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Aaron Karush

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WORKING THROUGH

BY AARON KARUSH, M.D. (NEW YORK)

I

After many years it is still difficult to explain the relationship of working through to various phases of the analytic process. Many psychoanalytic concepts, such as identification *(18)*, sublimation *(19)*, ego strength *(13)*, perception, and psychic representation *(12)*, which clinical experience has shown to be vague or ambiguous, have recently been redefined and restudied. Formerly efforts were made to preserve intact the assumptions and conceptualizations of instinct theory and of the related theory of psychoanalytic therapy, but now, in spite of a good deal of opposition, some hypotheses and concepts about instincts and about polarizing energies are being amended to fit the empirical needs of ego psychology and structural theory. Working through seems to need this kind of re-evaluation. Here I will point out aspects of the process of working through that have in the past either been dismissed entirely or regarded as of minor significance.

Several questions arise. 1. What do we mean by working through in the structural sense? And how is working through to be differentiated from the analytic process as a whole? 2. What is the relation between working through and the transference? To what extent does working through depend on dissolution of the transference? 3. Is working through a special instance of the rational aspects of learning? And conversely, are there nonrational aspects of the process of working through? 4. What part does interpretation play in working through? 5. What specific contributions, apart from interpretations, does the analyst make to successful working through?

From the Psychoanalytic Clinic for Training and Research, College of Physicians and Surgeons, Columbia University, New York.

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The answer to any one of these questions partly answers the others. To begin with, working through primarily signifies certain processes within the patient that help to complete the analytic task of structural reorganization; this reorganization frees the adaptive functions of the ego and superego from developmental distortions and fixations. And working through also includes the technical aspects of the exchange between patient and analyst that helps to release and reshape these dynamic processes.

To reach an acceptable definition of 'working through' it is helpful to trace briefly its history.[1]

From the beginning, Freud used various terms to describe certain phases of the therapeutic process. He spoke of 'abreaction', 'wearing away', and 'working over' as early as the chapter on cathartic therapy in Studies in Hysteria *(2)*. These terms seem to have been the precursors of Freud's later more sophisticated concept of working through.

In the cathartic treatment the goal was to make conscious, and hence amenable to 'wearing away', a repressed traumatic memory that had remained pathogenic. 'Wearing away' could take two forms, 'abreaction' and 'associative working over'. The latter is a kind of watering-down that supplies substitutes and displacements to replace the repressed ideas which were originally connected with the painful affect. It involves thought processes that are in some way associated with the repressed idea and it is an attempt to solve a threatening psychic situation by replacing painful affects with neutral thoughts. Associative working over is in this sense a fundamental property of the secondary process. Abreaction, however, 'wears away' by bringing together a pathogenic affect with the images, words, feelings, and actions that were cut off from the affect when it was

[1] Some of my discussion is derived from Mark Kanzer's commentary *(11)* on the historical development of Freud's ideas about working through, presented at a panel discussion. He drew attention to facets of Freud's thinking that have not generally been recognized. However, the inferences I have drawn from the different phases of Freud's approach to the processes of working through are my own.

first experienced. To be effective, abreactive experiences must be fairly intense paraphrases of both the original trauma and the strangulated response to it. In contrast to this, associative working over leads to the binding and taming of affects by the ego through associating them with relatively neutral and unrelated ideas. When an affect is bound in this way to ideational substitutes, it also acquires a signal function by which new pathways for thoughts are sought whenever the painful memory threatens to reappear. Associative working over thus aids repression. Avoidance of a painful memory seldom can resolve a conflict and rid the psyche of underlying anxiety. Only abreaction, a nonreasoned process, brings about a direct discharge of relevant affects and recovery of the traumatic memory.

This is not to say that Freud attributed only a defensive function to associative working over. As Kanzer pointed out, the concept of working through evolved from both abreaction and associative working over. In 1910, Freud *(3)* represented the analyst as making an interpretation which gives the patient a rational approach to overcoming resistance. The patient mentally 'works over' the interpretation of what he might expect to find until he 'discovers' the repressed idea by way of its similarity to the one suggested in the interpretation. Kanzer quoted Kris's related comment that interpretations achieve their effects through 'recognition leading to recall'. The essence of Freud's early view of working through is that abreaction and working over are set in motion by analytic interpretation to revive traumatic memories and strangulated emotional reactions.

Freud did not, however, remain satisfied with this broad but relatively simple view of working through. He was beginning to change his ideas about suggestion. In the 1910 paper he still acknowledged that suggestion was needed to produce the desired effect of an 'intellectual interpretation'. It was recognized that the positive transference endowed suggestion with power to motivate the patient to give up a resistance. Four years later when Freud first used the term 'working through' *(4)* he modified his conception. He now indicated that the effect of inter-

pretation is not merely strengthened by the magical aspects of the transference; interpretations are to be addressed to the transference itself wherever it provides evidence of repressed ideas and feelings which influence the patient's present behavior. The force of such interpretations appears to go beyond the power of suggestion. Just how interpretation of the magical transference gets its power to change the patient's infantile expectations (and perhaps his suggestibility), Freud could not yet explain.[2] Working over an interpretation with the motivation supplied by the powers of suggestion inherent in the transference had now become working through interpretations of the anti-analytic motivations, that is, of the resistances created by the transference. Freud seemed to push suggestion into the background and to substitute the rational force of understanding. Change would presumably result from that understanding rather than from the nonrational force of the analyst's suggestions.

This new emphasis recognized that the patient is impelled to change his analysis from a reconstructive process to a reenactment of infantile fantasies in which he tries to bribe or coerce the analyst into providing infantile gratifications without risk to the patient. Interpretations are directed toward such regressive resistances by making them conscious and neutralizing their opposition to the recovery of repressed memories. As Kanzer put it, working through involves the patient's acceptance of insight as a 'temporary substitute for immediate gratification'; the goal remains however the 'true confrontation with the infantile memory' with which the revision of personality was presumed to begin. The question of where interpretations of resistance get their ability to influence the patient continued nevertheless to be avoided. It remained unclear just what pleasure insight can offer to allow gratification to be postponed, let alone renounced altogether.

[2] Kanzer *(11)* pointed out that this approach to interpretation required concepts not used by Freud until the structural theory was developed, concepts such as the split between the experiencing and observing ego and the positive contribution of the transference neurosis to the therapeutic alliance.

Freud's changed view of suggestion as the motivating force of working over reflected his search for concepts that would define the analyst's influence for change in terms consistent with the views then held of the psychoanalytic theory of development. Transference replaced the more superficial, catch-all concept of suggestion. It is in some respects unfortunate that the function of suggestion and the mechanisms by which it operated in the analytic situation have since fallen into disrepute as respectable instruments of change. Certainly the transference includes those psychic processes in the patient that give the analyst's interpretations their unique force and their power to influence the patient. It is important to interpret the resistive aspects of the transference neurosis, but not *all* the transference is resistance. Some of the patient's unconscious and preconscious reactions to the analyst can be put to good use, for example to further the therapeutic alliance. To differentiate resistive functions of the transference from nonresistive facilitating functions requires a structural conception of the transference relationship. Infantile *regressive* tendencies live side by side with infantile *progressive* capacities in the transference relationship. Among these progressive capacities are forces essential to successful working through; these are the identifications out of which the ego ideal evolves and which help to strengthen the ego's tolerance for frustration and threat. The transference therefore includes psychic structures and functions that work for recovery and freer development, as opposed to regression and fixation. These segments of the transference transcend the role of reason and understanding in bringing about fundamental changes in behavior.

In many ways successful working through repeats a universal developmental process by which energy is provided both for the renunciation of infantile aims and for their replacement by new and more socially acceptable ones. The ego ideal is, I think, the psychic structure that serves as the internalized instrument of the force of suggestion that came originally from the analyst. In that sense it may be said that the ego ideal replaces sugges-

tion by the analyst. There are hints that Freud was approaching such a conception in his later papers, in which he seems to have recognized the weakness of his definition of working through.

In Inhibitions, Symptoms and Anxiety *(6)*, Freud first used structural terminology to describe working through as the work of the ego on resistances arising from the id. He still equated unconscious with id when he spoke of the attraction exerted by unconscious prototypes upon the repressed instinctual processes. Freud referred here to early memories and 'adhesiveness of the libido' to those early psychic representations that often persist even after the ego's resistances have been analyzed and its countercathexes withdrawn. Fixation 'from below' had been discussed in the early formulation of the concept of repression but Freud did not really clarify it with the concept of id resistance. To be sure the problem was restated in structural terms but only descriptively. What after all is responsible for the adhesiveness of the libido? In Analysis, Terminable and Interminable *(7)*, Freud underscored inherited ego qualities as well as id attributes which are not susceptible to analysis. He suggested that certain qualities of the ego and id contribute unanalyzable unconscious resistances. This led to a pessimistic conclusion about analytic therapy and followed logically enough from his doubts that the earliest neurotic formations can really be reproduced in the transference neurosis. If these tributaries to id resistance lie beyond the influence of the psychoanalytic process, of what use is the concept of working through as Freud had defined it? Freud may have given his answer when he omitted any further reference to working through as he had used it originally in his final papers on analytic therapy *(7, 8)*.

It is little wonder therefore that the working through that goes with the final resolution of neurosis has been extended to include all resistances. In fact, working through today means to some analysts the solution of almost every problem to be met in treatment. It has become synonymous with achievement of successful adaptation, with creation of healthy psychic struc-

ture, and with fulfilment of development and maturation that had been detoured or obstructed by neurotic conflicts in general.

This unfortunate diffusion of the meaning of working through results, I believe, from Freud's hopelessness about directly affecting id resistance. Adhesiveness of libido, however, which he included with psychic inertia as id resistance, is probably more accurately classified as an ego resistance. As Kanzer noted, adhesiveness of libido makes sense only in terms of object relationships and is therefore more closely related to ego processes. Of Freud's original conception of the subject matter of working through, only psychic inertia, the failure of drives to move along new paths of discharge that may be opened up in the course of analysis, remains as a possible manifestation of so-called id resistance. Even here the doubt remains whether working through can really approach this hypothetical form of id resistance except through the functions of the ego.

In Constructions in Analysis *(8)*, one of the most significant of the later papers, Freud suggests that the analyst's interpretative constructions go *beyond* work upon the patient's resistances. Interpretations should also arouse a sense of hopefulness and strength about the patient's past experiences and about his capacity to change. Such constructions intensify the therapeutic alliance and in so doing tap a new source of motive force which can move the patient from his developmental dead-end to new adaptive positions. These positions can be reached only when the patient recognizes and accepts the need both for new ways to cope and master and for renunciation. Just how, and from what structures, such new energies for change may come Freud never discussed. At one point, however, in Constructions in Analysis, he remarked that the actual return of a traumatic memory may not be necessary, that a *conviction* that an event had indeed occurred may follow an interpretative construction and be just as effective therapeutically as a full recollection. What, we must ask, can give such an idea shaped by the analyst's interpretation the necessary sense of conviction?

We seem to have come full circle and returned to Freud's earliest conceptions of the therapeutic process as springing from suggestion, direct or indirect. It would be helpful if the function of suggestion and its counterpart in the patient, suggestibility, could be harmonized with ego psychology and structural concepts.

In 1934, Strachey *(21)*, in his now classic paper on the nature and effects of interpretation, undertook to redefine the therapeutic forces unleashed by psychoanalysis. He emphasized the function of the superego in bringing about a structural change in the patient. Borrowing from Rado *(17)*, he suggested that the analyst acts as an 'auxiliary superego', temporarily taking over functions of the patient's superego during the analysis, and in so doing helps to bring about far-reaching structural shifts. We may not fully agree with Strachey's somewhat Kleinian conceptualization of good and bad introjects which are projected outward, but his emphasis on the positive function of the analyst as a real object in bringing about a lasting alteration in the balance of motivational forces is very close to the views expressed here about working through. In brief, working through, whether it is defined as dissolution of resistance from the id or of resistance from other sources within the personality, depends on more than the rational effects of interpretation; it depends also on nonrational forces set in motion by the analyst.

These nonrational forces for change are released by the analyst's real qualities (which I shall discuss later) in the therapeutic situation as distinguished from the illusory qualities projected on him in the patient's transference neurosis.

Strachey's view of the analyst's power to mold the patient's personality is best summed up in his own words: 'The patient's original superego is, as I have argued, a product of the introjection of his archaic objects distorted by the projection of his infantile id impulses. I have also suggested that our only means of altering the character of this harsh original superego is through the mediation of an auxiliary superego which is the

product of the patient's introjection of the analyst as an object. The process of analysis may from this point of view be regarded as an infiltration of the rigid and unadaptable original superego by the auxiliary superego with its greater contact with the ego and with reality. This infiltration is the work of the mutative interpretations; and it consists in a repeated process of introjection of imagos of the analyst—imagos, that is to say, of a real figure and not of an archaic and distorted projection—so that the quality of the original superego becomes gradually changed' (p. 157, n.). In another part of his essay, Strachey notes that 'this separation between the imago of the introjected analyst and the rest of the patient's superego becomes evident at quite an early stage of the treatment; for instance in connection with the fundamental rule of free association. . . . the "auxiliary" superego . . . usually operates in a different direction from the rest of the superego. And this is true not only of the "harsh" superego but also of the "mild" one. . . . The most important characteristic of the auxiliary superego is that its advice to the ego is consistently based upon *real* and *contemporary* considerations and this in itself serves to differentiate it from the greater part of the original superego' (p. 140). Strachey thus emphasized the transference importance of the analyst as a real person who corrects the patient's neurotic tendency to regressive distortion by his consistent delineation of what is 'real' and 'contemporary', especially in the analytic situation. I shall return to this question of the real as opposed to the fantasied analyst later.

Greenson *(10)* may have referred to the same processes in his recent discussion of working through when he stated that working through is the analytic task of removing resistances not affected by insight. The conclusion seems inescapable that the therapeutic success of analysis depends not only on the rational power of 'truth' and the patient's ability to grasp that truth but on nonrational forces generated in the object relations with the analyst.

There are other views of working through that differ mark-

edly from those presented here. At one end of the spectrum there is frank doubt that the concept has any value (*cf.*, discussions by Bird and Calder in the 1964 Panel on Working Through [*15*]). But during the 1964 discussion, Greenson considered the essential function of working through to be overcoming the resistance to transforming insights into changed behavior, regardless of the source of that resistance. Ekstein *(1)* expresses a somewhat different view: working through enables the patient to gain insight into his regressive tendency to hallucinate the primary mother-child relationship. Like all learning, says Ekstein, this task requires 'endless repetition in the service of adaptation'. How it works he does not explain. Wexler *(22)* suggests that 'structural rigidity' and 'fixity of drives' may be the greatest obstacles to analytic change, both being defenses against a psychotic illness. Wexler pessimistically believes that working through will not be better understood until we have a psychoanalytic theory of learning. Windholz, in the 1964 Panel *(15)*, considered working through a description of what happens during analysis of screen memories and screen affects; it is necessary for the recovery of repressed events. The precise place of working through in the analytic process, whether it depends on the prior development of the therapeutic alliance, or whether it begins at the very start of analysis as claimed by some, or is a later aspect of the therapeutic process, remained in dispute. Windholz is somewhat evasive when he suggests that the greatest value of working through is for conceptualizing the therapeutic process.

Keiser *(14)* recently re-emphasized his theoretical understanding of working through as a manifestation of repetition compulsion. He too seems to broaden the function of working through to include resolution of ego and superego resistances, if I understand him correctly. On the other hand, in his careful review of working through, Stewart *(20)* urged that we limit the term to its classic freudian definition—that of removing id resistances. He suggested that id resistance may be subdivided into psychic inertia, adhesiveness of the libido, and fixation.

Fixation is rooted in genetic factors, developmental experience, and disturbed object relationships, and is subject to the therapeutic action of insight mainly brought about through interpretation. Psychic inertia, characterized by a lack of mobility of cathexes, is apparently a largely constitutional or inherited predisposition. Adhesiveness of the libido signifies an inertia of object cathexis and in part at least may also be a matter of constitution and heredity. Like psychic inertia, of which it seems to be a special case, it does not yield, according to Stewart, to interpretation or to insight. Stewart emphasized Freud's admonition that only time and patience can bring about changes in these latter two aspects of id resistance and suggested that the patient's motivation for overcoming id resistance comes from the power of the transference to convince the patient of the 'necessity to submit to the reality principle'.

Patience and time are essential to every aspect of the therapeutic process and to the resolution of every type of resistance. Their effectiveness comes from re-education of the ego and relearning, but also especially from strengthening of the ego through the formation of new identifications.

Greenacre *(9)* usefully distinguished between the process of working out and the process of working through. It is not easy to tell where one ends and the other begins and, in fact, working through need not be limited to the final phase of analysis. It is interwoven throughout most of the analytic process from the very beginning. Working out is the process of bringing repressed memories, ideas, affects, impulses, and defensive characterological traits and attitudes into consciousness; it includes the patient's discovery of his habits of perception of inner needs and environmental demands and his responses to them. But repeated demonstration to the patient of the common elements in his repetitive neurotic behavior by itself seldom if ever constitutes the whole process of working through. For example, a patient often responds to his analyst's repeated interpretation of inappropriate or infantile qualities in his thoughts, feelings, and behavior by seeing projected into the analyst the critical

and punitive qualities of his own superego. The analyst continues patiently to interpret over and over the transference significance of the patient's sensitivity and of his fear of loss of love. Strictly speaking, although this type of repetitive interpretation is part of the process of 'working out' and is addressed to the transference neurosis, I believe it has the nonrational attributes described by Strachey that merge into working through proper.

The effect of working out is understanding, the intellectual component of insight. Some patients with this understanding can with relative ease go on to organize more appropriate ways of feeling, thinking, and behaving. Unfortunately there remain many patients with character disorders and severe psychoneuroses for whom insight and change are far from synonymous. In them, experience of the nonrational aspects of working through, as distinct from the intellectual understanding advanced during the stage of working out, is essential to the success of psychoanalytic therapy.

It is easier of course to describe what ought to happen in the analytic process than to explain how it happens. The crucial nonrational ingredient in working through is to be found in the transference relationship as distinct from the projections and displacements of the transference neurosis, which is but a part of the total relationship to the analyst. The tie to the analyst as a real person with the strength to persist in a difficult task, with consistency, tolerance, and realistic modesty makes it possible for the patient to complete an essential part of unfinished developmental business. As the transference neurosis is worked out and the fantasy analyst created by the neurosis is clearly revealed to the patient as unreal, the real analyst gradually comes to serve as a new and relatively conflict-free object for idealization and identification.

Idealization is used here in a specific and limited sense. It begins with recognition by the patient as treatment progresses that the analyst has emerged as patient, sincere, and tolerant, but not corruptible by the patient's demands. This acknowl-

edgment does not require that the patient 'love' the analyst; in fact he may not have freed himself fully from the hostility induced by the transference neurosis. Obviously, transparent countertransference in the analyst can be an immovable obstacle to this prologue to idealization.

Recognition of the real analyst's here-and-now qualities of mind and character is followed by the positive affective discovery that the analyst develops and maintains these qualities with effort and struggle, that they are ideals toward which the analyst continually strives. If the patient admires such qualities and respects the standards the analyst sets for himself in his contemporary relationship with the patient, they become desired and hoped for by the patient. It is this attitude of appreciation and respect for the aspiration and genuine achievement by the real analyst in the analytic situation that I call 'idealization'.

How can one distinguish this adaptive level of idealization from the regressive infantile delegation of omnipotence to the analyst that characterizes the patient's transference neurosis? Once the patient projects his own images of a 'good' or 'bad' object upon the analyst, the latter is in part at least turned into a fantasy analyst who embodies the archaic figures from the patient's past. All the patient's unaltered expectations of magic are then addressed to the fantasy analyst. Idealization during this phase of analytic work is no more than introjection of the analyst's illusory ability to give the patient immediate gratification, constant power, and instant health. The affective accompaniment of this kind of idealization and identification is elation. The end or object is all-important while the realistic means or skills necessary to attain one's aims are ignored. Idealization of the real analyst occurs on the other hand when the patient becomes aware of the analyst's realistic efforts to fulfil his own ideals in the analytic situation, even when they are not wholly successful. With it comes the sober recognition that some goals may have to be renounced and that the struggle to cope with the demands of reality is an endless one.

The level of idealization and identification reached by the patient depends upon his ability patiently to uncover and work out the reason he has created the fantasy analyst. As the projections of the past are interpreted and acknowledged by the patient, he is freed to relate to the genuine attributes of the analyst in the immediate analytic relationship. The change, a slow and reluctant one, might be compared to the gradual awakening from a strong wish-fulfilling dream.

Idealization of and identification with the real analyst foster the emergence of a newly effective ego ideal. Since the ego ideal arises originally from the earliest identifications with the parents, it becomes the vehicle by which the parents' wishes and expectations are continuously re-enacted without their actual presence or intervention. In other words, the ego ideal perpetuates the affectively-charged suggestions of parents. What gives parental suggestion such enormous motivating force? Here we can only speculate that the primary narcissism that we assume to be the natural state of every infant is at some point projected upon the parents. This delegation of omnipotence accompanies the child's earliest recognition of the differentiation of his self from the outer world. The parents become the prime ministers for his majesty, the child, who thereby acknowledges his own weakness while at the same time maintaining his illusion of omnipotence by proxy.

In later life we note a strange phenomenon. During and after the period of œdipal conflict, the child first discovers and is forced to admit his true vulnerability. Parents do not submit to his wishes. A partial solution is at hand however. The child admits painfully that he is indeed weak and not omnipotent. But he preserves the old illusion through the idea, 'I am not strong now, but I will be strong later by becoming like my good and powerful parents, teachers, or heroes'. Thus the ego ideal becomes the heir to infantile omnipotence. It fulfils the suggestions made by those upon whom the child was dependent in his early years and becomes one of the most powerful psychic structures, able to supply many of the motivational forces for binding the affective components of the drives.

The analyst's role as model for new identifications offers the patient a second chance to reconstitute a poorly integrated psychic structure. It is this re-enforced ego ideal that helps to counter (neutralize) the regressive forces of resistance from id, ego, or superego. Conversely when the ego ideal is not reconstructed, working through toward the ultimate therapeutic goal of structural rebalance is not likely to succeed. In other words, to time and patience we should add idealization and identification in the service of development as fundamental therapeutic instruments.

The relation of working through to the analytic process as a whole is not always easy to delineate. In general, I believe, working through serves two broad purposes. First, working through in the sense of uncovering resistance to engagement in the analytic situation or to opening up a new area of analytic 'excavation' involves strengthening the therapeutic alliance with the analyst. The analyst as a new and at least partly real object begins to impress his valued qualities upon the patient who is then able to make common cause with a trusted object.

The second broad purpose of working through is to carry intellectual understanding through a phase of assimilation and into association with energizing affects. It is a recurring culmination point, a climax to a laborious attempt during analysis to define a concrete problem of conflict or object distortion, or both. It also illuminates the way to a new perception of the problem and to a new way of coping with it. Its achievement brings a sense of relief and well-being due to renewed self-esteem and hopefulness. The new clarity of perception and sense of competence in using a different way of coping and mastering reflects to some degree qualities of the real analyst with whom the patient has begun to identify. These qualities first become clear to the patient in the way the analyst reacts to and interprets each aspect of the transference neurosis that is immediately at issue.

The analyses of patients who act out their character disorders show that narcissistic defenses and resistances lose their power to cause repetitive acting out according to the patient's

ability to identify himself with valued traits of his analyst. The extent to which the ego ideal is strengthened often decides whether the impulse to act out can be controlled. Since learning anything new can be difficult and frustrating, the patient's motivation for continuing his efforts must be constantly re-enforced. Re-enforcement of learning is based either on punishment for failure or reward for success, or both. Acting out is seldom seriously deterred by threat of punishment, but reward is often effective. The analyst rewards his patient by giving him understanding and by his tacit appreciation and approval, intrinsic components of his tolerance and nonjudgmental attitudes. By identifying with the analyst as a real person, the patient provides himself with the power of self-reward for successful renunciation of infantile impulsivity or inertia. Self-reward also re-enforces intellectual efforts to learn. Ego controls are ultimately strengthened by identification with the real analyst who has become the model for a refashioned ego ideal.

There are obvious dangers of misusing the therapeutic concept of 'identification with the real analyst'. The emphasis on idealization of the adaptive strengths demonstrated by the analyst in his contemporary relationship to his patient requires no more of the analyst than that he remain true to his role of objectivity, understanding, and empathy. He most certainly should not try to impress the patient with his perfection and saintliness, with omniscience and the power to foretell (and control) the future. The very opposite is essential. To allow the patient to 'idealize' and identify with qualities that he has himself projected onto the analyst through the transference neurosis is to encourage regressive imitative identifications with the fantasy analyst's imagined omnipotence. But an emulative identification with the real analyst's respected qualities leads the patient to accept new obligations. He can better tolerate the perpetual struggle to learn new skills, to deepen his understanding of his relation to real objects, and to recognize the limitations imposed by reality on gratification. The motive force for this sustained grasp of reality comes in the main from the ego ideal.

During the stage of analysis when the transference distortions and tendencies to regressive identifications are being worked out, interpretation can be considered to be the 'magic bullet'. It opens the overlapping second stage of therapy in which the patient gradually rebuilds his ideal image. Interpretation is no longer the primary instrument; the analyst's *example* in the analytic relationship to his patient becomes more and more important. Suggestion of the special sort described earlier is thus transmitted and adds stature and strength to the patient's image of what he hopes to be.

Difficulties in forming therapeutic identifications do not necessarily reflect the strength of resistance. They can issue from weaknesses in the transference relationship itself. These weaknesses may inadvertently be fostered by the analyst because of inexperience or because he regularly equates every aspect of the patient's relation to him with the transference neurosis. To do this, to try to interpret and dissolve away all aspects of the patient's interest in and identification with the analyst, can result in a cold and static process, in an analytic impasse which all too often is dismissed with the label 'resistance'.

Difficulties introduced by the analyst's countertransferences can invade both stages of working through—the intellectual and emotional resolution of unconscious transference distortion, and the formation of developmental identifications with the real analyst. The latter phase of working through may be most vulnerable. Trouble may be compounded because theoretical conceptions of proper analytic technique can easily be used indiscriminately by the unwary analyst to deny the patient the right to assimilate to himself his analyst's genuine strength in coping with the patient's problems. Sometimes reaction-formation in the analyst against his own passive dependent wishes may turn him into a 'health fanatic' who considers any change in his patient suspect if it comes from the affective responses, through 'suggestibility', to the analyst's idealized qualities no matter how real they are.

An opposite tendency can also distort the analyst's judgment: a need to manage and control the patient, to prevent any 'mis-

take' by the patient, reflects the analyst's unresolved strivings for omnipotence and his distrust of others; it may push the analyst to seduce or coerce his patient into abiding uncritically by all the analyst's precepts and values. Problems like these are of course well recognized and are always warned against but they are worth mentioning here because their power to negate, perhaps permanently, the value of the affective nonrational aspects of working through is especially great.

The effect of the so-called 'inexact' interpretation upon working through is not easy to evaluate. One may indeed ask if there is any other kind than an inexact interpretation, in the sense of being 'limited'. Obviously incorrect interpretations tend to strengthen defensive resistance against recognition of truths and against the process of assimilation. Assimilation brings recognized truths about the patient's past into direct association with truths about current relationships, especially the transference. Incorrect interpretations do more damage however. Inevitably the patient senses their falseness and judges the analyst unfavorably. If the patient repeatedly considers his analyst untrustworthy and unable to correct his own errors, he will distrust the analyst's positive qualities such as tolerance, patience, and sincerity. Idealization and adaptive identification will be blocked and working through will remain incomplete.

It commonly occurs that while the patient is furthering his development by identification of himself with the analyst, the analysis seems to be at a standstill. Time is essential to permit the identifications to be converted into independent energizing structures.

Freud *(5)* stated the issue concisely when he wrote:

> We have formulated our task as physicians thus: to bring to the patient's knowledge the unconscious, repressed impulses existing in him, and, for that purpose, to uncover the resistances that oppose this extension of his knowledge about himself. Does the uncovering of these resistances guarantee that they will also be overcome? Certainly not always; but our hope is to achieve this by exploiting the patient's trans-

> ference to the person of the physician, so as to induce him to adopt our conviction of the inexpediency of the repressive process established in childhood and of the impossibility of conducting life on the pleasure principle.

It seems therefore that we must distinguish two components of working through, the rational and the nonrational, both necessary if insight is to be converted into positive adaptive behavior. The rational aspect of working through is expressed through arousal of the patient's reasoning and cognitive functions by the analyst's interpretations of unconscious resistance and defense, of unconscious inner needs, of aggression, and of ambivalence in object attachments. In so far as the therapeutic alliance becomes a conscious effort at coöperation with the analyst it also reflects the rational aspect of working through. The nonrational aspect of working through is reflected in the responsiveness of the patient to indirect suggestion by the analyst, in the patient's trust in the analyst as a person, and in his ability to idealize the analyst's qualities as a real person and to identify himself with them.

Working through is helped by certain technical maneuvers of the analyst. We are accustomed to think of the analyst's technical contribution to working through as repetition of interpretations, administered without boredom or impatience over a long period of time. But working through may at times require not repetition but patient silence. Working through simultaneously tries to break down stabilized regressive forces and to reconstruct psychic structures that can release previously ineffectual adaptive energies. What is repeated by the analyst is a renewed emphasis on the original conflict and its infantile components. When working through really works, the dynamic, economic, and structural balance of forces is always slightly different after each return to the original conflict. Working through is nothing but repetition only when it does not work. Failure of the process does not necessarily mean that there was not enough repetition (of interpretation by the analyst or of practice by the patient) but often that there was nothing else.

II

There are different areas of emphasis in working through which are integral parts of almost every analysis, although they vary in relative importance for each patient. Each area requires a different type of renunciation. The affect that accompanies renunciation may be sadness and even grief, as with any serious loss. Fenichel suggested that it resembles mourning. The various forms of working through clearly overlap but it helps to divide them for purposes of discussion.

WORKING THROUGH AS MOURNING FOR RENOUNCED GRATIFICATION

This is a problem in every analysis but especially in resolving hysterical transference and hysterical psychopathology. The goal is renunciation of an unattainable libidinal gratification especially from the œdipal object and its replacement by an available substitute gratification or object. This kind of working through may be necessary very early in the analysis. And when it is, successful working through of a defensive resistance against analysis is essential to development of a workable therapeutic alliance.

Clinical Example

A woman in her late thirties came for treatment because her career and marriage were seriously threatened by her compulsive 'affair' with a man for whom she worked. For the past two years she had fondled him and exhibited herself to him in his office but there had been no sexual intercourse. Recently her husband had received an anonymous letter accusing her of misbehavior and her fright caused her to seek help.

Although she feared exposure and divorce she was as flippant and defiant as an adolescent. Every question was met by a smile and a denial of concern, obvious signs of resistance to examining the problem of her unconscious œdipal fixation. A parallel problem was strong masculine identification and a defensive reaction-formation against her homosexual interests. With such

extensive denial, a favorable analytic situation seemed impossible unless she could first work through this resistance. I decided to focus first on the exhibitionistic aspects of her behavior; she dressed like an adolescent, exposing herself provocatively and courting the jealousy of other women. Surprisingly she seemed unaware of the latter motivation. Once she recognized that her behavior was exhibitionistic and provocative, a defensive purpose to her exhibitionism was suggested. Her resistance to committing herself seriously to treatment was approached by analyzing her defensive exhibitionism with me in the treatment situation. Working through the fear that I would ignore her as an attractive woman and—still worse—expose her wish to be a man, occupied the first two months of what became an analysis. Her childlike insouciance, her pseudo-liveliness, and her naïve physical provocativeness with me were soon replaced by an underlying depression. She then began to try more seriously to work out the problems of the depression and of her self-destructive erotic acting out. A therapeutic alliance was begun with the working through that accompanied the renunciation of her infantile exhibitionism.

WORKING THROUGH AS MOURNING FOR A LOST OBJECT

This occurs especially in dissolution of the transference neurosis and renunciation of the analyst as a fantasy-parent whose function is to serve the patient's infantile dependency. Characteristically it occurs before vacations but especially during the period of termination of analysis.

Clinical Example

A woman of twenty-three came for treatment complaining of recurring anxiety and fears of hospitals, of marriage, and of pregnancy. Although she enjoyed sex play and could have orgasm with masturbation, she feared penetration and impregnation with phobic intensity. She was the older of two daughters of elderly parents. Her attachment to her strong and controlling mother often assumed a symbiotic quality and intensity. She

embraced the analytic situation eagerly and flung herself into a magical dependent transference. Over the years of analysis she was able to work out the oral and anal components of her sexual fears, her infantile dependence upon her mother, and her homosexual impulses. Throughout she clung to her investment of the analyst as the good and giving mother. After several years of analysis she married and was able to have a child without any anxiety. Then came the termination, an issue which she raised herself. As soon as I agreed to set a date for ending the analysis, she became depressed. It had not been unexpected and the date of termination was set a year off to allow enough time to work through the separation. All her symptoms returned. She hated me, her husband, and her child. She even made some spiteful efforts at homosexual acting out, but these she herself stopped. For the first time, however, she began to think of the analyst as a real, existing person. She showed a more genuine interest in my professional life and in my family. She speculated about me as a husband and as a father, which she had resolutely avoided doing before. I said little except to remind her of relevant aspects of her infantile conflicts about her mother which had prevented her identification with the mother's positive qualities of strength and ability to love. As she understood this, it became clear to her that she was regarding me as a fantasy-mother, and a slow but steady transformation began. From a childlike and demanding girl she changed into a seriously responsible woman and mother who could identify herself more with her husband's goals and who for the first time accepted me as a separate person whom she could leave behind. The substitution of objects, of real husband for fantasy analyst, and her assimilation of the maternal positive qualities assigned by her to me made possible her renunciation of the analyst as an object for dependency. The more real the analyst became, the stronger became her feminine identification. A more stable and conflict-free ego ideal was evident. In this case setting a date for termination proved to be of critical importance to the working through.

WORKING THROUGH AS NEUTRALIZATION OF AGGRESSION

Whether aggression once aroused can as such be directly altered is open to question. 'Neutralization of aggression' as used here means renunciation of the wish to attack and to control coercively an object's behavior, particularly that of a parental object. The anal prototypes of the drive to dominate and to injure give a spurious aura of reality to the power struggle. As a result renunciation of aggression is equated with an act of submission which invariably takes on a homosexual significance, at least in the male. Working through can be effective only after the memories surrounding the early anal conflicts have been recovered and the fixation to the anal power struggle worked out. A positive identification of patient with analyst as one who can be effective without aggression is especially important for fullest resolution of the repetitive impluse to attack and to control objects.

Clinical Example

A man of twenty-seven came for analysis with the complaints of depressions since childhood, peptic ulcer for two years, and disabling migraine for five years. He was short and powerfully built with a rigidly controlled facial expression and manner of speech. Obsessive-compulsive character traits were operative to the point of becoming symptoms: excessive orderliness and punctuality, isolation of feelings, and argumentativeness. He had always been fearful of physical attack and had made himself a better than average boxer and wrestler. Recently he had begun taking judo and karate lessons. There was a constant threat of explosive tension as he talked, which was directed to himself in the form of fantasies of suicide. There were occasional impulses to violence which he had never dared to carry out for fear of retaliation.

His early behavior in treatment was filled with distrust and apprehension that I would bully and criticize him as his father

had done. His mother and he were, he felt, the helpless victims of his father's compulsiveness, fears of violence, readiness to attack anyone at the slightest provocation, and especially his father's constant demands for obedience and submissiveness. He had often as a child fantasied killing his father.

