tried to ward off her awareness of anxiety as well as

analysis of it. I recalled that we had uncovered some of the meanings and historical determinants of such behavior. For example, her mother had been a great chatterer, had talked to the child as a grownup before she could understand. Her incomprehensible talking to me was an identification with her mother and an acting out in the analytic situation. Furthermore, the mother had used a stream of talk to express both anxiety and hostility to her husband, an essentially quiet man. The patient took over this pattern from her mother and re-enacted it in the analytic hour whenever she was anxious and hostile and when she was torn between hurting me and holding onto me.

We came to understand that this mode of behavior also denoted a regression in ego functions from secondary process toward primary process, a kind of 'sleep-talking' with me, a reenactment of sleeping with the parents. This peculiar way of talking had recurred many times during the first analysis and although various determinants had been analyzed it still persisted to some degree up to the interruption of that analysis. Whenever I tried to confront the patient with a misuse of one of the analytic procedures, we would be sidetracked by her reactions to my confrontation or by new material that came up. She might recall some past event which seemed relevant or, in the next hours, dreams or new memories would appear and we never really returned to the subject of why she was unable to do some part of the psychoanalytic work. In her second analysis, I would not be put off. Whenever the merest trace of the same disconnected manner of talking appeared, or whenever it seemed relevant, I confronted her with the problem and kept her to this subject until she at least acknowledged what was under discussion. The patient attempted to use all her old methods of defense against confrontations of her resistances. I listened only for a short time to her protestations and evasions and repeatedly pointed out their resistive function. I did not work with any new material until convinced the patient was in a good working alliance with me.

Slowly the patient began to face her misuse of the basic rule.

She herself became aware of how she at times consciously, at others preconsciously, and, at still other times, unconsciously, blurred the real purpose of free association. It became clear that when the patient felt anxious in her relation to me she would let herself slip into this regressive 'sleep-talking' manner of speech. It was a kind of 'spiteful obedience'—spiteful in so far as she knew it was an evasion of true free association. It was obedience inasmuch as she submitted to this regressive or, one might say, incontinent way of talking. This arose whenever she felt a certain kind of hostility toward me. She felt this as an urge to pour out a stream of poison upon me that led her to feel I would be destroyed and lost to her and she would feel alone and frightened. Then she would quickly dive into sleep-talking as though saying: 'I am a little child who is partly asleep and is not responsible for what is coming out of me. Don't leave me; let me sleep on with you; it is just harmless urine that is coming out of me.' Other determinants will not be discussed since they would lead too far afield.

It was fascinating to see how differently this analysis proceeded from the previous one. I do not mean to imply that this patient's tendency to misuse her ability to regress in ego functioning completely disappeared. However, my vigorous pursuit of the analysis of the defective working alliance, my constant attention to the maintenance of a good working relation, my refusal to be misled into analyzing other aspects of her transference neurosis had their effects. The second analysis had a completely different flavor and atmosphere. In the first analysis I had an interesting and whimsical patient who was frustrating because I was so often lost by her capricious wanderings. In the second, though still a whimsical patient she also was an ally who not only helped me when I was lost but pointed out that I was being led astray even before I realized it.

The third patient, a young man, entered analysis with me after he had spent two and one half years with an analyst in another city, which had left him almost completely untouched. He

had obtained certain insights but had the distinct impression that his former analyst really disapproved of infantile sexuality even though the young man realized that analysts were not supposed to be contemptuous of it. In the preliminary interviews the patient told me that he had the greatest difficulty in talking about masturbation and previously often consciously withheld this information. He had informed the former analyst about the existence of many conscious secrets but nevertheless stubbornly refused to divulge them. He had never wholeheartedly given himself up to free association and reported many hours of long silence. However, the patient's manner of relating his history to me and my general clinical impression led me to believe that he was analyzable despite the fact that he had not been able to form a working alliance with his first analyst.

I undertook the analysis and learned a great deal about this patient's negative reactions to his previous analyst, some of which stemmed from his way of conducting that analysis. For example, in one of the first hours on the couch the patient took out a cigarette and lit it. I asked him what he was feeling when he decided to light the cigarette. He answered petulantly that he knew he was not supposed to smoke in his previous analysis and now he supposed that I too would forbid it. I told him that I wanted to know what feelings, ideas, and sensations were going on in him at the moment that he decided to light the cigarette. He then revealed that he had become somewhat frightened in the hour and to hide this anxiety from me he decided to light the cigarette. I replied that it was preferable for such feelings and ideas to be expressed in words instead of actions because then I would understand more precisely what was going on in him. He realized then that I was not forbidding him to smoke but only pointing out that it was more helpful to the process of being analyzed if he expressed himself in words and feelings. He contrasted this with his first analyst who told him before he went to the couch that it was customary not to smoke during sessions. There was no explanation for this and the patient felt that his first analyst was being arbitrary.

In a later hour the patient asked me whether I was married. I countered by asking him what he imagined about that. He hesitantly revealed that he was torn between two sets of fantasies, one that I was a bachelor who loved his work and lived only for his patients; the other that I was a happily married man with many children. He went on spontaneously to tell me that he hoped I was happily married because then I would be in a better position to help him with his sexual problems. Then he corrected himself and said it was painful to think of me as having sexual relations with my wife because that was embarrassing and none of his business. I then pointed out to him how, by not answering his question and by asking him instead to tell his fantasies about the answer, he revealed the cause of his curiosity. I told him I would not answer questions when I felt that more was to be gained by keeping silent and letting him associate to his own question. At this point the patient became somewhat tearful and, after a short pause, told me that in the beginning of his previous analysis he had asked many questions. His former analyst never answered nor did he explain why he was silent. He felt his analyst's silence as a degradation and humiliation and now realized that his own later silences were a retaliation for this imagined injustice. Somewhat later he saw that he had identified himself with his first analyst's supposed contempt. He, the patient, felt disdain for his analyst's prudishness and at the same time was full of severe self-reproach for his own sexual practices which he then projected onto the analyst.

It was instructive to me to see how an identification with the previous analyst based on fear and hostility led to a distortion of the working relationship instead of an effective working alliance. The whole atmosphere of the first analysis was contaminated by hostile, mistrustful, retaliative feelings and attitudes. This turned out to be a repetition of the patient's behavior toward his father, a point the first analyst had recognized and interpreted. The analysis of this transference resistance, however, was ineffectual, partly because the first analyst worked in such a way as to justify constantly the patient's infantile neurotic behavior

and so furthered the invasion of the working alliance by the transference neurosis.

I worked with this patient for approximately four years and almost from the beginning a relatively effective working alliance was established. However, my manner of conducting analysis, which seemed to him to indicate some genuine human concern for his welfare and respect for his position as a patient also mobilized important transference resistances in a later phase of the analysis. In the third year I began to realize that, despite what appeared to be a good working alliance and a strong transference neurosis, there were many areas of the patient's outside life that did not seem to change commensurately with the analytic work. Eventually I discovered that the patient had developed a subtle but specific inhibition in doing analytic work outside the analytic hour. If he became upset outside he would ask himself what upset him. Usually he succeeded in recalling the situation in question. Sometimes he even recalled the meaning of that event that he had learned from me at some previous time, but this insight would be relatively meaningless to him; it felt foreign, artificial, and remembered by rote. It was not his insight; it was mine, and therefore had no living significance for him. Hence, he was relatively blank about the meaning of the upsetting events.

Apparently, although he seemed to have established a working alliance with me in the analytic situation, this did not continue outside. Analysis revealed that the patient did not allow himself to assume any attitude, approach, or point of view that was like mine outside the analytic hour. He felt that to permit himself to do so would be tantamount to admitting that I had entered into him. This was intolerable because he felt this to be a homosexual assault, a repetition of several childhood and adolescent traumas. Slowly we uncovered how the patient had sexualized and aggressivized the process of introjection.

This new insight was the starting point for the patient to learn to discriminate among the different varieties of 'taking in'. Gradually he was able to re-establish a nonhomosexual

identification with me in adapting an analytic point of view. Thus a working relation that had been invaded by the transference neurosis was once again relatively free of infantile neurotic features. The previous insights that had remained ineffectual eventually led to significant and lasting changes.[1]

Those patients who cling tenaciously to the working alliance because they are terrified of the regressive features of the transference neurosis should be briefly mentioned. They develop a reasonable relation to the analyst and do not allow themselves to feel anything irrational, be it sexual, aggressive, or both. Prolonged reasonableness in an analysis is a pseudo-reasonableness for a variety of unconscious neurotic motives.

For about two years a young social scientist who had an intellectual knowledge of psychoanalysis maintained a positive and reasonable attitude toward me, his analyst. If his dreams indicated hostility or homosexuality he acknowledged this but claimed that he knew he was supposed to feel such things toward his analyst but he 'really' did not. If he came late or forgot to pay his bill he again admitted that it might seem that he did not want to come or pay his bill but 'actually' it was not so. He had violent anger reactions to other psychiatrists he knew, but insisted they deserved it and I was different. He became infatuated with another male analyst for a period of time and 'guessed' he must remind him of me, but this was said playfully. All of my attempts to get the patient to recognize his persistent reasonableness as a means of avoiding or belittling his deeper feelings and impulses failed. Even my attempts to trace the historical origins of this mode of behavior were unproductive. He had adopted the role of 'odd ball', clown, harmless nonconformist in his high school years and was repeating this in the analysis. Since I could not get the patient to work further or con-

[1] This case is described in greater detail in a paper entitled The Problem of Working Through. In: *Tribute to Marie Bonaparte*. Edited by Max Schur. (In process of publication.)

sistently on this problem, I finally told him that we had to face the fact that we were getting nowhere and we ought to consider some alternative besides continuing psychoanalysis with me. The patient was silent for a few moments and said 'frankly' he was disappointed. He sighed and then went on to make a free associationlike remark. I stopped him and asked him what in the world he was doing. He replied that he 'guessed' I sounded somewhat annoyed. I assured him it was no guess. Then slowly he looked at me and asked if he might sit up. I nodded and he did. He was quite shaken, sober, pale, and in obvious distress. After some moments of silence he said that maybe he would be able to work better if he could look at me. He had to be sure I was not laughing at him, or angry, or getting sexually excited. I asked him about the last point. He told me that he often fantasied that perhaps I was being sexually excited by what he said but hid it from him. This he had never brought up before, it was just a 'fleeting idea'. But this fleeting idea led quickly to many memories of his father repeatedly and unnecessarily taking his temperature rectally. He proceeded to a host of homosexual and sadomasochistic fantasies. The persistent reasonableness was a defense against these as well as a playful attempt to tease me into acting out with him. My behavior, in the hour described above, was not well controlled, but it led to awareness that the patient's working alliance was being used to ward off the transference neurosis.

The working alliance had become the façade for the transference neurosis. It was his neurotic character structure hiding as well as expressing his underlying neurosis. Only when the patient's acting out was interrupted and he realized he was about to lose the transference object did his rigidly reasonable behavior become ego-alien and accessible to therapy. He needed several weeks of being able to look at me, to test out whether my reactions could be trusted. Then he became able to distinguish between genuine reasonableness and the teasing, spiteful reasonableness of his character neurosis and the analysis began to move.

THE CLASSICAL ANALYTIC PATIENT

The term classical in this connection refers to a heterogeneous group of patients who are analyzable by the classical psychoanalytic technique without major modifications. They suffer from some form of transference neurosis, a symptom or character neurosis, without any appreciable defect in ego functions. In such patients the working transference develops almost imperceptibly, relatively silently, and seemingly independently of any special activity or intervention on the part of the analyst. Usually signs of the working alliance appear in about the third to sixth month of analysis. Most frequently the first indications of this development are: the patient becomes silent and then, instead of waiting for the analyst to intervene, he himself ventures the opinion that he seems to be avoiding something. Or he interrupts a rather desultory report of some event and comments that he must be running away from something. If the analyst remains silent the patient spontaneously asks himself what it can be that is making him so evasive and he will let his thoughts drift into free associations.

It is obvious that the patient has made a partial and temporary identification with me and now is working with himself in the same manner as I have been working on his resistances. If I review the situation I usually find that prior to this development the patient has experienced some sporadic sexual or hostile transference reaction which has temporarily caused a strong resistance. I patiently and tactfully demonstrate this resistance, then clarify how it operated, what its purpose was, and eventually interpret and reconstruct its probable historical source. Only after effective transference-resistance analysis is the patient able to develop a partial working alliance. However, it is necessary to go back to the beginning of the analysis to get a detailed view of its development.

There is great variety in the manner in which a patient enters into the preliminary interviews. In part this is determined by his past history in regard to psychoanalysts, physicians, and

authority figures and strangers, as well as his reactions to such conditions as being sick or needing and asking for help *(15)*. Furthermore, his knowledge or lack of it about procedures of psychoanalysis and the reputation of the psychoanalyst also influence his initial responses. Thus the patient comes to the initial interview with a preformed relationship to me, partly transference and partly based on reality, depending on how much he fills in the unknowns inappropriately out of his own past.

The preliminary interviews heavily color the patient's reactions to the analyst. This is determined mainly by the patient's feelings about exposing himself as well as his responses to my method of approach and my personality. Here too I believe we see a mixture of transference and realistic reactions. Exposure of one's self is apt to stir up reverberations of past denudings in front of parents, doctors, or others, and is therefore likely to produce transference reactions. My technique of conducting the interviews will do the same the more it seems strange, painful, or incomprehensible to the patient. Only those methods of approach that seem understandable to him may lead to realistic reactions. My 'analyst' personality as it is manifested in the first interviews may also stir up both transference and realistic reactions. It is my impression that those qualities that seem strange, threatening, or nonprofessional evoke strong transference reactions along with anxiety. Traits the patient believes indicate a therapeutic intent, compassion, and expertness may produce realistic responses as well as positive transference reactions. The clinical material from the third case indicates how the manner, attitude, and technique of the analyst in the beginning of both analyses decisively colored the analytic situation.

By the time I have decided that psychoanalysis is the treatment of choice, I shall have gained the impression that the patient in question seems to have the potential for forming a working alliance with me along with his transference neurosis. My discussion with the patient of why I believe psychoanalysis is the best method of therapy for him, the explanations of the frequency of visits, duration, fee, and similar matters, and the pa-

tient's own appraisal of his capacity to meet these requirements will be of additional value in revealing the patient's ability to form a working alliance.

The first few months of analysis with the patient lying on the couch attempting to free associate can best be epitomized as a combination of testing and confessing. The patient tests his ability to free associate and to expose his guilt and anxiety-producing experiences. Simultaneously he is probing his analyst's reactions to these productions *(10, 18)*. There is a good deal of history telling and reporting of everyday events. My interventions are aimed at pointing out and exploring fairly obvious resistances and inappropriate affects. When the material is quite clear I try to make connections between past and present behavior patterns. As a consequence, the patient usually begins to feel that perhaps I understand him. Then he dares to regress, to let himself experience some transient aspect of his neurosis in the transference in regard to my person. When I succeed in analyzing this effectively then I have at least temporarily succeeded in establishing a reasonable ego and a working alliance alongside of the experiencing ego and the transference neurosis. Once the patient has experienced this oscillation between transference neurosis and working alliance in regard to one area, he becomes more willing to risk future regressions in that same area of the transference neurosis. However every new aspect of the transference neurosis may bring about an impairment of the working alliance and temporary loss of it.

ORIGINS OF THE WORKING ALLIANCE

CONTRIBUTIONS OF THE PATIENT

For a working alliance to take place, the patient must have the capacity to form object relations since all transference reactions are a special variety of them. People who are essentially narcissistic will not be able to achieve consistent transferences. Furthermore, the working alliance is a relatively rational, desexualized, and deaggressivized transference phenomenon. Patients must have been able to form such sublimated, aim-inhibited re-

lations in their outside life. In the course of analysis the patient is expected to be able to regress to the more primitive and irrational transference reactions that are under the influence of the primary process. To achieve a working alliance, however, the patient must be able to re-establish the secondary process, to split off a relatively reasonable object relationship to the analyst from the more regressive transference reactions. Individuals who suffer from a severe lack of or impairment in ego functions may well be able to experience regressive transference reactions but will have difficulty in maintaining a working alliance. On the other hand, those who dare not give up their reality testing even temporarily and partially, and those who must cling to a fixed form of object relationship are also poor subjects for psychoanalysis. This is confirmed by the clinical findings that psychotics, borderline cases, impulse ridden characters, and young children usually require modifications in the classical psychoanalytic technique *(13, 14, 17)*. Freud had this in mind when he distinguished transference neuroses which are readily analyzable from narcissistic neuroses which are not.

The patient's susceptibility to transference reactions stems from his state of instinctual dissatisfaction and his resultant need for opportunities for discharge. This creates a hunger for objects and a proneness for transference reactions in general *(3)*. Satisfied or apathetic people have fewer transference reactions. The awareness of neurotic suffering also compels the patient to establish a relationship to the analyst. On a conscious and rational level the therapist offers realistic hope of alleviating the neurotic misery. However, the patient's helplessness in regard to his suffering mobilizes early longings for an omnipotent parent. The working alliance has both a rational and irrational component. The above indicates that the analyzable patient must have the need for transference reactions, the capacity to regress and permit neurotic transference reactions, and have the ego strength or that particular form of ego resilience that enables him to interrupt his regression in order to reinstate the reasonable and purposeful working alliance *(*Cf. *23)*.

The patient's ego functions play an important part in the implementation of the working alliance in addition to a role in object relations. In order to do the analytic work the patient must be able to communicate in a variety of ways; in words, with feelings, and yet restrain his actions. He must be able to express himself in words, intelligibly with order and logic, give information when indicated and also be able to regress partially and do some amount of free association. He must be able to listen to the analyst, comprehend, reflect, mull over, and introspect. To some degree he also must remember, observe himself, fantasy, and report. This is only a partial list of ego functions that play a role in the patient's capacity to establish and maintain a working alliance; we also expect the patient simultaneously to develop a transference neurosis. Thus his contribution to the working alliance depends on two antithetical properties: his capacity to maintain contact with the reality of the analytic situation and also his willingness to risk regressing into his fantasy world. It is the oscillation between these two positions that is essential for analytic work.

CONTRIBUTIONS OF THE ANALYTIC SITUATION

Greenacre *(18)*, Macalpine *(24)*, and Spitz *(28)* all have pointed out how different elements of the analytic setting and procedures promote regression and the transference neurosis. Some of these same elements also aid in forming the working alliance. The high frequency of visits and long duration of the treatment not only encourage regression but also indicate the long-range objectives and the importance of detailed, intimate communication. The couch and the silence give opportunity for introspection and reflection as well as production of fantasy. The fact that the patient is troubled, unknowing, and being looked after by someone relatively untroubled and expert stirs up the wish to learn and to emulate. Above all the analyst's constant emphasis on attempting to gain understanding of all that goes on in the patient, the fact that nothing is too small, obscure, ugly, or beautiful to escape the analyst's search for com-

prehension—all this tends to evoke in the patient the wish to know, to find answers, to find causes. This does not deny that the analyst's probings stir up resistances: it merely asserts that it also stirs up the patient's curiosity and his search for causality.

Freud stated that in order to establish rapport one needs time and an attitude of sympathetic understanding *(8)*. Sterba *(29)* stressed the identificatory processes. The fact that the analyst continuously observes and interprets reality to the patient leads the patient to identify partially with this aspect of the analyst. The invitation to this identification comes from the analyst. From the beginning of treatment, the analyst comments about the work they have to accomplish together. The use of such terms as 'let us look at this', or 'we can see', promotes this. Loewald stressed how the analyst's concern for the patient's potentials stimulates growth and new developments *(23)*.

Fenichel *(2)* believed it is the analytic atmosphere that is the most important factor in persuading the patient to accept on trial something formerly rejected. Stone *(31)* emphasized the analyst's willingness to offer the patient certain legitimate, controlled gratifications. I would add that the constant scrutiny of how the patient and the analyst seem to be working together, the mutual concern with the working alliance, in itself serves to enhance it.

CONTRIBUTIONS OF THE ANALYST

It is interesting to observe how some analysts take theoretical positions apparently in accord with their manifest personality and others subscribe to theories that seem to contradict their character traits. Some use technique to project, others to protect, their personality. This finding is not meant as a criticism of either group, since happy and unhappy unions can be observed in both. Some rigid analysts advocate strictest adherence to the 'rule of abstinence' and I have seen the same type of analyst attempt to practice the most crass manipulative, gratifying 'corrective emotional experience' psychotherapy. Many apparently care-free and easy-going analysts practice a strict 'rule of ab-

stinence' type of therapy while some of this same character provoke their patients to act out or indulge them in some kind of mutual gratification therapy. Some analysts practice analysis that suits their personality; some use their patients to discharge repressed desires. Be that as it may, these considerations are relevant to the problems inherent in the establishment of the working alliance. Here, however, only a brief outline of the problems can be attempted. The basic issue is: what characteristics of personality and what theoretical orientation in the analyst will insure the development of a working alliance as well as the development of a full-blown transference neurosis?

I have already briefly indicated how certain aspects of the analytic situation facilitate production of a transference neurosis. This can be condensed to the following: we induce the patient to regress and to develop a transference neurosis by providing a situation that consists of a mixture of deprivation, a sleeplike condition, and constancy. Patients develop a transference neurosis from a variety of different analysts as long as the analytic situation provides a goodly amount of deprivation administered in a predictable manner over a suitable length of time. For a good therapeutic result, however, one must also achieve a good working relationship.

What attitudes of the analyst are most likely to produce a good working alliance? My third case indicates how the patient identified himself with his previous analyst on the basis of identification with the aggressor, on a hostile basis. This identification did not produce a therapeutic alliance; it produced a combination of spite and defiance, and interfered with the psychoanalytic work. The reason for this was that the personality of the first analyst seemed cold and aloof, traits which resembled the patient's father and he was not able to differentiate his first analyst from his regressive transference feelings. How differently he reacted to me in the beginning. He was clearly able to differentiate me from his parent and therefore he was able to make a temporary and partial identification with me, and thus to do the analytic work.

The most important contribution of the psychoanalyst to a good working relationship comes from his daily work with the patient. His consistent and unwavering pursuit of insight in dealing with any and all of the patient's material and behavior is the crucial factor. Other inconsistencies may cause the patient pain, but they do not interfere significantly with the establishment of a working alliance. Yet there are analysts who work consistently and analytically and still seem to have difficulty in inducing their patients to develop a working alliance. I believe this may be due to the kind of atmosphere they create. In part, the disturbance may be the result of too literal acceptance of two suggestions made by Freud: the concept of the analyst as a mirror and the rule of abstinence *(7, 10, 12)*. These two rules have led many analysts to adopt an austere, aloof, and even authoritarian attitude toward their patients. I believe this to be a misunderstanding of Freud's intention; at best, an attitude incompatible with the formation of an effective working alliance.

The reference to the mirror and the rule of abstinence were suggested to help the analyst safeguard the transference from contamination, a point Greenacre *(18)* has amplified. The mirror refers to the notion that the analyst should be 'opaque' to the patient, nonintrusive in terms of imposing his values and standards upon the patient. It does not mean that the analyst shall be inanimate, cold, and unresponsive. The rule of abstinence refers to the importance of not gratifying the patient's infantile and neurotic wishes. It does not mean that all the patient's wishes are to be frustrated. Sometimes one may have to gratify a neurotic wish temporarily. Even the frustration of the neurotic wishes has to be carried on in such a way as not to demean or traumatize the patient.

While it is true that Freud stressed the deprivational aspects of the analytic situation, I believe he did so because at that time (1912-1919) the danger was that analysts would permit themselves to overreact and to act out with their patients. Incidentally, if one reads Freud's case histories, one does not get the impression that the analytic atmosphere of his analyses was

one of coldness or austerity. For example, in the original record of the case of the Rat man, Freud appended a note, dated December 28, to the published paper *(5)*, 'He was hungry and was fed'. Then on January 2, 'Besides this he apparently only had trivialities to report and I was able to say a great deal to him today'.

It is obvious that if we want the patient to develop a relatively realistic and reasonable working alliance, we have to work in a manner that is both realistic and reasonable despite the fact that the procedures and processes of psychoanalysis are strange, unique, and even artificial. Smugness, ritualism, timidity, authoritarianism, aloofness, and indulgence have no place in the analytic situation.

The patient will not only be influenced by the content of our work but by how we work, the attitude, the manner, the mood, and the atmosphere in which we work. He will react to and identify himself particularly with those aspects that need not necessarily be conscious to us. Glover *(17)* stressed the need of the analyst to be natural and straightforward, decrying the pretense, for example, that all arrangements about time and fee are made exclusively for the patient's benefit. Fenichel *(2)* emphasized that above all the analyst should be human and was appalled that so many of his patients were surprised by his naturalness and freedom. Sterba *(30)*, stressing the 'let us look, we shall see' approach, hints at his way of working. Stone *(31)* goes even further in emphasizing legitimate gratifications and the therapeutic attitude and intention of the psychoanalyst that are necessary for the patient.

All analysts recognize the need for deprivations in psychoanalysis; they would also agree in principle on the analyst's need to be human. The problem arises, however, in determining what is meant by humanness in the analytic situation and how does one reconcile this with the principle of deprivation. Essentially the humanness of the analyst is expressed in his compassion, concern, and therapeutic intent toward his patient. It matters to him how the patient fares, he is not just an observer or a

research worker. He is a physician or a therapist, and his aim is to help the patient get well. He keeps his eye on the long-range goal, sacrificing temporary and quick results for later and lasting changes. Humanness is also expressed in the attitude that the patient is to be respected as an individual. We cannot repeatedly demean a patient by imposing rules and regulations upon him without explanation and then expect him to work with us as an adult. For a working alliance it is imperative that the analyst show consistent concern for the rights of the patient throughout the analysis. Though I let my patient see that I am involved with him and concerned, my reactions have to be nonintrusive. I try not to take sides in any of his conflicts except that I am working against his resistances, his damaging neurotic behavior, and his self-destructiveness. Basically, however, humanness consists of understanding and insight conveyed in an atmosphere of serious work, straightforwardness, compassion, and restraint *(19)*.

The above outline is my personal point of view on how to resolve the conflict between the maintenance of distance and the closeness necessary for analytic work and is not offered as a prescription for all analysts. However, despite great variation in analysts' personalities, these two antithetical elements must be taken into account and handled if good analytic results are to be obtained. The transference neurosis and the working alliance are parallel antithetical forces in transference phenomena; each is of equal importance.

SUMMARY

Some analyses are impeded or totally thwarted by failure of patient and analyst to form a working alliance. Clinical examples of such failure are examined, showing how they were corrected. Formation of the working alliance, its characteristics, and its relation to transference are discussed. It is contended that the working alliance is equally as important as the transference neurosis.

REFERENCES

1. DEUTSCH, HELENE: *Some Forms of Emotional Disturbance and Their Relationship to Schizophrenia.* This QUARTERLY, XI, 1942, pp. 301-321.
2. FENICHEL, OTTO: *Problems of Psychoanalytic Technique.* New York: The Psychoanalytic Quarterly, Inc., 1941.
3. FERENCZI, SANDOR: Introjection and Transference (1909). In: *Sex in Psychoanalysis.* New York: Basic Books, Inc., 1950.
4. FREUD: *Fragment of an Analysis of a Case of Hysteria (1905* [1901]). Standard Edition, VII, pp. 116-117.
5. ———: *Notes upon a Case of Obsessional Neurosis* (1909). Standard Edition, X, p. 303.
6. ———: *The Dynamics of Transference* (1912). Standard Edition, XII.
7. ———: *Recommendations to Physicians Practicing Psychoanalysis.* (1912). *Ibid.*
8. ———: *On Beginning the Treatment* (1913). *Ibid.*
9. ———: *Remembering, Repeating and Working Through* (1914). *Ibid.*
10. ———: *Observations on Transference Love* (1915 [1914]). *Ibid.*
11. ———: *Introductory Lectures on Psychoanalysis* (1916-1917 [1915-1917]). Standard Edition, XV, XVI.
12. ———: *Lines of Advance in Psychoanalytic Therapy* (1919 [1918]). Standard Edition, XVII.
13. GARMA, ANGEL: Contribution to Discussion on *The Curative Factors in Psychoanalysis.* Int. J. Psa., XLIII, 1962, pp. 221-224.
14. GILL, MERTON M.: *Psychoanalysis and Exploratory Psychotherapy.* J. Amer. Psa. Assn., II, 1954, pp. 771-797.
15. ———; NEWMAN, RICHARD; and REDLICH, FREDERICK C.: *The Initial Interview in Psychiatric Practice.* New York: International Universities Press, Inc., 1954.
16. GITELSON, MAXWELL: *The Curative Factors in Psychoanalysis. The First Phase of Psychoanalysis.* Int. J. Psa., XLIII, 1962, pp. 194-205.
17. GLOVER, EDWARD: *The Technique of Psychoanalysis.* (Chapters I-III, VII-VIII.) New York: International Universities Press, Inc., 1955.
18. GREENACRE, PHYLLIS: *The Role of Transference. Practical Considerations in Relation to Psychoanalytic Therapy.* J. Amer. Psa. Assn., II, 1954, pp. 671-684.
19. GREENSON, RALPH R.: *Variations in Classical Psychoanalytic Technique: An Introduction.* Int. J. Psa., XXXIX, 1958, pp. 200-201.
20. HEIMANN, PAULA: Contribution to Discussion on *The Curative Factors in Psychoanalysis.* Int. J. Psa., XLIII, 1962, pp. 228-231.
21. KING, PEARL: Contribution to Discussion on *The Curative Factors in Psychoanalysis. Op. cit.,* pp. 225-227.
22. KUIPER, PIETER: Contribution to Discussion on *The Curative Factors in Psychoanalysis. Op. cit.,* pp. 218-220.
23. LOEWALD, HANS: *On the Therapeutic Action of Psychoanalysis.* Int. J. Psa., XLI, 1960, pp. 16-33.

24. MACALPINE, IDA: *The Development of Transference.* This QUARTERLY, XIX, 1950, pp. 501-539.
25. MYERSON, PAUL G.: Footnote in Gitelson, Maxwell: *The Curative Factors in Psychoanalysis. Op. cit.,* p. 202.
26. NACHT, SACHA: *The Curative Factors in Psychoanalysis. Op. cit.,* pp. 206-211.
27. SEGAL, HANNA: *The Curative Factors in Psychoanalysis. Op. cit.,* pp. 212-217.
28. SPITZ, RENÉ A.: *Transference: The Analytical Setting and Its Prototype.* Int. J. Psa., XXXVII, 1956, pp. 380-385.
29. STERBA, RICHARD: *The Fate of the Ego in Analytic Therapy.* Int. J. Psa., XV, 1934, pp. 117-126.
30. ———: *The Dynamics of the Dissolution of the Transference Resistance.* This QUARTERLY, IX, 1940, pp. 363-379.
31. STONE, LEO: *The Psychoanalytic Situation.* New York: International Universities Press, Inc., 1961.
32. ZETZEL, ELIZABETH R.: *Current Concept of Transference.* Int. J. Psa., XXXVII, 1956, pp. 369-376.

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

The Significance of Scrotal Sac and Testicles for the Prepuberty Male

Anita I. Bell

To cite this article: Anita I. Bell (1965) The Significance of Scrotal Sac and Testicles for the Prepuberty Male, The Psychoanalytic Quarterly, 34:2, 182-206, DOI: 10.1080/21674086.1965.11926344

To link to this article: https://doi.org/10.1080/21674086.1965.11926344

THE SIGNIFICANCE OF SCROTAL SAC AND TESTICLES FOR THE PREPUBERTY MALE

BY ANITA I. BELL, M.D. (NEW YORK)

Psychoanalysis seems to have neglected the psychological importance of the scrotal sac and testicles at certain periods in the life of the male. These periods include the pregenital, prepubertal, and pubertal phases. (The time of the male climacteric is another such period but will not be discussed here.) Of these phases, prepuberty will chiefly concern us in the present paper.

Unfortunately, as Spiegel *(18)* has remarked, little has been written about prepuberty, especially in boys; most writers refer to it vaguely as part of adolescence. Anna Freud *(10)*, Blos *(6)*, and Aichhorn *(1)* take note of the quantitative and qualitative changes in the drives that cause a disturbance in the distribution of internal forces at puberty; there is a resurgence of pregenital gratification in consequence. But even a definition of prepuberty in the boy is lacking. Most case reports designate him as adolescent after eleven and make no mention of his physiological development. Some of this confusion is caused by the large individual variation among boys. For each boy there is a definite picture of a biological and psychological onset which may continue for three to seven years before full puberty sets in. We should be able to be more precise about so important and striking a change as occurs at prepuberty in boys.

Presented in abbreviated form before the American Psychoanalytic Association Prepuberty Panel, New York, December 1963, the Child Analysis Study Group, Los Angeles, May 1964, Georgetown University, Department of Psychiatry, Washington, D.C., June 1964, and the Western New England Psychoanalytic Society, October 1964.

The author is grateful to Drs. Augusta Alpert, Irving Clyne, Jules Gleen, Edward Joseph, and Mark Kanzer for their suggestions.

THE PHYSIOLOGICAL CHANGES OF PREPUBERTY

Numerous studies of male physical development *(11, 14, 15, 20, 22, 23)* suggest that we may assume prepuberty to begin with the first appearance of secondary changes, including endocrine changes, not evident to the naked eye. It begins earlier in girls, between seven and ten, than in boys, who start to change between eight and eleven. It extends until the menarche in the girl, which is usually between twelve and thirteen, and in the boy until the second rapid growth of testes and penis, which is followed by the first ejaculation at about fourteen or fifteen. Along with the secondary sex changes there is an earlier skeletal growth in the girl accompanied by pelvic adiposity so that during the prepuberty years of ten and eleven she is taller and bigger, and the changes in her breasts are visible. By the time she is about thirteen she is entering actual puberty. The years following the menarche in girls and the appearance of the ejaculate in boys are considered actual puberty, or adolescence as it is commonly called, which extends until full maturity has been reached.

In the boy the early changes are more gradual and, because they occur in the genitals, are visible to the pediatrician only upon examination. This is one of the reasons for the difficulties in determining the exact time of onset and duration of prepuberty in the boy. The first sign is a slight increase in the size of penis and testes with some downy hair on the pubis and some pelvic adiposity, usually at ten or eleven years. It is not until about fourteen that rapid growth of the genital and curly pubic hair appear. The period of rapid skeletal growth and appearance of axillary hair comes with the change of voice at fourteen or fifteen, closely followed by the appearance of ejaculate. Detailed studies *(16, 17, 21)* reveal that the penis gets longer and bigger in circumference, but the endocrine organ of greatest change in the boy is the testes. It changes in color, volume, and weight. From two grams before age six, it increases to four grams by age nine; between the ages of nine and seventeen, it again

increases in weight from four grams to twenty grams, and by adulthood reaches fifty grams. Its volume at nine is ninety-six cubic millimeters but by age fourteen it has reached a volume of two hundred forty-two cubic millimeters and weighs seventeen grams. The testicles also change in sensation and function, becoming sensitive to pain and producing androgens and spermatozoa.

We should expect such marked physiological changes to affect the psychological development of the boy. The age of onset and the rapidity of change must influence the boy's psychological structure. Ego strengths and weaknesses will obviously affect his readiness to accept these changes. Likewise a comparison with peers will play a role. Here we may ask: Will such changes exacerbate an underlying neurosis? Will they overwhelm an immature ego? How do they affect his body image?

CASTRATION ANXIETY IN PREPUBERTY

The castration anxiety that appears at prepuberty has an important pregenital source. In a previous paper *(4)*, I have shown that during pregenital development, at about two and a half to four years of age, anxiety related to early object loss (loss of breast and feces) is in part due to the simultaneous contractions of the anal sphincter and retraction of the testes during defecation. These findings were based on the verbalizations of a group of boys who experienced defecation as particularly anxiety provoking. They had developed fecal retention because of fears of sitting on the toilet. It was found that the parents of these children had uniformly failed to mention the scrotum and testes when reassuring them about fecal loss. Once the parents acknowledged the existence of the scrotal sac and testes, the children verbalized a confusion of sensation between movements of the fecal mass and those of the testes. Since they had not been able to ascertain which was moving, and in which direction, they feared that a testicle would drop off during defecation. In addition, the parents' failure to speak of the scrotal sac and testes as a separate organ caused the children to visualize scrotal sac,

testes, and anus as a composite 'dirty' area. Most of the children overlooked any sensations involving the penis because of their phase appropriate interest in anal activity; only one child in the group reported anything about his penis.

A biological basis for these confused sensations does in fact exist *(8)*. Sphincter ani, scrotal sac, testes, cremasteric muscle, and penis all receive their innervation simultaneously from a network of nerves originating primarily from two main trunks, one deep and one cutaneous. Perhaps it is his confusion of sensations of movement between testes and feces that accounts for the greater reluctance of the boy than the girl to sit on the toilet during training.

We must not forget that the pregenital anxiety felt by the little boy about loss of feces and testes is the forerunner of the later occurring phallic castration anxiety. The boy is likely to think that if the testicle can disappear, the phallus may do so too. With the development of phallic primacy, the older fears of loss of feces and testes tend to influence phallic castration fears in an unconscious way. Since with few exceptions the boy can see his phallus change but not disappear, it is quite possible that the mechanism of displacement—from testes to phallus—has its beginning here. Phallic primacy remains the center of the boy's attention throughout latency. However, concern about phallic erections, which seems to be the more prominent at this time, is intimately connected with testicular activity as well.

We must also remember that during the period of anal ascendency, the scrotal sac and testes, for the reasons stated above, are perceived by the child as an anal-testicular composite. In the phallic phase, for similar reasons, the scrotal sac and testes constitute a unit perceived together with the phallus. Hence, because of its lack of identity and its position as a bridge between phallus and anus, the scrotal sac and its contents are involved in both pregenital and phallic castration anxiety.

In prepuberty the increase in instinctual drives stimulates increased masturbatory activity, which is both gratifying and, because of associated œdipal fantasies, provocative of anxiety.

Anxiety is accompanied by specific physiological changes in the genital—retraction of the testes. At the height of orgasm when the phallus becomes turgid and erect, simultaneous retractile movements of the testes and contraction of the anal sphincter occur. This has been recorded by Masters and Johnson *(14)*. These movements of the testes associated with the orgasm of masturbation probably also contribute to the castration anxiety of prepuberty and puberty. Blos *(6)* states that the preadolescent boy reacts to nonspecific stimuli with an erection, and that an erection 'can be provoked by anger, fear, shock, or general excitement'. However he fails to mention testicular retraction which occurs simultaneously with such erection.

