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Termination of Psychoanalysis: Treatment Goals, Life Goals

TERMINATION OF PSYCHOANALYSIS: TREATMENT GOALS, LIFE GOALS

BY ERNST A. TICHO, PH.D. (TOPEKA)

Mental illness may be looked upon as an interruption and distortion of developmental processes. Psychoanalysis is a treatment method that aims at the removal of the causes of such an interruption so that development can be resumed. If this treatment goal is achieved it makes it possible for the patient to reach his life goals. A clinical distinction between treatment goals and life goals is important for the conduct of therapy, and this can be done despite their partial overlap. *Life goals* are the goals the patient would seek to attain if he could put his potentialities to use. In other words, they are the goals the patient would aim at if his 'true self' (Winnicott, 1960) and his creativity were freed. *Treatment goals* concern removal of obstacles to the patient's discovery of what his potentialities are.

TREATMENT GOALS

Treatment goals should be discussed with the patient at the very beginning of analysis, preferably in the first few hours, and then kept in mind throughout the entire treatment. It is one aspect of the therapeutic alliance for patient and analyst to repeatedly explore the treatment goals together. They should not appear to the patient as an unconnected addendum to analysis but should be permitted to unfold and develop (E. Ticho, 1966). Changes in the patient's initial treatment goals will occur during the course of the analysis as the patient becomes aware of the unconscious goals which are closely connected with his neurosis. When the patient understands his neurosis he will be in a position to assess the contradiction between conscious and unconscious goals; only then can he arrive at unified treatment goals. At this point he will have a

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better understanding of his potentialities and will begin to define his life goals in a more rational way.

A case in which conscious and unconscious goals differed widely at the beginning of the analysis illustrates this distinction. A menopausal woman indicated that her goal in treatment was a successful marriage. Having rejected several analysts who had been interested in working with her, she finally agreed to see one to whom she explained that she expected a very, very long analysis. This was obviously in contrast to her conscious goal of an early marriage. When analysis showed that unconsciously she wanted to fulfil her longing for the repetition of a childhood situation in which she could enjoy pregenital gratifications, the patient understood why she had avoided marriage up to that time. Consequently she was able to begin a more mature relationship with a suitable man and her expectations of analysis became more realistic.

Treatment and life goals have to be described dynamically and not statically. One can speak of an advance in the direction of life goals; the healthy personality continues to grow, while the neurotic stands still. Theoretically, there is no fixed concept of how much frustration one should be able to tolerate: each individual can continuously improve his frustration tolerance. There is no point where one can say, 'Here is maturity, true and perfect!'. Therefore it is important to estimate the patient's growth potential—what he may achieve by the end of analysis and also in what direction he can develop further.

Beyond this it is difficult to generalize about treatment goals. They are obviously dependent on the uniqueness of the patient's personality. But there are shared expectations expressed by many analysts. Briefly they are the establishment of mature personal relationships and the diminution of narcissistic self-centeredness. Other goals include increased frustration tolerance, freer access to the unconscious that permits freer communication with the outside world, and, finally, a change in superego functioning that leads to a more tolerant, integrated, and loving superego. Jahoda (1958) states: 'The healthy person

knows who he is and does not feel basic doubts about his inner identity'. To know who one is also means to know what one's goals and responsibilities in life are, and how to integrate them. The central importance of self-esteem and self-acceptance has never been described better than by Nietzsche (1882) in The Gay Science: 'For one thing is needful: that a human being attain his satisfaction with himself . . . only then is a human being at all tolerable to behold. Whoever is dissatisfied with himself is always ready to revenge himself therefor.'

In his pioneering Psychotherapy, Schilder (1938) wrote:

> Many human beings are afraid that they might not find love and admiration from persons of their own and the opposite sex. Most human beings are somewhat admirable and everybody is searching eagerly for persons who may allow him to give them admiration and love. If one doesn't hinder the other person, one can hardly escape being loved and admired. To be true, there are also hostility and aggression in oneself and others. It is good to know this. If one does, one will not expect to be loved and to be admired continually. One should allow oneself a good hate and should not shudder when he discovers such a good hate in others too. Only on the basis of conflicting tendencies which go through the whole realm of human emotions can one finally come to a social relation with others which is truly human. Companionship does not mean that one is free from hate, but it means that one can organize a human relation which appreciates one's own qualities as well as the qualities of others (p. 89).

At the end of analysis there is not only freer access to the infantile mainsprings of love and hate but also access to infantile dependent tendencies. The freshness of experience and the spontaneity of childhood—just as the initiative and activity of the phallic phase, and the enthusiasm and idealism of adolescence—will find sympathetic response in us and give richness and depth to our feelings. These early experiences echo and re-echo in life. If they do not, life becomes sterile, unimaginative, and barren.

The patient must achieve not only a good knowledge of his limitations but also the capacity to endure a certain amount of anxiety, suffering, and depression. The healthy human being knows his own weaknesses and learns to accept them. One patient described this at the end of his analysis as feeling that he could 'put up with the way I am and the way I am not'.

These attempts at enumeration of psychoanalytic treatment goals—useful guidelines as they are—may be misused by the common tendency to view them as perfectionistic absolutes. If analysts share perfectionistic fantasies with their patients and do not examine them, patients may be led into a situation where they will experience termination as a severe disappointment. The analyst who is unaware in his own mind what *his* treatment and life goals are will pursue his unconscious goals rigidly and will be unable to consider the patient's options. The analyst should know what he considers a mature human being to be. 'Sometimes we even confuse our professional model of a good analyst with what the individual goals of the patient should be' (E. Ticho, 1966). Moreover it is all too easy for the analyst to behave like a perfectionistic parent by setting unattainable standards to compensate for personal failures.

Only when the analyst's expectations are conscious can he separate his own treatment and life goals from the patient's treatment and life goals. He must see his task as helping the patient successfully to look at the conflicts and ego deficiencies of the past, to accept current assets and limitations, and to set his goals on this basis rather than on what others—including the analyst—seem to prescribe for him. If the analyst cannot separate his and the patient's treatment goals, then termination of the analysis inevitably brings anxieties about the analyst's own professional abilities as well as, at times, doubts about psychoanalysis itself as a treatment method.

LIFE GOALS

Now let us focus on life goals. My attention was first drawn to the importance of the difference between life goals and treat-

ment goals as a member of the Psychotherapy Research Project of the Menninger Foundation (Wallerstein, et al., 1956, 1958, 1960). Many analysts became anxious when we asked for permission to study their cases. Further inquiry revealed that anxiety reactions were elicited in cases with doubtful outcome as well as in cases which had been clearly successful. Similar reactions were noticeable in inexperienced and experienced analysts, as well as in supervising analysts who were interviewed about the cases treated by their supervisees. This anxiety reaction was so common that I called it 'research anxiety' (E. Ticho, 1966). Immediately after the termination of treatment, we interviewed the analyst and other professionals who had been associated with the patient's treatment, i.e., hospital physicians, social workers, and nurses. In addition, the analysand and his relatives were interviewed at termination and again two years later. Again and again we noted that many analysts viewed their work with unjustified scepticism; often the patient was much more satisfied with the results than was the analyst.

How can this anxiety associated with the termination of analysis be explained? Research anxiety might be caused by an analyst's uneasiness about whether he had made errors which he had overlooked, or whether he had gone far enough in the analysis of the patient's character, or whether there was a transference-countertransference impasse. The unwitting and unconscious perfectionism of the analyst, discussed before, might also lead to research anxiety. Such perfection is not achieved in the patient's, or analyst's, analysis and is, of course, unachievable. Some analysts seem to have retained a modicum of resentment at the outcome of their own analyses and this more or less conscious dissatisfaction contributes to a wish to achieve 'perfect' results with their patients.

One important and generally overlooked contribution to research anxiety seems to be the analyst's unconscious confusion between treatment goals and life goals. When a researcher studied the analyst's cases, the analyst was embarrassed because

the patient's life goals were not reached, and he was often unaware that treatment goals had been achieved.

Winnicott (1967) made the rather provocative statement that 'You may cure your patient and not know what it is that makes him or her go on living. It is of first importance for us to acknowledge openly that absence of psychoneurotic illness may be health but it is not life' (p. 370). I interpret this as Winnicott's concern with the distinction between treatment and life goals. Not surprisingly these lines come from a paper in which he theorizes about the origin of culture and creativity.

Life goals can be divided into *professional* and *personal* life goals. Professional life goals refer to achievements in one's chosen work. Personal life goals refer to what kind of human being one would like to be. Both goals are, of course, dependent on conscious and unconscious ideals. Some patients come to treatment with well-defined life goals but are unable to pursue them because of inner conflicts. Others claim not to have conscious life goals, and analysis helps them realize that their unconscious goals are so unrealistic that everything they achieve in their lives falls short.

The treatment of a patient who began analysis with no aptitude for making psychological connections but who became very 'psychologically minded' during his analysis illuminates the complex interplay between conscious and unconscious aims. The patient, a thirty-eight-year-old architect, was quite successful in his profession although he experienced little gratification and no genuine commitment to his professional life goals. He became an architect because his father and grandfather had achieved considerable success in this field and had been famous in their professional circles in Europe. His life goals seemed forced on him by his family. When his alcoholism and drug addiction became uncontrollable, hospitalization was recommended and he submitted. At the beginning of treatment his goals were very vague. He had no genuine wish to understand himself or to change; he just wanted to patch up things and get relief from his ego-dystonic symptoms.

In the transference he was friendly and somewhat obsequious. He was 'a good boy' and a 'diligent pupil', finding it extremely difficult to relate any real feelings. He fantasied therapy as a procedure where he would be passive, more or less asleep, where things would be done by the analyst with minimal participation on his part. In this way he would receive certain attributes such as strength, integrity, intelligence, tolerance, and kindness. He was unaware that he was vaguely expressing his personal life goals.

In the course of the analytic work his treatment goals were repeatedly discussed and expanded. He wanted to end his chronically unhappy marriage and to change his deeply troubled relationship to his parents as well as to people close to him. He did not want to be a 'lone wolf' any more. After first insisting that he could not completely give up drinking, he came to understand the complex causes of his alcoholism and was able to overcome it. Throughout the treatment the analyst's goal was a thorough analytic resolution of the patient's inner conflicts. The analyst never deviated from this goal which he was certain would have been the patient's goal if he had been able to see his past and future objectively.

The patient's professional life goals were set when he came to treatment, but he was unable to pursue them because of his inability to be assertive and successfully competitive with his architect father. This conflict was resolved and his life goals were taken up again. He considered the 'most dramatic change in himself to be the capacity to tolerate anxiety' which led to a good many changes in his personal life goals. He was able to enter into meaningful object relations. In addition he could observe and analyze himself and was happy and comfortable. Before the analysis he felt comfortable only under the influence of drugs and alcohol. His strong feeling that people around him determined his life and that he had little to say about it disappeared.

Those life goals that are carefully worked on throughout analysis, but of course cannot be fully achieved by the end of

analysis, may come to full bloom only in the postanalytic phase. They implicitly stress the analytic process as part of the life process. Consistent attention paid to what a person does with his life, and to what purpose, is immeasurably helped in the post-analytic phase by self-analysis. The goal of continuing self-analysis has recently come into the forefront of the analytic aims (*cf.*, G. Ticho, 1967). If the patient can use the psychoanalytic method, without the presence of the analyst, to further scrutinize conflicts that come to his attention as his life progresses, he will have acquired a unique tool which not only will make it possible to remove obstacles to further growth but will also enable him to realize his limitations and seek further help should that become necessary. The achievement of relative autonomy and increasing self-determination will remain a continuing effort with its successes and failures.

Intimately connected with autonomy achieved in self-analysis is the patient's awareness of his uniqueness and of the specific contributions he and he alone can make. This is linked with the 'emerging core' of Loewald (1960) and with the 'true self' of Winnicott (1967). A beautiful description of life goals is found in an obituary written by Loewald (1967) about a colleague:

> He was a person who continued to grow, whose inner life and whose range of experience and enjoyment of life became richer and more varied with age, who continued to gain new friends, new interests and greater emotional and intellectual freedom. His feelings and convictions were strong and passionate and often stubborn, but they could and would change with increased understanding and knowledge . . . (p. 605).

When Glover (1938) sent his questionnaire to British analysts, the majority responded to the question about the criteria for termination of analysis as 'essentially intuitive'. It seems that we have advanced considerably since then although some analysts may still have difficulty in recognizing when their patients are sufficiently freed from their inhibitions and may further develop on their own. There is no doubt that such a

judgment is difficult, but an analyst who has worked with his patient for a considerable time is able to respond to the patient's indications for termination, particularly if he constantly re-examines the patient's autonomous goals. This gives the analysts a reliable indication for the termination of psychoanalytic treatment. Those indicators that should be kept in mind when analyst and patient consider the termination of the treatment can now be pulled together for our scrutiny.

TECHNIQUE OF TERMINATION OF ANALYSIS

Psychoanalytic treatment follows an almost predictable, one could perhaps say, natural course. Nevertheless each patient has an idiosyncratic termination phase characteristic of his unique personality. One can generally speak of a preanalytic phase in which many expectations, wishes, fantasies, sometimes even transference phenomena are noticeable before the patient even sees the analyst. One can distinguish a beginning, middle, and termination phase followed by a postanalytic phase which, in spite of its great importance, has not been sufficiently studied.

What are the indications for the inception of the termination phase? I would suggest the following considerations:

1. How much has the transference neurosis been reduced?
2. Have the patient's symptoms and character pathology been analyzed sufficiently so that they do not interfere with his functioning?
3. Have the patient's treatment goals been reached?
4. What is the quality of the relationship (the 'real relationship') between analyst and patient? Does it move in the direction of becoming a relationship between equals that will enable the patient to establish equally mature relationships with other people in his life?
5. Does the patient perceive the analyst in realistic terms?
6. Have the patient's separation anxieties and his approach to the new beginning been analyzed?
7. Has the patient given up his perfectionistic and other infantile expectations?

8. Have the patient's ego skills improved sufficiently?
9. What are the transference residues?
10. What is the patient's future growth potential, his ability to define life goals, and to follow them creatively?

One important criterion for answering the question about termination of treatment is whether a considerable reduction of the intensity of the transference neurosis has taken place. Some authors have this in mind when they speak of the point of diminishing returns. Reduction of the transference does not exclude the possibility of intensive but shorter and better understood transference phenomena taking place during the termination phase.

Reduction of the transference neurosis leads to a noticeable change in the analytic atmosphere. The mood becomes more relaxed. The patient feels less dependent. Some analysts describe a freer atmosphere, and they react more spontaneously and are less constrained in their formulations. However, there may be an increased danger from uncontrolled countertransference, particularly if the analyst goes from depriving the patient (which is a necessary part of the growing process) to gratifying him, a tendency that may be strong in an analyst who follows the rules rigidly and who feels, at the same time, personally deprived of meaningful human relationships. The patient at times reacts to this situation by feeling that the analyst becomes 'human' to him only because he has 'made it'. This repeats a childhood situation in which parents were friendly and loving only when the child 'performed well'.