Working through and working out seemed to go together. As each level of resistance and defense was exposed, his rage at his father would mount and then subside. With it a more and more intense attachment to me became evident. His defensive identification with the aggressor had warded off the threat of homosexual abuse stimulated by identification with his mother. This had made it impossible for him in the past to form lasting ties to women, with whom he compulsively played the Don Juan. Working through after three years of analysis permitted him to form a new kind of relationship with a young girl, with whom he assumed a caretaking, undemanding masculine role. His fear of marriage was sufficiently reduced for him to become formally engaged. At the same time a dramatic change occurred in his chronic posture of violent counteraggression. His ulcer healed without medication and his migraine was much improved after the first year of analysis. The violence toward his father abated and an almost wistful forgiveness of him took its place. None of these changes were as striking however as the change in the transference. He had been guarded, suspicious, and defensively hostile with the analyst as, in his early days, with his father; now he became open, warm, and curious, and even called me by my first name. The transference neurosis was of course not fully analyzed in the first three years of his treatment. What I wish to emphasize is my deliberate avoidance of analyzing away his overt positive expressions of affection and warmth for me. At present the passive, feminine wishes and homosexual fantasies that interfere with his recognition of me as a real person in the analytic relationship are being worked out. By separating his neurotic fantasy creation of me from the friendly and positive aspects of the therapeutic alliance which were not challenged, I hope in time to encourage formation of

a stronger masculine but nonaggressive identification with me as analyst.

WORKING THROUGH AS RECOLLECTION IN PLACE OF ACTION

This process is concerned with recollection of repressed affects, especially those associated with infantile traumata that were responsible for specific fixations. Abreaction and the gradual replacement of affective by cognitive controls is the desired outcome. Working out and working through are intertwined. This aspect of working through is an essential part of every analysis. The resistances to be analyzed in working through are the defenses responsible for the original infantile fixations.

Achievement of a new balance in the defensive structure of the ego may be said to mark the beginning of working through. It is the direct outcome of the working out, which consists of interpretation by the analyst and recognition and understanding by the patient of his developmental conflicts. Interpretation must be directed to resistances and to the regressive infantile derivatives that continue to lead astray the patient's adaptive efforts. This stage of the analytic process consists both of uncovering interpretations that lead to insightful recollection and of repetitive interpretations of the regressive fears of renouncing infantile gratification. The secondary reactive affects are reviewed again and again until the primary affective components of the infantile prototypes behind the neurosis can be worked out and abreacted. Once the original affective pressures are made conscious the patient makes tentative efforts to test his new intellectual understanding against reality. His goal ostensibly is to become able to cope with problems without anxiety or helplessness, instead of being restricted by defenses.

At this point, the process frequently stalls. The efforts to cope often weaken and fail unless other structural forces are brought into play. Rebalancing of defenses is more likely to be lasting if accompanied by simultaneous creation of new levels of aspiration, by development of new sources of pride and self-esteem, and by adaptive transformation of what was once infantile nar-

cissism into a comparatively conflict-free ego ideal, based upon positive developmental identification with the analyst.

WORKING THROUGH AS A SPECIAL EXPRESSION OF LEARNING

Working through as an aspect of learning evolves from the interaction between patient and analyst. If working through were simply the same thing as learning in general, it would be a redundant and pointless concept. Yet, granting that working through involves more than rational intellectual processes, learning and re-education are nevertheless essential components of it.

Learning has two phases: *recognition* of meanings not previously understood, and *assimilation* of those meanings so that they become transformed into new structural elements in the ego and superego. Evidence of assimilation and reconstruction is found in the patient's automatization of new adaptive patterns of behavior. That is, successful assimilation leads to secondary autonomy of altered functions.

How each phase of the learning aspect of working through can best be fostered by the analyst has had far too little attention. Recent speculation by Gerhart and Maria Piers *(16)* as to how learning fits into the analytic process is however a valuable contribution. Interpretation remains of course the fundamental method by which the analytic process is furthered at any stage of treatment. Recognition of meanings usually necessitates, especially at the beginning of an analysis, interpretations of the recent past. As the patient digs up his more distant memories he first offers those that he has cherished and reworked into acceptable explanations of his past and even current behavior. If the analyst interprets at all, he may try to reveal contradictions and obvious but puzzling errors in these recollections. If the patient can be brought to recognize that some at least of the painful events in his life were in fact created by him, the result is a more propitious analytic situation, a deeper commitment by the patient to his working alliance with his analyst.

Interpretation of the patient's extra-analytic involvements

and conflicts, as distinct from the transference, may produce the same kind of recognition of truth as does transference interpretation, but seldom, by itself, leaves a lasting sense of conviction. Strachey *(21)* has pointed out that such 'distant' interpretations do not often contribute directly to structural change, perhaps because their affective impact is dampened by being part of the past. It is in the you-and-I atmosphere of the contemporary analytic relationship that affects generate their greatest heat and in so doing influence most powerfully the patient's attention, his associations, and his sense of conviction. Transference interpretations are the ones most likely to lead to changes in perceptions and to new states of feeling precisely because they arouse the strongest affects. Transference interpretations more than any others stimulate both recognition and assimilation. Recognition is largely a cognitive response while assimilation requires the addition of emotional arousal.

Interpretation of transference is best suited to stimulate the focal affects that can lead to assimilative learning, but other kinds of interpretation can on occasion do the same thing. Interpretations of superego functions of shame and guilt for behavior affecting one's parents, one's children, or one's spouse, for example, can be as moving as transference interpretations. Their effects are however transitory and are basically exaggerations of infantile guilt. During this period of transitory but strong feeling, permanent benefit usually depends on the analyst's seeking out the transference aspects of the shame and guilt as well as the extra-analytic causes that are more obvious. When that is successfully managed by the analyst, he establishes an emotional stimulus to assimilation that carries conviction further and deeper.

It must be admitted that conviction and actual change of psychic structure are not necessarily synonymous. Recognition and assimilation can both be produced under the influence of 'old' affects which are made conscious, especially when abreacted outside the analytic situation, as well as by newly experienced feelings generated in the transference relationship. The

emergence of the old affects alone can produce a sense of conviction ('insight') but without a change in behavior. Conviction needs the simultaneous activity of structural elements in the superego if it is to bring about fundamentally different attitudes and behavior.

Interpretation that stimulates both recognition and assimilative learning provides the force for evolution of the analytic process as a whole. Working through may then be regarded as a culminating period of analytic activity occurring at different stages of the analysis, from the opening phase to termination, in which assimilation is joined or followed by the nonrational but adaptive identification described earlier. This union of rational and nonrational forces is needed to complete successfully the analytic working through that ends in psychic reconstruction.

To sum up, learning in working through has two phases: recognition and assimilation. They have several results: 1, perceptions of drives and of cultural demands are broadened and engage consciousness (attention) more fully; 2, cognitive capabilities are extended and new cognitive elements become more precise; 3, relatively conflict-free affective states are associated with these new elements and come to govern the choice of behavior. During much of this learning phase of working through the analyst is both teacher and authority, and his weapons are truth and suggestion.

WORKING THROUGH AS RECONSTRUCTION OF THE EGO IDEAL

In large part this is the nonrational core of working through and has already been discussed. In the following clinical example the positive identification of patient with idealized analyst demonstrates how this identification helps to bring about the split into observing and experiencing parts of the ego. This cleavage in turn gives the analyst's interpretations their special power to influence. Identification with the analyst, the nonrational aspect of working through, intensifies the suggestibility of the patient and hastens the transformation of infantile omnipotence into the ego ideal.

Clinical Example[3]

The patient was a thirty-year-old woman whose attractiveness was well hidden by her plain dress and avoidance of cosmetics. She was both anxious and depressed, but was obviously intelligent, articulate, and psychologically sophisticated. Her reasons for seeking analysis were a recent divorce after eight years of childless and unhappy marriage and her growing fear that she could not form a healthy relationship with men; she also complained that she had never had orgasm in marriage or in other sexual relationships. She had serious difficulties with authority in her professional career and a long series of somatic complaints including dysmenorrhea, headaches, abdominal pains, and vomiting. Although obviously depressed, she did not include this among her complaints.

The patient soon revealed severe masochistic conflicts with reaction-formation, projection, and denial as favored defenses. Analysis promised to be long and the better part of the first year was, in fact, spent in cautious handling of the transference relationship. It was especially important to avoid precipitating a severe depression and to minimize her tendency to self-destructive acting out. A therapeutic alliance became firmly established on the basis of this first year's careful work and, with the support of this positive relationship to the analyst, she weathered four more years of stormy working out of her true feelings about her destructive psychopathic mother. Identification of herself with her analyst's presumed image of the feminine woman and identification with him as the personification of the good mother, seemed to be the sustaining forces that helped her to change. From a castrating phallic woman, she ultimately became a gentle and loving wife and mother.

The gradual dissolution by the analyst's repeated interpretations of the patient's transference involvement with the fantasy analyst as the phallic mother and less often as the weak cas-

[3]This patient was analyzed by a candidate of the Columbia Psychoanalytic Clinic for Training and Research under my supervision.

trated father was the primary work of the first three years of the analysis. During the middle of the fourth year the magical view of the analyst began to be replaced by a slowly dawning recognition of some of his real qualities. An example of this shift can be observed in the following sessions.

The patient had been struggling with her conflict about marrying a devoted suitor with whom she was periodically in love. She was always deterred, however, by her basic conviction that marriage would mean the loss of her hope of finally winning her mother's love. She reported a dream in which her mother informed the resentful patient that she owed mother a large sum of money. A second dream followed in which her superior at work, a woman, approvingly assigned her to torture and death. The patient interpreted this dream as punishment for failure to comply with the wishes of her mother, no matter how unfair. With much weeping, she said: 'I've always wanted to make up to my mother for the unhappiness she had at the hands of *her* mother. I felt the same when she was hurt by my brother's marriage. I had to make it up to her for being so miserable. It makes no sense, but yet if I married I could not *pay* as much attention to her. She would be less important.' Turning to the analyst, she said: 'Make me set a wedding date; force me to leave her. Maybe I would then get well.' The analyst interpreted her effort to substitute him for the powerful and frightening mother. She left the session sobbing.

The same theme recurred for several weeks until one day she said: 'When I left here yesterday I suddenly recalled how happy I'd been a few days before when I thought I had somehow pleased you. Yesterday, remembering that depressed me. All it takes is one smile from you, one token of approval, and everything brightens. Suddenly I knew it could be no accident that my feeling about myself depends on what I think is your conception of me or your attitude to me. It's the same thing I always hungered for from my mother—unqualified approval. I always blamed myself for my demands on my mother and in

that way I realize I've explained away her never fulfilling them. [Pause] Yesterday, and now again, I can sense how real this is. I feel I should go out and just marry B. Suddenly I understand and believe what I didn't want to recognize all these years. Why have I never recalled my mother as sensitive and tactful? Those dirty looks of hers could kill. The way she looks at my father and us—so full of contempt and disgust. And yesterday I wondered why I cried so much during the first year of my analysis.'

Thus far her understanding was primarily recognition of the truth about her mother and of her distorting projection of the mother upon the analyst in the transference neurosis. Then for a moment before the neurotic needs reasserted themselves, she abruptly asked the analyst, 'Why did you become a psychoanalyst? I wonder what pains in one's own life help one to appreciate the pain of someone else.' This flicker of recognition that the analyst was a real person faded before it could be assimilated and for many weeks she resumed the effort to supplant her ungiving mother by a good mother, the analyst. Interest in marriage temporarily faded too. Her concern was now more and more fixed on the fantasy analyst: 'If I marry, I lose you. I sever all the ties that mean most. I need to wrench myself away from you. It's you I must leave, but I can't; no, I don't want to. I also must give up my ways of protecting myself against being hurt, my childishness, my masculine pose, my mannishness, even my symptoms. I have to leave that all behind and be a woman, a trusting woman. I can't—I don't dare. I must hold on to everyone I've ever loved. I want B to be you.'

During the next six months she struggled toward a final resolution of her identification with the bad mother. It involved a twofold process. 1. The analyst continued to interpret how she clung to her mother by identifying with her destructiveness. He used the reality of the mother's day-to-day behavior as well as the patient's projections upon the analyst. The task was to separate the fantasy analyst from the real one. 2. At the same time, the patient was assimilating by identification the analyst's

tolerance, his respect for her efforts, his obvious belief in her ultimate capacity to change, and his unspoken but implied picture of the feminine woman—the reverse of the cruel, carping castrator represented by her image of the bad mother. Gradually, the patient's anger was expressed directly to her mother while the rage at the analyst was replaced by warmth and obvious respect. She could quietly speculate about his needs, his imagined family life—not in childishly idealized terms but with a sober realization of what he must be trying to achieve in his personal ties.

She at last committed herself to marriage, successfully confronted her mother, and withstood her callousness and obvious hostility. Now she could contrast clearly her mother's and the analyst's qualities. The phase of assimilative learning with its altered states of feeling now dominated the analytic process.

Her analysis continued after her marriage and the working through dealt with her fantasies about becoming a mother herself. She became pregnant and an extraordinary transformation occurred. She even appeared physically changed: she was softer, gentle, dressed attractively, and displayed a remarkable serenity. Her dreams and fantasies were not, as they had been before marriage, of a child as a phallus, but of how she could help her child feel loved, how she would patiently try to understand its frustrations, how she would try not to arouse shame and guilt for natural hungers. In these fantasies, her husband was usually included; the child was to be a shared fulfilment.

A few weeks before her child was born she mused about her analysis: 'My mother was the big problem. She had always maintained for me the illusion of being giving. When she was good, she was very good. I had trouble reconciling the bad, the cruelty, the indifference, with the good she could also do. I don't any more. I see elements of two faces now, even in the good things she does. I guess I transferred all of these problems onto other people rather than facing it out with her. I did it with you a lot, didn't I? But I also saw you as different. I trusted you immediately, after our first session. I can still remember

how you asked me to tell you whatever I could to help you to understand. It was such an easy, open question. I didn't have to run from it. Your whole manner was so accepting, which doesn't begin to describe it. I couldn't believe you cared what happened to me but I suspected that you really did. You were gentle with me. Whatever was positive was very, very positive and made me overcome my usual propensities to run away or to find fault. I used to feel hopeless; now it is not a question of hope or hopelessness but I realize that life is a matter of living on a daily basis. And I am happy to say I find it a happy life.'

After the analysis had been terminated by mutual agreement, she and her husband moved to another city. About a year later she wrote to describe how she and her family had fared. Obviously all was well although she had had to work out some temporary mild symptomatic relapses. She told how at such times she deeply missed the analyst but had succeeded in resolving her current difficulties without him. Then she lovingly described her baby daughter and her husband. She enclosed a photograph of herself and the baby that can properly end this report. The pose was of her holding the baby on her lap—both of them serious and pensive, neither smiling, yet obviously a unit. It was almost exactly like a Picasso print of a mother and baby which had hung in the analyst's office during her analysis. It was a positive facilitating identification with an idealized mother and I believe its significance for the patient's future could hardly be exaggerated.

CONCLUSIONS

1. 'Working out' or 'working toward' is the heart of analysis and is a prerequisite to working through. Working through is an equally essential ingredient of successful psychoanalytic treatment and marks a culminating point which can occur at various phases of the analytic process from its inception to termination.

2. The most important effects of working through are the experiencing of new perceptions and of conflict-free affects appropriate to those perceptions.

3. Several psychic mechanisms and functions form part, in varying degrees, of every piece of successful working through. These are recognition and assimilation of newly learned truths, altered balance among defenses, neutralization of resistance, formation of new identifications, and reconstruction of the ego ideal.

4. The analyst's contributions to working through are subtle and not always clear. The transference relationship has special significance; from it the therapeutic alliance mainly evolves. It must be distinguished from the transference neurosis in which the psychopathology is embedded and magnified. The talent and art of the analyst must strengthen the one without destroying the analytic usefulness of the other. But in most cases the analyst cannot remain simply a mirror, as was recommended in early classical analysis, if working through is to be fully effective. He must function as teacher, as definer of reality, as nonjudgmental object of drive-motivated behavior, as representative of the superego who influences by suggestion and even authority, and, last and perhaps most important, as an idealized object who influences by example. The idealization is inevitably fostered by the analyst's consistence, his tact and tolerance, his patience, and his strength in resisting the patient's seduction and coercion. Identification of patient with analyst in this sense is the basis for expansion and reconstruction of the ego ideal which stimulates future attainment and is the source of realistic self-esteem.

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Working Through

Aaron Karush

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WORKING THROUGH

BY AARON KARUSH, M.D. (NEW YORK)

I

After many years it is still difficult to explain the relationship of working through to various phases of the analytic process. Many psychoanalytic concepts, such as identification *(18)*, sublimation *(19)*, ego strength *(13)*, perception, and psychic representation *(12)*, which clinical experience has shown to be vague or ambiguous, have recently been redefined and restudied. Formerly efforts were made to preserve intact the assumptions and conceptualizations of instinct theory and of the related theory of psychoanalytic therapy, but now, in spite of a good deal of opposition, some hypotheses and concepts about instincts and about polarizing energies are being amended to fit the empirical needs of ego psychology and structural theory. Working through seems to need this kind of re-evaluation. Here I will point out aspects of the process of working through that have in the past either been dismissed entirely or regarded as of minor significance.

Several questions arise. 1. What do we mean by working through in the structural sense? And how is working through to be differentiated from the analytic process as a whole? 2. What is the relation between working through and the transference? To what extent does working through depend on dissolution of the transference? 3. Is working through a special instance of the rational aspects of learning? And conversely, are there nonrational aspects of the process of working through? 4. What part does interpretation play in working through? 5. What specific contributions, apart from interpretations, does the analyst make to successful working through?

From the Psychoanalytic Clinic for Training and Research, College of Physicians and Surgeons, Columbia University, New York.

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The answer to any one of these questions partly answers the others. To begin with, working through primarily signifies certain processes within the patient that help to complete the analytic task of structural reorganization; this reorganization frees the adaptive functions of the ego and superego from developmental distortions and fixations. And working through also includes the technical aspects of the exchange between patient and analyst that helps to release and reshape these dynamic processes.

To reach an acceptable definition of 'working through' it is helpful to trace briefly its history.[1]

From the beginning, Freud used various terms to describe certain phases of the therapeutic process. He spoke of 'abreaction', 'wearing away', and 'working over' as early as the chapter on cathartic therapy in Studies in Hysteria *(2)*. These terms seem to have been the precursors of Freud's later more sophisticated concept of working through.

In the cathartic treatment the goal was to make conscious, and hence amenable to 'wearing away', a repressed traumatic memory that had remained pathogenic. 'Wearing away' could take two forms, 'abreaction' and 'associative working over'. The latter is a kind of watering-down that supplies substitutes and displacements to replace the repressed ideas which were originally connected with the painful affect. It involves thought processes that are in some way associated with the repressed idea and it is an attempt to solve a threatening psychic situation by replacing painful affects with neutral thoughts. Associative working over is in this sense a fundamental property of the secondary process. Abreaction, however, 'wears away' by bringing together a pathogenic affect with the images, words, feelings, and actions that were cut off from the affect when it was

[1] Some of my discussion is derived from Mark Kanzer's commentary *(11)* on the historical development of Freud's ideas about working through, presented at a panel discussion. He drew attention to facets of Freud's thinking that have not generally been recognized. However, the inferences I have drawn from the different phases of Freud's approach to the processes of working through are my own.

first experienced. To be effective, abreactive experiences must be fairly intense paraphrases of both the original trauma and the strangulated response to it. In contrast to this, associative working over leads to the binding and taming of affects by the ego through associating them with relatively neutral and unrelated ideas. When an affect is bound in this way to ideational substitutes, it also acquires a signal function by which new pathways for thoughts are sought whenever the painful memory threatens to reappear. Associative working over thus aids repression. Avoidance of a painful memory seldom can resolve a conflict and rid the psyche of underlying anxiety. Only abreaction, a nonreasoned process, brings about a direct discharge of relevant affects and recovery of the traumatic memory.

This is not to say that Freud attributed only a defensive function to associative working over. As Kanzer pointed out, the concept of working through evolved from both abreaction and associative working over. In 1910, Freud *(3)* represented the analyst as making an interpretation which gives the patient a rational approach to overcoming resistance. The patient mentally 'works over' the interpretation of what he might expect to find until he 'discovers' the repressed idea by way of its similarity to the one suggested in the interpretation. Kanzer quoted Kris's related comment that interpretations achieve their effects through 'recognition leading to recall'. The essence of Freud's early view of working through is that abreaction and working over are set in motion by analytic interpretation to revive traumatic memories and strangulated emotional reactions.

Freud did not, however, remain satisfied with this broad but relatively simple view of working through. He was beginning to change his ideas about suggestion. In the 1910 paper he still acknowledged that suggestion was needed to produce the desired effect of an 'intellectual interpretation'. It was recognized that the positive transference endowed suggestion with power to motivate the patient to give up a resistance. Four years later when Freud first used the term 'working through' *(4)* he modified his conception. He now indicated that the effect of inter-

pretation is not merely strengthened by the magical aspects of the transference; interpretations are to be addressed to the transference itself wherever it provides evidence of repressed ideas and feelings which influence the patient's present behavior. The force of such interpretations appears to go beyond the power of suggestion. Just how interpretation of the magical transference gets its power to change the patient's infantile expectations (and perhaps his suggestibility), Freud could not yet explain.[2] Working over an interpretation with the motivation supplied by the powers of suggestion inherent in the transference had now become working through interpretations of the anti-analytic motivations, that is, of the resistances created by the transference. Freud seemed to push suggestion into the background and to substitute the rational force of understanding. Change would presumably result from that understanding rather than from the nonrational force of the analyst's suggestions.

This new emphasis recognized that the patient is impelled to change his analysis from a reconstructive process to a reenactment of infantile fantasies in which he tries to bribe or coerce the analyst into providing infantile gratifications without risk to the patient. Interpretations are directed toward such regressive resistances by making them conscious and neutralizing their opposition to the recovery of repressed memories. As Kanzer put it, working through involves the patient's acceptance of insight as a 'temporary substitute for immediate gratification'; the goal remains however the 'true confrontation with the infantile memory' with which the revision of personality was presumed to begin. The question of where interpretations of resistance get their ability to influence the patient continued nevertheless to be avoided. It remained unclear just what pleasure insight can offer to allow gratification to be postponed, let alone renounced altogether.

[2] Kanzer *(11)* pointed out that this approach to interpretation required concepts not used by Freud until the structural theory was developed, concepts such as the split between the experiencing and observing ego and the positive contribution of the transference neurosis to the therapeutic alliance.

Freud's changed view of suggestion as the motivating force of working over reflected his search for concepts that would define the analyst's influence for change in terms consistent with the views then held of the psychoanalytic theory of development. Transference replaced the more superficial, catch-all concept of suggestion. It is in some respects unfortunate that the function of suggestion and the mechanisms by which it operated in the analytic situation have since fallen into disrepute as respectable instruments of change. Certainly the transference includes those psychic processes in the patient that give the analyst's interpretations their unique force and their power to influence the patient. It is important to interpret the resistive aspects of the transference neurosis, but not *all* the transference is resistance. Some of the patient's unconscious and preconscious reactions to the analyst can be put to good use, for example to further the therapeutic alliance. To differentiate resistive functions of the transference from nonresistive facilitating functions requires a structural conception of the transference relationship. Infantile *regressive* tendencies live side by side with infantile *progressive* capacities in the transference relationship. Among these progressive capacities are forces essential to successful working through; these are the identifications out of which the ego ideal evolves and which help to strengthen the ego's tolerance for frustration and threat. The transference therefore includes psychic structures and functions that work for recovery and freer development, as opposed to regression and fixation. These segments of the transference transcend the role of reason and understanding in bringing about fundamental changes in behavior.

In many ways successful working through repeats a universal developmental process by which energy is provided both for the renunciation of infantile aims and for their replacement by new and more socially acceptable ones. The ego ideal is, I think, the psychic structure that serves as the internalized instrument of the force of suggestion that came originally from the analyst. In that sense it may be said that the ego ideal replaces sugges-

tion by the analyst. There are hints that Freud was approaching such a conception in his later papers, in which he seems to have recognized the weakness of his definition of working through.

In Inhibitions, Symptoms and Anxiety *(6)*, Freud first used structural terminology to describe working through as the work of the ego on resistances arising from the id. He still equated unconscious with id when he spoke of the attraction exerted by unconscious prototypes upon the repressed instinctual processes. Freud referred here to early memories and 'adhesiveness of the libido' to those early psychic representations that often persist even after the ego's resistances have been analyzed and its countercathexes withdrawn. Fixation 'from below' had been discussed in the early formulation of the concept of repression but Freud did not really clarify it with the concept of id resistance. To be sure the problem was restated in structural terms but only descriptively. What after all is responsible for the adhesiveness of the libido? In Analysis, Terminable and Interminable *(7)*, Freud underscored inherited ego qualities as well as id attributes which are not susceptible to analysis. He suggested that certain qualities of the ego and id contribute unanalyzable unconscious resistances. This led to a pessimistic conclusion about analytic therapy and followed logically enough from his doubts that the earliest neurotic formations can really be reproduced in the transference neurosis. If these tributaries to id resistance lie beyond the influence of the psychoanalytic process, of what use is the concept of working through as Freud had defined it? Freud may have given his answer when he omitted any further reference to working through as he had used it originally in his final papers on analytic therapy *(7, 8)*.

It is little wonder therefore that the working through that goes with the final resolution of neurosis has been extended to include all resistances. In fact, working through today means to some analysts the solution of almost every problem to be met in treatment. It has become synonymous with achievement of successful adaptation, with creation of healthy psychic struc-

ture, and with fulfilment of development and maturation that had been detoured or obstructed by neurotic conflicts in general.

This unfortunate diffusion of the meaning of working through results, I believe, from Freud's hopelessness about directly affecting id resistance. Adhesiveness of libido, however, which he included with psychic inertia as id resistance, is probably more accurately classified as an ego resistance. As Kanzer noted, adhesiveness of libido makes sense only in terms of object relationships and is therefore more closely related to ego processes. Of Freud's original conception of the subject matter of working through, only psychic inertia, the failure of drives to move along new paths of discharge that may be opened up in the course of analysis, remains as a possible manifestation of so-called id resistance. Even here the doubt remains whether working through can really approach this hypothetical form of id resistance except through the functions of the ego.

In Constructions in Analysis *(8)*, one of the most significant of the later papers, Freud suggests that the analyst's interpretative constructions go *beyond* work upon the patient's resistances. Interpretations should also arouse a sense of hopefulness and strength about the patient's past experiences and about his capacity to change. Such constructions intensify the therapeutic alliance and in so doing tap a new source of motive force which can move the patient from his developmental dead-end to new adaptive positions. These positions can be reached only when the patient recognizes and accepts the need both for new ways to cope and master and for renunciation. Just how, and from what structures, such new energies for change may come Freud never discussed. At one point, however, in Constructions in Analysis, he remarked that the actual return of a traumatic memory may not be necessary, that a *conviction* that an event had indeed occurred may follow an interpretative construction and be just as effective therapeutically as a full recollection. What, we must ask, can give such an idea shaped by the analyst's interpretation the necessary sense of conviction?

We seem to have come full circle and returned to Freud's earliest conceptions of the therapeutic process as springing from suggestion, direct or indirect. It would be helpful if the function of suggestion and its counterpart in the patient, suggestibility, could be harmonized with ego psychology and structural concepts.

In 1934, Strachey *(21)*, in his now classic paper on the nature and effects of interpretation, undertook to redefine the therapeutic forces unleashed by psychoanalysis. He emphasized the function of the superego in bringing about a structural change in the patient. Borrowing from Rado *(17)*, he suggested that the analyst acts as an 'auxiliary superego', temporarily taking over functions of the patient's superego during the analysis, and in so doing helps to bring about far-reaching structural shifts. We may not fully agree with Strachey's somewhat Kleinian conceptualization of good and bad introjects which are projected outward, but his emphasis on the positive function of the analyst as a real object in bringing about a lasting alteration in the balance of motivational forces is very close to the views expressed here about working through. In brief, working through, whether it is defined as dissolution of resistance from the id or of resistance from other sources within the personality, depends on more than the rational effects of interpretation; it depends also on nonrational forces set in motion by the analyst.

These nonrational forces for change are released by the analyst's real qualities (which I shall discuss later) in the therapeutic situation as distinguished from the illusory qualities projected on him in the patient's transference neurosis.

Strachey's view of the analyst's power to mold the patient's personality is best summed up in his own words: 'The patient's original superego is, as I have argued, a product of the introjection of his archaic objects distorted by the projection of his infantile id impulses. I have also suggested that our only means of altering the character of this harsh original superego is through the mediation of an auxiliary superego which is the

product of the patient's introjection of the analyst as an object. The process of analysis may from this point of view be regarded as an infiltration of the rigid and unadaptable original superego by the auxiliary superego with its greater contact with the ego and with reality. This infiltration is the work of the mutative interpretations; and it consists in a repeated process of introjection of imagos of the analyst—imagos, that is to say, of a real figure and not of an archaic and distorted projection—so that the quality of the original superego becomes gradually changed' (p. 157, n.). In another part of his essay, Strachey notes that 'this separation between the imago of the introjected analyst and the rest of the patient's superego becomes evident at quite an early stage of the treatment; for instance in connection with the fundamental rule of free association. . . . the "auxiliary" superego . . . usually operates in a different direction from the rest of the superego. And this is true not only of the "harsh" superego but also of the "mild" one. . . . The most important characteristic of the auxiliary superego is that its advice to the ego is consistently based upon *real* and *contemporary* considerations and this in itself serves to differentiate it from the greater part of the original superego' (p. 140). Strachey thus emphasized the transference importance of the analyst as a real person who corrects the patient's neurotic tendency to regressive distortion by his consistent delineation of what is 'real' and 'contemporary', especially in the analytic situation. I shall return to this question of the real as opposed to the fantasied analyst later.

Greenson *(10)* may have referred to the same processes in his recent discussion of working through when he stated that working through is the analytic task of removing resistances not affected by insight. The conclusion seems inescapable that the therapeutic success of analysis depends not only on the rational power of 'truth' and the patient's ability to grasp that truth but on nonrational forces generated in the object relations with the analyst.

There are other views of working through that differ mark-

edly from those presented here. At one end of the spectrum there is frank doubt that the concept has any value (*cf.*, discussions by Bird and Calder in the 1964 Panel on Working Through [*15*]). But during the 1964 discussion, Greenson considered the essential function of working through to be overcoming the resistance to transforming insights into changed behavior, regardless of the source of that resistance. Ekstein *(1)* expresses a somewhat different view: working through enables the patient to gain insight into his regressive tendency to hallucinate the primary mother-child relationship. Like all learning, says Ekstein, this task requires 'endless repetition in the service of adaptation'. How it works he does not explain. Wexler *(22)* suggests that 'structural rigidity' and 'fixity of drives' may be the greatest obstacles to analytic change, both being defenses against a psychotic illness. Wexler pessimistically believes that working through will not be better understood until we have a psychoanalytic theory of learning. Windholz, in the 1964 Panel *(15)*, considered working through a description of what happens during analysis of screen memories and screen affects; it is necessary for the recovery of repressed events. The precise place of working through in the analytic process, whether it depends on the prior development of the therapeutic alliance, or whether it begins at the very start of analysis as claimed by some, or is a later aspect of the therapeutic process, remained in dispute. Windholz is somewhat evasive when he suggests that the greatest value of working through is for conceptualizing the therapeutic process.

Keiser *(14)* recently re-emphasized his theoretical understanding of working through as a manifestation of repetition compulsion. He too seems to broaden the function of working through to include resolution of ego and superego resistances, if I understand him correctly. On the other hand, in his careful review of working through, Stewart *(20)* urged that we limit the term to its classic freudian definition—that of removing id resistances. He suggested that id resistance may be subdivided into psychic inertia, adhesiveness of the libido, and fixation.

Fixation is rooted in genetic factors, developmental experience, and disturbed object relationships, and is subject to the therapeutic action of insight mainly brought about through interpretation. Psychic inertia, characterized by a lack of mobility of cathexes, is apparently a largely constitutional or inherited predisposition. Adhesiveness of the libido signifies an inertia of object cathexis and in part at least may also be a matter of constitution and heredity. Like psychic inertia, of which it seems to be a special case, it does not yield, according to Stewart, to interpretation or to insight. Stewart emphasized Freud's admonition that only time and patience can bring about changes in these latter two aspects of id resistance and suggested that the patient's motivation for overcoming id resistance comes from the power of the transference to convince the patient of the 'necessity to submit to the reality principle'.

Patience and time are essential to every aspect of the therapeutic process and to the resolution of every type of resistance. Their effectiveness comes from re-education of the ego and relearning, but also especially from strengthening of the ego through the formation of new identifications.

Greenacre *(9)* usefully distinguished between the process of working out and the process of working through. It is not easy to tell where one ends and the other begins and, in fact, working through need not be limited to the final phase of analysis. It is interwoven throughout most of the analytic process from the very beginning. Working out is the process of bringing repressed memories, ideas, affects, impulses, and defensive characterological traits and attitudes into consciousness; it includes the patient's discovery of his habits of perception of inner needs and environmental demands and his responses to them. But repeated demonstration to the patient of the common elements in his repetitive neurotic behavior by itself seldom if ever constitutes the whole process of working through. For example, a patient often responds to his analyst's repeated interpretation of inappropriate or infantile qualities in his thoughts, feelings, and behavior by seeing projected into the analyst the critical

and punitive qualities of his own superego. The analyst continues patiently to interpret over and over the transference significance of the patient's sensitivity and of his fear of loss of love. Strictly speaking, although this type of repetitive interpretation is part of the process of 'working out' and is addressed to the transference neurosis, I believe it has the nonrational attributes described by Strachey that merge into working through proper.

The effect of working out is understanding, the intellectual component of insight. Some patients with this understanding can with relative ease go on to organize more appropriate ways of feeling, thinking, and behaving. Unfortunately there remain many patients with character disorders and severe psychoneuroses for whom insight and change are far from synonymous. In them, experience of the nonrational aspects of working through, as distinct from the intellectual understanding advanced during the stage of working out, is essential to the success of psychoanalytic therapy.

It is easier of course to describe what ought to happen in the analytic process than to explain how it happens. The crucial nonrational ingredient in working through is to be found in the transference relationship as distinct from the projections and displacements of the transference neurosis, which is but a part of the total relationship to the analyst. The tie to the analyst as a real person with the strength to persist in a difficult task, with consistency, tolerance, and realistic modesty makes it possible for the patient to complete an essential part of unfinished developmental business. As the transference neurosis is worked out and the fantasy analyst created by the neurosis is clearly revealed to the patient as unreal, the real analyst gradually comes to serve as a new and relatively conflict-free object for idealization and identification.

Idealization is used here in a specific and limited sense. It begins with recognition by the patient as treatment progresses that the analyst has emerged as patient, sincere, and tolerant, but not corruptible by the patient's demands. This acknowl-

edgment does not require that the patient 'love' the analyst; in fact he may not have freed himself fully from the hostility induced by the transference neurosis. Obviously, transparent countertransference in the analyst can be an immovable obstacle to this prologue to idealization.

Recognition of the real analyst's here-and-now qualities of mind and character is followed by the positive affective discovery that the analyst develops and maintains these qualities with effort and struggle, that they are ideals toward which the analyst continually strives. If the patient admires such qualities and respects the standards the analyst sets for himself in his contemporary relationship with the patient, they become desired and hoped for by the patient. It is this attitude of appreciation and respect for the aspiration and genuine achievement by the real analyst in the analytic situation that I call 'idealization'.

How can one distinguish this adaptive level of idealization from the regressive infantile delegation of omnipotence to the analyst that characterizes the patient's transference neurosis? Once the patient projects his own images of a 'good' or 'bad' object upon the analyst, the latter is in part at least turned into a fantasy analyst who embodies the archaic figures from the patient's past. All the patient's unaltered expectations of magic are then addressed to the fantasy analyst. Idealization during this phase of analytic work is no more than introjection of the analyst's illusory ability to give the patient immediate gratification, constant power, and instant health. The affective accompaniment of this kind of idealization and identification is elation. The end or object is all-important while the realistic means or skills necessary to attain one's aims are ignored. Idealization of the real analyst occurs on the other hand when the patient becomes aware of the analyst's realistic efforts to fulfil his own ideals in the analytic situation, even when they are not wholly successful. With it comes the sober recognition that some goals may have to be renounced and that the struggle to cope with the demands of reality is an endless one.