Obviously the pregenital castration fears associated with such uncontrollable movements will be revived. The older composite image of the sac and testes as a 'dirty' area associated with the anus is likewise revived *(4)*. Understandably defensive maneuvers will be mobilized to overcome the increased anxiety. We consistently find a regression to anality. The defenses of choice are repression, denial, and displacement to the phallus.

Moreover, as the testicle becomes larger and heavier, it becomes the boy's organ of greatest vulnerability. If hit, squeezed, or otherwise injured it is excrutiatingly painful. Boys regard a trauma or blow to the developing testes as extremely dangerous. 'You can die from that', we are told; or it is said that after a blow the testes will swell and burst, causing death. I have several times come upon the fantasy that if a boy cohabits with a girl his testicles will die, or fill up and burst and then he will die. One ten-year-old thought that a man can make only two children because after it gives out its seed each testicle shrivels and dies. Here we have fears of castration in which boys refer to the testicles rather than to the phallus. Another boy frequently referred to 'getting my ass cut off', a common expression among boys usually interpreted as phallic; closer examination points to the anal-scrotal composite.

Many authors (Anna Freud [*10*], Greenacre [*12*], Blos [*6*], and others) have reported that the regression to anality is more

characteristic of the boy than of the girl. Long ago Mark Twain gave us an unsurpassed picture of prepuberty in the adventures of Tom Sawyer and his friends. Although times have changed and sleepy towns have become bustling cities the boys he described may still be found. We still hear about Aunt Polly's futile attempts to get Tom to bathe, wash his neck, or clean behind his ears. Pockets are still full of all kinds of treasures, valued more highly than the most precious jewels—beetles, stones, marbles, bits of wire and pipe, cards, doorknobs (Tom's 'chiefest jewel'), and keys, to name a few. A possible explanation for the regression to anality, which is so much more in evidence in boys than in girls, may lie in the anal-testicular confusions and associated anxieties of the boy which are revived at prepuberty.

Perhaps it is at the height of his anal development that the boy first attempts to master his fear of the uncontrollable movements of his testes with their potential for bringing about a true disappearance of a part of his genital. It is then, at the time of bowel training, that, as Blos *(6)* says, the boy takes '. . . a decisive forward step in ego development. The achievement of sphincter control produces a sense of mastery and a delineation of body boundaries—marked by the excretory orifices —which establishes for good a separation of the self and the outside world.' Thus when the pregenital anxieties are revived in prepuberty we see—besides the regression to anality—denial, repression, and displacement to the phallus as the boy's principal defenses.

We are all familiar with the ten or twelve-year-old magician who is most adept at making objects disappear and reappear. The consuming interest and superior ability in ball games at this time is equally familiar. As Greenacre *(12)* states: 'If one doubts that the difference in genital and excretory functions in the two sexes, in themselves implicit in the very anatomical structure of the organs, influence, or are even transposed onto other activities of the individual, let him think of such simple things as that boys spit, whistle, and throw balls with so much more precision and aim than do girls'. It seems to me that these

are attempts at mastering the anxiety generated by the uncontrollable movements of the testes which become so important to the boy at this time because of their marked physical changes.

It is in prepuberty too that we are confronted with a burst of 'body-building'. Running, weight lifting, and other maneuvers to strengthen muscles seem characteristic of attempts at phallic achievement. Certainly in the face of the continued testicular castration threat the boy will attempt to displace to the phallus, which always was and continues to be a pleasure-giving organ. It gets larger, but it does not pose the real threat of disappearance as do the testes.

Why is the ability in science, mathematics, and mechanics commonly considered greater in boys than in girls? I think that the boy's constant awareness of changes in his genital stimulates intellectual attempts to explain them. He cannot avoid noticing that his penis changes and his testes move unexpectedly and frequently. The girl, on the other hand, can overlook changes in her genital when she is not premenstrual, menstrual, or in a state of sexual arousal. Both sexes, as educators well know, are much interested in human physiology during this time. Is the boy trying to solve the 'mechanics' of the movement in his genital? Elkisch *(9)* casts light on the boy's interest in mechanics, pointing out that 'boys seem to draw the human figure, that is themselves, in the disguise of the machine'. She adds, 'A machine is an inanimate "organism" where different parts are put together in such a way that if this organism is set in motion, it functions. It functions by virtue of the fact that the single pieces of machine are put together so that they really fit and, as it were, make sense to each other. Even a very minor misfit may bring the machine to a standstill. . . . If we interpret its symbolism, the inanimate organism stands for the animate, the *human* organism; and the child's concern about the fitting together of parts refers to his own body, to his sexual curiosity: fitting parts together, manipulation, motion, etc.'

It is more than likely that the deeper roots of the male's castration anxiety lie in his fears about the loss of his testes. It

is significant that in adult analyses we find much repression of fantasies about the testes and scrotal sac. Attempts to lift the repression are met with anxiety, intense anger, often caustic jokes about women, and complaints against the mother.

Although I seem to emphasize anal-testicular problems, I do not by any means imply that the goal for the boy is anything but phallic. These are additional facets; and in our wish to help him attain full genital development we must be aware of those physiological changes that influence his psychological development. We seem to have been overly zealous in offering phallic interpretations, thereby re-enforcing the very defenses we want to analyze—repression, denial, and displacement to the phallus.

Some boys we see in treatment seem to be much concerned with anal aspects of their development. However in boys who have not reached phallic genitality it seems more fitting to consider their libidinal interest as anal-testicular rather than simply anal. Perhaps, along with other predisposing factors, such boys are endowed with more active or more sensitive testicles. Also, as has been shown *(4)*, some boys experience greater anxiety during bowel training. A combination of such constitutional endowment and particularly traumatic bowel training probably causes a greater than usual degree of retraction of the testes, with consequent anxiety. Analysts are likely to interpret anal preoccupations, but I have seen instances in which interpretations that included the testicle helped the boy and adult male progress more easily to phallic genital development. In fact, a preponderance of anal fantasies in a male analysis, together with stubborn defenses of denial and displacement, has proved to be a sign of hidden testicular problems in some cases.

BISEXUALITY IN PREPUBERTY

Although I have touched upon bisexuality in the male in an earlier paper *(3)*, more can now be said. Actually much of the psychology of the prepuberty male is still unclear. The increased instinctual drives of prepuberty motivate the boy's turning away from incestuous objects within the family and turning

toward his peers. Girls are of little comfort to him during his early prepuberty. They are much bigger than he—taller, heavier, and usually with visible fullness of the breast. They show adiposity of the pelvic area; they begin to posture like young ladies; here and there a sophisticated hair-do appears. The boys are scrawny, small, and restless. They are sloppy and unkempt, often dirty. Their constant fidgeting annoys their elders. They present the maturational appearance of a boy of seven. Educators have noted that the progressive school, with its possibilities for active discharge of energy, was 'made to measure' for the boy in prepuberty.

The years between eleven and fourteen have brought the girl a long way. She is fully mature physically by fourteen, usually having passed her menarche at twelve or thirteen. Her breasts are developed and her figure is that of a young woman. She aggressively depreciates her undeveloped male peer who at twelve gives no outward indication that he will eventually become a man. His skin is soft and smooth; if he has any early sign of secondary change it is a few wisps of fine pubic hair, some pelvic adiposity, and a slight increase in the size of his penis and testes. Sometimes there is an elevation of the areolar tissue which, even though it disappears later, certainly does not bolster his feelings of masculinity. The rapid growth of his genital, especially the testicle, takes place at about fourteen.

During the years between nine and fourteen the boy lives through a most difficult period. He is socially unacceptable to his female contemporaries because of his developmental lag, and is frequently the butt of the girl's increased aggressive and castrating attitudes. Girls thus intensify his feelings of inferiority and his castration anxiety. He reactively turns to other boys, joining clubs, gangs, groups, or teams. Mark Twain described this aspect of prepuberty too—the oath 'never to tell' written with the blood of each member of the clan is just as binding today as in Tom Sawyer's day. The devil and the forces of magic have lost none of their power, and it is still a disgrace to be caught with a girl before the early years of prepuberty have run their course.

And there is a further complication. The visible changes in the girl's breasts, the talk of her menarche and ability to create babies, stimulate and re-enforce the boy's own pregenital wish to be like mother—to have breasts and create babies. Wishes of this type at prepuberty connote femininity, and hence suggest phallic castration; they must be defended against. The defenses of choice, as I have said, seem to be repression, denial, displacement to the phallus, and regression to anality.

Ideas about the uncontrollable growth of his testes, which seemed so insistently to pose a threat of femininity, have been verbalized by more than one boy thus: 'They're soft and round like breasts; there are two of them; and they grow fast like breasts. They can hurt too. Girls are so fussy about being hurt in the breasts.' Is this boy voicing the unconscious question of many boys—'Will I turn into a girl?'.

Perhaps here we find an additional reason for the prepubertal boy's hostility to his mother, his sisters, and other girls, and for his turning to male friends. The uncontrollable growth of this part of his genital arouses pregenital wishes to be feminine, but it also arouses hostility to the mother whom he holds responsible for the status of his testes. One boy verbalized his fear that the therapist would change him into a girl.

A man in his thirties, described by a colleague, felt ashamed of having particularly large testicles which to him meant being feminine. He had a fantasy that at certain times his mother had dragged him around by his genitals. He knew this never really had happened, yet the feeling persisted that this was the reason for his large testicles, which had made him particularly ashamed during his adolescence. In two of my own cases, the hostility in the transference was expressed as 'You don't give me functioning testes'. For boys who have never adequately resolved their resentment toward the female in this connection, and for those who have underlying difficulties with female identification, the course of events of prepuberty may be crucial to the successful development of ultimate phallic genitality and heterosexual object choice.

Let me stress once again that the phallic connotations of the

frequent penile erections are not overlooked at this point. I merely wish to include the testicular factor in the total picture.

Blos *(6)* states that 'the typical preadolescent conflict of the boy is one of fear and envy of the female. The identificatory tendency with the phallic mother tends to alleviate the castration anxiety in relation to her; normally a defensive organization is built up against this tendency.' I disagree; it seems to me that the mother with breasts may not be regarded as phallic by her son but rather as feminine, with female power which the boy believes to be greater than his own. We must remember that in prepuberty the boy feels inferior to his female peers and certainly to his mother.

Interestingly it is the breast which often occupies the center of his unconscious fantasies. The art of prepuberty boys frequently shows breast symbols or portrays the female form with emphasis on the breasts. He makes many jokes about the breasts in his attempts to build a defensive organization against wishes to be feminine. Bettelheim *(5)* reports a joke told by prepuberty boys: 'What is the strongest thing in the world? A bra, because it holds up two mountains and a milk factory.'

To repeat, it is at prepuberty that the boy has to struggle with and renounce his wish for femininity. At this time he must work out the conflict in part stimulated by the rapid growth and the movements of his testes. They are linked with both his pregenital and prepuberty castration fears, as well as with his wishes for femininity. They are now the organs which are involved in real danger to his body.

Blos also states that 'the castration anxiety in relation to the phallic mother is not only a universal occurrence of male preadolescence, but can be considered its central theme'. Here again I take issue. Is it not less provocative of anxiety to endow the mother with a phallus rather than breasts, which are symbolically so like the rapidly growing testes the boy would rather deny? To do so also makes the mother resemble him rather than an all-powerful female to whom he feels inferior.

In psychoanalysis we have always regarded 'two' as a symbol

of femininity. Round objects, soft, vulnerable, and containing a procreative element encased in a sac can hardly be regarded as a phallic symbol. Hence the concept of the 'phallic' mother seems inherently unlikely, except as evidence of the characteristic male defense of displacement from testes to phallus, or as an artifact we ourselves have created by offering phallic interpretations predominantly. Moreover, endowing the mother with a phallus may represent a denial of feelings of male inferiority in respect to the female, who procreates so visibly and directly.

CASE MATERIAL[1]

Lee, a well-developed boy of nine, had been in analysis for two years because of an eye tic, facial grimaces, learning difficulties, behavior disorders, and a continual cough with clearing of the throat. The classical analysis of phallic aspects, œdipal fantasies, and masturbatory conflicts has not been overlooked but will be omitted from this report. At the period in his analysis to be discussed, he still had inhibitions about masturbating, sucked his thumb during nocturnal fantasies, and feared the dark. His learning difficulties and behavior disorders had already improved with treatment. The tic had subsided but, during the period under discussion, it reappeared with a new characteristic of eye-widening. I am reporting just one part of his analysis, during which time his testes retracted periodically and finally had to be 'milked out' by his pediatrician.

As often happens in such boys, Lee introduced his unconscious preoccupation with the state and movements of his testes by means of jokes with anal overtones and symbolic references to the testes. At the same time his eye tic became exaggerated. The first of the jokes, a not uncommon one, was told after he had expressed anger because his father had not let him go to the movies the preceding day. 'A father asked his sons to find as

[1] To increase the objectivity of our case material I shall include part of the analysis of a prepuberty boy about which an experienced colleague consulted with me. We collaborated on examination of the daily material and decisions as to interpretations.

many ping-pong balls as possible. One son brought back two round, bloody things, and said: "I thought you meant King-Kong balls".' Lee's associations revealed a wish to kill his father, take away his power, and prevent him from making any more babies. It is of interest that he chose the testes, not the phallus, as the site for castration.

He mentioned a fantasy involving a man who put a special lotion on snakes and tarantulas so they could come up through the floor in a pipe to the back of his bed. His associations were to a hollow branch of a tree, and a nest with a mother bird sitting on eggs. He talked of a fantasy twin who threw eggs when he got nervous. While he talked his eye tic increased.

He next brought in a transistor radio which he had secretly torn apart. He wanted to get at the magnet in the radio 'that keeps things in place, because if the parts scatter they lose their power'. His association was to scattering glass which at one time had injured one of his eyes and threatened his vision. As he discussed this his eye tic reappeared and his eye widened. He jumped up and down on the couch speaking of his confusion of gender in French, for which he blamed a woman French teacher. He mentioned Jason and Medea, and Medea's acts of destruction. He seemed to think that the male potion which protected the tarantula in the preceding fantasy was more protective than the female magic, an idea also expressed by other boy patients.

Most interesting was an idea about a dummy he had made out of his gym clothes. Although it appeared that the dummy could not see because it had no head ('he lost it in an accident'), it really could see because its eyes had gone down into its stomach. This is a clear example of substitution of one part of the body for another and certainly indicative in a symbolic way of Lee's preoccupation with the activity of his testes which had in fact gone up into his 'stomach' rather than down.

These fantasies made it fairly clear that this boy was experiencing prepubertal sensations in his testes, probably because of his accelerated physical development. Certainly he seemed con-

cerned about their retractile movements and regarded them with considerable anxiety. This was interpreted to him by referring to the story of the dummy. As he told the story his eye tic increased; it was pointed out to him that one part of the body was being substituted for another. He responded with a story with anal overtones. A boy hid a box of chocolates, each individually wrapped, under his bed. He unwrapped foil after foil and finally found only one little chocolate ball at the bottom of the box. He ate the piece and everything he touched turned to chocolate. Further details suggested fears that a bowel movement or a testicle would fall off, evidence of confusion of anus and testes during the period of migration of his testes.

Gradually he began to insist that he could control all the movements of his body; as he said this he clutched his pants. When the interpretation was finally made that perhaps the movement of the eyes in the dummy and his own need to control movement might have something to do with the uncontrollable movement of his own testes, he sat at a table swinging his legs back and forth and expressed pleasure that this movement of his legs did not interfere with his concentration; he could even spell difficult words while doing it. Further verification of the interpretation came when in subsequent sessions he spoke of powder-caps exploding—'the higher they drop the more they explode' and if dropped from the twelfth floor all the caps would explode. A discussion of the danger of falling and moving things brought recollections of his former constipation and the enemas he had been given. But not as yet did he verbalize an awareness of anal and testicular sensations as connected with each other, even though his story of the chocolate ball suggested anal-testicular components. Probably his regression should have been interpreted: he talked of bowel movements when his analyst and I talked of testes. Queries about sap in a rubber plant led to his concern with his semen and sperm.

Slowly his productions became more focused. He brought his 'monsters' into the analysis. The most dangerous monster had a particular weak spot: he could be killed only by an arrow in the

eye. Another monster was just one big crawling eyeball. Alternating with these were stories of Narcissus. He showed that he felt like a monster by the distorting movements of his facial tic, which constituted a narcissistic injury. He also discussed his throat-clearing tic, which led to interpretations about fantasies of fellatio. He thereupon threatened to stop therapy but returned for the next session with the remark that it really takes 'guts' to be analyzed.

He finally brought his kit of monsters but did not want his teacher to see the one creature that really was most anal-testicular. This was a spider, which reminded him of an insect more deadly than the tarantula—'it has a sac full of poison which feeds a poker that is an extension of its tail, and penetrates in an attack'. The description is reminiscent of other boys' comments that the testicle enters the vagina and may be destroyed there. This 'insect' was an utterly undifferentiated creature whose most prominent feature was an eye. Early in the analysis, he had indicated hostility toward the udder of a cow, which he visualized as an attacking, threatening object. It seems that he similarly regarded the sac and testicles as the threatening, destructive agent of penetration. Breast and testicles appeared to be equivalent; in fact, Lee showed that the 'creature' was bisexual by calling it an 'in-between creature'.

There followed vigorous destruction of all the monsters he had assembled. He then stretched out on the couch and did calisthenics, using a pillow to toss about with his feet. He placed his torso on the couch and raised his feet to an upright position while balancing the pillow, a type of posturing I have come across in other cases. In these exercises he was showing his anus and testicles. (It seems more difficult for a male than a female therapist to recognize such activity, common in boys, for what it is and to interpret it.) After this there was a remarkable diminution of the tics, and having begun to free himself of the 'bisexual monster', he was now able to display more frankly phallic masculinity.

He made a 'moon goon' which could change in size from a

fraction of an inch to one thousand feet but was in control of all its changes. He agreed that it would be much easier if boys, like the 'moon goon', could be in charge of all changes and could control just when they feared an inability to control. He added how nice it would be to be able to predict, regulate, and know what is changing. As he said this, the ticlike movements of his eyes and face reappeared. The changes in size could be considered phallic, but in its present context, and with the appearance of the ticlike movements I would be more inclined to interpret the testicular component.

Shortly thereafter he hung a woven wastepaper basket from the door for a basketball game, repeatedly throwing a ball into it. During this period he expressed his preference for daydreams, which were under his control, over nocturnal dreams, which were not. After showing a secret rock collection, he narrated a fantasy. 'I am in a basket as large as this office, which weighs one ounce and is attached by a cable to an airplane. When the plane is a thousand feet high, a crane inside the plane releases the basket from the same place where a plane would drop bombs. The basket can never come off because it is attached to the plane by this cable. I sail through the air at six hundred miles an hour—it is scary but fun! There is a glass hood over the basket. No one can manipulate this basket but myself—I push the button that releases wings on the basket, and then push another button that does away with the wings and replaces them with a motor of a million atoms so they never have to get refueled, and stay in perpetual flight. One special tablet serves as food for one year. The cable remains attached to the plane and is pulled back into the plane as the basket takes off. "I'm on my own!".'

Despite the testicular anxiety apparent in the boy, the therapist viewed this fantasy as expressing a wish for rebirth, with the patient in control, by which he became an individual, independent of those who had formerly controlled him and upon whom he had felt dependent. Only after a review of the fantasy did it become apparent that his concern with getting

things into the basket might really be his concern with his testicles entering and leaving the scrotum. When he was told this and the fact of his bisexual confusion, he listened quietly and his eye tic diminished further. It was suggested by me that he go to his pediatrician for a check-up.

A period of acting out now began. Before his sessions he began to roam about the avenue where the analyst lived, wishing to gain entry into the various apartment houses. At first he thought about getting in through back, unguarded entrances but this he rejected as too 'sneaky'. He wanted to explore the basements and roofs rather than gain entry into specific apartments. He preferred to enter through the front entrance, but this meant gaining approval of the doorman. Interpretations concerning the superego and fantasies of entering the analyst failed to reduce the activity. The walks continued; he came into sessions quite noisily, and told jokes with anal overtones.

During one session he expressed a wish to ignite a firecracker and pointed out its disintegration as it exploded. Reference was made to swelling testicles and penis, and his fear of their exploding and disintegrating. He sat quietly making a 'wierdo', an amorphous shape with two dots on the top. His association to these two dots was the accident he had sustained with the exploding glass and near injury to his eyes (the two dots). It was related to his more immediate concern with his two testicles.

At this point his parents reported that a physical examination (preparatory to his going to camp) had revealed that one testicle was undescended. His physician had routinely examined the testicles during previous general examinations but had not mentioned this condition, according to the parents. But the pediatrician later told me that the boy had migrating testes and that he had reported this to the parents. Their defense against this disturbing information had been denial.

Lee complained to his parents at this time that boys in the neighborhood rejected him; he preferred the company of a tomboyish girl. His teacher noted a slight worsening in his school work and commented that it was not as neat as usual, sug-

gestive of regression to anality. He had been told by the pediatrician to take a warm bath and then attempt to feel his testicle. He reported to his analyst that all was fine.

He rushed into the next session, spoke of his tomboy friend, and said he liked her better than boys. He was informed that the analyst knew of his visit to the pediatrician and of his findings. It was suggested that his roaming about in her neighborhood might indicate a search for his lost 'ball'. He said nothing. Then he demanded to know the sources of things used in the office, such as clips and rubber bands, and how much they cost. He took apart a motor, became restless, aggressive, and hostile, and made derogatory comments about women who did not give him license to practice his birthright, his masculinity. His analyst now told him that he was disturbed over his unstable equipment which did not stay in place, and that he was trying to get things to stay in place. He retorted by aiming spitballs out the office window, demonstrated his strength by breaking a board over his knee, and left a doodle on which he wrote 'a boy is made' (he subsequently insisted that it said 'a boy is mad').

He finally confessed that he was not really sure whether or not his testicle was descended, that he did not understand what the pediatrician really meant him to do, and that he had merely told his father that everything was fine. Nevertheless, whenever the matter of testicles was mentioned, and especially when an attempt was made to link it to possible anxiety about going away to camp, he responded by exaggerated phallic behavior—throwing sharp things, interspersed with regressive anal behavior—, messing up the office, profane language, and frequent visits to the bathroom.

He then chose to play tiddly-winks, and one could inquire whether his own 'tiddly-wink' had returned to the 'basket'. He admitted that it had not and said he did not know what the pediatrician meant when he urged him to 'feel'. He then insisted that the analyst do all the talking and ask no questions but explain to him about the testicles. He inadvertently admitted that his association to testicles was 'piss'. He remained restless,

told more jokes, and remarked that he had always thought that 'fuck' had to do with 'pissing'. During this talk about 'jokes' he laughed and said, with lessened anxiety, that he could laugh his head off when the analyst talked funny about getting his 'balls into the basket'. (As he said this he sat cross-legged on the couch, bouncing a ball back and forth from a cushion between his legs.) He next began playing 'peek-a-boo' behind a bolster. The analyst remarked that perhaps his testicle was playing 'peek-a-boo'. He checked to see if it was peeking. He punned 'freak-a-boo' and offered the definition of a freak as an oddity of nature—something that has something extra like eleven fingers (a reversal of his actual condition; something was missing). Werewolves, he said, are females with great power, and might change males into females. Therefore the best policy would be to identify with such a powerful female. He went on to say that he did fear being changed into a girl by his analyst, a fear the author has heard prepubertal boys express when they become aware that their testes have begun to change in size and sensitivity.

Although much of the detailed working through of this boy's analysis has been omitted, we see clearly how the prepubertal boy shows evidence of castration anxiety referable to his testes. He uses ball games as the symbolic expression of his fears. His references to the eyes are obvious. He regresses to anal behavior each time reference is made to anxiety about his testes. His denial mechanisms are repeatedly evident. Subsequent displacements to phallic activity are equally evident. Lee's conflict about bisexuality has thus far been characteristic of the prepubertal boy. He unconsciously equated breast and testicle, showed fear of becoming female and hostility toward females, particularly mother and therapist and, what is most important, his associations began to flow freely as he was made aware of his anxiety about his testes and their movements. Confirming our clinical observations was the report from the pediatrician verifying the retraction of his testes into the canal, which necessitated a 'milk-

ing out' of them concurrent with the material just reported.

Shortly before his departure for camp he verbalized fears which we know to be typical of the cryptorchid boy (Lee was not a true cryptorchid)—that other boys would make fun of him or consider him a sissy. On his return from camp he brought a red rubber ball which he banged on the wall. He would not talk except to say that he had not enjoyed the summer, particularly swimming in the lake. His play with the ball suggested certain questions to me. Had his testes retracted again? (Jumping into a cold lake could make this happen.) Had the boys teased him about being a sissy? He insisted that he needed a gun and demanded that the analyst talk to his parents about this. This sounded to me like a displacement to the phallus.

Again I advised examination by his pediatrician, who reported that although the testes were in the sac as Lee undressed (which he was reluctant to do), they both retracted into the inguinal canal as soon as the pediatrician attempted to examine him.

To have failed to insist that he visit his pediatrician at this time would have been gross negligence. Here we have an instance of how imperative it is that the therapist of a boy in prepuberty bear in mind the condition of the patient's testes. Connolly *(7)* reports that steadily increasing damage occurs in maldescended testes as puberty progresses. He considers that 'watchful waiting be classified as obstinate inactivity, since its only proved efficacy is in cases of pseudo-cryptorchidism when time corrects the diagnostic error', i.e., when pseudo becomes true cryptorchidism. Connolly also states: 'From six years on there are gradually increasing changes apparent which become marked between ages nine and eleven'. Hence when testes are migratory but still fall within the norm—that is, are not actually cryptorchid—we must be extremely careful to notice any indication of prolonged periods of retraction that may eventually impair function. Lee was clearly aware of movements and changes in his testes, and he gave numerous hints of his condi-

tion. Tragic examples can be cited in which cryptorchidism has been neglected in spite of numerous references to it by the child that should have alerted the therapist.

Others have reported that child patients played games of balls disappearing and appearing, but this seems to have been interpreted as pertaining to the penis. Sterba *(19)* has described a two-year-old boy with psychogenic constipation who certainly had masturbatory fears relating to his phallus but was also distressed about his anal and testicular movements. The boy was interested in his father's and other male's 'behinds' but showed no interest in penis and urine. His excitement when given a big, long, red, sausagelike balloon was great. He cried out: 'I'll make two little sausages on top of it'. Evidently he was an excellent observer of male anatomy. His game with wooden beads, which he called the 'bally game', was similar to that of a nine-year-old boy reported by Beiser *(2)*, whose school phobia was precipitated by a second herniorrhaphy. The child's first repair of bilateral inguinal hernias had occurred at four. He too played games with balls, especially a repetitive game in which little clay balls magically disappeared into a clay sac, which he had slashed in several places, and then reappeared from it. This seemed to express his wish to know what had happened to his testes during the two hernia operations and to be an attempt to master his fears about their disappearance.

I am reminded of another boy in psychotherapy, aged nine-and-a-half, who after an episode when he was either 'goosed' or assaulted by an older boy refused to go back to the park where he had had this experience. He played with a younger boy and wet at night. He brought in drawings of a tank which had two round appendages at the rear with an opening below. The rear part, he said, was the most vulnerable part. He went on to speak of fears about his own 'rear' and what could happen to it. He asked about seeds and babies. Does a boy keep his seeds all his life? A father can make one baby with one seed and there is only one in each testicle. As he continued with his conflict about mas-

culine or feminine identification, he was preoccupied with his body, remarking that his testes go up sometimes and when he took a bath he could feel them go down. Like other boys, he expressed the fear that to cohabit with a woman is to lose the testicle. These boys try to strengthen their bodies by running, push-ups, or weight lifting, probably thus attempting to deny testicular anxiety and displace it to the phallus.

Some years ago a nine-year-old boy came to me in a state of panic because of the violence of his mother, who was close to psychosis and terrified him by beating him severely. She complained that he insisted on wearing pants very tight in the crotch. During his treatment, hour after hour was spent on one game: he shot marbles into a boxed-in area. As he tried his skill at this he commented on the great strength of his mother, his fear of her, and his firm conviction that he would 'never be as strong as my mother no matter how strong my muscles become'. The testicular retractions induced by fright over his mother's violent outbursts caused him to wear his pants tight in the crotch so that his testicles would not move; such movement suggested that they might fall off.

SUMMARY

It has been shown on the basis of biological data, direct observation of boys, and psychoanalytic case studies of prepuberty boys that the physiological changes occurring in the testicles and scrotal sac at prepuberty, separate and apart from the phallus, play a significant role in the psychological development of the boy, particularly in the resolution of his castration anxiety and his problems of bisexuality.

We have seen that prepuberty begins well into the period we customarily refer to as latency, comes later in the boy, and extends for a longer period of time than for the girl.

The testes change more than any other endocrine organ in the body. They change in weight, volume, color, sensation, and function; they become sensitive to pain, and produce an ejacu-

late. The penis enlarges but retains its original function as a pleasure-giving organ.

The prepuberty changes in the testes, plus their tendency to move with fear, cold, anger, and defecation, as well as with the increased sexual arousal of this period, are in part responsible for the boy's increased castration anxiety, which is often displaced to the phallus. Testicular movements also revive the earlier pregenital castration anxiety vested in an anal-testicular amalgam, previously postulated. The regression to anality takes place along this path. Because of their position as a bridge between anus and phallus, the testes also become amalgamated with the phallus during phallic primacy, and are associated with fears of phallic loss.

In our case material we have seen that the awareness of such movement of the testes stimulates castration fantasies in the prepuberty boy which may be analyzed if one is attuned to this material.

In so far as problems of bisexuality are concerned, it has been indicated that the rapid growth of the testes in prepuberty stimulates pregenital fantasies about having breasts, becoming female, and bearing children. The defensive turning away from the female, the feelings of hostility and envy, have likewise been discussed and shown in the case material. The turning to the male at this point, with the possibilities of later homosexual object choice, has yet to be worked out in detail in this connection.

There is considerable evidence in analytic literature that boys are concerned about their testes, both in the pregenital and prepubertal periods. They continue their preoccupation in puberty and adulthood as well.

Thus the organ that is the seat of so much anxiety, is so uncontrollable, connotes dirt, shame, and femininity as well, will not readily be kept in consciousness. It is not at all surprising therefore to see the massive repression, denial, and displacement to the phallus that we find in analytic literature. A preponderance of anality along with these defenses should be a signal for prob-

lems involving the testes with all the implications we have mentioned. We have tended to overplay the role of the phallus, reenforcing defenses of repression, displacement, and denial, and completely neglected the rest of the male genital, which constitutes two-thirds of the whole. Let me repeat, however, that what has been said in no way minimizes the role of the phallus; we simply want to include the total picture of male castration anxiety and bisexuality.

I have stressed detailed physiological changes because they play so integral a part in psychological development and have been so overlooked. It goes without saying, and has been mentioned, that the psychological content of the œdipal fantasies occurring during the phallic œdipal phase, prepuberty, and puberty will influence penile erections and retractile movements of the testes. Our case material shows this. Likewise in a circular way the physiological concomitants will further intensify the existing castration anxiety of any particular period mobilizing increased defenses.

Finally and most important we have indicated how imperative it is for the therapist of the male child, particularly the prepuberty boy, to be aware of material referable to the testes and scrotal sac.

REFERENCES

1. AICHHORN, AUGUST: Some Remarks on the Psychic Structure and Social Care of a Certain Type of Female Juvenile Delinquent. In: *The Psychoanalytic Study of the Child, Vol. III & IV.* New York: International Universities Press, Inc., 1949.
2. BEISER, HELEN R.: Panel on *Prepuberty and Child Analysis,* Meeting of American Psychoanalytic Association, December 1963.
3. BELL, ANITA I.: *Some Observations on the Role of the Scrotal Sac and Testicles.* J. Amer. Psa. Assn., IX, 1961, pp. 261-286.
4. ———: *Bowel Training Difficulties in Boys* (1963). J. Acad. Child Psychiatry, III, 1964, pp. 577-590.
5. BETTELHEIM, BRUNO: *Symbolic Wounds. Puberty Rites and the Envious Male.* Glencoe, Ill.: The Free Press, 1954.
6. BLOS, PETER: *On Adolescence. A Psychoanalytic Interpretation.* New York: The Free Press of Glencoe, Inc., 1962.
7. CONNOLLY, NEVILLE K.: *Maldescent of the Testes.* Amer. Surgeon, XXV, 1959, pp. 405-419.

8. CORNING, H. K.: *Lehrbuch der topographischen Anatomie.* München: S. F. Gergman, 1923.
9. ELKISCH, PAULA: *Significant Relationship between the Human Figure and the Machine in the Drawings of Boys.* Amer. J. Orthopsychiatry, XXII, 1952, pp. 379-385.
10. FREUD, ANNA: Adolescence. In: *The Psychoanalytic Study of the Child, Vol. VIII.* New York: International Universities Press, Inc., 1958.
11. GALLAGHER, J. R.: *Medical Care of the Adolescent.* New York: Appleton-Century-Crofts, 1960.
12. GREENACRE, PHYLLIS: *Trauma, Growth, and Personality.* New York: W. W. Norton & Co., Inc., 1952, pp. 149-164.
13. HOLT, L. E. JR.: and MC INTOSH, R.: *Pediatrics.* Appleton-Century-Crofts, 1953.
14. MASTERS, W. H. and JOHNSON, V. E.: *The Sexual Response of the Human Male.* Western J. Surgery, Obstet., and Gynecol., LXXI, 1963, pp. 85-95.
15. NELSON, W. E.: *Textbook of Pediatrics.* Philadelphia: W. B. Saunders Co., 1954, pp. 1484-1497.
16. SCHONFELD, WILLIAM A.: *Primary and Secondary Sexual Characteristics. Study of Their Development in Males from Birth Through Maturity, with Biometric Study of Penis and Testes.* Amer. J. Diseases of Children, LXV, 1943, pp. 535-549.
17. ———: *Deficient Development of Masculinity. Psychosomatic Problem of Adolescence.* Op. cit., LXXIX, 1950, pp. 17-29.
18. SPIEGEL, LEO A.: Comments on the Psychoanalytic Psychology of Adolescence. In: *The Psychoanalytic Study of the Child, Vol. VIII.* New York: International Universities Press, Inc., 1958.
19. STERBA, EDITHA: Psychogenic Constipation in a Two-year-old. In: *The Psychoanalytic Study of the Child, Vols. III & IV.* New York: International Universities Press, Inc., 1949.
20. STOLZ, H. R. and L. M.: *Somatic Development of Adolescent Boys.* New York: The Macmillan Co., 1951.
21. STUART, H.: *Normal Growth and Development During Adolescence.* New England J. Med., CCXXXV, 1946.
22. TANNER, J. M.: *Growth at Adolescence.* Springfield, Ill.: Charles C Thomas, 1955.
23. WATSON, E. H. and LOWRY, G. H.: *Growth and Development of Children.* Fourth edition. Chicago: Year Book Medical Publishers, 1962.

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

The Sense of Maleness

Robert J. Stoller

To cite this article: Robert J. Stoller (1965) The Sense of Maleness, The Psychoanalytic Quarterly, 34:2, 207-218, DOI: 10.1080/21674086.1965.11926345

To link to this article: https://doi.org/10.1080/21674086.1965.11926345

THE SENSE OF MALENESS

BY ROBERT J. STOLLER, M.D. (LOS ANGELES)

For most psychoanalysts it is axiomatic that the development of male sexuality is dependent on how the little boy manages the fantasied dangers and pleasures of having a penis. His pride in the power of his penis and his growing awareness of its value as a source of physical pleasure are threatened by his knowledge that there exist penisless creatures and his fear that he may be made into one. Recently there has been increasing discussion in the literature, especially by Greenacre *(2)*, of a period of phallic awareness earlier than the classic phallic stage. It is likely that from birth the infant boy becomes more and more aware of his penis, first by feeling that it is there and later by endowing it with meaning.

The two theses here presented are derived from these beginnings of phallic awareness. The first is that the sense of maleness—the person's unquestioned certainty that he belongs to one of only two sexes, the male—is permanently fixed long before the classic phallic stage of age three to five. The second is that although the penis contributes to the sense of maleness, it is not essential. It should be noted that neither of these theses contradicts the importance, as contributions to the boy's developing masculinity, of the phallic stage or the œdipal conflict and its resolution.

By the sense of maleness I mean the awareness, 'I am a male'. This essentially unalterable core of gender identity is to be distinguished from the related but different belief, 'I am manly (or masculine)'. The latter attitude is a more subtle and complicated development. It emerges only after the child has learned how his parents expect him to express masculinity, that

Presented at the Sixth Western Divisional Meeting, West Coast Psychoanalytic Societies, September 28, 1963, in San Francisco.

From the Department of Psychiatry, University of California School of Medicine, Los Angeles.

is, to behave as they feel males should. He will also have some idea of what it means to be feminine, to the extent of having such fantasies as 'I should like to have a baby', or 'I should like to have breasts', the sort of wishes that make up part of the 'latent homosexuality' ubiquitous in many cultures. But the knowledge that 'I am a male', with its biological rather than gender implication, starts developing much earlier than either the sense that 'I am masculine' or such disturbances in gender identity as 'I am feminine, I am like a female'. Such attitudes cover over the core gender identity, but it is nevertheless present behind them. Transvestitism is a clear example of this: a man with a sense of being feminine while 'cross-dressing' is excitedly aware of being a male. Essential to his perversion are the two aspects of gender identity—the later one, 'I am feminine' and the earlier core gender identity, 'I am (nonetheless) a male'.

The sense of gender identity (that is, of being male or female) in the normal individual is derived from three sources: the anatomy and physiology of the genitalia, the attitudes of parents, siblings, and peers toward the child's gender role, and a biological force that can more or less modify the attitudinal (environmental) forces. It is not easy to study the relative importance of each of these factors in normals because one factor cannot be dissected from the others. However, certain rare patients provide such an opportunity as is shown in two boys, both born without penises, who yet seem to have matured with no question of their core sense of maleness.