Another indication of the termination phase may be seen in the patient's comments about his relatives and friends whom he describes as 'considerably changed'. He also perceives similar changes in the person of the analyst. The patient may quote friends who have noticed changes in him; he is much easier to get along with, is more goal- and task-oriented, more productive; he no longer sees everything in absolute terms. Generally the patient becomes more realistic. He accepts assets and liabilities in himself and in others, particularly in his analyst,

and fluctuations between idealization and contempt decrease. Finally, the patient experiences himself as changed, and welcomes this change; he had always hoped to achieve something like this in treatment. While the termination also leads to mourning and disappointment, the patient often experiences this phase as a new beginning. He feels truly liberated and is aware of a considerable amount of energy that he could never before muster. Sometimes analysts do not recognize this as a new beginning and their failure to do so may result in a hindrance to future growth.

During the middle and termination phase, patient and analyst have had ample opportunity to see what kind of relationship replaces the transference neurosis. The patient can become aware of it only with the help of the therapeutic alliance with the analyst which is, in itself, based on a mutually accepting, coöperative, and trusting relationship that makes the transference neurosis possible. With the understanding of the transference neurosis, the real relationship with the psychoanalyst (that has been going on all through the analysis) expands into a new object relationship 'which serves as a focal point for the establishment of healthier object-relations in the patient's "real" life . . .' (Loewald, 1960, p. 32).

In the psychoanalytic treatment of the architect, described earlier, the transference neurosis was analyzed and the therapeutic alliance expanded into a real relationship. This is how the patient expressed his feelings to the research team of the Psychotherapy Research Project at the point of termination:

> Well, at first it was me against the world. Then I had a feeling it was me and part of the time that the analyst was really a friendly figure. For a while I felt that he was taking the 'hands-off' attitude and was not intervening right then but that he would. [This was when he dated a woman friend.] And then I decided no, he wasn't going to do anything, that he was going to leave it up to us to work out our life plans—whatever seemed best—and all I had to do was just to discuss it with him. And then during the last two years it changed

> and I felt this was really a team. . . . I guess it just became a very close working relationship. . . .

The patient went on to say, 'In a way I felt I wanted to continue forever; on the other hand I knew I had a friend and that I could turn to him if I needed him. But at the same time I knew I had my own life to lead.'

At the follow-up interview two years later, the patient said:

> . . . in the therapeutic process, . . . this is all transference, these are feelings about earlier object relationships which you throw at the therapist. Now that's certainly true, but we are far enough out of it now so we can say—but it isn't all earlier relationships . . . that some of it had to do with the way these two people interact as people . . . you're not only re-creating memory traces of earlier situations, but you're creating a whole series of new situations into which two people embark. [Later in the interview he added:] . . . without any feeling that this was a blank smooth wall, that I was talking to . . . that I was still feeling that this was a member of the human race, and not a kind of depersonalized object.

One could say the termination of any important and real relationship leads to mourning, and unresolved remnants of the transference neurosis lead to disappointment. This may often be the case, but the circumstances are too complex for such a simple formula. Throughout the entire course of the analysis attention is paid to separation experiences and anxieties in the patient's history. It is not only separation experiences in early childhood, in school, and in professional life which need to be analyzed, but also the patient's reactions to interruptions in the analysis, i.e., absences due to illness, vacations—both of the analyst and of the patient—all must be carefully analyzed. These serve as clues to how the patient will react to the termination of analysis.

Every ending of a phase in the life cycle brings separation problems to the fore. The mother-child separation is of great importance but we also have to keep in mind 'that the fantasies and conflicts involved in the experience of termination cover

a wide range that not only recapitulates separation from the mother in early childhood but also activates fantasies about completion versus incompletion, castrated versus phallic, life versus death, and disappointment over the fact that the analysis has failed to fulfil all those unconscious childhood fantastic wishes that the patient brings into the analysis under the guise of the wish to get well' (Arlow, 1970). This has been pointed out in adolescence by Lampl-de-Groot (1966) and by Miller (1965) who says: 'In some respects, then, the terminal phase might be compared to a therapeutic adolescence, wherein the increasing awareness of improved functional adaptability threatens the patient with a similar loss and revives a regressive, defensive clinging to previous (childhood) anxieties via the return of symptoms' (p. 500).

It is also important to observe how the patient refers to the end of his analysis. Does he speak of the long-expected goal of complete independence, does he threaten to terminate the analysis and thereby 'drop' and disappoint the analyst? Does he talk about termination as giving up every hope of further improvement? Some patients talk endlessly about termination of analysis, while others never mention it. Among the latter we find patients for whom analysis in itself becomes a life goal.

Another important task of the termination phase is a more detailed scrutiny of the patient's behavior in daily life in order to understand how the patient's ego functions have changed because of what he has gained in the analysis. Did he acquire new skills? (Here I am referring to patients who were unable to achieve new skills because of neurotic difficulties, such as phobias, severe problems with authority figures, masochistic tendencies, etc.)

Some authors, particularly Nacht (1965), suggest that the analyst should become less 'neutral' in the termination phase. He suggests having face-to-face interviews in the termination phase and then 'establish[ing] less rigid, less artificial relationships between patient and therapist by putting them on the new level of adult to adult' (p. 113). In the termination phase,

as in any other phase of the analysis, we must still consider carefully the oscillation between transference neurosis and reality. Discarding the couch and having the patient sit up during the termination phase may suppress the residues of the transference. However, this may be inadvisable because a careful scrutiny of what the patient does with the transference residues is most important for the prevention of future psychopathology.

Countertransference difficulties play a larger part in the termination phase than in other phases of the analysis, although of course this is not to discount harmful countertransference in other phases. However, it may explain why some analysts terminate the analysis too early, and others too late. Premature termination may be linked to the analyst's own narcissistic difficulties. Both analyst and patient at times attempt to avoid the painful but necessary disappointment and mourning reaction by premature termination. In a too lengthy analysis it seems clear, as we have indicated, that the analyst's inability to keep life goals and treatment goals separate, and/or his perfectionism, play a part. Another factor is the difficulty in permitting the patient to grow up and lead an independent life. Some analysts defend interminable analyses with the rationalization that further understanding would be advantageous for the patient. However, we are not only interested in increasing the patient's self-knowledge but also his application of this knowledge to his daily life. At times the great advantage of a patient's independence is underrated. For some patients treatment goals have to be modest, and unrealistic expectations may make further growth less likely. But even in these patients we should not underrate how much better they may feel at the end of treatment and how, with limited goals achieved, they may continue to grow. After the patient has made some progress and has been in treatment for a considerable time, we must seriously weigh whether the time and money and effort are worth the investment. Countertransference problems may make it difficult to evaluate such a situation objectively.

Buxbaum (1950) has pointed out that analysts 'may, through [their] own behaviour, help the patient to dissolve the transference or to continue it to a large degree after the analysis by overlooking [their] own counter-transference . . . . it is through our counter-transference that we keep a transference alive in the patient longer than need be' (p. 190). This is a particularly serious problem in the terminal phase where further reduction of the transference neurosis is necessary for successful termination of treatment. Some analysts—often those who were analyzed by analysts who had social contact with their patients too soon after termination of the analysis—have great difficulty in analyzing the separation conflicts of their patients. They are not too clear about the patient's reaction of disappointment in the terminal and postanalytic phases. Thus they misjudge the patient's disappointments as a need for more extensive analytic work. G. Ticho (1967) says, 'A greater awareness of the disappointment reaction would lead to a careful analysis in the termination phase of the analysand's handling of his disappointments in the past, and would enable the analyst to connect these with the mourning process and the separation anxiety . . .' (p. 316).

SETTING THE TERMINATION DATE

Some authors stress the analyst's activity in the concluding phase of the analysis. Rangell (1966) states that setting the termination date is the only exception to the neutrality usually maintained by the analyst. Glover (1955), in his Technique of Psychoanalysis, made it abundantly clear that the analyst decides the termination of the analysis. He says: 'I indicated that we would aim at terminating the analysis in four months' time. The manoeuvre proved successful.' Further on, with a different patient, Glover says, 'I decided to terminate the analysis'.

But it seems to be an indication of the newly achieved relationship between analyst and analysand that they jointly

agree on the final phase and that as far as possible the first move for termination of the analysis should come from the patient. Recurrence of symptoms and of already given up transference manifestations is often mentioned in the literature as the patient's reaction to the announcement of the impending termination of analysis. This is correctly seen as a desperate attempt by the patient to delay the final leave-taking.

At other times, however, a noticeable recurrence of the symptoms and intensification of the reduced transference neurosis seem to be connected with the way in which the analyst suggests the termination of analysis. If the patient and the analyst have already agreed on a termination date, and if the patient has been reminded of his previous reaction to separations, we can expect that a recurrence of his symptoms, while at times quite stormy, will be more easily controlled and short-lived since by this time the patient has a much better understanding of himself.

Borderline patients and narcissistic patients often have a sharp reaction to setting a termination date. In the termination phase the patient is confronted with the fact that he can no longer maintain his fantasies of the analyst's omnipotence and grandeur, and consequently he reacts with a sudden fear of terrible loneliness, with anxiety and rage, and with an intensive recurrence of his earlier symptoms.

The termination phase consists of two separate steps: 1, mutual agreement between the patient and analyst that the analysis should terminate; and 2, the setting of the termination date proper. Both steps should not be taken at the same time. Even though the patient sets the termination date himself, the analyst should wait for the patient's reaction. No longer do we use setting the date to overcome resistance.

Although we know that a complete dissolution of the transference is not possible, a substantial reduction of the transference neurosis, particularly in the termination phase, can be expected. Interpreting the displacement of the remnants of the transference is indicated during the terminal phase as these remnants can lead to a recurrence later of neurotic difficulties.

Some analysts feel a need to 'reassure' the patient at termination that he may return to treatment if he feels a need for further help. This would, of course, be a very natural comment to make at the end of a comparatively brief psychotherapy, but if it is said at the end of an extended psychoanalysis, one wonders whether the patient would not construe it to mean, 'I don't believe you will ever be able to stand on your own feet', thus indicating the therapist's doubts about the patient's capacity to continue growing. If the patient had not already learned that the therapist would help him again whenever it became necessary, then something may be wrong with the therapist-patient relationship.

There is no uniformly agreed upon rule whether one should taper off analytic sessions or terminate analysis without cutting down on the number of hours. This depends on the patient's pathology. Termination without reducing the hours represents the position of most analysts. This would discourage a denial of the separation from the analyst. There are cases (e.g., oral-dependent patients) where 'weaning' would be indicated but this should not be overdone.

There is still some uncertainty about the further growth after termination of analysis. Good clinical evidence shows that further growth after termination does occur in many patients. It is our assumption that growth takes place all through life, and that the removal of obstructions to growth opens the way for increased maturity.

Research projects where patients are reinterviewed a number of years after termination of treatment provide us with important and badly needed information about the postanalytic phase. If more knowledge about the postanalytic phase were available, psychoanalysts would have fewer difficulties in terminating patients earlier and have more trust in the growth potential of their patients after the main inhibiting factors have been analyzed. They would then be able to distinguish more sharply between treatment goals and life goals.

SUMMARY

Treatment goals, i.e., the removal of obstacles to the patient's growth and the discovery of what his potentialities are, and life goals, i.e., the goals the patient would arrive at if he could put his potentialities to use, are distinguished. The successful attainment of the treatment goals enables the patient to terminate psychoanalysis and to proceed toward achieving his life goals. From this point of view the technique and the indications for termination of psychoanalysis and for setting the termination date are discussed. Data for these formulations were drawn from the Psychotherapy Research Project at the Menninger Clinic where patients were interviewed at termination and two years later.

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Herman Roiphe & Eleanor Galenson

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EARLY GENITAL ACTIVITY AND THE CASTRATION COMPLEX

BY HERMAN ROIPHE, M.D. and ELEANOR GALENSON, M.D.
(NEW YORK)

Roiphe's (1968) paper, On an Early Genital Phase, described a series of observations on normal toddlers and young psychotic children which suggested to him that children, both boys and girls, between the ages of fifteen and twenty-four months, normally and regularly demonstrate a marked increase in manipulation of their genitals, including frank masturbatory behavior; they also show curiosity about and reactions to the anatomical difference between the sexes. A sharp upsurge in sexual interest and activity was thought to follow from the increase in endogenous genital sensation that children of this age experience. The endogenous genital sensation probably results from a change in bowel and bladder function, independent of any toilet training efforts, in the early months of the second year. This early sexual activity normally is concerned with the consolidation of the self and object representation and serves to establish a primary schematization of the genital outline of the body. As far as can be determined such early sexual development is free of any œdipal content (Roiphe and Galenson, 1970).

Roiphe (1970) further reported that some children who had already shown evidence of such sexual arousal developed moderate to severe castration reactions after they had observed the anatomical difference between the sexes. He stated in that paper that these castration reactions appeared to develop *only* in children who had had earlier experiences that served to interfere with a stable body schematization, such as severe illness, birth defect, and surgical intervention; or experiences

From the Albert Einstein College of Medicine, Department of Psychiatry, Bronx, New York.

that interfered with a stable object schematization, such as loss of a parent and depression in or gross emotional neglect by the mothering figure.

In her paper on perversions, Greenacre (1968) offered a formulation concerning early sexual activity and castration reactions in the second year of life. She stated: 'It is now a common observation that fear of castration in boys and penis envy in girls occur earlier than used to be thought—i.e., well before the phallic phase, quite commonly about the age of two' (p. 51). From our reading of the psychoanalytic literature, we cannot agree with Greenacre that it is now 'a common observation' that castration reactions occur about the age of two. Other than our own work (Roiphe, 1968, 1970; Roiphe and Galenson, 1970; Galenson and Roiphe, 1972) and a paper by Sachs (1962), we have been unable to uncover any detailed or comprehensive presentation of castration reactions occurring in the second year of life.

Greenacre (1968) continues: 'In the earlier years, these problems [i.e., castration reactions in the second year] are much more involved with body narcissism in the investment of the own body parts as possessions. I have thought that toward the end of the second year there was regularly some enhancement of genital sensitivity (phallic or clitoral) that occurred simultaneously with the increasing maturation of the body sphincters' (p. 51). She refers to Anna Freud's (1951) comments in discussing observations at variance with established analytic findings concerning chronology: 'Penis envy, which we expected to see in girls in the phallic phase, appeared with extreme violence according to some of our recordings in girls between eighteen and twenty-four months. In these cases the responsible factor may have been the bodily intimacy between boys and girls as it exists in a residential nursery where the opportunities for watching other children being bathed, dressed, potted, etc., are countless' (pp. 27-28). Anna Freud tentatively suggests that the provocative force of the observation of the anatomical difference between the sexes produced extremely

violent reactions of penis envy in these children. This thesis, however, does not explain the curious age clustering, nor does it establish the conditions for the narcissistic cathexis of the genitals implied in such a reaction (*cf.*, Freud, 1923, 1925).

In order to investigate systematically sexual development in the second year of life, we have established a research nursery at the Albert Einstein College of Medicine, patterned on the model developed by Mahler at the Masters Children's Center (*cf.*, Mahler and Furer, 1960; Pine and Furer, 1963). The children, who are about one year of age when enrolled, attend the nursery with their mothers four mornings a week for two hours each day throughout their second year. The nursery is set up as a large indoor playground where the children have ready access, visually and physically, to their mothers. Each mother-child pair is assigned its own observers, who follow them throughout the year. The following case illustrates 'typical' observations made possible by our investigations.