The level of idealization and identification reached by the patient depends upon his ability patiently to uncover and work out the reason he has created the fantasy analyst. As the projections of the past are interpreted and acknowledged by the patient, he is freed to relate to the genuine attributes of the analyst in the immediate analytic relationship. The change, a slow and reluctant one, might be compared to the gradual awakening from a strong wish-fulfilling dream.

Idealization of and identification with the real analyst foster the emergence of a newly effective ego ideal. Since the ego ideal arises originally from the earliest identifications with the parents, it becomes the vehicle by which the parents' wishes and expectations are continuously re-enacted without their actual presence or intervention. In other words, the ego ideal perpetuates the affectively-charged suggestions of parents. What gives parental suggestion such enormous motivating force? Here we can only speculate that the primary narcissism that we assume to be the natural state of every infant is at some point projected upon the parents. This delegation of omnipotence accompanies the child's earliest recognition of the differentiation of his self from the outer world. The parents become the prime ministers for his majesty, the child, who thereby acknowledges his own weakness while at the same time maintaining his illusion of omnipotence by proxy.

In later life we note a strange phenomenon. During and after the period of œdipal conflict, the child first discovers and is forced to admit his true vulnerability. Parents do not submit to his wishes. A partial solution is at hand however. The child admits painfully that he is indeed weak and not omnipotent. But he preserves the old illusion through the idea, 'I am not strong now, but I will be strong later by becoming like my good and powerful parents, teachers, or heroes'. Thus the ego ideal becomes the heir to infantile omnipotence. It fulfils the suggestions made by those upon whom the child was dependent in his early years and becomes one of the most powerful psychic structures, able to supply many of the motivational forces for binding the affective components of the drives.

The analyst's role as model for new identifications offers the patient a second chance to reconstitute a poorly integrated psychic structure. It is this re-enforced ego ideal that helps to counter (neutralize) the regressive forces of resistance from id, ego, or superego. Conversely when the ego ideal is not reconstructed, working through toward the ultimate therapeutic goal of structural rebalance is not likely to succeed. In other words, to time and patience we should add idealization and identification in the service of development as fundamental therapeutic instruments.

The relation of working through to the analytic process as a whole is not always easy to delineate. In general, I believe, working through serves two broad purposes. First, working through in the sense of uncovering resistance to engagement in the analytic situation or to opening up a new area of analytic 'excavation' involves strengthening the therapeutic alliance with the analyst. The analyst as a new and at least partly real object begins to impress his valued qualities upon the patient who is then able to make common cause with a trusted object.

The second broad purpose of working through is to carry intellectual understanding through a phase of assimilation and into association with energizing affects. It is a recurring culmination point, a climax to a laborious attempt during analysis to define a concrete problem of conflict or object distortion, or both. It also illuminates the way to a new perception of the problem and to a new way of coping with it. Its achievement brings a sense of relief and well-being due to renewed self-esteem and hopefulness. The new clarity of perception and sense of competence in using a different way of coping and mastering reflects to some degree qualities of the real analyst with whom the patient has begun to identify. These qualities first become clear to the patient in the way the analyst reacts to and interprets each aspect of the transference neurosis that is immediately at issue.

The analyses of patients who act out their character disorders show that narcissistic defenses and resistances lose their power to cause repetitive acting out according to the patient's

ability to identify himself with valued traits of his analyst. The extent to which the ego ideal is strengthened often decides whether the impulse to act out can be controlled. Since learning anything new can be difficult and frustrating, the patient's motivation for continuing his efforts must be constantly re-enforced. Re-enforcement of learning is based either on punishment for failure or reward for success, or both. Acting out is seldom seriously deterred by threat of punishment, but reward is often effective. The analyst rewards his patient by giving him understanding and by his tacit appreciation and approval, intrinsic components of his tolerance and nonjudgmental attitudes. By identifying with the analyst as a real person, the patient provides himself with the power of self-reward for successful renunciation of infantile impulsivity or inertia. Self-reward also re-enforces intellectual efforts to learn. Ego controls are ultimately strengthened by identification with the real analyst who has become the model for a refashioned ego ideal.

There are obvious dangers of misusing the therapeutic concept of 'identification with the real analyst'. The emphasis on idealization of the adaptive strengths demonstrated by the analyst in his contemporary relationship to his patient requires no more of the analyst than that he remain true to his role of objectivity, understanding, and empathy. He most certainly should not try to impress the patient with his perfection and saintliness, with omniscience and the power to foretell (and control) the future. The very opposite is essential. To allow the patient to 'idealize' and identify with qualities that he has himself projected onto the analyst through the transference neurosis is to encourage regressive imitative identifications with the fantasy analyst's imagined omnipotence. But an emulative identification with the real analyst's respected qualities leads the patient to accept new obligations. He can better tolerate the perpetual struggle to learn new skills, to deepen his understanding of his relation to real objects, and to recognize the limitations imposed by reality on gratification. The motive force for this sustained grasp of reality comes in the main from the ego ideal.

During the stage of analysis when the transference distortions and tendencies to regressive identifications are being worked out, interpretation can be considered to be the 'magic bullet'. It opens the overlapping second stage of therapy in which the patient gradually rebuilds his ideal image. Interpretation is no longer the primary instrument; the analyst's *example* in the analytic relationship to his patient becomes more and more important. Suggestion of the special sort described earlier is thus transmitted and adds stature and strength to the patient's image of what he hopes to be.

Difficulties in forming therapeutic identifications do not necessarily reflect the strength of resistance. They can issue from weaknesses in the transference relationship itself. These weaknesses may inadvertently be fostered by the analyst because of inexperience or because he regularly equates every aspect of the patient's relation to him with the transference neurosis. To do this, to try to interpret and dissolve away all aspects of the patient's interest in and identification with the analyst, can result in a cold and static process, in an analytic impasse which all too often is dismissed with the label 'resistance'.

Difficulties introduced by the analyst's countertransferences can invade both stages of working through—the intellectual and emotional resolution of unconscious transference distortion, and the formation of developmental identifications with the real analyst. The latter phase of working through may be most vulnerable. Trouble may be compounded because theoretical conceptions of proper analytic technique can easily be used indiscriminately by the unwary analyst to deny the patient the right to assimilate to himself his analyst's genuine strength in coping with the patient's problems. Sometimes reaction-formation in the analyst against his own passive dependent wishes may turn him into a 'health fanatic' who considers any change in his patient suspect if it comes from the affective responses, through 'suggestibility', to the analyst's idealized qualities no matter how real they are.

An opposite tendency can also distort the analyst's judgment: a need to manage and control the patient, to prevent any 'mis-

take' by the patient, reflects the analyst's unresolved strivings for omnipotence and his distrust of others; it may push the analyst to seduce or coerce his patient into abiding uncritically by all the analyst's precepts and values. Problems like these are of course well recognized and are always warned against but they are worth mentioning here because their power to negate, perhaps permanently, the value of the affective nonrational aspects of working through is especially great.

The effect of the so-called 'inexact' interpretation upon working through is not easy to evaluate. One may indeed ask if there is any other kind than an inexact interpretation, in the sense of being 'limited'. Obviously incorrect interpretations tend to strengthen defensive resistance against recognition of truths and against the process of assimilation. Assimilation brings recognized truths about the patient's past into direct association with truths about current relationships, especially the transference. Incorrect interpretations do more damage however. Inevitably the patient senses their falseness and judges the analyst unfavorably. If the patient repeatedly considers his analyst untrustworthy and unable to correct his own errors, he will distrust the analyst's positive qualities such as tolerance, patience, and sincerity. Idealization and adaptive identification will be blocked and working through will remain incomplete.

It commonly occurs that while the patient is furthering his development by identification of himself with the analyst, the analysis seems to be at a standstill. Time is essential to permit the identifications to be converted into independent energizing structures.

Freud *(5)* stated the issue concisely when he wrote:

> We have formulated our task as physicians thus: to bring to the patient's knowledge the unconscious, repressed impulses existing in him, and, for that purpose, to uncover the resistances that oppose this extension of his knowledge about himself. Does the uncovering of these resistances guarantee that they will also be overcome? Certainly not always; but our hope is to achieve this by exploiting the patient's trans-

> ference to the person of the physician, so as to induce him to adopt our conviction of the inexpediency of the repressive process established in childhood and of the impossibility of conducting life on the pleasure principle.

It seems therefore that we must distinguish two components of working through, the rational and the nonrational, both necessary if insight is to be converted into positive adaptive behavior. The rational aspect of working through is expressed through arousal of the patient's reasoning and cognitive functions by the analyst's interpretations of unconscious resistance and defense, of unconscious inner needs, of aggression, and of ambivalence in object attachments. In so far as the therapeutic alliance becomes a conscious effort at coöperation with the analyst it also reflects the rational aspect of working through. The nonrational aspect of working through is reflected in the responsiveness of the patient to indirect suggestion by the analyst, in the patient's trust in the analyst as a person, and in his ability to idealize the analyst's qualities as a real person and to identify himself with them.

Working through is helped by certain technical maneuvers of the analyst. We are accustomed to think of the analyst's technical contribution to working through as repetition of interpretations, administered without boredom or impatience over a long period of time. But working through may at times require not repetition but patient silence. Working through simultaneously tries to break down stabilized regressive forces and to reconstruct psychic structures that can release previously ineffectual adaptive energies. What is repeated by the analyst is a renewed emphasis on the original conflict and its infantile components. When working through really works, the dynamic, economic, and structural balance of forces is always slightly different after each return to the original conflict. Working through is nothing but repetition only when it does not work. Failure of the process does not necessarily mean that there was not enough repetition (of interpretation by the analyst or of practice by the patient) but often that there was nothing else.

II

There are different areas of emphasis in working through which are integral parts of almost every analysis, although they vary in relative importance for each patient. Each area requires a different type of renunciation. The affect that accompanies renunciation may be sadness and even grief, as with any serious loss. Fenichel suggested that it resembles mourning. The various forms of working through clearly overlap but it helps to divide them for purposes of discussion.

WORKING THROUGH AS MOURNING FOR RENOUNCED GRATIFICATION

This is a problem in every analysis but especially in resolving hysterical transference and hysterical psychopathology. The goal is renunciation of an unattainable libidinal gratification especially from the œdipal object and its replacement by an available substitute gratification or object. This kind of working through may be necessary very early in the analysis. And when it is, successful working through of a defensive resistance against analysis is essential to development of a workable therapeutic alliance.

Clinical Example

A woman in her late thirties came for treatment because her career and marriage were seriously threatened by her compulsive 'affair' with a man for whom she worked. For the past two years she had fondled him and exhibited herself to him in his office but there had been no sexual intercourse. Recently her husband had received an anonymous letter accusing her of misbehavior and her fright caused her to seek help.

Although she feared exposure and divorce she was as flippant and defiant as an adolescent. Every question was met by a smile and a denial of concern, obvious signs of resistance to examining the problem of her unconscious œdipal fixation. A parallel problem was strong masculine identification and a defensive reaction-formation against her homosexual interests. With such

extensive denial, a favorable analytic situation seemed impossible unless she could first work through this resistance. I decided to focus first on the exhibitionistic aspects of her behavior; she dressed like an adolescent, exposing herself provocatively and courting the jealousy of other women. Surprisingly she seemed unaware of the latter motivation. Once she recognized that her behavior was exhibitionistic and provocative, a defensive purpose to her exhibitionism was suggested. Her resistance to committing herself seriously to treatment was approached by analyzing her defensive exhibitionism with me in the treatment situation. Working through the fear that I would ignore her as an attractive woman and—still worse—expose her wish to be a man, occupied the first two months of what became an analysis. Her childlike insouciance, her pseudo-liveliness, and her naïve physical provocativeness with me were soon replaced by an underlying depression. She then began to try more seriously to work out the problems of the depression and of her self-destructive erotic acting out. A therapeutic alliance was begun with the working through that accompanied the renunciation of her infantile exhibitionism.

WORKING THROUGH AS MOURNING FOR A LOST OBJECT

This occurs especially in dissolution of the transference neurosis and renunciation of the analyst as a fantasy-parent whose function is to serve the patient's infantile dependency. Characteristically it occurs before vacations but especially during the period of termination of analysis.

Clinical Example

A woman of twenty-three came for treatment complaining of recurring anxiety and fears of hospitals, of marriage, and of pregnancy. Although she enjoyed sex play and could have orgasm with masturbation, she feared penetration and impregnation with phobic intensity. She was the older of two daughters of elderly parents. Her attachment to her strong and controlling mother often assumed a symbiotic quality and intensity. She

embraced the analytic situation eagerly and flung herself into a magical dependent transference. Over the years of analysis she was able to work out the oral and anal components of her sexual fears, her infantile dependence upon her mother, and her homosexual impulses. Throughout she clung to her investment of the analyst as the good and giving mother. After several years of analysis she married and was able to have a child without any anxiety. Then came the termination, an issue which she raised herself. As soon as I agreed to set a date for ending the analysis, she became depressed. It had not been unexpected and the date of termination was set a year off to allow enough time to work through the separation. All her symptoms returned. She hated me, her husband, and her child. She even made some spiteful efforts at homosexual acting out, but these she herself stopped. For the first time, however, she began to think of the analyst as a real, existing person. She showed a more genuine interest in my professional life and in my family. She speculated about me as a husband and as a father, which she had resolutely avoided doing before. I said little except to remind her of relevant aspects of her infantile conflicts about her mother which had prevented her identification with the mother's positive qualities of strength and ability to love. As she understood this, it became clear to her that she was regarding me as a fantasy-mother, and a slow but steady transformation began. From a childlike and demanding girl she changed into a seriously responsible woman and mother who could identify herself more with her husband's goals and who for the first time accepted me as a separate person whom she could leave behind. The substitution of objects, of real husband for fantasy analyst, and her assimilation of the maternal positive qualities assigned by her to me made possible her renunciation of the analyst as an object for dependency. The more real the analyst became, the stronger became her feminine identification. A more stable and conflict-free ego ideal was evident. In this case setting a date for termination proved to be of critical importance to the working through.

WORKING THROUGH AS NEUTRALIZATION OF AGGRESSION

Whether aggression once aroused can as such be directly altered is open to question. 'Neutralization of aggression' as used here means renunciation of the wish to attack and to control coercively an object's behavior, particularly that of a parental object. The anal prototypes of the drive to dominate and to injure give a spurious aura of reality to the power struggle. As a result renunciation of aggression is equated with an act of submission which invariably takes on a homosexual significance, at least in the male. Working through can be effective only after the memories surrounding the early anal conflicts have been recovered and the fixation to the anal power struggle worked out. A positive identification of patient with analyst as one who can be effective without aggression is especially important for fullest resolution of the repetitive impluse to attack and to control objects.

Clinical Example

A man of twenty-seven came for analysis with the complaints of depressions since childhood, peptic ulcer for two years, and disabling migraine for five years. He was short and powerfully built with a rigidly controlled facial expression and manner of speech. Obsessive-compulsive character traits were operative to the point of becoming symptoms: excessive orderliness and punctuality, isolation of feelings, and argumentativeness. He had always been fearful of physical attack and had made himself a better than average boxer and wrestler. Recently he had begun taking judo and karate lessons. There was a constant threat of explosive tension as he talked, which was directed to himself in the form of fantasies of suicide. There were occasional impulses to violence which he had never dared to carry out for fear of retaliation.

His early behavior in treatment was filled with distrust and apprehension that I would bully and criticize him as his father

had done. His mother and he were, he felt, the helpless victims of his father's compulsiveness, fears of violence, readiness to attack anyone at the slightest provocation, and especially his father's constant demands for obedience and submissiveness. He had often as a child fantasied killing his father.

Working through and working out seemed to go together. As each level of resistance and defense was exposed, his rage at his father would mount and then subside. With it a more and more intense attachment to me became evident. His defensive identification with the aggressor had warded off the threat of homosexual abuse stimulated by identification with his mother. This had made it impossible for him in the past to form lasting ties to women, with whom he compulsively played the Don Juan. Working through after three years of analysis permitted him to form a new kind of relationship with a young girl, with whom he assumed a caretaking, undemanding masculine role. His fear of marriage was sufficiently reduced for him to become formally engaged. At the same time a dramatic change occurred in his chronic posture of violent counteraggression. His ulcer healed without medication and his migraine was much improved after the first year of analysis. The violence toward his father abated and an almost wistful forgiveness of him took its place. None of these changes were as striking however as the change in the transference. He had been guarded, suspicious, and defensively hostile with the analyst as, in his early days, with his father; now he became open, warm, and curious, and even called me by my first name. The transference neurosis was of course not fully analyzed in the first three years of his treatment. What I wish to emphasize is my deliberate avoidance of analyzing away his overt positive expressions of affection and warmth for me. At present the passive, feminine wishes and homosexual fantasies that interfere with his recognition of me as a real person in the analytic relationship are being worked out. By separating his neurotic fantasy creation of me from the friendly and positive aspects of the therapeutic alliance which were not challenged, I hope in time to encourage formation of

a stronger masculine but nonaggressive identification with me as analyst.

WORKING THROUGH AS RECOLLECTION IN PLACE OF ACTION

This process is concerned with recollection of repressed affects, especially those associated with infantile traumata that were responsible for specific fixations. Abreaction and the gradual replacement of affective by cognitive controls is the desired outcome. Working out and working through are intertwined. This aspect of working through is an essential part of every analysis. The resistances to be analyzed in working through are the defenses responsible for the original infantile fixations.

Achievement of a new balance in the defensive structure of the ego may be said to mark the beginning of working through. It is the direct outcome of the working out, which consists of interpretation by the analyst and recognition and understanding by the patient of his developmental conflicts. Interpretation must be directed to resistances and to the regressive infantile derivatives that continue to lead astray the patient's adaptive efforts. This stage of the analytic process consists both of uncovering interpretations that lead to insightful recollection and of repetitive interpretations of the regressive fears of renouncing infantile gratification. The secondary reactive affects are reviewed again and again until the primary affective components of the infantile prototypes behind the neurosis can be worked out and abreacted. Once the original affective pressures are made conscious the patient makes tentative efforts to test his new intellectual understanding against reality. His goal ostensibly is to become able to cope with problems without anxiety or helplessness, instead of being restricted by defenses.

At this point, the process frequently stalls. The efforts to cope often weaken and fail unless other structural forces are brought into play. Rebalancing of defenses is more likely to be lasting if accompanied by simultaneous creation of new levels of aspiration, by development of new sources of pride and self-esteem, and by adaptive transformation of what was once infantile nar-

cissism into a comparatively conflict-free ego ideal, based upon positive developmental identification with the analyst.

WORKING THROUGH AS A SPECIAL EXPRESSION OF LEARNING

Working through as an aspect of learning evolves from the interaction between patient and analyst. If working through were simply the same thing as learning in general, it would be a redundant and pointless concept. Yet, granting that working through involves more than rational intellectual processes, learning and re-education are nevertheless essential components of it.

Learning has two phases: *recognition* of meanings not previously understood, and *assimilation* of those meanings so that they become transformed into new structural elements in the ego and superego. Evidence of assimilation and reconstruction is found in the patient's automatization of new adaptive patterns of behavior. That is, successful assimilation leads to secondary autonomy of altered functions.

How each phase of the learning aspect of working through can best be fostered by the analyst has had far too little attention. Recent speculation by Gerhart and Maria Piers *(16)* as to how learning fits into the analytic process is however a valuable contribution. Interpretation remains of course the fundamental method by which the analytic process is furthered at any stage of treatment. Recognition of meanings usually necessitates, especially at the beginning of an analysis, interpretations of the recent past. As the patient digs up his more distant memories he first offers those that he has cherished and reworked into acceptable explanations of his past and even current behavior. If the analyst interprets at all, he may try to reveal contradictions and obvious but puzzling errors in these recollections. If the patient can be brought to recognize that some at least of the painful events in his life were in fact created by him, the result is a more propitious analytic situation, a deeper commitment by the patient to his working alliance with his analyst.

Interpretation of the patient's extra-analytic involvements

and conflicts, as distinct from the transference, may produce the same kind of recognition of truth as does transference interpretation, but seldom, by itself, leaves a lasting sense of conviction. Strachey *(21)* has pointed out that such 'distant' interpretations do not often contribute directly to structural change, perhaps because their affective impact is dampened by being part of the past. It is in the you-and-I atmosphere of the contemporary analytic relationship that affects generate their greatest heat and in so doing influence most powerfully the patient's attention, his associations, and his sense of conviction. Transference interpretations are the ones most likely to lead to changes in perceptions and to new states of feeling precisely because they arouse the strongest affects. Transference interpretations more than any others stimulate both recognition and assimilation. Recognition is largely a cognitive response while assimilation requires the addition of emotional arousal.

Interpretation of transference is best suited to stimulate the focal affects that can lead to assimilative learning, but other kinds of interpretation can on occasion do the same thing. Interpretations of superego functions of shame and guilt for behavior affecting one's parents, one's children, or one's spouse, for example, can be as moving as transference interpretations. Their effects are however transitory and are basically exaggerations of infantile guilt. During this period of transitory but strong feeling, permanent benefit usually depends on the analyst's seeking out the transference aspects of the shame and guilt as well as the extra-analytic causes that are more obvious. When that is successfully managed by the analyst, he establishes an emotional stimulus to assimilation that carries conviction further and deeper.

It must be admitted that conviction and actual change of psychic structure are not necessarily synonymous. Recognition and assimilation can both be produced under the influence of 'old' affects which are made conscious, especially when abreacted outside the analytic situation, as well as by newly experienced feelings generated in the transference relationship. The

emergence of the old affects alone can produce a sense of conviction ('insight') but without a change in behavior. Conviction needs the simultaneous activity of structural elements in the superego if it is to bring about fundamentally different attitudes and behavior.

Interpretation that stimulates both recognition and assimilative learning provides the force for evolution of the analytic process as a whole. Working through may then be regarded as a culminating period of analytic activity occurring at different stages of the analysis, from the opening phase to termination, in which assimilation is joined or followed by the nonrational but adaptive identification described earlier. This union of rational and nonrational forces is needed to complete successfully the analytic working through that ends in psychic reconstruction.

To sum up, learning in working through has two phases: recognition and assimilation. They have several results: 1, perceptions of drives and of cultural demands are broadened and engage consciousness (attention) more fully; 2, cognitive capabilities are extended and new cognitive elements become more precise; 3, relatively conflict-free affective states are associated with these new elements and come to govern the choice of behavior. During much of this learning phase of working through the analyst is both teacher and authority, and his weapons are truth and suggestion.

WORKING THROUGH AS RECONSTRUCTION OF THE EGO IDEAL

In large part this is the nonrational core of working through and has already been discussed. In the following clinical example the positive identification of patient with idealized analyst demonstrates how this identification helps to bring about the split into observing and experiencing parts of the ego. This cleavage in turn gives the analyst's interpretations their special power to influence. Identification with the analyst, the nonrational aspect of working through, intensifies the suggestibility of the patient and hastens the transformation of infantile omnipotence into the ego ideal.

Clinical Example[3]

The patient was a thirty-year-old woman whose attractiveness was well hidden by her plain dress and avoidance of cosmetics. She was both anxious and depressed, but was obviously intelligent, articulate, and psychologically sophisticated. Her reasons for seeking analysis were a recent divorce after eight years of childless and unhappy marriage and her growing fear that she could not form a healthy relationship with men; she also complained that she had never had orgasm in marriage or in other sexual relationships. She had serious difficulties with authority in her professional career and a long series of somatic complaints including dysmenorrhea, headaches, abdominal pains, and vomiting. Although obviously depressed, she did not include this among her complaints.

The patient soon revealed severe masochistic conflicts with reaction-formation, projection, and denial as favored defenses. Analysis promised to be long and the better part of the first year was, in fact, spent in cautious handling of the transference relationship. It was especially important to avoid precipitating a severe depression and to minimize her tendency to self-destructive acting out. A therapeutic alliance became firmly established on the basis of this first year's careful work and, with the support of this positive relationship to the analyst, she weathered four more years of stormy working out of her true feelings about her destructive psychopathic mother. Identification of herself with her analyst's presumed image of the feminine woman and identification with him as the personification of the good mother, seemed to be the sustaining forces that helped her to change. From a castrating phallic woman, she ultimately became a gentle and loving wife and mother.

The gradual dissolution by the analyst's repeated interpretations of the patient's transference involvement with the fantasy analyst as the phallic mother and less often as the weak cas-

[3]This patient was analyzed by a candidate of the Columbia Psychoanalytic Clinic for Training and Research under my supervision.

trated father was the primary work of the first three years of the analysis. During the middle of the fourth year the magical view of the analyst began to be replaced by a slowly dawning recognition of some of his real qualities. An example of this shift can be observed in the following sessions.

The patient had been struggling with her conflict about marrying a devoted suitor with whom she was periodically in love. She was always deterred, however, by her basic conviction that marriage would mean the loss of her hope of finally winning her mother's love. She reported a dream in which her mother informed the resentful patient that she owed mother a large sum of money. A second dream followed in which her superior at work, a woman, approvingly assigned her to torture and death. The patient interpreted this dream as punishment for failure to comply with the wishes of her mother, no matter how unfair. With much weeping, she said: 'I've always wanted to make up to my mother for the unhappiness she had at the hands of *her* mother. I felt the same when she was hurt by my brother's marriage. I had to make it up to her for being so miserable. It makes no sense, but yet if I married I could not *pay* as much attention to her. She would be less important.' Turning to the analyst, she said: 'Make me set a wedding date; force me to leave her. Maybe I would then get well.' The analyst interpreted her effort to substitute him for the powerful and frightening mother. She left the session sobbing.

The same theme recurred for several weeks until one day she said: 'When I left here yesterday I suddenly recalled how happy I'd been a few days before when I thought I had somehow pleased you. Yesterday, remembering that depressed me. All it takes is one smile from you, one token of approval, and everything brightens. Suddenly I knew it could be no accident that my feeling about myself depends on what I think is your conception of me or your attitude to me. It's the same thing I always hungered for from my mother—unqualified approval. I always blamed myself for my demands on my mother and in

that way I realize I've explained away her never fulfilling them. [Pause] Yesterday, and now again, I can sense how real this is. I feel I should go out and just marry B. Suddenly I understand and believe what I didn't want to recognize all these years. Why have I never recalled my mother as sensitive and tactful? Those dirty looks of hers could kill. The way she looks at my father and us—so full of contempt and disgust. And yesterday I wondered why I cried so much during the first year of my analysis.'

Thus far her understanding was primarily recognition of the truth about her mother and of her distorting projection of the mother upon the analyst in the transference neurosis. Then for a moment before the neurotic needs reasserted themselves, she abruptly asked the analyst, 'Why did you become a psychoanalyst? I wonder what pains in one's own life help one to appreciate the pain of someone else.' This flicker of recognition that the analyst was a real person faded before it could be assimilated and for many weeks she resumed the effort to supplant her ungiving mother by a good mother, the analyst. Interest in marriage temporarily faded too. Her concern was now more and more fixed on the fantasy analyst: 'If I marry, I lose you. I sever all the ties that mean most. I need to wrench myself away from you. It's you I must leave, but I can't; no, I don't want to. I also must give up my ways of protecting myself against being hurt, my childishness, my masculine pose, my mannishness, even my symptoms. I have to leave that all behind and be a woman, a trusting woman. I can't—I don't dare. I must hold on to everyone I've ever loved. I want B to be you.'

During the next six months she struggled toward a final resolution of her identification with the bad mother. It involved a twofold process. 1. The analyst continued to interpret how she clung to her mother by identifying with her destructiveness. He used the reality of the mother's day-to-day behavior as well as the patient's projections upon the analyst. The task was to separate the fantasy analyst from the real one. 2. At the same time, the patient was assimilating by identification the analyst's

tolerance, his respect for her efforts, his obvious belief in her ultimate capacity to change, and his unspoken but implied picture of the feminine woman—the reverse of the cruel, carping castrator represented by her image of the bad mother. Gradually, the patient's anger was expressed directly to her mother while the rage at the analyst was replaced by warmth and obvious respect. She could quietly speculate about his needs, his imagined family life—not in childishly idealized terms but with a sober realization of what he must be trying to achieve in his personal ties.

She at last committed herself to marriage, successfully confronted her mother, and withstood her callousness and obvious hostility. Now she could contrast clearly her mother's and the analyst's qualities. The phase of assimilative learning with its altered states of feeling now dominated the analytic process.

Her analysis continued after her marriage and the working through dealt with her fantasies about becoming a mother herself. She became pregnant and an extraordinary transformation occurred. She even appeared physically changed: she was softer, gentle, dressed attractively, and displayed a remarkable serenity. Her dreams and fantasies were not, as they had been before marriage, of a child as a phallus, but of how she could help her child feel loved, how she would patiently try to understand its frustrations, how she would try not to arouse shame and guilt for natural hungers. In these fantasies, her husband was usually included; the child was to be a shared fulfilment.

A few weeks before her child was born she mused about her analysis: 'My mother was the big problem. She had always maintained for me the illusion of being giving. When she was good, she was very good. I had trouble reconciling the bad, the cruelty, the indifference, with the good she could also do. I don't any more. I see elements of two faces now, even in the good things she does. I guess I transferred all of these problems onto other people rather than facing it out with her. I did it with you a lot, didn't I? But I also saw you as different. I trusted you immediately, after our first session. I can still remember

how you asked me to tell you whatever I could to help you to understand. It was such an easy, open question. I didn't have to run from it. Your whole manner was so accepting, which doesn't begin to describe it. I couldn't believe you cared what happened to me but I suspected that you really did. You were gentle with me. Whatever was positive was very, very positive and made me overcome my usual propensities to run away or to find fault. I used to feel hopeless; now it is not a question of hope or hopelessness but I realize that life is a matter of living on a daily basis. And I am happy to say I find it a happy life.'

After the analysis had been terminated by mutual agreement, she and her husband moved to another city. About a year later she wrote to describe how she and her family had fared. Obviously all was well although she had had to work out some temporary mild symptomatic relapses. She told how at such times she deeply missed the analyst but had succeeded in resolving her current difficulties without him. Then she lovingly described her baby daughter and her husband. She enclosed a photograph of herself and the baby that can properly end this report. The pose was of her holding the baby on her lap—both of them serious and pensive, neither smiling, yet obviously a unit. It was almost exactly like a Picasso print of a mother and baby which had hung in the analyst's office during her analysis. It was a positive facilitating identification with an idealized mother and I believe its significance for the patient's future could hardly be exaggerated.

CONCLUSIONS

1. 'Working out' or 'working toward' is the heart of analysis and is a prerequisite to working through. Working through is an equally essential ingredient of successful psychoanalytic treatment and marks a culminating point which can occur at various phases of the analytic process from its inception to termination.

2. The most important effects of working through are the experiencing of new perceptions and of conflict-free affects appropriate to those perceptions.

3. Several psychic mechanisms and functions form part, in varying degrees, of every piece of successful working through. These are recognition and assimilation of newly learned truths, altered balance among defenses, neutralization of resistance, formation of new identifications, and reconstruction of the ego ideal.

4. The analyst's contributions to working through are subtle and not always clear. The transference relationship has special significance; from it the therapeutic alliance mainly evolves. It must be distinguished from the transference neurosis in which the psychopathology is embedded and magnified. The talent and art of the analyst must strengthen the one without destroying the analytic usefulness of the other. But in most cases the analyst cannot remain simply a mirror, as was recommended in early classical analysis, if working through is to be fully effective. He must function as teacher, as definer of reality, as nonjudgmental object of drive-motivated behavior, as representative of the superego who influences by suggestion and even authority, and, last and perhaps most important, as an idealized object who influences by example. The idealization is inevitably fostered by the analyst's consistence, his tact and tolerance, his patience, and his strength in resisting the patient's seduction and coercion. Identification of patient with analyst in this sense is the basis for expansion and reconstruction of the ego ideal which stimulates future attainment and is the source of realistic self-esteem.

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Leon J. Saul & Silas L. Warner

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IDENTITY AND A POINT OF TECHNIQUE

BY LEON J. SAUL, M.D. AND SILAS L. WARNER, M.D. (PHILADELPHIA)

I

A vitally important point in the technique of making interpretations, insufficiently emphasized in the literature, is the conveying to the patient of the sharp distinction between the mature part of his personality and that portion of the childhood part which causes his difficulties.

An example of this is a young man who had had some psychoanalytic treatment but was in a state of depression, rage, withdrawal, and severe self-depreciation. He told his new analyst that the previous treatment had showed him the kind of person he was: infantile, dependent, withdrawn, lonely, hostile, and unable to feel. It quickly turned out that all this was true, but with the very important limitation that it was true for only part of his personality. His therapist had naturally focused upon that part of the personality which made the trouble, and by interpretations of it exclusively had given this young man the impression that his entire self—his total personality—was meant, rather than a sort of disturbed foreign body in an otherwise mature adult.

The first task was to make him see realistically and without flattery, with complete honesty, his mature characteristics. To correct his limited image of himself as nothing at all but a guilty, shameful person ridden by infantile impulses, he needed to realize that he was mainly a person with a strong, healthy physique, good looks, intelligence, and education; in short, an individual with adequate instruments, in body, mind, and personality, for the requirements of life.

Essentially he was given a more complete picture and was shown that he had sufficient maturity, or at least capacity for maturity, to use these instruments to make his way in the world, to love and to be loved, to marry and have children, to enjoy friendship and contribute to society. Interference with

his doing this, then, originated in the disturbed childhood part, which exists to some extent in all of us. Childhood characteristics that make trouble for the mature part must be dealt with, but the patient must never lose sight of the fact that the mature part has, indeed, perfectly adequate capacities. One cannot go through life with any feeling of confidence or peace unless one sees his strengths and eventually finds he can trust in them through experience in living and in handling his infantile motivations.

Besides giving the patient a realistic self-image which he can validly respect, awareness of the mature part of the patient's personality should be kept in sharp focus because of the nature of analytic treatment. The therapeutic effect of the analytic procedure depends largely upon the patient's discriminating between present reality and past patterns which have been derived from the realities of childhood and which interfere with the current mature functioning. Since in the course of the analysis the patient projects his superego onto the analyst, the analyst willy-nilly becomes part of the patient's superego. In so far as the patient identifies with his parents or is seeking such identification, he will identify himself strongly with his analyst. Therefore, if in making interpretations the analyst unwittingly gives the impression of seeing the patient as an infantile personality, the patient through identification with the analyst is apt to continue this attitude toward himself, reenforced and entrenched rather than corrected.

This is one of the pitfalls of interpretation. If the analyst, focusing upon the infantile reactions, conveys to the patient that this covers the patient in toto rather than merely a part of his personality, then, even though every interpretation is correct, the patient may emerge from the analysis in a beaten-down condition; feeling himself a disturbed infantile individual rather than one whose total, otherwise adequate personality includes the conflicting inadequacies. The importance of the analyst not conveying any sense of criticism or depreciation in his interpretations, spoken or unspoken, cannot be exaggerated.

II

Historically, the development of psychoanalysis has depended very largely upon the achievement of insight; first into the nature of neurotic symptoms and then into the nature of the personality, including the relationship with self and with others. To judge by the literature, emphasis in treatment is naturally upon the achievement of insight. When this is difficult, because of resistances, then the procedure is to obtain insight into the nature of the resistances. It is generally recognized that insight alone does not cure the patient's difficulties. Another important and well-recognized element is the transference—the relationship of the patient to the therapist. The handling of this, however, also involves insight; that is, the gradual discerning of how the patient repeats with the analyst his old relationships and conflicts with persons in childhood. The patient obtains support from the transference relationship; this is inadequate without insight and even somewhat risky, since it makes the patient too dependent upon the analyst.

If insight into the transference relationship alone does not resolve the patient's problem, what does? The usual answer is 'working through', which however is largely a matter of more insight into the patient's emotional patterns as they are repeated in different aspects and facets of the transference and of his life.