The first patient, genetically normal, was born with no external penis but with bilateral testes in a bifid scrotum which resembled *labia majora* and *labia minora,* and with a perineal urethrostomy. He was given a boy's name and reared as a boy. Severe right hydronephrosis with infection and fever in the first three months of life led to removal of the diseased kidney at ten months. The perineal urethrostomy at this time was shifted so that the new urethral meatus was approximately

where the penis would have been. The bifid scrotum was left unchanged. He has a normal prostate. For four months after surgery, he did well, but in his second year, because of recurrent infections, an indwelling catheter was placed in the bladder to preserve the remaining kidney. This instrument has remained almost constantly to the present.

Before he was born, this patient's mother left his father, who dropped completely out of the child's life. Some months later she remarried, so the patient and his three-years-older brother now had a stepfather and a stepsister, the patient's age. The stepfather quickly took an active role in the family. A masculine man, he has served as an excellent object for the child's identification processes. Therefore, in spite of the early dangerous illness, the surgery, the unending medical attention, and the constant presence of the catheter, the patient, now four years old, is considered by both parents to be a psychologically normal boy. They compare him to his seven-year-old brother who they consider more sensitive, more shy, and a little effeminate. The patient is described as rough, active, and unquestioning in his status as a boy; he enjoys playing football and baseball with his father as well as wrestling with his older brother and sister, these vigorous activities being surprisingly little hampered by the catheter and bottle he carries with him. To quote his mother, '. . . he likes to wrestle and box. He likes all kinds of sports—likes to watch sports on television, and he told me that he wants to be a wrestler—big and fat—when he is big. He plays with dolls, but when he does, he is the father and his sister the mother. He is different altogether than our daughter; she can't occupy her time by herself. You can give him a little stick and send him out to play and he can make everything out of that stick you can imagine. He doesn't need other people to play with, yet when there are other children he can play with them. They know he has a catheter on. They have seen it and they accept it and treat him like he was a boy.

'At first I was real shook up about all this because I had never heard of anything like it. At the time he was born my first hus-

band and I were on the verge of divorce, and at one time I even thought about giving the baby up for adoption before he was born, but I changed my mind the minute I saw him. He dislikes anything that looks girlish to him—any kind of shirt that even looks like it might belong to a girl—he wants everything boy's. He will play in the den by himself. Sometimes he is Superman. He will mimic quite a bit; in other words, when it comes time to comb his hair, he will comb way back like his father. . . . Someone may hit him hard and really hurt him and then he will come to me and cry, and I will say, "Go fight your own battle". One day he was mad at his brother for something—let him have it in the stomach and took his breath away. When he gets mad he has a temper, but he treats his sister pretty well; he doesn't fight with her.' His stepfather reports, 'He likes to go down to where I work. I think he wants to be like me.'

Of his catheter and its collecting bag, his mother says, 'For a while, I had to talk to him about showing it to everybody. He would lift down his pants and show it to everybody and I had to tell him that you just don't do that. He was proud; to me and everybody else he gave the impression that he was something special because he had this and they didn't. He thinks the tube is part of him. When they took the tube out for four months, he missed it. I think he missed it because it was part of him. He wasn't uncomfortable. After they took it off, they also took his bottle off. Every night he would go to bed and would want to take that bottle to bed with him even though the tube was not actually in.'

The patient loves to imitate his stepfather, who has a gun collection; the little boy imitates him with his own toy guns. His stepfather manages a gas station; the child's favorite game is 'gas station', digging in the dirt, building a station with blocks, or using the cat's tail as a gasoline pump. Obviously this interest is overdetermined, being influenced not only by his stepfather's business but also by the tremendous interest and concern with his own 'gas pump'.

The parents are convinced that he would not wish to be

changed to a girl. Some months before I saw him a urologist suggested that perhaps he should henceforth be raised as a girl. His sister was present during the discussion. The patient's mother later heard her telling him that he was now going to be a girl and he said very vehemently, 'No!'. His mother told him to pay no attention to her. He has never again mentioned it.

In summary, the parents clearly describe a little boy with a masculine identity shown in his relation with his mother and stepfather. Father and mother appear to have no significant problems in their own gender roles. The appearance of the child corroborates all the information the parents give. He is an alert, friendly, intelligent, warm, and unafraid child, so openly likable that one cannot adequately account for his obvious ego strength in the face of the continually traumatic medical experiences except by attributing his excellent mental health to his good luck in the parents he has. He talks easily of the games he likes to play–baseball, hunting; of his toys–trucks and gas stations; his relationships with his sister and brother–the games of house in which he says he always plays the part of a father, his sister the mother, and his older brother the policeman. He talks a great deal and with great pleasure about his dog, his puppies, his cat, and his chicken. In appearance, mannerisms, and expression of interests, he leaves no doubt that his gender identity is well formed and he is unquestionably masculine.

When asked why he was in the hospital, he picked up his tube and held it out to be seen. When asked why he had the catheter, he replied, 'Because I was born . . . in October'. Thus he revealed not only his knowledge but also his method of dealing with it and of trying to get it out of his mind. It is impressive that this child who has been severely handicapped anatomically, who has been subjected to many medical and surgical experiences, who knows he is abnormal and ill, whose mother was divorced early in his life, has nonetheless progressed in a remarkably normal manner in his general psychological development and, more specifically, in his development as a boy with masculine identifications. It is a tribute to his mother and his

stepfather that all this has been accomplished in the face of such great obstacles.

Some experts in the Medical Center recommended that the child be converted to a girl and that the parents' efforts be devoted to assisting him to transform himself into a woman as the years pass. This recommendation was made because of all the surgery required to construct an adequate penis which, even so, could never have a sexual function. However, because he was so clearly masculine, because it was believed that his gender role could not be shifted by means of psychotherapy or other learning, and because his life span will not be very long by reason of the disease in the remaining kidney, the psychiatric recommendation was that he continue to be a boy. The parents were relieved by this recommendation, which has been followed by the attending physicians.

The second boy, now fifteen, also was born a genetically and anatomically normal male except for having no penis and a perineal urethrostomy. Both testes lay within a normal scrotum. He is the youngest of four children, the oldest a mongoloid, the others a normal girl and boy. Before the patient was born, his mother was no longer interested in having more children. Given the proper assignment of sex at birth, he was raised as a boy without question by a relatively uninterested mother and a natty, bejeweled father who was a perfume salesman.

Beginning at one and one-half years, this patient was in the hospital six times in five years, the last time being for three years unrelieved by a single visit home. His many operations, a laparotomy followed by repeated plastic procedures, resulted in a phallus which a urologist has recently described as a 'monstrosity of unearthly appearance'. It is not surprising that in adolescence his behavior became a problem at school and in his neighborhood. He has also created a fantasy life which in times of stress spills over into real life in a paranoid manner. 'I am the grandson of God and maybe I am the Messiah', he said in white-faced, fear-ridden rage in a critical moment in treatment.

Out of a mass of clinical data related to the development of this boy's gender identity only two observations directly pertinent to a sense of maleness will be discussed. The first of these is concerned with the patient's 'homosexuality'. Since the age of seven he has played with neighborhood boys sexual games that have evolved into ceremonies with rules that must be maintained. For example, in one called 'The Pull' each of the two partners pulls forward on the other's penis in order to produce pain. The first to cry out in pain loses and must do to the other whatever he asks. Although the patient, with his skin pedicle, feels no pain, at times he cries out. Both children know this is a false cry, but neither ever admits it. In the mutual masturbation that follows, the patient usually permits his partner only a few minutes—timed by the watch—for he does not want his partner to have an orgasm. After this, the partner has to do exactly the same for the patient (except with anal intercourse which the patient cannot perform because the skin pedicle has no erectile ability). It is clear from his descriptions that a main purpose of these activities is to force the partner to treat him as if his 'penis' were as good as one that works (a mechanism of 'proving' the penis that seems related to the dynamics of exhibitionism). Besides using homosexuality in this successful defense against loss of the sense of maleness, these activities, plus a peculiar form of masturbation (described below), are also the patient's sexual life. He scarcely dares to contemplate heterosexuality, though he is friendly with girls. He gets some instinctual gratification from these games though it is scarcely direct, for he has never been able to have an orgasm. He has no genital, perineal, oral, or anal sexual sensations analogous to the genital sexual excitement of normal men but simply feels an increased body tenseness that gradually exhausts itself. Almost every night he has a 'fight', a hypnagogic masturbatory writhing with a blanket between his legs during which he has only homosexual fantasies of being ruler over a man, such as a movie star, and commanding this man to play the 'games'. The patient has never fantasied having an erection or an orgasm. After the

'fight' he wets the bed while asleep. This is accompanied by dreams of the same activities he has fantasied or has actually performed. The elements of these dreams make little recognizable use of such dream mechanisms as condensation and displacement.

There is a second factor in this patient's life that he uses to augment gender identity: knives. This is not simply the interest in knives seen in so many boys; though it has the same psychodynamic meaning, it is more intense and concrete. Much of the child's personality is expressed through knives. Each has a name, a different function, and a different hiding place in his room. All, of course, are used for a language of aggression. For example, the knife, 'Uncle Eddie', is always placed in a special pocket of a special knapsack. When the patient is angry at home, he takes the knapsack from a shelf and rides off on his bicycle. He rides once around the block; if he then throws knapsack and knife on the lawn, he is only moderately angry; if he rides off with knapsack and knife, he is very angry and will be gone for an indefinite number of hours in an unknown place; if he throws the bare knife on the lawn serious trouble lies ahead.

Obviously he is a very disturbed child. Nonetheless, for all his disturbances in ego functions and problems with formation of an identity, his core gender identity is intact. He has no question that he is a male. For him, the critical issue is that although he is a male, he is a very defective one. Both his normal development and his psychopathology are aimed at repairing the psychological damage or learning to live with it, not in becoming a female. He does not offer himself as a female to his sexual partners, nor is he feminine in appearance or action. His 'homosexual' activities are, rather, a pathetic and grandiose attempt to insist to other males that his 'penis' is as good as theirs. He of course does not really believe this but in the real-life fantasy of these sexual games there is at least the momentary belief that he is intact.

DISCUSSION

These two cases are presented as evidence to support two theses, that the sense of maleness (or core gender identity) is present and permanent from earliest life, and that the penis is not essential to this sense of maleness. A variety of psychological and biological forces causes the male child to develop from birth an increasing awareness that he is himself. This 'himself' includes an awareness that he belongs to a gender, and early in life he recognizes that not everyone belongs to this gender. Later he learns that not everyone possesses the prime insignia of this gender—the male external genitalia, a disturbing discovery. By this time, he knows he is a male (whether a masculine one or not). Normally the male external genitalia are a sign to the individual and to society that this is a male, but they are not essential to producing the sense of maleness.

It follows from this argument that clinical states in which there are fantasies and behavior of a feminine sort—both in normals and those who develop perversions—are not evidence that the core gender identity, the sense of maleness, has been made uncertain, but rather that these fantasies and their behavior overlie and hide the core gender identity. For example, behind Schreber's delusion that he can give birth as a woman to God's children is that unalterable knowledge against which, in part, he raises the delusion as a defense, his awareness that he is a male.

The four-year-old boy shows us that the sense of maleness is established before the fully developed phallic stage. His parents report that his behavior well before the age of four was decidedly masculine. It is apparent that the child is not simply normally masculine but has had to exaggerate his masculinity because of his parents' fears that he might not be sufficiently so as well as his own independent discoveries of his defectiveness. Nonetheless, although the expressions of his masculinity are intensified, his sense of maleness is unquestioned. Establishing a sense of maleness seems to be more difficult without the proper

genitalia, but obviously it can be done. However, it is not necessary to turn to this boy to demonstrate the thesis, for observation of any normal child of either sex of one and one-half or two years shows that clear distinctions are established very early between the gender roles of the two sexes. The second thesis, that the penis is not necessary for a sense of maleness is demonstrated by each of the boys described, for neither of them doubts that he is a male.

It has been said that the core gender identity is produced in the normal by the anatomy and physiology of the genitalia, by attitudes of parents, siblings, and peers, and by a biological force. These three re-enforce each other; to speak teleologically, their redundancy may serve the purpose of more securely guaranteeing the masculinity that will be required for procreation. Be that as it may, the cases presented show that these three factors are not all essential. In our two cases, inadequacy of the external genitalia did not destroy the capacity for a clear-cut core gender identity to develop as long as the parents felt unquestioningly that their child was male.

One question must be raised although it cannot be answered. Though the penis played no part in these boys' gender identities, may not the testes and scrotum have done so? Most theorizing on male sexuality by analysts takes into account only the penis. Bell *(1)*, in a paper not concerned with the problems of identity considered here, stresses the need to consider all the external male genitalia, not the penis alone, in order to understand castration anxiety.[1] We may ask, is not the sense of maleness created by scrotum and testes even when there is no penis? I do not think so, though they undoubtedly contribute, at least by confirming to the parents that the ascription of maleness is proper. But this opinion requires support from clinical evidence—the study, for example, of persons without penis, testes, or scrotum who are nonetheless raised from birth as males. I believe such studies would support an even broader

[1] See also, Bell, Anita I.: *The Significance of Scrotal Sac and Testicles for the Prepuberty Male,* This QUARTERLY, XXXIV, 1965, pp. 182-206 [Ed.].

thesis than the one I have stated, namely, that although the external genitalia—penis, testes, and scrotum—contribute to the sense of maleness, no one of them is essential for it, nor even all of them together. In the absence of complete evidence, I agree in general with Money and the Hampsons *(3, 4)*, who show in their large series of intersexed patients that gender role is determined by postnatal psychological forces, regardless of the anatomy and physiology of the external genitalia.[2]

It is interesting that both the little boy with kidney disease and the older boy with the long period of hospitalization in childhood have, in a psychological sense, created a penis that has the same symbolic, aggressive, and intrusive meaning as in normal males. For the first child, it is his catheter and collecting bottle; for the second, it is his knives. Whether there is a primitive biological (instinctive) need for a penis that tends to compel these children to invent the organ if they cannot grow one or whether such invention is due to psychological pressures, or results from a combination of the biological and environmental, cannot be answered by the data. However, these two cases at least suggest that when a little boy knows he is a male, he creates a penis that functions symbolically the same as those of boys with normal penises.

SUMMARY

In order to substantiate the two theses of this paper—first, that core gender identity (the knowledge and unquestioned acceptance that one is a male) is permanently fixed long before the classic phallic stage, and second, that although the penis contributes to the sense of maleness, it is not essential—I have described two boys born without penises. Both boys are masculine and have clear awareness that they are males, awareness that has been present since they first showed signs of an awakening sense of self.

[2] I would make the exception that the biological forces may at times play a significant role, even outweighing the kind of rearing the child is given (*5*).

REFERENCES

1. BELL, ANITA I.: *Some Observations on the Role of the Scrotal Sac and Testicles.* J. Amer. Psa. Assn., IX, 1961, pp. 261-286.
2. GREENACRE, PHYLLIS: *Early Physical Determinants in the Development of the Sense of Identity.* J. Amer. Psa. Assn., VI, 1958, pp. 612-627.
3. MONEY, JOHN and HAMPSON, J. G. and J. L.: *An Examination of Some Basic Concepts: The Evidence of Human Hermaphroditism.* Bull. Johns Hopkins Hosp., XCVII, 1955, pp. 301-319.
4. ———: *Imprinting and the Establishment of Gender Role.* Arch. Neurology and Psychiatry, LXXVII, 1957, pp. 333-336.
5. STOLLER, ROBERT J.: *A Contribution to the Study of Gender Identity.* Int. J. Psa., XLV, 1964, pp. 220-226.

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

The Hand and the Breast with Special Reference to Obsessional Neurosis

Jule Eisenbud

To cite this article: Jule Eisenbud (1965) The Hand and the Breast with Special Reference to Obsessional Neurosis, The Psychoanalytic Quarterly, 34:2, 219-248, DOI: 10.1080/21674086.1965.11926346

To link to this article: https://doi.org/10.1080/21674086.1965.11926346

Published online: 29 Nov 2017.

THE HAND AND THE BREAST WITH SPECIAL REFERENCE TO OBSESSIONAL NEUROSIS

BY JULE EISENBUD, M.D. (DENVER)

I

CLINICAL DATA

Various data indicate that the grasping and sucking reflexes of the nursing situation are associated from birth in a complex pattern that persists for from three to seven months and, on a habitual basis, is often later in evidence. However, no simple reflex can account adequately for the relationships involved. In breast-fed babies grasping is especially strong at the time of maximum hunger—when the mother with the child in her arms is baring her breast for the feeding—and diminishes as satiety is reached, when sucking movements also fade. All movements are part of a total pattern of the infant's behavior aimed at securing the gratifying object at the time of greatest need. According to Halverson, who studied about two hundred neonates in a hospital setting *(9)*, 'the situation [in which grasping occurs] is a complex of contact, hunger, sucking, odor, taste, and probably warmth'. Certain data point also to the importance of visual stimuli in this setting.

Two of the most notable papers in the analytic literature on the importance of the hand itself in the development of the individual are those of Hoffer *(10)* and Linn *(12)*. Hoffer, on the basis of observations of infants in the Hampstead Nurseries, traces the development of the hands from primarily accessory tension relievers during the early sucking stage into tools for controlling the outer world. 'Considering also the fact', he

---

Presented before the Topeka Psychoanalytic Society, November 1960, and before the San Francisco Psychoanalytic Society, November 1961.

writes, 'that the infant places everything that is within reach into his mouth with the help of his hands, the accumulation of experience as a result of the mouth and hand relationship by the end of the first year seems to be rather rich and promising. We can therefore safely assume, that when entering the second year, the infant has built up an oral-tactile concept of his own body and the world around him and regulates to a certain extent by this means his erotic and aggressive (active) drives.'

On the basis of observations on brain-injured patients, the drawings of children (in which, for instance, the upper extremities grow directly out of the face), and such observations as those of Hoffer, and Spitz *(15),* Linn postulates a primordial face-hand-breast experiential cluster from which the body image emerges through a repetition of the process of discovery of separateness. When the breast is withdrawn, according to Linn, continuity of the cluster is maintained by substituting the hand for the absent breast, and later on, apparently, the hand is also substituted in the body image for the primordial face, which is early fused with both hand and breast. Traces of this relationship can be seen in the brain injured where the hands sometimes act out responses to facial stimulation and where patients may speak of 'the hand of my face' and 'the palm of my cheeks'.

I shall now present data from analytic sources indicating that shadows of this early experiential cluster, as Linn terms it, may be seen in various aspects of the disturbed function of the neurotic. I shall focus particularly on the relationship between the hand and the breast—which I refer to as the hand-breast complex—in cases of obsessional neurosis.

A twenty-six-year-old analysand with classical features of obsessive-compulsive neurosis, including endless handwashing and rituals around *not* touching, frequently fantasied beating people, mostly men, with his fists. He had never carried out such an action, however, and tortured himself with incessant rumination about being a coward because, as a teenager, he

once ran away from a fight. Since puberty he had carried out systematic body-building exercises, and currently presents the picture of a typical bull-necked muscle man. His upper limbs, especially his forearms and hands, received special attention in his body-building program; one of his exercises was to bend a beer can in two with one hand. Despite this prowess, he worried that his left hand and forearm were not bulging as muscularly as he would like. He was obsessed with the desire to steal a look at his hand and forearm in order to check on them, but this was blocked because he felt he must not be caught doing this, especially during his analytic hour. However, he confessed to thoughts of later sneaking a look at his hand unobtrusively—perhaps when walking down the corridor, or in the elevator with some inconspicuous little gesture like pushing the button or reaching for his briefcase, or in the men's room on the lobby floor where he could at the same time, and with the same motion, sneak a glance at his penis, whose size was also a matter of some concern to him.

One might assume this to be a displacement of masturbation guilt, since the patient denied having any particular guilt on this score. However, an interesting twist to the meaning of masturbation was provided by his own peculiar version of the Isakower phenomenon. He sometimes had the vivid illusion, on falling asleep or awakening, that his penis, which he was fondling and which may have been in any state of turgescence up to full erection, was forked, protruding from its base in a sort of V. That this double penis was a breast derivative may be presumed from the fact that the patient's almost invariable masturbation fantasy was of a woman masturbating him, while he fondled her breasts, and urging him to press her breasts tightly at the moment of ejaculation. It should be noted, incidentally, that during the one period when the patient made an effort to give up masturbation, during his first year at college—not out of any particular conscious guilt but because he felt it would give him additional strength physically and spiritually—he also gave up eating meat. Both these renunciations were

vaguely associated with his feeling of being a coward which, in turn, was connected with his feeling that he should not have pleasure or enjoy anything.

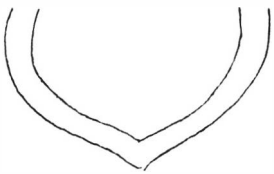
This nuclear feeling of 'badness', discomfort, fearfulness, horridness, anxiety, and general unpleasure, which pervaded all the patient's experiences, was associated with another part of his complex Isakower phenomenon. This was the feeling, also in the semidissociated state between sleeping and waking, of the pressing upward in him, vaguely in the abdominal region, of something he perceived as a dome-shaped structure—he described it as a dome-shaped 'feeling'—which he experienced as 'bad', 'uncomfortable', 'fearful'.

This man's classic obsessional symptomatology, with incessant handwashing and rituals connected with touching and being touched, warranted the usual presumption of a complex of factors involved. Behind almost everything which can be adduced along classic lines, however, may be glimpsed some disturbance rooted in the very early feeding situation. That this involved some interference at that time with the grasping role may be inferred from evidence which developed within the transference. For example, the patient came in one day, after several months of treatment, with a dark, tense look and claimed that he was not sure but what his hand was injured by a cylindrical fiber-glass lampshade which he brushed by on the way to the consulting room. Why must I have such things around? Then he fantasied having got some injurious paint on his hand from painters' pots he noticed in the corridor on his way to my office. This reminded him that he frequently imagines his hand gets contaminated by paint which he 'feels', rather than visualizes, as white and injurious. He then reproached me for my inactivity and wanted to know what I was doing for him anyway. Nothing, as far as he could see. I did not even talk to him, and so on.

In another hour the patient returned, as he did repeatedly, to his rage against a doctor who damaged him by a course of insulin treatments. He conceptualized the insulin as a harmful

poison which was put into him by this malevolent individual who, from his fantasies, was clearly *in loco maternis*. He was consumed by fantasies of throwing acid in this doctor's face, which, in his fantasy, appeared to be generically a breast, or at least part of the early breast-face complex described by Spitz *(15)* and recently by Almansi *(1)*. On one occasion, when the patient was fuming about the poison insulin and his rage against the doctor who gave it to him—it was one of the times, of course, when he felt he was getting absolutely nothing from me—he stated, 'I feel like a hand grenade with the pin pulled out'. In this hand-breast linkage, the patient appeared to identify with the breast onto which he had projected his violent aggression. At another time the shadows on the ceiling reminded him of a giant spider, and then of a giant hand coming to get him, reminding him of his cowardice and fear of fighting which, on this occasion, he referred to as a fear of 'coming to grips' with people.

The patient had many dreams in which oral aggression was punished—e.g., voracious rats killed by poisoned food (which the patient, however, was able to hold safely in his hand)—or in which attacking breast-mother figures threatened violence of one sort or another specifically done by the hands (boxing, barroom fisticuffs, and similar episodes). In one of these an Oriental figure was chasing the terror-stricken patient down a double-curved garden path that met at a tip, thus (the patient's drawing):



The figure was threatening him with a crescent-shaped knife which the patient also described as 'double-curved'. I cite this dream, for which I can give little more than the manifest content, because it offers points of instructive connection with

material to be presented later.[1] Here I will simply say that the crescent, represented in this dream by the 'double-curved' knife (which the patient also drew for me) has a long and varied history as a symbol, one of whose roots appears to be the unconscious idea of the disappearing breast, as, for example, in a crescent moon (which also incorporates the idea of reappearance or restitution). In the present dream the crescent turns up in the hand of a threatening and attacking mother-figure—a clear projection—on a background which the patient recognized at once, when he drew it, to represent the breast.

I do not wish to convey the impression that this patient, with the amount of violence present in his fantasies and dreams (and implicitly in his muscle-building program), was especially dangerous, perhaps meriting 'poisoned' insulin or being held in watchful custody. Actually, his balance between thinking and acting out was a nice one. A good deal of buffering by intellectual defenses provided some guarantee against paranoid inclinations to smash faces with his fists, throw acid in people's faces, and in fact, to blow up or otherwise destroy the world which, in his more advanced *weltuntergang* moods, he always saw as a globe (not infrequently the case with those who fantasy world destruction). His acting out was along other lines. He once ripped the toilets out of a courthouse men's room after being given a fine for speeding.

The nature of his intellectual defenses further supports our hypothesis about the basic roots of this man's difficulties. As a teenager, when so many of his problems had their resurgence, the patient used to draw spheres, shade them, and take pleasure in contemplating them. Becoming interested in mathematics, he adopted the sphere and the straight line, which he saw before him out in space, as his personal symbols, the crest of arms of his intellectual self. This contemplation had, at this time, a pleasant quality. But with the crucial incident of his

[1] I would like to state emphatically that I do not hold with those who misapply Freud's warnings against interpreting solely from the manifest content to the extent of refusing to derive any information at all from such data.

running away from a fight, which occured in his last year in high school, came the coalescence of all his feelings of 'badness' with his shame at being a coward. Not long afterward, as his obsessional and handwashing rituals took over and became more deeply grooved, there was flight into mental physics, yoga exercises, attempts at astral projection—all efforts to dissociate himself from his 'bad' body—and vegetarianism which, as indicated earlier, came when he also attempted to give up masturbation. This stepped-up defensive program culminated, not surprisingly, in a psychotic breakdown during which he was hospitalized and given the above-mentioned insulin treatments. His visual sphere preoccupation seemed to have receded or disappeared at this time. Recovering from his psychosis, his interest in mathematics, augmented by his rigid intellectual and compulsive-obsessive defenses, developed into an interest in philosophy, particularly symbolic logic and epistemology.

One day, at the age of twenty-four, the patient was reading Kant's Critique of Pure Reason when he came across the word 'sphere' used in the sense of subject or domain. This reminded him of the pleasure he used to take in contemplating the sphere as the perfect form, but now he found that he could contemplate only the word 'sphere', not the form itself, and that whatever pleasure he derived from even this was alloyed by a feeling that he should not have such enjoyment and that he should be tortured or punished because he was a coward. This soon developed into anxiety amounting to panic when the visualization of the word 'sphere' was sometimes accompanied by fleeting images of the form itself. When the patient tried to suppress the visualization of this supercharged form, in an effort to deal with his intense anxiety, he began to worry about whether he visualized it correctly or perfectly whenever it succeeded in slipping into his thoughts anyway. He tried to deal with this, in turn, by substituting looking at his hands for looking at the sphere, but obsessional doubts invaded this activity too, and he began to torture himself with incessant rumination about whether or not he did this right, or correctly

performed rituals connected with the hand, such as washing them in a certain way. With the return to the hands, and the feelings of aggression connected with it from which the patient was attempting to dissociate himself, the sphere, one might say, came full circle.

In one climactic stage of the patient's third year of analysis he went through a brief period of aching teeth and jaws. This was followed by a stage in which his left hand became the anguished and painful respository of all his almost ineffable 'bad' feelings, as if *it* were experiencing these twisted and involuted tensions, anxieties, and affects while, at the same time, persecuting and torturing him with them. This lasted several months. When the patient finally cut himself off from the financial help he was receiving from his mother and tried to pay for further analysis himself (he had to interrupt his treatment at this time in order to secure himself in a position to do this), these symptoms virtually disappeared overnight. In their place, in this period of critical decision, he went around squeezing a hard rubber ball—to strengthen his grip, he explained. On the day he announced his decision to 'let go' of mother he came to his analytic hour pumping away at his rubber 'sphere'.

I had the opportunity during this man's analysis to interview his mother, for whom, at the time, he had only feelings of contempt. She confirmed my suspicions of a very early disturbance in the nursing situation by informing me that she had had to take the patient off the breast at two weeks because she had dried up, and had turned him over to a nurse. According to her, the switch was accomplished without difficulty and the patient proved himself to be a very good and quiet baby who slept all the time, a story which obviously cannot be taken at face value since the mother may very well have been describing a primal depression.

The question arises as to why there was not more manifest orality in this patient. Actually, the only symptoms directly referable to the oral sphere (outside of what was mentioned as developing briefly during his third year of analysis) were his

transient teen-age period of vegetarianism and his compulsive habit, which developed sometime later and has persisted to the present, of drinking exactly twelve glasses of water daily—not eleven and not thirteen. (This number, I have been told, has been recommended in army manuals.) One might consider, however, the close connection between early feeding difficulties, the presumably associated disturbances in the development of reality testing functions, and the later development of interest in logic and epistemology. It was not difficult to understand this latter as an attempt at control of the mother which at the same time provided one kind of buffer against object loss by reducing concepts, sensations, feelings, and experience in general to invariant and constant elements and symbols. Indeed the word and the symbol became for this patient, as for so many obsessive individuals, magic things to conjure with and the ultimate factors in control. But while this succeeded in getting mother into a straightjacket, inevitably it left the patient a sort of skim-milk mother in all his life investments and relationships. (You can't *not* have your mother and eat her too.)

I might mention that the patient's present professional activity is in programming giant computers which, with the intermediate implementation of logic and mathematics, is still not too far from counting on one's fingers. ('This little piggy went to market, this little piggy stayed home; this little piggy ate roast beef, and *this little piggy had none*'.) He has come a long way from some of his original complaints but, by way of reassuring himself that he has mother just where he wants her, he still occasionally gives himself over to wild fantasies of virtual control of the world and even of destiny by means of computer designed and mediated automation. This would appear to be morbid in the extreme if it were not that such fantasies are about par for the field as can be seen from almost any textbook or symposium on this subject.

Before going on to a second obsessional analysand with somewhat similar difficulties—again someone interested in episte-

mology, as it happens—I should like to say something about a peculiar symptom of another patient that reminds one of the masturbation fantasies of the patient just discussed. This man's disturbances—he was a severe obsessional with a paranoid schizophrenic underlay—had first shown up, in childhood, with eating difficulties, obsessive spoon wiping, fantasies of contamination and vomiting, the last only in the presence of girls and women. His mother, who later had a mastectomy when the patient was ten, had removed him abruptly from the breast at six weeks, when she developed an abscess. At this time she disappeared for six weeks when she went away to convalesce, leaving the patient in the charge of a nurse. The patient was full of oral symptomatology, both direct and transformed into various symbolic and ritualistic forms, including oral reaction-formations. One of his most interesting symptoms, however, and one bearing directly on our hypothesis, was the fact that he masturbated only intercrurally, claiming never to have learned to use his hands; the idea, he said, had never occurred to him. When he finally began to use his hands for masturbation—an idea he attributed to me—he considered this to be nothing less than a stroke of genius, an invention easily on a par with the cotton gin or the latest advances in automation.

The second obsessive-compulsive patient was a man in his thirties who had retired from business several years before when the development of severe fears of contamination by germs followed the death from polio of a young girl, a family friend, whom the patient was putting through school. This girl was apparently a stand-in for the patient's sister who had died some years earlier at about the same age. The excessive handwashing which developed along with fears of contamination by germs left the patient little time for anything except a course or two at the university. One of these was epistemology, which was the fulfilment of a long standing need on the patient's part to learn about how things got into the mind—how the mind got contaminated, one might say. Data from this

man's analysis offers some warrant for presuming here too a connection between the patient's hand symptoms, including the washing ritual, and early feeding difficulties. And in this case too the very development of the obsessional defense, with its characteristically ambivalent investment of the symbol-word-thought trinity, can be traced largely to this source.

This is not meant to suggest that early trouble at the breast was the only root of the obsessional fear of contamination and handwashing symptoms presented by these cases. It is merely an emphasis on one dimension of this complex problem. From the beginning of treatment the patient himself contrived to draw attention to his hands in a striking fashion. After the first few interviews, during which a more or less formal psychiatric history was taken, the patient sank into prolonged and seemingly intractable silences, which sometimes lasted for several consecutive hours despite attempts to deal with this difficult problem by means of conventional interpretive and noninterpretive interventions. The patient would lie immobile on the couch with a sour expression, his hands invariably clasped together, one thumb stroking the other, and he would occasionally make a sort of rooting motion into the pillow with the back of his head. I could hardly help thinking of the patient, so tall, gaunt, and sallow as to give an almost cadaverous appearance, as re-enacting the role of a marasmic child as he lay on the couch in an attitude of complete hopelessness.

Unfortunately no one who might have been able to supply information about this patient's early feeding situation was living, and he himself could tell me nothing directly. His mother had died when he was four, of cancer of the stomach; his four-year-older sister, his only sib, had died at sixteen of acute intestinal obstruction; his father had died some thirteen years earlier of a coronary.

Occasionally the patient would tell the manifest content of a dream. His communications, however, usually stopped there. Apparently the dream was a preformed structure and needed no effort on his part to 'suck' out of his mind. Otherwise, when

asked, for instance, why he just could not say anything—if not his thoughts then what he did the previous evening or something about what he had read (I was reduced to downright unanalytic coaxing and exhortation),—he would simply repeat, despairingly and in a weak voice, 'It's impossible, it's impossible'. This hopelessness about ever getting anything from his own thoughts—this 'dry suck', so to speak—was to continue in waves throughout the analysis, as was his despair of ever getting anything from me or the analysis. Often, as he settled into his characteristic pose at the beginning of an hour, he would profess an absolute foreknowledge of the complete emptiness of the session. This foreknowledge, presumably the repetition of an early 'dry feeding', he would then proceed to implement. (The first patient, incidentally, before the final massive projection onto his hand that was described, sometimes went through phases of projecting this kind of hopelessness and despair onto his left hand so that it was as if *it* felt these things.)

The manifest content of this patient's dreams, which constituted the major portion of his verbal communications, covered a wide range of topics, from violence and funerals to thinly disguised homosexual nightmares, but perhaps the most consistent theme dealt with was that of oral deprivation—being repeatedly late to dinner, dating girls with disappointingly small breasts, etc. Numerous dreams, however, dealt with hands and breasts in various relationships. In the fourth month of his analysis, the patient dreamed that he was demolishing a house by throwing grenades at it; later he saw the grenades piled up in a kind of pyramidal mass. Here, as in the case of the first patient's use of the symbol, we can infer the projection of aggression onto the rounded breastlike grenade. Months later, in a more communicative mood, the patient volunteered an association to the pyramidal mass that he thought obvious but which did not occur to me. 'Of course', he said, 'the pyramid suggests the pyramids of Egypt, the desert, and dryness. I thought you saw that.' In a dream shortly after the grenade dream, the patient was with a group of bathing beauties. He

tried to 'grab a handful of breast' of one of them but when he tried to kiss her he found she had halitosis. When he tried to grab the breast of another one (to tug at the other breast, presumably) he was pushed away. (The patient characteristically used phrases like 'grabbing a handful of breast', 'taking a fistful of sleeping tablets'.)

In other dreams, in which the breasts were represented symbolically, the hands were missing or in danger of being amputated; for example, by a harvesting machine that had to be 'declogged'—a process the patient likened to analysis. In one dream in this category the patient was with a party of disabled veterans—amputees with mostly hands missing—sitting around in wheel chairs and 'doing nothing'. A hint of an oral latent content in the dream was the patient's remark about veterans 'putting the bite on me with their license plate racket' (as it happened, his tags came in the following day's mail) and possibly in his noting that the amputees in the dream were all dressed in 'bad taste'. It was not until months later, however, that the breast-symbol meaning of the wheels on the wheel chairs (which the amputees were 'doing nothing' with) dawned on me. At this time the first patient, who was still in treatment, dreamed of the crash of a twin-motor plane and volunteered that this represented the breasts conking out. He illustrated his point by drawing the two motors, seen head-on, with the propellers going, thus

Following my delayed interpretation of this dream the present patient casually revealed that his father's sudden death had occurred while bowling—with breast in hand, as it were.[2]

[2] The wheel as a presumptive breast symbol occurred also in a dream cited by Ames *(3)* in the case of a patient, treated psychoanalytically, whose chief symptoms were fear of his own and other people's hands. 'I was on a merry-go-round. . . . Overhead were a lot of sweaters. I took one, saying, "This will come in handy". Someone said, "Don't take that, it is not yours and you will be arrested".' The patient, described as having a strongly passive bent, gave as associations petty thefts and fear of his mother.

In another dream of this patient the symbol of the disappearing breast that we have already seen in a dream of the first patient, the double-curved or crescent-shaped knife, was incorporated in a way clearly suggesting a nursing-situation root of this patient's obsessional rituals surrounding touching and not touching. It occurred near the end of the patient's second year of analysis, when he was beginning to bring out some of the destructive fantasies which would pop disturbingly into his head and which he had heretofore only hinted at. After fifteen minutes of silence in one hour I asked him if any of the fantasies he had alluded to ever involved me. Very diffidently he confessed that they did, that only the day before he had fleeting thoughts of murdering me. Silence for another five minutes as the patient turned toward the wall, hands clasped, as usual. I broke the silence by asking him what kind of instrument he had in mind for doing me in. 'What do you mean? [A gun, a blunt instrument, a knife?] Well, a knife, actually.' Silence for another few minutes. [By any chance a curved knife?] 'Well, as a matter of fact, yes. I dreamed of a curved knife last night, now that I think of it.'

> I was in the kitchen and was holding this curved knife. I was going somewhere, I think. In the kitchen it dropped out of my hand and I wanted to catch it before it hit the floor because I didn't want it to touch the floor. But I was afraid to catch it because I was afraid it would injure me. I didn't know where to grab for it. But somehow I did. At the beginning I was carving something in the kitchen, carving for a meal.

The patient's immediate (and, unfortunately, only) association was that the day before he actually had had a lightning-like fantasy of carving me up like a chicken or turkey, a thought no doubt brought on, he hastened to add, by a TV program he saw in which someone had tried to dispose of a victim in this way.