Suzy was a dainty, small-boned child of thirteen months when she entered the program. She had already worked as a model for many months and was capable not only of making the rounds of the modeling agencies with her mother in a quiet, poised manner but also of sitting through one or two-hour sessions of photography, patiently doing as she was told. Her birth was normal; her early development was reported as 'good'. She had been walking for three months when she first came to the nursery and was sure-footed and agile.

She was an only child. Her mother, an attractive young woman who worked intermittently as a model, had gained forty-five pounds during her pregnancy. In the early months she had been so eager to show that she was pregnant, she had worn maternity clothes long before they were necessary. She dressed herself and Suzy with style and flare. She was proud of her little girl's appearance and reacted grievously to each bruise, cut, or scar her daughter suffered. Suzy's father, energetic and ambitious, was considered a loving and devoted husband and father.

At thirteen and fourteen months Suzy showed very little interest in her genitals. Occasionally when exposed during the changing of her diapers, she would touch her genitals but this activity seemed of no more importance to her than her curiosity about the rest of her body. At fifteen months she suddenly began to show definite and pervasive curiosity about the genitals of other children. As soon as any child was taken to the changing table at the nursery, Suzy would come over and watch intently as the diaper was being changed. No matter what she was doing, she never missed an opportunity to witness the whole procedure. Regardless of how involved she was in any activity, there always seemed to be some measure of attention focused on the changing table. In all other ways, in her interests and play, she seemed no different from any of the other children.

The first time this behavior was observed, a little boy about her own age was being changed after a bowel movement. He touched his penis and pulled at it during the process. Suzy, with her eyes riveted on the boy's genitals, pointed to his penis and then touched herself, through her diaper, in the genital area. She then began to wipe the area with a paper towel. Her mother took it away from her but Suzy quickly got another. On subsequent occasions when she watched a little boy being changed, she either tried to touch his penis or pointed to it and then either touched her genital area if fully clothed or her genital directly if she were being changed and was exposed. Her mother always tried to stop her by taking away the towel with which she wiped herself, or by removing her hands from her genitals when she began to masturbate, or by placing her on the toilet when she clutched her genital area, apparently assuming that Suzy had to urinate.

During this same period, when a little girl was being changed, Suzy would watch intently but without pointing or making any effort to touch the genitals of the little girl. Then she would clutch her backside. This difference in behavior in response to observing the anatomical difference between the sexes

persisted without variation over a period of several months. Her consistent tendency to clutch her backside whenever she saw a little girl exposed was interpreted as an incipient denial of the anatomical difference between the sexes by way of displacement to the rear.

When Suzy was seventeen months old, she began to lift her skirt and giggle excitedly. During this same period she often made an effort to lift the skirts of the women in the nursery, never the little girls, and tried to peer under their dresses. She did the same at home to her mother who became quite upset by this behavior. It was only at this point that we learned that Suzy had been showering regularly either with her father or her mother since the age of twelve or thirteen months. We were unable to learn whether she had ever made any effort to touch her father's penis or to explore her mother's pubic area. However, her intense curiosity about the genital anatomy of adult women, betrayed by her persistent effort to look under their skirts, probably reflected perplexity from having seen pubic hair. The difference between her genital and her mother's may have raised the question of whether her mother had a penis hidden somewhere. Her mother, apparently with some appreciation of the relationship between Suzy's recent sexual curiosity and the experience of exposure, discontinued the joint showers.

When Suzy began showering with her parents, she also started to hold food in her mouth for a long time when she was fed. Her cheeks puffed, she would hold the food in her mouth in spite of her mother's mounting irritation. So long as her little daughter was passive, compliant, and showed off well, the mother was able to read her cues and provide for her needs. However, when Suzy developed a will of her own and seemed to react to the narcissistic insult from having observed the anatomical difference between the sexes, discord developed between mother and daughter. We speculate that some of this behavior was related to a fantasy of acquiring a penis by eating one.

It would seem that the intensity of Suzy's sexual curiosity was stimulated by early and repetitive exposure to her nude parents. However, the timing of the appearance of Suzy's sexual curiosity and her behavior are common to all of the children we have studied thus far, no matter what their experiences have been. Moreover, the behavior of Suzy's parents, while perhaps different in degree, is by no means different in kind from that observed in most families we have studied, regardless of social, economic, or cultural differences. While the number of families (thirty-five) in our research is too limited to make any general inference, we are struck by how common it is for parents of children of this age to expose themselves before their children.

Before proceeding with the further vicissitudes of Suzy's sexual attitudes and behavior, let us review the history of her toilet training. From the age of eight months, she had been placed on the toilet by her mother after breakfast and lunch without much success. The family word for urination was 'tee-tee' and for bowel movements, 'blinkie'. (This unusual word was derived from the parents' observation that Suzy would blink her eyes when she had a bowel movement.) By the age of seventeen months, she was already using these words either in an anticipatory fashion or to indicate that she had wet or soiled herself. When she used the toilet, her parents would applaud, make a big fuss, and wave bye-bye to the bowel movement. Over a period of a month she attained reasonably reliable sphincter control, particularly over her bowel movements.

At eighteen to nineteen months of age, after some six weeks of established toilet control, Suzy developed an interesting confusion in language concerning toilet activities. She began to say 'blinkies' when her diaper was wet or when she held her genital area, usually a signal that she had to urinate. At other times she would lift her skirt in front in an exhibitionistic manner and say 'hiny', a word which she had consistently used earlier to refer to her backside.

This behavior of Suzy's should be viewed against the background of our observations of how children learn to name the parts of the body. In our experience with thirty-five children and their families, all the boys by the age of eighteen to nineteen months have been told the words for the penis and the backside, for urination and bowel movements. Up through the second year none of the boys have been given a term for the scrotum or testes although by this time most of them show some interest in these body parts (*cf.*, Bell, 1961). The girls, while they have been given separate and distinct names for toilet functions and for the backside, have not been given any discrete word for their genitals. After their little girls have shown intense sexual curiosity, a few mothers have given them a word for their genitals.[1]

To return to Suzy's sexual curiosity and behavior, let us consider the developing confusion over body parts and functions that arose when she was seventeen months. It will be recalled that Suzy had taken every opportunity to observe children being changed and had manifested consistently different behavior when seeing little boys and little girls exposed. With boys she pointed to or attempted to grasp the penis and would then hold her own genitals. When she observed a girl, she did not point or touch, but would clutch her own backside. This behavior reflected her observations of the anatomical difference between the sexes. She also displayed intense curiosity about the genital anatomy of adult women by attempting to peer under their dresses. During this period and up to the age of nineteen months, there was progressively more intense sexual activity and exploration on Suzy's part. In the bath or on the changing table she would engage in genital masturbation. Whenever she saw her mother's breasts, she would touch them and was often seen touching or pulling her own nipples.

[1] We believe that to omit naming such an important part of the body reflects a cultural manifestation of the castration complex. It suggests how early and how fundamentally cultural attitudes toward little boys and girls diverge (*cf.*, Abraham, 1911).

In the nursery, Suzy would often undress the dolls, scrutinize the area between their legs, and then say 'hiny'. This doll play became increasingly elaborate: she would pretend to shower the doll, place her on the toilet to have a bowel movement, wipe her, and then wash her hands. Her play reflected the underlying bodily concerns that Suzy was struggling with at this time.

At nineteen months, there was an abrupt cessation of most of the sexual activity described above. She no longer went to the changing table to watch the other children while they were exposed. She no longer made any effort to peer under women's skirts. All of her genital masturbatory activity stopped. The only behavioral remnant, which was probably a derivative of the earlier sexual interest, was a persistent tendency to touch her mother's backside and breasts as well as her own.

As we have seen, some two months earlier there began some confusion about naming body parts and functions—she would say 'blinkies', her word for bowel movement, when she was already wet or had to urinate; when she lifted her skirt and held her genital area, she would at times say 'hiny', her word for her backside. At nineteen months, this was no longer an intermittent practice; it became her consistent behavior. The word for urination entirely dropped out of her vocabulary. When she used the toilet to urinate, she wiped her backside. Earlier, when she wished to refer to her genitals, she would use the functional name, 'tee-tee'; now she always referred to it as her 'hiny'. During this time she developed a mild anxiety when the toilet flushed. This anxiety varied in intensity over the ensuing months. She also developed transient and shifting fears of birds, dogs, horses, and other animals. From time to time she would be seen scrutinizing her finger or leg with some apprehension, dolefully saying 'boo-boo', her word for a cut or sore, when as a rule no sign of injury was apparent.

When Suzy was almost twenty months old, a little boy her own age spent the day with his mother at her house. She followed him into the bathroom when he went to urinate. She

reached out to touch his penis and said 'pee-pee', a word never used before by her or her mother to refer to either the penis or urination. For several days after this experience all the earlier sexual behavior—for instance, going to the changing table, touching her own genitals and masturbating, lifting skirts, etc.—flared up again but in a short while disappeared. On three other occasions over the next several months when a boy visited and she had the opportunity to witness him urinating, this behavior reappeared.

It is an unfortunate limitation of the observational method that children so young have limited verbal capacity. Accordingly, the meaning of such an intriguing detail of behavior as Suzy's consistent tendency whenever she saw a little boy's penis exposed to either point or reach out to touch it, must remain open to question. Perhaps this behavior reflects some shocklike response to the perception of the anatomical difference between the sexes (*cf.*, Greenacre, 1956) with some effort to establish through touch that the penis is real, or it may already betray a partially inhibited aggressive impulse to take the penis.

It is possible, we feel, that both interpretations may be true. Suzy's persistent need to repeat the observation of the penis over and over again in a relatively unvarying manner suggests that she reacted to the sight of the penis in a traumatic fashion. The repetitiveness seems to point to a need to establish the reality of the percept. The tendency to touch the penis suggests an effort to re-enforce the visual perception by using a more primitive perceptual modality. That this same behavior may also serve the fantasy of aggressively grasping and acquiring the penis seems equally probable and entirely in keeping with the principle of multiple determination of behavior. In a similar fashion, clutching the backside when she saw a little girl's genitals, referring to her genitals as a 'hiny', dropping the word for urination and subsequently using the word for a bowel movement to signal urinary urgency, all seem to point

to a profound denial of genital difference. At the same time, this behavior seems to signify an incipient restitutive fantasy along the lines of the well-known stool = penis equation. In any event, it seems likely that this wide array of behavioral phenomena reflects a fairly severe castration reaction. This interpretation of Suzy's development is supported by the development of fear of the flush of the toilet, fear of animals, and her scrutinizing her body for cuts and wounds.[2]

By the time Suzy was twenty months of age, there was a complete deterioration of her toilet control, which persisted over the next few months. Her mother's irritation over this lapse in control was considerable. It seems to us that this deterioration of toilet control was a direct outcome of castration anxiety. Confirmation of the castration concern was seen in Suzy's statement to her mother, 'Michael has a pee-pee. I have no pee-pee. Why?'

This case, as well as several others we have studied, illustrates how bowel and bladder control in the second year may break down as a consequence of castration anxiety. Along these lines, it is our impression that the constipation which tends to develop at the end of the second year and many cases of intractable enuresis may be related to castration anxiety developing in the second half of the second year.

One of the unexpected findings of our research is that the whole process of toilet training is subject to the influence of the 'minor' castration insults, such as a child of this age may quite readily come by in the ordinary course of events. For example, a little boy sees his mother exposed and is constipated for several days; a little girl whose bladder control has been reasonably reliable for some time sees a boy urinate and begins to wet for about a week. We have been accustomed to thinking about the training situation as something which the child does for

[2] Apropos of the fear of the flush of the toilet, we note that in earlier papers (Roiphe, 1968, 1970; Roiphe and Galenson, 1970) we suggested that castration anxiety which is encountered during this period of development has some connection with earlier anxieties concerning body dissolution and object loss.

the parents. Thus we interpret the training experience too rigidly in terms of the struggle for independence that is characteristic of this phase of development. We wish to add that the vicissitudes of the child's sexual interests, curiosity, and activity, also typical of this period, appear to have an influence upon the whole training process and may be at the center of some of the psychopathology that perhaps begins at this time.

Following the deterioration of Suzy's control of her bowels and bladder there was a profound general behavioral regression and negativism. When she came to the nursery, she would refuse to get out of her stroller. She would sit there for a considerable time in a sullen and distressed state. She would not permit her mother or the nursery teacher to remove her jacket. She would scream if any of the children tried to touch her. When she was finally coaxed out of her stroller, she stayed close to her mother. If her mother were momentarily out of sight, Suzy would panic and could not be reassured until her mother picked her up and comforted her. This, indeed, was a contrast to the confident, competent, cheerful little girl of only a few months before, who would come into the nursery eager and smiling and seek out children or adults quite independently of her mother. Her earlier play with dolls rapidly became constricted and all but disappeared. Suzy's mother became perplexed, frustrated, and angry. She seemed quite unsympathetic and responded sharply and harshly to Suzy's negativism and clinging.

Thus we see that in this child the process of sexual arousal and the discovery of the anatomical difference between the sexes produced a castration reaction which affected her psychic development. Her overwhelming anger and disappointment with her mother are reflected in the almost paralyzing hostile dependence that developed toward the mother. Suzy clung to her mother and demonstrated a sullen mistrust of other adults and children. Such a development does not augur well for the developing individuation thrust appropriate for this age. These developments are in accord with Mahler's (1966) ideas about the

particular vulnerability of the child at this time. The characteristic ambivalence of the child toward the mother, which is aggravated by castration anxiety, seems to call forth an early defense mechanism of splitting the good and bad mother images and of turning of aggression against the self.

Concurrent with the undermining of the child's developing object relations is the indication of an interference with and weakening of several aspects of the maturing ego functioning. Most dramatic was the pervasive inhibition of Suzy's curiosity in general and of her sexual curiosity in particular; parallel with this was a marked inhibition and regressive deterioration of play. An outstanding effect of Suzy's castration anxiety was a loss in self-esteem and the emergence of a depressive mood.

Mahler (1966, 1967) has described the period from about fifteen to twenty-two months, the so-called rapprochement subphase, as a period of particular vulnerability. This is a time when the child's self-esteem may suffer abrupt deflation. The collapse of the child's belief in his omnipotence, together with an uncertainty about the availability of the mother, tends to foster a hostile dependency. Mahler also states that in a number of presumably normal mother-toddler relationships, rapprochement occurs with conspicuous drama and may even constitute a crisis in the relationship. When both timing and behavioral indications are taken into consideration, Suzy seemed to show just such a crisis in her relationship to her mother. It is interesting that in this case, as well as several others we have studied, it is the mobilization of castration anxiety that seems to precipitate the so-called rapprochement crisis. It would be worth while to investigate the question of whether there is any regular relationship between the castration reactions, such as we have described, occurring during the second year of life and Mahler's rapprochement crisis.