Is there not more that can be done to make use of the insight for which we strive? It has been recognized that the patient's absorption in his conflict makes him see life as holding a limited number of choices. For example, a young man who has had a very dominating mother may feel that there are only two attitudes: to be submissive, as he was to her, or to domineer by way of an identification with her. Locked in this relationship, he sees only the two roles—the child's toward the mother or the mother's toward the child. In such a situation, it must indeed be legitimate for the analyst to point out the unreality

of the patient's thinking and to discuss with him solutions to the conflict.

How then do we make the most effective therapeutic use of the insight which we obtain? Certainly many analysts, while agreeing with what has been said above, in actual practice do appear only to keep repeating the same interpretations and if the patient does not progress, to recommend 'more analysis', perhaps with a different analyst. Often, however, the process of making the unconscious conscious goes on for long periods of time without improvement in the patient. In fact, some patients become much worse in this situation.

III

This brings us to the solutions to the patient's problems, whether the analyst can see them, and whether it will be therapeutically helpful or only cause an unjustified interference to discuss possible solutions with the patient. The following example will, perhaps, make this point clear.

An attractive young woman who, a few years before, had completed four-and-a-half years of full-scale, five-day-a-week analysis, came to see an analyst because of a severe state of indecision and confusion which affected all areas of her life. She was undecided as to how to handle her children at mealtime; whether or not to let them have sweets; whether to take them to shows; what to buy them to wear; what clothes to purchase for herself; whether to change the decorating of the house, and so on throughout her life. It soon appeared that she felt compelled to do everything perfectly. This was part of her childhood pattern. It was her way of winning love. With her parents, she felt insecure and could only assure herself of their acceptance by perfect behavior. This pattern had been dealt with intensively and extensively in her analysis, but persisted uncorrected. In fact, the patient complained that she was worse now than when she first went for treatment. The situation was clear; she had the insight but was totally unable to use it for therapeutic effect.

In such an instance, should not the analyst take the position that the insight has been achieved and that the central problem is to find inner emotional solutions to discuss with the patient? Freud *(6)* took the position of helping the patient find solutions when he wrote that psychoanalysis was '*after-education*' by which the analyst could 'correct the parental blunders'. What 'after-education' can analysis offer a patient in this young woman's situation?

The analyst imparted to this patient and discussed with her, with therapeutic effect, the following: first, he emphasized that the young woman herself was not neurotic, indecisive, insecure, perfectionistic and the like, but that this was only a part of her childhood pattern; that this was only a part of her personality in sharp contradistinction to the mature part of her make-up; her mature self had good sense of reality, good judgment, was able to marry and have children, to take responsibility for her home and to relate adequately to people. The first step, in other words, was to separate the pathodynamic pattern, to make clear what was the pathologically infantile and what the mature. Several points were involved here: 1, to give her a perspective on her problem; 2, to give her a good image of her own self in maturity; and 3, to use the mature part of her ego as a basis for understanding, while keeping the infantile in perspective. In this process we could come back to Freud's original simile of the reclamation of the Zuyder Zee: the task is to build on the mature ego at the expense of the disordered childhood pattern.

The second step continues the first. In this case, the obvious realities were pointed out to her. Her husband loved her and she had friends, and not to see this was unrealistic. We understood why she did not: her childhood insecurity in relation to her parents persisted. She was told that there were dynamic reasons, as well as historic reasons, for her feeling and that guilt made her feel that she was unworthy of love. The main point that was emphasized, however, was that her feeling of being unloved was a delusion; and her ideal of perfection had in

fact been attained in order to get what, all the time, she actually had.

The third issue discussed with her was the ineffectiveness of such methods as she used to get love. Others would not give her love if she was too directly demanding. In reality, the way to get love is not to demand it; this leads to frustration and rejection and hence, to anger and vindictiveness. To get love she should use the mature part of her personality to do a good job with her husband, her children, her friends, and with her community and other activities. One gets love by giving it, not by being perfect or anything else.

In the interest of brevity, all the material has not been given, and the three points discussed have been presented in condensed, almost schematic form, to convey the essential; namely, that in many cases the analyst cannot depend upon insight alone.

In these cases, one of the resources of the analyst is to stop and think what uses he can make of the insight he has gained; one of these is the formulation by the analyst, at first in his own mind, of the patient's essential problem. The second step is for the analyst to think out what the solutions to this problem may be. Naturally, these solutions are not given to the patient in any dogmatic fashion but only after, in Freud's spirit of after-education, the analyst, in a face-to-face sitting interview, takes stock and reviews with the patient the nature of the problem and the main dynamics, and then considers the possible solutions. We have not dealt with the supportive, after-educative, corrective effect of the transference and its analysis, nor with the analyst's personality and the countertransference. About these a few words must suffice.

IV

When the analyst makes interpretations, which come through to the patient as an infantile image of himself, then this interpretation of the patient's infantile quality has behind it the full force of the analyst's authority—of the authority the par-

ents originally had over the patient as a child. If the analyst implies that the patient is infantile, this must be true, for it repeats what the parents said or implied. To have and to hold the love of the parents is the most important single goal of the young child's life. This same need is the core of the transference. It must be fully recognized by the patient and the analyst must be aware of its potential for damage.

Actually, the analyst becomes a powerful part of the patient's new superego. The patient through his need for the analyst's love and approval, his fear of the analyst's criticism, accepts the analyst's opinions and interpretations, no matter how devastating. It is unrealistic to think it possible to analyze any patient in such a way that when the analysis ends, it is as though the patient never met the analyst. As Freud clearly stated the analyst has become part of the patient's superego, an influential part of the patient's personality. If he has used his role as the patient's new parent wisely and therapeutically, the residue of the transference is friendly, and the patient usually feels warm and grateful toward him. If he has used it badly, there is an undercurrent of resentment for many years and the patient may be unimproved or worse. The patient's original pattern of feelings toward the parents, repeated with the analyst, is never completely outgrown or resolved. However, a diminution may tilt the balance in the patient's life from one of neurotic distress to relative freedom. This is reflected in a countertransference atmosphere that encourages the mature to see and to learn to handle and outgrow the disturbing infantile.

V

Much has been written on the general subject of identity including selected papers by Erikson *(4)*, a review of recent literature by Jacobson *(10)*, and a panel discussion reported by Rubinfine *(16)*. Recent papers have also been contributed by Devereux *(3)*, Lomas *(14)*, Hayman *(9)*, and Tabachnick *(23)*. However, writings which deal directly with the precise

points of this paper are few although many authors bring out closely related points. Hartmann remarks that 'in comparing theoretical and technical development in psychoanalysis, I believe the lag today is rather on the side of technique. In the process of gradual replacement of the older layer concepts by structural concepts, not all the implications have so far been realized' *(8,* p. 153*)*. Perhaps it is also related to the paucity of studies of maturity as a review by Saul and Pulver and a book by one of us suggests *(20, 19)*.

Historically, psychoanalysis has passed through various development phases to the present emphasis on psychoanalytic ego psychology. In applying ego psychology to analytic technique, it has been stressed that interpretations should include all three psychic structures (id, ego, and superego) and also should include (the) external (world and) reality. Hartmann says, 'the necessity for scrutinizing our patients' material as to its derivation from all the psychic systems, without bias in favor of one or the other, is nowadays rather generally accepted as a technical principle' *(8,* p. 150*)*. Anna Freud *(5)* warns against 'onesidedness in analytic technique', by confining oneself too exclusively to an investigation of the id or of the ego and superego. She is speaking to one of the main points of this paper when she warns that 'if we give the preference to any one of the means of analytic investigation, at the cost of all the others, the result will inevitably be a distorted or at least an incomplete picture of the psychic personality—a travesty of the reality' (p. 26).

Hartmann is of the opinion that there are 'incidental effects of interpretation, which frequently transcend our immediate concern with the specific drive-defense setup under consideration, and which are not always predictable' *(8,* p. 152). Such an interpretation produces not only a 'local' reaction but 'goes beyond the stimulated "area" changing the balance of mental energies and affecting a variety of aspects of the dynamic system'. This is relevant to our point that an interpretation of an infantile drive or reaction may be correct technically, but if

not put in the context of the entire personality may have an injurious effect on the self-concept which transcends the immediate aim of making id material conscious. By including interpretations of how the entire personality deals with these infantile reactions, both successfully and unsuccessfully, the analyst can give the patient a truer concept of himself and not add the weight of his authority to the patient's tendency to see himself critically. Hartmann thinks that even 'conflict-free spheres' can be approached analytically as 'these observations and considerations can lead us to a better understanding of impairment and distortion of function . . .'.

Analysts generally agree that the patient is strongly influenced by his identification with the analyst. More narrowly, the patient's ego-identity is influenced by his identification with the analyst, as it was in childhood by the identification with his parents and others. The nature of this influence needs further clarification. Recently Rapaport *(15)*, Brody *(2)*, Koff *(11)*, A. Balint *(1)*, Lampl-de Groot *(12)*, and others have made contributions to our understanding of introjection, identification, and incorporation both from a theoretical and technical standpoint. Freud *(6)* repeatedly acknowledges the importance of the patient's identification with the analyst. He states that, 'if the patient puts the analyst in the place of his father (or mother), he is also giving him the power which his superego exercises over his ego. . . . The new superego now has an opportunity for a sort of *after-education* of the neurotic; it can correct mistakes for which his parents were responsible in educating him.' He warns that the analyst should not misuse this influence. 'If he does, he will only be repeating a mistake of the parents who crushed their child's independence by their influence, and he will only be replacing the patient's earlier dependence by a new one' (p. 175).

For fuller understanding of how the patient identifies with the analyst and how this influences his sense of identity, it is helpful to review the formation of early object relationships as has been done by the aforementioned authors. Loewald *(13)*,

in discussing how object relationship theory can be translated into the therapeutic action of psychoanalysis, states that the analyst makes himself available as a new object by 'being a screen or mirror onto which the patient projects his transferences, and which reflects them back to him in the form of interpretations'. He goes on to say: 'The analyst in actuality does not only reflect the transference distortions. In his interpretations he implies aspects of undistorted reality which the patients begin to grasp step-by-step as transferences are interpreted. This undistorted reality is mediated to the patient by the analyst, mostly by the process of chiselling away the transference distortions, or, as Freud has beautifully put it, using an expression of Leonard da Vinci *"per via di levare"* as in sculpturing, not *"per via di porre"* as in painting. In sculpturing, the figure to be created comes into being by taking away from the material; in painting, by adding something to the canvas. In analysis, we bring out the true form by taking away the neurotic distortions. However, as in sculpturing, we must have, if only in rudiments, an image of that which needs to be brought into its own. The patient, by revealing himself to the analyst, provides rudiments of such an image through all the distortions—an image which the analyst has to focus in his mind, thus holding it in safekeeping for the patient to whom it is mainly lost. It is this tenuous reciprocal tie which represents the germ of a new object-relationship' *(13,* p. 18*)*. The successful treatment 'analyzes out' the disturbing infantile patterns in favor of a mature, friendly, independent relationship *(18)*.

This 'image of that which needs to be brought into its own', of which Loewald speaks, is contained in the analyst's understanding of the patient's whole personality and of his direction of development to maturity. This should be conveyed to the patient in interpretations so that a realistic self-concept can evolve in the analysis.

There are only a few papers with clinical material describing the points in analytic technique which we have discussed.

Greenson *(7)* describes a group of analytic patients who developed an 'unexpected difficulty in the course of psychoanalytic therapy' because of 'the failure of the patients to develop a reliable working relation with the analyst'. In one case the analysand developed an 'identification with the previous analyst based on fear and hostility'. Although this was properly analyzed as a transference resistance, the interpretation 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'. Greenson points to certain personality traits which the analyst may show that do not allow for development of a therapeutic alliance because they correspond to similar character traits in a parent, and thus are re-experienced as negative transference reactions.

We would add to this that the analyst can also create such an impression by his handling of interpretations in the analysis. If, with all good intentions, he overemphasizes one aspect of the patient's personality, such as his infantile reactions, he may be seen as critical and hostile and an identification made with the analyst on this basis will tend to re-enforce these already troublesome trends in the patient's personality. There is a fear on the patient's part that whatever self-depreciation has already been developed from the parents, directly or indirectly, will be added to by the analyst.

Stone *(22)* writes that there has been too strict adherence to three of Freud's early concepts: 1, the principle of abstinence; 2, the surgeon as a model; and 3, the 'mirror reference' (p. 22). He warns against 'the withholding or undue limitation of certain legitimate and well-controlled gratifications, which can provide a palpably human context for the transmission of understanding, which is, by general agreement, the central function of the analyst' (p. 108). Our emphasis in this paper of differentiating the infantile from the more mature ego functioning could be considered as an example of 'essential gratification of the patient's mature transference striving' *(17)*.

A further elaboration of the mature and infantile 'patterns of motivation and reaction which underlie [each person's] thinking, feeling and behavior' is found in a review of the literature on the after-effects of early influences *(21)*.

SUMMARY

Every person's sense of identity stems from its nucleus in the relationships to the parents and siblings (or substitutes) in the earliest years, especially prior to age six. This occurs by object relations with the parents, e.g., feeling loved or unloved, and by identification with them, taking over their attitudes, feelings, reactions. Both processes involve very largely introjection of the parents to form the superego, which continues the images and authority of the parents. Both processes determine in large degree a person's image of himself, his self-esteem and his ego-identity. This develops without problems where relationships with the parents are basically good; when they are not, the sense of identity is vague, insecure, unacceptable, or otherwise disordered in a variety of ways.

The importance of this in analytic technique is great, for the analyst comes into the position of the parents as a significant part of the patient's superego, with some of the power the parents exercised over the child. Inevitably, therefore, the analyst influences the patient powerfully. Part of this influence is on the patient's view of himself. If the analyst implies, wittingly or unwittingly, through his interpretations that the totality of the patient's personality consists of the disordered infantile patterns which the analyst interprets, then the patient comes to see himself as only this—a depreciated, infantile, inadequate, hostile, shameful, guilty creature. Hence, it is essential that the analyst give the patient a realistic view of himself, enabling him to see clearly and in perspective his mature qualities and capacities, and to discriminate the disordered infantile patterns, i.e., the psychopathology, from the mature. The mature is used as a base for dealing with the disordered infantile, the pathodynamics. In this way, the patient achieves a

sound, realistic ego identity, building up and being conscious of the mature healthy part of his personality; and his identity gives self-respect and confidence in dealing with the infantile parts in the analysis and in life. The transference and countertransference can thus correct faults in the object relations and identifications of childhood with the parents, moving these toward a more adult-to-adult relation of the patient with the analyst, with persons in life, with his parents, and with himself.

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David W. Allen

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EXHIBITIONISTIC AND VOYEURISTIC CONFLICTS IN LEARNING AND FUNCTIONING

BY DAVID W. ALLEN, M.D. (SAN FRANCISCO)

The person who can go on learning or doing research but has difficulty in showing his results in cold print is familiar in academic circles. In this paper I will discuss conflicts concerning looking and being looked at in several persons who came for treatment. These conflicts affect one's ability to learn, one's wish to learn, and one's ability to teach or to show what he has learned.

Each of these patients had difficulty in looking openly at me or my things. Each showed anxiety about being looked at. Each had some complaints referable to eyes, such as photophobia or clouding of vision. Each had some specific learning inhibitions and an interest in subjects that had for him sexual and aggressive meanings of voyeuristic-exhibitionistic connotation. Each had been influenced in style of living and occupational choice by exhibitionistic-voyeuristic conflicts. Each had had a series of experiences running back to the earliest prephallic relationships that tended to cathect, in a way that caused conflict, exhibitionistic-voyeuristic elements.

Freud, Fenichel, and others have observed that exhibitionism is regularly found as a defense against voyeuristic impulses, and vice versa; and that, in such cases, approximately equal amounts of voyeuristic and exhibitionistic content come into the associations during the course of analysis *(2, 4, 7, 10, 16)*.

Patients who have prominent voyeuristic-exhibitionistic elements in their thought and behavior show a number of common

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From the Department of Psychiatry, University of California Medical Center, San Francisco.

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characteristics. In my experience such patients have early in life been thwarted in efforts to establish a gratifying relationship with the mother; nevertheless, each developed a strong and ambivalent relationship with the mother or mother surrogate. Toward the mother there was a great deal of resentment that could not be openly expressed because of the need for her and because she was seen as potentially rejecting or castrating. Mothers of these patients tend to be seen as both phallic and castrated, the patients never being quite able to decide which.

In addition in each of these cases there was at least one exceedingly vivid traumatic incident, usually in the phallic or latency phase, in which childish voyeurism and exhibitionism were severely reproved by the mother, who threatened the child with losing her love. (It is my impression that it is not nearly so harmful if the father, rather than the mother, disapproves of these impulses.) In these incidents a playmate or a sibling of the opposite sex participated but escaped parental blame, the full blame being felt by the patient. The vivid memory of the incident with playmates became a screen for castration anxiety and a nidus for complusive repetitions or re-enactments in adult life. Repeated betrayals by others, first by the mother in the oral-tactile period, result in fear of intimate involvements and a tendency to show and look from a psychological distance.

In each of these cases, the father was viewed, at the very least, as not having been fully effective as a man, and often as having been castrated. However, as with the mother, the image of the father was split and he was seen contradictorily as latently potent, and as possibly rising up as a kind of primordial castrator himself. Not infrequently the father seemed a passive and loving, almost maternal, figure to whom the child turned for some of the nurturing not obtained from the mother.

The patient in each case felt in some vague, uncertain way disappointed and betrayed by both mother and father, whose sexual inadequacies were complementary. This increased the conflict over approach and avoidance, a dilemma tending to

produce isolation, repression, withdrawal, and distance-taking. Often the child began to procrastinate, prolong, and withhold, or to be impulsive and hasty. These maneuvers seek to avoid too much showing or looking.

In the male cases an essential element in the repeated voyeurism was the defensive use of fantasy. The woman, representing the superego, was imagined to be encouraging the patient to experience sexual feelings and participating guiltily with him; she was therefore not punitive toward him for his sexuality. An imagined acceptance of his voyeuristic-exhibitionistic impulses permitted escalation of sexual feeling. Each of the male patients had a fantasy life dominated by thoughts of fantastic accomplishment: feats of looking and showing magically repaired the disrupted union with the distant good mother.

Each of these patients, both male and female, had much free-floating homosexual concern. Several of them had tried to allay it by acting out homosexually at a time of depression and separation anxiety. They also used masturbation and heterosexual activity to try to control homosexual anxieties. There was sometimes an attempt to heal the split sexual identity through group sexual activity. Modification of the superego was sought through group approval of sexual impulses. 'We're all in this sex thing together', is the way one patient put it. The voyeurism in these patients is not only directly sexually stimulating but serves temporarily for relief of shame and guilt. The patient tends also to use his activity, however, as a source of shame and guilt that have some usefulness in the psychological economy for restraining dangerous instinctual impulses. Through suffering the superego can be appeased, and in time further instinctual release permitted.

CASE I

An attractive young woman in her middle twenties came into analysis after flunking out of graduate school during her second year. She had previously been an excellent student and except

for some difficulty in a course in human anatomy in first-year graduate studies in physiology she had been an average student. She had become depressed and nervous in the second year and had great difficulty in studying, doing poor work in all her courses and completely failing a course in human pathology. She began to feel that certain faculty members were keeping a close watch on her and that perhaps unfavorable reports were being filed in a secret dossier in the dean's office. She did not believe in this watching with paranoid intensity, but she felt the faculty were tending to gang up on her. She attempted to get some psychiatric help through the student infirmary but felt that she could not talk frankly with the psychiatrist there because of fear that the information might be communicated to the school authorities. A faculty committee, which included a psychiatrist, reviewed her work and talked with her. She was dismissed from school with the recommendation she seek psychiatric treatment and with the understanding that, if all went well, she might apply after a year for readmission. She entered analysis and was subsequently re-admitted to school. Since that time she has been a better-than-average student and is expected to finish on schedule her work for a Ph.D. in physiology.

This patient was almost deflected from treatment by several faculty members who, the patient thought, were derisive toward psychiatry and suggested that they would never allow their minds to be examined by a psychiatrist. However, a much-admired woman physician who was herself undergoing psychoanalysis encouraged the patient to undergo treatment. This physician's example and encouragement seemed to tip the balance for the patient in the direction of treatment.

Like some of the others described in this paper, this patient led two lives alternating and intertwined at almost every level of identity and functioning. In school she dressed neatly, wore glasses, and looked rather prim. Outside the school she often wore either provocative feminine clothes or tight-fitting jeans and boots. At such times she wore either contact lenses or no glasses at all. In high school she was a good student but often

ran with a motorcycle-riding, promiscuous group. She alternated between periods of promiscuity and attempts at total abstinence. In a casual affair late in her college career she had an illegitimate child, fathered by a Negro intellectual. She went to another part of the state while pregnant and had the child given in adoption, and none of her friends or family knew of this episode.

In my office she felt much anxiety about looking at me or at anything in the room. She also felt uncomfortable about being looked at by me, though it was only some time after analytic work had begun that these attitudes came to light. Early in the analysis she regularly removed her glasses before coming into the office so as not to be able to see me or my things clearly and because it gave her the illusion (in the manner of the fabled ostrich) that I could not see her clearly. She liked to wear dark glasses and have her long hair fall around her face because she felt she could then see more and be seen less. And yet she knew these things tended to call attention to herself. She was always in a dilemma about such procedures. Once in my office and on the couch, however, she could reveal quite a lot about herself. In fact, even before she developed confidence in me and before the analytic method was fully established, she showed great intellectual integrity in exhibiting her thoughts to me and looking with me at them and at her behavior. Partly, this was because she urgently needed to make certain that she could see and know about herself all that anyone else could see or know about her. She had great fear of being trapped or helpless, was fearful of being off-guard, and yet aware of intense pleasurable excitement in fantasies of rape. This kind of dilemma appeared in multifarious ways. For instance, she liked preceding a man upstairs because her buttocks were attractive; yet she felt panic at the thought of being 'goosed'. Sometimes she felt compelled to tell the man of her fear of being 'goosed' and beg him to assure her he would never do it. And even if this did not produce the feared 'goosing', her expectations of that possibility were heightened.

Analysis revealed that deformity of all kinds, physical and mental, was highly charged with interest and fear for her; she thought her interest in such things so intense as to be indecent and obscene. For her to look at a congenital malformation in child or adult seemed to reveal something ugly about herself.

Looking through or with the aid of various instruments, such as a microscope or ophthalmoscope, caused anxiety. She had great difficulty in learning to hold and use the ophthalmoscope. She thought her index finger too weak to turn the dial. And she was fearful and resentful toward the instructor who attempted to teach her. More abstract subjects such as chemistry or mathematics held no anxieties for her. A class involving some elements of physical diagnosis was a torture to her. She feared being examined by a physician at the student health service who might see stretch marks which would reveal that she had had an illegitimate child. Genital abnormalities were of special interest to her.

She was no stranger to the idea of penis envy and knew that penis and baby may be equivalent in the unconscious. She had both nurturing and castrating impulses toward men. Just as she sometimes had fantasies of being attacked and raped or killed, she sometimes had fantasies of attacking or killing others. One turning point in her analysis came when she correctly guessed that an adolescent boy seen on the street was my son and reported in her next analytic hour that she had had the fantasy of seducing him. I said I would rather she would seduce him than kill him. She laughed in relief and thereafter it was clear that she felt freer in revealing her fantasies and acting out to me.

She resented anything that seemed to reveal a depreciatory attitude toward women by men, and yet she felt women were inferior to men, especially in the genitals. For example, she sometimes talked bitterly of couples who wanted to have sons rather than daughters. She particularly condemned one man who had expressed a wish for a son; when I asked about the possibility that this man felt inhibited or guilty for some reason

about wishing to have a daughter, she asserted that I knew very well girls are inferior to men, that they are 'shitty and cloacal', and that I was just trying to make her feel better about her own femininity.

In some of her work she had to look at and examine patients for learning purposes. Whenever an instructor asked her to look at a patient's trouble and 'see what it is', she felt a great wave of anxiety. After a while I was able to show her the connection between this anxiety in looking and several incidents in childhood, such as a forbidden looking through the bathroom keyhole at her father's and brother's genitals and watching them urinate. These incidents were heavily tinged with incestuous feelings. Gradually, with analysis, the forbidden looking became less frightening to her. She could sometimes joke about herself as an 'old keyhole peeper'.

The patient spent many months writing a paper on various forms of double sexuality such as hermaphroditism. It became apparent that part of her interest in physiological research came from a magical wish, residual from childhood, to be able to change sex. Some of her uncertainty about her own value came from prephallic experience, but what made it so intense was her belief during her phallic conflict that her mother preferred her brother. The patient had strong mixed feelings about her brother. Part of her adolescent promiscuity resulted from some threatening incestuous impulses heightened by her older brother's tendency to 'goose' her and to talk to her in a sexually provocative way. In her adult sexual life the patient could bring herself to orgasm by masturbating with the fantasy of being raped by a gang. But it was important to her not to allow any man to 'make' her have an orgasm, since for a man to see her have a climax would be a shameful exposure.

She was always ashamed if she seemed ignorant. Yet some kinds of knowledge, it became clear, were so sexualized and so burdened with shame that she could not reveal correct answers to questions when in fact she knew them. When an instructor showed approval of a piece of work, a paper, or an

answer, the patient felt such a thrill of pleasure that it was, to use her own words, 'almost like an orgasm'. This pleasure had to be carefully concealed.

Authority of almost any kind presented an especially sharp dilemma to the patient. To be on good terms with figures in authority who represented parents was a delight to her but presented the risk of her losing the love of her father and her mental representation of him. Her father himself had a most ambivalent relationship to authority, toward which he was openly and insistently rebellious. (His own father had been a sheriff.) He resented all policemen and political figures. However, this hostility diminished somewhat after he married the patient's mother, a nurse, a few years older than himself. He was a plumber, most of whose adult life was spent working under the protection of civil service. The patient knew that her father had had an illegitimate child by another woman before he married her mother. The patient's mother was an affectionate woman who had some rather bizarre ideas of a spiritualistic sort, but was a strong and nurturing figure for the entire family.

The patient's father had a quasi-paranoid feeling toward his superiors at work. He kept a journal or diary for years in which, among other things, he recorded what he had done at work so that if ever questioned later about what he had done he could refer to his record. The patient discovered as an adolescent that some of her own doings were being recorded by her father in his journal and that he sometimes followed and watched her when she went to gathering places of the motorcycle crowd. She believed also that her mother, who may have resented her own philandering father, got vicarious pleasure from knowing something about her sexual activities.

Childhood play had much to do with the development of this patient's scientific curiosity. In mutual genital exposure with other little girls she tried to figure out through close observation what various apertures were for; asking her playmate to urinate she would try to see whether the urine came

out of the vaginal opening or out of the urethra. During the course of analysis the patient was astonished to discover a 'wave of feeling' occur when while masturbating she inserted her fingers in her vagina. 'I could always remember masturbating as a child', she said, 'but it was amazing how convincing that wave of feeling was. I knew, I really knew, that's just the way it was when I was a child. When I was little I knew it was wrong. I don't know how I knew but I knew it was wrong to play with myself; and I used to wash my hands afterward so the smell wouldn't be there—just the way I used to have to clean up my thoughts here. Maybe that started when I heard about two girls I knew in bed together examining each other's genitals and the mother of one coming in and saying, "It smells like a whorehouse in here".'

This patient, like some of the others, tended to have a split body image. For example, she remembered that for about five years before puberty she often fantasied having a 'good left side which was feminine and a bad right side which was more masculine'. The restitutive functions of the fantasy are apparent. For instance, she felt castrated but in fantasy had a male part; she felt that her genitals were dirty, her brother's clean, but in the fantasy it was the male right hand that became dirty in masturbation; she felt girls were not as good as boys but in the fantasy her left side was both good and feminine. At puberty she was surprised to discover her left breast enlarging more than her right. She also thought of her body as divided into a bad, dirty, female lower part and a good, clean, masculine upper part. In her unconscious she tended to equate head (intelligence, competence) with penis (power, potency).

If it is true that in order to succeed one needs first the approval of the parent of the opposite sex and second the example of the parent of the same sex to show one how, then this patient had no clear-cut mandate on either side. Explicitly the father gave the patient permission to be attractive and to challenge and supersede authority, but implicitly he forbade her to become an authority. To be both attractive and a scientist un-

consciously to the patient meant to win her father by outdoing her mother (a nurse) but to lose him by becoming an authority. It meant to outdo her brother (a plumber) in the mother's eyes but to risk loss of being nourished by her. It is obvious that to some extent these messages could not be reconciled. Explicitly the mother showed the patient how to succeed as a woman, but implicitly the message the patient felt was that to succeed as a woman meant to lose first place in her mother's affection to the males—her father and brother.

As some of these inner contradictions were exhibited and examined repeatedly in analysis the patient sometimes jokingly began to refer to herself as 'old damned-if-you-do-damned-if-you-don't'. She was able to become more and more her own authority. And while she had long made a point of associating with highly intellectual, creative men in the hope of acquiring some of their powers, she began to show evidence of developing a considerable degree of creativity on her own.

CASE II

An intelligent, æsthetic man in his late thirties had been trained as a chemist but became a successful manufacturer of ornamental screens. He lived quietly with his homosexual partner, collecting antiques, gardening, raising orchids, attending concerts, and listening to his hi-fi set. Outwardly his life was calm, respectable, and well ordered. He dressed expensively with modest good taste and drove a Mercedes-Benz. Behind this façade he was full of anxieties. He led a secret life hidden even from his regular sexual partner and from his business partner. This secret activity consisted in periodically dressing in rough, close-fitting jeans, heavy boots, and leather jacket, and driving in a pick-up truck to certain outlying places where he engaged in voyeuristic-exhibitionistic activities leading to brief, anonymous homosexual encounters. This behavior was stereotyped in almost every detail and occurred when certain anxieties reached a high level. He carried with him a small hand auger for use in the public toilet where the ritual took

place. If it was a place to which he had not been before, he would go into a toilet stall, usually the last in line, and bore a hole in the wall of the stall, carefully placing it to command a view of the urinals or into the adjacent stall. He then watched men urinating, becoming progressively sexually aroused himself. Sometimes he masturbated to the point of orgasm while watching. More often he was able to make a homosexual contact by exchanging signs with potential partners. He looked especially for a man 'who has a face which looks as if it had been cut out of a chunk of concrete, a truck driver or a cowboy type'. He liked then to thrust his penis through the prepared hole in the toilet-stall wall and have the man perform fellatio on him. He was particularly thrilled if the man had 'teeth like a shark' and if he knew the man was uncircumcised. The patient was willing to masturbate the other man but was reluctant to engage in mutual fellatio. While the patient might repeat this performance a second time in the same evening, he usually hurried home directly, relieved of anxiety but beginning to feel shame, remorse, and guilt. About once a year he went to one of the national parks for a week or two to engage in such activity with many willing partners and to watch various natural wonders involving water. He was especially fond of Yellowstone Park and was fascinated by the Old Faithful geyser.

In school he had feared any focus of attention on himself. He avoided speaking before the class or participating in plays and sports. He made 'safe' grades—good enough to please his parents but not quite the 'all A's' which he felt would excite envious retribution from his classmates. In college he preferred to work alone in the laboratories. He quit his first job because he was tortured by telephone calls which he felt 'stabbed' into his privacy like someone 'suddenly peering' at him through a hole in the wall. While not a heavy drinker, he often took a drink before social situations, such as cocktail parties, since it reduced his dread of his hand trembling or dropping his glass.

The patient was an only child in an immigrant Jewish family. He thought of his father, who retired after a rather successful

career as a textile manufacturer, as a man who drove a fine car and was a good swimmer, but as otherwise weak and ineffective, rarely at home when the patient was a child and unable to show the patient how to be a man. He believed that his father never allowed him to see his penis or to watch him urinate. One of the father's principal employes, a muscular Italian man who wore jeans and boots, sometimes drove the patient with him in one of the firm's trucks. The patient pictured his mother as a large-breasted, heavy-set, orally aggressive dreadnaught whose every wish was expected to be the patient's command. She had a male twin who died in infancy and she grew up as an only child. All her life she tended to wear black clothes until her mother, who had lived in the home with the patient, died. Since then she had worn only bright-colored, frilly, feminine clothes. The patient felt that his parents always led a secret life in a ghetto of their own creation, guarded by a series of concentric physical and psychological barriers with twin centers in the bedroom and bathroom. He thought of himself as a twin in various ways. Sometimes he thought he might indeed have had a twin, probably female, who died in infancy, and whom he was expected to replace for his mother. He believed she had dressed him effeminately and kept his hair long in childhood. He was fearful of barbers and having his hair cut. He felt angry but ambivalently divided between his American and Jewish identities. Even his name was twinned: he went by a nickname but retained his original name in business matters. His homosexual partner had the same original first name as the patient.

Walls, sights, surfaces were heavily cathected in memory and in the present. For example, the patient had a vivid early memory of the flowered wallpaper in his bedroom where he attempted to get his nurse, an attractive young woman, to show herself to him sexually. Another vivid memory was of the walls of his parents' bedroom where his mother discovered him with an erection when he was lying on her bed waiting for her to apply some zinc oxide ointment to his crotch. This seductive

behavior he again acted out in a somewhat different way in adolescence and with a friend's wife as a young adult. He had many recollections of trying to visualize what went on inside the walls of his parents' bedroom and in the bathroom. Seeing things grow was also important to him. Not only did he love to garden, but he had an early anguished childhood memory of his formidable grandmother uprooting a weed he was tending in the backyard. Recurrent childhood dreams had to do with fire and water; he saw the walls and floor of the house being on fire near the chimney or in the basement, especially in the first of the two houses where the patient lived as a child. In these dreams he was trying to put out the fire, but felt frightened and helpless. He was, almost needless to say, a bed-wetter. In a vivid early memory he was terrified when the father was trying to teach him to swim and withdrew his supporting hand and the patient felt he was going to drown. He could as an adult barely swim but was nevertheless deeply attracted to the sea. His military service was in the Navy. One of his favorite places for sexual adventures was at the beach near a well-known restaurant.

In his business his partner designed the screens; a hired executive dealt directly with employes, the union, and the public; and the patient quietly checked on technical details of manufacture and business, assiduously avoiding telephone calls and personal confrontations.

'Burnt orange' was his favorite color and he surrounded himself with it. Analysis revealed that for him this color combined properties of fire, urine, menstrual blood, and feces.

He believed an uncircumcised old man may have tried to seduce him into mutual fellatio at age five when he was in the men's room of a movie theater. He was uncertain whether this idea was a fantasy or a memory, but he knew the idea was very exciting to him. At about the same age a little girl with whom he was playing exhibited her genitals to him but he 'absolutely went blind and could not see the lower half of her body'.

The patient's acting out occurred after he had been active in his business for a while but was beginning to feel bogged down, increasingly nervous, and unable to make decisions. The acting out then focused his whole attention on his sexual ritual, which caused him anxiety; he was very much aware of the risk he ran and was hyperalert, cautious, and as discreet as possible about it. These actions and their associated state of mind overwhelmed and screened out temporarily all his other anxieties. The sexual release brought a sense of relief, but he soon suffered greatly from remorse, shame, and guilt; after a time he would begin to feel angry at the world and the people who caused him to feel so much distress. At this point he again became aggressive in business and social relations, which at first relieved some of his anger as he felt he was getting even. But anxiety soon mounted as he felt he might be going too far. Then the cycle was repeated.

CASE III

An architect in his middle forties, who was rather good-looking, smoked a pipe, dressed in tweeds, and wore glasses, had a rather penetrating way of looking at one at first meeting. He consciously used this mannerism to attract the attention of women in whom he was interested. He was highly intelligent and creative, but somewhat erratically successful. He achieved some national recognition, but tended to put off starting, and especially finishing, work. He agonized over this procrastination and often felt that he was waiting for that magic moment when the ideas would flow effortlessly from brain to paper. His average yearly income was high and should have been adequate but he was often on the verge of not being able to meet his payroll and other financial obligations. He had begun psychiatric and analytic treatment several times in the past, but each time had broken off the treatment after running up a large bill with the doctor. We agreed that he would pay me in advance, and he was able to continue in treatment with me over

a period of several years. He resented this arrangement but stuck to the bargain.