DISCUSSION

This paper presents certain aspects of what I have termed the hand-breast complex. As a dynamic and symptomalogical

pattern related to object loss, this may be presumed to be derivatively related to the inborn connection between grasping and sucking in the early nursing situation, and to the later fragmentation of the primordial face-hand-breast experiential cluster as described by Linn. Data from the analysis of instances of obsessional neurosis are given to highlight an important dimension of this picture, one easily overlooked when emphasis is placed primarily on the anal level of development. These data point to the role played by displacements and projections of oral longings, aggressions and guilt onto the hand, along lines whose early prototypes were also described by Linn. Conceiving the genesis of obsessional neurosis as significantly related to disturbances in the early nursing situation also provides a useful framework for the understanding of the overdetermined dynamics of other of the classical features of this syndrome, such as exaggerated ambivalence (which, in general, cannot be adequately understood without implicating early oral experience [*4*, *13*]) and the characteristic disturbances of thought and reality testing.

It is not only in obsessional neurosis, however, that various aspects of the hand-breast complex can be seen. I have observed it in several guises. In one instance, where analysis was undertaken principally for a character disturbance, a seemingly intractable paresthesia of the hands and fingers disappeared (it had to be worked through again later, of course) immediately following a transference interpretation based upon the oral significance of the symptom. On this occasion the patient revealed for the first time—after three years of analysis—that he could fall asleep at night only when holding a tip of his foam rubber pillow. In another instance, where the entire quality of the patient's psychic life was conditioned by the primacy of the tactile model for all perceptive and cognitive functions, a recurrent numbness of the finger tips when the nails were pared could be traced to an early displacement onto the finger tips of the response to breast-object loss. This, and not primarily castration anxiety, was responsible for the fact that as

a child this patient used to insist on letting his nails grow as long as possible, much to the distress of his nurse.

II

ARCHEOLOGICAL DATA LINKING THE HAND AND THE BREAST

Perhaps man's earliest efforts in graphic expression have been the limning or imaging of his own hand. Hundreds of outlines of hands that were drawn, printed, stenciled, or pecked can be found on rocks and in caves all over the world. The significance of these early images, some many thousands of years old, is obscure. Not infrequently the hands appear to be missing fingers, in whole or in part, and this is thought by some to represent a memorial, either feigned or actually executed in the flesh, to departed leaders or family members.

The hand has frequently been represented in association with, or actually holding, round or discoid objects whose meaning is far from clear. The commonest artifact of this kind is the sun circle, or solar disk, which appears to have had multiple, highly condensed symbolic significances. It was the most frequent symbol used in ancient funerary art and ornamentation, where it clearly represented the hope of immortality, or of resurrection to a full and satisfying afterlife. Sometimes, especially where the idea of resurrection was emphasized, as on Egyptian funerary monuments (and also in pictographs dating from paleolithic times), the solar disk was represented in conjunction with erect phalli. However, the essential oneness of the sun in its phallic and fertility connotations and in its meaning as the font of the 'divine fluid', as the 'nurser' of all life and, as numerous references testify, as milk itself, has been conclusively shown.[3] At any rate, there can hardly be any doubt,

[3] In his comprehensive survey of the ancient origin of the various disks, circles, rosettes, and cognate sun circle artifacts subsumed under the term 'round objects', Goodenough *(7)* brings out the interesting fact that in early Semitic and in Greco-Roman and Christian life these 'round objects', regularly found on funerary monuments, came to be fused with loaves of bread which were actually baked in the round and whose meaning, as the sustainer of life, they absorbed en route and later gave to Christian symbology in the Eucharist.

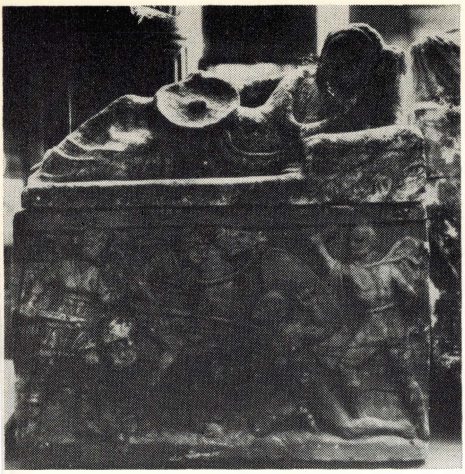


FIG. 1 Etruscan burial urn. 3rd to 2nd century B.C.

FIG. 2 Medieval Bogomil gravestone.

FIG. 3 Madonna and Child, tomb of Isabella of Aragon, Cozenza Cathedral, Italy.

FIG. 4 Swedish Madonna and Child of the late Middle Ages.

FIG. 5 Madonna and Child, by **Basaiti.**

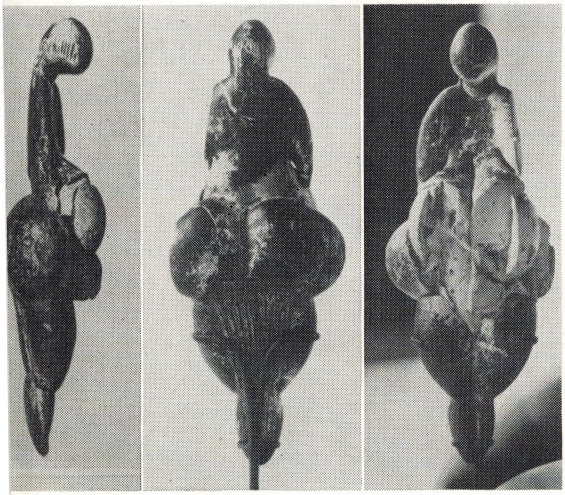
FIG. 6 Madonna of the Milk, by Lorenzetti.

FIG. 7 Etruscan funerary monument.

FIG. 8 Mayan funerary urn.

FIG. 9 Shin Chou Chang, God of Longevity, holding Peach of Immortality. (15th century).

FIG. 10 Venus of Willendorf, Austria. Height, 4⅛ in.



G. 11 Venus of Lespugue, France. 5¾ in. high.

FIG. 12 Venus of Willendorf, from rear.

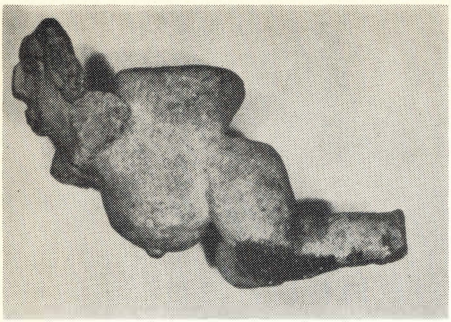


FIG. 13 A late (Christian Era) "Venus" from American Hohokam culture (Arizona). 7 inches long; 3½ inches kneeling height.

FIG. 14 Venus of Willendorf from above.

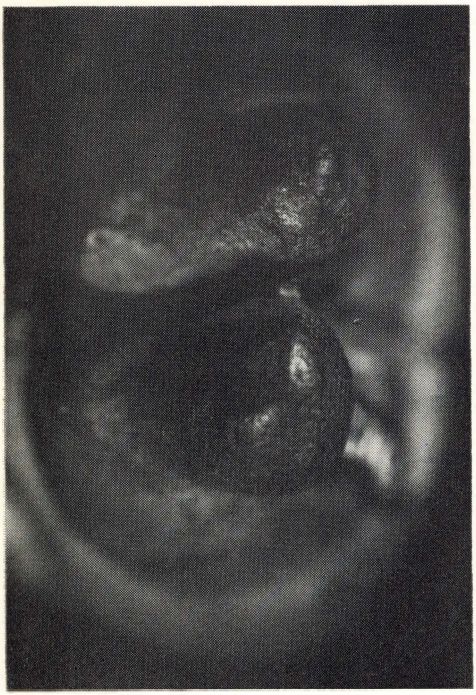


FIG. 15 Leg stumps of Venus of Willendorf, from below.

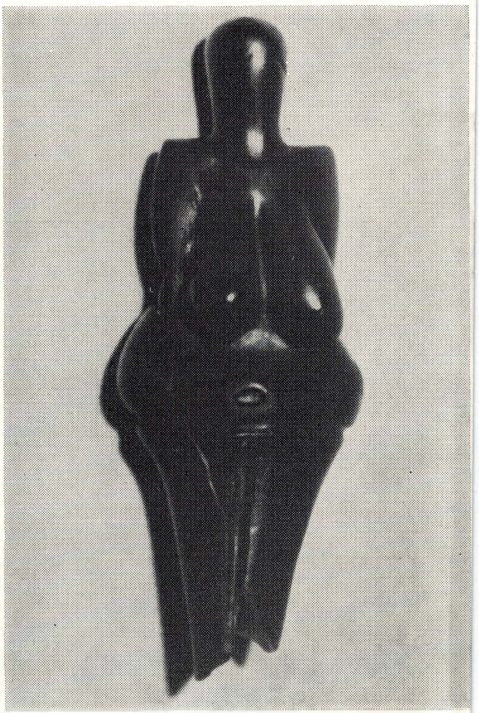


FIG. 16 4⅜ inch high statuette from Dolni Vestonice, Czechoslovakia.

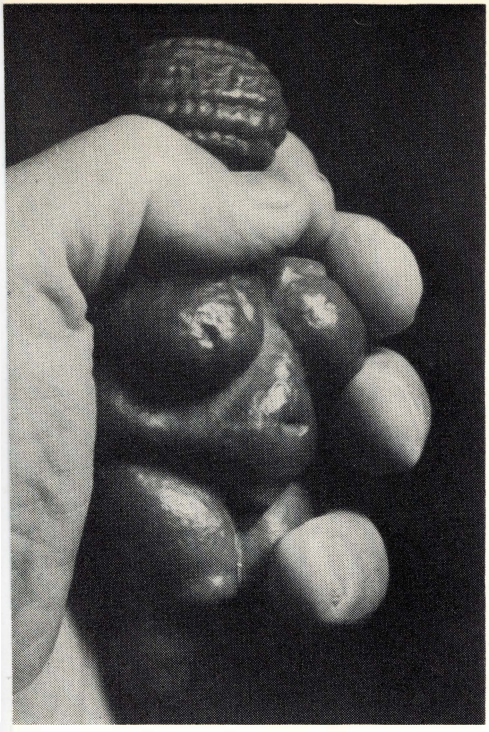


FIG. 17

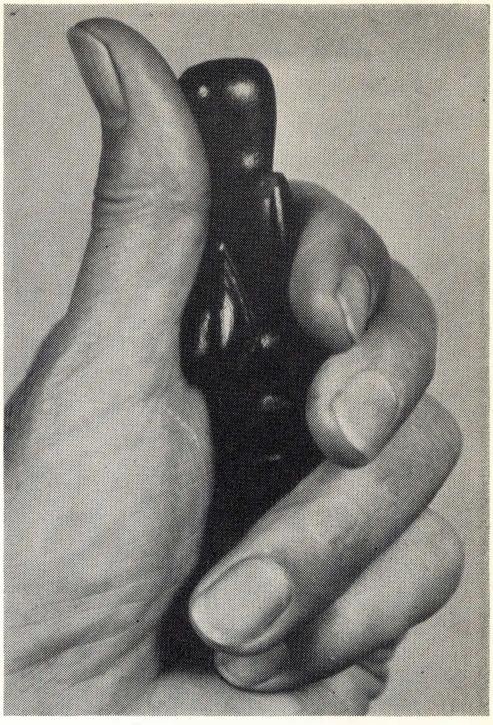


FIG. 18

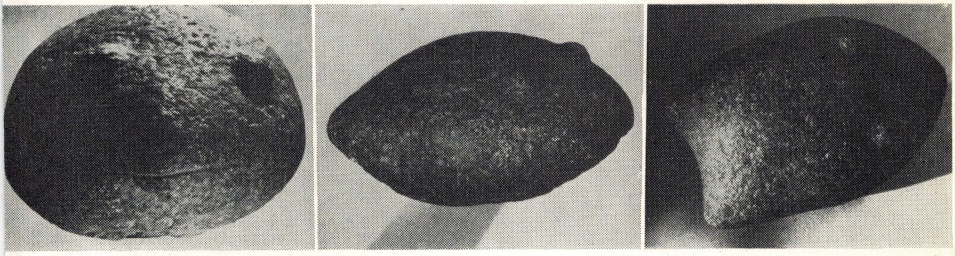


FIG. 19 The Browne Site effigy.

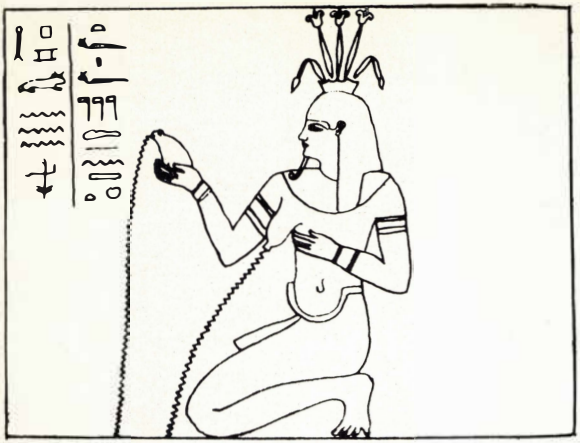


FIG. 20 Nile deity.

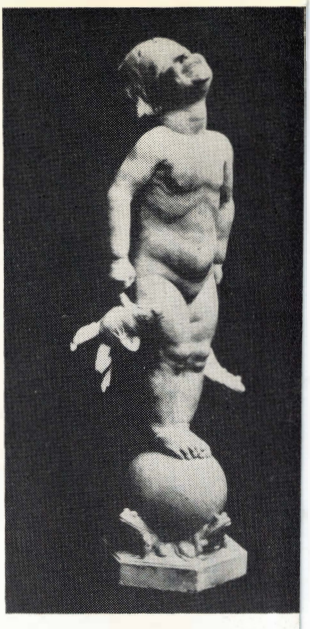


FIG. 21 "Frog Baby." (Editl
Baretto Parsons)

FIG. 22 Tlatilco statuette.

FIG. 23 Neolithic figurine from Czechoslova
8½ inch high.

FIG. 24 Neolithic Czechoslovakian figurine from rear.

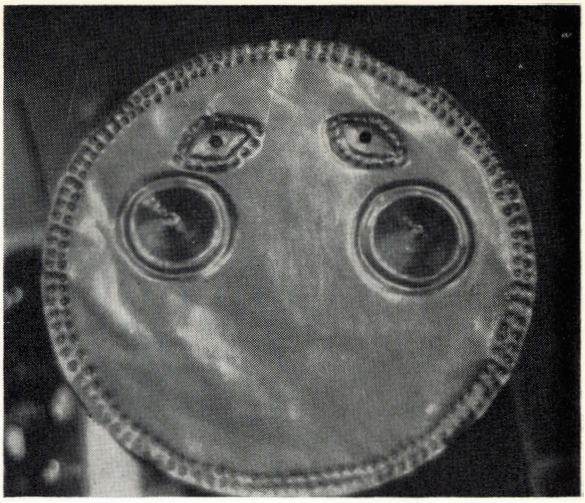


FIG. 25 Pre-Columbian Costa Rican amulet to protect against deprivation.

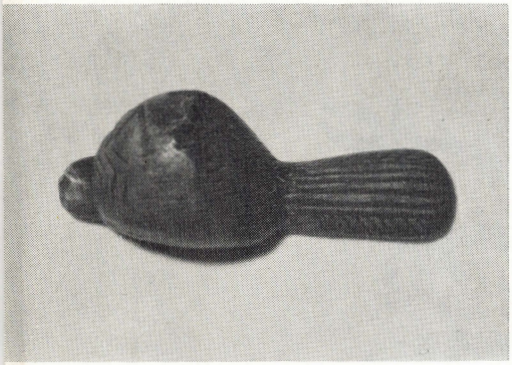


FIG. 26 Siberian figurine, 3⅝ inches long.

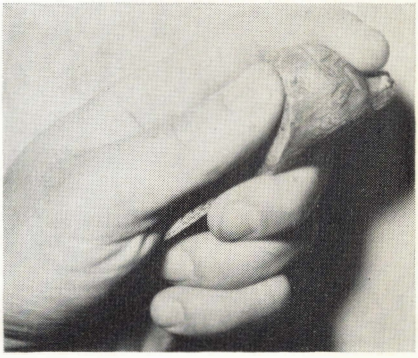


FIG. 27

FIG. 28

FIG. 29 Demon figures from Spanish cave rock pictographs.

FIG. 30 Possible demon figures. Cueva Negra de Meca, Alpera, Spain.

from the many nursing scenes on Egyptian, Etruscan, Roman, and Greek sarcophagi and funerary urns, and from the textual tie-ups between nursing and the hope of immortality to be found on these monuments and in other sources, that immortality and the afterlife were conceptualized in regressive terms whose prototype was the original nursing situation; and that the idea of security in the *unio mystica* with the basic sources of nature, expressed in solar worship, also had one root in the wish for reunion with the eternal maternal breast.

One does not have to look too far, then, to discover representations of the hand in association with various types of 'round objects' that conceivably bear reference, however encrusted by the ritualistic or æsthetic accretions of great spans of time, to the important relationship between hand and breast in that early situation of security to which man is wont to regress under conditions of threat or stress. But little, if any, attention has been paid to the hand-'round object' association as such by archeologists. This may well be, in part, because the hand is so regularly a part of human activity as to be inconspicuous by its very ubiquity. But it is also, no doubt, because the helter-skelter rubble of linguistically mute prehistoric artifacts, whose symbolic origins have for the most part been obscured or distorted by thousands of years of conscious overlay and rationalization, has itself bred no unifying hypotheses.

Certain types of data, however, support conjectures consistent with the hypothesis advanced. One of the best sources of insight into the origin and meaning of particular kinds of hand-'round object' representations is a vein of material which can be studied beginning with Etruscan funerary art. The Etruscans (eighth to first century B.C.) whose written language still baffles us, used to bury their dead in hemispherical mortuary mounds, and sometimes the ashes of the deceased were put in a hollowed-out space in the breast of a female statue, sometimes of the deceased herself, placed upon the tomb. The most characteristic statues on the lids of Etruscan sarcophagi and cinerary urns represented the deceased reclining for the 'eter-

nal banquet', as one commentator has put it, with a shallow bowl in one hand (Fig. 1). This common banquet bowl, into which the Etruscans presumably put bits of food from the feasting table, was frequently nippled in the center. This feature, thought by some to represent a coin supposed to be the fee to the underworld, probably derives from the forms on which these so-called metal Calene bowls were hammered out. However, the banquet bowl itself, often flat and disklike, probably served as merely one component of the final symbolic condensation signifying the security that can be grasped in the hand. In certain funerary monuments the disk bowl becomes a ball in hand, in which form it can be seen throughout Roman Gaul and Britain (Brittania holding the ball and scepter first appears in the second or third century A.D.) while in other funerary monuments, from Neo-Punic steles of the second century A.D. to thousands of gravestones of the medieval Bogomil sect (Fig. 2), the hand is shown in conjunction with sun circles (sometimes nippled) which make no pretense of being 'banquet bowls'. Finally the disk, in its straight solar disk form, appears as late as 1270 A.D. in the hand of the Christ Child in such works as the Madonna and Child on the tomb of Isabella of Aragon in the Cathedral of Cozenza, Italy (Fig. 3), where, in this symbolic religious representation of the ultimate in security, it has again achieved separation from the physical symbols of banquet bowls.

From the latter third of the thirteenth century European art became flooded with innumerable Virgin and Child representations, in both painting and statuary, where the Child is holding in His hand either a ball or a bird (Figs. 4, 5) or nursing directly from the breast, which He is often shown grasping (Fig. 6). The rarity of representations of this religious symbol of ultimate security where the Christ Child is both nursing *and* holding a bird or ball can be explained, according to Schnier, in his excellent paper on the Symbolic Bird in Medieval and Renaissance Art *(14)*, only on the assumption that the ball, the bird, and breast have equivalent symbolic

value, a thesis he convincingly corroborates with both clinical psychoanalytic and other data.[4]

An intermediate stage between the breast and ball-in-hand representations occurs in an Etruscan funerary monument showing Prosperina holding a pomegranate in one hand and what is thought to be a seed in the other (Fig. 7). A much later Mayan funerary urn (Fig. 8) shows the same fusion of regressive and resurrective wishes and hopes where one hand is holding the symbol of maize and the other what is probably a drinking vessel. The Chinese version of the ball-in-hand theme, which can be picked up today in various sizes and materials in any Chinese bazaar, may be seen in the figure of Shin Chou Chang, the God of longevity, holding the peach of immortality. A fine fifteenth century example is shown in Fig. 9.[5]

It is quite possible that the hand-and-breast configuration as a symbol of basic oral security goes back to the earliest stage for which we have any artifactual records at all, but the missing link—the hand, in this case—may have had to be supplied by the beholder, or, more properly, the holder. Some support for this hypothesis has recently turned up in an important finding by a University of California archeological team. But before coming to this let me say something of the class of objects which drew my attention to the possible anthropological aspects of the hand-breast complex in the first place.

From the Western plains of Europe to the outermost reaches of Siberia can be found statuettes of women with massive

[4] For other material bearing on the symbolic equivalence of bird and breast see also *5, 6.*

[5] Another aspect of the oral regressive fantasy complex behind the reactions to death that presumably go into the development of the immortality concept is the widespread notion that evildoers (so often the orally aggressive individuals in life) do not go on to perpetual nursing after death but are, on the contrary, eaten up. Innumerable representations, in cathedral art and elsewhere, represent the 'jaws of hell' as literally the jaws of a viciously fanged monster into which the damned are being herded. A beautiful example can be seen on a frieze of the famous church of *La Madeleine,* Vézelay, France. Bosch and Breughel, among others, have painted the theme, and non-Christian examples (e.g., in Buddhist Japan) are widespread.

breasts, hips, and buttocks which vary in size from a little over one to eight or ten inches in height. These so-called Mother-Goddesses, or fertility symbols, as they are thought to be, dated roughly from five to thirty or more thousand years old, give no clue to their meaning or function beyond the striking femaleness of the anatomical features represented. But even these have been differently interpreted. Some observers feel that the idea of pregnancy was being emphasized as a magic image to coax members of the life sustaining game herds likewise to swell and increase. Others are not sure but what this was simply the way multiparous women of those early days—that is to say, all females, presumably a few years past puberty —may have looked a good deal of the time. (It seems to be generally agreed, however, that the marked steatopygy in these figures was more symbolic than representational.)

No doubt in some of these Mother-Goddesses the fertility idol aspect of the figure is meant to be emphasized in the markedly swollen abdomen (and also, in some, in the carefully molded genital area). But in others the status of the abdomen is either somewhat ambiguous, because of the over-all obesity of the figures represented, or the idea of pregnancy is possibly not intended at all but simply the full breastedness of the figure. However, even in those statuettes where the abdomen is represented as swollen, the enormous enlargement of the breasts, in some cases providing comfortable arm rests for their possessors, is far and away the most striking aspect of the carvings, as in the steatopygous Venuses of Willendorf and Lespugue (Figs. 10, 11). One wonders, in this class of figures, whether the primary point was not again to aim at a sort of superpotent double-action effect by compounding the hoped-for magical results of a fertility idol with the suggestion that everything will be as plentiful, and living as soft, as it was at the breast. Indeed, in some of these highly stylized early works of art, the swollen abdomen, in the kind of economic symbolic condensation that we see in dreams (and in fact in all kinds of art), is itself represented as breastlike, as are also the but-

tocks and the hips (Fig. 12). A late example of a breastlike abdomen is shown in Fig. 13. One can hardly help wondering, moreover, whether certain features such as the areolalike 'hairdo' of the Venus of Willendorf (Fig. 14), or her nipplelike leg stumps (Fig. 15), or the nipplelike head and fused leg stumps of the Venus of Lespugue (Fig. 11), were not meant to suggest something along this line, if not actually to serve functionally (in the case of the nipplelike protuberances) as oral pacifiers.

One other striking thing about these obese and full-breasted figures is, with rare exceptions, their facelessness. But the lack of facial features in these objects is not due simply to any indistinguishability of once present features worn away in time, or to vagueness because of lack of skill on the artist's part. The lack is due to a perfectly clear and indubitably intended flat absence of such features in objects whose creators, in some cases, were obviously quite capable of finely detailed work. (The mons and labia of the Willendorf Venus, for example, are sculpted with lifelike precision.) By contrast there are a number of statuettes, of roughly the same size range and geographical and chronological distribution, which show little suggestion of obesity or particularly rounded contours, and where the breasts are sometimes hardly distinguishable, but where the facial features are clearly indicated. In any case, whether or not a generalized differentiation along these lines can be validly established, the tendency toward facelessness of the obese Venuses is quite consistent with the hypothesis that these apparently symbolically overdetermined figures primarily represented breasts (as faceless figures in dreams sometimes do) since there are data indicating, as Spitz, Linn, Almansi, and others have pointed out, that the face and breast are merged in the neonatal period into one perceptual gestalt.

It is one thing, however, to suspect that these carvings may have symbolized breasts and quite another to be able to establish the presumption that these 'breast objects' were meant to be held in the hand for a particular magical purpose. While

some of them could undoubtedly have played such a role, others almost certainly did not. Several, however, seem to fit the hand quite naturally. (Numerous persons, from whom I received a variety of affective responses, aided me in this evaluation.) The two which appeared most interesting from this point of view are the Venus of Willendorf, about thirty-two thousand years old, and the Venus of Dolni Vestonice, which was presumably carved some six or seven thousand years later (Fig. 16). The former, reposing now in a velvet-lined case in a vault of the Naturhistorisches Museum of Vienna, slips so comfortably into one's grasp from several angles and in several positions that the idea practically suggests itself that it may have been intended for such a purpose, in addition to other possible uses. Holding one's thumb and forefinger in the notch under the faceless head that seems almost deliberately fashioned for this purpose (Fig. 17), it is not difficult to visualize early man clutching this object in his chilly cave and, as he wondered where his next bear or bison was coming from (or whose next meal he might be unlucky enough to be), grunting out some magical spell to insure his hand never losing the skill and efficacy it had when it had held the breast. In the case of the Venus of Dolni Vestonice, a cast of which was kindly sent me by Dr. Jan Jellinek, of the Moravske Museum in Brunn, Czechoslovakia, the thumb and forefinger tend to adopt a somewhat different position from what appears natural in the case of the Willendorf Venus (and from what, as far as I can make out, would probably also be the case with the Venus of Lespugue and certain others which provide what appear to be specially contrived notches under their faceless heads). Here, if the fingers are placed as shown (Fig. 18), it not only would account for the slitlike fish mouth slightly worn away (as it appears to have been) but would also render the head a fairly serviceable nipple. A cluster of four pinpoint sized indentations or 'holes', which seem to have been deliberately made on the top of this head, could conceivably have been intended to represent duct openings. The legs, which have been broken off

at the base, seem to fuse, and could conceivably have provided another nipplelike appendage, as appeared to be the case with the Lespugue Venus.

While it is most unlikely, as I have already indicated, that any unitary hypothesis could plausibly be applied to all the prehistoric Mother-Goddesses and so-called Venuses that have been found, it might nevertheless be of considerable interest and importance to gather data bearing on the presumption that some of them, at least, were meant to be held in the hand for magical purposes. In this connection the important finding mentioned earlier is of decided relevance.

In 1961 a perfectly sculptured stone object suggesting the upper half of a frog or toad was found in Southern California by an archeological team of the University of California at Los Angeles. Besides the protuberant eyes, which are easily seen on the carving (Fig. 19), some shaping along the sides, not shown in this picture, is described as possibly indicating developing legs or a squatting position *(8)*. The carving, known as the Browne Site effigy, measures about six and one half inches in length, four and three-quarter inches in diameter, and three inches in height. It is of diorite, a dense igneous rock, and was brought into present shape by pecking. Provisionally dated at about five thousand years of age, it is thought to be one of the oldest objects of art of the Western Hemisphere. Of interest in connection with this discussion are the remarks of one of the commentators on this frog effigy *(2)*: 'Photos cannot do justice to this piece. One has to hold and feel it and look at it while it moves in one's hands. It seems inconceivable that it was intended to be appreciated otherwise. And it invites to be picked up. One's fingers fold so naturally around the concavity of the one end that one wonders whether this object had not served as a tool. However, the surface does not show any place revealing marks of battering on gross examination.'

The frog, like many other widely used symbols, may have various meanings, depending on context and usage. Like the solar disk (which might conceivably be one of the forms symbol-

ically condensed into the Browne Site figure) the frog is known to have phallic and fertility significance. However, one particular band or range in the spectrum of symbolic values the frog seems to have had from very early times would give special significance to the presumption that the Browne Site effigy, although showing no signs of having been used as a tool (and despite its massiveness),[6] may, nevertheless, have been intended to be held in the hand. The frog always has been widely held to be a symbol of abundance, of actual cash abundance, in fact, in China, where jade good luck pieces representing frogs being held in the hand can be bought in any bazaar. A more direct suggestion of the equivalence of the frog and the breast can be seen in the ancient Egyptian representation of the all-sustaining, all-nourishing hermaphroditic Nile deity (Fig. 20). (Hermaphroditic representations of this sort were not uncommon, incidentally, where invokers of this kind of magic apparently held it inexpedient to neglect the male fecundating principle while placing exclusive reliance on the magical re-establishment of the more regressive nursing situation.) As to a direct tie-in of the frog, the hand and the mouth, pipe bowls in the shape of frogs, which apparently had a ceremonial significance, are fairly common among the artifacts found at prehistoric Indian sites. Here the oral tranquilizing effect of the tobacco (or of whatever was smoked) must have made this a highly potent symbolic constellation.[7]

The unconscious connection between the frog and the original source of security still persists. A recent full-page jeweler's

[6] I did not fully appreciate the difficulty of casually handling its six pounds, three ounces until, in the Spring of 1964, through the courtesy of Mrs. Roberta S. Greenwood, a Southern California archeologist, I had the opportunity of making a firsthand examination of the piece. I am forced to presume that ancient man in America was somewhat more powerful than some of the people who now write about him.

[7] Dr. Bruce Ruddick, in a personal communication, has pointed out the extensive orality of the frog in the myths and sculptures of the Coastal Indians of the Pacific Northwest. He further suggested that the frog may represent an archaic body image from the oral phase, recalling the frog-like 'homunculus' of cortical representation.

advertisement[8] pictured a 'tranquilizing frog' to be used when milady gets nervous. 'One lady . . . (who wears hers on her sleeve)', ran the ad, 'reports that she doesn't need her analyst any more'. (I am happy to report, however, that the reverse sometimes also occurs. Dr. Sydney Margolin has shown me a jade frog 'rubbing stone' given up by an obsessional patient at the successful termination of his treatment.) The underlying connection also seems to have been captured through the unconscious insight of the artist who created the ecstatic expression on the face of the child grasping the frogs in the statue, 'Frog Baby' (Fig. 21).

When looked at from the standpoint of this particular symbolic meaning, the idea presents itself that not only does the Browne Site carving as a whole—this 'beautiful work of sculpture in the round', as it has been called—double as a breast on a symbolic level (just as many similar shaped solar disk forms presumably do) but also that one of its most prominent features, the bulging eyes, may have been intended to incorporate this meaning as a symbolic condensation. The shape of these small protuberances is very close to that found characteristically as breasts on the Tlatilco statuettes of Mexico, some of which date from before the present era (Fig. 22). In the Old World, these small hemispherical forms can be seen as breasts (and, in a somewhat obscure stylized linkage which is found also in their common philological associations, as knees too) in Etruscan, Roman, and Minoan native figures, hermaphroditic and other, and can be found at least as far back as the neolithic (circa 2500 B.C.) Czechoslovakian statuette shown in Fig. 23. The buttocks of this figurine (Fig. 24), resembling those of the much older Venus of Lespugue (Fig. 11), could very well also have doubled as breasts. (This eight-and-three-quarters-inch-high Venus, incidentally, may be seen to incorporate that one touch of Adonis which, while it could possibly have served as a nipple in connection with one form of regressive practice connected with the hand, makes one wonder if it was not pri-

[8] The New Yorker, September 22, 1962.

marily a masturbatory prop for magical fertility rites.) That the symbolic connection, finally, between the more or less abstract form of these protuberances and eyes was not unappreciated in the Western Hemisphere is suggested by the pre-Columbian Costa Rican breastplate of practically the same diameter (Fig. 25). This amulet is said to have been used, as I have suggested that the frog carving may have been, to protect against deprivation.

Another class of ancient animal effigy that may conceivably have utilized the peculiar condensation possibilities of morphology and symbolism to incorporate a breast meaning is the bird figurine (dated at about twenty thousand years) originally found in Mal'ta, Siberia, and now in a collection of artifacts from that place in the State Historical Museum, Moscow.[9] The breastlike quality of the semi-abstract bodies of these bird pieces is quite apparent, while the protrusions which are ordinarily taken to represent the birds' bills plainly suggest nipples. What is more, in the figurine shown (Fig. 26), there are, both on the dorsal side of the tail (not shown) and on the caudoventral side of the body, grooves which perfectly fit a thumb, suggesting that holding the effigy with the thumb placed in either of two positions might have facilitated the use of the object as a pacifier, possibly for ceremonial purposes (Fig. 27). In other effigies of this class where the tails have been broken off, the grooves on the underside of the body are still intact. This is the earliest instance I have come across, incidentally, of the seemingly universal symbolic tie-in between the bird and the breast.

One of the most interesting possible 'hand-breast' objects I have encountered is one in which the mammary wheel may have come full circle. The artifact in question was found in a cist and burial area (near some human mandibles which conceivably could have been used ceremonially in connection with

[9] I am indebted to Professor V. P. Yakimov, of the Institute of Anthropology of the State Historical Museum, Moscow, for having accorded me the privilege of examining these pieces, and for having sent me magnificent casts of several of them.

it) of the Fremont Culture Indians who, until about 1150 A.D., occupied sites in what is now the State of Utah *(16)*. The object is in the Turner-Look Site Collection of the Denver Museum of Natural History whose Curator of Archeology, Dr. H. Marie Wormington, brought it to my attention and kindly allowed me to photograph it. It is of alabaster, the size and shape of a human female nipple and surrounding areola, and is shown next to the nipple of a four-day postpartum multiparous woman (Fig. 28). As may be seen from the photograph, the nipple of the carving seems to have been rubbed somewhat smooth. One wonders whether this object, which was initially considered just another concretion of unknown significance, does not represent one of the final stripped-down and functionally economical versions of what began tens of thousands of years before in the form of the so-called Mother-Goddesses and passed through forms like those of the Mal'ta birds and that of the Browne Site effigy. Numerous transitional forms, objects considered to be of unknown or problematical significance, must be steadfastly keeping their silence in museums all over the world.[10]

A last source of data which enables us to draw inferences about the role of the hand in connection with the presumptive 'breast objects' that have been found are the many prehistoric representations of what are thought to be some of the earliest forms of persecutory demons. Curiously these are not, as they are apt to be in later historical periods, fanged monsters viciously ready to devour the unwary earthling, but rather forms whose outstanding feature seems to be their threatening hands (Fig. 29). (The closest we come in the prehistoric period to oral demon forms are figures on which appendages looking mainly like grasping claws [Fig. 30] also suggest mouths.) One wonders whether these demon hand representations—these

[10] But not in the marketplace, where the 'rubbing' stones (or 'touchstones', as these widely distributed good luck or 'security' stones have sometimes been called) have always been in vogue and have always had legends attached to them that have not been too far from the truth.

beautiful 'sermons in stones'—do not already indicate the beginnings of a guilt infused stage of a particular culture and, if you will, the birth of conscience, possibly as a consequence of the changing over of the family structure from nomadic hunting to the more settled agricultural complexes with, perhaps, a longer period of suckling maternal dependency. Many associated artifact complexes found in Europe at the supposed time of the creation of these hand demons—the ones shown are from rock pictures in different Spanish caves and are dated roughly from 2500 to 1300 B.C.—indicate that some such transition was taking place there *(11)*. It is significant, at any rate, that the onset of the tendency toward projection seen in the various demon forms of this early period—a tendency that marks the real beginnings of modern times—should show itself in connection with the hand, whose relationship to the breast, and whose basically oral 'aggression' and 'guilt', I have tried to demonstrate.

SUMMARY

Data have been presented indicating the memorialization in various types of artifacts of that early relationship between the hand and the breast which comes to symbolize security at its maximum. A hypothesis as to the significance of certain types of prehistoric 'Venus' figures and other artifacts is offered. It is that these artifacts served as breast substitutes to be held in the hand for magical regressive practices related to threatened or actual famine, object loss, or other stressful situations. Certain artifacts also indicate the beginnings in prehistoric times of the type of displacement of guilt and projection of oral aggression onto the hand that can be seen classically today in obsessional neurosis.

REFERENCES

1. ALMANSI, RENATO J.: *The Face-Breast Equation.* J. Amer. Psa. Assn., VIII, 1960, pp. 43-70.
2. ALTMAN, RALPH C.: *A Note on the Effigy from the Browne Site.* The Masterkey, XXXVI, 1962, pp. 7, 38.

3. AMES, O. B.: *Fear of His Hands: With Psychoanalysis of the Same.* Alienist and Neurologist, XXXIX, 1918, pp. 298-300.
4. BERGLER, EDMUND: *Three Tributaries to the Development of Ambivalence.* This QUARTERLY, XVII, 1948, pp. 173-181.
5. BRADLEY, NOEL: *The Vulture as Mother Symbol: A Note on Freud's Leonardo.* Amer. Imago. In press.
6. EISENBUD, JULE: *Two Approaches to Spontaneous Case Material.* J. Amer. Soc. Psychical Res., LVII, 1963, pp. 118-135.
7. GOODENOUGH, ERWIN R.: *Jewish Symbols in the Greco-Roman Period, Vols. I-VIII.* New York: Pantheon Books, Inc., 1953-1958.
8. GREENWOOD, ROBERTA S.: *A Stone Carving from the Browne Site.* The Masterkey, XXXVI, 1962, pp. 4-7.
9. HALVERSON, H. M.: *Studies of the Grasping Reflexes of Early Infancy.* J. Gen. Psychology, L, 1937, pp. 371-449.
10. HOFFER, WILLI: Mouth, Hand and Ego Integration. In: *The Psychoanalytic Study of the Child, Vol. III-IV.* New York: International Universities Press, Inc., 1949, pp. 49-55.
11. KÜHN, HERBERT: *Rock Pictures of Europe.* London: Sidgwick and Jackson, 1956.
12. LINN, LOUIS: *Some Developmental Aspects of the Body Image.* Int. J. Psa., XXXVI, 1955, pp. 36-42.
13. MEERLOO, JOOST A. M.: *The Two-Faces of Man.* New York: International Universities Press, Inc., 1954.
14. SCHNIER, JACQUES: *The Symbolic Bird in Medieval and Renaissance Art.* Amer. Imago, IX, 1952, pp. 1-29.
15. SPITZ, RENÉ A.: The Primal Cavity. In: *The Psychoanalytic Study of the Child, Vol. X.* New York: International Universities Press, Inc., 1955, pp. 215-240.
16. WORMINGTON, H. M.: *A Reappraisal of the Fremont Culture.* Denver: Denver Museum of Natural History, Proceedings, No. One, 1955.