SUMMARY

This paper, one of a series of reports on the findings of an investigation of sexual development in the second year of life,

examines systematically a set of hypotheses which had been developed by Roiphe earlier. 1. All children between the ages of fifteen and twenty-four months normally show evidence of a sexual arousal as indicated by a sharp increase in the manipulation of the genitals, including frank masturbatory activity; they also show evidence of sexual curiosity, particularly about the anatomical difference between the sexes. 2. Children in the second year of life who have already experienced such sexual arousal and who have had the occasion to observe the difference between the sexes will develop distinct castration reactions provided there have been earlier experiences which tend to produce an unstable body image or experiences which tend to result in an unstable object representation.

In the present paper longitudinal data on one of the children studied are presented in detail in order to illustrate the typical behavioral phenomena of early sexual arousal and moderately severe castration reaction. It should be emphasized that this early sexual development is involved with the consolidation of the body-self schematization and developing object representation and does not, as far as we can determine, have any relation to typical œdipal wishes.

The emergence of the castration complex in this little girl, as with several others in our research, had fateful implications for some of the major developmental currents during the second year of life. It resulted in a far-reaching inhibition of both sexual and general curiosity, marked constriction in play, and symbolic confusion regarding anatomical parts and functions. There was an intensification of ambivalence toward the mother. Anxiety about separation from the mother increased and self-esteem and mood were markedly depressed.

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Silence: A Clinical Exploration

Peter Blos Jr.

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SILENCE: A CLINICAL EXPLORATION

BY PETER BLOS, JR., M. D. (ANN ARBOR, MICHIGAN)

The term silence is applied to at least three separate phenomena which occur in the psychoanalytic hour. There is the silence of the analyst; the listening attitude in which he gives his attention to the patient. The silence of the patient may occur in two circumstances: when the patient is receptive to what the analyst is saying as he offers a comment or interpretation, i.e., receptive to outer stimuli, or when some internal psychic stimuli has interrupted or halted the flow of the patient's verbal material. If both the patient *and* the analyst have inhibited speech, each for his own reason, then both are silent, in a silent room. As Balint (1958) has stressed, silence is a phenomenon that occurs between two people. Theodor Reik (1968) carries this idea further when he discusses the antinomic relationship between speech and silence, and observes that we can have 'meaningless speech and meaningful silence'.

The thesis of this paper is that silence in the therapeutic relationship is an analyzable phenomenon involving an abundance of feelings, fantasies, and even long forgotten, affect-laden events, and that the analyst's internal reaction to the palpable quality of the silence is of great assistance in understanding some aspects of the repressed material. In this formulation, silence can also express various underlying psychic forces. As Loewenstein (1956) suggests, we must put into words the fantasies which live behind these silent events in order to facilitate communication, reality testing, clarity, and, above all, psychic growth.

Depending upon whose silence is the focus of the author's attention, the psychoanalytic and psychiatric literature falls into two natural divisions.

An early version of this paper was presented to the Department of Psychiatry, St. Louis University, St. Louis, Missouri, on April 14, 1970.

1. The role and meaning of the therapist's silence. Pressman (1961a, 1961b) and Zeligs (1961) both stress that the analyst's silence differs from that of the patient, that is to say, the operational baseline is the analyst-as-listener and the patient-as-talker. Pressman (1961b) goes on to assess the dynamic effects of the analyst's silence and the meaning of this silence to the patient.

2. The role and meaning of the patient's silence. This subject has been more intensively studied, perhaps because the patient's silence arouses feelings in the analyst of anger, self-reproach, or frustration which interfere with the analytic work. Several approaches have been used by different authors: (a) phenomenological and descriptive studies of silence; (b) silence as a communication, in which the concept of acting out is central; (c) the symbolism of silence; (d) dynamic and motivational aspects of silence; (e) silence as a sociocultural phenomenon.

By phenomenological and descriptive studies I mean papers such as one by Weisman (1955) in which he states:

> A patient's silence should be given as much attention as his words. Silence is not necessarily an enigmatic interruption of the flow of communication but an integral part of the psychotherapeutic process. It can occur at specific moments in accordance with well-defined psychodynamic principles. Silence has a meaning of its own which supplements speech. Its motives can be clarified and several kinds of silence can be clinically differentiated.

Weisman goes on to discuss the clinical characteristics of silence and describes variations in onset, periodicity, precipitants, and terminations of silent periods. He presents cases in which silence and withdrawal have, since childhood, been useful means of adaptation to emotional stress. Weisman reduces to three the principle areas of stress and identifies them as: '(a) the threat of positive feelings which led to withdrawal from stimulating situations; (b) the fear of separation, annihilation, or domination; and (c) the conflict over oral masochistic

impulses'. In each of these circumstances, protection or provocation will be found to be the fundamental underlying motivation.

Also essentially descriptive is a paper by Jarrett (1966). He studies silence in psychiatric interviews and lists a number of reasons that might cause the patient to become silent. Technical suggestions as to what the therapist might say in some of these situations are offered. Jarrett's central point is that since silence is inevitable, it is appropriate to ask if it is useful and, if not, should we try to prevent it. The answer, he feels, lies in the meaning of the particular instance of silence as seen by both the patient and the therapist: it could be either a help or a hindrance to therapeutic work.

Silence as a form of communication was discussed by Zeligs (1961) as part of a panel discussion on the silent patient. He examined the phenomenon in terms of ego psychology. As one example of silence as communication, he presented a clinical vignette in which the patient's silence was an acting out within the context of an analysis of a traumatic life experience.

Khan (1963) has described an analytic case in which the silence of the patient, an eighteen-year-old boy, was a vital communication to the therapist. Here again, the silence could be seen as an acting out. What makes Khan's example particularly interesting is that it was by experiencing the patient's silence, and observing his own inner reactions to it, that the analyst was able to understand a traumatic experience which the patient was not able to put into words: 'I [Khan] was the child, Peter, and he was the other person from the original childhood situation'. This paper is especially valuable because the analyst presents to us his own feelings and reactions to the silent patient as they develop. Khan tells us in detail the way in which he then could use these self-perceptions to understand the patient's otherwise perplexing behavior.[1]

Symbolically silence has often been equated with death.

[1] Greenson (1961) speaks of a similar phenomenon when he notes that silence may be the result of identification with a silent person.

'The rest is silence', Horatio says in announcing Hamlet's death to the court. An interesting sidelight is that students of the theater have debated whether the word *silence* was meant to be spoken or taken as a stage direction. Thus: 'The rest is silence', or 'The rest is—' (Silence).

Silence has also been studied from the dynamic point of view. Fliess (1949) related certain patterns and styles of speech to psychosexual levels of development, and went on to offer clinical examples which demonstrated that silence could be considered in the same manner. Within this framework he finds oral, anal, urethral, and phallic silences and notes that their aims are determined by the level of development. This is a shorthand commentary which implies that silence, like speech, has a drive discharge function.[2]

In my opinion, Baker (1948) makes a similar mistake in his discussion of 'two main forms of inter-personal silence: (a) silence characterized by psychic equilibrium and reciprocal identification between parties, [in other words, a close and comfortable companionship] and (b) a tense silence characterized by acute psychic disequilibrium and nonidentification between the situational partners'. He goes on to say that 'the unconscious aim behind all speech is silence. The silence we try to achieve is one of complete psychic equilibrium of agreement, contentment, and tranquility.' There is a confusion here between the aim of the silence and the aim of the underlying fantasy. In addition, this proposition is reductionistic to a degree that obscures the richness and range of meaning with which the phenomenon of silence can be endowed. Common language usage demonstrates that there is more to silence than unity and tranquility. We speak of silence as pregnant, cold, warm, stony, ominous, empty, tense, and so on. Again we can say that these figures of speech reflect the affective quality of the unspoken content of the particular silence.

Arlow (1961) goes further in his discussion and shows

[2] Arlow (1961) notes that such characterizing of silence is incorrect since these qualities are in fact a property of the underlying unconscious fantasy, not the silence.

how, on the basis of the topographical theory, silence has to be viewed as a resistance just as speech has to be seen as discharge. It was only with the advent of the structural hypothesis, he notes, that it became possible to be aware of the manifold meanings of silence. Arlow divides the silences of the analysand into two groups, according to the dominant function served by the silence. The alternatives are the function of defense or the function of discharge. He stresses that there is considerable overlapping and that discharge is related not only to the id but also to the superego.

Pressman (1961a) also proposes a classification of silence based on the structural hypothesis. He divides the patient's silences into ego, superego, and id categories. In the latter, the id wish may be derived from the oral, anal, or phallic levels.

Sociocultural aspects of silence are suggested by White, et al. (1964) in their study of the occurrence of silence in psychiatric interviews of clinic patients. Among other things, the results indicated that in the lower class patient silence may indicate conscious suppression of verbalization as opposed to unconscious repression. White further suggests that because these patients are unfamiliar with interview procedures, they approach the situation with an expectation best characterized by the old adage: 'Do not speak until spoken to'. This, I believe, is an example of silence as a culturally determined phenomenon which, if misunderstood by doctor or patient, can lead to an early rupture in treatment. This is not to say that psychic determinants do not play a role, but that cultural aspects must be dealt with also. There is a similarity here to other cultural phenomena, such as how far people stand apart from one another while conversing, the use of eye and facial movements, and the style and frequency of physical contact.

Thus, silence occurring in psychotherapy can be approached in various ways. Rather than treating silence as a hindrance or obstacle to obtaining verbal material, the study of a silent period can reveal a great deal about a patient. The various ways in which authors have approached this problem show us

that there are indeed many layers of understanding. Each layer has something to contribute to our understanding of a particular event and patient. In other words, silence is an overdetermined event governed by the principle of multiple functioning (Waelder, 1936).

CLINICAL EXAMPLES

My first case demonstrates the effect of the therapist's silence on the patient and how it can be used by the patient.

I

Mrs. Z was in the fourth year of her analysis and had just returned from a week's sailing trip. The first hour was filled with complaints about constipation, bad sunburn, inadequate medicines, and poor food. It was interpreted as a defensive reaction to having gone away. In effect, I commented that she was saying, 'See, I know I broke the rules by going away. But I didn't even have a good time, so don't be mad at me.' She acknowledged this and then went on to talk with much greater zest and spontaneity about the trip and its pleasures. She described how one night she had slept alone on the deck of the boat under the stars, and how beautiful it had been. Suddenly she interrupted herself, paused, and reported in a low, sad voice that she felt she had said too much. She then fell silent. After a few minutes I asked her what had happened. She answered that during her description she had suddenly become aware of my silence and experienced it as rebuff; that I, her doctor, did not understand and was not interested.

Descriptively, then, the patient had manifestly experienced my silence as a rejection. Reacting to this perception she had interrupted herself and withdrawn before I might laugh at her enthusiasm and hurt her. To substantiate this interpretation, she later recalled that her parents often met her enthusiasm with uncomprehending silence as well as with devaluing comments and ridicule. It now appeared that my silence was

like a blank screen upon which the patient projected a transference reaction.

When this patient's verbalizations are considered with the dynamics, we find that she unconsciously used my silence in a defensive maneuver. In the course of her rapturous description of the night when she lay alone under the stars, a thought about me had almost entered her consciousness. My silence then entered her awareness and replaced her thoughts about me as an object. This kept her from any awareness of her sexual feelings for me and her disappointment at my unavailability. Consciously she perceived my silence as a disapproving, withholding act; her awareness of my silence was all that remained of her unconscious transference wish.

In this example the silent interval allowed the patient time in which to withdraw and to get her emotions under control. From her history and from her analysis we knew how important control was for her, especially in the area of sexuality, and how dangerous and threatening too much stimulation could be. As a communication the silence said, 'hands off'.

Following Khan (1963), it is appropriate to report the course of my response to this episode. I had, in fact, been listening with interest to the patient's vivid description of the night under the stars and it had stimulated the recall of a similar pleasant experience of mine. Her abrupt lapse into silence rudely interrupted this mood and I felt annoyed, all the more so because to me her accusation was unrealistic and unjustified. Her silence, then, had provoked my taking a mental step away from her. All of this was transitory and none of it had escaped into the verbal analytic situation. Nevertheless, it gave me a new and useful clue about how this patient ambivalently kept men at a distance, which had been one of her primary complaints at the start of treatment.

A patient's silence as an expression of his character and how differently the analyst's silence may be used is illustrated in the following example.

II

Mr. A, a journalist, has been in analysis about four and a half years. Silence on the part of the patient has been a frequent and dramatic occurrence. Usually he talks clearly at the beginning of the hour, but slowly the rate and volume of his speech decreases until he is totally silent. If, after some minutes he does not resume talking and I ask what has happened, he answers that he thought he was still talking but guesses it had just gone on inside his head. There is something quite provocative about this since the silence comes just at the point when my interest or curiosity is aroused, and then I am left dangling. Thus he seems to challenge me to pursue or nag him with words, which consciously he professes to hate. Somehow the patient expects me to follow him into his mind: to know what he is thinking without his having to make the effort to verbalize it. To put it another way, I am to force him to speak by penetrating his mind; in effect, administer a mental enema. (It is relevant to note that there is a history of much use of enemas in childhood.) On other occasions Mr. A will wait in silence for me to say something. Further investigation revealed that for him to ask something of me by direct appeal vitiates the validity of the response and the interest shown in him, as if to say, 'If you really cared you would know what I wanted without my having to ask it'. From other material brought out in his analysis it is apparent that this man desires to be understood without words, and yet, interestingly enough, he is a writer who wishes the world to listen to his words.

Descriptively, Mr. A uses silence to negate words; silence expresses his longing and fantasy for union where words are unnecessary. Words are intrusive and also emphasize separateness. In terms of communication, the silence is an acting out of an earlier time when life was good and union with the object was felt as possible. Since it is also an identification with a mother who had been silent at a critical time, the patient's silence is a re-enactment through which he can communicate to me what it is like to be met by silence.

Symbolically for this patient, the silence seems to represent 'refueling' or an opportunity to do so. On his way to the door after a long silent hour, Mr. A will mumble, 'Thank you'. As Arlow (1961) has stated, silence is the negative of the unconscious fantasy. It has the magical power of infusing strength whereas words, in this man's profession, are endowed with magic powers, at times phallic and at other times anal.

To press this patient to speak would be unwise therapeutically as well as unsuccessful. I know this because I tried, and failed. As I came to understand Mr. A better I realized that urging him to talk, however subtly, represented a penetrating anal attack, as well as a seduction. It proved more useful to invite him to engage in a search for what was being communicated by his lapses into silence. Only then did he feel unchallenged and that he would not be punished for disobeying the analytic rule of verbalization. His attitude reflected itself in my becoming aware of feeling less threatened, less thwarted, and, consequently, less angry at him. What was most difficult for me thereafter was to learn to stay with the patient emotionally and not let my mind wander to personal and other matters.

Parenthetically it is noteworthy that although it was precisely this 'wandering' that proved useful in listening to Mrs. Z's sailing experience and has been of help in other situations, the meaning of Mr. A's silence was different and imposed different demands upon me. The importance of the analyst's ability to shift and vary his attitudes is not new and has been raised with respect to understanding the patient's verbalizations. Here the idea is extended to the understanding and the analysis of silence.

The next example is taken from work done with a nine-year-old boy whom I saw six or seven times on a once-a-week basis.