He usually could not bear to disclose to friends or colleagues his need for assistance of any kind, but he sometimes was driven to do so. He liked to be in a position to take care of others in a fatherly or big-brotherly way, not so much because he felt it more blessed to give than to receive but because it was so much more congenial for him to be in a position to do so. He thought himself good in emergencies because then he saw what must be done. At other times he felt situations were often very confused, and in fact that his whole life was a 'confused mess'. He had studied art and painted as a hobby. He liked to make paintings hazy and veiled, giving an impression of depth upon depth, but he felt that there was some emptiness beyond all the elusive, evocative images. He often spoke of seeing things unclearly, with a kind of 'grey scrim' interfering with clear perception. When he entered my office he removed his glasses, pipe, and coat and often spoke of being unable to see me clearly and being uneasy at looking at things in my office. He was nevertheless hyperalert to any sounds that I might make, such as shifting in my chair or clearing my throat.

He was divorced and an accomplished Don Juan. He was very adept at encouraging sexual activity in others. He had participated in some group sexual activities as an adult and was particularly skilful at encouraging others to exhibit themselves. He felt secretly, however, that such behavior was 'dirty and perverted'. It was important for him to make the woman reach a climax or become 'abandoned' in her behavior, and he was sometimes inwardly enraged if this took a long while and was difficult, although outwardly he was always calm and patient. At the same time he purposely deferred his own ejaculation in intercourse and in masturbation. He was interested in orogenital sexual activity, both as an active and a passive participant. He had engaged in some homosexual behavior, apparently principally in an exploratory, counterphobic way.

After several days or a week of work he felt he could indulge in what he called his perversion of going to 'peep shows' (nude

or strip-tease movies) or pornographic movies. This followed a stereotyped pattern. He ate dinner, bought several cigars and some 'nudy' magazines or pornographic novels, and went to the peep show where he sat in the dark, smoked the cigars and masturbated under his coat or through his pocket, prolonging the masturbation for hours, and generally allowing himself to ejaculate only after he returned home and in connection with sexual fantasies stimulated by the magazines or books he had purchased. He liked the atmosphere of these peep shows to be as 'degenerate' as possible so that he felt like 'a dirty old man', although he was ashamed and guilty afterwards. Early in analytic treatment he stated that he felt his voyeuristic behavior was compulsive and that it released nervous tension and served as an earned reward after a period of hard work. He also complained that he could not afford the expense involved and often upbraided himself for not stopping it. He seemed much surprised when on one occasion I pointed out to him that since he was evidently going to continue to seek voyeuristic experiences I wondered whether he had ever considered including in his budget a sum of money expressly for this purpose. He did not take this as a strictly analytic inquiry, but was startled and angrily accused me of attempting to encourage his perversion rather than helping him overcome it. However, he did begin to devote some money in his budget for these regular trips to the peep shows and reported that he felt the behavior becoming less compulsive.

The analysis ultimately revealed that this ritualized voyeuristic behavior was an expression of his identification with a seductive woman and at the same time a reassurance of his masculinity through the constant fondling of his penis. But even more important, it became clear that the woman's exhibiting gave a kind of approval for the exhibitionism gratified by his work of designing. Many factors, of course, in the patient's past history combined to produce this behavior, but one traumatic incident fixed its format, like the keystone slipping into an arch.

The patient was the youngest child in an immigrant family.

His father, although a moderately successful lawyer, seemed to the patient a passive, ineffective man completely dominated by the patient's mother. The father had rebelled against a rather rigid religious background and the patient believed that his father always felt himself to be an outsider. The patient also had the feeling of never fully belonging. The patient's mother and two older sisters were pictured as aggressive, dominating women alternately seductive and castrating. The patient believed that they resented all men and that they treated him best when he was passive and especially when he was ill. The patient had a slightly deformed index finger, the result of an older sister's slamming the car door on his hand when he was a child. When he was a child his mother had an operation for a breast cancer and he was told that this probably resulted from his having traumatized his mother's breast as an infant. At puberty he became nervous when he developed a unilateral fatty gynecomastia. Subsequently this breast tumor was excised.

The patient engaged in some sexual games with other children in the neighborhood and was encouraged by a neighbor boy to engage in some peeping at older girls. He was generally a follower in these games, but on one occasion initiated mutual exhibition with a little neighbor girl. She related the incident to her mother, who promply notified the patient's mother, who chastised the patient severely. He felt betrayed by the girl playmate and believed that his mother would no longer love him if he engaged in any further voyeuristic activity. This was the keystone of the arch. The memory of it, of course, served as a screen, just as his adult acting out screened anxiety. Much of his adult behavior can be understood as his making sure that the woman exhibits first and hence, by example, is both the guilty one and the superego giving approval for his own voyeuristic-exhibitionistic impulses.

In school this patient was an erratic student. He believed that his teachers, like his parents, thought he showed glimpses of unfulfilled brilliance. He oscillated between feeling that he had fooled them and that he indeed possessed a kind of creative

mental magic. He was constantly torn between attempting a sustained effort of productivity to demonstrate his abilities, thereby risking unveiling himself as truly inadequate, or attempting merely to preserve an illusion of vast, unused potential. As unsatisfactory as this latter stance was, he felt that it offered surface rewards in the form of giving him a kind of tragic appeal to women and a kind of casual, outside-it-all superiority with men.

In his analytic sessions this patient was particularly interesting. He was alternately seductive and critical. He often spoke in a poetic and evocative, melancholy way, or with vivid verbal images. He often gave a clear chronological account of his activities but deleted any dangerous intercurrent associations. Or he might shift into a kind of false free association that protected him from revealing certain activities. In a sense, he cloaked himself in mystery even when uncovering himself, like a woman dancing with veils, or like a woman who exposes her legs but wears a high-necked dress, or who wears a long skirt while exposing her bosom.

Specific masturbation fantasies were the most difficult of all for the patient to reveal to me. At times he developed considerable anxiety during the session when, after he had revealed to me certain things about himself, I refused his invitation to answer his inquiries about what I thought or to confirm or deny his speculations about my private life. This patient, incidentally, had settled a bill with a former psychiatrist by giving him several of his paintings, and he had in the course of his many sexual conquests had one affair with the wife of a psychiatrist.

CASE IV

This patient worked for a telephone company, and his chief hobby was amateur radio communication. He often complained that his eyes were sensitive to light and on entering the office sometimes thought he could not see clearly because of the dim

lighting. He was often preoccupied with daydreams of fantastic achievements of one kind or another: he developed a bigger and better radio antenna, he was a great baseball pitcher or coach, or he became a financial tycoon. He had a sense of humor and spoke of himself sometimes as a 'real Walter Mitty'. For a time he was able to reveal a good bit about himself, including his interest in voyeuristic activities such as observing girls in nearby apartment buildings and going to striptease bars, peep shows, and the like. He was particularly fond of going to a bar run by a woman who made jokes and innuendoes with orogenital themes.

The patient's mother died when he was three years old. He and his sister lived with their paternal grandmother for several years. When their father remarried they returned to live with father and stepmother, both of whom were strict Catholics. The patient tried to establish better contact with this mother surrogate in a variety of ways, including talking almost constantly to her, keeping her continually located, as it were, by a kind of sonar contact. This behavior came suddenly to an end when one day his stepmother, apparently nearly talked to death, told him that he 'talked too much', and that he was a 'mean, nasty, rotten little snot'. Thereafter he talked to her as little as possible, observed her from a distance, and withdrew into fantasy and into some secret acting out that included attempting to burn the house down after a stepbrother was born. He also began to fail in school. Although he was able in arithmetic, he had begun to have more difficulty in reading and spelling. He refused to read aloud in class.

In the course of his analytic work with me, after telling a good bit about himself, he became more and more silent, and sometimes fell asleep on the couch. In one of these periods of resistance the patient's sister, who had been sharing an apartment with him, decided to move with her little daughter to an apartment of their own. This coincided with my vacation. While I was away, the patient got drunk and exhibited himself in a

hesitant way to an older woman on the street and was arrested; on my return it was necessary for me to write a report to the court to prevent his being sent to a corrective institution for several months. I pointed out that the patient was a useful citizen, generally quite reliable, and that this was his first offense.

After this incident, several things became clear. The patient's silence and sleeping on the couch had to do with an identification of himself with his dead mother, as well as involving a wish to sleep with me as an infant might sleep with his mother. His acting out was an attempt to communicate with me from a distance, as his early religiosity had been an attempt to communicate with his mother across the barrier of death, and his silences were a re-enactment of his response to his stepmother's telling him not to talk so much. There was a more specific element too. As a child he had inquired of his stepmother after a bath what his testicles were for. She told him not to ask such nasty questions and not to touch his genitals. Moreover, his watching the striptease girls was a partial satisfaction for his partial feminine identification, and since he felt that these girls were encouraging him to have sexual feelings toward them, it also was permission by his superego which undid his stepmother's prohibition of his interest in his sexual feelings and genitals.

It was characteristic of this patient that he could observe better than he could show. For instance, even in learning radio code he quickly learned to receive messages but was much slower than others in learning to transmit.

This patient had barely finished high school. But in his third year of analysis, despite being in his early thirties and working full time, he entered college and carried nearly a full schedule of studies. In a remedial basic English course he improved his language skills. Taking courses in advanced mathematics and science, he was progressing satisfactorily toward a degree when he concluded his analysis a couple of years later.

CASE V

This case illustrates some of the earliest prephallic roots of 'look-show' behavior. The patient was an attractive, highly intelligent young woman college student who always dressed so as to be the center of attention. She smoked constantly, talked fluently, and experienced much anxiety. She had done much sexual acting out. Perhaps the most striking thing about her was that she always rapidly established some sort of rather intense relationship with everyone she met. She came to treatment when she was caught up in a sadomasochistic relationship with a student in his late thirties who had a chronic inability to finish any course of study leading to a degree. The son of a psychiatrist, he had diagnosed himself as having a character neurosis that predestined him to failure, a diagnosis in which at times he seemed to revel since it excused his failures and defeated his father's aspirations for him. He and the patient read much psychiatric literature. They had read together Fenichel's The Psychoanalytic Theory of Neurosis much as some young couples might read poetry. The patient knew the book thoroughly. Whatever the interest of any companion, whether teacher or friend, she drank in and shared. These traits made her an unusually good student since she readily and intuitively discovered her teachers' interests and showed them what they wanted to see. Analysis traced this need to maintain intense and constant contact to her earliest prephallic relation with her mother. Her mother had much anxiety about being a mother. In the patient's earliest infancy she attempted to compensate for this concern about herself by maintaining constant contact with the patient, feeding her at every little whimper, often sleeping next to her, changing her diapers, and powdering her, sometimes every few minutes. Her mother continued to be oversolicitous for her even at the time when the patient began treatment. The patient's behavior was an attempt to maintain contact and at the same time emancipate herself from her smothering mother. As a child she had

had fears of losing contact with her mother and often had night terrors and called out to her mother to come and be with her. Naturally in treatment she talked the psychiatrist's language and was quick to acquire pseudo-insight. Only after long and arduous working through did she basically improve.

CONCLUDING REMARKS

The patient with perverse and complusive forms of exhibitionism and voyeurism is clearly not only attempting to achieve libidinal contact across distance, but is also keeping at a distance. The child who in his earliest libidinal body-zone contact with his mother learns to feel that he and his body and all its parts are lovable and fundamentally gratifiable will not be likely to develop the ambivalent (enjoyed and shunned) compulsive activity of the exhibitionist-voyeur, almost no matter what later strains occur. The boy who at puberty, under pressure of the increased sexual drive, develops a compulsion to touch women's breasts does so for some compelling reasons; in one such case the mother restrained his hands during the nursing procedure because she felt uncomfortable when his hands clutched her breast.

In writings on exhibitionism and voyeurism, narcissism and castration anxiety are emphasized, and oral-sadistic incorporation, anal-sadistic retention, and anal-passive receptivity have been mentioned *(4, 5, 8, 15)*. An interchangeability of food and sex in the unconscious has been observed *(16,* pp. 39-44*)*. Looking as a defense against genitality in connection with the œdipus complex has been pointed out *(1)*. Although they are not infrequently mentioned, the prephallic elements in the exhibitionistic-voyeuristic complex have been too little emphasized. Ego functions have physiological counterparts. But ego functions are also the outcome of imprinting experiences, neurophysiologically determined in maturational phases.

Let us watch, for example, the first few experiences of the newborn infant when he learns to suckle. See how quickly a

hungry baby reacts to a warm, human touch on his cheek with an instantaneous, alert snapping of the head into position and locking onto the nipple. 'That's it', the infant seems to say, 'no doubt about it, that's it'. I propose that this is the initial human *Anlage* of insight; it is the fundamental, primary, largely intuitive understanding experience that becomes the core, the taproot, of all later learning. It is the first 'click' of insight, to use Fenichel's expression. The scientist, the mathematician, the poet, the analyst, and the analysand experience or re-experience with each insight something truly akin to that first 'that's it' response. Of course, this 'that's it' response in ourselves is not invariably to be trusted, since it can occur in distorted forms, for instance, in psychedelic drug taking, religious conversions, and the like.

The analysand's response to a correct interpretation resembles the infant's locking onto the nipple. Correct interpretation provides such strong nourishment for the therapeutic alliance that where there is enough healthy ego the diluting 'pap' of support and transference gratification is unnecessary.

The work of Bowlby, Harlow, Hess, Maclean, Lorenz, and Spitz *(3, 11, 12, 13, 14, 17)* seems to confirm that early gratification of exploratory interest in seeing and showing with others is inversely related to reactions of apathy, withdrawal, and depression in childhood and adulthood. The vicissitudes of the partial instincts of looking and showing do much to determine success and failure in adaptation in later life.

What can be said of the effect of voyeuristic-exhibitionistic factors intrinsic to the psychoanalytic situation? Freud's statement that his use of the couch as a technical device to avoid being looked at constantly by patients tells us of his awareness of the force of some of these exhibitionistic factors as they affect the analyst *(9)*. And what of the patient? It is my contention that, at least for such scopophobic patients as the five sketched in this paper, the process of analysis and the act of interpretation in themselves stimulate the voyeuristic-exhibitionistic defensive systems.

Any interpretation, however correct for the patient, is also a revealing, an exhibiting, of the analyst. The interpretation is correct only in so far as it meets the immediate need of the patient for resolving instinctual conflict. The very correctness of the interpretation, in fact, reveals to the patient that he has been accurately perceived; the correctness of the interpretation also reveals to the patient that the analyst is at ease with his own voyeuristic impulses and can employ them with acuity and can exhibit his findings. An inquiry by the analyst may imply to the patient that the analyst is trying to see or is willing to understand. But a correct interpretation implies: 'I see and understand what you are doing; I show you; and you can see also'. Visual elements are prominent in the primary process, and through these visual elements the ego is subjected regressively in analysis to the conflicts associated with the scopophilic-exhibitionistic partial instincts. Perhaps it is in the medium of these partial instincts that a significant part of the working through occurs. At any rate, the process of analysis, apart from any specific content of interpretation, becomes a process that constantly proves that the impulse to look and show can be, as Little Hans said, 'Good all the same' *(6)*.

SUMMARY

The partial instincts of exhibitionism and voyeurism are present in everyone. They tend to form defensive polarities in the psychological economy. Several cases have been presented to demonstrate how these defenses affect adult learning and functioning; traumatic looking and showing incidents of early life can become the basis for later screen memories and acting out. Exhibitionistic-voyeuristic factors constantly influence the psychoanalytic process for both the analysand and analyst. Every correct interpretation, for example, indicates to the patient that he has been accurately perceived and that the analyst is able to observe and exhibit his findings.

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Frustration and Externalization

Peter L. Giovacchini

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FRUSTRATION AND EXTERNALIZATION

BY PETER L. GIOVACCHINI, M.D. (CHICAGO)

Various transference reactions occur in patients suffering from characterological defects. Some of these reactions may go unrecognized because of their unfamiliar qualities. The patient's adaptive techniques and defenses often reveal that the apparent lack of transference involvement is in itself a reaction toward the analyst, a response determined by frustrations stimulated by the analytic process.

Here I will discuss two related reactions, frustration and externalization, which occur in all patients but may have unique features in patients suffering from characterological problems. These two reactions belong to different conceptual levels. Externalization represents an ego mechanism that requires theoretical clarification; frustration produces a behavioral response. My clinical data suggest that frustration besides being a reaction to thwarted instinctual impulses is also a result of failure of the patient's adaptive techniques.

Freud *(6, 7)* described the psychotic patient's conflict as between the ego and the outer world. Not all patients who suffer chiefly from characterological defects are manifestly psychotic, but all have a more or less distorted perception of the environment. Many of these patients have failed to live in a fashion that corresponds to their distorted perceptions. This failure frustrates their adaptive efforts, and the results appear in their analyses. The patient attempts to re-create in the transference an environment that he believes he can cope with. In the transference he is externalizing some aspects of his inner organization as well as projecting affects, impulses, and attitudes. In so far as he fails in this externalization, he feels frustrated.

Read before the Los Angeles Psychoanalytic Society on April 21, 1966.

CASE REPORT

A middle-aged housewife sought treatment because she felt that everything in her life was wrong. She complained that her husband mistreated her, that her children made unreasonable demands, and that her friends were selfish and inconsiderate. She lacked, however, both the fixity and fervor one often sees in the paranoid patient. It was unclear why the patient wanted therapy when she did rather than previously. It seemed that she was finally unable to tolerate feeling miserable any longer; only later did it become apparent that her friends and family were forming attachments elsewhere.

She revealed a traumatic and chaotic childhood. Both parents beat her frequently and demanded that she shoulder the responsibility of raising her siblings since she was the oldest child. Her father was described as an unpredictable alcoholic; the patient 'never knew' what to expect from him, a caress or a blow. She believed that her mother was more consistent for varying periods of time, but from the patient's description it seemed that her mother was suffering from periodic agitated depressions. She recalled episodes lasting several months when her mother was warm and loving and very much concerned about her daughter's well-being. Paradoxically, the patient felt uncomfortable and anxious at these times. After such benevolent periods she would find herself in a situation of physical jeopardy when her mother had violent outbursts and continuously attacked her in the midst of agitation and tears.

I rather quickly formed the impression that the patient was not seriously uncomfortable. It was apparent that she wanted me to fight with her but I did not think this was typically sadomasochistic, although at times there was considerable masochism. It seemed that she wanted to preserve the atmosphere of the battlefield rather than experience or inflict pain.

After several months of this behavior, during which I was silent, I pointed out that she had a need to see me as an opponent and that as long as she felt herself fighting with me she

could feel some security. I emphasized that it was the battleground that she seemed to find necessary rather than the actual fight. She quickly replied that high-ranking military strategists always fascinated her and she had often seen herself standing over a huge map, planning campaigns, but at the same time she could visualize the enemy playing the same game.

Next day she had lost all her exuberance. She had an air of wistful melancholy which she could not attribute to anything in particular. She then reported her first dream.

> An amorphous person (she could not distinguish whether male or female) came at her with a club, but she was not frightened. She knew that she would not be hit and enjoyed the challenge of being what she later called the 'artful dodger'.

She spontaneously pictured me as the amorphous attacker, saying this before expressing the feeling that I would want her to talk about the dream. This feeling made her even sadder. She was beginning to believe that I was not at all like the person with the club and this upset her. She now thought of me as a warm, generous person who wanted to understand her.

Primitive pregenital elements now emerged rather than associations expressing the more obvious sexual implications of the dream. Instead of playfully enjoying herself, she presented herself as anxious and desperate. She was begging for a fight, and at the same time she felt that she was 'falling apart'. She had many dreams of houses crumbling and of drowning, but surprisingly all these catastrophic events occurred in a warm, pleasant setting.

This period of obvious dissolution reached its climax with a short dream.

> She was dressed in tattered rags and walking in a dirty slum. As she continued walking the disordered slum gradually changed into a well-lit and rich neighborhood. She then found herself in front of a mansion, but at this precise moment she disappeared.

This was difficult to describe; she felt panic and thought of herself as a flimsy and empty shadow. After reporting this nightmare, she had an angry outburst at me and emphasized the unmanageable frustration she was experiencing.

I commented that in the dream she would have felt safer and more comfortable in the slum, and that she had made me into a mansion. She agreed and pointed out that she wanted to make me into a slum so that I could be as dirty, horrible, and angry as she was, but it was my stubborn refusal to be anything but kind and understanding that made her feel so miserably frustrated. She then remembered a story she had either seen in a motion picture or heard in a 'soap opera' on the radio during childhood. A kind and beautiful heiress brings a disheveled, deprived ragamuffin to her luxurious home where she has provided a playroom filled with toys. As soon as the heiress is out of sight, the little girl quietly walks to the window and climbs out, getting back to the slums as quickly as possible.

The patient wanted to see me just as she saw herself; she also wanted me to be 'at the same level'. She had to externalize her feelings, to see the outside world in the same terms as she perceived her inner organization. She felt I was presenting her with an experience she could not integrate with her usual perception of the world; especially did my attitude of desiring to understand her disturb her. This attitude she believed she had never before experienced.

In the course of treatment she gradually began to realize that there was hope of raising herself from the 'slum level' to the level she attributed to me. Her view of me was favorable but still primitive in so far as it had megalomanic elements. But the 'mansion' was not unattainable; she had after all created it herself. If she could ascribe such qualities to me, it was possible that she could develop them for herself.

The fact that the analytic relationship could survive the regression was also helpful, and she gradually became stronger although, as in any analysis, there were many fluctuations due to emergence of sexual and other conflicting feelings.

DISCUSSION

Paradoxical seeking for a situation that to the observer seems likely to be painful is the essence of masochism. Certain features of the self-defeating behavior of patients with character disorders should be distinguished from masochism. Masochistic behavior requires a degree of coherent ego organization with a fairly well-defined superego and a capacity for experiencing guilt. Patients with character defects have undergone considerable maldevelopment, and their self-defeating behavior is not functionally organized to protect them from the harsh dictates of the superego. Self-defeating behavior that has a defensive purpose must be distinguished from that resulting from a faulty organization or breakdown of the personality.

At the outset this patient's ego had considerable structure. Her provocativeness was well organized and may have contained masochistic elements even though she did not seem to react to interpretations that referred to them. Later her ego lost its organization and her need to construct a painful reality did not result from masochism. It is possible, however, that her psychic disorganization resulted from regression from a masochistic defensive position.

As her ego regressed, she attributed the trauma she experienced to inability to cope with the external world. This is often the complaint of patients suffering from character defects. Their environment is seen as inordinately complex, impossible for them to cope with by the adjustive techniques available to them. Another patient expressed his dilemma by stating that the world was at the level of calculus and he had barely mastered arithmetic. The patient feels helpless and vulnerable, a helpless babe who is cast out into an environment he is totally incapable of handling.

One would expect the reality these patients are describing to be harsh and demanding, and often it is. Some, however, like the woman I have described, react paradoxically. They cannot cope with a warm and nonthreatening environment. They

react to a benign situation as if it were beyond their level of comprehension. These patients do not have the adjustive techniques to interact with a reasonable environment. Their formative years were irrational and violent. They internalize this chaos and their inner excitement clashes with their surroundings. When the world becomes benign and generous, the patient withdraws in panic and confusion, just as my patient described herself as doing during a phase of ego dissolution. This was particularly emphasized by her story of the heiress and the slum child.

To feel secure in one's identity one has to know where he stands in his universe. The self-image contains numerous introjects, so one perceives the self in the same way as the external objects that have been introjected. External objects are among the first representations of reality. So one's sense of identity, if it is firm and coherent, corresponds to the environment that contributed to its formation. The early environment of patients with ego defects is different from that experienced by persons with a relatively good psychic organization. The ego of the person with a character disorder is not in resonance with any reality that differs radically from the one he knew in early childhood. The degree of difference determines how well he can master external stimuli and perceive himself as a meaningful person in a knowable, acceptable world.

The ego with primitive fixations or one that has undergone defective development can maintain some coherence in a setting similar to the one from which its introjects were formed. For my patient the analysis represented an infantile situation; being understood or having someone interested in what was going on within her was an entirely foreign experience in which she could not feel at ease.

This woman's requirements from the world are those often seen in persons who have suffered much trauma in childhood. Their egos have been acclimated to a frustrating environment. The person with a character disorder expects and brings about his failure; he adapts himself to life by feeling beaten in an un-

predictable, ungiving world. Obviously this situation is different from a masochistic adjustment that is designed to effect a psychodynamic balance; the defensive situation described in this patient is one that is vital for maintaining a total ego coherence instead of dealing with specific conflicting destructive impulses.

This patient's psychopathology can be understood in several ways. Very often she saw herself as a frightened little girl who was given everything but love and intimacy. At other times, her provocative behavior was a defense against her libidinal attachment to the analyst. By regarding the analysis as of little value, she need not become painfully dependent and thus expose her helplessness and vulnerability. She could maintain control by projecting the despised aspects of her self onto the analyst. Her underlying œdipal wishes might destroy her as well as others; to avoid them she forbade herself a warm and receptive relation with external objects, including the analyst. When the analytic situation did not support her defenses, she felt traumatized.

Freud *(5)* described the tendency of patients to repeat traumatic situations of the past. He believed that this repetition represented, in part, a need for mastery, but he pointed out that a characteristic of the id, the repetition compulsion, is also involved. Undoubtedly the repetition compulsion is also operative in these patients, who resemble those with traumatic neuroses although the trauma began early in life and was repetitive and cumulative *(10)*.

The analyst is faced with a seemingly paradoxical situation when the patient feels frustrated because the analyst refuses to frustrate him. The analytic setting provides consistency, the constant reliability Winnicott describes *(14)*, and hence is conducive to regression; it causes the patient to hope that infantile needs can be gratified. Because of past experiences this hope cannot be trusted; instead of risking the inevitable disappointment of megalomanic expectations, the patient prefers relating in a setting to which he has learned to adjust. If the analyst does not frustrate him the patient's psychic balance is upset.

To reinstitute ego equilibrium the patient attempts to make the analyst representative of the world that is familiar to him. This defense must be distinguished from projection. Projection was very early described by Freud in 1896 and 1911 *(3, 4)*, as the attribution of a disruptive, unacceptable impulse to an external object. In the course of time the concept has been broadened to include not only unacceptable id impulses but also disruptive affects, as well as discrete psychic contents such as introjects *(9)*. There is always some interplay between projection and introjection.

Such primitive defenses as projection are often employed in character disorders but what my patient was attempting to achieve in her analysis was more than projection. Although one can describe the inner and outer world only in terms of their content, her reconstruction of reality was not based solely upon unacceptable impulses and affects. These patients are attributing a particular level of integration to reality, a process better described as externalization. The need to be frustrated is not primarily projection of hostile wishes upon a persecutor; rather, it represents a mode of adjustment that makes the interaction between ego and outer world possible. According to Freud *(4)* the patient projects inner impulses that have become disruptive. Externalization provides the patient with a setting that enables him to use adjustive techniques that he has acquired during his early development. Although there is always an element of projection in every externalization (in so far as the construction of reality will invariably involve the attributing of some unacceptable impulses to external objects), there are additional factors.

Externalization can be conceptualized as the 'projection' of an ego mechanism whereas the defense mechanism called projection deals with impulses, affects, and self- and object-representations closer to the id. For example, if the chief adjustive modality of the ego is repression, then it seeks a repressive environment. But if the ego makes its adaptation to a world perceived as full of rage and violence, then the mechanism of act-

ing out becomes its chief interaction with the world. The type of acting out displayed by my patient, however, was not flagrant antisocial behavior. In character disorders there is a greater tendency to act out and to externalize. Many ego mechanisms can be attributed to the environment; this attribution enables the ego to maintain itself, not in a vacuum but in a familiar even though painful and frustrating world.

Brodey *(1)* in a recent article describes externalization as 'distancing . . . without separation'. According to him, projection also occurs but the manipulation of reality referred to as externalization has the 'purpose of verifying the projection'. Other aspects of reality are simply not perceived.

Externalization can be defensive in so far as it maintains a tenuous psychic balance. It can also be part of any defense because defenses have to operate in a setting that is to some extent compatible with them. Van der Heide *(13)* stated that in so far as a defense is ego-dystonic the ego changes the environment in order to 'justify' the defense. Persons with character disorders do more by their externalization than merely make the environment compatible with their defenses. Their basic identity is involved. The environment has to be constructed so that their total ego organization is maintained.

But externalization is not confined to persons with character defects; it occurs in normal development. In psychoneurosis it helps to maintain defenses, but as the ego develops it helps to establish reality testing. The child's ego not only constructs an imago, it also incorporates the setting characteristic of the object. The mother is a means by which the child becomes adapted to the environment; hence the child not only 'registers' a maternal imago but he perceives the mothering process as an adaptive technique. Introjects function by helping the child to establish a relation with the inner and outer worlds and to develop and use subsequent experiences for acquisition of further adaptive techniques *(9)*.

When my patient tried to make me representative of a specific traumatic environment she was, at the same time, project-

ing parental imagoes and hated parts of herself onto me. The latter process is, of course, characteristic of transference but with this patient it was an uneasy and conflicting transference because she could not reconcile her projections with the analytic setting. This had, nevertheless, therapeutic advantages, since it did not lead to a transference fixation and made possible the understanding of irrational and infantile expectations.

Anna Freud *(2)* discusses externalization as a mechanism that externalizes parts of the self or the inner conflict, or both. She describes how the therapist may become representative of conflicts or of a psychic agency, such as the superego. Clinically this transformation of the environment has to be described in terms of specific content. To speak of conflict and superego is to introduce a categorization that goes beyond clinical observation and description. One can describe the patient's construction of external reality in terms of his perceptions. The psychic mechanisms involved in his conflicts or in a psychic agency, such as the prohibitive or judgmental aspects of the superego, are elaborated into experiences which can be reported as perceptions and feelings. Anna Freud also seems to distinguish externalization from projection but she does not emphasize the differences. Furthermore, she believes that when the patient 'externalizes', the therapeutic relationship differs from one in which a transference has been established.

Whether the phenomenon of transference should be restricted to the projection of an object or part object *(8)* or whether it should include the adaptive function and setting of the object is an interesting question. Here I emphasize that some patients suffering from character disorders may find themselves in an analytic situation that is discrepant from their projection of an archaic imago. This can lead to disruptive regression but it can also be potentially useful for analysis.

The analysand's response to the hope stimulated by the consistent analytic situation is of crucial importance. Because these patients present themselves as so needful, the analyst sometimes feels that he must offer some gratification in order to achieve

sufficient stability for the analysis to proceed. The patient often misunderstands the analyst's helpful attitude and believes that he is being promised gratification of needs that would have been appropriate to childhood. The analytic situation, by providing a setting that facilitates regression, sometimes causes the patient to believe that such gratification is possible, and if the analyst also seems to offer help, the expectation of primitive satisfactions may be re-enforced.

Two of the many possible reactions to this therapeutic interaction must concern us. First, the patient may for the moment relinquish his distrust and his insistence that the environment is frustrating. He acknowledges that gratification is possible, and since the needs he hopes to satisfy are primitive, his expectations will be megalomanic. The transference is characterized by fusion with the analyst; the patient expects to be rescued from his assaultive depriving introjects. In so far as megalomanic expectations are thwarted, this attitude usually leads to bitter disappointment. Second, occasionally this fusion persists and the therapeutic relationship is maintained on the basis of a delusion. Strachey *(12)* believes that many so-called supportive relationships continue because the analyst unwittingly fosters such a delusion.

The patient may not accept the analyst's offer of help. Since he has always been suspicious and wary such an offer may lead to a strengthening of distrust. He can then view the analyst as insincere and convert him into a replica of the frustrating environment he once knew. This transformation involves a projection of the bad self as well as externalization.

Either reaction to the analyst's interventions precludes analysis. To some extent, such reactions will occur regardless of what the analyst does. But if he has maintained the analytic setting by avoiding involvement with the patient's infantile needs or defenses he has established a frame of reference in which such responses can be examined. He is an observer and the patient begins to realize that the analyst's primary aim is to understand how his mind works, a unique and new experience for him.

This attitude becomes characteristic of the external analytic reality and when internalized *(11)* constitutes an ego mechanism. The externalization of this mechanism occurs in an ego that has achieved sufficient structure so that it can maintain itself in nonfrustrating surroundings.

SUMMARY

Patients suffering from characterological defects emphasize certain defensive reactions that are not frequently encountered in the psychoneurotic. Some of these patients have an unusual orientation to the outer world. They *must* fail. They unconsciously attempt to create an environment in which they feel frustrated. This constitutes an adjustment; frustration has become a way of life. In so far as they cannot master a benign environment they construct one that is harsh and ungiving. The patient's attempt to reconstruct such a frustrating environment is highlighted in the transference. The patient feels frustrated because the constant reliability of the analytic situation refuses to frustrate him. This compensatory defense—the creation of a traumatic but familiar setting—is referred to as externalization, which is distinguished from masochism and projection. The techniques of working with such 'needy' patients demand further scrutiny.

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Alcoholism and Ornithophobia in Women

Victor Calef

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ALCOHOLISM AND ORNITHOPHOBIA IN WOMEN

BY VICTOR CALEF, M.D. (SAN FRANCISCO)

The external manifestations of illness suffered by four patients were remarkably similar. The symptoms have not to my knowledge previously been linked and described as a typical psychiatric syndrome. The symptom complex had not been recognized perhaps because their common dynamic roots have been overlooked.

Four women suffered from severe anxiety which at times bordered on panic. A long-standing fear of birds which became intolerable at the sight of a bird in flight was a part of the symptom complex in all the patients. However, none of the women reported the phobia of birds as a chief complaint. They treated the ornithophobia much in the manner of 'doesn't every woman hate birds?' and managed to circumvent the fear by avoidances. In every case the therapist did not learn about the existence of the phobia until the therapeutic work unveiled it.

Only one of the four patients was concerned about her drinking and described herself as an alcoholic. Yet all of them drank to excess and their husbands considered the drinking a problem. Whether a diagnosis of addiction could be properly made depends on the criteria used.

The four women shared several other characteristics. They were all bright and yet had an exaggerated contempt for their intellectual capacities and for themselves. (Obviously the narcissistic overevaluation of their intellectual functions and a devaluation of the mental capacities of others were only just below the surface; the feelings of intellectual inferiority were defensive, partly by a negation of their potential.) They harbored intellectual ambitions which they believed they could not satisfy and thus kept them hidden and under control. They maintained the position that they were unable to function in therapy and that they did not understand the sub-

The author wishes to express his thanks to Drs. Robert Wallerstein and Edward Weinshel, and his special indebtedness to Dr. Emmy Sylvester for invaluable criticisms and suggestions.

tleties of it; nevertheless, they retained a sharp-tongued wit to find numerous cynicisms with which to belittle and negate the therapeutic efforts.

The intense anxieties which were such a prominent feature of the clinical picture in the four patients were accompanied by the conviction that they would become insane. Thus sanity was constantly, though only subjectively, in question. None had made any overt suicidal attempt, though all were depressed and spoke openly of suicidal wishes and fantasies. None had had episodes of psychosis and none showed any objective, overt evidence of psychotic thought despite the intensity of the depressions and anxieties. They came to analysis reluctantly and resisted the analytic process though therapeutic gains could be demonstrated.

Obviously, the coincidence of the drinking and the bird phobia does not establish the psychological relationship between the two symptoms. Indeed, understanding of both evaded analysis until one of the women reported a dream. In the evening of the day in which she finally overcame some of her resistances and tried to work on the analytic couch for the first time she dreamed that she was lying on her former analyst's couch where she had never lain; (her first psychotherapeutic venture occurred during her adolescence and had extended over a long period of time). In the dream she was stroking a cat in her arms. Her analyst seemed busy with many other patients who were coming and going. She was angry and anxious and began to remonstrate that if he were too busy with so many others it was of no value for her to try to work in analysis. However, she finally realized that her former analyst was not her present analyst (she had recognized both her analysts by name in the dream) and with that thought she experienced relief.