ACKNOWLEDGMENTS

The author gratefully acknowledges permission to reproduce the illustrations from the following sources:

Fig. 1. The Chicago Natural History Museum.
Fig. 2. Harcourt, Brace & World, Inc., New York. In: Benac, Alojz and Bihalji-Merin, Oto: *Bogomil Sculpture.*
Fig. 3. Simon & Schuster, Inc., New York. In: Berenson, Bernard: *The Passionate Sightseer.*
Fig. 4. Harry N. Abrams, Inc., New York. In: Feininger, Andreas: *Maids, Madonnas, and Witches.*
Fig. 5. National Gallery of Art, Washington, D. C.
Fig. 6. San Francisco Seminary, Siena, Italy.
Fig. 7. Oxford University Press, New York. In: Goldscheider, Ludwig: *Etruscan Sculpture.*

Fig. 8. Museo Nacional, Mexico City.
Fig. 9. Carnegie Institute, Pittsburgh, Pennsylvania.
Fig. 10. Naturhistorisches Museum, Vienna.
Fig. 11. Musée de l'Homme, Paris.
Fig. 12. Denver Museum of Natural History, Denver, Colorado, (cast).
Fig. 13. Southwest Museum, Los Angeles, California.
Fig. 14. Denver Museum of Natural History, Denver, Colorado, (cast).
Fig. 15. *Ibid.*
Fig. 16. [Author's cast, supplied by Dr. Jan Jellinek, Moravske Museum, Brunn, Czechoslovakia.]
Fig. 17. [Author's cast.]
Fig. 18. [Author's cast.]
Fig. 19. The Masterkey, XXXVI, 1962, No. 1, University of California, Los Angeles.
Fig. 20. In: Lanzone, R. V.: *Dizionario Mitorlogia Egizia* (1881).
Fig. 21. Chapman and Grimes, Boston. In: Dodd, Loring Holmes: *The Golden Age of American Sculpture.*
Fig. 22. Spring Books, London. In: Forman, W. and B.: *Exotic Art.*
Fig. 23. Moravske Museum, Brunn, Czechoslovakia. Denver Museum of Natural History cast.
Fig. 24. *Ibid.*
Fig. 25. Meerloo, Joost A. M., private collection.
Fig. 26. State Historical Museum, Moscow. [Author's cast.]
Fig. 27. *Ibid.*
Fig. 28. Denver Museum of Natural History, Denver, Colorado.
Fig. 29. Sidgwick and Jackson, London. In: Kühn, Herbert: *Rock Pictures of Europe.*
Fig. 30. *Ibid.*

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

Transference, Countertransference, and Being in Love

Carl M. Grossman

To cite this article: Carl M. Grossman (1965) Transference, Countertransference, and Being in Love, The Psychoanalytic Quarterly, 34:2, 249-256, DOI: 10.1080/21674086.1965.11926347

To link to this article: https://doi.org/10.1080/21674086.1965.11926347

TRANSFERENCE, COUNTERTRANSFERENCE, AND BEING IN LOVE

BY CARL M. GROSSMAN, M.D. (BEVERLY HILLS)

There is agreement among psychoanalysts that the core of therapy is the handling and fate of the transference. The major difference between psychoanalysis and other therapies is that only in psychoanalysis is there careful and systematic analysis of the transference, the major resistance. In a sense, all psychotherapeutic accomplishments are 'transference cures'; only in psychoanalysis is the aim the resolution of the transference neurosis.

Transference has been a subject of unceasing discussion and elaboration since its inception *(7)*. There are nevertheless many psychoanalysts who protest that transference and countertransference are not clearly and simply defined so as to assure maximum understanding and efficiency in their application; also, it is felt that there is much too much emphasis on the introduction of new terminology, which adds nothing to a better definition of the psychodynamics or of a more cogently reasoned recommendation for their remedial clinical employment.

In this endeavor, it is proposed that the applications to transference of the qualifications 'positive' or 'negative' are redundant; furthermore that their use distorts the basic psychoanalytic meaning of the concept.

The mechanism of transference is a universal human psychological characteristic which causes the internalized representation of certain objects—such as parents or parental surrogates from one's infantile past—to be projected onto a succession of later, ostensibly unrelated, persons. The transferring person then reacts to new objects with the anachronistically habitual reaction in adult life that he had had toward the originally

cathected object in infancy. This is an entirely normal function of the ego, a means of learning, understanding, and adapting oneself to the external world. Like projection, it becomes pathological only when its quantity and intensity preclude sufficient realistic evaluation of new objects to distinguish them clearly from the infantile object.

To use the term, countertransference, to describe the analysts' reactions to their patients, is confusing and uneconomical. It has been defined as synonymous with transference by Fenichel *(1)* and more recently by Greenson *(5)*. Freud originally described countertransference as a pathological reaction in the therapist but discussed it in terms which made it sound like transference *(2)*. To define transference and countertransference as identical makes no more sense than to define a projection as a response to it, or to make stimulus synonymous with response. The term, countertransference, should either be dropped entirely, as suggested by Gitelson *(4)*, or used only to signify a response to a transference, as recommended by Heimann *(6)*, Racker *(8)*, and Spitz *(9)*. Transference could then be discussed with clarity as the reaction of a patient or of a therapist.

To agree that there is confusion but then condone it on the basis of customary usage—or to invoke the authority of Freud—is common practice. The latter is an injustice to Freud who was the least dogmatic of discoverers. Those, however, who prefer to use one name for their own reactions and a different one for the reactions of their patients may betray a wish to be placed in a different category. Such defenses are among the compelling reasons for the requirement that the analyst himself be analyzed. If he cannot recognize in himself certain feelings of his patients, it is just those feelings which will be inaccessible to his exploratory efforts.

To present the subject in nontechnical language, 'falling in love' or 'being in love' may be substituted for the psychoanalytic term, borrowing from Freud's comments about transference: 'There is no love that does not reproduce infantile prototypes. . . . The transference love has perhaps a degree less of

freedom than the love which appears in ordinary life and is called normal; . . . the condition of being in love in ordinary life outside analysis is also more like abnormal than normal mental phenomena' *(3)*.

A male patient had begun his treatment with a woman by making contemptuous remarks about the inefficiency of women doctors. One day she was obliged to change their next appointment. Subsequently he said to her: 'You are my idea of a perfect woman. You know what you want and you go after it.' This man had complained to his analyst how like his passive father he was, and about how sorry for his father he was because the mother 'pushed him around all the time'. The patient's flattering compliance was not therefore a simple transference reaction, being based on his need to be pushed around as his father had been. He sustained personal relationships only with the women he succeeded in goading to dominate him.

Attitudes of anger from patients early in treatment usually signify first, that the patient is behaving like one of his parents; second, that he is unconsciously seeking to provoke retaliation from the analyst—akin most often to the habit of the mother, especially among male patients. Hurting or being hurt was in one patient a conscious requirement for all his close relationships with both sexes, to determine which role he should play.

A young man had been catatonic for months. One day, reacting to a sluggish response, accompanied by a smirking contemptuous grimace, the therapist snapped his fingers, a singular bit of behavior on his part. This first seemed to rouse the young man to greater activity, but soon he became destructively hateful: 'You are a pigeon', he said, 'and I am going to eat you'. This, in due course, was found to have several determinants. His father gave the pigeons he bred more attention and affection—he frequently fondled and caressed them with open mouth —than he gave the boy who was terrified of his habitually impatient father. Squab was often served at home as a delicacy. Much later the patient disclosed that, in addition to expressing anger, his menacing threat had also meant, 'You are good

enough to eat'. What then, in this instance, entered into the transference were an overt destructively cannibalistic threat and a covert wish to be eaten by way of identification with the impatient therapist (father) and regressively with the pigeons that his father treated tenderly and subsequently ate with relish.

Hateful reactions frequently occur as a defense against transference. A commonplace is the stereotype that says in effect, 'I know that patients are supposed to fall in love with their analysts—well, you won't catch me doing that'. There are overt paranoid reactions, especially if the primal object caused anguish and fear of destruction (sadomasochistic object). The patient may also be identified with the aggressor. Among the last is the resistance of the highly erotized transference that led Freud to conclude: 'These are women of an elemental passionateness; they tolerate no surrogates; they are children of nature who refuse to accept the spiritual instead of the material . . .' *(3)*. Initial reactions of hatred toward the therapist are sometimes unconscious resistances based on the fear that the fixation to the original object will be irremeably destroyed by the analyst. Provocative behavior that stems from the well-known sequence of incurring a thrashing that evokes subsequent remorseful overindulgence from the parent requires no comment.

Love requires no defenses against it unless it arouses a conflict of painful feelings. A man who avoided all loving ties said: 'My mother could only love me if I did everything her way and thought her way. She ignored me or looked right through me even if I considered a difference of opinion from hers. I tried to be like her; but then it was as if only she was there; somehow, there was no I; only empty space.' To fall in love threatened him with a state of nonexistence.

As stated above, it is proposed that the word countertransference be limited to mean only one thing: reaction to transference. Countertransference then is that universal human psychological reaction which occurs in one person toward another as a result of exposure to the transference feelings of that other person. It is a response appropriate to an immediate stimulus

and may or may not be accessible to consciousness. Clearly, this definition does not limit the reaction to therapists.

It is of interest to speculate about countertransference from the point of view of the person who is the object of a transference. When one consciously or unconsciously perceives that someone has fallen in love with him, however much he may pretend to regard it as a romantic fiction, it is easy to imagine that he has some kind of pleasurable response, including possibly some warmth toward the person who bestows it. Feelings of embarrassment or other defensive reactions cannot be excluded. In terms of this speculation, it may not be farfetched to advance the idea that one can respond to transference love and be aware of the response.

Because the mode of being in love differs among individuals, it follows that the responses will vary correspondingly. In each instance, it is the feeling of response, whether or not we are aware of it, that suggests to us the role the lover expects us to play. The role, of course, was created and enacted by the infantile love object (parent), and if we can become aware of our reactions we may learn something of the characteristics of the infantile object.

Heinrich Racker gives an excellent discussion of the value of such awareness *(8)*. It would be even clearer were he to limit the meaning of countertransference to the therapist's reaction to the patient's transference. He introduces confusion by dividing countertransference into a complementary identification of the therapist with the patient's internal objects; and a concordant identification of the therapist with the patient, totally or partially (ego, id, or superego). Mentioned but not discussed is the motive of a therapist's transference to his patient. This complicated definition is confusing. When, for example, Racker asks, 'To what imagined or real countertransference situation does the patient respond with a particular transference?' *(8)*, he appears not to know that the patient's transference is borne over from a primal object to a current surrogate.

When a patient behaves fearfully as though expecting a blow

from the therapist, he may not be the least conscious of his angry feelings. On some occasions, when such an expectation is interpreted and angry or critical feelings are exposed, with the subsequent relief comes the memory of having given vent to an anger toward a parent which resulted in physical punishment or severely hurt feelings. If, instead of expressing fear, the patient voices a direct threat or makes a threatening move toward the therapist, he almost invariably has had a fantasy of being attacked by the therapist. If the therapist is not sure what is happening within his patient he typically becomes anxious; or he may, as a defense, develop a feeling of anger toward the patient. If the analyst can analyze his own feelings, he may understand what role the patient is transferring to him.

A patient, early in therapy, suddenly rose and stood menacingly over the therapist. 'You see these fists?' he shouted, waving them under the therapist's nose, 'They're weapons!'. The therapist's greatest surprise was that he was little frightened; only then could he acknowledge that his initial fright had quickly disappeared. It was now not difficult to tell, with assurance, that the patient shouted down his own fears by terrorizing others. The patient thereupon burst into tears and began to recount instances of his constant pressure to avoid showing fear, especially to a woman who exploited him as a protector but taunted him whenever he was timid, and whenever he made awkwardly tentative sexual advances.

Paula Heimann *(6)* suggests that whatever are our feelings and reactions—however neurotic—in a patient's presence, they are in part, at least, a response to some need of the patient. The question, 'What is operating in my patient to arouse my present feelings, and how is it manifested in him?' is often a guide to the patient's unconscious struggle to restore his original love object. It may in addition intuitively suggest some manner of behavior of that infantile object toward the patient as a child, mirrored in the full awareness of our own impulse toward the patient.

When an analyst becomes the 'beloved' of his patient, the patient has displaced to him the role of an archaic object. The analyst's feelings and reactions to these stimuli from his patient cannot be called anachronistic or pathological unless they become allied with the analyst's own transference love. Perhaps many psychoanalysts, including Freud, have regarded countertransference as neurotic because such a fusion or alliance is a universal occurrence in varying degrees (but still are two different items).

The response in feeling to transference love will vary as does the transference itself. If the one who loves treats us in a manner similar to the way he treated his infantile love object we will have the urge to respond to that treatment by behaving as did the original love object. If we can become aware of that urge we are in a position to understand its source. By virtue of such understanding we can behave differently from the original object, either by interpretation or other ways of responding. If we are unaware, we run the risk unknowingly of acting upon the urge in a manner similar to the original object's habit: for example, an interpretation may be correct in content but punitive in phrasing or manner of delivery.

As Racker says, 'The danger of exaggerated faith in the messages of one's own unconscious is . . . less than the danger of repressing them . . .' *(8)*. And Heimann states: 'The basic assumption is that the analyst's unconscious understands that of his patient. This rapport comes to the surface in the form of feelings which the analyst notices in response to his patient in his countertransference' *(6)*.

A therapist has an additional way of becoming aware of his countertransference even when it is fused to a moderate degree with his transference to the patient: his patient may react to his therapist's transference with a countertransference of his own. As the patient is much less likely to interpret than to act, the observant therapist should silently ask himself, 'What did I do to stimulate that?'. The therapist thus has a perceptible sign to redirect his attention to himself.

SUMMARY

The concept of transference love is clarified by omitting the qualifications, 'positive' and 'negative'. To define countertransference as only a reaction to transference love lessens confusion and aids therapeutic technique. To apply special terminology to differentiate psychological phenomena in therapists from identical phenomena in their patients is a defense in the therapist against his awareness of unacceptable feelings. Any efforts directed at breaching our own defenses and clarifying concepts must have salutary effects on therapy.

REFERENCES

1. FENICHEL, OTTO: *The Psychoanalytic Theory of Neurosis.* New York: W. W. Norton & Co., Inc., 1945, p. 580.
2. FREUD: *The Future Prospects of Psychoanalytic Therapy* (1910). Coll. Papers, II.
3. ———: *Further Recommendations in the Technique of Psychoanalysis. Observations on Transference Love* (1915). *Op. cit.*, pp. 385-388.
4. GITELSON, MAXWELL: *The Emotional Position of the Analyst in the Psychoanalytic Situation.* Int. J. Psa., XXXIII, 1952, pp. 1-10.
5. GREENSON, RALPH: On Classical Psychoanalysis. In: *American Handbook of Psychiatry, Vol. Two,* edited by Sylvano Arieti. New York: Basic Books, Inc., 1959, pp. 1407-1408.
6. HEIMANN, PAULA: *On Countertransference.* Int. J. Psa., XXXI, 1950, pp. 81-84.
7. JONES, ERNEST: *The Life and Work of Sigmund Freud, Vol. I.* New York: Basic Books, Inc., 1953, pp. 223-225.
8. RACKER, HEINRICH: *The Meanings and Uses of Countertransference.* This QUARTERLY, XXVI, 1957, pp. 303-357.
9. SPITZ, RENÉ A.: *Countertransference. Comments on Its Varying Role in the Analytic Situation.* J. Amer. Psa. Assn., IV, 1956, pp. 256-265.

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

The Role of Hatred in the Ego

Ping-Nie Pao

To cite this article: Ping-Nie Pao (1965) The Role of Hatred in the Ego, The Psychoanalytic Quarterly, 34:2, 257-264, DOI: 10.1080/21674086.1965.11926348

To link to this article: https://doi.org/10.1080/21674086.1965.11926348

Published online: 29 Nov 2017.

THE ROLE OF HATRED IN THE EGO

BY PING-NIE PAO, M.D. (ROCKVILLE, MARYLAND)

In the treatment of hospitalized and severely disturbed patients, I have had the opportunity to observe the rise and fall of intense feelings of hatred. Sometimes I was the target of these feelings; at other times I was accused of hating the patient. This exposure to the feeling of hatred led me to consider that it is so complex a human phenomenon that it cannot be encompassed by such common expressions as anger, rage, aggression, hostility, or destructiveness though these expressions often are used interchangeably with hatred.

HATRED AND RAGE

Spitz *(10, 11)* noted that rage in the form of screaming can be observed in infants of two to three months. It is an ego organized expression of frustration of instinctual needs. And as the mother repeatedly responds to the infant's rage by modifying his frustration, he learns that his rage has an intimidating effect on her. In this sense rage is an ego response to the conflict between the ego and the object.

With the acquisition of new ego functions, rage gradually undergoes a metamorphosis (see Fenichel [2] and Jacobson [5]), and eventually transforms into hatred which involves the participation of all three psychic structures: id, ego, and superego. In hatred the ego is not only in conflict with objects in the external world, as in the case of rage, but with internalized objects as well.

Although hatred and rage are both organized affective responses of the ego to frustration, they can be distinguished *(5, 7)*. Unlike hatred, the earlier and less complicated human experience of rage in a form of communication. Both hatred and rage reflect a conflict between the ego and outside objects, but hatred also reflects a conflict between the ego and internalized

objects. In rage there is concern only with the power and status of the external object without going beyond realistic bounds; in hatred, influenced by the internalized object, there is a tendency to ascribe enormous status and power to the external object, often accompanied by a feeling that one's own existence depends on the object. In rage the instinctual drives seek immediate muscular action, such as shouting, kicking, or hitting; in hatred the interposition of the ideational process results in suppression of muscular release. Rage tends to come and go with the exciting cause; hatred can linger on and grow in intensity. In rage one attempts to modify the object's frustrating behavior in order to insure immediate gratification, using past knowledge only to help modify the object's frustrating action; in hatred one dwells on the past, thinks of revenge in the future, and is not concerned with the present. Rage serves no ego-syntonic defensive purpose; hatred, in linking past and future, establishes a sense of continuity and may be used as an ego-syntonic defense, as a basis of relationship, and as the core of a person's identity.

HATRED AS AN EXPERIENCE OF ENTRAPMENT

Freud said, 'The affective states have been incorporated in the mind as precipitates of primeval traumatic experiences, and when a similar situation occurs they are revived in the form of memory symbols' *(3)*. Hatred as an affective state results from old traumatic experiences and can be revived in similar situations in later life. In this section we are concerned only with the phenomenology of the ego state of hatred as it is revived.

When hatred becomes a conscious experience, the one who hates is beset with fears and feels pulled in different directions. The hater tends to ascribe unrealistic power and importance to the object of his hate and believes it would be disastrous to offend the omnipotent and omnisicient object. But he feels wronged by the object and 'wants to get even with it'. Thus he finds himself in a state of bondage. If he remains close to the object, he may betray his hatred and provoke the wrath of the

object, who could crush him. On the other hand, if he attempts to avoid the hated object, he is denying himself needed libidinal supplies. Caught in a dilemma, the hater feels trapped and schizophrenic regression, manic flight, suicide or homicide, promiscuity, perversion, or crime may ensue.

Two cases show how hatred is experienced as entrapment.

For about four months following the birth of her second child, a patient was physically weakened by recurrent bleeding. Although she was very fond of the baby, she developed fears about not being able to care for her. Then she began to feel that her husband neglected her, that he was too engrossed in his work. She entangled him in quarrels but when he still failed to heed her, she hated him. She threatened to leave him, made two tentative attempts to see a lawyer about divorce, and after several months decided to act promptly. Instead she drove around aimlessly for several hours and then returned home. That evening she was found sitting alone in the car in the garage. She was catatonic and was taken to a hospital. In the course of therapy she explained that she hated her husband and wanted to leave him. On the day she had driven around aimlessly, she had intended to check into a hotel but as she approached the hotel she became more and more alarmed and reluctantly returned home. She could not remember what happened after that.

A manic depressive woman accompanied her husband to a business meeting in a distant city. Left alone for four days while he was engaged in 'talks with the boys', she complained. Her husband, in turn, criticized her for lack of understanding. They then went on a vacation trip and she felt that her husband continued to neglect her by playing golf and drinking with strangers. She hated her husband for not loving her, and hated herself for living with him. She thought of divorce but dreaded being alone and did not want to see her husband happily remarried. Feeling trapped, she attributed all her unhappiness to him. Before the vacation was over she became excessively energetic, loud, flirtatious, irritable, and argumentative. This be-

havior was followed by such a degree of disorganization and incoherence that she had to be hospitalized.

These two patients illustrate how the ego state of hatred locked each in a type of bondage with the most significant person in their lives. Neither could move close to, nor away from, this significant person. Bak *(1)* has postulated that 'the aggressive drive is instrumental in bringing about the [schizophrenic] regression'. In the two cases cited it seems that the aggressive drive was instrumental in bringing about the ego state of hatred, which may be an intermediate step to further regression and psychosis.

EGO SYNTONIC USES OF HATRED

That hatred can be used for ego syntonic purposes has been described in the literature. Ernest Jones *(6)* showed how hatred can serve to cover fear or guilt. Hill *(4)* observed that it can serve to avoid 'feelings of dependency, of a need to be loved, of passivity and helplessness, or a desire to dominate and control (as a reaction-formation against passivity), and even feelings of affection'. Searles *(8, 9)* indicated that vengefulness or scorn can serve as a defense against repressed grief and separation anxiety.

To hate is to feel something, which is far better than feeling purposeless, empty, amorphous, or swamped by anxieties. Hatred may become an essential element from which one derives a sense of self-sameness and upon which one formulates one's identity. Thus a young paranoid man said to me, 'I don't like to hate but I have to. If I am not a hater, I am nobody. And I don't want to be nobody.' When his hatred receded he became more disorganized and paranoid. Similarly another young schizophrenic man said, 'I hate my mother. Even though at times I think she is not too bad, I still hate her. For hatred is a pleasant emotion.' In his case hatred served to relieve him of all sorts of unmanageable emotions and uncertainties.

That hatred has great power to sustain one's life is seen in the following case. A borderline patient entered the hospital voluntarily because of an uncontrollable urge to injure her body. One year later she decided to leave the hospital and her analyst. Af-

ter six months she sought out-patient treatment with the same analyst and stayed with him for six years. She explained: 'When I left the hospital, I hated it. I did not hate you. I had no idea if I could hold out on my own, but I knew I had no choice. I simply had to do what I did. . . . But I managed all right. I found an apartment and a job which occupied me in the daytime. At night I was often seized with the urge to kill myself. But I couldn't do it because I hated the hospital and didn't want to live up to the hospital's prophecy that I could not manage outside.'

An important aspect of this case was the displacement of the patient's hatred from her analyst to the hospital which allowed her to form a bond with the analyst to whom she could return and eventually work through her problems. Displacement of hatred to an object of lesser significance is a common experience. In setting up national, racial, or personal enemies one can then live more peacefully with one's loved ones.

HATRED AS A BASIS OF HUMAN RELATIONSHIP

Hatred tends to incite hatred in others. And he who hates detests most those who feel indifferent toward his hatred, and will make every effort to goad the other person into hatred too. A young schizophrenic woman expressed her hatred for her husband through incessant tirades. Following one such tirade, the husband told her with sincerity that he loved her. Her hatred mounted and she pushed her fist through a pane of glass. She said, 'He was so superior. I hate him even more.'

When hatred becomes the basis of a human relationship it can perpetuate the relationship as durably as love. One can grow accustomed to such a relationship and feel lost without it. The manic depressive patient mentioned earlier and her husband were in a hateful state of bondage for most of the twenty years of their marriage. Until the wife became psychotic, they were considered by others to be happily married and both were outgoing and successful. However, they scarcely communicated and each did his best to expose the other's weaknesses.

When they did speak to each other, a bitter quarrel would soon break out. Each secretly thought of leaving the other. For a time the husband shared a more peaceful life with another woman, but finding this life unexciting, returned to his wife and they resumed the hateful struggle. It is to be noted that a relationship perpetuated by hatred is not like a sadomasochistic relationship where there is fusion of libidinal and aggressive drives. In hatred there is little libidinal component.

For several years two elderly women occupied adjacent rooms on a ward. Every day they complained to the nursing staff of the other's behavior in the shared bathroom. They made no attempt to resolve their differences, refused to talk to each other, and would not accept suggestions from the nursing staff when they tried to arbitrate. They hated each other. When one was transferred to another hospital, the patient who remained said, 'I am sad because Mrs. A is my only friend'.

As stated above, when one is accustomed to a hateful bond with another, one feels lost without it. It is not always wise for the analyst to disturb the bond. Sullivan *(12)* observed that in some instances manic depressive patients who had been previously analyzed committed suicide after resuming treatment; he did not offer any explanation of this observation. Others have suggested that the new analyst may fall short of the patient's expectations and thus extinguish the patient's last hope. I should like to suggest that re-entering treatment may weaken the bond of hatred which the patient has already firmly established with his particular significant object and thus create a disequilibrium that leads the patient to drastic action.

HATRED IN THE COURSE OF TREATMENT

In the course of treatment that is inherently frustrating, many patients will turn their hatred toward their analyst. When the analyst, in turn, does not hate them, these patients feel an even greater sense of frustration. For instance when I began working with a patient who had begun to emerge from a severe catatonic reaction, she stood in the doorway during each session and

cursed me. When I maintained my detachment, she attacked me physically. After eight months of this behavior, she one day scornfully cried out: 'You are full of hatred. You hate me. You have a heart full of black blood.' By this time I did hate her and I realized that often in the past months when restraining her, I had had an urge to strangle her. I said: 'You may be happy to find someone who hates as much as you do, but you are the only one of us who is ashamed of feelings of hatred'. It is uncertain whether my statement influenced her so that she was no longer ashamed of her hatred, or whether she was gratified by her success in making me hate her. In any event that particular hour was a turning point in the treatment and thereafter her behavior markedly improved: she stopped being assaultive, ceased soiling her clothes, and began taking care of her person.

As the analyst helps his patient to rid himself of his hatred, he must discern what the hatred means to the patient. The untimely removal of such a useful ego syntonic defense may leave the patient completely deprived and invite undesirable complications. Unpleasant as it is for the analyst when he becomes the target of the patient's hatred, it is necessary for him to recognize that when the patient allows himself to reveal this affective state, the patient is more committed to attempting a constructive personality change. To quote Novey *(7):* 'It is of considerable importance to envision [affective states] as being not only disruptive psychopathological experiences but also as attempts at the re-establishing of a more stable and more constructive integration of the personality'.

SUMMARY

Hatred, an ego affective state, appears at a later stage of development and is more complex than rage. From the treatment of severely disturbed hospitalized patients, examples are presented to show how hatred may play an ego organizing and defensive role and may help to establish a sense of continuity and identity in the patient.

REFERENCES

1. BAK, ROBERT C.: *The Schizophrenic Defense Against Aggression.* Int. J. Psa., XXXV, 1954, pp. 129-134.
2. FENICHEL, OTTO: The Ego and the Affects. In: *The Collected Papers. Second Series.* New York: W. W. Norton & Co., Inc., 1954.
3. FREUD: *Inhibitions, Symptoms and Anxiety* (1925-1926). Standard Edition, XX.
4. HILL, LEWIS B.: *The Use of Hostility as Defense.* This QUARTERLY, VII, 1938, pp. 254-264.
5. JACOBSON, EDITH: The Affects and Their Pleasure-Unpleasure Qualities in Relation to the Psychic Discharge Processes. In: *Drives, Affects, Behavior.* Edited by Rudolph M. Loewenstein. New York: International Universities Press, Inc., 1953.
6. JONES, ERNEST: Fear, Guilt and Hate (1929). In: *Papers on Psychoanalysis.* Baltimore: Williams and Wilkins Co., 1950.
7. NOVEY, SAMUEL: *A Clinical View of Affect Theory in Psychoanalysis.* Int. J. Psa., XL, 1959.
8. SEARLES, HAROLD F.: *The Psychodynamics of Vengefulness.* Psychiatry, XIX, 1956, pp. 31-39.
9. ———: *Scorn, Disillusionment and Adoration in the Psychotherapy of Schizophrenia.* Psa. and Psa. Rev., XLIX, 1962, pp. 39-60.
10. SPITZ, RENÉ A.: Aggression: Its Role in the Establishment of Object Relations. In: *Drives, Affects, Behavior.* Edited by Rudolph M. Loewenstein. New York: International Universities Press, Inc., 1953.
11. ———: Ontogenesis: The Proleptic Function of Emotion. In: *Expression of the Emotions in Man.* Edited by Peter H. Knapp. New York: International Universities Press, Inc., 1963.
12. SULLIVAN, HARRY STACK: *Clinical Studies in Psychiatry.* Edited by Helen S. Perry, et al. New York: W. W. Norton & Co., Inc., 1956, p. 299.

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

A Traumatic Dream

Harold L. Levitan

To cite this article: Harold L. Levitan (1965) A Traumatic Dream, The Psychoanalytic Quarterly, 34:2, 265-267, DOI: 10.1080/21674086.1965.11926349

To link to this article: https://doi.org/10.1080/21674086.1965.11926349

Published online: 29 Nov 2017.

A TRAUMATIC DREAM

BY HAROLD L. LEVITAN, M.D. (NEW YORK)

This brief case report describes the unusual occurrence of a shocking event which was succeeded by an equally shocking dream. It shows that the dreamer was as unprepared for the denouement in her dream as she had been for the tragic occurrence earlier the same day. In the dream or series of dreams that follow a severe and sudden trauma, as we know from our experience with the traumatic neuroses, the same or analogous events are ordinarily presented with the accompaniment of anxiety so that the dreamer is not surprised a second time. The failure of this mechanism throws some light on the defensive processes in dreams.

The patient, a forty-five-year-old woman, was informed of her husband's death in the following manner: while upstairs in her bedroom she heard her brother-in-law call to her from the downstairs hall. She went to greet him quite unconcernedly even though it was unusual for him to visit in the middle of the day. When she reached the bottom step he took her in his arms and blurted out the awful news that her husband had suddenly died one half hour before. She experienced a sense of great shock, a sharp sinking feeling in the abdomen, and seemed on the verge of fainting but did not lose consciousness. For the rest of the day she was not so much sad as groggy and in a fog.

Toward morning she dreamed.

> She was wandering about the first floor of her house when she encountered her mother. She asked her, 'Where is my husband?'. Her mother rather casually replied, 'He is upstairs in the kitchen'. Thereupon she climbed the stairs with the full and happy expectation of seeing her husband at the top, but just as she reached the top step and was about to greet him a blinding flash of light occurred which lasted a split second.

Next she knew that she was awake and crying.

Before the denouement the dream is filled with reversals and substitutions of the real situation in the service of wish-fulfilment. For example, her mother is substituted for her brother-in-law as the bearer of the message, and she states that the husband is upstairs and alive rather than dead. Also the dreamer is asking a question rather than being told the upsetting news. However, although the patient had reported no visual reaction in reality, the moment of

denouement in the dream which (as in reality) was the moment of her becoming aware, is unmistakably marked by a visual impression.

A flash of light that takes the dreamer by surprise and blots out all images seemed to me very unusual and on further research I could not find reference to it in the literature. There are, however, some reports in which rather mild phenomena of light are incorporated into the manifest content of the dream (*1, 4*). But in these instances the light had been subject to the dream-work and had therefore a different origin. Indeed, strictly speaking, the flashing light in this case is not part of the dream. It is rather a component of the shock consequent to her sudden awareness of loss. The phenomenon of visual shock or 'seeing stars' is, of course, well known in waking life. Ernst Kris and Phyllis Greenacre *(5, 4)* have suggested that the edging of light possessed by certain screen memories is a displacement from the light-effect of the visual shock that precedes by an instant the formation of the screen memory. It is not unlikely, as both Paul Schilder *(6)* and Max Stern *(7)* have pointed out, that so-called primary hallucinations which include flashes of light are mediated not through the visual organ directly but through an acute disturbance to the vestibular system which in turn affects the other sensory systems. Possibly too the near loss of consciousness at the moment of trauma is another effect of sudden changes in the vestibular system.

The reworking of traumatic experience by the screen memory by definition precludes the possibility of a renewal in full of the realization of the traumatic events. In the nightmares of the traumatic neurosis and in the nightmare generally the intense anxiety due to the dreadful content causes the dreamer to awaken before the denouement. Any consideration of the reasons for the failure of the protective and alerting mechanisms in this instance must include the extensive denial which was a prominent feature of the patient's personality, but which was significantly facilitated and altered by the state of sleep. The denial in the patient's waking state was very important in the handling of the trauma from the moment of its occurrence. As noted earlier, she was, throughout the rest of the day, in a fog so that she did not apprehend the significance of what had happened. Thomas French *(2)* has stressed the pain-absorbing powers of sleep and its corollary, the increased reality orientation of the latent thoughts as sleep lightens. The combination of these

two factors may shift the balance from a state of extensive denial into an abrupt and traumatic awareness of reality. First, because of the lulling of the denial mechanism by sleep, the patient was able to gain more awareness of her situation during the early part of her dream than had been possible during her foggy state in daytime. This faint awareness was shown by her questioning of her mother as to the whereabouts of her husband. Thereafter, however, in spite of this faint awareness the denial was still so broad that no manifest anxiety could develop. Thus she persisted in thinking of her husband as alive until too late; whereupon she was once again overcome by the trauma of her real situation. The negative hallucination which was the unawareness of the shock of her husband's death could not be maintained as reality testing increased concomitantly with the lightening of sleep. Freud *(3)* has stressed the two levels of awareness that exist in states of denial. As shown very clearly here, these two levels in dreams may be described as simultaneous states of positive and negative hallucination which are maintained in dynamic tension under conditions of delicate balance; this balance may, however, under certain circumstances be abruptly upset.

SUMMARY

Full experience of trauma rarely occurs in dreams. This paper presents an instance of miscarriage of the defensive process in a dream which allowed re-experiencing of the traumatic state as manifested by a flashing light during sleep. Some of the reasons for this failure, with special reference to alterations in the process of denial during sleep, are discussed.

REFERENCES

1. ABRAHAM, KARL: Transformations of Scoptophilia. In: *Selected Papers on Psychoanalysis.* New York: Basic Books, Inc., 1953.
2. FRENCH, THOMAS: *Reality Testing in Dreams.* This QUARTERLY, VI, 1937, pp. 62-77.
3. FREUD: *Splitting of the Ego in the Defensive Process* (1938). Coll. Papers, V.
4. GREENACRE, PHYLLIS: *Vision, Headache and the Halo. Reactions to Stress in the Course of Superego Formation.* This QUARTERLY, XVI, 1947, pp. 177-194.
5. KRIS, ERNST: Quoted in Ref. 4.
6. SCHILDER, PAUL: *Mind: Perception and Thought in Their Constructive Aspects.* New York: Columbia University Press, 1942.
7. STERN, MAX: *Blank Hallucinations: Remarks about Trauma and Perceptual Disturbance.* Int. J. Psa., XLII, 1961, pp. 205-215.

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

Essays on Ego Psychology. Selected Problems in Psychoanalytic Theory. By Heinz Hartmann, M.D. New York: International Universities Press, Inc., 1964. 492 pp.

Maxwell Gitelson

To cite this article: Maxwell Gitelson (1965) Essays on Ego Psychology. Selected Problems in Psychoanalytic Theory. By Heinz Hartmann, M.D. New York: International Universities Press, Inc., 1964. 492 pp., The Psychoanalytic Quarterly, 34:2, 268-305, DOI: 10.1080/21674086.1965.11926350

To link to this article: https://doi.org/10.1080/21674086.1965.11926350

BOOK REVIEWS

ESSAYS ON EGO PSYCHOLOGY. SELECTED PROBLEMS IN PSYCHOANALYTIC THEORY. By Heinz Hartmann, M.D. New York: International Universities Press, Inc., 1964. 492 pp.

It is one of the impossible tasks: to review a book which, in fact, has been written over the course of a major career. The impact and influence of the papers assembled in this volume have kept them under continuous review as each has appeared. Beginning with his first great generalization,[1] Hartmann's individual papers and those produced in collaboration with Kris and Loewenstein have compelled attention and study, have evoked criticism, and have stimulated inquiry and research. In the view of many this work has effected a major extension of the horizons of psychoanalysis toward which they have themselves been impelled to move. Others have been stimulated to re-examine hard-won positions based on the classical discoveries of Freud. Not all have been convinced, despite the fact that the concepts which Hartmann has developed are rooted in these discoveries and are extensions of Freud's structural theory.

Hartmann was well aware of the difficulties he was facing in attempting to establish grounds for a general psychology of human behavior. In the concluding paragraph of his introductory monograph, Ego Psychology and the Problem of Adaptation, he said:

> Many of these lengthy—but still incomplete—considerations are not psychoanalytic in a narrow sense, and some of them seem to have taken us quite far from the core of psychoanalysis. Much of our discussion has been in the nature of a program which must be filled in and made concrete by detailed empirical investigations. I will agree with you if you should find that I have been one-sided, stressing certain relationships and neglecting others of equal or greater importance—particularly those which usually concern us the most: that was my intention. I will be pleased if you should agree with me that the problem of autonomous ego development, of the structure and rank order of ego functions, of organization, of central regulation, of self-suspension of function, etc., and their relations to the concepts of adaptation and mental health have a just claim on our attention.

[1] Hartmann, Heinz: *Ego Psychology and the Problem of Adaptation.* New York: International Universities Press, Inc., 1958. (Originally presented before the Vienna Psychoanalytic Society in 1937, and published in German in the *Int. Ztschr. f. Psa. und Imago* in 1939.)