III

George's main symptom was an excessive and restrictive need for his mother's presence. In the hour before the one to be

reported, George had informed me that his parents were going away on a week's trip. He was sad and openly acknowledged some anxiety. He feared that his older brother's sadistic teasing would get worse without his mother's protection. By unfortunate coincidence I was to be away the same week, and when I informed him of this he became visibly upset but said little about his feelings.

The next hour was the last one before his parents' and my departure. As I was inviting him into the office his mother told me that as soon as they had entered the waiting room he had felt sick and thought that he was going to vomit. When he came into the office George smiled wanly, and his characteristically strained facial expression was more tight than usual. He sat down and told me he was sure he was going to throw up. He vaguely mentioned something about an upset stomach but went on to talk of his mother's impending trip. I suggested that his nausea might be related to his feelings about this event. He weakly nodded, looked sicker, and went to the bathroom, expecting to vomit. He did not do so, however, and after several minutes we returned to the office. He then asked if his mother could come in, saying that he would feel more comfortable. (I might add here that he had insisted that his mother be present at several sessions after he had experienced the first interview alone.)

The mother was surprised at the invitation but came into the office. Thereupon, George plumped himself down in a big easy chair cater-cornered to where his mother sat and said not a word. Minutes passed and his mother began to fidget. After a while I asked him what we should talk about and he quietly informed me that he had nothing to say. More silence. George giggled and smiled enigmatically at his mother who was getting visibly more upset. Finally, I asked how he thought his mother was reacting to his silence. He guessed she was uncomfortable. I then asked her how she felt. She felt awful, she replied, and confessed to a great urge to encourage, cajole, or in some way get George to speak. It would be for his

own good, she added. At this point George spontaneously acknowledged that his silence might be a way to hurt his mother as revenge for going away. Nevertheless, he still felt he did not have anything to say. Later he began to speak a bit more freely and reported that when he did not talk his nausea decreased and when he spoke, it got worse. So, it seemed, we could suffer with his silence or with his vomit. The hour ended with his telling us that at home he would sometimes hide, in silence, in a dark place. Like today, it was when he was mad and sad.

Clearly, by his silence George was inflicting pain on his mother in revenge for her going away. He was giving her the well-known 'silent treatment'. The hostility and the sadistic pleasure were evident. Yet at the same time he was evoking an old nonverbal pattern which would arouse his mother's attention, albeit in a nagging, cajoling manner; in his desperation, he was holding on to mother. It is interesting to note that George's silence had a similar effect upon me. I too felt impelled to question, push, and prod. At times the strain and discomfort were so great I found it difficult to resist the urge to look at the clock to see when this hour would end. George had managed to evoke in me the feeling which he feared most: the wish to get rid of him! I could now better understand how George and his mother were bound together in a vicious circle.

In this case the anal, tight, withholding qualities are self-evident. The impulse to mess, to cause trouble, to destroy, is displaced upward in the intestinal tract and experienced as the urge to vomit. The rage is no longer expressible in speech but displaced into the body. Only silence allowed this boy the parsimonious solution of both the control of the forbidden impulse and its disguised expression. The punitive superego was also satisfied since the silence stimulated the punishment of abandonment. Silence here became a symptom in the classical sense.

Was it also a communication as in Khan's case? Was I the

boy and he the silent, unresponsive adult present in early childhood? Was George identifying with his silent, dead father? These questions must be left unanswered since only through further therapeutic work will clarification come.

The following final example highlights the use of silence as communication.

IV

Jean was seventeen and just finishing her senior year in high school. In addition to some academic difficulties, her favorite person, her maternal grandmother, had just died of a malignancy and there was a longstanding estrangement from her parents. One afternoon, after meeting three times weekly for about four months, she was telling me about one of her teachers who, rumor had it, could not have children. Jean wanted to talk to the teacher about this but was afraid of being rebuffed. She then fell silent. After about fifteen minutes I interrupted her silence to ask what her thoughts had been. She slowly came back from her self-absorbed state and reported two thoughts. 1, She had been thinking of having her own apartment in the city and that if she did, she would still spend some time with her parents. 2, A girl friend had offered her brother as a roommate for my patient and jokingly suggested that they could have an affair. Jean then went on to talk of her wish to have a new affair (a brief one had taken place over the past summer).

At this point I directed her attention to the moment at which she had fallen silent, saying that we had been talking about reaching out and being rebuffed. I asked her if she had ever experienced any rebuff by silence. Jean responded to this by becoming more lively and outer-directed. She told of two instances in which attempts to reach out to her mother had been met by what she called 'nonreaction' and how hurt and angry she had been. We were back on the track of verbal communication again.

I think it would be of interest here to report what went on in my mind during the silence. At first I thought that Jean was just pausing before going on with the theme which she had been developing. However, looking at her made it clear that she had withdrawn into herself. I noted that her gaze had shifted from me and the room to her own lap. I continued to watch her, wondering as I did so what had triggered the withdrawal and hoping she would spontaneously begin to tell me what she had been thinking about during the withdrawn silence. But time passed and a contemplative smile crossed her face. I was mystified. I began to feel that something interesting was going on and I was being left out. *I* was beginning to feel rebuffed and ignored. My mind began to wander. It was at this point that I intervened by asking Jean what her thoughts were, and received the not particularly revealing comments about apartments, affairs, boy friends. Only when I linked the silent period with the content preceding it, were the memories of her mother's disappointing responses recalled.

Had I felt as Jean had—disappointed, rebuffed, left out? Was this involved also in her hesitancy to speak to her teacher? It occurred to me that Jean, by acting out an event, had managed to make me experience an important feeling which she could not yet put into words. Thus my suggestions had, in part, been stimulated by my own subjective experience and in part by my treating the silence as an association to the immediately preceding idea of being rebuffed.

We could now begin to work with fantasies related to the theme of rebuff and retaliation. In structural terms Jean's observing ego had withdrawn its cathexis from the outer world. This occurred as a result of the stimulus of the 'reaching out-rebuff' constellation which had been nuclear and traumatic in her life. A retreat into a private fantasy life or a temporary narcissistic withdrawal was the result. The silence was also an identification with the aggressor, her mother, who had so often been unresponsive. Finally, Jean's strict superego was evident in her silence. The enigmatic space—like that which

occurs in a censored letter—contained the rage and disappointment at her mother's insensitivity.

Too often what is valued in interviews is the verbal content, the historical facts, and the open affective display. Frustration at not getting such information leads us to prematurely label the silent patient as hostile, uncoöperative, or, at best, resisting. Much of this is projection and unfortunately inhibits us from trying to understand the silent episode in terms of what it can tell us about the patient.

The silent period is filled with pitfalls. Two common errors ought to be mentioned. One is what Glover (1955) has called 'the pugilistic encounter'. This occurs when the therapist counters the patient's silence with his own silence in an attempt to force the patient to speak. Another error is the urge to nag the patient to speak—'what are you thinking now?'—or to pull words from the patient as in asking questions. I believe these and other pitfalls can be avoided if we and our patients study silence rather than attempt to fill it with words. At times I have invited a patient to join the research as a partner in order to understand his own silent episodes which, it turns out, are often an enigma to the patient.

It is necessary to note that silence on the part of the therapist is also a significant occurrence and can be a powerful force. For example, for the therapist to be silent at the wrong time can be a devastating event for the patient. Conversely, to be silent at the right time can be perceived as a great gift of understanding and compassion. At times we may have to sanction a patient's silence about certain matters until sufficient ego strength has been mustered.

It is important to recognize our own aversion to long silent periods. Undeniably they are a strain. And so, when silence is prolonged beyond a certain subjectively experienced point, there is a tendency to fill the void with our own thoughts and personal preoccupations. We then lose touch with the patient. Furthermore, as Greenson (1961) has observed, how we feel

about a silent period can be transmitted by nonverbal means. The sensitive patient astutely picks up such clues.

SUMMARY

Silence is a ubiquitous phenomenon in all psychotherapy. There are varied reasons for silence and a particular silent episode has many facets. Hence if we allow ourselves to become preoccupied with the idea of silence only as resistance, we forfeit the opportunity to examine important nuances of a silent period. In the analyses of two adults and in the psychotherapy of an adolescent and a child, periods of silence, the patients' associations prior to the silence, and the analyst's reaction to the silence, were useful in identifying fantasies and other repressed material.

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On the Presence of a Variant Form of Instinctual Regression

Stanley Friedman

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ON THE PRESENCE OF A VARIANT FORM OF INSTINCTUAL REGRESSION

ORAL DRIVE CYCLES IN OBESITY-BULIMIA

BY STANLEY FRIEDMAN, M.D. (NEW YORK)

INTRODUCTION: PURPOSE OF STUDY

In recent years a new dimension has been added to sleep-dream research. A hypothesis has gradually developed that the so-called sleep-dream cycle is part of a basic biological ultradian cycle of 90-100 minutes in duration, potentially observable during wakefulness as well as during sleep (Friedman, 1968; Friedman and Fisher, 1967; Globus, 1966; E. Hartmann, 1968; Kleitman, 1963, 1969, 1970; Kleitman and Engelmann, 1953). Kleitman (1963) was the first to speculate about such a basic cycle, stating that 'the basic rest-activity periodicity which appears in . . . sleep as a series of dreaming episodes may also manifest itself in the . . . wakefulness phase of the 24-hour rhythm in recurrent fluctuations in alertness' (p. 365).

Despite the attractiveness of such a hypothesis, actual studies that could test it or provide relevant data have been few in number. West and his co-workers (1962) studied a sleep-deprived man. The resulting temporary psychosis contained a nighttime waxing and waning of symptoms 'perhaps in the range of 90 to 120 minutes . . . and very likely reflecting the same basic neurobiological . . . rhythm that underlies dreaming' (p. 69). Globus (1966) studied subjects who took many naps and noted that, while the time of sleep onset was markedly variable, the onset of the REM periods clustered around specific times, and statistically implied cycles of about 120 min-

From the Department of Psychiatry, The Mount Sinai School of Medicine of the City University of New York.

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utes. One possible explanation for these data was that the REM state occurs throughout the day and may be independent of sleep.

Friedman and Fisher (1967) approached the problem using a psychoanalytic model. Noting the relationship between the REM state and a state of instinctual activation, they speculated that the REM state is only the sleeping manifestation of a basic biological rhythm at least partly related to the organization of instinctual drives. Selecting the oral zone for observation, they made and tested the hypothesis that spontaneous oral activity should wax and wane in cycles similar in duration to the REM cycle. This hypothesis was supported statistically and the mean cycle duration was 96.4 minutes. It was proposed that the concept of a sleep-dream cycle be amended to that of a 24-hour cycle, at least partially related to instinctual drive accumulation and discharge.[1] A second study of oral activity cycles (Friedman, 1968), this one of mild chronic schizophrenics, also yielded cyclic oral activity of approximately the same duration as the REM cycle.

More recently, a few other studies have appeared that support the concept of a continuous 24-hour cycle. Oswald and his co-workers (1970) carried out a replication study of Friedman and Fisher's findings. Although their research techniques were slightly different, they obtained the same significant results and concluded that it seems 'probable that a one and a half hour cycle of oral events in waking life would be related . . . to the cycle of events that follow a similar periodicity within sleep . . . [and] would serve to illustrate how covert urges may shape our waking lives' (p. 960).

Other confirmatory studies have been made with abnormal subjects and with animals. Passouant and his co-workers (1968, 1969) observed narcoleptics around the clock. At least one

[1] Although it has not yet been 'proven' that the oral activity cycle is the daytime equivalent of the nocturnal REM cycle, the evidence linking the two can be characterized as 'highly suggestive'. Therefore, for purposes of descriptive convenience, terms describing the two cycles will be used interchangeably throughout the remainder of this paper.

subject showed REM intrusions in an approximate 100-minute cycle. Kripke, et al. (1970), using electrophysiological techniques, showed that rhesus monkeys had a diurnal cycle equivalent to their REM cycle in their muscle tone recordings.

Sterman and his co-workers (in press) carried out an operant conditioning study of oral and reward seeking behavior in cats. Four experiments were carried out in which the cat could signal for a reward of food or stimulation of reward centers in the lateral hypothalmus. In all four studies, such signals waxed and waned in a cyclic frequency that was similar in duration to the REM cycle of these cats when they slept.

Observations during the two original oral activity cycle studies (Friedman, 1968; Friedman and Fisher, 1967) raised some questions for further study. One finding was that of a waxing and waning of alertness and intellectual activity concurrent with the oral activity cycle and in agreement with Kleitman's (1963) proposal. Of equal interest were the findings that many common psychological 'tension states', such as boredom and anxiety, were accompanied by a tendency to have shorter cycles of oral activity. The cycles seemed to approach 60 minutes in duration instead of the approximately 90-minute cycles of normal subjects and chronic schizophrenic patients.

For example, one of the normal subjects in the first study (Friedman and Fisher, 1967) had his cycles measured from the time he awoke to a point where he had spent eight hours in laboratory isolation, a total of ten hours (Figure 1). His mean cycle duration for his first eight waking hours was about 105 minutes. At this point he produced three peaks of oral activity with mean cycle durations of 50 minutes. After the observation period, the subject stated that he had felt relaxed and comfortable for most of the period but that he had begun to feel bored and restless over the last two hours. A further attempt to observe this phenomenon was made one month later. The subject was observed a second time on the day before the beginning of his end-term examinations. He studied throughout his observation period and felt quite 'nervous', bored, and restless.

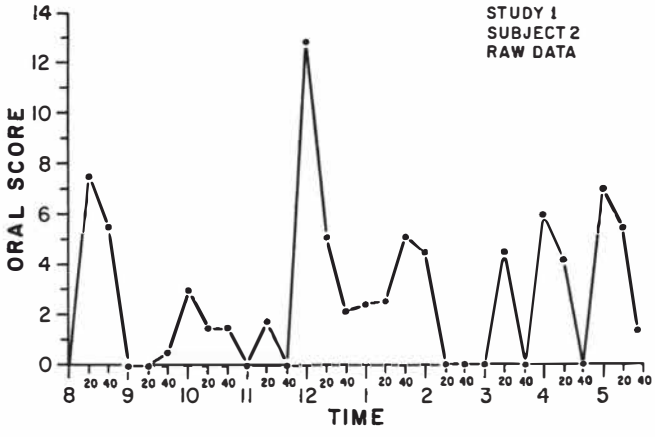

Figure 1

Raw data of normal subject who became bored and restless late in the observation period.

During this second period, the subject's oral activities increased by 14 per cent over the first period and his mean cycle duration was 63 minutes (Figure 2).

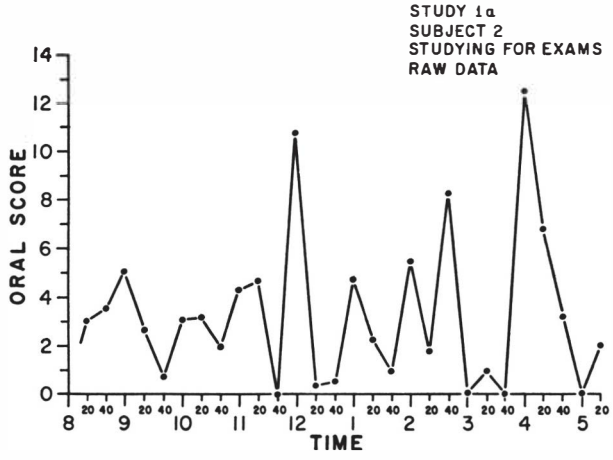

Figure 2

Same subject, studying for examinations.