The simplicity and transparency of the dream permitted associated material and connections to be made which were not previously available. Although the patient was reluctant to associate to the dream and did not understand it, she felt its importance and realized that it would not be difficult to analyze. The masturbatory meaning of stroking the cat was obvious and made it possible to interpret her fear of masturbation. Whereupon she recognized that she knew the cat as a symbol for her genitals and remembered that her mother and grandmother had repeatedly warned her to guard against the cat who chased birds, killed, and ate them. The female

genital was regarded by her as a destructive and devouring mouth. She then spoke of her fears of people and her efforts to avoid involvements in which she might be recognized as a hostile, competitive, devouring, and destructive person. She could not stand any controversy. In this context her drinking appeared as efforts to 'kill' her fears and her appetites, a means to avoid the oral destructive connotations of her behavior.

It should be emphasized that the four women had such great fear of masturbation that they had repressed all knowledge of early childhood and adolescent masturbation. The early infantile masturbation could only be reconstructed, while evidences of concealed and substitute masturbatory practices were revealed by the therapeutic work. In three of the four women masturbation was something which was said to have been learned during adulthood and infrequently practiced. Obviously, masturbatory habits had to be and were given up at an early time.

The bird as a phallic symbol is well known and the fear of fluttering wings in flight has been described as a derivative of the fear of the penis and of sexuality. However ornithophobia as a manifestation of penis envy has not previously been related to alcoholism. The latter is an attempt to avoid and defend against the oral-incorporative, destructive aspect of the penis envy linked to the earliest masturbatory conflicts and fantasies. The bird phobia and the alcoholism are expressions of the same unconscious contents. The alcoholism is not simply an expression of the satisfaction of the instinctual needs but it also serves an additional function. The fear of insanity, related to the intense masturbatory impulse, constantly threatens as if the functions of repression and those which maintain controls will not do their work. Drinking is a regressive attempt to quiet the impulse and to perform the function which the forces of repression did not seem to be able to handle. The patients do not trust their psychic functions to take over and control by repression, and other defensive means, that which most people handle by defense. In the same manner they distrust their own perceptions and feelings. Alcohol provides the quieting effect upon the instinctual demands and blots a sufficient amount of psychological awareness so that it appears to function as a force of repression or, more correctly, as an inadequate external substitute for it.

It is not the intent to explore the genetic roots of the phobia and the alcoholism. Yet it should be noted that the histories of the four patients were studded with memories of repeated disappointments with the mothers, perhaps best characterized in the final act of abandonment experienced by one of the patients when her mother committed suicide following years of depression; by the second patient when her mother suffered an accidental death following years of marital discord; and by the third and fourth patients as a consequence of the hospitalizations of their mothers for mental illness following years of chronic narcissistic and hypochondriacal preoccupations.

SUMMARY

An attempt is made to describe what may be considered a psychiatric syndrome in women who have a severe masturbatory conflict accompanied by intense subjective fears of insanity which seem genetically rooted in feelings of disappointment with and abandonment by the mother. Such women are moody, depressed, intelligent, and they hide their ambitions and their intellectual potential out of a fear of controversy, conflict, and competition. The specific clinical form in which their conflicts become manifest is the fear of birds associated with alcoholism as an attempted regressive solution which seeks an external agency to do the work of repression.

The report of a dream by one patient represented the beginning of analytic work with her. It led to an interesting correlation between the drinking and the bird phobia of this patient as well as others, a correlation which could not have been suggested without metapsychological theory which differentiates the regressive products of illness from fixations. The bird phobia is certainly a product of the return of the repressed, and is in itself regressive—a psychoneurotic symptom. Nevertheless it has elements of fixation from early periods of development. The alcoholism is a regressive solution, a symptom which takes its psychological characteristics by a turning to the oldest fixation points from which the phobia of birds was built.

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Smiley Blanton, M.D. 1882–1966

G. F.

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OBITUARIES

SMILEY BLANTON, M.D.
1882-1966

Dr. Blanton, who was analyzed by Freud for one year and spent parts of others with him in Vienna and London, saw no incompatibility between psychiatry and religion. In The Pastoral Counselor (Fall 1963) he recorded some of Freud's opinions on this subject and others, including Jung, Adler, and their analytic methods. In 1937 Blanton founded, with Dr. Norman Vincent Peale, the American Foundation of Religion and Psychiatry; he had also organized the Minneapolis Child Guidance Clinic and the Vassar College Nursery School, as well as holding several professorships. His books include studies of speech disorders and several devoted to the problem of healing by psychiatric and religious means. His wife, Margaret, who collaborated in some of his writings, survives him.

G. F.

I. PETER GLAUBER, M.D.
1899-1966

Dr. Glauber, a native of Lithuania, was graduated in medicine from New York University and after five years of general practice served as Resident at Central Islip State Hospital. His analytic training was at the New York Institute where he supervised therapy in the Treatment Center; he was Chief of the Speech Division of University Hospital and consultant to several agencies. Besides widely respected papers on functional speech disorders, he published Specialized Techniques in Psychotherapy (Basic Books, 1952), and Stuttering, A Symposium (Harper, 1958). In 1963-1964 he was President of the Westchester Psychoanalytic Society. He is survived by his wife, Helen, and a son, Neil.

H. R. B.

JOSEPH M. KRIMSLEY, M.D.
1909-1966

Dr. Krimsley, who died at the age of fifty-seven, had been a member of the New York Psychoanalytic Institute since 1952 and Assistant Director of its Treatment Center from 1961 until shortly before his death. During the Second World War, he served in the Army as a Captain and was awarded the Bronze Star for outstanding bravery under fire. In the last five years of his life he was seriously ill and lived under constant restrictions, but he fully mastered the great trials of this illness and lived with graciousness and joy. He is mourned by his wife and daughter, as well as by his many close friends.

WALTER A. STEWART

EDWARD LISS, M.D.
1891-1967

Child psychiatry and child analysis lost a devoted friend with the death of Edward Liss, one of the early pioneers in work with children. His whole life was dedicated to his love and concern for children and during his early experience as a pediatrician he became aware of the emotional components involved in the care of children in pediatric practice. In his search for more insight, he studied child psychiatry and psychoanalysis in Vienna and Berlin in 1928 and 1929. When he returned to this country, he worked with children with educational as well as emotional problems at several schools and institutions near New York. As early as 1936, he lectured on educational and emotional aspects of the learning process at the Progressive Education Association and later at the Philadelphia Psychoanalytic Society, the Long Island College of Medicine, and the State University of New York. His many published articles covered a wide range of subject matter: education, mental hygiene, and child guidance. Many of these papers stimulated the thinking of the early workers in the field of child guidance and child psychiatry.

We shall always be appreciative of Edward Liss's enthusiasm and his eager involvement in discussion in the conferences and meetings of our professional associations.

MARION E. KENWORTHY

SAMUEL NOVEY, M.D.
1911-1967

Sam Novey died suddenly and unexpectedly from a heart attack on May 23rd in Baltimore. He had been a training analyst and member of the Education Committee of the Baltimore Institute for many years. A man of exceptional gifts as a clinician and teacher, his psychoanalytic and psychiatric papers, as well as his forthcoming book on the reconstruction of personal history in psychoanalytic treatment, bear witness to the sound originality of his mind, to his scholarship, and his deep and truly critical understanding of the practice and theory of psychoanalysis. He taught at the Baltimore Institute, at Johns Hopkins Medical School, and during the last year of his life, was Director of Training at Sheppard-Pratt Hospital.

HANS W. LOEWALD

GEORGE W. SMELTZ, M.D.
1884-1967

With the death of Doctor George W. Smeltz at age eighty-three psychoanalysis lost another of its pioneers. His fifty-four years of unflagging commitment to analysis began with his auditing Freud's study sessions in 1913-14, continued over more than twenty-five years of relative isolation as 'the first psychoanalyst west of the Alleghenies' and the only qualified analyst in Western Pennsylvania until his teaching activities began to attract and develop younger men in the field. He was active as a training analyst, first at the Philadelphia Psychoanalytic Institute and later at the Institute of the Philadelphia Association for Psychoanalysis. Quietly devoted to his identity as teacher and physician, George Smeltz labored for over thirty years in the School of Medicine of the University of Pittsburgh, bringing psychoanalytic concepts to the medical student and practitioner, and becoming Professor and Chairman of its Department of Psychiatry.

JAMES T. MC LAUGHLIN

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Sigmund Freud—Lou Andreas-Salomé Briefwechsel. Edited by Ernst Pfeiffer. Frankfurt: S. Fischer Verlag, 1966. 293 pp.

Martin Grotjahn

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BOOK REVIEWS

SIGMUND FREUD—LOU ANDREAS-SALOMÉ BRIEFWECHSEL. Edited by Ernst Pfeiffer. Frankfurt: S. Fischer Verlag, 1966. 293 pp.

A full-length psychoanalytic dialogue by correspondence is presented. Again Sigm. Freud writes letter after letter of great historical and personal interest. The letters cover the twenty-five years from 1912 until shortly before the death of Lou Andreas-Salomé. (Lou Andreas-Salomé was born in 1861, met Freud at the turn of the century, and died in 1937.) Of all the letters, approximately three hundred, the ratio is perhaps three to two, indicating that Lou wrote oftener and longer letters. Anna Freud preserved the letters and supplied them for this publication.

The first letter, dated September 27, 1912, was answered almost immediately by Freud. At first both correspondents salute each other formally. While Lou's salutation is best translated, Dear Professor, and changes little during the years, Freud changes from Dear Madam to Dearest Lou and finally settles for Dear Lou. Once Lou addresses a letter to C. A. Freud (p. 29), the initials of her husband. The slip is at once taken up and interpreted by Freud. There appears to be little censorship, mostly in order to protect the anonymity of several patients; some omissions seem to refer to the relationship between Lou and Anna (pp. 104, 115, 124, 128, 151, and 181).

The first and most amazing feature in this correspondence is how much these two people really cared—for each other, for their communication, and for the psychoanalytic movement. Almost everything mattered. Lou's handwriting alone, page after page, would tax the patience of any current analyst. Her style is somewhat forced and stubbornly defended. It is very different from Freud's direct, straightforward, masculine way of expressing himself. For instance, she rarely, if ever, refers to Anna Freud as Anna or Daughter but writes consistently about 'Anna Daughter'. She uses her own technical language, translating regression as *zuruck rutsch* and coins words like *grenz tatsache* or *schicksalsgemeinheit*. Her style gets simpler and more direct over the years while Freud's style seems to be perfect from the beginning. She writes long letters, his are shorter. She frequently apologizes for writing while he occasionally

refers to her formulations, 'Your sentences which I cannot always conquer . . .' (p. 150). Her writing is often sentimental, forced, feminine, or, as mentioned previously, 'she thinks with her heart and she feels with her brain'.[1]

Freud repeatedly makes a peculiar slip of the pen and refers to her 'six big brothers' (p. 89). Actually Lou was the sixth child after five brothers but Freud seems to have accepted her as one of them. Or, this slip was a disguised interpretation: You live, behave and relate yourself to men as if you were 'one of the brothers'. The relationship between the two deepened after Anna Freud and Lou Andreas-Salomé became friends.

Lou's letters are exclusively Freud-directed and persons of early psychoanalysis are mentioned only at random with a few references to Rilke and Nietzsche. The restless Lou seems to have settled down in her friendship to Freud and all other great men of her life moved into the background. Georg Groddeck, whom Lou respected as a friend of Ferenczi, is mentioned. She refers to Groddeck's book, *Der Seelensucher* (The Soul-Seeker), as *Der Wanzenmann* (the bedbug-man). Ferenczi and his wife, visits from Abraham, and her reading of Rank and Reik are mentioned. She was a passionate reader of psychoanalytic literature and Freud introduced Ernst Simmel's work to her. It was Simmel's work on war neurosis that appeared to open the door for official recognition of psychoanalysis by military psychiatrists. Freud's recognition of it is an indirect hint of his awareness of his tendency to build an analytic empire. There is no doubt that, in the beginning of their friendship, Freud realized the great influence this woman could exercise on the analytic atmosphere of Europe.

Freud wrote: 'I will neither say yes, nor no, nor will I give out any question marks, but I will do what I always do with your remarks: enjoy them and allow myself to be impressed by them' (p. 68). He thought that what he had to say was prose which she changed into poetry (p. 125), while she considered it her function to translate paternal truth into femininity. Freud often repeated the assurance: 'You always give more than you receive' (p. 115). Much later (p. 211) when Freud read her essay, My Thanks to

[1] *The Freud Journal of Lou Andreas-Salomé*. Translated and introduced by Stanley A. Leavy. New York: Basic Books, Inc., 1964. Reviewed in This QUARTERLY, XXXIV, 1965, pp. 274-276.

Freud, he thought it 'exquisitely feminine'. With authoritarian sternness he rejected the title as impossible and much too personal. It is surprising and touching to see how Lou stood up to him. 'This title is so intimately related to the text that a change is out of the question.' In their discussions it almost seems that Freud saw a projection of the artist in himself onto her (p. 213).

During the First World War and shortly thereafter Lou lost contact with her five brothers in Russia and also her fortune. After that Freud occasionally mentioned outright gifts of money, transfers of patients, packages of books, journals, or other necessities. Freud's enthusiastic support of the German side became clear, followed by his concern for his three sons and the general misery when the war did not turn out the way he had hoped. Lou was careful and guarded for she was in a difficult position; married in Germany she still had to think of her brothers in Russia (p. 86).

There are tantalizing 'letters of consultation and supervision' in which Lou presents case material and Freud responds to it. The names of the patients are, of course, omitted and many details assumed as already known, and much taken for granted, all of which makes reading difficult. Some of these patients offered bizarre behavior, especially startling in a small German university town. One agoraphobic patient needed a waitress or servants to march in front of her, a special physician at her side, and somebody else behind her. All of them marching as a group through the streets of Gottingen must have amazed, bewildered, and probably shocked the silent observers behind drawn curtains along the little street leading up the hill to Lou's house.

One little girl is described as of preschool age, suffering from pav[or] noct[urnus] (pp. 76-81). This child developed nightmares after she had had scarlet fever and an ear operation. She dreamed about fire, murder, blood, creeping frogs and worms, kidnapping, and black men. To gain her confidence Lou told about her own nightmares. So far as she could see there was no sexual traumatization. The girl never slept with her parents and she was on good terms with her little brothers. In his interim report Freud says, 'Where there is smoke, there is fire' (December 4, 1917), and hints at sexual temptation and conflict. Still Lou is reluctant. The girl confesses masturbation but not after the scarlet fever and operation. And what should she do about that since, after all, masturbation

is unhealthy? Freud answered with a quotation from Goethe (p. 80, December 23, 1917). Mephistopheles asks Faust: 'You are on such intimate terms with the devil and then you want to be afraid of fire?'. Lou is impressed and the girl is soon free of symptoms.

Later Lou mentioned a little patient not quite two years old who perhaps introduces a new phobia into psychoanalytic literature. The boy was very much afraid of flowers; otherwise he was normal, courageous, curious. But he was horrified when he touched even the most harmless or most beautiful flower. Lou observed him warning a bird not to sit on a blooming bush because terrible things could happen to him (pp. 87-89). Freud answered with startled amusement (p. 89, May 29, 1918). 'A case like your little boy who is afraid of all plants is really something which never came to my attention before. The flora totem I always thought to be late and secondary.'

At a later date (February 1919) Lou discusses her correspondence with a young girl of twenty-one who had obsessional features changing into a severe hysteria (pp. 101-103). Freud's opinion (March 9, 1919): 'Whether you should try to give relief to your new problem child by letter writing? What speaks against it? It is worth the attempt. The change from compulsive to the hysterical symptom seems to indicate an inner progress in the sexual organization and may be favorable. (It just so happens that I could not analyze such a case recently.) Obsessive neurotics are not especially accessible with insufficient intensive treatment: they always produce very much but success is not among their productions.'

Finally Freud sends a severe case of agoraphobia (p. 161) to be treated by Lou in Gottingen. He makes a special point about the financial arrangements since he wants her to ask not less than twenty gold marks. The letter is delayed and Freud is unhappy when Lou made arrangement for less than half the fee he considered appropriate. Again, therapeutic advice is given in June 1925 (p. 174). 'To prepare your patient for divorce is not your job. You are not a legal advisor, also not a helpful aunt, but a therapist who can work only when he is given the requested conditions'.

Freud summarizes his opinion on supervision (p. 133, March 23, 1923): 'It belongs to the special advantages of the analytic trade among other things that here the practice of consultations is hardly possible. The "guest for a while" sees nothing that the host does not show him and he usually has no judgment which was developed

in the other person on the basis of numerous imponderabilities. Therefore, I do not dare to tell you anything useful in the case you describe.'

There is no introduction and no endorsement to this book and editor Ernst Pfeiffer remains tactfully, though clearly visible, in the background. He has added sixty pages of explanations, footnotes, references, dates, and bibliographical notes to Lou's and Freud's work, especially her two books, In School with Freud and My Thanks to Freud, but he refrains from any interpretation. Translation of these letters will have almost insurmountable difficulties. The peculiarities of Lou's style will have to be disregarded as well as some of the witty implications of Freud's words which are so intimately connected wth his mastery of the German language.

In his letters the reader feels keenly that Freud stands behind every one of his words honestly and directly. In these letters he shows great, enduring affection for a friend.

MARTIN GROTJAHN (BEVERLY HILLS)

PSYCHOANALYTIC PIONEERS. Edited by Franz Alexander, Samuel Eisenstein, and Martin Grotjahn. New York: Basic Books, Inc., 1966. 616 pp.

Despite its shortcomings this book is a valuable addition to the psychoanalytic library. In a series of essays, the volume sketches the lives and contributions of forty individuals who have played a more or less decisive role in the growth and development of Freud's original work. Two additional essays present historical reviews of psychoanalysis in England and in the United States.

As a source of biographical data the work fills a void in a field which has been dominated by the towering image of one man. This has tended to relegate the image of some of Freud's early followers to a position of relative obscurity. As a consequence, members of that first generation of psychoanalytic pioneers—(pioneers of psychoanalysis would have been a more felicitous term)—are known to contemporary analysts chiefly as names attached to certain theoretical formulations, as authors of well-known books and papers, or as the principals in certain celebrated psychoanalytic controversies.

The same faceless anonymity does not apply to the second generation of pioneers—those achieving prominence since the end of the first World War—for these have often been familiar figures at present-day professional gatherings and have served as the analysts and teachers of many of the current generation of psychoanalysts.

Perhaps it is partly because members of the first generation of pioneers are relatively remote from our own times that the essays dealing with them tend to be static and lifeless. The dates, places, and salient facts are there, but in comparison with, say, the Ritvos' warm and poetic portrait of Ernst Kris, or the lively and somewhat Daumieresque sketch of Róheim by Weston La Barre, the earlier essays convey as little of the living personality of their subject as does the likeness of Washington on a one dollar bill. In general, there is a marked unevenness, not only of convincing portraiture, but of presentation of the major scientific work of each subject. Indeed, in some instances the latter would appear relatively incomprehensible to a reader not previously acquainted with it.

There is also a conspicuous unevenness in the literary quality, probably inevitable in a volume by many authors, but some of the lapses of style and literary elegance might have been avoided by more conscientious and careful editing. It is disconcerting, for example, to encounter the phrase, 'Hans first met up with psychoanalysis,' in the biography of Zulliger (occasionally referred to as 'Little Hans'), and to discover almost verbatim repetitions of the texts on nearly consecutive pages of the articles on Melanie Klein and Hanns Sachs. Another curious lapse is in Greenson's otherwise excellent essay on Fenichel which contains virtually nothing about Fenichel's life prior to his arrival in Los Angeles in 1938 when he was forty.

A more serious criticism concerns a statement that, in his 'bione-orgone' experimentation, Wilhelm Reich had 'disassociated himself from acceptable psychoanalytic theory and practice'. This he certainly did; but the statement reflects a lamentably parochial view, suggesting that Reich was guilty of heresy. The basic objection to his final work is that it had nothing to do with the traditions and methodology of science.

Two concluding chapters, Psychoanalysis in England by Edward Glover and Psychoanalysis in the United States by John A. P. Millet, review the historical development, problems of organization,

and the political and ideational vicissitudes of psychoanalysis in these two countries. Glover presents his material in a relatively objective manner and makes some dynamic formulations. Millet's essay, while offering a detailed, informative and usually interesting account, is contaminated by polemics. Viewing the development of psychoanalysis in America in terms of reaction versus liberalism, he attacks the American Psychoanalytic Association in general and its Board on Professional Standards in particular for a 'remarkable trend toward conformity', 'wielding of power', and 'insistence on centralized control of teaching and membership certification'. In contrast to this allegedly bureaucratic dragon, the Academy of Psychoanalysis is portrayed as a latter-day Saint George.

While there is some justification for discerning an element of parochialism in the practices and policies of organized psychoanalysis in America (chiefly in the past), there is nothing reactionary in the establishment of an apparatus by which a scientific discipline strives to maintain adequate standards of teaching and membership. Indeed, the existence of a powerful board on professional standards demands no more justification than does the system of accreditation that organized medicine has established for medical training. Nor is Millet on sounder ground when he accuses the American Psychoanalytic Association of failure 'to encourage experimentation, research and critical testing of traditional theories and techniques'. Neither the power nor the policies of the Board on Professional Standards has hindered such fruitful psychoanalytic research as, say, the studies on anaclitic depression, gastric psychophysiology, and the nature of dreams and dreaming. This work has been done by distinguished and unreconstructed members of the American Psychoanalytic Association.

The rationale for the inclusion of these two final chapters is unclear. They would seem more appropriate in a volume dealing exclusively with the history of psychoanalysis. A concluding chapter containing a survey and summary of the biographic data presented, with a search for possible generalizations concerning personality, motivations, and other dynamic considerations, would have been more fitting. (One gains a tentative impression, for example, both from this volume and from other sources, of a conspicuous incidence of emotional instability, of overt psychopathology, and of violent death among the earlier followers of Freud.) Such a chapter

might impart a sense of unity to a work which, commendable in many respects, suffers from diffusion.

BERNARD C. MEYER (NEW YORK)

PSYCHOANALYTIC TREATMENT OF CHARACTEROLOGICAL AND SCHIZOPHRENIC DISORDERS. By L. Bryce Boyer, M.D. and Peter L. Giovacchini, M.D. New York: Science House, Inc., 1967. 379 pp.

Boyer and Giovacchini aim to demonstrate that the classical psychoanalytic method is therapeutically effective with a wide spectrum of severely disturbed patients, ranging from character disorders through the borderline states to the schizophrenic patients one encounters on the acute ward of a psychiatric hospital.

Boyer first appraises Freud's early theoretical formulations regarding the psychoses, particularly his statement that, because in narcissistic neurosis no transference reaction can be formed, psychoanalytic treatment is impossible. Clinical experience has not upheld Freud's dictum that total withdrawal of object cathexis is an integral part of psychosis. Boyer suggests that Freud, faced by Mr. X and the Wolf-man who were potentially psychotic patients, lost faith in the classical psychoanalytic method and responded with interventions motivated by countertransference. As a result his patients failed to improve. Boyer believes that had Freud not acted upon his fear of imminent psychotic decompensation in these patients, the therapeutic results would probably have been favorable and subsequent generations of psychoanalysts would be less timid in widening the scope of classical psychoanalysis.

In the light of the structural hypothesis and ego psychology, the authors view the neuroses and psychoses as a continuum of disorders to be differentiated chiefly by variable regressive alterations of ego functions. If such a continuum exists what better method of treatment than classical psychoanalysis?

In a chapter on Freud's followers, particular attention is given to Melanie Klein and Harry Stack Sullivan. Boyer's description of his own therapeutic work suggests that he was more strongly influenced by them than is apparent from his critical analysis of many of their basic concepts.

In the last chapter Boyer succeeds in giving the reader a feeling for his therapeutic style. Considerable emphasis is placed upon

adherence to orthodox procedures; for example, patients are seen regularly four times a week, always on the couch except for one or two initial interviews face-to-face; medication is withheld; telephone calls are discouraged; direct support is avoided. The reader may gradually come to feel that orthodoxy of procedure is not clearly differentiated from analytic process.

Treatment is divided into two phases. The initial 'noisy' phase is directed at 'the establishment of reasonably stable, loving introjects, psychotic thinking patterns are removed, or markedly diminished.' Once this is accomplished and the transference psychosis has been supplanted by a transference neurosis, analysis continues as it would with a neurotic patient. Here and there interesting comments are made about therapeutic attitudes or maneuvers. For example, Boyer 'tends to ignore material stemming from sexual drives unless an unwieldly transference develops'. As does Sullivan he suggests the occasional use of deliberate misstatements in an effort to have the patient make corrections. One patient included in his series had previously been given a course of electroshock treatments by the author. Apparently this is not regarded as a significant deviation from usual practice.

Although the clinical discussions range widely one is impressed by the recurrent suggestion that improvement rests largely with the patient's ability to introject various aspects of the analyst's personality. As Boyer puts it 'the ego and superego structures of a number of these patients now approximate my own'. To the reviewer this statement suggests that either efforts are not made to resolve the transference or that such efforts have not met with success.

In a brief paper by Hoedemaker on technical aspects of psychotic identifications, the therapeutic value of introjection of aspects of the analyst's personality is again a predominant theme. Hoedemaker feels that such introjects have permanent quality and are to be regarded as 'psychologic grafts'. Through a clinical vignette he describes how he handles a provocative schizophrenic patient who repeatedly ignores what he is trying to tell her. In exasperation he pounds his fist on the chair arm exclaiming angrily, 'I insist that you listen—apparently I have to fight for my existence'. The patient was treating him as her mother had treated her. In such instances Hoedemaker clearly favors blunt confrontation over interpretation. In the therapeutic situation the analyst deals with his anger by ex-

pressing it. He cannot afford the consequent guilt of suppressed rage, which would hamper his therapeutic efforts.

In the final three chapters Giovacchini discusses treatment of character disorders. As neither author makes more than a nosological distinction between schizophrenia and character disorders, this may initially seem confusing. However, Giovacchini differs in position and style from the earlier contributors. He is freer in discussing controversy and accepts the uncertainties of his own as well as other formulations.

He is concerned to have the patient reach an autonomous position, but this position is but one part of a series of introjections that includes the analyst's neutral attitude and his secondary process thinking which replaces the primary process thinking of the patient. Giovacchini believes that interpretation has a feed-back function which fosters structuralization of the ego. This in turn leads to greater capacity for introjection, further ego integration, and still further introjection. This process suggests that the patient may introject certain relatively discrete ego functions of the analyst rather than the more or less total ego and superego as Boyer supposes.

Giovacchini discusses the problem of how the analyst reacts to and handles 'objective' information that comes to him without his seeking it. Clinical examples illustrate the problems of setting limits to behavior with provocative patients. Where does the analyst stop reacting with analytic objectivity? Are his reactions influenced by fear or personal feelings of propriety, or by countertransference reactions?

If these patients are to develop a capacity for self-observation, Giovacchini believes they must be given freedom to project infantile wishes and introjects onto the analyst. In this way they gradually learn to distinguish between the real analyst and their projected distortions. This leads to a similar attitude toward themselves.

The analyst does not 'cause' transference, but Giovacchini states that he can and should make efforts to 'prime' it. Initially all the patient's productions are treated as transference phenomena relating to the analyst. In this way attention is directed to the interaction between analyst and patient and the patient gradually begins spontaneously to examine what he says. 'What was previously a minimal transference element now becomes a predominant theme.'

From a discussion of the possible transference and countertransference implications of Freud's response to the Rat-man's request for food, the author concludes that such gratifications should not interfere with the progress of an analysis as long as no therapeutic intent lies behind the analyst's response.

This book contains much of interest to the psychiatrist and psychoanalyst who works with schizophrenic patients. The bibliography is broad, containing over six hundred references. The reviewer has touched upon only a few themes that seemed pertinent to the authors' fundamental thesis. The reported therapeutic results are certainly encouraging, but it is debatable whether they have been reached by following the classical psychoanalytic method. Attempting to rework the patient's personality into a facsimile of the analyst has not in the past been an aim or function of the psychoanalytic approach.

PETER RICHTER (NEW YORK)

THE ANNUAL SURVEY OF PSYCHOANALYSIS, VOLUME VIII. Edited by John Frosch and Nathaniel Ross. New York: International Universities Press, Inc., 1964. 371 pp.

In the series of Annual Surveys reviewed in This QUARTERLY, all reviewers have been highly commendatory with the exception of Roger C. Hendricks who raised questions as to the value of the Survey as such, the accuracy and value of specific condensations, and the general needs it filled for the analyst.[1]

This volume, published in 1964, deals with the psychoanalytic material of the year 1957. It provides carefully prepared abstracts written without passing judgment on the merits of the particular articles. The abstracts, arranged under a number of headings, are skilfully integrated into a cohesive whole for each chapter. They are woven together in readable fashion with an introduction for each section and a conclusion which summarizes the trend for the year in that particular subject area. There is an excellent subject index.

Thirty-eight periodicals and ten books provided the source of psychoanalytic literature reviewed. From the original Introduction, one infers that the major psychoanalytic periodicals, which are 'strictly psychoanalytic', are covered comprehensively and the 'para-

[1] This QUARTERLY, XXIX, 1960, pp. 111-113.

psychoanalytic' publications are culled to include for synopsis only those articles that are 'strictly psychoanalytic'. As a result of this editorial policy, the reader is provided not only with a summary of the articles in the basic journals, with which he may be familiar, but also with a summary of articles in other journals, domestic and foreign, to which he is not likely to have ready access. It is impressive that whereas Volume I covered only seventeen journals, the number in the current volume is more than doubled. That Volume VIII covers so many more periodicals indicates the growth and acceptance of the Annual Survey as an important psychoanalytic publication. Another important addition, not present in previous editions, is the inclusion of the name of the abstractor responsible for each synopsis.

Though the coverage is complete with respect to some major publications, omissions of psychoanalytic articles in others is puzzling. It is difficult to ascertain whether these omissions are based on oversight or intent. Clerical oversight in a work of this magnitude, though regrettable, is entirely understandable. If the omissions are intentional, however, the reasons are not clear since a number of these articles appear to be quite important. Their omission does not fit in with the avowed policy to include all psychoanalytic articles. These omissions are particularly difficult to understand because authors whose articles have been omitted are represented in abstracts from other journals. Nor do the omissions seem to be based on merit as some articles of questionable value are included. The omission of articles from the Annual Survey is particularly serious since a generalization as to the trend in a particular field under discussion is based upon the review of only the articles included. Conceivably, a consideration of the omitted articles would present a somewhat different picture of the trend.

The selection of ten psychoanalytic books for review is based entirely upon the editors' choice. This is reasonable since a publication of this type could hardly be expected to review all important books that appear in a given year. However, the question as to the factors determining the editors' selection of books remains largely unanswered. Furthermore, it is not clear what factors determine the length of the reviews. For example, Ernest Jones' third volume of The Life and Work of Sigmund Freud, a book of five hundred thirty-seven pages, is reviewed in three pages, whereas René Spitz's

monograph, No and Yes: On the Genesis of Human Communication, one hundred seventy pages, has a thirteen-page review. Similar disproportion in length of review occurs in some of the synopses of articles.

Although not always avoidable, it is unfortunate that such a long period of time, seven years, had to elapse between the year that Volume VIII covers and its date of publication. Nevertheless, the Annual Survey with its increasing coverage and excellent reviews is a valuable contribution and highly recommended.

ALEXANDER GRINSTEIN (DETROIT)

COLLECTED PAPERS ON SCHIZOPHRENIA AND RELATED SUBJECTS. By Harold F. Searles, M. D. New York: International Universities Press, Inc., 1965. 797 pp.

Reading this fascinating book is like reading two separate novels at the same time. Such an impression is surprising since the book contains twenty-four of Dr. Searles' scientific papers published between 1951 and 1964. The first major theme is schizophrenia, presented in a rich collection of clinical gems mined from innumerable agonizing hours of intensive psychotherapy with schizophrenic patients.

Dr. Searles considers the following as the major concepts that run through and link these papers: autism and symbiosis; the etiological role and the role in therapy of various feelings; love and hate; the interrelatedness between emotions and ego structure, ego functions, and the technique of psychotherapy; 'non-human' phenomena and the issue of therapist neutrality and feelings concerning change and death; the distinction and interaction between intrapsychic processes and interpersonal processes; and the over-all process of therapy.

The second major, unplanned theme is the story of Dr. Searles himself. While reading these chapters, one observes the emotional growth and development of the therapist-author. One watches him from his early years of work with patients and personal analysis (during which time he struggled valiantly with his feelings of anxiety and ambivalence) to the later years of maturation of increasing comfort with his intense feelings of love and hate. This is best shown in his own words: 'As I have become more and more deeply convinced that I, in keeping with my fellow human beings, am a basically lov-

ing and constructively oriented person rather than a basically malevolent and destructive one, I feel increasingly free to interact, whether in a subjectively loving or subjectively malevolent manner, with my patients'.

This picture of Dr. Searles' work with his patients confirms Freud's experience that an analyst cannot go further in his work with his patients than he has been able to go in his own analysis. In addition, it extends the dictum as follows: the schizophrenic patient in intensive psychotherapy will attempt to help in his therapist's personal growth so that in turn the therapist will be able to help the patient to take the same step forward.

The consistent response of the reader of this book to the story of Dr. Searles is seen in Robert P. Knight's Preface and in J. D. Sutherland's Editor's Preface. Both pay tribute to the personality of the author as well as recognizing the excellence and importance of his contributions. Dr. Searles in the years during which these papers were published was one of the pioneers who contributed greatly to those psychodynamic studies of schizophrenia which have illustrated the importance of early life experiences and primary process thinking. This book offers encouragement toward intense psychotherapeutic experiences with psychotic patients.

PETER A. MARTIN (DETROIT)

SCHIZOPHRENIA AND THE FAMILY. By Theodore Lidz, Stephen Fleck, and Alice R. Cornelison. New York: International Universities Press, Inc., 1966. 477 pp.

The psychoanalytic view of schizophrenia has focused mainly on conflicts stemming from the oral phase with consequent disturbances in ego development and the persistence of primary narcissism. Logically, attention had to be paid to disturbances in the child-mother relationship which have been viewed as crucial in the development of this condition.

Lidz and his co-workers have felt that this approach to understanding schizophrenia is too limited. They undertook studies of the families of schizophrenics because 'within the family the action of

any member affects all, producing reactions and counterreactions in the family's equilibrium. . . . The emerging child assimilates its mores, its ways of thinking and communicating and its patterns of interrelating as well as internalizing parental characteristics.'

Seventeen families of schizophrenic patients were intensively studied to learn as much as possible about the characteristics of each member and to illuminate the role each plays in the family subsystem. These studies, reported in great detail, reveal an unusually high incidence of psychopathology and demonstrate the impact of the parents' disturbances on the entire family, often placing specific children in unusual pathogenic situations.

The approach is an exploratory, naturalistic investigation. The cases are systematically presented from different angles focusing separately on the father, mother, patient, siblings, the marital situation, and the family as a whole. They indicate that disturbances occurred at all levels of the schizophrenic child's development and that more than impoverished nurturance and oral fixation are etiologically significant. The authors conclude that a family, to be conducive to the integrated development of its children, must 'form a coalition as members of the parental generation, and adhere to their appropriate sex-linked roles and be capable of transmitting the basic instrumental ways of their culture to offspring'. All the families studied failed in all these areas and, while the impact of their problems fell differentially on the children, all of them were deleteriously affected. These studies are rooted in psychoanalytic theory but have added a number of important dimensions that shoud lead to significant new contributions. The findings are not yet definitive and the authors suggest many more investigations that should be undertaken.

Most of the chapters in this book consist of papers previously published. This has led to some repetition and slight confusion, which could have been avoided with more careful re-writing and editing. Despite this minor fault, the book is a most important offering. It should lead to the careful review of current ideas regarding personality development and its disturbances, to a better understanding of clinical conditions, particularly schizophrenia, and to a more rational and effective therapy.

LEWIS L. ROBBINS (GLEN OAKS, N.Y.)