It is well to be reminded thus that ego psychology is not one of the prevalent simplistic attempts to 'unify' the behavioral sciences but rather a profound and far-reaching, though sometimes obscure, effort[2] to trace the eddies, excursions, and confluences of the processing stream which is the human mind. Hartmann's work during the twenty-five years in which these papers have been written has been devoted to an elaboration of his original 'considerations' and to filling in the 'program' that he considered his monograph to be. From this point of view the monograph is itself a '(p)review' of the contents of Part I of Essays on Ego Psychology. Indeed those who read it for the first time in English translation in 1958, and who were by then already familiar with the papers that had followed its original presentation, were really presented with a substantive outline of those papers. Thus ten of the first sixteen 'essays' are 'post-cited' in the monograph and are seen to be further developments of its ideas; while two of them which do not receive such explicit notice (Contribution to the Metapsychology of Schizophrenia, and Problems of Infantile Neurosis) are, nevertheless, cogent extrapolations. The other four essays in Part I may be looked upon as postscripts to Hartmann's statements on ego psychological theory. They do not contribute to the theory as such but rather are commentaries on contingent problems.

In Technical Implications of Ego Psychology one may find an answer to the not infrequent question as to what, if anything, this aspect of metapsychology has contributed to psychoanalytic technique. Hartmann is unequivocal in his view that interpretation still rests more on factors related to dynamic and economic considerations than on those of psychic structure (and identification), and that in this respect technique lags behind theory. Still, he believes that important clinical contributions from ego theory are to be found in the prognostic aspects of diagnosis. And with respect to this he refers to the importance of the newer understanding of the 'etiology' of mental health, and of the relation of ego functions to ego strength in modifying the 'absolute' view of the opposition between defense and instinct. This understanding has brought changes

[2] Regarding the speculative character of ego psychology Freud stated that *'the character of the material itself is responsible, and the fact that we are not accustomed to dealing with it'* (italics added). *New Introductory Lectures on Psychoanalysis.* New York: W. W. Norton & Co., 1933.

in the way we deal with the clinically observable interaction of neurotic and normal functioning, and it has also stimulated better comprehension and handling of the reality aspects of patient behavior. In this connection ego theory has contributed to understanding of functional splitting of the ego, of segregation of resistances within the ego, and of that change of function of defense and drive which leads to their secondary autonomy and adaptive application. Thus ego theory has produced sharper insight into defense, and contributed to the management of resistance.

In The Development of the Ego Concept in Freud's Work, Hartmann presents a historical analysis of the antecedents of his own studies. In effect this paper fills one of the gaps in the first presentation of his ego psychology, for he had considered that presentation 'incomplete' partly because it lacked a demonstration that ego psychological theory is intrinsic to and inseparable from the general theory of psychoanalysis. From this point of view the essay does not seem to examine closely enough Freud's dynamic and economic views of infantile development in their relation to the development of structure. Nevertheless, in tracing out the path followed by Freud toward a specific consideration of the psychology of the ego, Hartmann does respond to the existence of the need for a detailed systematization of the *whole* of psychoanalytic theory.

The last two chapters of Part I are concerned with psychoanalysis as science. One was presented before a psychoanalytic audience,[3] the other at an assembly consisting largely of philosophers.[4] They therefore differ in emphasis but their content is largely overlapping. Both stress that psychoanalysis is a general science of man which historically happens to have originated from Freud's clinical interest in psychopathology. As if responsive to the view that ego theory may be teleological, Hartmann dwells considerably on the problem of data and theory in psychoanalysis. 'Good theory cannot be written without broad clinical experience', he says; and 'nobody would consider science a mere summary of facts'. Neither can science be a collection of concepts, no matter how great their ad hoc usefulness, if these do not also enter into a broad theory. It is the elaboration of such considerations as these that makes these lectures

[3] Brill Lecture, March 25, 1958.

[4] Second Annual New York University Institute of Philosophy, March 1958.

relevant in a collection of essays on ego psychology. For the attempt at a holistic synthesis is what is characteristic of Hartmann's work.

Part II consists of four papers which retrospectively can be seen to be premonitory of Hartmann's later interest in ego psychology. The first of these, written in 1924 with Stefan Betlheim, is the well-known Parapraxes in the Korsakoff Psychosis that previously appeared in English translation in David Rapaport's Organization and Pathology of Thought (Columbia University Press, 1951). In this study of cases of putatively organic amnesias in which crudely sexual material was shown to emerge in symbolic disguise, Hartmann and his collaborator conclude, among other things, that in such cases a mechanism analogous to repression is operating, that original impressions are retained, and, in certain situations, 'even the registration of memories (of some contents) may take place in symbolic form'. The careful clinical investigation which led to these conclusions is already demonstrative of Hartmann's pervasive interest in the functioning of the ego.

The remaining papers appear in English translation for the first time. Understanding and Explanation[5] is a critique of the school of *'verstehende psychologie'* of Dilthy, Jaspers, Spranger, et al. from the point of view of psychoanalytic findings and theory. The paper was responsive to the fact that at the time, because of a misunderstanding of the psychoanalytic literature, a tendency was appearing to regard psychoanalysis as a branch of this school. It is reproduced here because ideas similar to those of the *'verstehende'* school are reappearing in the American literature. The misunderstanding stemmed from the fact that Freud did not 'always clearly differentiate between "meaningful" and "causally determined" ' because the 'psychical determinants which Freud always encountered in his analyses of parapraxes, dreams, and neuroses may also turn out to be "meaningful" '. The emphasis of the paper is on the position that 'the goal of psychoanalysis is not the understanding of the mental, but rather the explanation of its causal relationships'. Then, as now, Hartmann was concerned with the position of psychoanalysis as an inductive science which must obtain and verify its propositions empirically. Then, as now, he was struggling with the teleological

[5] *Verstehen und Erklären.* In: *Die Grundlagen der Psychoanalyse.* Leipzig: George Thieme, 1927, pp. 36-61.

problem: ' "teleological" interpretation, which is also used in psychoanalysis . . . does not contradict a causal explanation. . . . A teleological framework can generally in biology be a valuable methodological principle—the indication of the totality of relationships, of purposiveness, facilitating the first causal connection between parts and whole.'

An Experimental Contribution to the Psychology of Obsessive-Compulsive Neurosis,[6] written in 1933, reports a repetition of Zeigarnik's investigation[7] of the effect of current needlike tensions on certain forms of recall. The original investigator found that 'on the average, uncompleted tasks were recalled about ninety per cent better than the completed ones' and concluded that a 'quasi need is produced which by itself strives for the completion of the task'. Dynamically this corresponds to the creation of a tension which aims at relaxation. Completion means discharge. An interrupted task thus survives as a tension residue since the quasi need is not satisfied and the 'recall' in such instances is an indicator of needlike tensions. The Hartmann experiment was directed toward testing the idea that, since the thinking of obsessive-compulsive neurotics is characterized by incompleteness or inability for closure, ' "tension systems" might in their case act differently from the way in which they act in normals' and, if this be so, light might be thrown on the tendency toward repetition. Hartmann's crucial finding was that 'obsessive-compulsive neurotics recall uncompleted activities hardly better than completed ones'. And he concludes that in the obsessive-compulsive the apparent 'completedness' of an action remains subjectively relative (i.e., relatively incomplete), and that the 'need to repeat' arises from the fact that the Lewin-Zeigarnik 'quasi need' depends on the existence of (unconscious) 'true needs'. Finally Hartmann decides that 'Lewin's dynamics is in need of—and is capable of—being completed by a more comprehensive theory of drives . . . [that is] psychoanalytic dynamics of drives and affects'. Again we see the precursor of the general views which Hartmann was to develop later about psychoanalysis as a general psychological theory.

The last of this group of papers, Psychiatric Study of Twins, is a

[6] *Ein experimenteller Beitrag zur Psychologie der Zwangneurose.* Jahrb. f. Psychiatrie und Neurologie, L, 1934, pp. 243-278.

[7] *Über das Behalten erlidigter und unterlidigter Handlungen.* Psychologie Forssch., IX, 1927.

translation of parts of a study dealing with identical twins.[8] This excerpt presents mostly the theoretical discussion, and is chiefly concerned with the question of the role of genetics and ontogeny in character formation as discernible in the anamnestic study of ten pairs of monozygotic twins. Hartmann calls special attention to a group of traits which psychoanalytic characterology has defined most clearly—those of the anal character: orderliness, cleanliness, stubbornness, handling of money, ambition, and vanity. He found differences in orderliness, stubbornness, and stinginess especially pronounced and most frequently demonstrable, and he concluded that 'we evidently have here a cluster of traits subject to a large degree of paravariability'. These traits 'are to a large extent independent of one another'; this fact is important because 'characterologies (for example, *verstehende psychologie*) which classify personality traits according to their understandable relationships can never do justice to such a far-reaching independence of forms of behavior which appear to be similar'. This points to the probability that character *Anlage* reside 'in primitive biological factors of the vital psychic layers [while their] differentiation into character *traits* of the phenotype would be caused paratypically'. The paper has relevance to the concern of ego psychology with the problems of nature versus nurture. It could have been omitted from this collection without detracting from it.

The guiding motive of Hartmann's work has been, explicitly and implicitly, the need for a systematization of the whole of psychoanalytic theory. Inevitably this is inclusive of ego theory. It follows that this volume of essays and the pending publication of Hartmann's collaborative works with Kris and Loewenstein[9] must be looked upon as collections of primary sources. Meanwhile Hartmann is confirmed in his hope that ego psychology has a 'just claim' on the attention of psychoanalysts. The modesty of his early concern for this may now give way to assurance of his great achievement.

†MAXWELL GITELSON (CHICAGO)

[8] *Psychiatrische Zwillingsstudien*. Jahrb. f. Psychiatrie und Neurologie, L and LI, 1934 and 1935.

[9] *Papers on Psychoanalytic Psychology*. Psychological Issues, Monograph 14. New York: International Universities Press, Inc., 1964.

THE FREUD JOURNAL OF LOU ANDREAS-SALOMÉ. Translated and with an Introduction by Stanley A. Leavy. New York: Basic Books, Inc., 1964. 211pp.

It is difficult to introduce Lou Andreas-Salomé to the psychoanalytic reader in America: the problem of her position has to be stated before an attempt can be made to understand her and her role in psychoanalysis. It is fortunate that her two latest friends, H. F. Peters and Stanley Leavy, give an outstanding, scholarly, careful, and loving, even though sketchy, portrayal of her.

Lou Andreas-Salomé was a famous novelist, poet, essayist, and friend and interviewer of many great men at the turn of the century. She was respected, admired, and befriended by Freud, who considered her 'superior to us all'. She was fifty years of age when she came to Vienna and to Freud, who warned her not to see in him and psychoanalysis 'a Santa Claus loaded with presents to give'. She was an incorrigible romanticist in the best German tradition. It was said of her that she thought with her heart and felt with her brain. She took it upon herself to rescue lonely men from their loneliness—often with disastrous result. After her therapeutic and human encounter with Freud she settled down to a quiet life and became a practicing psychoanalyst in Göttengen, where she died two years before Freud (1937).

The Journal of her study of psychoanalysis in Vienna does not solve the problem of who this woman was and why she was admired by so many men. Actually her life and thought were opposite to Freud's, who lived like a Victorian and interpreted dreams in the language of rational life. Andreas-Salomé lived like an emancipated woman of the Twentieth Century and interpreted life in the language of dreams. Perhaps her charm to Freud and to almost all analysts of these early years (1912-1913) was her capacity for unlimited listening and asking understanding questions—almost as an analyst does. Freud addressed his lectures to her or to her empty chair when she could not be present. At the Wednesday evening seminars at Freud's house she never spoke. This Journal contains one speech she planned to give when she took her final leave, but which she never delivered. It ended with the words: 'Men fight, women give thanks'.

Stanley A. Leavy's introduction to his translation of the first

Journal is a masterpiece of analytic and human understanding of his subject, her time, and her work. His translation can be fully valued only by one who has struggled with the style of Andreas-Salomé's German. Thanks to the translator the English edition of this Journal is easier to read than the German original. Her way of writing, often so emotional, at times even girlish, is less annoying in English since it is underplayed. She was fully aware of Freud's unequivocal honesty in his writing but remained uninfluenced by it.

The Journal is an eyewitness account of early times in psychoanalytic development. It is a most striking addition to Otto Rank's Minutes of the Vienna Psychoanalytic Society (edited by Herman Nunberg and Ernst Federn. New York: International Universities Press Inc., 1962). All pioneers of psychoanalysis go through the pages of this Journal: Otto Rank, about whom Freud speaks with great love and affection; Sandor Ferenczi, who discussed his thoughts with Andreas-Salomé; Karl Abraham, who visited from Berlin; Wilhelm Stekel; and Alfred Adler, who walked for hours with her and discussed his differences with Freud. There are some anecdotes of significance and meaning which will make the Journal dear to the psychoanalyst; for instance, the story of the narcissistic cat that introduced Freud to the joys and sorrows of an animal lover, or the story of Freud's reaction to Andreas-Salomé's The Hymn to Life. There are descriptions or hints about the long walks through the deserted streets of Vienna at night, the weekly meetings with a group of friends in Freud's apartment and continued in coffee-houses. There are discussions and attempts to understand terms, theories, applications of psychoanalysis. They may not enrich our knowledge of psychoanalysis much but they portray the early days and the creative atmosphere in Vienna. There is a revealing statement concerning Freud's antagonism toward philosophy (p. 104). Andreas-Salomé says that it was essential for Freud to struggle against the need to think as a philosopher for ultimate unity, recognizing this need as a product of the anthropormorphic roots of philosophy.

The modern reader may develop a vague feeling of frustration when reading this Journal. He may hope for more insight than could be given. Here was an experienced writer and journalist who had interviewed almost every great and important man in Europe around the turn of the century and who had a unique chance to observe Freud and his friends in Vienna and who failed to do so, or

was apologetic and restrained about it. She did not study Freud but psychoanalysis. This was her intention and she stuck to it with determination, as expected from a good student. Her other journals, notes, and Freud's letters, yet unpublished, will tell the next chapter in the story of Lou Andreas-Salomé.

MARTIN GROTJAHN (BEVERLY HILLS)

AGORAPHOBIA IN THE LIGHT OF EGO PSYCHOLOGY. By Edoardo Weiss, M.D. New York: Grune & Stratton, Inc., 1964. 132 pp.

Following Federn, Weiss defines the ego as the core of the personality rather than as a substructure of the mind. In the present work, which is chiefly devoted to clinical studies, he shows how this concept of the ego offers a clue to human problems not otherwise intelligible. Dr. Weiss first described agoraphobia in a case observed in 1912, and has published fragmentary cases since then, but now for the first time he presents cases at considerable length, and this is his first published series of analyzed cases of this type.

The author summarizes his long-sought understanding of agoraphobia with these words: 'I now recognize that it is based on specific threats to the patient's ego unity'. The ego psychology of Weiss and Federn differs from the usual concepts in that the ego is conceived not as merely the sum of all its functions but as the cathexis which unites the aggregate into a new mental entity. Parallel to this metapsychological definition of the ego is the phenomenological one, that the ego is a phenomenon of experience (*Erlebnis*) that is sensed consciously and preconsciously as the ego feeling. Conscious ego feeling is sensed through a sharply focused awareness, whereas preconscious ego feeling is sensed as a feeling of confidence in the ability to perceive, to remember, or to repeat a familiar action. What is crucial, then, is proper sensing of reality by means of adequately cathected ego boundaries. Reality testing, the usual term for this function, is a misnomer according to Weiss: it appears in early childhood when motor experiences differentiate between self and nonself, and throughout life in complex processes of learning. When the cathexis of the ego at its various points of contact (ego boundaries) with its own components as well as with the unconscious and with the external world is adequate for its functioning, both the function-

ing of the ego and the ego feelings are normal. However when the integrative capacity of the ego is threatened, the cathexis at the ego boundaries is altered or the feeling of confidence and familiarity in various ego functions and ego feelings is impaired. There ensues what Weiss calls a unique and characteristic feeling of ill-being to which the patient reacts with anxiety. This is central to agoraphobia.

What is this feeling of ill-being and whence does it arise? Weiss found that every agoraphobic patient has a strong but blocked sexual urge which is included in a dissociated and repressed portion of his ego, a portion that usually belongs to a stage of childhood ego development or may have developed from some later identification. This portion, strongly activated in the unconscious by the inherent blocked sexual tension, cannot be integrated within the consciously functioning ego nor can it alternate with the functioning ego as in cases of dissociated or double personalities. The patient's effort to protect his ego against intrusion of the dissociated portion of the ego weakens his ego feeling and integrative capacity. Weiss calls such an impoverishment 'dynamic mutilation of the ego' resulting from excessive expenditure of ego cathexis. A dynamically mutilated ego is afraid to pass from one normal ego state to another, and when leaving a place of support it feels as though it is losing its identity; while parts of the patient's body, often his legs, lose their normal ego feeling, the patient feels insecure when walking on the street and may lose the sensation of the ground under his feet.

Weiss contrasts these impairments of the economy of the ego with the usual psychoanalytic explanations, which consider almost exclusively situations that arouse in the agoraphobic patient strong repressed impulses. But patients with strong exhibitionistic tendencies (women, for example with prostitution fantasies) are also caught by that feeling of ill-being in isolated places that offer no sexual temptations. The patient's attachment to mother and dependency on her, and his consequent separation anxiety are usually considered basic. However, regression to a dependent attachment to a mother figure—symbolically to one's own home—does not explain the ego disturbances productive of so much anxiety. Weiss emphasizes that such a regression in agoraphobia is the result, not the cause, of ego disturbance that increases the ego's need for security measures. None of the many interpretations of agoraphobia except

that of Weiss explains the frequent disturbances of the patient's sense of self.

This book contains a number of astute observations and practical ideas I have not encountered elsewhere. Weiss notes, for example, the importance of considering the postclimactic libidinal efflux (or its absence) in a total appraisal of the sexual life; also, the fact that the process of repression does not necessarily cancel the ego's excited expectation which is sensed as 'the feeling of emotional incompleteness'. Elsewhere he writes: 'In studying paranoiac patients I have noticed that they sensed their "false reality" with a different perceptive tone than the "true reality", even though they feel certain about hallucinatory and delusional contents. Many years ago I suggested to an intelligent schizophrenic patient that he call "reality A" the voices and sounds which I also could hear, and to call "reality B" those voices and sounds to which he responded but which I could not hear. Whenever I asked him then whether a voice or a sound which he heard pertained to reality A or B, he could always immediately distinguish one reality from the other. I subsequently found that all intelligent psychotics could immediately distinguish one perceptive tone from the other.' This of course offers important implications for therapy.

The book's appendix is a condensed summary of Federn's ego psychology, including chapters on The Ego Experience, Reality Testing, The Phenomenon of Egotization, Ego Boundaries and the Sense of Reality, Identity and Identification, and Protective Mechanisms Serving Ego Integration.

My critique will concern itself with some aspects of the ego and with phobic anxiety. Inevitably the wish arises to compare Federn's ego-psychological approach with the more usual analytic view of the ego. However, strictly speaking, they are not comparable. Niels Bohr stated that when a complex of phenomena is observed by means of two different sets of instruments, one gets two sets of findings, each finding having a relation to the others in the same set but not to those in the other set. He called this the law of complementarity. As our definitions determine our tools, they invoke this law of mutual exclusiveness. Thus we cannot compare ego manifestations defined mainly in terms of ego feelings with the same manifestations defined 'by no means only in terms of ego feelings'. Bohr's principle explains Waelder's comment on Federn's ego psychology: 'It is

legitimate to define it as the seat of sensations about oneself and the outside world. But one cannot do both at the same time without further investigation, i.e., one cannot take it for granted that integrative activities and sensations are always so closely associated that they must be attributed to the same agency. The ego of Federn which experiences the boundary between the self and the outside world, or between different parts of the self, need not be the same as the ego of Freud which signals danger and represses dangerous impulses.' On the basis of Weiss' findings, it may be said that although his view of the ego is, as Waelder states, that of a sensate organization, the meaning of the vicissitudes in the sensations derives from the economic variations within the cathexis of the ego. We do not yet know enough about the differentiations and other complexities of these cathexes, as Weiss himself noted. But one fact has been established by Freud—and perhaps more completely used by Federn and Weiss than by anyone else—: that the fundamental cathexes of the drives and of the ego are identical. Thus changes in each instantly affect the other economically and through resonance. We must also take into account the great mutability of the cathexis at the boundaries in contrast to its constancy at the ego core. There are differentiations both gross and subtle in the ego functioning; sensing danger and signaling danger illustrate this. But to speak literally of two egos is not to answer the question but only to open it. It seems to me that Federn's ego psychology neither displaces nor depreciates the ego functions; rather, by taking into account the economic vicissitudes of the ego cathexes it offers an additional and sensitive dimension for comprehending dynamic (intrasystemic) changes in the integrative capacity of the ego and their relation to dynamic (intersystemic) conflicts.

Nevertheless, the fact that Federn's ego psychology demonstrates its usefulness so dramatically in agoraphobia perhaps tells us something unique about each. The ego of the agoraphobic does appear to be somewhat special. Weiss tells us that these patients have more concern about the security of their countercathexes. They fear the loss of their identity or of being invaded by a dissociated portion of their egos more than do other neurotic patients. Their resistances take longer to resolve. After the lifting of their repressions their egos often need educational parameters to help them cope with the synthesis of the repressed drives and ego stages. While dynamic impair-

ment of the ego is part of every neurosis, it is in some patients recognized only by implication through lessened integrative capacity, preoccupations with one's own existence, and other similar signs; but all these to a relatively lesser degree than seen in agoraphobia. We deal here probably with a quantitative factor and certainly also with the factor of greater awareness on the part of the therapist. But awareness of these and other intrasystemic phenomena of the agoraphobic can sensitize one, as it has the author (also the reviewer), to the same phenomena in all syndromes where they are present to a lesser or greater degree. Indeed, Federn's findings about the ego are by no means confined to schizophrenic and other narcissistic conditions, as is sometimes stated.

A final word about the large and still moot question of anxiety, especially the relation between phobic and signal anxiety. Freud established the concept of signal anxiety—the inoculation by a small dose of anxiety as a means of warding off complete traumatic anxiety—in two cases of phobic anxiety, Little Hans and the Wolfman. Thus there is no doubt that for him phobic anxiety was purposive; it was defensive. Perhaps from this concept is derived the current tendency to comprehend all anxiety and all other pathological constructions as purposive. The tendency seems excessive. True, ego impairment is implied in the definition of a symptom and is recognizable in such expressions as unusual self-consciousness or ruminations about existence, but are there not realistic expressions of ego breakdown? Federn wrote: 'Anxiety primarily does not have a function; it is evidence of damage and of a functional defect', and 'In signal anxiety only the ego boundary is cathected; in real anxiety, the whole ego. Full anxiety is hallucinated terror, a signal is an approach to danger, and signal anxiety is hallucinated danger. . . . The anxiety signal (not the complete anxiety) is a later phobic mechanism but does not belong to "actual" anxiety and not to symptom formation.' I do not know quite how Weiss stands in this matter. At one point in the book he mentions that agoraphobic anxiety may also serve as an anxiety signal, it may secondarily become purposive or adaptive. But in several of the descriptions of cases I note a quality of complete anxiety—massive and disorganizing. The impression is less of a signal and more of an 'actual' type of reaction; or does Weiss make a distinction between the feeling of ill-being and the reaction of anxiety? Perhaps there is a continuum. At any rate,

it seems to be quite a problem to discern at what point evidence of damage and of disorganization is experienced as such and simultaneously used as an adaptation.

Another question. According to Federn, 'anxiety is hindered flight, hindered by masochistic ties, resulting in a feeling of terror—it is a feeling of nearness to death'. This leads to questions, not raised by Weiss, about the role of defused aggression and deneutralization in agoraphobia. These questions are especially relevant in a view of the ego that places the central importance on cathexis and its transformations. Though he may have some of the clues and answers, I believe that Weiss places these in the borderland of our knowledge for eager spirits to pursue. In this pursuit, I feel certain they will be stimulated by Weiss's seminal contributions in ego psychology and agoraphobia.

I. PETER GLAUBER (WHITE PLAINS, N.Y.)

ELEMENTS OF PSYCHOANALYSIS. By W. R. Bion. New York: Basic Books, Inc., 1963. 110 pp.

In this monograph, published originally for the Melanie Klein Trust, the author depicts psychoanalytic phenomena from a novel point of view: as elements that fit into a grid. This is, to the reviewer, a kind of psychological Mendeléyevian table of elements in which the ordinate or vertical axis is represented by categories of thought or emotion arranged in the order of shift from primary to secondary process (the primitive to the most abstract thought) and the abscissa or horizontal axis by a set of functions or uses to which the thought or emotion is put. This reviewer finds himself unable to assess the value of this approach, since it depends not only on prior knowledge and definition of Kleinian concepts but also on familiarity with previous works by Bion. For example, he writes: 'I have already discussed the signs L, H, and K in *Learning from Experience*. . . . The realizations from which they have been abstracted are usually represented by the terms "love", "hate", and "know". Using the notation R derived from the word "reason" . . . and *I* derived from the word "idea" and all realizations it represents including those represented by "thought", *I* is to represent psychoanalytical objects composed of α-elements, the products of

α-functions. I have described what I mean by this term elsewhere . . .' (pp. 3-4). Most important, the key to the understanding of the grid elements is said to depend on certain Kleinian concepts, not discussed but symbolized as follows: 'On the PS $\leftrightarrow$ Dep operation depends the delineation of the whole subject: on the successful operation of ♀ ♂ depends the meaning of the whole object' (p. 90).

This is a serious attempt to describe psychoanalytic phenomena in a manner the author finds clinically useful. 'The signs chosen to represent the elements are to aid in working on and thinking about the experience of the analysis' (p. 68). 'The object of such extra-sessional work is to substitute creative thinking for laborious and frequently meaningless note-taking; it provides practice, analogous to the musician's scales and exercises, to sharpen and develop intuition. It becomes increasingly possible to arrive at conclusions instantaneously which at first are the fruits of laborious intellectualization' (p. 73).

It is most likely that the average student of psychoanalysis in this country will have difficulty in reading this monograph. Besides the difficulties mentioned, this reviewer finds the idiosyncratic mixture of English capital letter symbols (not always meaning the same thing, for example, H may stand for 'algebraic calculus' or 'hate'), Greek letter symbols, and biological symbols more confusing than illuminating. The analogies the author makes to mathematical and chemical concepts are stimulating and challenging, but their appropriateness is questionable and they demand a clearer and fuller exposition than can be found in this volume.

DANIEL SILVERMAN (PHILADELPHIA)

DREAM INTERPRETATION. A New Approach. By Thomas M. French and Erika Fromm. New York: Basic Books, Inc., 1964. 224 pp.

In the second volume of The Integration of Behavior French outlined his theory of the dream. He depicted the dream work as consisting primarily in a struggle to solve a current problem of life and operating in the intuitive practical manner that we use when sizing up a real life situation. French stated that every dream has many meanings which can be fitted into a close-knit logical structure, the cognitive structure of the dream which also fits into the structure of the dreamer's waking thoughts and behavior. In the present volume,

written more for the general reader than his earlier work, French collaborated with Erika Fromm in an extension of these concepts.

The first section, Even the Thought Processes in Dreams Make Sense, considers the imaginative and critical use of empathic understanding in dream interpretation. The authors state that in reconstruction of the cognitive structure of the dream, the current focal conflict is revealed as well as many subfocal conflicts reaching back to infancy. Study of the manifest dream and of the dream's cognitive structure may also throw light upon the character and intensity of defensive operations.

French and Fromm consider that Freud failed to recognize the importance of problem solving in dreams, that his description of the primary process did not do justice to the thought processes involved in dreaming, and that use of the traditional method tends to direct the analyst's attention prematurely to the past and to bypass the current conflict. 'It is impossible to conceive', they write, 'how thought processes based only on free and massive displacement of energy along any available pathway could give rise to the sensitive, intuitive understanding that gifted artists possess'. Freud was satisfied, in French and Fromm's view, with finding the infantile wish and did not deal adequately with the dreamer's motive that is reactive to the wish. In their own method of dream interpretation they first aim to discover the dreamer's problem, that is, how to reconcile a disturbing wish with the reactive motive to which it has given rise. They next inquire how this problem is related to other parts of the dream and its associations and can then reconstruct the cognitive structure of the dream.

In the study of the dreamer's thinking, the functional units are problems—not wishes or fantasies. Wishes are the dynamic stimuli that activate problems and wish-fulfilling fantasies are attempts to solve problems.

The second section, An Operational Approach to Interpretation and Theory, is concerned with the use of two kinds of language in the authors' interpretive procedure. In the phase of empathic understanding, the analyst requires an intuitive grasp of the evocative language of the unconscious; in the phase of conceptual analysis, he translates what has been grasped empathically into the language of scientific analysis, enabling him to test against evidence what has been grasped intuitively.

The third section on The Psychology of Dreaming extends the authors' views of the dream work and its relation to the thought processes underlying rational behavior in waking life. Comparing their theory with that of Freud, they criticize the concept of the primary process as a distortion in that it assumes that primary process thinking is an early stage of rational secondary process thinking. They contend that nonverbal thinking undergoes an autonomous development suited to the practical understanding of problems and people and relate this development to Piaget's observations on symbolic play in the child, on the growth of the child's mechanical sense, and on the origins of the child's empathic understanding. They describe the child's intuitions of the mother's emotional reactions as the basis of nonverbal understanding which is later supplemented by the development of empathic understanding of another person's feelings and behavior by identifying with him. Empathic understanding involves an act of imaginative identification followed by introspection and projection. There is a close structural similarity between empathic understanding of another person and introspective insight. In empathic understanding there is a token identification only, permitting the observing part of the ego to sense the quality of the other person's feelings.

French and Fromm state that the process of listening to the chain of associations does not make sense out of the dream. This is because the chains of association are the disintegration products behind which the significant empathic thought processes are hidden. In the dream work, the verbally expressed latent dream thoughts have undergone disintegration. The result is what seems to be a free displacement of energy without regard for reality or syntactical logic. Displacement of energy from one psychic element to another is deliberately playful yet may be a step toward solution of a problem or an attempt to make play of it and abandon commitment to it—like the manic flight of ideas.

In waking life the person will not let himself be committed to a problem that is too disturbing but turns back in 'a prophylactic defense' to one that is soluble in the real world. In sleep, he does not have this recourse but may replace disturbing problems with wish-fulfilling illusions. As the depth of sleep diminishes, however, the pressures of the emerging conflict force the dreamer to awaken and realize he has only been dreaming. The dreamer may then find him-

self prematurely committed to a disturbing problem. He may endeavor, in the dream work, to turn to some less disturbing problem, may ridicule his conflicts by playing with the fragments of his previous thinking, or may awaken with anxiety.

In an attempt to break down the primary process concept into more precisely defined categories, the authors distinguish between inadequate forms of empathic thinking and the disintegration products of verbal thinking. Inadequate forms of empathic thinking include those that have succeeded in postponing commitment to disturbing problems as in empathic fantasy, simple wish-fulfilling dreams, or substitution of a less disturbing problem.

The dreamer's attempts to find a solution to his focal conflict are based upon a hierarchy of attempts in his past to find solutions to those nuclear conflicts from which his current conflict derives. Analysis of the historical background of a dream makes it possible to reconstruct significant problems from the dreamer's early life and mechanisms employed in the dream may be related to their development in the early history of the ego.

In their consideration of preconscious processes and ego functioning in dreams the authors have made a useful contribution. They offer an imaginative and meaningful discussion of problem solving in which the ego functions integratively and defensively in a manner related to its attempts to find solutions to past conflicts. Again, their comparisons of the dream work with Piaget's observations on symbolic play and learning processes in the child are in line with the broadening interest of psychoanalysts in Piaget and offer possibilities for further study.

In their approach to the manifest dream, the authors' method is somewhat similar to that described by Erikson in his Dream Specimen of Psychoanalysis but they have not shown, as Erikson did, the pervasive influence of the infantile wish. They tend, in fact, to devalue infantile material and the primary process, a tendency which has impoverished their illustrative clinical data. A fuller pursuit of the chains of associations to their infantile origins might well have strengthened their intuitive interpretations.

Little attention is given to the problem of regression and although they present an interesting description of playfulness as a defense and compare it with the manic flight of ideas, the authors do not refer to Lewin's psychoanalytic studies of mania.

The reviewer feels that French and Fromm in their ambition for a 'new approach' have missed an opportunity to correlate their work with the main body of psychoanalytic thought. It would have been consistent with their interest in cognitive structure to have related their contribution either to the structural or the topographical theory. It is well known, however, that this omission is by no means characteristic of Dr. French's clinical teaching which reveals a broader, more inclusive approach. Publication of some of these seminars would be a welcome supplement to this volume.

DOUBLAS NOBLE (WASHINGTON, D. C.)

SCIENCE AND PSYCHOANALYSIS. Vol. VI. Violence and War; with Clinical Studies. Edited by Jules H. Masserman, M.D. New York: Grune & Stratton, Inc., 1963. 284 pp.

This volume is sixth in a series issued by the Publications Committee of the Academy of Psychoanalysis, and consists of papers grouped under three sections. Part I, on Violence and Warfare, includes contributions from anthropologists and sociologists and is primarily concerned with the relationship between group behavior and social structure.

Part II, Clinical Research, begins with Masserman's A Dynamic Story of the Homoclite, a term suggested by Percival Bailey 'to apply to my group of healthy conformists'. Although he gives lip-service to genetic and structural frames of reference in an attempt to understand the so-called normal personality, the author barely passes beyond descriptive psychodynamic observations. It is evident that he is unable to get far because he does not apply the psychoanalytic method to his material. Another paper makes certain observations on parental reactions to their children's dreams. The paper on The Dissociation-Association Continuum is purportedly concerned with 'levels of awareness', and bases one of its conclusions upon a misunderstanding of Freud's concept of 'repression', resulting in the substitution of a theory that confuses rather than explains the phenomena. Electronic Computers in Psychoanalytic Research fails to demonstrate what more the computer can tell us than can be gained from the psychiatric interview, to say nothing of the psychoanalytic process. The advantages of 'systematization' are question-

able, not only as to whether additional knowledge of the patient is obtained by use of the computer, but whether its use is of therapeutic value. One may speculate that its use is intended to dispense with the therapist. This section certainly raises a doubt about the proper meaning of 'research'. The papers make many valid observations, but research is more than a descriptive accounting and recording of facts. In psychoanalytic investigation the term requires redefinition.

The papers in the third section are so eclectic in their orientation that a psychoanalyst, in commenting upon them, finds himself in a difficult position. He either must contend that they are not concerned with psychoanalytic matters, or he must argue about basic concepts. The papers range from discussions of techniques of therapy, anxiety, somatic symptoms, and dreams, to drug therapy—certainly a potpourri if not a plethora.

I would like to make a few general comments on a book such as this one. Is this Science *and* Psychoanalysis? If the two terms, 'science' and 'psychoanalysis', are joined together, the one must have something to do with the other. Does this series of volumes have as its purpose to delineate the place of psychoanalysis in science? Or, in its eclectic way, does the editor simply intend to collect papers from various overlapping disciplines under one cover? (In logic one does not couple the generic with the specific by a conjunction.) Psychoanalysis is a science. It is the science of the psychic structure and function of the human mind; therefore one should not speak of 'science *and* psychoanalysis', but rather the 'science *of* psychoanalysis'. This confusion is understandable when we realize that many of the contributors to this series may not be clear about the fundamental concepts of psychoanalysis.[1]

The contributions to this volume are committed, implicitly or explicitly, to what has come to be called a culturalist bias. Hartmann has discussed how individual conduct is affected by cultural factors, either by their influence on 'the central structure of the personality' (e.g., by provoking reaction-formation, or a severe superego reaction), or where their effect is remote from the 'nucleus of the personality'. In the latter, the superficial layers, rather than the

[1] A good book to read for clarification on this subject is Waelder, Robert: *Basic Theory of Psychoanalysis.* New York: International Universities Press, Inc., 1960.

psychic structure itself, are affected, as in choice of rationalization or mode of expression. For the influence of cultural factors on 'the frequency and type of neuroses', Hartmann introduces the term, 'social compliance' (analogous to Freud's concept of 'somatic compliance') to designate how social factors are operative 'in the direction of the selection and effectuation' of expression of emotional tendencies; i.e., how social factors may encourage or inhibit the expression of potentialities in the structure of the individual's personality, and how such factors may facilitate or aggravate the solution of conflicts. Hartmann reminds us that the structure of reality is never excluded from psychoanalytic considerations; that Freud's theory of anxiety relates internal to external danger; and that Anna Freud, identifying the defenses, describes them as functioning both against the external and internal world. Although psychoanalysis emphasizes the developmental and structural aspects in any conflictual situation, the role of economic and other social factors are regarded as 'partially independent variables'; moreover, psychoanalysis is interested in all the variables that are applicable.[2] We must add that emphasis of ego psychology on the development of object relationships establishes the basis for an understanding of the interdependence of individual and environment; furthermore, in analyzing the aims and objects of the drives, their vicissitudes and sublimations, reality is assessed according to its dynamic and genetic impact.

The preface to this volume by the editor is in answer to a communication by Dr. Maxwell Gitelson[3] in which Gitelson questions the authority of the Academy to appear as a spokesman for psychoanalysis. The proof lies in the evidence rather than in the exhortation to which Masserman resorts. Judging by the contributions of its members, not only are there distortions of psychoanalytic concepts, but attempts to redefine them, the one often confused with the other. If the last section of this volume were only an attempt at the latter, the term suggested by Dr. Gitelson, 'neo-analysis', should be accepted. Then the argument would be drawn around the specific question of whether the new concepts better explain psychic

[2] Hartmann, Heinz: *Essays on Ego Psychology. Selected Problems in Psychoanalytic Theory*. New York: International Universities Press, Inc., 1964.

[3] Gitelson, Maxwell: *The Curative Factors in Psychoanalysis. I. The First Phase of Psychoanalysis*. Int. J. Psa., XLIII, 1962, pp. 195-205.

phenomena. As it stands, Masserman seems to want his cake and to eat it at the same time. But such is the inevitable course of eclecticism. The basic concepts of psychoanalysis have been clarified, and well-delineated as to their specific application in the theory of neuroses, and in their general application to the historical and behavioral sciences. Scholarly and authoritative studies are continually being done in these areas by analysts who are neither confused, nor feel an urgency to overthrow the 'old order'. None of this has any relevance to the dogma of the Catholic Church nor to partisan politics, which are invoked by Masserman in his reply to Gitelson.