Preliminary observations of other subjects yielded similar data. For example, one unstable schizophrenic subject[2] who subsequently had a severe catatonic collapse had irregular cycles with a mean duration of approximately 60 minutes. A mild, chronic schizophrenic woman had regular cycles of oral activity until late in the observation period (Figure 3). She then had an attack of panic anxiety at 1:40 P.M. followed by a peak of oral activity at 2:10 P.M. that yielded a short (60 minute) cycle. After the observation period, she spontaneously told the writer about an increasing boredom that led to the panic attack and an urge to smoke and eat to help control the anxiety. One other type of preliminary observation yielded similar data. A REM-deprived subject had shorter cycles than he had during his control days.

The possible significance of stress-related shorter cycles of oral activity was considered. The original hypothesis of an 80-120 minute oral drive cycle in normal adults was made on the assumption that there is a daytime continuation of the nocturnal REM cycle. REM cycle length in babies and very young children (Kleitman and Engelmann, 1953; Roffwarg, Dement,

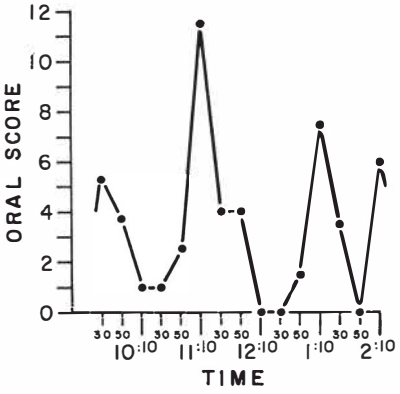

Figure 3

Raw data of schizophrenic subject who showed a short cycle (60 minutes) late in the observation period (Friedman, 1968).

[2] See Friedman (1968) for a definition of this term.

Fisher, 1964) is approximately the duration of cycles in these subjects under tension. Since the change to an infantile cycle duration is concurrent with a variety of psychological stresses, it may be a manifestation related to instinctual regression in that the release from limbic system inhibition of the hypothalmic drive-regulating mechanism reverts to the rhythms of early childhood. The primary purpose of this study is to test further the hypothesis that there is a relationship between states of tension and shorter oral activity cycles.

Subjects with short cycles also seem to have an impaired capacity to carry out sublimated activities. All of them complained about or showed signs of marked restlessness, distractibility, and boredom. They found it relatively difficult to sustain their intellectual pursuits, skipping through magazines and changing activities with marked frequency. The secondary purpose of this paper is to study further the relationship between short oral activity cycles and intellectual activity.

METHODOLOGY AND HYPOTHESES

There are a number of research procedures that could be used to test the hypotheses of this study. Unfortunately, some of the best of them could not be used because of external difficulties: for example, the method of using subjects who are studying for end-term examinations, with pre-examination and postexamination observation periods used as controls. One such subject, properly tested, would require three weeks. Since end-term examination times occur only twice a year, it would take too great a length of time to collect sufficient data, and this excellent method had to be discarded. Another method of having a 12-hour observation period, hypothesizing shorter oral cycles during its second half as boredom increased, was also discarded as this procedure would have had to be carried out at all times of the day to control for possible circadian cycle effect, putting too great a strain on the capacities of the laboratory and the writer.

It was decided instead to employ an experimental group that

already had a symptom and a chronic tension state in the mouth and upper gastrointestinal tract: subjects suffering from severe obesity-bulimia. The original 'normal' group of subjects (Friedman and Fisher, 1967), none of whom were obese, could serve as a control group. The main hypothesis of this study is that subjects with obesity-bulimia will have significantly shorter oral activity cycles than will normal subjects. The secondary hypothesis is that subjects with obesity-bulimia will change their intellectual activities significantly more frequently than will the normal subjects.

SUBJECTS AND SCORING SYSTEM

Subjects used in this study were obtained from three sources. Three were inpatients of the Institute of Psychiatry, The Mount Sinai Hospital, New York. Three were referred by colleagues. Two answered a newspaper advertisement for obese subjects. Each subject had a history of psychiatric treatment, six of them having required hospitalization.

The degree of obesity was a difficult variable to control because sex, height, and bone structure play an important role in weight. The women ranged from 250 to 390 pounds while the men ranged from 295 to 330 pounds. However, these differences in weight and degree of obesity themselves yielded significant results (see below).

The system of scoring oral activity is the same as in the previous studies. The slight quantitative differences relate only to unavoidable differences in the size of the items from study to study. The rationale for this system is discussed in the original study (Friedman and Fisher, 1967). The major items and their scores are listed below:

Cigarette	3 points
Milk or noncaloric carbonated beverage, 9 oz.	5 points
Coffee, 7 oz.	3 points
One-half meat sandwich	5 points
Doughnut	1½ points

As in the previous studies, only subjects with at least moderate mouth activity were used since only such activity was to be observed. It was required that male subjects have a 'mean score' per hour of at least seven points and female subjects a score of at least six for their data to be used in the study. Data from two female subjects were excluded, being 5.0 and 2.8 points per hour. Another subject, a male, had an anxiety attack after one hour and withdrew from the study. The eight remaining subjects ranged in age from eighteen to forty-nine years with a mean of thirty-three. Three were men and five were women.

RESEARCH PROCEDURE

The subjects were studied in a research laboratory of The Mount Sinai Hospital. They spent the observation period in a comfortable air-conditioned room containing books, popular magazines, a small refrigerator filled with food and drink of their own choosing, an electric coffee pot and their usual brand of cigarettes. The author was always observing from the adjacent room through a large one-way mirror. The subjects were informed they would be observed in this way. The three inpatients were told that the observation period was designed to test their patterns of isolated relaxation. The other subjects were told the period was a 'relaxed control run' for a future experiment. They were directed to do exactly what they wanted while in the laboratory: no activity would be scheduled, everything in the room was for their use alone, and they should try to follow their inner wishes as freely as possible. There were no timepieces in the laboratory. The subjects were kept in a state of 'semi-isolation' throughout the observation period. A description of this state and its rationale can be found in the two previous studies.

As in the two previous studies a score was kept of all the oral activities observed during each twenty-minute interval. For example, if a subject smoked one cigarette and drank one cup of coffee during a twenty-minute interval, his 'oral activity

score' would be six for that interval. Scores were prorated when activities straddled two or more time intervals. The resultant data are a consecutive series of twenty-minute scores over the duration of the six-hour observation period. Scores can be plotted on a graph, yielding curves of spontaneous oral activity.

RESULTS

The oral activities of the subjects yielded data that support the hypotheses of the study.

1. The data of seven of the subjects were clearly cyclic in nature. Those of the eighth were insufficiently clear in this respect. Figures 4 and 5 illustrate the cycles of two of the subjects who showed very clear cycling. Their mean cycle durations are 60 minutes and 70 minutes.

2. Each subject's raw data yielded an average cycle duration. These averages were taken for the entire sample. This mean for the entire group was 78.7 minutes. The control group of normal subjects had a mean of 97.0 minutes. This difference is significant at the .05 level of confidence (Mann-Whitney test, two tailed, $t = 2.25$).

3. Within the obese group alone, the question could be raised as to whether there was any correlation between degree of obesity and shortness of the oral drive cycle. This can be tested in two ways: 1, a correlation between cycle duration and the researcher's subjective impression of degree of obesity and, 2, a correlation between cycle duration and actual weight.

a. Cycle duration and subjective ranking of obesity: Subjects were ranked from one to eight in terms of the mean duration of their oral activity cycles. The author then ranked them by degree of obesity, the hypothesis being that the greater degree of obesity should correlate with shorter cycles. The rank-order correlation coefficient (rho) was +.78, significant at the .02 level of confidence, supporting the hypothesis.

b. Cycle duration and weight: Subjects were also ranked

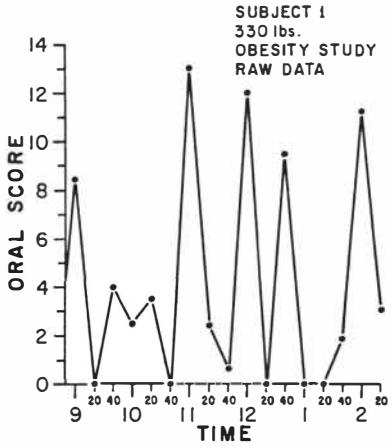

Figure 4

Raw data of obese subject whose mean cycle duration is 60 minutes.

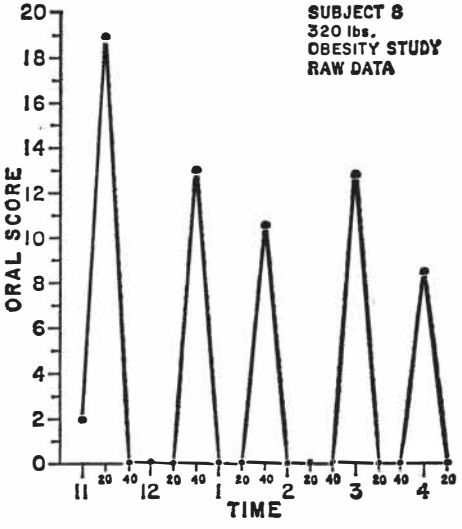

Figure 5

Raw data of obese subject whose mean cycle duration is 70 minutes.

by their actual weight and correlated with the mean duration of their oral activity cycles. Again, the hypothesis was that the heaviest subjects should have the shortest cycles. The rank-order correlation coefficient was +.89, significant at the .01 level of confidence and, again, supported the hypothesis.

4. As noted above, preliminary observations in the previous studies had left the subjective impression that the circumstances that led to shortening of the oral activity cycles also led to a relative impairment in the ability to think or concentrate. The hypothesis that shortened oral cycles are correlated with impaired sublimation was tested by keeping a record of the number of intellectual activities carried out by the obese and normal subjects during their observation period. It was hypothesized that the obese subjects would change their activities significantly more frequently than would the normals because of their intellectual restlessness. The results supported the hypothesis. The least changeable subject was one of the control group. He read the New York Times and a magazine, then settled down to a novel for the remainder of his observation period, a total of three activities. The most restless subject was an obese man who switched from book to book and from one activity to another. He was scored as having carried out nineteen different activities during his six-hour period. The normal subjects had a mean of 5.7 activities while the obese subjects had a mean of 11.8 activities for their observation periods. This difference is significant at below the .02 level of confidence (Mann-Whitney test, two tailed, $t = 2.74$), thereby supporting the hypothesis.

5. The marked obesity of these subjects makes analysis of the nature of their oral activity of interest: Do the data reveal only that fat people eat more and more often than normals? Obese subjects could eat more than normals but in a 90-minute cycle, or at irregular intervals without any cycling. Neither took place. Although the oral activity of the obese subjects was 21 per cent higher than that of the normals, the

majority of their oral activity was noncaloric in nature. Cigarettes and noncaloric drinks, such as soda and coffee, comprised the bulk of their scores. The eight subjects totaled 534 points of which 180 were food and calorie containing drinks. In contrast, 354 points consisted of smoking and noncaloric drinking.

An example of this distribution of types of oral activity can be exemplified with one subject who had five peaks during her six-hour observation. Her first peak of 15 points consisted of a 5-point sandwich and 10 points of cigarettes and coffee. Her second peak of 10.5 points was completely noncaloric, consisting of a cup of coffee and two and a half cigarettes. Her third peak contained some food but her last two peaks were gained exclusively by the use of cigarettes and noncaloric drinks. It can be seen, therefore, that the greater oral activities of the subjects go beyond the increased ingestion of food.

DISCUSSION

It would be well to begin this discussion with a review of the factors that might allow us to think of the shortened oral drive cycles as being a variant form of instinctual regression. This requires a justification both of the REM-oral drive state as being related to instinctual drive organization, and of the shortened cycles as fulfilling the psychoanalytic definition of regression.

Many workers have noted that the REM state seems to be related to a cyclic waxing and waning of instinctual drive activity mediated through the limbic system. The REM state has been found to be synchronous with certain types of drive-related physiological activity, including penile erection (Fisher, Gross, Zuch, 1965), increased vaginal plexus blood flow (Cohen and Shapiro, 1970), increased gastric secretion in duodenal ulcer patients (Armstrong, et al., 1965), and activation of the anterior and posterior pituitary (Mandell and Mandell, 1965; Weitzman, Schaumburg, Fishbein, 1966). Animal studies in which the REM state is blocked by various techniques yield

results that reflect increases in instinctual behavior. These findings include marked increases in hunger and eating (Dement, 1965; Jouvet, 1961), and striking increases in sexual activity (Dement, 1965). Finally, many leading workers in the field of sleep-dream research have concluded that the REM state seems to be related to instinctual drive activation (Dement, 1966; Ephron and Carrington, 1967; Snyder, 1968). Fisher (1965) summarizes sleep-dream research by noting 'that it deals with the discovery of a major biological cycle involving possible alternating phases of energy . . . conservation and energy discharge, and having important implications for psychoanalytic drive theory' (p. 300).

If we grant the likely relation between the REM state and drive activation, is it possible to relate shortened oral drive cycles to instinctual regression? This seems plausible, especially since babies and young children have similar shorter REM cycles and the change to short cycles appears to be one consequence of a variety of states of emotional 'tension'. Although psychoanalytic definitions of instinctual regression usually include the idea of regressive change of zone, this is not a necessary prerequisite. Freud (1917), speaking of libidinal regression, noted 'that there are regressions of two sorts: a return to the objects first cathected . . . and a return of the sexual organization . . . to earlier stages' (p. 341). In A Glossary of Psychoanalytic Terms and Concepts (Moore and Fine, 1967), the definition of libidinal regression begins by calling it 'a retreat to an earlier phase of instinctual organization, especially of the infantile period' (p. 86). It would appear that the phenomenon of shortened oral drive cycles fulfils such definitions, even though knowledge is preliminary and such claims must remain tentative and await future research.

If the data allow a consideration of short oral drive cycles as a variant form of instinctual regression, it becomes necessary to place it, however speculatively, within the psychoanalytic framework of regression. It is known that there are profound and relatively permanent instinctual regressions, such as in the

perversions, psychoses, and other psychopathologies. However, it is also known that there are many manifestations of regression that are fleeting, temporary, and nonpathological, such as in sleep, illness, and drug influence (Moore and Fine, 1967). A review of the meager available data on oral cycles indicates normal cycle length in mild chronic schizophrenic patients. However, short cycles have been seen at times of stress in both schizophrenic and normal subjects. In terms of current preliminary knowledge, it may be speculated that short cycles are an early and reversible regressive response to stress, much in the sense that shock absorbers on a car are protective devices for dealing with rough areas in a road. When the stressful situation is ended, it may be that the individual returns to the adult-length cycle. The disrupted homeostasis may be dealt with by an increase in direct drive discharge through this earlier infantile limbic system rhythm and accompanied by a temporary reduction in the capacity to sublimate. In addition, because the research sample reflected a seemingly *permanent* reversion to shortened oral activity cycles, it must also be considered that certain types of symptoms, such as the oral ones under study, may be accompanied by a more permanent shift in cycle duration. These individuals, under chronic stress or 'tension', may be in a continuous state of regression in which the basic biological cycle will rarely revert to normal adult form during the waking state.