GRIEFS AND DISCONTENTS. THE FORCES OF CHANGE. By Gregory Rochlin, M.D. Boston: Little, Brown and Co., 1965. 403 pp.

Dr. Rochlin states that the aim of this book is to present the development of a central psychological conflict, the loss complex. The book is based on previous papers appearing in The Psychoanalytic Study of the Child and The Journal of the American Psychoanalytic Association. The papers reappear in slightly modified form as chapters. Rochlin amplifies and shows further applications of the central theme in several additional chapters. The nucleus of his thought is that object loss, a ubiquitous occurrence in human life, leads to constant restitutional attempts which he considers a principal motive for the individual's development and achievements, 'an important engine of change'.

Dr. Rochlin feels that analysts have overstressed the pain and damage resulting from loss without sufficiently acknowledging or investigating the beneficial effects it can engender by stimulating efforts at restitution. He points out that Freud's writings were, from the outset, pervasively oriented to the theme of loss and restitution from the child's birth onward. He quotes Freud in his 1908 paper, The Relation of the Poet to Day-Dreaming: 'Really we never can relinquish anything; we only exchange one thing for something else. When we appear to give something up all we really do is adopt a substitute.'

An experienced analyst with children and adults, Dr. Rochlin presents case material from all ages. He considers the loss complex (the reaction to object loss) to have different manifestations at different ages relative to the nature of the personality development. For example, true depression cannot occur in children because of the nondevelopment of a full superego, a point of view shared by many analysts. He feels that the earliest and simplest expression of the loss complex is to be found in the dread of abandonment. In the chapter on fear of death he adumbrates some experimental studies with children. Like others, he has come to the conclusion that children are preoccupied early in life with death as a loss. This produces significant effects eventually leading to religious concepts of immortality as restitution. Creativity is considered in a similar vein.

Although it may appear to the psychoanalytic reader that Dr. Rochlin presents nothing startlingly new, the book does make a worth-while contribution to object loss and its restitution. In many analyses this complex is a cardinal preoccupation. It is, therefore, disconcerting that, in criticizing Phyllis Greenacre's papers on creativity, he accuses her of foreshortening infantile development in the manner of Melanie Klein and considering all subsequent events in the individual's life as only of secondary importance in comparison to what was established in earliest infancy. Nothing could be farther from the truth.

Equally unfathomable is Rochlin's characterization of Freud as cynical (p. 206), because Freud felt that only the great produced products of the highest value for mankind. He states that Freud failed to consider the endless efforts expended by the many in relieving the human condition. This statement is in a similar vein to Rochlin's idea that psychoanalysts do not give sufficient credit to efforts at restitution for object loss. If this were so, how many analysts would undertake the analysis of so many difficult cases if they were so lacking in belief of the possibility of beneficent change? To some degree, Dr. Rochlin sets himself up as the champion of man's innate striving toward mastery, restitution, nonrelinquishment of goals, fulfilment, and all other positive ends.

An important defect of the book is Rochlin's failure to take into account Hartmann's concepts of adaptation, autonomous and conflict-free functioning. If he had, he might have been able to treat the subjects of restitution and mastery in a more fruitful way. Similarly, no mention is made of the widely discussed impact of structural conflicts on ego development. Is not object loss one of the major danger situations in structural conflicts between ego defenses and id derivatives? Not only will the subject attempt to hold onto, or restore, the threatened or actual object loss but, in the vicissitudes of his structural conflicts, various ego activities will be stimulated. Indeed, it is impressive that the structural conflict is at least as powerful an 'engine of change' as the simple need to overcome object loss. Had Dr. Rochlin taken these concepts into consideration, some of the small deficiencies in his presentation would have been mitigated.

BERNARD BRODSKY (NEW YORK)

REVOLUTIONARY DOCTOR. BENJAMIN RUSH 1746–1813. By Carl Binger, M. D. New York: W. W. Norton & Co., Inc., 1966. 326 pp.

The official emblem of the American Psychiatric Association adopted in 1921 incorporates a copy of an engraving by William Haines of the subject of this biography. It has appeared on the cover of each issue of the American Journal of Psychiatry since July 1933. Of its fifteen thousand members, one wonders how many know much of the man whose likeness looks out at them each month.

For those who knew him not, this work presents an unequaled opportunity to make his acquaintance. For those who 'know' him, this work presents a delightful opportunity to renew friendship with an amazing and vigorous man of his age; a contemporary of Washington, Franklin, Adams, and Jefferson, a patriot and humanitarian, and the author of the first textbook on mental diseases published in this country.

Born in the outskirts of what is now Northeast Philadelphia and buried in Christ Church Burial Ground in a grave near that of Benjamin Franklin, Benjamin Rush lived a life of devotion to philanthropic causes: abolition, temperance, independence for the colonies, equal education for women, and, in his later years, the humane care of the mentally ill. He is remembered today as the father of American psychiatry.

Dr. Binger, with winning style, sketches the background of the times in which Rush lived; life in colonial Philadelphia, life in Edinburgh where Rush studied medicine, life in London and Paris where Rush visited before returning to America, life during the Revolution when Rush was a military surgeon. He reintroduces us to the early struggles of the new nation and to the medical teaching and practice of the eighteenth century. His dramatic account of the yellow fever epidemic of 1783 and the subsequent controversies in which Rush was involved is graphically presented. Two chapters are devoted to Rush as physician to the mentally ill in the wards of the Pennsylvania Hospital. Here too, the background material is excellent in description and documentation.

Many have written about Benjamin Rush, but none so engagingly as Carl Binger. His acknowledgments and introduction give an understanding of why this is so. With admirable restraint, Dr. Binger

does not offer any conjectures regarding the unconscious determinants of Rush's complexities of personality, preferring to allow the reader to make what he will from the data he provides from sources so carefully mined.

Why read about a man who lived two hundred years ago? The closing sentences of Dr. Binger's introduction provide an answer. 'If one wants to know where one is going, it is not a bad idea to get one's bearings from time to time by looking backward. This makes the present more comprehensible and the future more meaningful.'

Although the author disclaims any intention of writing a definitive biography, he has in effect done so with meticulous scholarship, allowing Rush to speak for himself from nearly every page. An extensive bibliography, references carefully annotated chapter by chapter, and an index are included.

ROBERT S. BOOKHAMMER (MERION, PA.)

ON AGGRESSION. By Konrad Lorenz. New York: Harcourt, Brace and World, Inc., 1966. 306 pp.

This significant phylogenetic study of the aggressive drive was undertaken by a brilliant naturalist-ethologist who has made outstanding contributions to the study of instinctive behavior. Dr. Lorenz hoped that the understanding of the natural history of aggression achieved by evolutionary biology would make it possible to gain insights into the cause of aggressive disturbances in man. He discovered unexpected correspondences between the findings of psychoanalysis and behavioral physiology concerning the aggressive drive. He describes aggression as an instinct, inherited and endogenous, which in natural conditions helps to insure the survival of the individual and the species. In the complex patterning and interacting of instincts the aggressive impulse may have destructive results, but Dr. Lorenz does not see this as the primary goal of the biologically normal aggressive drive. He does not compare the periodicity, rhythmicity, and discharge patterns of aggression with other drives. He begins with a description of typical forms of aggressive behavior, their biological functions, and the interrelated physiology of instinctual motivation in the 'great parliament of instincts'. Instincts constantly interact with varying coöperation, cancellation, or compromise formations.

Dr. Lorenz illustrates the evolutionary mechanisms established to channel aggression, and particularly the role played by ritualization in the inhibition of aggression. He lucidly demonstrates the remarkable patterns governing instinctive behavior and its inhibitory mechanisms. He examines the release and control of aggression in types of social organization ranging from the anonymous crowd, the family and social life of various birds, the large family of rodents who do not recognize each other as individuals, and finally the type of social organization where there are bonds of apparent friendship and 'love'. A personal bond is found only in animals with highly developed intraspecific aggression, a phylogenetic confluence of love and hate.

Dr. Lorenz is particularly concerned with the functions of species intraspecific aggression and its great importance in achieving balanced distributions of animals of the same species over the available environment, the selection of the strongest and most capable by rival fights and defense of the young. But he is also aware of the role of aggression in behavior patterns that outwardly have nothing to do with aggression, including the paradoxical relationship of aggression to the most intimate bonds between living creatures. While Dr. Lorenz cannot accept a death instinct in man or animals, the aggressive drive is recognized as a major inherent biological drive in homo sapiens and his agreement with Freud's dual instinct theory is implied. After fascinating descriptions of the territorial fights of the coral fish and the bloody mass battles of the rats, the ritual surrender of the defeated wolf, and the ritualized inhibitions of the social animals, Dr. Lorenz notes the analogies to the inhibitory customs and rituals of civilized man. He emphasizes that man lacks the evolutionary instinctive mechanisms of inhibition of aggression against his own species. However, he implies that in man sacred custom is essentially inherited, that innate stimulus-releasing mechanisms govern man's social behavior, and that the evolution of culture is not only analogous, but possibly homologous to the evolution of the species. While he recognizes that phylogenetically innate activities and reactions need to be complemented by cultural traditions, he also derives the complex problems of 'militant enthusiasm' and mob psychology from conditioned stimulus response situations and compares this to the phenomenon of imprinting seen in certain animals (but never proved in man). The dynamics and dangers

of what he calls 'militant enthusiasm' as applied to the political sphere are compared to the behavioral dynamics of flock formation.

The problem of intraspecies aggression and its inhibition in man is unquestionably of vast importance. But great changes have occurred in man's evolution beyond his innate discharge thresholds and the automatic species specific instinctual inhibitions so brilliantly described in other animals by Lorenz. For example, there is no longer a 'maternal instinct' in man, to insure proper baby care comparable to that of other animals. The complex development of parental attitudes in man, and the mastery of aggression toward offspring and other humans (and animals) depends on a uniquely human endowment and experience.

Dr. Lorenz gives insufficient consideration to the great complexity of the psychosocial life of man. The evolution of the ego and the differences between human drives and animal instincts are not carefully distinguished. Ego development and object relations are apparently reassigned to their biological roots. The controlling inhibiting organization of drive discharge in man is reinstinctualized and assigned to phylogenetic instinctive behavior. While it is true that ritual, ceremony, and tradition inhibit the release of sadistic behavior, the complex development of the superego and inhibitory ego functions is overlooked. Intrapsychic defense against the aggressive drives in man seems to be considered mainly instinctual, though hatred of the neighboring human tribe can be better understood in terms of displacement and projection rather than as analogy to the olfactory stereotyped hostile response of the brown rat to a member of a foreign tribe. The complicated problems of delay, defense, and displacement, as well as possible neutralization and fusion of drives in man are not elaborated. The role of such uniquely human capacities as symbolization and identification in ritual and custom is not discussed nor is the difference between defensive and adaptive functions of human ceremonies. Self-directed aggression is scarcely reviewed, in spite of its special importance in man and its relation to the discontents of civilization.

This book is notable for its lucid presentation of ethology, its candor, and humor. Dr. Lorenz recommends the increasing development of laughter, friendship, enlightenment, and love as vital agents in the control of human aggression. While in hearty agreement, we must consider these achievements as mutually influencing

each other's development and implying some mastery of uncontrolled aggressive discharge. Dr. Lorenz also recommends the first precept of 'know thyself' and deepening our insight into the causes and regulation of human behavior. He also recommends further psychoanalytic study of sublimation, 'the specifically human form of catharsis that will do much toward the relief of undischarged aggressive drives'. The psychoanalyst and humanist wholeheartedly concur in the importance of these vital pursuits.

HAROLD P. BLUM (HEMPSTEAD, N. Y.)

PSYCHIATRY AND PUBLIC AFFAIRS. Reports and Symposia of the Group for the Advancement of Psychiatry. Chicago: Aldine Publishing Co., 1966. 465 pp.

The role of the psychoanalyst in relation to his society is an important one particularly when the analyst ventures outside of his consulting room and views the multitude of problems in society. The social responsibility of the psychoanalyst has been recognized in recent times by actions of the American Psychoanalytic Association, by its panels dealing with different aspects of the relationship of the psychoanalyst and the community, by the formation of its Committee on Social Problems under the chairmanship of the late Joseph J. Michaels, and by actions such as its position statement on the Joint Commission report, Action for Mental Health.

The Group for the Advancement of Psychiatry with its Committee on Social Issues has for twenty years brought forth a series of reports and symposia dealing with important social problems. Besides psychiatrists and psychoanalysts the membership of GAP has included sociologists, anthropologists, and other scientists.

The reports and symposia deal with the relationship of psychiatry to desegregation, to international relations, to the area of forceful indoctrination, and finally to the threat of nuclear war. Data have been collected from a variety of fields, including sociology, anthropology, economics, and the physical sciences. These data are examined in an attempt to determine dynamic processes involved in intra- and intergroup relations. An effort is made to understand the specific group psychological phenomena as well as the role of individual psychological processes in determining the forces at work and the ultimate outcome. The reports point the way toward the

development of criteria for social action, but do not recommend social action. They present a mixture of observational data and conclusions derived from such data and from psychoanalytic theory.

Any one report is worthy of a full-length review. The findings have not lost their relevance with the passage of time. Many of the panels were held ten or more years ago, yet their lessons have not been learned. For example, the reports of psychiatrists who studied brainwashed prisoners during the Korean War contain material that is still relevant to the current Vietnam war and to the events in China today. One problem for the professional and intellectual is to make his knowledge known to those who make decisions concerning the destiny of nations. It is hoped that appropriate governmental officials have read these documents. In the sections devoted to the threat of nuclear warfare, the authors pay great attention not only to the nature of basic instinctual drives, but to the role of fear in determining counteractions that may be against one's own interests. Along with fear one might add suspicion, mistrust, lack of information, and wishful thinking, all of which play a role in decision making. The importance of these irrational factors often seems to be omitted from consideration by those who make important policy decisions.

This book should be widely read by psychiatrists and psychoanalysts who are concerned with their responsibility in society.

EDWARD D. JOSEPH (NEW YORK)

MENTAL ILLNESS IN THE URBAN NEGRO COMMUNITY. By Seymour Parker and Robert J. Kleiner. New York: The Free Press, 1966. 408 pp.

Drs. Parker and Kleiner present a detailed exposition of their research into the social and social-psychological factors in mental illness. The study was conducted in a Negro community of Philadelphia where they had previously studied the rates of mental illness in migrants and natives. This work stimulated them to study the psychopathogenic effects of goal-striving behavior. As social scientists they have drawn the theoretical and conceptual framework for this project from their field and have assigned central importance to the discrepancy between achievement and aspiration as a fundamental element in goal-striving stress.

Because of the complexity of the specific content of this book, only some of the principal features of its format are reviewed here. The first chapter discusses the theoretical orientation and goals of the study. The latter are specified in five major hypotheses and their corollaries which predict certain correlations between the selected social-psychological variable (those of goal-striving stress, reference group behavior, and self-esteem) and the severity of mental illness. The second chapter outlines the over-all research design and describes the technical procedures used in executing it. Special measuring scales and the interview schedule, consisting of some two hundred items, appear in the appendices. The basic research design involved the comparisons of two populations from the Philadelphia Negro community: one representative sample of one thousand four hundred eighty-nine individuals for whom psychiatric treatment had not been recommended and one of one thousand twenty-three individuals diagnosed as mentally ill. Members of each sample were individually interviewed and all of the interviewers were Negro. The community sample was further subdivided into a low symptom group and a high symptom group. The ill sample was subdivided into a psychotic group and a neurotic group. These four mental health groupings comprise an 'illness continuum'.

The succeeding nine chapters present an immense amount of data in the form of tables and graphs and the text contains detailed discussion of the interpretations of the data within the framework of the hypotheses. Chapters three through seven are concerned mainly with relating each of the social-psychological study variables to mental illness. The objective in chapters eight through ten is an evaluation of the relationship between the study variables and the sociological factors of socio-economic status, social mobility, age, and others. Chapter eleven re-examines the data from the standpoint of assessing the interdependence and interrelationships of the study variables. Chapter twelve reviews the authors' findings in the light of the original hypotheses, re-evaluates the theoretical framework of the study, and suggests areas for further research. There is an extensive bibliography interposed between the text and the appendices. Literature review sections are dispersed throughout the text.

I have one critical question: where do the authors stand in regard to the psychoanalytic theory of human behavior? They make quite

clear that there are numerous scientific approaches to the study of mental illness in addition to theirs and mention neurophysiology, biochemistry, genetics, and psychiatry. As social scientists, they chose the social-psychological approach, which is laudable since too little work has been done within this conceptual framework. However, it is difficult to consider adequate a psychological approach that omits recognition of both conscious and unconscious forces in the determination and motivation of human behavior. My criticism is not that the study is not psychoanalytic, for it was not designed to be, but rather that the authors write as though psychological phenomena in the human individual are exclusively conscious. References to freudian psychoanalytic psychology are conspicuous by their absence.

The authors comment that an overview of the research on mental illness by other scientific disciplines is for them 'a painful reminder of the story of blind men excitedly describing an elephant after each has felt a different part of the aminal'. The question is whether Drs. Parker and Kleiner are not similarly afflicted. Their study has its *raison d'être* and makes its contribution; but the whole 'elephant' will not be accurately conceptualized by a psychology that recognizes only conscious phenomena.

DORIS M. HUNTER (PITTSBURGH)

UNOBTRUSIVE COMMUNICATION. Essays in Psycholinguistics. By Joost A. M. Meerloo. Assen: Koninklijke van Gorcum & Co. N. V., 1964. 198 pp.

Only in recent years has there been an upsurge of interest in problems of language and communication among psychoanalysts. Dr. Meerloo was one of the pioneers in this area. He believes that the psychoanalytic process can be viewed as 'a laboratory for the study of microlinguistics'. This monograph is a digest of his experiences with, and some of his conclusions about, the role of nonverbal signals in the therapeutic process.

Most analysts would readily agree that the communication process in free association consists of much more than the verbal exchange between patient and analyst. Most would assert that patients respond to more than the therapist's verbal message and that the

good therapist attends as much to paraverbal signals such as tone, gesture, facial expression, dress, as he does to the purely referential aspects of his patient's utterances. Dr. Meerloo, however, looks for cryptic signals in even less obvious phenomena. In addition to observing 'patterns of speech', 'patterns of silence', and 'patterns of confession' he observes 'patterns of functioning' of organs and organ systems which he attempts to correlate with neurotic and psychosomatic entities. In the 'network of communication' in which he is most interested the author includes phenomena such as skin eruptions, body odors, bodily secretions, and visceral activities. The phenomenon of 'mental contagion' discussed by Freud in Group Psychology and the Analysis of the Ego is of special interest to the author. He believes that this phenomenon is elicited more by these 'unobtrusive' signals than by any other variety. Perhaps the adjective 'concealed' rather than 'unobtrusive' would better describe that aspect of the transmission of information with which the author is primarily concerned.

Both Dr. Meerloo's clinical observations and his suggestions for the decoding of these subtle panorganismic reactions are ingenious and stimulating. His monograph, however, raises some semantic questions concerning the limits in the use of the terms 'language' and 'communication'. In the total flux of events which are part of any therapeutic process there are spoken (and occasionally written) communications that are strictly linguistic in nature. There is also a great deal of communication that is 'paralinguistic' in nature; i.e., although nonverbal it consists of signals that are more or less easily translatable into language symbols. A large number of peripheral phenomena occur which have no demonstrable communicative function at all for either the patient or analyst (beyond that which fantasy can distil from them).

Dr. Meerloo's terminology does not always make clear which of these three orders of phenomena he is discussing. As far as I can judge, he does not use the theory or nosology of modern structural linguistics as a guide in dealing with the technical distinctions between various aspects of language and paraverbal communication. When the author steps outside of his own field, he does not refer to an organized lexicon of disciplined knowledge with which we can compare his particular 'idiolect'. This failure to make clear distinctions between verbal, paraverbal, kinetic and extraverbal phe-

nomena interferes with the full development of the author's ideas and with the high-level theoretical constructs that might be expected from such a richly documented essay.

VICTOR H. ROSEN (NEW YORK)

THINKING WITHOUT LANGUAGE. Psychological Implications of Deafness. By Hans G. Furth. New York: The Free Press, 1966. 236 pp.

Professor of Psychology at the Catholic University of America and Director of its Center for Research in Thinking and Language, Furth has provided an instructive and challenging book.

Concise chapters are devoted to historical considerations and current problems in work with the deaf, psycholinguistics, theories of cognition, and experimental methodology. A series of ingeniously conceived experiments are reported; for example, on cognitive functions of deaf children as compared with normal and mentally retarded children, and on memory and perception with hearing and deaf adolescents. Studies of identical twins are critically reviewed.

These impressive clinical and experimental findings lend support to the hypothesis that 'intellectual functioning cannot depend basically upon language'. The severe linguistic incompetence of most congenitally deaf persons (and those deafened in childhood before the attainment of verbal competence) and their meager numbers among college students and in the professions are not attributable to inexorable crippling effects of deafness on the development of the intellectual functions. Some limited experience with deaf children and schools for the deaf also support Furth's conviction that their severe difficulties in learning and other problems are results of the imposition on them and their families of frustrating verbal language standards and 'oral' educational techniques in schools for the deaf.[1]

Furth recommends that the mothers of deaf infants be taught sign language which the infants can easily learn. This is essential for a normal development of their object relationships, curiosity, and self-esteem. Proficiency in sign language facilitates their ac-

[1] Blank, H. Robert: Discussion of Altshuler, Kenneth Z.: *Traits and Depressive Symptoms in the Deaf*. This QUARTERLY, XXXII, 1963, pp. 472-475.

quisition of 'finger spelling' (manual alphabet), reading and writing. He describes an experiment in teaching logical thinking that employs the nonverbal method of symbolic logic. This was successful in terms of conceptual learning and the enthusiastic participation in it of the deaf children.

In championing the deaf who, as a group, are victims of stereotypic discrimination, Furth is at times less than objective. He tends to minimize the ego problems of most congenitally deaf adults, regardless of the etiology. He engages too in moralizing about the 'independence' of the deaf contrasted with the 'dependence' of the blind, which detracts from the otherwise high quality of his work.

Furth supports Piaget's theory of the development of the intellectual functions.[2] Action is stressed as '. . . the source and medium of intelligence and the reality of concepts must be sought in the action of thinking which can become embodied in a symbolic medium. But human intelligence is neither tied to any particular type of internal images, nor to any particular type of symbols.' The human mind creates symbols as the need for them arises. These serve intelligence and human communication. The earliest manifestation of thinking characterizes the '. . . sensory-motor stage of adaptation which only knows "things-to-react-to". . .'. Corresponding to such objects are 'substitute objects or signals which elicit a determined reaction according to a learned or species-specific pattern'.

Mature thinking is characterized by objects as they are known, the correlates of which are symbols. 'All thinking activity which is directly concerned with events not perceptually present employs symbols. . . . As logical thinking develops there is increased freedom from the internal symbolic event with decreasing degrees of immaturity or distorting ego-centrism. The operational stage is reached when thinking is no longer inherently based on specific symbols, though symbols may be present as concomitant activity.' Operational thinking is abstract 'precisely because it is not tied to a symbolic representation of a perceptual event but can deal freely with possibilities and their combination'.

While I can accept the foregoing as a genetic-adaptational view

[2] Piaget, Jean: *Psychology of Intelligence.* Patterson, N. J.: Littlefield, Adams, 1960; *Play, Dreams and Imitation in Childhood.* New York: W. W. Norton & Co., Inc., 1962.

of thinking as an autonomous ego function, I cannot accept the conclusion 'that a relation between language and operational thinking is not essential and is not specifically required during the developmental stage'. Part of the problem is the confusion that Furth creates by defining language as verbal language while repeatedly he implies that he means any language. Proficiency in some language—verbal or nonverbal (e.g., finger spelling)—is essential for the development of operational thinking. Operational thinking then can and does function in the intuitive creative way described by Piaget and Furth. But can operational thinking be sustained without intermittent internal symbolization? There is probably a feedback between operational thinking and internal symbolization.

Furth's theoretical efforts would be strengthened by familiarity with the work of Wolff[8] who compares Piaget's theory of development with psychoanalytic theory, lucidly indicating where they complement each other and where there is disagreement.

H. ROBERT BLANK (WHITE PLAINS, N. Y.)

ICTAL AND SUBICTAL NEUROSIS. Diagnosis and Treatment. By A. D. Jonas, M.D. Springfield, Ill.: Charles C Thomas, Publisher, 1965. 128 pp.

Jonas believes the incidence of microscopic cerebral scars (temporal lobe, rhinencephalon, thalamus) due to minimal encephalitis following childhood diseases or trauma is far greater than is generally recognized, and that these scars produce masked forms of epileptic discharge ('ictal and subictal states'). Following two observations of what seemed to be purely psychogenic disorders, but proved to be epilepsy, he studied one hundred sixty-two psychiatric patients over a period of twelve years. He concluded that one hundred twelve gave satisfactory clinical evidence of 'spontaneous firings', i.e., epileptic electrical discharges producing a great variety of clinical psychiatric states. These include hysteria; bizarre forms of hypochondria; sharply defined somatic symptoms with minimal or

[8] Wolff, Peter H.: *The Developmental Psychologies of Jean Piaget and Psychoanalysis.* (Psychological Issues, 1960, Vol. II, No. 1.) New York: International Universities Press, Inc., 1960. Reviewed in This QUARTERLY, XXX, 1961, pp. 576-580.

no objective pathological findings (headaches, pain, neuralgia, urticaria, precordial pains, diarrhea, stranguria, vasomotor changes, etc.); 'schizoid episodes in an otherwise nonschizoid personality'; 'unexplainable and motiveless behavior,' and 'recurrent violent emotional episodes'; homosexual panic; tics and anxiety. The author finds the 'ictal state' sometimes combined with neurotic or psychogenic syndromes.

He applies 'the only meaningful [diagnostic] tool, namely the administration of anticonvulsants in all cases' presenting the above manifestations. In his experience this tool is highly successful diagnostically and therapeutically. The EEG is of litttle value: Jonas reports impressively large percentages of false negative readings in unequivocal cases of epilepsy, and conversely, false positive readings under a great variety of circumstances without epilepsy.

On the basis of his studies he is prepared to 'abandon determinism' (psychological causality) in order 'to assign to these psychic phenomena a nondeterministic basis': electrical firings from the cerebrum. 'Statistics and objective findings have little meaning in this context. Intuitive understanding is the predominantly useful tool [when] tempered with available evidence.'

Jonas rests his entire case on the observation that anticonvulsants, especially dilantin, can abolish intrapsychic upheavals: 'this one fact will be considered the only concrete proof of the existence of the subictal syndrome'. The depth of his conviction is illustrated by his unequivocal statement that 'an unsuccessful response to anticonvulsants does not rule out the possibility that epileptic equivalents exist'. These sweeping observations are contradicted by his numerous references to the use of 'psychoanalytically oriented dynamic and nondirective psychotherapy' in conjunction with his dilantin therapy. His argument is further weakened by our lack of knowledge of the side effects of anticonvulsants. One might equally well conclude that because antihistamine drugs have for many people a sedative effect, insomnia is caused by allergy. The evidence he adduces in support of his thesis is unconvincing.

JOSEPH LANDER (SCARSDALE, N. Y.)

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ABSTRACTS

International Journal of Psychoanalysis. XLVI, 1965.

Working Through in the Therapy of Schizophrenia. Milton Wexler. Pp. 279-286.

Working through involves overcoming resistances to structural change within the id, ego, and superego. In schizophrenia there is a failure of the basic identification processes upon which a structure of the psychic apparatus is built. Therefore, working through does not properly apply to schizophrenia. Instead, the focus must be on approaches which in the infant and child tend to build psychic structure, such as education, restriction of destructive impulses, support, affection, and providing effective models for thought, feeling, and action. In different terms, the effort in the treatment of schizophrenia is in developing and deepening a 'working alliance', with working through necessarily playing a secondary role.

Transference, Incorporation and Synthesis. Peter L. Giovacchini. Pp. 287-296.

Optimally, a child's experiences with his parents are smoothly incorporated and synthesized by the ego toward the end of mastering the drives and enhancing the ego's autonomous potential. If the relationship interferes with this autonomous potential, the ego institutes defenses against this experience that prevent the establishment of introjects utilizable for ego adaptation. Instead, the parental relationship becomes fragmented from the rest of the ego. In psychoanalysis the analyst becomes cathected and consequently there is a relative withdrawal of cathexis from introjects, including destructive and archaic ones. The impact of object relations as an integrative factor is highlighted in the transference regression. The incorporation of the analyst corresponds to the acquiring and synthesis of introjects in the infant, but the reaction to the introject is multidimensional and all stages of development contribute to it.

The Internalized Representation of the Object in the Presence and in the Absence of the Object. Kenneth Gaarder. Pp. 297-302.

It is useful to distinguish between internalized representation in the presence as opposed to the absence of the object. In the work of mourning, for instance, the individual must decathect that aspect of the internalized representation of the object which requires its presence but not that aspect which does not require its presence. In many cases of phobia the presence of another person is required to protect him from the feared situation. This means the individual cannot maintain an internalized representation of the needed person in his absence because negative feelings lead to destruction of the internalization. In analytic treatment there are three stages: first, the patient's not having an internalized representation of the analyst apart from the global transferences attributed to him; second, a consensus between patient and analyst but only when the latter is present; and finally, a consensual representation in the patient that exists in the absence of the analyst.

Identification as a Defence Against Anxiety in Coping with Loss. George R. Krupp. Pp. 303-314.

Three cases are used to illustrate four internalization mechanisms that can be identified in connection with object loss: 1, depressive introjection as part of the work of mourning; 2, symptomatic identifications functioning simultaneously to bring back the loved one and punish death wishes; 3, personality identifications occurring frequently under stress and taking the form of the loved one's mannerisms and traits; and 4, constructive identifications following the depressive period in which the mourner takes up the life and interests of the loved one.

On Beating Fantasies. David L. Rubinfine. Pp. 315-322.

A patient developed excessively sadistic impulses when her timid, gentle parents allowed her to tyrannize them. Another patient, blind from birth (reported by Omwake and Solnit, 1961), developed sadistic impulses in the face of withdrawal of the mother and the latter's failure to make up for visual deprivation through other sensory modalities. In both cases beating fantasies formed as a means of protecting their 'good' objects and selves. The fantasies also permitted a safe differentiation of the sexes in the first case and of the object from self in the second.

On Having the Right to a Life: An Aspect of the Superego's Development. Arnold H. Modell. Pp. 323-331.

Certain forms of the negative therapeutic reaction can be understood as manifesting a more basic feeling of not having a right to a life of one's own, that is, to a separate existence. In one case, the woman was dominated by an unconscious fantasy of having in infancy robbed the two siblings who followed her of all of her mother's love (milk). Her basic attitude to life was that if she had anything, it meant someone else was deprived; more specifically, that her family would starve. In the transference a therapeutic alliance could only be established after it was discovered she unconsciously felt she had no right to live and, therefore, to the treatment. Such attitudes are especially intense in more disturbed cases but are present to some extent in less severe ones. The disturbance may be called separation guilt and relates to a failure in the phase of self-object differentiation with the mother. The guilt appears to relate to genetic elements in the superego rather than to the superego itself.

The Role of a Specific Father-Child Interaction Pattern in the Genesis and Psychoanalytic Treatment of Obsessional Character Neurosis. Beulah Parker. Pp. 332-341.

The successful treatment of two males with obsessional character traits is described in considerable detail. Both patients suffered masked authoritarianism from their fathers in the form of 'freedom to make their own decisions', which, however, had to be in keeping with the fathers' covert wishes. The first case

was an eighteen-year-old boy suffering an acute learning block in college. The second was a thirty-year-old married professor lacking warmth toward his wife and spontaneity in their sexual relationship. Both cases showed much release of affect followed by improvement after they were made aware of their fathers' masked authoritarianism. Treatment of the first case lasted three months; the second, four years and included working through in the transference of the unconscious wish to be treated as the father had treated him.

Notes on a Case of Ulcerative Colitis. H. Sidney Klein. Pp. 342-351.

The analysis of a case of ulcerative colitis in a sixteen-year-old male which included an interim episode of psychosis is related. The colitis was seen as an effort to expel the internalized bad object containing the sadistic part of himself that was felt to reside in the bowel. Experiencing emotions as physical sensations appeared to derive from a period when the infant experiences painful emotions so concretely that they are felt as physical sensations. This phase was apparently kept alive in part through failure of the mother to tolerate his emotions without withdrawal or recrimination. Five years after the beginning of treatment the patient was free of diarrhea except for occasional lapses, was living away from home, succeeding in his career, and maintaining physical improvement.

Unmarried Motherhood: A Paradigmatic Single Case Study. John E. Gedo. Pp. 352-357.

The satisfactorily terminated analysis of an unmarried mother supports previous conclusions from diagnostic studies as to the dynamics involved but adds further factors that indicate greater complexity of dynamics than previously realized. The need for illegitimate pregnancy was a reaction to death of the father in her latency period. This event precipitated a regression in which a trauma from the second year of life was re-enacted which had involved temporary loss of her mother due to illness. The pregnancy was an attempt to replace the object loss of the father (and of the mother from an earlier period), and identification with a sister who had an illegitimate pregnancy, and represented a self-punishment for unconscious rage. The avoidance of marriage was a pseudo-independence based on fear of object loss and on a masochistic conception of marriage derived from her mother's experience. The need to place the child for adoption was an attempt to master the trauma of passive object loss by actively giving up the object.

All Dis-Ease is Not Disease: A Consideration of Psychoanalysis, Psychotherapy, and Psychosocial Engineering. F. Gordon Pleune. Pp. 358-366.

In psychoanalysis, as contrasted with physical, chemical, and other forms of behavioral engineering, the analyst is more candid and accurate if he takes the position of trying to be helpful to the patient as a person rather than regarding him as sick and in need of cure. His own moral values and traits as a person will inevitably play a role.

The Development of the Concept of Intrapsychic Conflict in Freud's Writings. John C. Nemiah. Pp. 367-371.

The author traces succinctly the various considerations that led Freud from the traumatic theory of the neuroses to the topographic point of view and from this, in turn, to the structural model of the psychic apparatus.

Coital Movements in the First Year of Life. Earliest Anlage of Genital Love? William C. Lewis. Pp. 372-374.

The author has repeatedly observed eight to ten-month-old infants of both sexes clasping the mother, during periods of complete security, in the form of throwing their arms about her neck, nuzzling her chin, and making rapid rotary pelvic movements for about ten to fifteen seconds. Informal inquiry reveals widespread knowledge of this behavior among mothers, but there is much resistance to systematic investigation of it. Except for mention by Brody, Escalona, and Kinsey as to related but not identical types of behavior, there is no literature on the subject. Even Freud, Anna Freud and her co-workers do not mention observing it, an indication of the extent to which infantile sexuality still remains subject to omnipresent repression. The behavior appears to be an instinctual precursor to adult coitus.

Nightmares, Conflict, and Ego Development in Childhood. John E. Mack. Pp. 403-428.

The conclusions in this paper are based on material from relatively normal clinic children seen by several staff members. The author concludes that the extreme anxiety of the nightmare derives not only from current conflicts but reactivated fears from an earlier period when the ego was more vulnerable. A complex interrelation of several factors in the precipitation of the nightmare is emphasized which includes environmental forces, developmental thrust, current and past conflicts, the state of the ego at the time, and physiological factors such as illness. A development in the child's mastery of the nightmare is traced from total helplessness in infancy, through various degrees of partial success in modifying or warding off the frightening dream, to final prevention of it in latency. This sequence parallels development in reality testing and relation to primary objects as well as an evolution in structure of the nightmare and the complexity of the psychic apparatus producing it. The nightmare is seen as a desperate creativity serving both defense and discharge. At times, it signals a developmental advance, at others, an onset of lasting symptom-formation and impaired ego functioning. Further study is necessary to determine which is happening in a particular instance.

Dreams in Which the Analyst Appears Undisguised. A Clinical and Statistical Study. Milton Rosenbaum. Pp. 429-437.