Masserman is so palpably tendentious that one is hard put to decide how to approach this volume critically: whether to dissect each paper for its distortions and misinterpretations, or to give a general impression, and alert the reader to areas of basic disagreement with psychoanalysis in both language and concept. There are any number of published contributions to these subjects that much better warrant the expenditure of a busy practitioner's time and efforts. There are current classics in the field of clinical and applied psychoanalysis that clarify rather than confuse, for instance, The Psychoanalytic Study of the Child.

Z. ALEXANDER AARONS (WALNUT CREEK, CALIF.)

AN EGO-PSYCHOLOGICAL APPROACH TO CHARACTER ASSESSMENT. By Ernst Prelinger and Carl N. Zimet, with the collaboration of Roy Schafer and Max Levin. New York: The Free Press of Glencoe, 1964. 211 pp.

The definition of character continues to be one of the most difficult and ultimately elusive propositions in psychoanalytic research. The authors of this volume have drawn together some of the major relevant contributions to their subject, from Freud through Erikson. One misses references to such major contemporaries as Lewin and Greenacre, not to mention Nunberg's classic paper on the synthetic function. The authors deserve credit for granting a fuller emphasis than is usually given to Wilhelm Reich's fundamental and lasting contributions to psychoanalytic characterology.

Although a significant number of sophisticated approaches to the study of character have been devised in recent years, the techniques

advocated often lack a unitary theoretical orientation and tend rather to have an *ad hoc* character. They are directed toward a specific purpose—for example, the selection of officers for the army or students for the ministry. These the authors designate 'assessment-*for*' rather than 'assessment-*of*' techniques, and they propose instead a more generalized method with a unitary, psychoanalytic orientation.

The authors adopt as a text Fenichel's concise statement: 'Character, as the habitual mode of bringing into harmony the tasks presented by internal demands and by the external world, is necessarily a function of the constant, organized, and integrating part of the personality, which is the ego'. The system which they present, and illustrate with two fully detailed protocols, consists of a formidable list of seventy-eight rating scales, each representing a dimension of character (adequacy of reality testing, cognitive reactivity, etc.). The dimensions are grouped into eight categories (ideational styles, prominent affects, adaptive strengths, etc.).

This all looks very thorough; however, one wonders what may be lost in subtlety and flexibility through the application of such a 'systematic' check list to the examination of character. The distinction between 'assessment-*for*' and 'assessment-*of*' is also questionable. If the purpose of such an examination is neither selective nor validative, what might it be? It is not diagnosis, for the authors specifically address themselves to the evaluation of 'nondisturbed' individuals and to processes of 'normal development' and 'normal functioning'. They claim to focus on 'understanding' rather than 'prediction', but they would have done well to say what they mean by 'understanding'. Without such a definition they are begging the question.

HENRY EDELHEIT (NEW YORK)

PASSIVITY. A STUDY OF ITS DEVELOPMENT AND EXPRESSION IN BOYS. By Sylvia Brody, Ph.D. New York: International Universities Press, Inc., 1964. 184 pp.

The problem of passivity is a chronic one in psychoanalytic theory and practice. As a concept it has been examined by a succession of thinkers from Freud to our day, each approaching it from a some-

what different point of view and each adding to our enlightenment, although not providing the definitive conceptual clarification we seek. In a previous book, Patterns of Mothering, Sylvia Brody, an eminent child analyst and investigator, cast sharp light on the variations of early interactions of mother and infant. She now explores the problem further in an extensive and detailed report of the analyses of two preadolescent boys whose hypnagogic experiences formed the basis of much of their analytic work.

Much of the difficulty in earlier considerations of the question of passivity has been a failure to define adequately the terms used. Dr. Brody avoids this pitfall. By surveying the literature in detail she succeeds in exposing our conceptual confusion, and by clearly differentiating among passive aims, passive experiences, and passive behavior, she removes a good deal of the chaos. For example, she emphasizes the fact that the infant who is cared for by his mother is not necessarily passive; he may, to the limit of his maturational capacities, be active in pursuit of his aims and he may be involved in aims which are in themselves active, such as to suck or move about. Dr. Brody sees passivity essentially as the persistence of, or regression to, oral aims in later developmental phases. In this she follows the lines of thought laid down by Lewin. She uses, to great advantage and with remarkable penetration, his conception of the oral triad, integrates the hypnagogic experiences reported by her patients with his observations on the dream screen, and shows how wishes to be cared for by mother, and to submit to her, underlie the clinical neurotic patterns in these children.

Particularly brilliant and incisive is Dr. Brody's chapter on the formation of the body image, in which she shows how vicissitudes in early mothering help to shape the infant's conception of his body and the distribution of self and object cathexes. It is unfortunate, however, that she adheres to Freud's early views on narcissism, ignoring the recent reformulations of the concept offered by Jacobson and by Hartmann and his associates. Indeed, it is rather remarkable that in a volume dealing with aspects of early personality development the name of Hartmann does not appear once, and no reference is made to his work in the extensive bibliography.

The tendency to focus on the vicissitudes of drives to the relative exclusion of the ego is a consistent and, I am sure, intentional characteristic of the book. Thus the author dismisses rather per-

functorily Rapaport's brilliant and searching, even though incomplete, effort to conceptualize activity and passivity in terms of the ego's mastery over drives. In the process, she deprives herself, this reviewer believes, of the ability to explain how and why some children pursue their passive instinctual aims by passive means, while others (such as the children described in this book) are vigorously and effectively active in doing so. Similarly, in her concluding chapter Dr. Brody offers a schematic outline of the maturational and developmental conditions that, in her view, foster the emergence of active rather than passive aims. This turns out to be a statement in environmental, behavioral, and metapsychological terms of the conditions that are optimal for healthy development in general, and the development of an effective adaptive ego in particular. Dr. Brody relates this material to considerations of drive, but it requires little effort on the part of the reader to supply the necessary extrapolations to ego constructs.

It is not until the very end of her text that Dr. Brody deals at any length with the question of constitutional predisposition toward the development of passive modes of function. This she does only to dismiss it, at least in so far as her interest or range of inquiry are concerned. Here again it seems to me she flies in the face of much recent work on constitutional activity patterns, special sensitivities, innate tension-reduction dispositions, and the like, which strongly indicate that some innate factors are operative at least as contributing, and perhaps as necessary if not sufficient, elements in the developmental determination of broad patterns of adaptation. Again, a disinclination to consider structural aspects of development seems to direct the author away from a body of data which is, at the very least, highly suggestive.

In the introduction Dr. Brody states that she proposes to offer a set of heuristic hypotheses bearing on the genesis of passivity in boys. In her conclusion she indicates the need for detailed longitudinal studies of development to confirm, amplify, or refute her hypotheses. In the first case, she builds on her unique clinical experiences a theoretical structure that is capable of being pursued and tested by others in both clinical and investigative settings. In the second, she acknowledges what all who venture into the area of early development must ultimately come to terms with—that the definitive resolution of conceptual confusions can emerge only from direct obser-

vation of development by increasingly refined methods. Dr. Brody has contributed an enormously thoughtful and provocative guideline for such investigations. For this, as well as for her splendid descriptions of clinical analytic work with children, her book should be welcome fare for all psychoanalysts and students of child development.

AARON H. ESMAN (NEW YORK)

MODERN PERSPECTIVES IN CHILD DEVELOPMENT. IN HONOR OF MILTON J. E. SENN. Edited by Albert J. Solnit and Sally A. Provence. New York: International Universities Press, Inc., 1964. 666 pp.

Present and former colleagues and students of Professor Milton J. E. Senn honor his sixtieth birthday in this collection of papers. The table of contents traces the growth of Dr. Senn's professional interests. The first section deals with the biological aspects of child development; later ones with theoretical and clinical considerations in pediatric practice and education, child psychiatry, and child development. Dr. Senn, as Professor of Pediatrics and Psychiatry at the Yale Medical School, established the well-known Child Study Center. The editors point out, in a touching foreword, Dr. Senn's dedication not only to scientific investigation but also and especially to the education of those who care for children.

The content of this volume is so rich and comprehensive—and, incidentally, scarcely 'reviewable'—that one can think of it as a kind of selected reference work. After a first section concerning physicians and human development as a science, come biological studies, including a case study of congenital multiple enzyme deficiency, and an essay on mammalian developmental enzymology which points out the age-specific variations in activity of a number of enzymes. A study of visual behavior of newborn infants shows that ninety-five percent were able to follow a visual stimulus with their eyes. A short note on retardation of growth associated with maternal deprivation in a five-year-old boy with 'emotionally engendered hyperadrenocorticism' follows.

The editors point out that although Dr. Senn has identified himself as an eclectic in child development, he has committed himself to a psychoanalytic view of the child in the family. In subsequent papers Anna Freud defines the concept of regression in various

areas and points out its applicability in pediatric observation. A longitudinal study from Yale illustrates Ernst Kris and Dr. Senn's methodology as applied to the development of motor activity, showing the relation between the child's innate equipment and his mechanisms of adaptation. Alan Frazer presents clinical evidence of the relation between transitional (material) objects and later thought processes showing how they are both used in experimental investigation of inner and outer reality. There are a comprehensive review and criticism of the intellectual evaluation of the brain-damaged child and a longitudinal study of familial mental retardation which emphasizes the complexity of the biological and psychosocial factors involved. A sensitive paper by Solnit and Green describes pediatric management of the dying child; another by these writers concerns collaboration between the pediatrician in the hospital and the child psychiatrist in adolescent suicidal crises. Dane Prugh presents a very long, inclusive review of the literature, with extensive bibliography on modern theories of health and disease.

In the fourth section Morris Green, Barbara Korsch, Richard Cushing, and Morris Dixon, Jr. discuss problems of the practice of pediatrics. Richard Wolfe considers the needs of the child in the hospital and how they can be met, Norman Cohen and Martha Leonard contribute a clinical article on the pediatric management of 'acute school avoidance', and Roswell Gallagher writes a knowledgeable piece about what the physician can offer the adolescent.

Part Five, Child Guidance Today, contains an article showing how the complexity of our knowledge of child development has entered into the work of psychiatric clinics for children, and another that considers the parents' motivation for bringing the child to a clinic and how this can be effectively included in the treatment.

Part Six, on Medical Education Today, includes Wallace Grant's description of a teaching program in 'pediatric ecology, the family's total environment' and Joe D. Wray thoughtfully considers the problem of children in other countries, especially in undeveloped areas, and what American pediatrics can contribute. Mary Stark writes about the contribution the social worker can make to pediatric education and to the armamentarium of the pediatrician. Morris Wessel discusses training in neonatal pediatrics, pointing out the possibility of integrating both our physiological and psychologi-

cal knowledge. Finally, Seymour Lustman and Julius Richmond perceptively describe the problems of the transition of the medical student into intern and intern into practicing physician.

The final section on Education for Children, Parents, and Teachers, contains a discussion by Evelyn Omwake of play, spontaneous and 'adult prescribed', in terms of cognitive development and the assessment of later learning patterns. Henk Veeneklass contributes an interesting historical account of a day nursery in The Netherlands from 1945 to 1960, as it reflected the change in the surrounding society. Anna Wolfe contributes a retrospective reflection about parent education; Julius Richmond and Betty Caldwell, a review of the changing ideas of child rearing and their effect as seen in follow-up studies of children. The final article, by Seymour Sarason, considers the contribution the mental health profession can make to education of teachers. The volume contains a list of the publications by Dr. Senn.

MANUEL FURER (NEW YORK)

THE PSYCHOLOGY OF LEARNING AND TECHNIQUES OF TEACHING. By James M. Thyne. New York: Philosophical Library, Inc., 1964. 240 pp.

In a book intended for student teachers, the author aims to show how a knowledge of the nature of learning can give guidance to the act of teaching. Thyne restricts himself to a limited group of topics in order to establish a systematic relationship between the technique of teaching and the 'necessarily limited knowledge the student-teacher can be expected to acquire'.

After defining learning briefly as adopting a new response to a situation, Thyne offers a 'theory of learning' (differentiated only in an ambiguous fashion from the better-known learning theories) which we are to understand by its four requirements: cue, force (initiating a behavior), pilot cue, and tie. Thyne goes on to offer a poorly integrated mixture of Pavlovian conditioning and behavioristic theory to explain the various methods of learning through habit-formation, habit-breaking, and explanation. He even suggests and approves of the 'habit-breaking technique' for curing enuresis by the mattress-bell conditioned reflex warning system.

The significance of internal forces, instinctual drives, ego functioning, identifications, and motivation (as analysts understand it) is completely omitted, minimized, or denied. Everything is external and can be understood by observing overt behavior. Analogies are frequently made with physical theory; rarely are psychological concepts or theories considered. Even the academic learning theorists are almost completely ignored; so is the interplay between maturation and learning.

In the latter half of the book the author attempts to offer a simple manual (in general terms) for beginning teachers with suggestions and rules for classroom and individual teaching. However, the basic orientation of the book remains unchanged, and it offers no contributions or clarifications to the psychology of learning or the techniques of teaching.

On page 80, we read, 'In this account I have said nothing of the Freudian view of forgetting, but it is of interest to observe that material which is "repressed" is usually "out of accord" with the subject's established ways of thinking, acting, or feeling. It does not "fit into" a dominant mode of behavior. The Freudian view, and the view I have been advocating here, are probably not so very different.' After this statement, one can read on more in sorrow than in anger.

The book cannot be recommended.

BERNARD D. FINE (NEW YORK)

THE UNIVERSAL EXPERIENCE OF ADOLESCENCE. By Norman Kiell. New York: International Universities Press, Inc., 1964. 942 pp.

The present volume, a companion of Dr. Kiell's earlier collection of passages from fiction that deal with the experiences of adolescence, sets out to establish the universality of psychoanalytic propositions, such as 'the universal application of the recapitulation of the œdipal conflict during adolescence'. To this end, passages from more than two hundred autobiographies, diaries, and letters are collected as documentary evidence of the sameness of the 'psychosocial' and 'psychobiological' experiences of adolescents in all ages and cultures. These passages come almost exclusively from the Western World of the last two thousand years. The documents are presented

under eighteen topical headings, such as Psychosexual Characteristics, Contradictions, Ambivalences, Polarities and Defenses, and Sibling Feelings. Each chapter is prefaced by a psychological exposition of the adolescent experiences to be documented by the excerpts that follow. These introductions, as well as all other passages by Dr. Kiell, are so heavily burdened by quotations that his own writing often fades into paraphrase of the experts. Dr. Kiell is, indeed, sophisticated in scientific use of autobiographical data (evaluation of credibility and reliability) but the psychoanalyst can hardly suppress a disquietude as he reads this volume, filled with the most thought-provoking pieces of writing put together to validate psychoanalytic theory. We have, of course, long been accustomed to the artist's lending a poignant illustration to some special aspect of a psychoanalytic paper,—Gloucester's soliloquy, for example, in Freud's The 'Exceptions'—, or to have a piece of writing subjected to analytic study in the light of the writer's life history; but to use literary or autobiographical passages to give credence to the universality of a psychological theory presents a new and not too convincing approach.

In a critical consideration of Dr. Kiell's book two points should be made. The first concerns his rather schematic and doctrinaire use of psychoanalytic theory, equating the content of a passage with its psychological meaning. By so doing the highly complex and multifaceted adolescent process is fitted into simplified categories. Pre-œdipality or pregenitality occupy an awkward place, if any at all, in the total picture. As I read passages under one topical heading, I found myself thinking that this piece might equally well belong under several others. Apparently the classification of a given excerpt has been determined by its obvious theme. But the psychological introductions to the topical selections expound genetic, dynamic, and structural theory. Abstractions of this kind cannot be supported by descriptive data of only thematic relevancy. The documentary selections had better be left to speak for themselves.

The second point of criticism concerns method. For a psychological interpretation or classification at least two sets of data are needed: either the document and the circumstances of its author's life or the document and the relevant prevailing ethos of the times. Then and only then can a point of intersection be obtained—the point to be made. Since the study of any individual adolescent is not

the object of Dr. Kiell's work but rather the formulation of psychological universalities, the autobiographical documents ought, I believe, to be placed in the respective historical setting that gives adolescence its very special countenance. To illustrate, in the Werther period of the late eighteenth century, affectionate friendship and a flood of tears among older male adolescents were the signs of true manliness in contrast to the 'playing it cool' of present-day youth. Can documents from the Werther period prove the universality of homosexual tendencies in adolescence? Certainly not. Conscious guilt over masturbation will be conspicuously absent from autobiographies of today's sophisticated adolescent, compared with the tortured outcry of such pre-freudian confessions as those of Theodore Dreiser. Does this mean that guilt over masturbation has lessened or ceased to exist? Certainly not.

As a source book this volume should be welcomed by all interested in adolescence. Regrettably, there is no index to help the reader find either authors or topics. But we are indebted to Dr. Kiell for his gigantic and erudite labors in compiling these remarkable and often totally unknown documents.

PETER BLOS (NEW YORK)

PSYCHOANALYTISCHE SCHRIFTEN ZUR LITERATUR UND KUNST. Ausgewahlt und herausgegeben von Egenolf Roeder von Diersburg. (Psychoanalytic Writings about Literature and Art. Selected and edited by Egenolf Roeder von Diersburg.) By Georg Groddeck. Weisbaden: Limes Publisher, 1964. 338 pp. Illus.

The psychoanalyst will find this an informative selection from Georg Groddeck's writings. Egenolf Roeder von Diersburg tries to introduce Groddeck and to help in the transition from chapter to chapter—but does so in an old-fashioned, schoolmasterish way, complicated by a Germanic style thought to have been outmoded fifty years ago but which seems to persist. It stands in strange contrast to the language used by Groddeck himself who, like Freud, was a master of the German language.

The selection shows Groddeck at his best, emphasizing his enormous capabilities and his incredible knowledge of linguistics, history, art, literature, mythology, philosophy, and medicine. Groddeck's wisdom in its more gentle form is shown; Groddeck's wildness, his

often provacative masochistic exhibitionism, and his, at times, demonstrative rebelliousness against conformity is tactfully underplayed.

Groddeck's preanalytic period (approximately until 1917, when he wrote his first letter to Freud) is represented by his studies of Ibsen and some of his early philosophical essays. The middle third of the book contains some samples of Groddeck as a psychoanalyst, among them an interpretation of the Ring of the Nibelung which contains deep insight into the nature of the Aryan character, equaled only by Fritz Wittel's later essay on the same topic. It is followed by an undated and unknown essay on music, leading to two of Groddeck's best essays, on Peer Gynt and Faust, which show Groddeck in his lifelong love and study of Goethe. In all his wildness and in his pride in being untamed he shows himself here somewhat like an abstract painter who suddenly puzzles his friends by exhibiting a Raphael-like mastery of technique. Groddeck was a true *Goethe Froscher,* as he was a truly devoted friend of Freud, who wrote to him letters of great understanding, tolerance, and friendship.

The last third of the book brings a study of Hoffman's *Struwwelpeter,* skilfully compiled from four different manuscripts and lecture notes given in Berlin to the Psychoanalytic Society in 1918.

Finally, quotations are given from The Book of the It and The World of the Symbols. There are many short sketches not mentioned here, among them the famous Visit to a Museum from *Der Seelensucher* which has never been translated into English and which, together with a hilarious railroad scene from the same book, delighted Freud so much.

To the German-reading analyst, this selection is a nostalgic reunion with a friend from the time after World War I.

MARTIN GROTJAHN (BEVERLY HILLS)

THE ENCYCLOPEDIA OF MENTAL HEALTH. Six Volumes. Editor-in-Chief, Albert Deutsch; Executive Editor, Helen Fishman. New York: Franklin Watts, Inc., 1963. 2,228 pp.

This large undertaking was designed to meet the public need for sound information on mental health presented in simple terms that the general reader could understand. Albert Deutsch who was ap-

pointed Editor-in-Chief in 1960 wrote in the original Prospectus: 'The publishers have assured me that they want a sound compendium on mental health that could provide useful, authoritative information for the general public, and this is what I intend to give them'. Following his death in 1961, Helen Fishman became the Executive Editor.

The six volumes contain one hundred seventy original articles by one hundred forty authors and co-authors, a list of agencies, a bibliography, glossary, name index, and subject index. A board of consultants was selected to review the articles, write some themselves, and suggest authors. The articles are arranged alphabetically by title and, for the most part, the treatment is in the form of question and answer. The typical article is about twelve pages in length. The articles cover just about every conceivable subject from abortion to young adulthood.

An examination of these volumes will prove that a significant portion of the articles is extremely well done and provides an authoritative and comprehensive coverage for the layman of this broad field. Well-organized and well-written, it has an attractive format and is easy to use. There is probably no other work in the field that is comparable to this one in scope, treatment, and arrangement. The articles, clearly and carefully written with a minimal usage of technical terms, are refreshing to read. The question and answer treatment of the articles proves to be a help in the organization and clarity of the writing, and in readability.

Some of the articles seem disproportionately short or long. Adoption, for example, is given thirty-nine pages, Abortion twenty pages, whereas Anxiety is given only five pages (less than is given to the topic, Animal Psychology), and Ego is given only six pages (seven less than Existential Therapy). The contributing authors represent many diverse disciplines and points of view. Though many of the articles are not written by psychoanalysts, or from a psychoanalytic point of view, the impression remains that the psychoanalytic viewpoint is the predominant one in the large majority of instances.

This is a useful and reasonably accurate nontechnical presentation for laymen and can be recommended to libraries and interested individuals.

JOHN B. MC DEVITT (NEW YORK)

ILLNESS AND CURE. Studies on the Philosophy of Medicine and Mental Health. By Joost A. M. Meerloo, M.D. New York: Grune & Stratton, Inc., 1964. 282 pp.

In this short monograph Meerloo deals with a variety of topics including historical concepts of disease from Hippocrates to Boerhaave, the Seventeenth Century Dutch physician from Leiden (where Meerloo received his medical training). He writes about epistemological concepts applied to medical thought, ambivalence, regression, professional preoccupations and prejudices, analysis of curative motivations and directions, and the meaning of therapeutic contact between psychiatrist and patient. It is often unclear how the concepts that Dr. Meerloo discusses pertaining to somatic medicine apply to psychiatry.

Meerloo underscores again and again the eclecticism of his approach and indicates his opposition to being considered a member of any school. Nevertheless the concepts behind his psychiatric thinking are almost all freudian, but attenuated. One might describe him as an eclectic by dilution. For example, although he states that transference is more than fifty per cent of the secret of cure, he devotes approximately two pages to this important topic, making a few such unrewarding statements as that the patient unwittingly wants his physician to be God, magician, and miracle worker.

Regression likewise becomes the theme for an unenlightening discussion in which we are informed that it sometimes has a kind of intrinsic curative function epitomized by the saying, *'Reculer pour mieux sauter*—walking back in order to jump better' (p. 101). We are informed that 'The mysterious processes of regeneration on which all cure depends continually utilize these backsliding habits of cells and tissues in the service of repair. Regression often takes place in the service of reconditioning and man's renewed planning in futurization' (p. 100). We see here an example of the unwarranted jump that Meerloo makes from physical medicine to the mental. What he says about regeneration of cells and tissues he displaces to mental structures and functions without realizing that the connection is merely analogical.

In general, Meerloo does not think much of the theory of psychic determinism nor of the systematic application of theory to practice.

He likes to minimize the value of thinking out one's approach and favors the intuitive art of medicine, for, after all, as he himself fondly quotes, 'The physician dresses the wounds while God heals'. These are the last words in a chapter entitled Those Who Cure but Don't Heal.

BERNARD BRODSKY (NEW YORK)

CHILDREN OF BONDAGE. The Personality Development of Negro Youth in the Urban South. By Allison Davis and John Dollard. (Orig. published by the American Council on Education, 1940.) New York: Harper & Row, Publishers, Inc., 1964. 299 pp.

This work has marked relevance to the problems with which the nation as a whole, through its War on Poverty, and a large segment of the clinical psychiatric world are now actively engaged. Published first in 1940, its freshness and contemporary flavor attest both to the farsightedness of the authors and to the dearth of scholarly work on the subject of the specific effects of poverty on the development of Negro youth which, as the authors show, is undoubtedly the most pervasive and far-reaching effect of systematic segregation and discrimination.

Drs. Davis and Dollard, using the technique of 'depth interviewing', then in its early stages of development as a tool of sociological research, have given us intimate and life-sized views of several Southern Negro youths, and of the specific familial, social, economic, and political environments in which they grew up. The portraits are of individual human beings, rather than of 'types', though the effort to delineate group characteristics as a means of furthering the scientific goal of classification is clearly visible, and properly so, throughout the work.

The authors believe that personality is formed by the interplay between the infant's reactive tendencies molded in his early relationships to parents and siblings, and the larger social milieu into which he emerges at the end of infancy. Their case studies clearly demonstrate the validity of this concept. Although much attention is given to some aspects of constitutional or genetically determined traits, only in one case (Judy) is the impact of socially related physical deprivation on personality development noted. In fact the

authors emphasize that the physical violence attendant on lower class life is neither disturbing nor harmful. No distinction is made between the fatal and the merely chronic effects of repeated trauma, such as head injuries due to blows or falls; disfigurement due to burns and cuts; or physical exhaustion due to premature and rapidly repeated childbearing under less than ideal medical and hygienic circumstances.

Although the social cost to the individual of limited educational goals and loss of class mobility is clearly presented, the psychological effects of what is described as lower class behavior patterns are perhaps painted in rather too rosy hues. The focus is on the presumed psychological benefits of freedom of expression of impulse, particularly of aggressive impulses (though the authors distinguish between aggression ruled out by the Southern caste system, and permissible aggression, that is, aggression within one's own class).

The authors possibly could not carry their probing far enough to discover the deeply repressed and denied anxiety about body intactness which is one of the abiding problems of the lower class boy particularly, and which constantly must be opposed by actions that reassure him of his intactness, usually actions involving physical conflict. Perhaps the truly greatest cost of social and economic oppression is precisely this, that lower class children have little opportunity to develop motivation for learning very much beyond techniques of physical survival and modes of self-reassurance that the trauma really has not damaged them, or modes of denial when it actually has.

ELIZABETH B. DAVIS (NEW YORK)

THE EIGHTH GENERATION GROWS UP. Cultures and Personalities of New Orleans Negroes. Edited by John H. Rohrer and Munro S. Edmonson. New York: Harper & Row, Publishers, Inc., 1964. 346 pp.

Rohrer and Edmonson, and their colleagues at the Urban Life Research Institute of Tulane University, have laudably undertaken a follow-up study, twenty years later, of a group of Negro adolescents in New Orleans originally studied by Davis and Dollard, whose book of 1940, Children of Bondage, is a little-known classic in its

field. The original Davis and Dollard work concluded that for both Negroes and whites modes of personality functioning follow lines of social class rather than color-caste membership. Ten years later, Kardiner and Ovesey, in a study of a smaller sample of New York Negroes, concluded that color-caste, not social class, produces a distinct Negro personality type. Others, especially Allport, express the belief that extreme importance in personality organization should be imputed neither to class nor caste membership alone: to do so is to overlook the basic uniqueness of human personality, to ignore the obvious relevance of inherited differences in temperament and the idiosyncratic nature of life experience in a particular family, to discount the fact that all persons are a dynamic complex of potential 'selves', and to contradict the common observation that widely ramified social roles and memberships can overlap in a conflict-free fashion.

Rohrer and Edmonson are to be commended for their avoidance of sweeping generalization. Not so praiseworthy is their too limited approach: they state that they tried to ascertain ' . . . separately for each subject the possibility that race, religion, political position, profession, class, sex, age, or intellect might be *the* dimension [reviewer's italics] of his primary role identification . . . ' (p. 83). Moreover, only forty-seven of the original seventy-six adolescents were located and studied, and too few of those coöperating with the follow-up were of lower class origin. Of the forty-seven subjects, twenty were studied by psychological tests, psychiatric interviews, and home visits. The authors do not give a clear impression of how many subjects support the Davis-Dollard or the Kardiner-Ovesey hypothesis, although we are told that data on some subjects might support either and data on others could support neither. The authors do not find a typical personality or family type, nor a uniform child-rearing experience for this Negro group.

It was the combined impression that the 'primary role identification', the basic core of ego identity or personality, was not the racial or ethnic role for any of the twenty subjects. Primarily, three were basically committed to the role of being a middle-class person; four women saw themselves as carriers of the maternal role in a matriarchal family; three men lived their lives mainly as members of peer-group gangs; six were committed to family roles as members of stable, tightly knit, conventional, nuclear families; while four

others had such marginal connections with any group or role that they were believed to demonstrate what Erikson refers to as 'identity diffusion'. It must be said that the clinical data as presented do not elucidate Erikson's developmental phase approach to ego psychology, nor do they make clear the relation of the various social roles to the obvious psychiatric illness of some of the subjects. Also, the study does not show how the increased tempo of favorable social change during these past twenty years may have affected the growth from adolescence into adulthood of these adolescents.

Despite these shortcomings, the book should be read by all psychoanalysts seriously interested in problems of the effects of membership in a minority group, the effects of poverty, and the effects of a particular Southern regional origin on the processes of ego development and function.

JAMES L. CURTIS (BROOKLYN)

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

International Journal of Psychoanalysis. XLIII, 1962.

Eugene V. Nininger

To cite this article: Eugene V. Nininger (1965) International Journal of Psychoanalysis. XLIII, 1962., The Psychoanalytic Quarterly, 34:2, 306-315, DOI: 10.1080/21674086.1965.11926351

To link to this article: https://doi.org/10.1080/21674086.1965.11926351

Published online: 29 Nov 2017.

ABSTRACTS

International Journal of Psychoanalysis. XLIII, 1962.

Interpretation and Reality in Psychotherapy. Sidney Tarachow. Pp. 377-387.

Psychoanalysis and psychotherapy are constrasted in several respects: 1, Analysis does not gratify the patient's wish for the infantile object but, instead, frustrates and removes it through analyzing its manifestations and resistances in the transference. Psychotherapy, on the other hand, does gratify the infantile wish in the person of the therapist and leaves the transference unanalyzed. 2, Displacements of the infantile wish are exposed in analysis, and are then destroyed and replaced by sublimations. In psychotherapy, displacements to new symptoms are supplied or permitted by way of inexact interpretation and through projection and introjection. 3, The reintegration sought in analysis is replaced by supplying stability in psychotherapy. The latter is accomplished by supporting the ego defenses, supporting the superego by commands and prohibitions, educating and supplying information, and effecting reality changes.

Beyond the Reality Principle. Charles Rycroft. Pp. 388-394.

Freud viewed the primary process as developing first and operating according to the pleasure principle, the secondary process as developing later and operating according to the reality principle. However, the healthy infant not only expresses wishes but actively seeks to gratify them through the mother. His secondary process operates coevally with the primary process, and his ego functions cannot initially be differentiated from his instinctual discharges. The thesis of this paper is that the secondary processes are 'realistic' when they are used to relate to the external world objectively, while the primary processes are 'realistic' when they are used to relate affectively to objects of emotional interest. If this hypothesis is correct, the aim of psychoanalytic treatment is not primarily to make the unconscious conscious, nor to strengthen the ego, but rather to establish the connection between dissociated psychic functions so that the patient ceases to feel an inherent antagonism between his imaginative and adaptive capacities.

The Discriminatory Function of the Ego. Frederick J. Hacker. Pp. 395-405.

The adaptive capacity of the ego involves not only a synthetic but a discriminatory function. The latter includes selecting and rejecting among various possible courses of action and, especially in our own time of overabundance, the erection of barriers against overabundance of stimuli. The concept of the synthetic function of the ego arose during a period of scarcity when the few objects available had to be incorporated at all costs. The concept of the discriminatory function becomes necessary in a period of supply exceeding demand in such degree as to overwhelm the ego and result, according to the author, in the prevailing pathology of our age.

Notes on the Anal Stage. Paula Heimann. Pp. 406-414.

The anal and later stages of development have been somewhat neglected in the last two decades due to interest in the oral and prenatal stages. The anal stage not only receives contributions from the oral stage but makes its own unique contributions. The oral experience reinstates the original oneness of mother and infant, whereas the anal experience denotes withdrawal from the mother and autonomy. In this later stage of ambivalence, narcissism is expressed by aggression, self-assertion, contrariness, and sadism, and the sense of identity depends largely on the opposition: 'I against you.'

Narcissism and Defensive Processes in Schizophrenic States. Thomas Freeman. Pp. 415-425.

The unconscious conflicts in neuroses do not differ materially from those in schizophrenia. The difference lies in the defense reactions which ensue. In the former, anxiety leads to a series of defensive maneuvers on the part of the ego which sometimes include regression to the precœdipal phase; in the latter, the very organization which initiates the defensive process, namely the ego, is itself injured by the disease process. The primary defense in schizophrenia is regression to the narcissistic phase. Breakdown of the ego results in alterations in the functions of attention, conceptual thinking, perception, and memory which are secondary defenses against the conflict. Failure of countercathexis may lead to a breakthrough of the primary process. A psychotic reality then develops that consumes the cathexis previously directed to real objects and includes delusions and hallucinations that are outcomes of the restitutive processes. During treatment this psychotic reality may be transferred to the therapist and so remain until capacity for object cathexis develops. If the latter should occur, the usual ego defenses make their appearance both in and outside the transference. The paper, a preliminary inquiry by the author along lines suggested by Freud, contains interesting clinical material.

The Placement and Movement of Hallucinations in Space: Phenomenology and Theory. Leston L. Havens. Pp. 426-435.

While other aspects of hallucinations have been extensively investigated, their location in space has been neglected. Careful attention to this aspect reveals that patients prone to experience them at a distance initially and to 'allow' them to come closer with improvement finally introject them. Affects accompanying this movement inwards are flatness, anger, and depression; after introjection, there is bodily discomfort. The changes appear to mark one of the paths of development of hallucinations. It is suggested that hallucinations exist to satisfy specific needs for external objects.

On a Specific Aspect of Countertransference Due to the Patient's Projective Identification. Leon Grinberg. Pp. 436-440.

When the analyst receives an especially violent projective identification from the analysand, he may be able to react in the normal way, namely, by interpreting it. However, he may be unable to tolerate it and consequently react with equally

violent rejection of the material, reject it but deny he is doing so, displace his rejection of it onto another patient, or unconsciously allow himself to play the role assigned to him by the analysand. The last reaction is the main subject of the paper and is illustrated by clinical examples.

A Contribution to the Analysis of Resistances in Neurotic Dependence. Hernán Davanzo. Pp. 441-447.

During the analysis of neurotic dependence a state usually develops in the patient in which he behaves as though he could go ahead and become well but must balk at doing so. A study of this situation indicates he is in conflict over the wish to grow and become independent. A side of himself wishes this; a side fears it as a danger. The solution is a compulsive dependence on the analyst. The conflict and its solution repeat an original one with the mother, who defeated the infant's wishes for independence through forcing on him her preconceived ideas of his needs rather than being guided by the child's patterns and confining herself, where impositions were concerned, to realistic, constructive frustrations. The healthy solution to the patient's conflict lies in incorporating the analyst as the equivalent of the ideal mother who aids and realistically frustrates but does not force, and who remains fond of the patient during all the ambivalence and negativism in the course of treatment, the circumstances of its termination, and the post treatment period.

The Charge of Suggestion as a Resistance in Psychoanalysis. Frank T. Lossy. Pp. 448-467.

In this paper, awarded a Clinic Essay Prize in 1961, a patient is presented who used as an important resistance at crucial points in her analysis the feeling that material emerging into consciousness was not from her own psyche but was the result of suggestion by the analyst. Analysis of the resistance revealed that it both served to negate unacceptable drive representations emerging into consciousness and to gratify libidinal drives from all pregenital levels. The most important pregenital meaning of the charge was that it represented anal rape by the analyst and that her confirmatory responses were gifts of feces (baby) resulting from this act. Delusions of influence commonly found in paranoid patients appear to have a dynamic structure similar to the charge of suggestion in this patient and may be both a defense against the superego and a disguised gratification of the passive homosexual wish.

EUGENE V. NININGER

Psychoanalytic Review. LI, 1964, No. 1.

The Psychological Significance of Words. Warren Gorman and Louis G. Heller. Pp. 5-14.

In this concise review of the psychoanalytic literature on the subject of words and language, words are described as a substitute for body activities. They are associated with secondary process thinking and come from the 'hunger call' of the infant and the 'sexual call' of the adult, as Darwin suggested. They are

magical, ambiguous, and antithetical. Freud's interest in speech and language is discussed.

Body Words. Warren Gorman. Pp. 15-28.

Body words which are highly developed linguistically carry a low investment of cathexis and vice versa. The author reviews the literature on body parts, including hand, finger, tongue, genital, brain, and breast. Body parts and implications of their meaning at different stages of development are described.

Some Misuses and Abuses of Our Private Language. Jean B. Rosenbaum. Pp. 29-37.

Private language is that which should remain private and frequently does not. In psychoanalytic psychiatry technical jargon is sometimes used with the patient. Two examples are given of the use of either inexact interpretation or interpretation which is really an indictment of the patient, both reflecting the anger and frustration of the therapist. Devereux, Sterba, and Orr are quoted in a plea to limit the use of our scientific vocabulary to matters of scientific communication and not as technical jargon in therapy, community, or social encounters.

Slang and Dream Symbols. Calvin Hall. Pp. 38-48.

Using the Partridge Dictionary of Slang, a list of terms for the male and female genitals and for coitus was compiled and compared with a list of dream symbols that represent the genitals and coitus. The lists were sorted into categories such as references to shape, the likening of the genital to a tool, etc. The author suggests that slang is forbidden because words are the intermediary between fantasy and fulfilment; hence words are incipient actions. He does not discuss the possibility that putting an idea into words can make it unnecessary to act it out. He asks a question that deserves further elaboration: why should a dreamer deceive himself during sleep with the same symbols which he employs during waking life?

Resignation, Humor, and Wit. Walter E. O'Connell. Pp. 49-56.

Using Freud's articles on Wit and Humor, the author has devised a multiple choice test to evaluate statistically whether resignation, which Freud referred to briefly, could be measured as separate from humor and hostile wit. Resignation was found to be capable of measurement and is similar to humor in avoiding panic reaction to severe stress. Humor as Freud described it is rebellious and thus is not resignation. Hostile wit was found to be preferred more by men than women and is understood in the way described by Freud as a more regressive mechanism than humor, providing release for both sadistic and sexual urges.