The presence of a regressed form of oral drive cycle during the waking state permits some speculation in the area of psychosomatic medicine. Although a review and criticism of this field are beyond the scope of this paper, it can be noted that such concepts as psychosomatic specificity, unresolved core conflicts, and even the occurrence of a psychosomatic rather than psychological illness, all illustrate the many unresolved and obscure issues in this field. More recently, however, ideas have appeared relating psychosomatic illness to marked regression and its consequences. These have restimulated thinking in this

difficult area. Among the most interesting papers with this approach have been those of Schur (1953, 1955). He proposed that psychosomatic phenomena are linked to ego regression and are also accompanied by primary process thinking, primitive defenses, and the breakdown of neutralization.[3] Schur (1953) notes that, 'of greater practical importance and more clearly evident is the physiological regression implied by the reappearance of discharge phenomena which were prevalent in infancy. The failure of desomatization represents physiological regression. We can now establish another relation: on the one hand, coördinated motor action, desomatization, and secondary processes; on the other, random response, involvement of basic vegetative response, and primary processes. . . . It is obvious that the concept of somatization, as one of the main manifestations of physiological regression must be one of the foremost considerations of "psychosomatic medicine" ' (p. 79).

Reiser (1966), in a more recent theoretical paper on psychosomatic disorders, agreed with Schur's formulations and extended them in speculations about such disease precipitation. He felt that the failure of defense and reactivation of conflictual drives may mobilize nonspecific neuroendocrine channels. Regressive changes in the ego may interrelate with these hormonal reactions. Such reactions, if sustained, may recircuit pathogenic central nervous system pathways and 'gain access to outflow paths to the periphery of the body' (p. 578).

Reiser also notes that patients with psychosomatic disease show marked disturbance in the physiology of the autonomic nervous system. The dysfunctions include excessive lability and range, plateaus of hyper- and hypoactivity, and disturbances of integrative patterns.[4] These features are similar to autonomic functioning in infants, and regularly accompany REM sleep. Reiser then speculates that REM sleep may provide the condition in which psychosomatic pathogenic circuits are ac-

[3] See also, Fisher, et al. (1970).

[4] A similar proposal has been made by Margolin (1953).

tivated in predisposed individuals. This speculation circumvents the difficulty in relating REM sleep physiology to psychosomatic disorder. Since all humans experience this physiological instability with rhythmic regularity, the speculation would require the addition of the idea of prior disposition in such patients. However, this speculation may become even more promising when it can be argued that the REM state exists during wakefulness and that it is possible, under stress, to regress to an infantile form of this state. This reversion to the shorter cycles would include a reactivation of ontogenetically old central nervous system circuits that are part of the medically pathogenic pathways. It can then be speculated that those patients with psychosomatic illness may be people whose conflicts and severity of regressive potential lead to more permanent and chronic infantile daytime oral cycles. Such a state may be an additional precondition for the occurrence of psychosomatic disorders. Finally, it can be noted that this speculation can be cast as hypotheses in potentially testable form. These hypotheses would be that patients with early or incipient psychosomatic illness should have shorter oral activity cycles than a comparable group of normal subjects, and that the same group of patients should have their cycles return to a normal duration when their illness goes into remission. An additional necessary control for such a study would be a group in a comparable crisis state whose members do not develop a psychosomatic illness. Another testable hypothesis would be that short oral cycles are accompanied by a significant increase in the indices of autonomic instability.

The previous oral cycle studies have yielded a number of chance observations that related to sublimation. In the first study (Friedman and Fisher, 1967), a relationship was found to exist between intellectual activity and oral activity in some of the subjects. In addition, degree of alertness also seemed to correlate with the most active phase of the cycle. These findings were consistent with current psychoanalytic thinking on sublimation and were discussed in these terms. Special notice was

paid to H. Hartmann's (1955) idea of a reservoir of neutralized energy and Kris's (1952) concept of energy flux.

In the second study (Friedman, 1968), preliminary findings indicated that there was a relationship between shorter oral cycles and an intellectual distractibility that seemed to imply some failure of sublimation. This preliminary observation was tested in the present study with significant results.

Unfortunately these results can be discussed only in limited fashion. One reason for this is that the two groups being compared are not controlled for such variables as intelligence and education, controls that would be essential in any study of intellectual activity. A second limiting factor is that the results do not settle any controversial theoretical issues surrounding sublimation (Jacobs and Rosett, in preparation). However, the finding that regression seems to be accompanied by a relative impairment of the capacity to sublimate is entirely consistent with current clinical theory. A laboratory study that could provide data with implications for such metapsychological issues as neutralization and psychic energy, although potentially possible, still lies in the future.

SUMMARY

1. It was hypothesized that subjects placed under stress or 'tension' would have oral activity cycles that would resemble in duration the REM cycles of young children instead of those of adults.

2. Patients with obesity-bulimia were used as subjects with oral symptoms that would exemplify such tension. It was hypothesized that these patients would have oral activity cycles significantly shorter than a normal control group.

3. An a priori scoring system of oral activity was constructed. Eight obese subjects were put into a relaxed and semi-isolated situation. Their oral activities were recorded and scored in consecutive twenty-minute periods for six-hour durations of observation. These results were compared with those of a group of ten normal subjects from a previous study.

4. The obese group had statistically significant shorter oral activity cycles than did the normal control group.

5. Within the obese group, degree of obesity was found to correlate significantly with shortness of the oral cycle.

6. The results are described as reflecting the presence of a variant form of instinctual regression. This regression is accompanied by an intellectual restlessness and inability to concentrate; i.e., a relative failure of sublimation.

7. Recent speculations are noted on relationships between regression and psychosomatic illness. The additional speculation is made that such illnesses may be related to the presence of chronic states of shortened oral drive cycles.

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David L. Mayer

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COMMENTS ON A BLIND SPOT IN CLINICAL RESEARCH

A SPECIAL FORM OF TRANSFERENCE IN THE PSYCHOANALYTIC CLINIC

BY DAVID L. MAYER, M.D. (PRINCETON, N. J.)

Many analyses are conducted by students under the auspices of psychoanalytic institutes. Each is a clinical research, and provides an opportunity for supervision. experience, and service to the community. Such clinical research is ordinarily thought of as research in analysis, study of analysis, and training in analysis. Because such thought prevails, there is a tendency to minimize or obscure differences between analysis in the clinic situation and in private practice. The rationale for clinical analyses includes the assumption, for training and heuristic purposes, that in general they are like other analyses; it may be that this assumption, in addition to more specific resistances, diverts our attention from special characteristics and differences occurring in the clinic that are of interest and importance. The clinical observation and exploitation of such differences, as opposed to their partial but systematic exclusion from observation, should offer the opportunity for further understanding of the vicissitudes of these analyses and potentially for broader research.[1]

The three clinic cases described below demonstrate circumstances of transference split[2] directly related to the clinic situ-

I am indebted to Dr. Jacob A. Arlow for his theoretical and technical assistance in the writing of this paper, as well as to the Affiliated Staff of the Treatment Center of the New York Psychoanalytic Institute, from whose work the clinical material is drawn.

1 This principle has been elaborately defined and extended to behavioral science in general by Devereux (1967).

2 'Transference split' is used here to describe the situation which arises when certain transference attitudes, expectably part of the transference neurosis, are not focused on the analyst but instead are directed consistently toward some other person or entity.

ation, forming a particular syndrome of analytic events. The split is shown to arise in a congruence of the realistic setting of the analysis with the patient's earlier history and conflicts.

Published observations of differences between clinic and private analyses are rare. To my knowledge only one contribution, that of Lorand and Console (1958), deals primarily with these differences. Their focus is on possible drawbacks in establishing clinics where psychoanalytic treatment can be offered without charge, or for a very modest fee. They state: 'difficulties encountered in this new milieu of treating patients without charge were very little different from the general difficulties which are found in office practice' (p. 63). They emphasize that the differences are not important as barriers to the goal of providing service. This goal seems to motivate the observers to minimize differences rather than to use them for further understanding, as though differences mean difficulties. I believe this attitude is paradigmatic for the formation of a 'blind spot' in clinical research.

Before there were such clinics, Freud (1913) said: 'Free treatment enormously increases some of a neurotic's resistances—in young women, for instance, the temptation which is inherent in their transference-relation, and in young men, their opposition to an obligation to feel grateful, an opposition which arises from their father-complex and which presents one of the most troublesome hindrances to the acceptance of medical help. The absence of the regulating effect offered by the payment of a fee to the doctor makes itself very painfully felt; the whole relationship is removed from the real world, and the patient is deprived of a strong motive for endeavoring to bring the treatment to an end' (p. 132).

Two references in the literature touch directly on the syndrome described in this paper. Sloane (1957) reports a brief comment in a panel discussion: 'Maxwell Gitelson brought up a question which may arise when the patient discovers inadvertently that his analyst is being analyzed. The patient may

wonder whose patient he really is, the supervisor's or the young candidate's' (p. 545). Windholz (1970) states: 'The syncretic dilemma [the conflict between the pedagogic and therapeutic roles of the supervisor] may interfere with the recognition that supervision affects the course of the analysis of a patient. It is not always easy to uncover its meaning, since its exploration is opposed not only by the patient but also by the student. Moreover, the supervisor, caught in the dilemma, may be reluctant to pursue the subject in order to avoid humiliating the student' (p. 397). Windholz describes how a patient developed a brother transference to her student analyst, excluding him in her fantasy from her relationship to the 'supervisor-mother'. Termination became possible when confrontation with the fact that her analyst had graduated led to awareness of the patient's need to deny reality. A second patient believed her student analyst needed her as insurance against his possible failure with another patient, in accord with her belief that her mother conceived her as insurance against the possible loss of her other children. Windholz points out that 'the supervisory constellation may be used to maintain a "replica" of a significant constellation which was real in the patient's childhood' (p. 399).[8]

Other atypical settings have been reported in the literature.

1. *Training analyses*: Here there is a voluminous literature. Of particular relevance to our discussion are Greenacre's (1966) observations of transference to the institute among candidates, and jealousies occurring about placement of candidates with analysts of greater or lesser status, similar to the jealousies and rivalries of childhood. A frequent concern of supervisors and of students' advisers is the possibility of trans-

[8] Since this paper was submitted for publication, a further work has appeared pertaining to this patient and the supervisory situation. *Cf.*, Oremland, Jerome D. and Windholz, Emanuel: *Some Specific Transference, Countertransference, and Supervisory Problems in the Analysis of a Narcissistic Personality.* Int. J. Psa., LII, 1971, pp. 267-276.

ference splits between training personnel and the student's analyst.

2. *Analyses of patients with psychosomatic illnesses*: Lawrence Deutsch (1969) reports serious transference splits between attending internists and the analyst, often fostered by the internist. Here there may be open competition for the patient's primary allegiance not only to a physician but to a method and philosophy of treatment.

3. *Neurotic depressives seen in consultation*: Greenson (1967) reports splits of transference in candidates and in neurotic depressives. Jacobson (1971) warns that neurotic depressives are often disappointed at the loss of the referring consultant, resulting in transference splits with negative aspects of the transference directed to the prospective therapist. Here it is especially clear that the split accords with the current reality situation on the one hand, and the depressive psychic structure on the other.

4. *Analyses with additional experimental observations*: Many observations confirm the influence of the unusual analytic situation on the transference. Haggard, Hiken, and Isaacs (1965) report the extension of the transference to include various objects associated with the therapist and the therapy, including the tape recorder and persons involved in collecting physiologic data. Watson and Kantor (1956) report a research patient who developed a strong feeling of rapport with unseen observers. Fox (1958) reports the case of a man whose urine and blood were examined during the course of treatment. The actual interest of the analyst in the blood and urine reenforced certain infantile fantasies of the patient including, for instance, the theory that babies resulted from the mixing of the mother's and father's 'wee-wee'. A research patient of Knapp and Bahnson (1963) reacted to rising intense transference longings by trying to 'play the psychiatrist and psychologist off against each other'. In her analysis, their patient reported her ability to talk to the psychologist as she never could talk to the psychiatrist in the treatment sessions. Will

and Cohen (1953) electronically recorded treatment sessions. Their patient 'felt as if she had an ally in the machine—something to back her up in the difficult dealings with the therapist who so often was found to be as severe, frightening, uncomprehending, and distant as her father' (p. 266). Here again there was an explicit connection between the structure of the treatment situation and the childhood experience.

This paper describes transference manifestations related to the clinic situation in a patient analyzed by the author and similar findings noted in the reports of analyses of two other patients. All three patients developed a transference to the analyst and to the fantasied supervisor, a split related to the patient's experience with an important parental surrogate in childhood.

CASE MATERIAL

I

A, a young professional man, applied to the clinic for analysis while in the process of divorce. His complaints centered on feelings of inadequacy, sexually with women and professionally with men. He had previously been in analysis for six months with a private analyst; ostensibly he had given this up for financial reasons. Prior to that he had applied in another city for a clinic analysis and had been told by a consultant that such analyses were conducted by students under the supervision of a senior analyst.

From the beginning, his clinic analysis was characterized by rather open hostility and a demeaning attitude toward the analyst. In his first interview he wondered why his new analyst's couch was an 'ordinary' one rather than the classical analytic couch of his private analyst. He noted that his new analyst's sitting room arrangement was different from the 'real' office of his former analyst. The fixed financial and time arrangements were compared with the relaxed policy of hour changing and the casual arrangements about money attributed to his former analyst. His new analyst's 'rigidity' about these matters was excused by him as a student's need to conform

to the rules of the clinic. Soon after beginning treatment he dreamed:

> One of my bosses was giving a keynote speech. I went out for a coke, came back and listened, but became thirsty again. The first coke had been warm; this time I left to look for a cold coke. I found a place where I could get one but the second cost thirty cents. I couldn't decide whether to get a cheap, warm coke, or an expensive, cold coke. I felt that I was missing nothing by leaving the speech, but I was reprimanded.

His associations included a young superior being irritated with him when he did not come to lunch. He thought about being asked to accept the authority of a book after seeing the author 'demolished' in a personal presentation. He brought up the fact that his fee with the private analyst had been thirty dollars. This was the first of his dreams suggesting a transference split. It clearly related to his change in analysts and his doubts about clinic analysis with his present young analyst. Genetic factors beyond that of his prior analytic experience were not yet evident.

As the analysis proceeded, it was soon clear that the patient was preoccupied with a brother twelve years older than he, and that in the transference he identified the student analyst with his brother. His attitudes toward the student analyst were fraternal. He talked comparatively about himself, his skills as a student, and the process of learning. His behavior with the analyst was casual and he spoke in a manner that assumed a shared awe of a powerful consultant and of private analysts he had seen in the past. His earliest open scepticism and anger toward the student analyst centered around the analyst's unwillingness to 'share' and his 'arrogance' in behaving as though he had authority when he really did not.