These dreams appear far more frequently in analytic patients and still more so in analytic patients who have completed analysis. Statistically the dreams have no prognostic value, whether occurring early or late in analysis. No correlation was found between the frequency of their occurrence and an especially intense transference or countertransference. They appear to be linked in sym-

bolic meaning to the breast-face equation and therefore indicate early conflicts in the oral stage. They are of special significance and should signal the analyst to search within himself as well as within his patient.

Passivity and Failure of Identity Development. Peter Lomas. Pp. 438-454.

Passivity, according to Lomas, is not normal to women and abnormal to men but very often is an abnegation of natural, authentic development. It is the fate of the child reared in a family discouraging growth and rewarding parasitism. The belief that it is natural to women and children fosters the myth that they are inferior to men. Similarly its excessive association with men fosters a search for a spurious identity and unduly penalizes passivity in them. Current theory also wrongly assumes that the sense of identity develops primarily through identification with the parents rather than through healthy unfolding of the person's native identity in a favorable medium. On the other hand, where pathological identity is concerned the tendency is to underestimate the effect of pathogenic parental attitudes and overestimate innate factors. An analytic case presented in considerable detail is used to support the above assertions.

Verbalization and Identity. Anne Hayman. Pp. 455-466.

Two adolescent cases showed both identity disturbance and difficulty with verbalization. Clear verbalization by the analyst of inchoate feelings removed intense anxiety and restored feelings of identity. Developmental considerations suggest that the two factors are closely related. The child first refers to himself in the third person and only as 'I' after a clear sense of himself apart from others is established. Descartes' 'I think, therefore I am' appears to refer to this connection and may be emended to read, 'I verbalize: and therefore I have a sense of personal identity'.

Three Psychoanalytic Views of Identity. Norman Tabachnick. Pp. 467-473.

The paradox of self-realization versus social definition is an important consideration in theories of human identity. Freud linked self-realization to the drive of the instincts to find satisfaction against the opposition of the environment, which then exerted still further pressure against the instincts through the ego and superego. Hartmann and other ego psychologists indicated that identity formation need not be thought of as conflict between self-realization and social definition but stressed the synthesizing capacity of the ego to 'put together' biological and social pressures from the viewpoint of the self. Erikson postulated the concept of 'mutuality' between biological needs of the individual and the need of society but also indicated identity can exist apart from the principle of mutuality.

The Narcissistic Self in a Masochistic Character. August M. Kasper. Pp. 474-486.

A successfully analyzed male showed surface behavior that invited the conclusion that he was castrated and could only attain modest results with marked plodding effort. Actually this behavior was a defense against underlying narcissistic fantasies of omnipotence which had to be protected from precœdipal dan-

gers of castration. Early conflicts with his mother and their transference manifestations occupied the early phases of the analysis and conflicts with the father the closing phases. Two years after analysis he persisted in his change from the pseudo-castrated figure to that of a forthright, effective personality.

On the Return of Symptoms in the Terminal Phase of Psychoanalysis. Ira Miller. Pp. 487-501.

The return of symptoms during analysis signifies an insufficiency of working through and their regressive foothold in another area of psychosexual development. In the terminal phase they indicate the need to work through that aspect of the transference relative to the earliest phase of libidinal development—the anxiety of separation.

Death and the Mid-Life Crisis. Elliott Jacques. Pp. 502-514.

At age thirty-five the individual has reached the summit of life and sees a declining path before him with death at its end. This results in a crisis, stronger in some than others, connected with having to accept the reality of one's death. It is a period of anguish and depression at the anticipated loss of one's life and revives the infantile experience of loss of the good object (mother). Working through the infantile experience again increases one's confidence in being able to love and mourn what has been lost and increases the possibility of enjoying full maturity and old age. If creativity is present, it may take on new depths and shades of feeling. Dante's descent through Purgatory is essentially an expression of the mid-life crisis and its resolution.

The Significance of Determinism and Free Will. Lawrence Friedman. Pp. 515-520.

Friedman objects to Martin Hoffman's contention (1964) that persistent belief in determinism is empirically unfounded and that free will is only a variable feeling of freedom from internal compulsion. Determinism need not be evaluated as an isolated concept but survives consideration of the validity of memory, the meaning of personal identity, the possibility of communication, and the concept of enduring objects.

EUGENE NININGER

Bulletin of the Philadelphia Association for Psychoanalysis. XV, 1965.

Psychoanalysis and Utopia. Ernest van den Haag. Pp. 61-78.

This paper includes a survey of some of the sources and transformations of utopian ideas, together with a discussion of current salvationism. These ideas usually have been associated with religious inspiration. More recently science has been used as a basis for redemptionist hopes, replacing religious revelation. People find more hope in science than religion and their hopes are more for salvation in the present than in the hereafter. There is a tendency to lodge basic utopian hopes in psychoanalysis. The views and teachings of Gnostic psychoanalysts, for instance, Erich Fromm, and theoreticians such as Herbert

Marcuse and Norman O. Brown are critically reviewed. All of these share utopian views, belief in the natural goodness of man, and the view that capitalist institutions are corrupt. They cannot recognize that the human condition may limit the full gratification of man's deepest wishes; they insist that a change in his social condition will alleviate his suffering and bring about the fulfilment of his desires.

Biological Foundations of Psychology: Freud versus Darwin. Lili E. Peller. Pp. 79-96.

Peller traces the influence of Darwinian psychology which has had a particular influence on general and child psychology. It emphasizes the fight for survival as the chief influence shaping behavior and upon localization of conflict between the organism and its environment. On the other hand psychoanalytic theory and observation sees pleasure and pain as determinants of behavior and the locus of significant conflict as internal. Peller argues that psychoanalytic psychology refutes or limits the validity of most of Darwin's views of psychology. Freud's early work was close to many Darwinian views. Later changes in psychoanalytic theory share in the movement away from Darwinism.

On Analytic Goals and Criteria for Termination. Z. Alexander Aarons. Pp. 97-109.

The task of analysis is to effect structural change, accomplished by the mobilization and analysis of conflict, anxiety, and defense mechanisms. In this process drive energies bound in conflict are neutralized, secondary autonomous ego functions are liberated, strengthened, and consolidated.

Practical indications that this task has been fulfilled are: an estimate that no further significant change will take place; it appears that the patient will not be bound to a repetition of pathological means of coping with external circumstances; the patient's ability to effect adaptation along with the capacity for achievement and gratification. An explanatory rather than judgmental attitude is an analytic aim. The discovery of new aims along with a replacement of conflict is one criterion of successful analysis and another is to achieve the ability to inspect conflict rather than succumb to it.

The importance of working through is scored. Aarons argues for the importance of analyzing and working through intrasystemic, as well as intersystemic, conflict. The task of analysis, especially for the analyst, requires more, rather than less, time. Freud's recommendation that the analyst periodically resume his own analysis is recalled.

Arthur F. Valenstein's discussion of this paper (pp. 110-113) is in substantial agreement with Aarons, though he takes issue on several points. Valenstein stresses the primary aim of analysis as reduction of conflicts at the '*paradigm level* of their genetic origination'. The resulting effect upon the ego in terms of redistribution of energy, consolidation of function, is secondary to conflict resolution. Valenstein also regards intrasystemic conflicts as secondary to intersystemic conflicts.

Early Ego Development in a Mute Autistic Child. Bruno Bettelheim. Pp. 127-136.

Infantile autism raises questions about origins, steps, and sequences in the development of personality. Are there critical periods for the development of certain functions? If these have been bypassed, does there remain the possibility of making up for the omissions? Hopefully, the autistic child going through a delayed personality development can articulate some of his experiences and thus perhaps shed some light on development which ordinarily occurs in the preverbal infant. Bettelheim describes the treatment of a mute autistic child, beginning when she was ten years and nine months old. Marcia's 'twiddling' was her greatest achievement in her striving toward active mastery. Treatment, based on need fulfilment, acceptance, and permissiveness, was directed toward using 'twiddling' as a basis for developing higher forms of achievement. The infant's experience that efforts bring about positive responses outside himself starts the self going. Marcia demonstrated that remarkable progress could be made, even in an older child, although not as great as it might have been if treatment had begun four or five years earlier.

Excerpt from the Analysis of a Boy with Congenital Club Feet. Eleanor Fiedler. Pp. 137-159.

This analysis of a boy with club feet began when the child was four and continued almost six years. During the analysis there was a surgical correction of his feet and this experience became an important part of the analysis. The author analyzes in great detail the boy's reactions to his club feet and how these reactions influenced his œdipal experiences, narcissism, and strivings for mastery. The analysis helped the patient to attain 'a good footing in latency'. A number of character traits of which the patient was aware but which could not be analyzed at this time of life remained.

Passivity and Homosexual Predisposition in Latency Boys. John J. Francis. Pp. 160-174.

Francis reviews some of the literature on passivity in latency boys and presents two cases of passive boys with feminine orientations whom he studied. He was especially impressed with the importance of the fathers in producing passivity and feminine orientation in the patients. This was not the result of any single traumatic experience but of prolonged and repeated behavior of the fathers. From his findings and those in the literature, Francis concludes that there may be multiple etiologic factors in the production of passivity and homosexuality. Prolonged seductive behavior on the part of the father may be of great importance. Prolonged and repeated experiences emphasize the importance of quantitative factors.

A Young Girl and Her Horse. Gerald H. J. Pearson. Pp. 189-206.

It is a rather common impression that girls in latency and early adolescence develop marked interest in horses and riding. Pearson discusses such interests of a girl patient. It became clear that the horse incorporated a phallus for the

girl and that riding was an acceptable form of masturbation. Pearson shows how these meanings of the horse and riding are not exclusive for his patient but have an ancient, universal history. In addition, the analysis showed that the horse, and the patient's relationship to it, represented her lost mother.

Phallic Aspects of Obesity. Stanley A. Conrad. Pp. 207-223.

Literature on psychological factors underlying obesity is reviewed. Conrad raises the possibility that obesity may have a phallic significance in line with the body=phallus equation. Obesity for the woman may have the significance of an illusory penis. At the same time the obese woman may be denying feminine passivity and masochism. Obesity in the man may be related to a 'small penis' complex and give him the illusion of having a large, powerful penis.

Regression of the Superego. William E. Kelly. Pp. 224-235.

Kelly reviews the literature for concepts relating to regression and the superego. In Freud's original concepts the superego was characterized by its resistance to change. Subsequently, Freud recognized that the superego reacts to regressive changes in the id and ego. More recently, various authors have conceptualized the superego itself as the site for regressive change and have asserted that the superego, being a later structure, was 'more fluid and less stable than the ego'. Kelly points out the contradiction between this later concept and Freud's earlier thoughts about the durable quality of the superego. The problem remains: is the superego subject to regressive change? If so, how are we to understand its resistance to change?

EDWIN F. ALSTON

American Imago. XXIII, 1966.

Tausk's *Influencing Machine* and Kafka's *In the Penal Colony*. Gordon G. Globus and Richard C. Pillard. Pp. 191-207.

In this analysis of In the Penal Colony the apparatus is understood to be an influencing machine and a projection of the Officer's body. Tausk saw the influencing machine as a projection of the body and a defense against regression to primary narcissism. In the Penal Colony portrays the dissolution of such a defense; the Officer submits himself to the machine, becomes fused with it, and reverts to the placid blank nirvana of the infant. This article lends greater understanding to Tausk's article, Kafka's story, and to regressive ego states.

Giorgio de Chirico. Henry Krystal. Pp. 210-226.

This informative, illustrated study of the life and work of de Chirico reveals that prior to 1917 his paintings reflected his depression and anxiety states and evoked similar affective responses in viewers. Drafted into the Italian army in 1915 he became ill and was hospitalized with a psychiatric diagnosis. After his discharge he painted in a new style which was incoherent, enigmatic, and evoked no empathy. Correspondingly his development took a narcissistic and paranoid course.

It is easy to follow Krystal in his understanding of the change as one in which the artist became free of painful affects through the relinquishment of internal objects. However, he sees these changes as a product of ego mastery and arrest or regression and feels that the ego has achieved a victory, albeit a pyrrhic one, in consideration of the damage to the artist's talent. We see, instead, narcissistic regression, and neither mastery nor victory.

The Enigma of Michelangelo's Pietà Rondandini. Gerda Frank. Pp. 287-315.

Frank attempts to account for the relative neglect of the Pietà Rondandini by the Church and art public. Considerations of the postures of the figures in the sculpture and of Michelangelo's life history lead to the conclusion that this pietà portrays the return of the son, at his death, to his mother's womb. It is understandable the Church would tend to ignore a work which presents a heretical version of Christ's ultimate fate. The public too would tend to shun a sculpture which portrays death as oblivion without hope of resurrection.

Freud, Signorelli and Lacan. The Repression of the Signifier. Anthony G. Wilden. Pp. 332-366.

The Signorelli incident described by Freud in Psychical Mechanisms of Forgetting (1898) and in The Psychopathology of Everyday Life (1901) is elaborated in two directions. Freud, whose focus was on the mechanisms of repression, was satisfied to indicate he was avoiding the theme of 'death and sexuality'. Wilden attempts to show that this theme pertained to Freud's œdipal struggle with his father, recently dead. Freud employed a diagram to help demonstrate the nature of the association between the lost name and the repressed theme; Wilden reworks the material using a form of schematic representation originated by Jacques Lacan, a French depth psychologist.

JOSEPH WILLIAM SLAP

Psychoanalytic Review. LIII, No. 3, 1966.

Thirty-nine Theses and Counter-Theses on Psychoanalysis. John Sullivan. Pp. 5-49.

By the dialectic method the author makes thirty-nine propositions, attacks each one, and then develops his thinking with further discussion and an extensive bibliography. The goal appears to be an attempt to reconcile psychoanalysis with other psychological systems. Each reader will want to add propositions and quote from additional masters in this beginning effort to codify psychoanalysis.

Lee Harvey Oswald. An Adlerian Interpretation. Heinz L. Ansbacher, et al. Pp. 55-68.

The authors discuss an assassin to explain and justify the Adlerian approach versus the freudian. They object strenuously to freudian emphasis on the unconscious, on myth (œdipus complex), and on incestuous forces that, according to Katz to whom they refer, forced Oswald to murder. Instead, they offer the Adlerian alternative of sticking to facts of current reality, such as birth order, and alternatives that offer some hope of remedy in other potential killers. They

state that the feeling of inferiority alternating with grandiosity leads to murder. This stems from the child having been neglected or unwanted and also pampered, plus an organ inferiority. This concept offers the promise of a 'common-sense' remedy rather than suggesting that all is determined in childhood and cannot be changed in later life, as in a myth dealing with fate. A good Adlerian, it is said, prepares her child for a life of coöperation, contribution, and trust which may sound idealistic if not naïve. Oswald would have been very happy to see so much printed about his consummate act and perhaps would be amused at the naïveté of the authors suggesting that there was 'no possibility of any long-term plan' to kill.

Four Perspectives on Anti-Achievement. Howard Halpern and Thelma Halpern. Pp. 83-93.

This is a continuation of an article by Halpern in Psychoanalytic Review, Volume LI, 1964. Learning inhibition is discussed from the points of view of castration fears having been aroused and a sensitivity to the mother being upset and nonloving. Work inhibition is discussed as a contradictory rebellion in an effort to be independent of the parent which only leads to greater dependency. Regarding the mother as possessive and narcissistic, the father is seen as tense, angry, and competitive. Beyond the parents the authors make pertinent remarks about the impact of the modern adult world that tends to produce anti-achievers in ever-increasing numbers.

Jewishness as Resistance. Joseph M. Natterson. Pp. 94-98.

This is a brief and lucid report of two Jewish patients treated by a Jewish analyst. The patients used their cultural background as ego resistances manifested in the transference. Other authors have pointed out that excessive attention to cultural factors in psychoanalysis is to be avoided. Natterson suggests that neglect of cultural issues may leave unanalyzed pockets of resistance. This article is directed to those analysts who assert that cultural factors are of no importance to the analyst especially when he apparently has no curiosity or knowledge about the patient's cultural origins.

Nonregressive Ahistorical Means of Transference Examination. Louis Paul. Pp. 99-106.

This excellent article, brief and carefully worded, considers specific guides applied to therapy (and analysis?). Six ways of opposing regression are listed and discussed fully. Various analysts are named as identified with 'nonregressive ahistorical therapy' as opposed to 'classical' psychoanalysis.

The Use of a Reverse Format in Now Psychotherapy. Douglas Q. Corey. Pp. 107-126.

The title indicates the reverse of traditional implication of technique or goal of therapy. In 'now' therapy the patient is accepted as he is with his defensive systems. These are acknowledged to be useful and necessary versus the 'traditional' attitude of the defense being criticized and the patient urged to change to what the therapist considers to be good, clean, and healthy. The basic

defense of the patient is denial of omnipotence—that the patient needs someone such as an omnipotent mother and denial that he cannot control her. This is related to obsession with the past. Corey provides eight verbatim examples from interviews demonstrating 'now' therapy in which the patient finds self-realization. The 'now' therapist neither ignores resistance nor tries to take it away. Through self-discovery the patient is able to make important decisions and act on them.

Interpretations and Treatment. Their Place, Role, Timing and Art. Emmanuel F. Hammer. Pp. 139-144.

The author demonstrates the many different ways in which interpretation can be useful, thus contradicting another author who has recently claimed that interpretation and insight are inconsequential to therapy. Hammer's final comment with a quote from James Baldwin has an impact that conveys his sincerity and purpose.

Interpretation and the Therapeutic Act. Jule Nydes. Pp. 145-157.

There is a need to define and use appropriate nonintellectualized interpretations phrased in such a way that they can be used by the patient. Freud skilfully used anecdotes, fables, and quotations. Seven cases illustrate successful interpretations to patients who were overwhelmed by homosexual fears, were in panic, or were provocative. All examples reject the idea that the analyst is a cold, blank wall.

The Analyst's Role, to Interpret or to React? Bertram Pollens. Pp. 158-165.

Pollens states that not too many years ago our training analysts taught us to communicate insight through correct interpretations offered in an objective, dispassionate manner. Now, however, one should be spontaneous and react as an equal with the patient in a process of growing together. Depending on the type of patient, whether he is still infantile and needs authority, the analyst should be prepared either to be like Freud, the authority, and interpret, or like Ferenczi and react in a more spontaneous way to the feelings involved. Seven points of emphasis that distinguish the schools of therapy which have descended from Ferenczi are outlined.

The Maturational Interpretation. Hyman Spotnitz. Pp. 166-169.

Spotnitz thinks that instead of trying to overcome resistance the analyst should use interpretation to create the precise emotional experience which will resolve the problems of the patient. This frees the maladaptations which arose in early damage to maturation. After a preparatory period of analysis the patient is mature enough for interpretation. Until this time the analyst will have made only symbolic, emotional, and reflective interventions which are really primitive forms of interpretation. One case example is of an absolutely correct interpretation which led to the suicide of the patient who was not yet at the proper maturational stage.

STEWART R. SMITH

International Journal of Group Psychotherapy. XVI, 1966.

Group Therapy of Women with Severe Character Disorders. The Middle and Final Phases. Saul Scheidlinger and Marjorie A. Holden. Pp. 174-189.

Eight, and later five, socially disadvantaged Negro women were treated in group therapy. These women had all suffered from a lack of mothering and the presence of authority figures symbolizing harshness and failure which had produced in them a sense of worthlessness, depression, impaired object relationships, difficulties in reality testing, and impulse control. The first phase of the therapy, designed to strengthen the ego of the patients, involved much activity on the part of the therapist to demonstrate her positive feelings for the members. The group gave them support both on realistic and fantasy levels and the members banded together for mutual mothering. Fifty sessions were required for them to change from passive suspicion to verbal participation.

In the second phase the group, with an enhanced sense of identity in themselves and others, studied their feelings and expressed them. The positive feelings for the therapist and the group alleviated whatever tension this caused. The therapist encouraged consideration of values and goals for the members and their families. The hope of magic, characteristic of the first phase, changed to realistic assessment of the present. Denial, projection, and isolation lessened and were replaced by appropriate anxiety and depression. The members realized they could have an objective attitude toward their experiences. Connections between members' attitudes to their children and their own upbringing was sought.

In the final phase these women contrasted the helpfulness of the group with that of previous therapeutic experiences. Their topics moved from pregenital to a more mature psychosexual theme. The members reacted to the idea of termination with indignant disbelief, followed by separation anxiety, apparently aroused more by the idea of leaving the group than of leaving the therapist. Each of the five showed notable progress in independence and self-direction. Improvement has been maintained during the year since termination.

The Role of the Mother in Group Psychotherapy. W. Schindler. Pp. 198-202.

Group members find a mother image in the group itself rather than in an individual. The more integrated the group becomes, the more its members use it to correct wrong images of their mothers which they have projected onto society. The father, at first a transference figure, through therapy becomes an example of a more rational relationship to the world, an ego strengthening authority who permits growth until finally he appears on the same level as the members themselves. Clinical examples support the author's contention that empathy with and in a group is the principal therapeutic factor. Schindler comments on the great need for psychiatric help among 'the masses in communities challenged by economic, social and psychological pathology', and the difficulty of getting involved in treatment with a middle-class therapist.

The Phenomenology and Dynamics of Silence in Psychotherapy Groups. S. R. Slavson. Pp. 396-404.

Silence can be considered a function of the adaptive style of the individual, its relation to libido and aggression, and its relation to therapy. Silences may be classified in group therapy as individual, group, selective, and general. General individual silences occur in those to whom verbal communication is a minimal necessity, who identify with silent parents or with catatonic defenses, to whom verbal retention parallels fecal retention, or as a reaction to overwhelming repressed hostility or a fixation in early development.

Neurotic causes for silence include anxiety, fear, timidity, family constrictions, anticipated punishment, a threat to self-esteem, sexual insecurity, defective body image, fear of self-revelation, and guilt.

Selective individual silences appear when the discussion does not concern the individual, is beyond his intelligence or emotional development, induces anxiety, engenders hostility. General group silences are due to heightened anxiety such as is seen in the initial stages of treatment, during discussions beyond patients' understanding, negative transference to the therapist, general hostility or other emotion, emotional cogitation, or a need to provoke a response from the therapist. Selective group silences occur at the mention of taboo topics, evocation of strong emotions toward a member, or intense anxiety.

Silences are imposed by interruptions, changes of subject or quarrels, onslaughts often defensive in intent, and may arise from transference from close relatives who prohibit conversation. They may indicate the therapist's failure to meet the group's needs. Silences representing various forms of hostility may be translated by means of nonverbal communication. Silences should be interpreted or questioned but patients cannot be expected to function beyond their temperaments.

The Concept of Empathy in Group Psychotherapy. Saul Scheidlinger. Pp. 413-423.

A comprehensive survey of the literature on empathy reveals many definitions of the concept. The author views empathy, either spontaneous or deliberate, as linked to intuition and perception where the subject's ego boundaries and coherence of self are maintained. Ferreira noted that empathy exists from the youngest days and is related to the mother-child relationship. Spitz postulated a preverbal dialogue which was the precursor of conversation. Erikson pointed out that mutuality provides a safe pole of self-feeling from which the child can reach out for his first love objects.

In therapy the analyst oscillates between experiencing, observing, and conceptualizing. Katz observed that the therapist, regressing in the service of the ego, expands his ego boundaries. This is not the same as overidentification with the patient or the activation of the therapist's unconscious content. Fenichel expressed empathy as identification with another and then awareness of one's own feelings afterwards.

GERALDINE PEDERSON-KRAG

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Irving B. Harrison

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NOTES

MEETINGS OF THE NEW YORK PSYCHOANALYTIC SOCIETY

September 27, 1966. SUPEREGO AND DEPRESSION. David Beres, M.D.

The author considers the question of separating depression from other affective states, such as sadness, apathy, and grief, especially in terms of psychodynamic differences, and then considers the role of superego functions in depression. He discusses the importance of differentiating guilt from such allied affects as remorse and shame. Depression may not be complained of as such but may find expression in a need for punishment. An essential determinant of true depression is a sense of guilt that carries with it the assumption of a structured superego and an internalized conflict, but this does not imply that guilt is the sole cause of depression. Clinical examples are given to illustrate the differentiation among various painful affects and their causes, and to point up the special quality and special cause of the one state which Dr. Beres would diagnose as depression.

The author does not agree with those who have advanced as causative factors of depression what he believes to be its accompanying manifestations. Thus his view is at variance with Bibring who emphasizes the state of helplessness of the ego and with Jacobson who emphasizes narcissistic injury. In Civilization and Its Discontents, Freud says we should speak of a sense of guilt only after authority is internalized through the establishment of a superego, but later in the paper he seems to reverse himself, stating that the sense of guilt is in existence before the superego. In Dr. Beres' view, the crucial factor is internalization, which is the final step in a series beginning with identifications based on incorporation. In clinical instances of incomplete internalization, psychoanalysis may foster a delayed development of the superego. 'One may observe then the increasing expression of guilt and depressive reactions. . . .'

Descriptions of alleged depressions in childhood, as presented by various authors, are unconvincing. Beres notes that both Rochlin and Mahler maintain that the infant or child is not capable of depression as seen in the adult.

Factors found in patients suffering from depression are a tendency to identification; aggression and ambivalence; masochistic manifestations; regression in libidinal drive and ego functions; disturbances in self-esteem; object loss; and an ego state of helplessness—all of which are secondary to superego conflict and the evocation of guilt. The significance of the role of guilt is not only theoretical: 'It makes a great deal of difference in our therapeutic approach . . . whether the conflict is an internal one between different structures of the psyche or whether we are dealing with an individual whose conflict is with outer forces'.

DISCUSSION: Dr. Rudolph Loewenstein spoke of the possibility of guilt feelings in childhood before the development of the superego. Similarities between the child's guilt feelings and later guilt feelings are sufficient so that one 'cannot define them away'. Dr. Loewenstein noted that the child has partially identified with the punishing person even before the completion of superego formation.

If guilt is an essential element in every depression, why are severe guilt feelings so often seen with no depression? Dr. Loewenstein feels that the character of the object relations may be an essential factor, conferring variety to depressive illnesses.

Dr. Manuel Furer raised the question of the narcissistic elements in depression. In his experience it has not been possible to separate guilt from moral failure as a narcissistic mortification. The classical triad of melancholia in the adult—profound, painful dejection, psychomotor retardation, and self-reproach—is never found in childhood even after the period assigned to superego formation. Dr. Furer noted two factors of development and maturation which are relevant to the differences between childhood symptoms and later depressions: the continuing need of the child for an actual love object and his ability to tolerate greater distortion of reality in the service of defense. He doubted the wisdom of limiting the use of the term 'depression' to only those symptoms involving the superego in a manner implying complete internalization.

Dr. Edith Jacobson agreed that it is desirable to distinguish among the affective states, but she believes that there are depressive states in which there is no superego conflict. She has used the term 'mood condition' to refer to depression in which the 'whole self and correspondingly the world is changed' and to distinguish this from superego conflicts to specific impulses which arouse guilt feelings but do not lead to 'mood condition'.

In response, Dr. Beres emphasized that the superego is an abstraction referring to a group of functions, and not an object which 'does' things. He did not speak of complete internalization; a great deal of ego development takes place before internalization. He noted that the superego develops gradually, but when it has not yet developed he feels that one cannot correctly call the affect state a depression.

IRVING B. HARRISON

October 11, 1966. OVERIDEALIZATION OF THE ANALYST AND OF ANALYSIS: MANIFESTATIONS IN THE TRANSFERENCE AND COUNTERTRANSFERENCE RELATIONSHIPS. Phyllis Greenacre, M.D.

Dr. Greenacre focused on a relatively small but important aspect of transference and countertransference, namely, the overidealization of the analyst and of analysis. Special emphasis was placed on the importance of the second year of life as furnishing the genetic core for later development of idealization which is reproduced in the transference relationship, and on other conditions in the individual's early life and in the transference-countertransference relationship during analysis.

While there has been major emphasis on the importance of the mother in the infant's development, the role of the father in the first two years of life has been neglected. The author believes that the father is a very important figure even in the early months, not only as his influence is mediated through the mother but because of his contribution to magic and omnipotent qualities in

the child's life. At first the father is probably sensed as a 'twilight figure' actually associated with morning and evening. Often romping games with the father will stimulate diffuse body erotism different from the merging response to the mother's body. This can lead to an identification of the child's movements with his father's and the illusion of being big and active. Generally the child's relationship to the father is not based on an extension of his relationship to the mother.

Dr. Greenacre described certain neurotic patients with a history of fairly marked and often prolonged disturbances in the precœdipal years. In analysis they seem unusually 'good' patients but they do not want to relinquish the analyst and often attempt to idealize him, not as part of a postœdipal identification but rather as part of a magic world of omnipotence.

The development of overidealization of the analyst or of passive magic expectations from analysis relate to the origins of transference. This is rooted most deeply in the physical dependence of the infant on the mother but is also influenced by elements from the second year when the child reacts to the parents, especially the father, as being all-powerful and godlike. The analytic transference relationship contains elements of both. The countertransference attitudes of the analyst which may promote his overidealization by the analysand are often counterparts of the transference problems of the patient. It is not only the analyst's narcissistic needs but his failure to recognize his own hostile drives that may set up a difficult transference problem. These factors act to keep the patient in a state of continued dependence or even transference bondage.

DISCUSSION: Dr. Heinz Hartmann felt Dr. Greenacre's ideas were an enlargement of the psychoanalytic theory of early childhood and a contribution to the precœdipal phase of developmental psychology. He emphasized, however, that it is often difficult to discern the precise relationships between early childhood experiences and the form of the transference during adult analysis.

Dr. Margaret Mahler stated that overidealization has the aim of re-creating a 'new edition' of the toddler's delusion of closeness, glory, and power stemming from the separation-individuation phase. She felt that Dr. Greenacre's reconstructions of the development of the object relationship with the father constituted a classical contribution. One of the most significant points of the paper is the emphasis on the gap in our reconstructive and direct observational researches relating to the father's place in the very young child's intrapsychic development.

Dr. Joachim Flescher discussed related aspects of his various papers on anxiety and countertransference, emphasizing that repressed hostility in the child makes separation from the parents quite threatening. He described his views about analytic therapy requiring a triadic arrangement, with two analysts, one of each sex, as otherwise we force the patient to constrict his experiences into one 'transference groove'.

In closing, Dr .Greenacre expressed her appreciation of the discussants' contributions but emphasized her sharp disagreement with Dr. Flescher's views.

BERNARD D. FINE

MEETING OF THE PSYCHOANALYTIC ASSOCIATION OF NEW YORK

November 14, 1966. NOSOLOGICAL AND DIFFERENTIAL DIAGNOSTIC CONSIDERATIONS IN THE GROUP OF SCHIZOPHRENIAS, REGRESSOPHRENIAS. Jan Frank, M.D.

The author presents a classification of the regressive disorders, differentiating process schizophrenias from similar but prognostically and etiologically different disorders, called 'regressophrenias', as well as from the epileptogenic schizophrenias. Patients suffering from epileptogenic (especially temporal lobe) schizophrenic-like psychoses, in the post-ictal state may have paranoid ideas, ideas of influence, auditory hallucinations, and occasionally thought disorders. The affect, however, is warm and appropriate. The state of consciousness is disturbed and there is disturbance of attention.

The regressophrenias are characterized by regressophilia, i.e., a tendency to regress and a concomitant phobia about this regressive tendency. Typically the phobic aspect recedes, leaving the regressive behavior in the foreground. At this time the symptomatology may be egosyntonic and the patient may be resigned to his illness. There is object and affect hunger with an inability to satiate the hunger. The integrative function of the ego is unimpaired. The etiology of this group is based on an intense fixation to one psychotic parent. If this parent shows fragmented attention cathexis and thought disorganization, the patient, by identification, will display fragmentation of attention similar to hysterical or epileptic fuguelike states. Two cases are presented to illustrate this group.

Dr. Frank then discussed the process of the nuclear schizophrenias. These patients show impaired integrative function of the ego and disturbances of attention cathexis with oscillating states of awareness. There is disturbance of the harmonizing drive distribution into the smaller and delayed quanta of thinking. The characteristic obsessional thinking of many schizophrenics is rigid and unable to adapt to significant data of experience and sensory input. Case histories were presented to illustrate this group.

The author next considered the concept of the depth of stratification of consciousness. In acute episodes there are rapid shifts from cloudiness to overluminous primary process stimulus-boundedness. Perception is intact but due to continuous changes in levels of attention and awareness, the decoding of the messages of the environment is nonadaptive. There is similar chaos in self-image and sexual identity. The patient makes use of autosymbolic phenomena. Citing the work of Lord Adrian, Dr. Frank hypothesizes that due to lack of editing of the impinging stimuli, the schizophrenic exhausts his reserve of psychic energy.

After discussing treatment of the nuclear schizophrenias, Dr. Frank spoke of their etiology. He feels that nuclear schizophrenia is due to a lag in the maturational phase of specific evolution due to genetic, biochemical, metabolic causes, birth injuries, and a generally traumatized life in the first two years. The consequent maturational scatter and cerebral disharmony produce an individual who is prone to further traumatic experiences in later life.

DISCUSSION: After summarizing Dr. Frank's views, Dr. Judith Kestenberg agreed that the primary disorder in schizophrenia is likely to be an increased

permeability in impulse conduction. Further, she agreed that schizophrenia is an organic disorder, arresting and distorting development in children and breaking down previous development in adults. However, she does not envision this breakdown as a 'maturational lag'. She suggested dividing the regressophrenics into defectively cured schizophrenics and psychogenic disorders which simulate schizophrenia. She agreed that regressophrenics differ from schizophrenics in that the ego apparatus remains unimpaired, and that they are phobic about their regressive tendencies and suffer from object and affect hunger. The schizophrenic-like symptomatology is a hysterical identification with the psychotic mother. The regressophrenic uses mechanisms that resemble those of a five to ten-month-old child. However, an adult schizophrenic can only resemble a deviant, disturbed infant, never a normal one.

Dr. Max Schur emphasized the prognostic importance of the diagnosis of psychotic-like states which arise from identification with psychotic parents. He gave three examples of such patients, one from an unpublished vignette in Freud's correspondence with Fliess.

In conclusion, Dr. Frank agreed with Dr. Kestenberg that, though important, maturational lag and scatter is not a sufficient explanation of the etiology of schizophrenia. In addition there is a traumatophilia which causes difficulty in coping with reality.

GERALDINE FINK

The Twenty-fifth Annual Meeting of the AMERICAN PSYCHOSOMATIC SOCIETY will be held March 29-31, 1968, in Boston, Massachusetts. Abstracts of original work to be considered for presentation should be submitted by November 15, 1967, to the Chairman of the Program Committee, William A. Greene, M.D., 265 Nassau Road, Roosevelt, New York, 11575.

The Mid-Winter Meeting of the AMERICAN ACADEMY OF PSYCHOANALYSIS will be held December 1-3, 1967, at the Hotel Roosevelt, New York City. The theme of the meeting will be Psychoanalysis and Dissent.

A two-year program of Research Training in Psychiatry is offered by the Graduate Educational Program of the State University of New York, Downstate Medical Center. Fellowships are awarded each applicant accepted into the program. For additional information write to: Office of Admissions, Downstate Medical Center, 450 Clarkson Avenue, Brooklyn, New York, 11203.

In Biological Aspects of Infantile Sexuality and the Latency Period (This QUARTERLY, XXXVI, 1967), Dr. Richard V. Yazmajian states on page 217: 'A growth curve of the gonads shows a steady climb; a burst around three years; a peak and leveling off at four to five years; then a practically level state until puberty'. The author informs us that the sentence should read: 'A growth *and*

maturational curve . . .'. Although some gonadal growth does occur postnatally, the more important aspect is the maturational crystallization. This is especially important, as indicated in the article, when viewed in relation to adrenal morphological differentiation and functioning, and the total adrenal-gonadal physiological complex.

ERRATUM: The title of the book by Fredrick C. Redlich and Daniel X. Freedman, reviewed in This QUARTERLY, XXXVI, 1967, pp. 436-439, should read: THE THEORY AND PRACTICE OF PSYCHIATRY.

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