The Oral Side of Humor. Jule Eisenbud. Pp. 57-73.

In a paper that must have been a pleasure to listen to, the author discusses various forms of humor including shaggy dog jokes, cartoons, the dreams of Charlie Chaplin and Robert Benchley, two case examples, and the smiling of infants. He quotes Freud's only remark on the relationship between nursing and humor and then derives from his examples of humor the idea that humor is a

restitution type of defense against the threat of external deprivation. It reassures the threatened person that he is not dry, bereft, and empty, but has an endless source of supply from within which will nourish him. Cannibal cartoons are a way of dealing with the child's fear of being eaten by the witch-mother, a projection of his own frustrated, devouring aggression.

Jung's Sermons to the Dead. Nandor Fodor. Pp. 74-78.

Fodor reports that in 1925 he received a typewritten copy of a strange publication by Jung, entitled Seven Sermons to the Dead. Written in 1918, it revealed Jung's views on life after death and his communications with the dead. Jung stated: 'quite early I learned that it was necessary for me to instruct the figures of the unconscious or that other group which is so often indistinguishable from them, the spirits of the departed'. In 1911 Jung had had a dream of distinguished spirits from an earlier century. This was before he wrote The Psychology of the Unconscious.

The Seven Sermons to the Dead is associated by Fodor to the break between Jung and Freud. Jung wrote: 'when I had parted from Freud I knew that I was plunging into the unknown, beyond Freud; after all, I knew nothing, but I had taken the step into darkness'. Fodor states that this break had the effect on Jung of a full-blown psychosis; at the time he had a dream in which he was told 'if you do not understand this dream you must shoot yourself'.

The Word in the Beginning. A. Bronson Feldman. Pp. 79-98.

In his quest for the origin of the primal name, the first word uttered by man, the author investigates language from the standpoint of its development in early childhood, in the history of mankind, and in the history of religion in particular. Gesture came before speech and speech represents an inhibition and translation of gesture. One theory of the origin of speech is the bow-wow theory, that it is onomatopoeia. Another theory asserts that the first words were calls of allurement, calls for help, warnings, and war cries. The Sterns in 1907 showed from observations of infants that one-word syllables voice the wish to possess the mother, and Schilder concluded from this that primitive language is partly expressive movement and partly magic action.

Feldman speculates that the thunderous sounds made by the murdered father were re-experienced in dreams that added the visual lightninglike effects and that the sound uttered by the dying father would have been *YO* or *You, Iaoue,* thus accounting for the forbidden and death-dealing original religious name of the deity; *Yahu, JwHw, Yahweh.* The lightninglike effects account for the halo around the deity and are included in the case example that the author describes. He traces the development of the primal name of the deity through some ten ancient and three modern languages.

The Case of Franz Kafka. Frederick G. Glaser. Pp. 99-121.

In a study that might serve as a guide in psychography the author discusses his thesis that Franz Kafka was a normal if not a supranormal man. His theory is supported by several literary critics and by the personal observations of Kafka made by Jan Frank, M.D., a psychoanalyst. His study was prompted by the

widely accepted assertions that the works of Kafka were largely the products of a diseased mind. Three critics are cited who speak of Kafka as being sickly, schizophrenic, paranoiac, an obsessional neurotic, and an anal type 'who suffered from a combination of castration and œdipal complexes'. Kafka, to those who knew him, was shy and quiet and one of the most amusing of men. A *summa cum laude* barrister, he was a section chief in an excellent national health organization where he worked smoothly with other employes.

The author accounts for the portrayal of Kafka as sickly by suggesting that his works are ambiguous enough to be used as a kind of Rorschach projection and that thus the critics themselves are the sickly ones and do not know the difference between regression in the service of the ego and an ego that is regressing.

The Touching of the Body. Arthur Burton and Robert E. Kantor. Pp. 122-134.

The authors begin this thought-provoking and sometimes clinically useful article with some statements that need to be questioned. They assert that the reason therapists are reluctant to touch the patient is the horror or fear of touching and the dislike that the therapist has for his own body. They argue that since the psychiatrist is trained to be a physician he should act like one and touch the patient. They also make the deduction that psychotherapy resolves itself into a relationship best subsumed under the word 'love'.

After some remarks on development and the importance of both touch and smell in the relationship between mother and infant, the specific clinical problem is taken up as to whether to shake hands with the patient. The authors conclude that with rare exceptions the patient need not be touched.

STEWART R. SMITH

Journal of Nervous and Mental Disease. CXXXVIII, 1964.

The Institutional Framework of Soviet Psychiatry. Mark G. Field and Jason Aronson. Pp. 305-322.

This paper describes the administrative set-up and orientation of psychiatry in the Soviet Union. Of course, all of medicine including psychiatry is socialized and services are available at no direct cost. There is, however, a system of priorities in which those members of the population who perform the most important functions are apparently provided with earlier and better treatment. The core of Soviet psychiatric services is the outpatient clinic which strives to maintain the psychiatric patient within the community. The mental hospital provides active treatment for short periods rather than custodial services. Chronic patients with residual work capacity are sent to work colonies where they engage in simple tasks. The disinclination to hospitalize patients and emphasis on maintenance in the community was observed to agree with the thinking of Western workers in mental health.

The Empathic Process in Psychotherapy: A Survey of Theory and Research. Ronald E. Fox and Paul C. Goldin. Pp. 323-331.

Empathy as a critical factor in psychotherapy is defined and examined. The process is felt to represent not only an identification with, but also an awareness

of, one's separateness from the observed—features of both involvement and detachment, 'the ability to step into another person's shoes and to step back just as easily into one's own shoes again'. Greenson's observation that empathy requires the capacity for controlled and reversible regression is noted. As far as the analyst is concerned empathy is felt to represent 'remembered corresponding affective states' (Schafer) which he can experience by having achieved insight into his own 'ego alien wishes and devices for dealing with them so that he is able to detect and comprehend the patient's repressed wishes and his defenses against them' (Knight). From the patient's point of view the ability to empathize is thought to represent a key aspect of his learning experience during psychotherapy. The learning process involves first a stage of unconscious identification with the therapist, then a phase of quasi-conscious imitation. Finally imitation becomes empathy only after the positive transference aspects of such imitation have been resolved. The authors point out the difficulties and limitations of research that has been carried out on this subject, chiefly because of the problem of evaluating the ongoing therapeutic process.

Homosexuality as a Defense Against Feminine Strivings: A Case Report. Marvin H. Lipkowitz. Pp. 394-398.

A case is reported of a patient who adopted active homosexuality as an elaborate defense against burgeoning feminine drives. As the feminine strivings were stimulated, pressing toward the surface, the defense system collapsed and there was a suicide attempt. The author supports Bychowski's view that in homosexuals 'conflicting identifications with various parental images are followed, each time they are made, by their dethronement. This weakens the ego, since considerable countercathexis must be used to maintain these various identifications which have become not only unconscious but dissociated from each other and the conscious ego as well.'

BENNETT F. MARKEL

Archives of General Psychiatry. X, 1964.

Selection of Patients for Definitive Forms of Psychotherapy. Marc H. Hollender. Pp. 361-369.

Hollender is concerned with optimal utilization of the initial interviews. He focuses especially on the question of what the individual wants to do about his problems; whose idea it was to seek help; the effect of psychic distress; the use of confrontation to clarify the patient's objectives; and the purpose for which self-knowledge is sought. A further important index is the kind of relationship the person seeks and has sought habitually. The author makes the interesting observation that many drop-outs from psychotherapy reflect people who really had not decided upon therapy but only seemed to be engaged in it because of faulty evaluation in the initial interviews.

Evaluation and Treatment Planning for Autistic Children. Blanche Garcia and Mary A. Sarvis. Pp. 530-541.

A philosophy for understanding and handling autistic children is presented. The multiplicity of etiologic factors, both hereditary and environmental, is em-

phasized. These factors are seen as overwhelming at a vulnerable early developmental stage. The consequent stress is construed by the child as caused by mother who is persecuting him. This results in a basic paranoid position, which is seen as the core of the autistic reaction and the reason for the need for psychological treatment. The authors argue against separating the evaluation process from treatment. On-going treatment planning furnishes the best information and opportunity for investigating such things as organic features if they are found to be important. Flexibility is essential in the therapeutic approach to each child except that the therapist must always side with reality. Informative case histories are presented.

Psychotherapy Research: Dilemmas and Directions. Clyde H. Ward. Pp. 596-622.

In this long essay Ward examines the problem of adequate research designed to investigate the question he considers central: what therapeutic influences effect the most durable changes in what psychopathology? He does not consider the enormity of the fully explored problem, such as the number of variables necessarily involved and the time required, to be an excuse for giving up. We have not done enough work in this direction. Of particular interest is the attention called to the bias against and reluctance on the part of analysts to submit to recording and observation procedures.

Psychodynamics of Echo-Reactions. Charles Carluccio, John A. Sours, and Lawrence C. Kolb. Pp. 623-629.

The sparse literature, especially involving dynamic considerations, concerning echolalia and echopraxia is reviewed. Two cases of schizophrenic reaction are presented in which the use of these mechanisms indicate a regressive manifestation of hostility toward and mockery of a feared mother. Thus nothing is digested that comes from the feared and hated person. Features of identification with the aggressor are also prominent, as both mothers used mimicry in a hostile, mocking manner. Consequent therapeutic technique is considered briefly.

KENNETH RUBIN

Revista de Psicoanalisis. XXI, 1964.

Notes on Psychoanalytic Treatment of Organic Diseases with Subsequent Psychosomatic Integration. Angel Garma. Pp. 1-18.

In a patient suffering from an organic disease, only part of the resistance is from the patient himself since medicine tends to separate the psyche from the body. The superego operating in both analyst and patient favors repressing meaningful symbolic and genital interpretations of the material, giving preference instead to oral interpretation (for example, the patient's ulcer) in which the content is the idealized maternal breast. The only way to achieve true psychosomatic integration, especially in this type of patient, is to make him aware of the splitting in the transference neurosis, thereby incorporating the entire psychic apparatus.

Lethargy. A Reaction to the Loss of an Object. Fidias R. Cesio. Pp. 19-26.

Different ego reactions in the loss of a love object present meaningful aspects such as mourning, melancholia, and the negative therapeutic reaction, and lethargy is a manifestation of this mechansim. The fixation point, according to Cesio, is in the prenatal phase of development. As a consequence, the lost object is the prenatal forerunner of the ego ideal, the most archaic and chaotic repression of the primal scene. Among these archaic forms the author includes incest and matricide. By noting the importance of lethargy, the analyst can sometimes identify the primitive lost object (the 'lethargic object'). If this element is resolved, the negative therapeutic reaction can be modified.

Hallucination as a Pseudoabstraction. Edgardo Rolla. Pp. 27-36.

The author believes that, as a rule, hallucinations appear in the psychotic, and perhaps in the child, because of a lack of environmental confrontation. Since this lack prevents any perception or sensation, it is equivalent not only to the loss of an object but to the loss of part of one's ego. Hallucinations become pseudoabstractions or pseudosymbols in an attempt to integrate unconscious fantasies with the environment.

In discussing complementary pairs in symbols, such as satisfaction-love, frustration-hate, Rolla believes that encapsulation in hallucination acts as a bridge between distorted pairs, such as hunger-repugnance, necessity-despicability, satisfaction-envy, and frustration-persecution. These elements of hallucination are thought to be a motivation and motorization in the need to use muscular sensation in acting out, looking for substantial reality. To Rolla hallucination appears to be a genetic element in the development of psychopathy.

Function and Dysfunction of Intelligence. Isabel Luzuriaga. Pp. 38-57.

This well-conceived, theoretical and clinical presentation of the energetic and dynamic aspects of 'counter-intelligence' demonstrates its applicability in obsessive-compulsive thinking, inductive and deductive reasoning, and in psychotic patients. Different components and intellectual functions are discussed and elaborated on in connection with 'counter-intelligence'. This article is so compact, so well-reasoned, and the clinical cases so graphic, it is impossible to do justice to the author with a mere summary. It deserves to be read.

The Impostor. A Contribution to the Study of Psychopathic Types. Joel Zac. Pp. 57-74.

A peculiar alternating mechanism of fusion and diffusion of unconscious fantasies is established in the impostor, as well as in any other psychopathic individual. These images appear as units in an attempt to structuralize an unstable equilibrium of particular interest to any defense mechanism.

In the case presented, the stereotyped manner of committing a crime became rigid and structuralized as a definite way of behavior because the individual needs coincided with those of the environment (family, society). Therefore, the patient developed his own style of living and his own future projections. The learning process was then encapsulated within the ego; hence the means of com-

munication was through stereotyped behavior of a repetitive, codified system. The need for conditions favorable for this permanent behavior helped the patient to avoid facing isolation and loneliness, but the latent means of autistic communication became apparent.

GABRIEL DE LA VEGA

Jornal Brasileiro de Psiquiatria. VIII, 1959.

Artistic Creation in Relation to Destructive and Restitution Needs in a Group. Walderedo Ismael de Oliveira, Mara Salvini de Souza, and Luiz Cerqueira. Pp. 239-251.

Analyzing the interaction in a group around anxiety, defense mechanisms, and fantasies, the group evolves through similar phases as in individual analyses. If it is handled properly the group will show the most primitive unconscious fantasies. The predominant anxieties in any group were caused by hostile impulses and restitution efforts to repair fantasied damage to the object. Therapeutic success involves relinquishing fantasy in favor of realistic adaptation and real satisfaction in object relations. The more the analyst is evaluated (latent idealization), the greater the therapeutic progress. The group went through a transference involving envy, competition, and psychosexual development. An attempt is made to work through seductive œdipal fantasy and paranoid œdipal rivalry.

Œdipus Complex and Envy in a Therapeutic Group. Walderedo Ismael de Oliveira and Heitor de Andrade Lima. Pp. 253-263.

Fantasies are usually shared by the group and reveal œdipal conflicts that are more easily seen in psychoanalysis of the individual. The analyst is considered the 'chief' in the sense of the primal horde of Freud. One has to work through conflicts arising from the destructive impulse against the father, the omnipotence attributed to him, and the consequent need to submit (fear of castration). Abundant illustrative clinical material is presented.

GABRIEL DE LA VEGA

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

Meetings of the New York Psychoanalytic Society

John Donadeo

To cite this article: John Donadeo (1965) Meetings of the New York Psychoanalytic Society, The Psychoanalytic Quarterly, 34:2, 316-325, DOI: 10.1080/21674086.1965.11926352

To link to this article: https://doi.org/10.1080/21674086.1965.11926352

Published online: 29 Nov 2017.

NOTES

MEETINGS OF THE NEW YORK PSYCHOANALYTIC SOCIETY

September 15, 1964. SOME ASPECTS IN EARLY-ORPHAN ADULTS' ANALYSIS. Jose Remus Araico, M.D.

This presentation is a further elaboration of some ideas, developed in earlier papers, regarding the psychopathology and treatment of adults who had lost a parent in early childhood, and a report on an experimental modification in analytic technique, consisting of the interpolation of extra sessions with no time limit with some patients.

Citing Fenichel on the role of object loss in the etiology of traumatic neurosis in childhood, and adhering closely to Bowlby's concepts regarding mourning reactions to loss in infancy and childhood, the author correlates varied clinical manifestations in his patients with their incomplete or inadequate mourning in childhood for a dead parent. A child is not capable of 'mourning within the normal' and, therefore, is prone to fixations to incomplete mourning states, engendering both immediate and long-range pathological consequences within the personality. The early loss of a parent, before important œdipal resolutions have been achieved, and especially if the loss has been sudden, imposes profound defensive and adaptational readjustments on the child, causes a disruption in normal maturational sequences, and sensitizes the child to respond with extreme reactions to separations, changes, and losses of all kinds. Libidinal and aggressive drives are deprived of the object necessary for their expression, stimulation, channeling, and regulation. Phase-specific fantasies come into conflict with drive remnants, perceptions, and memory traces still attached to the recently lost object.

The patients studied, four men and eight women, suffered from depression. In some the depression was masked by character traits, usually obsessive, or by a degree of ego disorganization. One man, whose father had died when he was three years old, complained of dizziness and vagueness, while at the same time he laughed with pleasure. Analysis revealed this to be associated with painful memories of a game repeatedly engaged in when his father, on returning home, would grasp the child by the hands and both would whirl until they became dizzy and then laugh with great pleasure. Another patient, a woman, became irrationally fearful if she were asked unexpectedly to go somewhere; she had been suddenly taken from kindergarten one day to see her dying mother.

Sessions with no time limit were introduced in order to deal with resistances to the time limit of the regular sessions, to promote more complete catharsis, and to circumvent the defensive ego reorganization occurring in the interval between sessions. A total of seventeen such sessions were held with four patients, the minimum two and the maximum five for any one patient. During such sessions phobic reactions and mild depersonalization gave way to a deepening depression which then burst into a full mourning reaction. 'Re-experiencing of the mourning was such that the analyst felt he was witnessing the mourning

before the corpse.' The sessions were brought to a close when associations indicated fatigue had set in. During subsequent regular sessions, all fantasies pertaining to the extra sessions were analyzed, including the wish to repeat them, until they had become an integral part of the 'very history of the analysis'.

DISCUSSION: Dr. Manuel Furer called attention to the important clinical issues raised in the paper, namely, the roles of trauma, grief, and mourning in actual object loss in childhood. Until recently these had been relatively neglected in psychoanalytic literature. The concepts elaborated by the author, as well as those of Bowlby, represent more descriptive than explanatory statements, since they say little about the underlying processes in grief reactions and in the ego organization the child undergoes in response to object loss. Dr. Furer questioned whether the mourning reactions experienced by adults in analysis were actually the recovered mourning states of childhood. They might rather be considered the results of ego maturation promoted by analysis. The child's capacity to mourn is commensurate with the level of development at the time of the loss, and is especially influenced by the degree of object constancy achieved by the child. Regarding the extra sessions with no time limit, Furer cited the example of a young woman in analysis with him who in a previous treatment had been given extended sessions of two hours or longer. These proved to have been masochistically experienced by the patient; they were related to beating fantasies and 'preserved a secret love' for the lost father with whom she would some day be magically reunited.

Dr. Peter Neubauer, drawing on his own clinical experiences with children who had lost a parent in their prelatency period, stated that the type of acute reactions and the variety of clinical pictures in the child will be determined by such factors as the nature of the pretraumatic relationship to the object, the age and condition of the child at the time of loss, and the attitude of the remaining parent. He could confirm many of the findings reported by the author: ambivalent fantasies indicating that the urge to recover the object is itself bound by ambivalence, idealization of the lost parent, pseudomaturation, and extreme sensitivity to subtle differences between the lost and new substitute objects. He asked whether the extra sessions were deemed necessary because the pathology went beyond that of a neurosis, and thought there might be some similarity between such sessions and the pretreatment procedures reported by Alpert, which supply oral needs and designated corrective object relations.

Dr. Elisabeth Geleerd cited clinical experiences and studies which demonstrate that complete mourning is not possible in childhood, nor even in adolescence. What appears in the child as indifference to loss, is a manifestation not of coldness but of a defensive reaction against being overwhelmed by the loss.

Dr. Martin Wangh concurred in the opinion that the child is unable to mourn fully for a lost parent. He likened the extra sessions to those religious practices and rituals observed toward those who have suffered a loss.

In reply, Dr. Remus Araico said that the traumatic neurosis in childhood following the loss of a parent could be considered in every way a fate neurosis. He could not, in the paper, give its panoramic scope nor go into metapsychological details, but said these would be elaborated as a result of further study.

The extra sessions with no time limit were still in the experimental stage, though he thought much had already been gleaned from them.

JOHN DONADEO

September 29, 1964. CIRCUMCISION AS DEFENSE: A STUDY IN PSYCHOANALYSIS AND RELIGION. Howard H. Schlossman, M.D.

Psychoanalytic case material available for comparison with religious ritual was used by the author to study some aspects of the ancient and widespread circumcision rite, particularly its role in serving defensive needs.

A patient of Orthodox Jewish background, who had sought analysis because of recurrent depressions, on one occasion overpaid his bill for treatment. On analysis the overpayment related initially to the repression and denial of feelings that the analyst got paid without doing any work. These feelings, when made conscious, were followed by similar feelings toward the patient's parents, who had made a living by receiving interest from lending money. Further associations to the overpayment indicated it was an act of circumcision regressively expressed in anal terms. This meaning was also expressed by various small sacrifices which the patient had made throughout life to gain advantages. The deepest unconscious meanings of these symbolic acts of circumcision, on the œdipal level, warded off the danger of castration from the father. On preœdipal levels, the danger of castration arose from passive wishes to be impregnated by the father and oral fantasies of incorporating the breasts of the mother.

A study of the rite of circumcision suggests that defensive functions similar to those found in the patient are an important part of the fantasy content of the religious ritual. The history of its connection specifically with the Jewish religion is summarized. At the time the god, Jehovah, came into being, the ancient world appeared to be in ferment between two powerful religions. One involved the Mother Goddess with her son-consort, worshipped under many names—Ishtar, Atargatis, Cybele—and imbued with orgiastic mysteries. (The Virgin and Christ myth is probably the last and most highly idealized version involving the worship of an all-powerful woman.) A basic pattern appeared to be annual dismembering of the son-king or castration with sacrificial offering of the genitals to the Goddess by priests and adherents in the throes of religious ecstasy. The other, also an orgiastic religion, concerned the worship of a phallic god and his sister-consort, such as Zeus and Osiris. Both religions worshipped personifications of the instinctual drives. Then a new, austere, punitive religion arrived, demanding submission to one God. This was the Jewish religion and it served to protect against the dangers inherent in the instinctual excesses of the preexisting religions. The rite of circumcision itself served to ward off the danger of punishment for regression to the orgiastic religions and the primitive bisexual gratifications they provided. It placated a new, severe God who demanded submission and instinctual repression, while promising fruitfulness and the fruits of this world to his adherents.

DISCUSSION: Dr. Milton Malev described the Jewish ritual of circumcision as it is carried out today and discussed how it appears to confirm Dr. Schloss-

man's thesis that circumcision is a defense against castration fear. He concluded that the Jewish circumcision ritual is a condensed defensive maneuver on the part of the father against his own castration anxieties when the birth of a son returns them from repression.

Dr. Warner Muensterberger accepted the point that many clinical findings help illuminate social and cultural traditions and indicated how analytically derived conclusions regarding the meaning of circumcision were later confirmed by various field studies and observations. He also emphasized that it is always treacherous to transpose clinical observations of clinical disturbances to cultural institutions. It is generally accepted that circumcision where practiced is a socio-religious rite in the normal progress toward heterosexuality, but it may be absent altogether or some other form of anatomical mutilation may be practiced. One wonders why certain peoples perform this rite while others find different channels by which to achieve control in their œdipal defensive struggle.

Dr. Simon Weyl related a finding of Róheim regarding the meaning of circumcision as found in some primitive tribes: 'We [say the fathers to the sons] but take your foreskin when we are powerful enough to kill you. Let you remember this in our old age when you are strong enough to kill us.'

In conclusion, Dr. Schlossman stated that caution must indeed be exercised in applying clinical findings to cultural phenomena. However, the attempts must nevertheless be made because of the enrichment of understanding such applications have supplied in the past. He thought circumcision may be such a prominent part of the Jewish religion because total castration was so central to the preceding religions of the Near East. The absence of circumcision in various rites needs to be explained but does not appear to contradict the basic point of the paper. Róheim's finding appears to explain the origin of mercy.

EUGENE V. NININGER

October 13, 1964. TWO CONTRIBUTIONS TO THE THEORY OF WORKING THROUGH. Bernard Brodsky, M.D.

Dr. Brodsky begins with Greenson's definition of working through 'as the analytic work upon those resistances which prevent insight from leading to significant change', and expands the concept to emphasize the problem of the mastery of painful affects, especially anxiety. He traces Freud's development of the concept and points out that Freud applied the term only to the problem of id resistances that act as obstacles to the use of insight. Freud, however, recognized that rigid structuralization of ego and superego, as well as the hierarchy of danger situations, all require working through. It is in this broadened sense that the term is used by most analysts today.

The author notes that the techniques of working through, 'repetition and elaboration of interpretations as well as reconstruction of the past and its patterns', do not explain its *modus operandi*. It is generally agreed that 'the development of a transference neurosis accompanied by a therapeutic alliance is most favorable to a successful working through', but does not basically explain it. Freud saw 'working through as a dissipation via repeated fractional discharge of repressed drives or affects'. Dr. Brodsky emphasizes the importance of the con-

cept of structure for the understanding of the process of working through; structures cannot be discharged but must be changed. The question is what brings this about. Valenstein and Kris emphasized the importance of transforming insight from intellectual into total (affective) experience, and that it is affect-charged insights which lead to change in character, behavior, and self-representation. Brodsky believes there is a more germane consideration in the relationship between affects and working through—the problem of the mastery of painful affects, especially anxiety. The transference situation provides a setting which, by its very nature, affords an unparalleled opportunity for the mastery of anxiety mobilized in the transference neurosis. By interpretation, elaboration, and repetition, the patient learns that he can face anxiety without the threat of being overwhelmed. Defenses become less urgent and automatic, and instinctual impulses may also be faced and mastered. Working through then is a beneficent change in structure that requires mastery of suffering. In essence, the author suggests a dynamic and structural theory of change in place of Freud's original economic theory of working through as a process of dissipation through discharge. A case is reported to support his hypothesis.

DISCUSSION: Dr. Phyllis Greenacre, while in general agreement with Dr. Brodsky, emphasized the significance of the relation of reality and reality testing which is at least a concomitant and probably an essential part of working through. She felt that the actual move toward reality testing marks an important stage in the working through process, one feature of which is the response obtained from the outside world to internal changes. These tend to solidify the modifications going on in the analysand. The relationship between the sense of reality and working through was especially observable in a group of talented people who tended to embellish reality with their own fantasies, or who easily and convincingly interchanged reality and fantasy. Such patients may show gains in the analysis that appear to be quite fundamental but prove in fact to be quite ephemeral. Dr. Greenacre cautioned that the analyst must beware of the temptation to seduce, encourage, or 'pressure' the analysand to confirm apparent changes which occur in the course of treatment. Results seem better, she noted, when the therapeutic correction is mostly silent and more automatized, taking on some of the qualities of growth. In regard to the importance of recovery of critical events of childhood, Dr. Greenacre felt that it would be difficult to understand adequately the patterning established around the childhood memories without the recovery of critical memories. She also noted the difficulty of dealing with screen affects, especially since these have such a destructive effect on the therapeutic alliance.

Dr. Sidney Tarachow emphasized that the factors which bring about change in analysis are no different from those which bring about change in any other situation in life. He does not feel that working through in the sense of repetition of the past is crucial; working through of the real elements in the relationship to the analyst, especially those favoring identification with the analyst as a real person, is the important factor. In his view, the patient uses his analyst exactly as a child uses his parents. Change depends on convincing events within the analytic situation—events that are convincing because there is a real relationship

between patient and analyst. The final crucial factor is the separation that leads to identification with the analyst. While Dr. Brodsky emphasized the mastery of suffering through mastery of anxiety, Dr. Tarachow emphasized the mastery of disappointment at the hands of the analyst.

In conclusion, Dr. Brodsky voiced his disagreement with Dr. Tarachow who he felt placed too much stress on the relationship to the analyst and minimized the many other factors involved in the problem of working through.

IRWIN SOLOMON

October 27, 1964. THE EGO FACTOR IN PSYCHOANALYSIS IN INDIA. T. C. Sinha, D. Sc.

Dr. Sinha, taking as his point of departure Freud's statements in Analysis Terminable and Interminable, pointed to the difficulties which arise in the psychoanalytic treatment due to penis envy in women and the struggle against the passive feminine attitude in man. He noted that the concept of bisexuality is not a simple one to define from a psychological point of view; such terms as active and passive, for instance, can be applied to both masculine and feminine attitudes and 'the whole problem again boils down to the question of identification in a subject-object relationship.' The author suggests a re-examination of the question of the psychological preference for a penis. In the modified matriarchal tribal society of the Garos in Assam (India), the castration complex does not seem to be very prominent in women; the real difficulty lies not in the acceptance of the woman's role. In his view it is the inflated and false vanity which the ego attaches to the male role, that is the most difficult factor to overcome.

Two cases (a male and a female) were presented to illustrate the role of the castration complex and the ego's reaction to it. Difficulty in accepting femininity did not appear to be due to overvaluation of the penis, but to the social devaluation of the feminine role with the consequent low ego value assigned to it. In these patients the basic fear involved the feeling of void and aloneness. The desire to take a masculine role is seen as a defense against these fears by maintaining the primary narcissistic valuations.

Dr. Sinha noted the similarities between many aspects of psychoanalytic theory and the findings of Sankhya philosophy, the basis of Yoga.

DISCUSSION: Dr. Samuel Z. Orgel commented that Yoga philosophy seems to strive for perfection far beyond that sought by psychoanalytic treatment. Analysis, unlike Yoga, is not expected to free man of all passions. He noted that Dr. Sinha's paper was essentially a plea for psychoanalytic progress into a proper evaluation of the workings of the ego and its relationships to the id, superego, and reality.

Dr. Warner Muensterberger also discussed the concepts of the Yoga psychology and compared it to psychoanalytic theory, especially ego psychology. He pointed out that environmental conditions influence not only the pathways of discharge but also the form of the superego, ego ideal, value orientations, and partial identifications. For example, repression would have a different impact in the Judeo-Christian environment than in India where sexuality plays such an

important part in art, literature, and religion. He stressed, however, that the fundamental experiences, such as separation anxiety (the forerunner of castration anxiety), are common to all cultures. Dr. Muensterberger recalled that Dr. Bose had also found that in Indian patients the castration complex does not seem to play as important a role as in European patients.

Dr. Edward D. Joseph expressed interest in the comparison of psychoanalytic concepts and the Yoga philosophy and drew attention to a similar dualistic concept among the Greeks. However, he pointed out that psychoanalysis differs from philosophic systems in that its theory is based on clinical evidence derived from observations. He cited Hartmann's differentiation of Freud's use of the term 'ego' as at times referring to a portion of the mental apparatus and at other times to the concept of self, and suggested that when Dr. Sinha speaks of ego he refers to self-representation or the concept of identity. Dr. Joseph also thought that what Dr. Sinha calls the male and female role may have to do more with social and cultural evaluations. He commented on the severe degree of castration anxiety in the two patients reported. The fact that the male patient seemed to accept the actuality of castration but shifted his defense to the more abstract level of values testified to the strength of his anxiety. It would be interesting to know some of the precœdipal factors involved in this particular type of problem.

REBECCA G. SOLOMON

MEETINGS OF THE PSYCHOANALYTIC ASSOCIATION OF NEW YORK

May 18, 1964. BEYOND THE FUTURE OF AN ILLUSION. Nathaniel Ross, M.D.

Dr. Ross states that religious experience requires further investigation by analysts. The sense of reality and profound conviction of religious mystics are also seen in schizophrenics and many normal individuals during dreams, and occasionally at the height of orgasm. Freud called religion an illusion, a universal compulsion neurosis, and a projection of man's terrible need for a protective father. He was not too impressed by Romain Rolland's emphasis on the 'oceanic feeling' as a core of religious experience.

The claims of religion to validity equal to the results of a scientific investigation are challenged by the author, who presents the genesis and nature of religious experiences in the light of ego psychology. His thesis is that the need for religious faith is based on dread of object loss, the need for the eternal external existence of an immutably protective loving object. Dread of death and the wish for immortality essentially represent a fear and denial of object loss. The apparent limitless love that men can give to a god is dependent upon the immutable, entirely perfect, infinitely loving qualities of this idealized love object, which protects the believer against abandonment and promises eternal reward. Love for man, with its risks and difficulties, may be more difficult than love for a 'living' god.

While he acknowledges that religious belief will continue to be necessary for many, Ross believes that more mature human values can be derived from the theory and goals of psychoanalysis. Mastery of fear of object loss, relinquishing

of infantile dependence and infantile omnipotence, and ability to adhere to the reality principle can lead to greater love and a fuller capacity to contend with problems. Children growing up free from neurotic fear and guilt will have an advantage over the generations that required the solace of the supernatural.

DISCUSSION: Dr. Renato Almansi agreed with Dr. Ross that the essential psychology of religious belief is rooted genetically in the universal fear of object loss and its equivalent, death, and in the need to offset this by illusion, by the attempt to fuse with the everflowing breast, by the search for the protecting all-powerful father, and by the free use of magical thinking. In addition to the dread of object loss, Dr. Almansi cited the need to control libidinal urges, the need to control aggression to resolve ambivalence, and the intrinsic human need for moral codes in which both the ego and the superego are involved. Dr. Almansi also spoke of the great psychological differences between the mystic who experiences religious ecstasy, the obsessive for whom religion is reduced to an endless repetition of ceremonies, and the individual to whom religion represents merely a controlled illusion. He postulated that stranger anxiety is one of the early infantile determinants of the need for belief in religion.

Dr. Earl Loomis felt that the fear of object loss as the basic unconscious motive for religious belief was a cogent hypothesis. He cited William James on the varieties of religious experience, and raised the question whether these applied to all such experiences. While it is true that religion exploits fear, according to Pfister, Loomis commented on the religious ideology of Protestantism which protests and demands doubt. This need for questioning was contrasted with Erikson's concept of basic trust and the need for the establishment of constancies in order to allow doubt to appear.

Dr. Jan Frank felt that Dr. Ross did not sufficiently differentiate between institutionalized religions with dogmatic codes and personal religious beliefs. Dr. Otto Sperling raised several points. If religious belief is based on fear of object loss, one would expect it to increase in soldiers in combat; a study directed to this question showed that this is not the case. He wondered if religion as a controlled illusion should not be differentiated from other forms of religious practice. A need for religion may be based on the necessity for compensation for the sacrifices of communal life.

In conclusion Dr. Ross stated that Dr. Almansi's contribution about stranger anxiety in the origin of belief was valuable, but noted that stranger anxiety, as well as separation anxiety, depends on the existence of object relationship with the mother. In regard to Dr. Loomis' comments, he felt that it was most important to distinguish between ethical, moral, and supernatural, and their relations to each other.

HAROLD P. BLUM

October 19, 1964. CONTRIBUTION TO THE UNDERSTANDING OF THE CONCEPT 'THE UNIVERSALITY OF THE UNCONSCIOUS.' Charles A. Sarnoff, M.D.

The author presents results of a psychoanalytic study of pre-Columbian art made during visits to archeological sites in Central and South America. Variants of repeated elements in stone carving and pottery designs are treated as though

they were psychoanalytic associations. Thus, myths relatively free from Western preconceptions are derived; for example, 'fluid from the body of a special person brings fertility to the earth' and 'a snake gives birth'. These myths are then compared with the productions of patients. Dr. Sarnoff briefly reviews some of his findings and theoretical conclusions, and discusses the symbolizing function of the ego as it relates to the formation of symbols and metaphors. The first step in the formation of a symbol is the establishment of symbolic linkages, the precursors of symbols. Links are made through association by way of superficial similarities between body-ego elements and objects in the environment (i.e., phallus-snake). From the economic point of view, the establishment of a symbolic linkage means the creation of a pathway for the displacement of instinctual energies. A symbol is formed when this link is used, without conscious awareness, as a pathway for the discharge of drive energies away from the body or primary object to the word representation of the linked environmental object. This effects the discharge of drive energies in such a way that meaningful object representations are spared. The author elaborated on the nature of the core fantasy in relation to symbols, myths, and personal fantasies. In pre-Columbian culture, the expression of the drives through symbols as reflected in myths was sanctioned and encouraged, while in our culture it is not.

DISCUSSION: Dr. William Niederland noted that Dr. Sarnoff's paper belongs to the legacy left to us by Freud, but had some questions about the methodology involved. He cited Gustav Landauer, who felt that the history of some peoples, because of their spatial and cultural remoteness, is not readily available to the historian and sociologist. It remains to be seen whether psychoanalysis can supply us with better tools for the study of history of remote and isolated cultures.

Dr. Melitta Sperling discussed the snake symbolism mentioned in Dr. Sarnoff's paper. In her experience, few children use snake symbolism persistently so that its occurrence is of special significance and transcends that of the snake as a phallic symbol.

Dr. Max Stern emphasized the importance of the historical development of the myth. He questioned that the myth and symbol were created in the child, which Dr. Sarnoff's formulations seemed to indicate.

In conclusion, the author agreed with Dr. Niederland about the pitfalls in the methodology involved. Concerning Dr. Sperling's clinical observations about snake symbolism, he felt that with progressive ego development the snake 'goes into repression of the underworld' and is seen in connection with early pregenital regressions. He stated that he too could not accept any concept that explained myth and symbol simply as if they were created in the child.

NORMAN N. RALSKE

Bertram D. Lewin was elected an Honorary Member of the PITTSBURGH PSYCHOANALYTIC SOCIETY on January 11, 1965.

George E. Daniels delivered the Ninth Annual SANDOR RADO LECTURE, sponsored by The Psychoanalytic Clinic for Training and Research, Columbia University, on March 26 and March 27, 1965.

Howard P. Rome, president of the staff and senior consultant of the section of psychiatry at the Mayo Clinic, has been appointed the thirty-third ALFRED P. SLOAN VISITING PROFESSOR in the Menninger School of Psychiatry, Menninger Foundation.

The Institute for Research and Training of the Devereux Foundation has announced Internships and Fellowships in Clinical Psychology. For further information write: Dr. Henry Platt, Devereux Foundation, Devon, Pennsylvania.

BERNICE ENGLE, a writer particularly in the field of psychiatry, and associated with the University of California Medical School, died in October 1964 at the age of seventy-one.

Mrs. Engle co-authored books on psychiatry, was editorial assistant for others, and published articles on a wide variety of subjects that attest to the range of her interests and knowledge. She is known to readers of This QUARTERLY for her highly esteemed contributions to it in applied psychoanalysis: *Melampus and Freud,* Vol. XI, 1942; *The Amazons in Ancient Greece,* Vol. XI, 1942; and *Some Psychodynamic Reflections Upon the Life and Writings of Solon,* Vol. XX, 1951, the last in collaboration with Dr. Thomas M. French.

ERRATUM: In the summary of Dr. Max Schur's Freud Anniversary Lecture, This QUARTERLY, XXXIV, 1965, p. 146, line 33, Stefan Zweig should read Arnold Zweig.