His older brother, R, a member of another profession, had been a powerful athlete but often a poor scholar. R's failing in high school at one time had provided a special setting for the patient's hoped for, and often realized, academic triumphs. During their childhood, R had taken upon himself, intermit-

tently and inevitably disappointingly, the role of sworn comrade and strict, critical father. Often there had been periods when R took A everywhere with him—to the opera, to games, to supper with his girl friend—and swore to be his 'closest buddy'. A had responded to his brother's attention with awe and devotion, and at age six had reacted with a deep sense of loss when R went into military service. He was jealous of R's girl friends and fantasied sharing them as well as a much older sister who was close to R. When the patient was ten he had felt a special loss and jealousy when R married. At other times, A was enraged at R's harsh discipline; he also feared he had a homosexual interest in his brother. His rage expressed his protest but also fended off his homosexual longing; he discounted R as a cheat and ridiculed his promise to share. The central area of competition became A's academic brilliance and his acquisition of valedictory honors, always within the shadow of physical fear of his 'giant' brother. All the conflicts seemed to come together in the problem of how to function with R as a team, as a partner, and yet win while R lost.

The patient's father, who was in his fifties at the time of the patient's birth, was described as somewhat withdrawn, turning over his paternal role to R. At times, however, A's awe of his father's skills and powers was evident.

With discussion of his relationship to his former analyst, the transference split appeared to shift to one between the analyst and the analyst's supervisor. At first A fantasied that the former private analyst might be the new clinic analyst's supervisor. He then dreamed of seeing his present analyst four times a week instead of five, and seeing his former analyst one time, on Friday (the day the student analyst actually saw his supervisor).

> I was afraid you would be angry. I told Dr. X [the former analyst] that you discussed my case with an outside professor. He reassured me that you would have no right to dismiss me as a patient because I was going to a second analyst.

The patient's associations to this dream included a fear of being caught by the Internal Revenue Service for claiming a status he did not have. He said he had been told that student analysts see their supervisors once a week. Now enrolled in courses himself, he commented that 'each of us goes to class once a week'. He noted that he had been browsing in a senior professor's book, not assigned for his course, before his examination. He was afraid to tell his boss that he had been spending time studying for the examination. He remembered his pleasure in his brother's failing professional licensure examinations. He was afraid that his boss would feel as if he were going over his head. He had what he regarded as a condescending idea of writing an article with his professor and letting his young boss be a co-author. He revealed a fantasy of being in a basketball game in which the man guarding him fouled out. As the man left, the patient congratulated him for having done a pretty good job. And he recalled an interview with the head of the clinic.

During the preceding months, the patient's income had risen beyond the point where he could be maintained as a clinic patient, and he was transferred to the analyst as a private patient. He had refused to sign the release sent to him for this purpose. Now, in his associations to the dream, he wondered if not signing the release meant maintaining a link with the clinic director with whom he had had the interview. He recalled a fantasy that he might go to school full time, be without income, and so be eligible for treatment under clinic auspices again. He then compared his analytic sessions with 'sessions' between his former wife and her new husband.

In this instance, the transference split separated the negative œdipal longings for the father from the actual analysis. The student analyst was seen as standing between the patient and the senior man, and the relation of student and supervisor was compared with that of his former wife and her husband. The latter relationship was one that he had consciously fantasied long before it occurred and had unconsciously fostered. His

identification with the brother-analyst was of course also evident in his Friday 'consultation'. He dreamed of his 'performance appraisal' at work.

> Samples of my work were all around, but no one was there to tell me how I was doing. I saw a few reports like, 'Hasn't been working' or 'Doesn't work'.

In association he recalled a fantasy of getting permission at school to hand in some work late, for which a graduate student gave him a 'zero'. He asked the professor angrily: 'Who's running this course? You or X [the graduate student]?' During this hour, it emerged that he was angry that the analyst did not tell him whether he would damage himself by masturbating. Also he wondered if there was a tax he had failed to pay that he did not know about. He then recalled wanting his father to buy him a book 'with knowledge in it', for which he yearned.

He complained about the student analyst's failure to give him sufficient guidance, particularly sexual guidance. His brother had promised him many lessons but had given him few. He had longed to get the real information from his father. In high school the split between brother and father, and his rage at his brother, had allowed the gratification of academic triumph and prevented anxiety over positive and negative œdipal wishes, especially the homosexual concerns about his brother. In college, away from home for the first time, he acted out these conflicts with his instructors and professors. His school work began to suffer moderately. He was disparaging of the instructors as he had been of his brother: they did not have 'real' authority and knowledge, and he would have to get it from a book or a professor. Nevertheless, he graduated high in his class at college.

From college, A had joined a corporation in a job situation that was a remarkable model of his family. He worked as part of a consultant team with an older man who earned more than he and got more credit although A felt sure he was

brighter and had the more important ideas. In turn the two worked for a manager who was separated from A by his older cohort, and whom A could not convince that he should be on an equal footing with the older man.

A also began a Ph. D. program during his student analyst's first summer holiday, introducing an academic competition. He felt he was in an open race with the analyst for the doctorate. He wished the analyst to fail in analyzing him and continually sought a solution to the dilemma this posed in terms of his own hope that he would be successfully analyzed. He reported a dream.

> I was stirring up trouble with S [his immediate superior]. Just as though I wanted a showdown with the general manager.

In associating to this dream, he brought out a fantasy that S would go to the manager and say: 'I can't handle this guy', and the manager would say: 'S, this is a test of your managerial ability'. He went on to say that he attributed his difficulty in completing his Ph.D. to the analyst's failure to help him.

His wish to expose the analyst before other analysts took many forms, including fantasies of committing a murder and having the resultant notoriety include a newspaper article mentioning the analyst's name.

Systematic interpretation of the patient's wish for the analyst to fail and of the various functions of the transference split brought out increasing material about his parents, who had been as mysterious in the analysis as the supervisor had been to the patient. The primary triangle came under scrutiny and was reconstructed, with confirmations: the patient had been aware from the beginning that he had in fact displaced his father, who had moved out of his mother's bedroom at the time of A's birth. His denial of his own strength and phallic potentialities, and the myth of his brother's interference in his learning and in his contact with both men and women, were related to feelings like those of a character

'wrecked by success' in the very act of being born. Both his difficulties with women and his smoldering competitive rage at work were ameliorated, and there was a diminution in the ambivalence of his relationships with his mother, father, and brother. After termination of analysis, the patient's functioning seemed to continue to improve. This fact may have been related to one of the patient's fantasies of how to succeed while his brother failed; that is, the analyst-brother had not succeeded entirely; he himself could go ahead on his own.

It seems clear from this case material that while classical analysis was conducted in the clinic situation and a transference neurosis at least partially resolved, the work had to be based on the recognition and acceptance of the special conditions afforded by the psychoanalytic clinic and their congruence with the patient's history. Any avoidance of the special nature of the clinic situation or of the patient's dealing with his analyst in a persistently demeaning fashion as less than a 'real' analyst would have materially interfered with the process.

II

B, a young, single professional woman, sought a clinic analysis because of anxiety and depression, inability to sustain a relationship with a man for very long, and the recognition that she provoked situations where she would leave men.

B's father died before she was born. Early in B's childhood her mother remarried; her stepfather died two years later. She had close relationships with numerous surrogate fathers, co-workers, and parents of friends. In these intense relationships she regarded herself as being 'nearly adopted'. Often she found herself dropping these surrogate fathers with a feeling of revenge. She was able to recognize that she perceived men as 'ones who leave'.

From the first day of her analysis, B was negativistic, provocative, and utterly uncoöperative in her conscious attitudes,

which were acted upon in and out of the analysis. Initially she refused to pay her bill to the analyst, preferring to pay the Institute directly. It was the Institute to which she really belonged, as to her real, if unknown father; the Institute had chosen her and would watch over her silently and protectively.

B said that her real father's death had only been indirectly confirmed. She often had the fantasy that he was really alive and enjoying himself in a warm semitropical climate. When she was able to confront the idea of her father's death more directly, she expressed the wish to die and join him in heaven.

The analyst, like the stepfather, had not chosen her at all. For him, she came as part of the 'package deal' accepted because he wanted to graduate. 'I don't belong to you, I belong to the clinic. I have been imposed upon you. It is hard to feel good when you belong to an amorphous blob like the clinic.' She said she did not feel herself to be his patient; she felt like a boarder. Concurrently with analysis, she attended other kinds of therapy sessions and volunteered for experiments. She wanted to pay the bill to the clinic to avoid confusion about 'where my allegiances are'. She recalled in childhood feeling a traitor in taking the name of her second father. Her analyst's private patients seemed to her to be his real children, a feeling she related to those about her half brother, the real son of her stepfather. She had been jealous of the half brother in childhood—*he* really belonged at home. She dreamed:

> I was eating at a lunch counter and being served only part of a hamburger while my friend was being served a whole one. I complained that I wanted a whole one but in the meantime, my brother came in and ate my part of a hamburger so that I had none.

Her thoughts often turned to the analyst's supervisor, whom she never saw and never knew but whom she felt was always there like the unseen and unknown real father. The 'good' supervisor was contrasted bitterly with the analyst who she felt did not care for her. She wished to punish the analyst by

interfering with his graduation. She fantasied quitting before her analysis had continued long enough, as this would force him to take a new patient and delay his graduation.

When she was notified by the Institute, following her analyst's graduation, that she would become his private patient, she at first refused, like A, to sign the authorization. After signing, she became depressed, mourning the loss of the supervisor. She had seen herself as really talking to him through the analyst and often thought of him scolding the analyst for not being nicer to her. Having 'two analysts' made her feel special, not like the others with one doctor. This defensive idea compensated for the loss of her father and expressed her hostility to the analyst in his transference role of stepfather-impostor.

For patient B, the transference split defended against the undoing of her denial of the real loss of her father as well as against the positive and erotic components of her feelings about the analyst.

III

C, a young married woman, applied for a clinic analysis complaining that she had always been an anxious person and was filled with feelings of pessimism. She had never been happy about anything and could not separate the feeling of unhappiness from the feeling of anxiety. C was the only child of her father's second marriage. She had stepchild fantasies related to the loss of her father's first wife who, in her family romance, seemed to represent her real mother. She had had an unusual relationship with a chronically ill half brother, a number of years older. During their childhood, while both parents worked in her father's shop, the boy had taken on a parent-surrogate role toward her and was remembered as the most affectionate, helpful, warm person she had ever known before her husband. He was described as the 'sunshine' and the playmate of her early years, but also as caring for her physical needs; for instance, cleaning up after her frequent episodes of

vomiting. Family life was marked by various bizarre accusations of one member toward another about illicit behavior, including accusations against the brother of having sexual relations with her. The brother had a schizophrenic illness while in the service and returned with violent feelings, including an admitted intention to rape the patient. The girl, then sixteen, was questioned about whether this had occurred and, in fact, was examined by the mother who wished to satisfy herself that it had not occurred.

C openly expressed contemptuous and erotic feelings toward the analyst very early in the treatment. Strong masochistic and self-destructive trends were reflected in her anticipation of a very 'painful' analysis; she was receiving 'second-class treatment' from her student analyst. C dreamed of being a prisoner in a second-class section of a jail. The sense of exclusion appeared to be a masochistic representation of a complicated maternal transference. However, it emerged that the patient was deeply immersed in prostitution fantasies and 'the punishment for prostitution is jailing'. As an adolescent she had fantasied saving her brother from psychiatric illness by having intercourse with him.

She anticipated ruining the student analyst's career by her failure as a patient and competed openly with him; for instance, like A, she entered a Ph.D. program. She was a 'cut-rate patient' belonging to the clinic. Associations to this led to her envy of males and her wish to urinate like her brother, indicating a fraternal transference with a split to the clinic of the parental transference. Her behavior toward the analyst became abusive; he would never cure her. She manifested pseudo stupidity, pseudo deafness, and pseudo ignorance. When a date was being set for termination after more than three years of analysis, she assumed that she was no longer useful to the analyst and his training. When difficulty began to occur in her Ph.D. work, she blamed the analyst for not understanding the symptoms which were interfering with her studies. She expressed the wish to ruin the analyst by de-

nouncing him to his colleagues and on two occasions sought and obtained consultation, with the confessed motivation of maligning the analyst to senior analysts belonging to the same group. She wished to show his failure in treating her just as she had triumphed in vanquishing her husband by defeating his efforts to bring her to orgasm.

In this case, as in the others, the real clinic situation offered a vehicle for more than one transference split—here, between the two 'mothers' and between the half brother and the father. The splits served, among other functions, to defend the patient from confrontation with the original œdipal triangle in which she felt triumphant over the mother and drawn to the seductive father. She blamed the analyst for keeping her from the 'real' nurture of the Institute or senior analyst, as she had blamed her father for 'destroying' her 'real' mother. Her abusive behavior was an identification with the father; she wished to do to the analyst what father had done to her lost 'parent'.

DISCUSSION

The phenomena described above delineate a recurring form of transference resistance. Some problems of character development are underscored which stem from close relationships to surrogates who do not have the authority of a real parent, and from whose authority one can always appeal, if only in fantasy. Any individual reared in a multiadult family may make such an appeal, especially if the adults differ significantly in their values or are otherwise easily divided. The extreme case would be that of the institutional child who is confronted with an endless series of adults. A sense of authority achieved through a unified, internalized structure of values and ideals may not develop, but rather a functional capacity to use various external figures to serve his needs.

What qualities of the clinic situation attract certain patients and offer opportunities for acting out? The clinic im-

plicitly offers two analysts as objects for transference under circumstances that may be difficult to bring under scrutiny. Also, the clinic setting may foster the direct expression of aggression toward the analyst. The patient can defend the maintenance of a painful relationship, claiming neither he nor his analyst has a real choice. This is another situation which requires the student to confront directly issues he may be impelled to deny.

Open depreciation of the analyst to the extent that all three of the above patients permitted themselves would be less likely in a private setting where the implicit challenge to leave may exert a suppressive force on openly demeaning behavior. Patient A may have unconsciously selected the clinic situation precisely because of the fit it offered for his conflicts: he had seen several analysts privately, had been previously enrolled in another psychoanalytic clinic, and he knew of the supervisory situation. He transferred from a private analysis to the clinic analysis with a rationale that was partly realistic, but must have been supported also by unconscious wishes.

Inquiry into the attraction of the clinic for certain patients leads to an implicit challenge to predict what the course of the analysis of a given clinic patient would be like in other circumstances. In Analysis Terminable and Interminable, Freud (1937) expressed doubts that conflicts which are only potential for a patient can be mobilized in analysis. It may be that the clinic situation is an exception to that precept, but perhaps only an apparent exception since once the clinic analysis is established such potential conflict may become real. For instance, in the cases described intrafamilial conflicts of loyalty may have been especially stimulated.

It may be that each psychoanalytic transference neurosis includes some of the characteristics so prominent in these cases. Every patient who confers the quality of a father onto an analyst knows that the analyst is not really his father. He may therefore be expected to resent the authority he has conferred on the analyst, especially if the analyst, acting in the

transference with the patient, behaves as though he had such authority. It is also evident that the 'real' relation to the analyst, whatever its nature, always offers some opportunity for the expression of conflicts of loyalty. These conflicts are often expressed openly by patients of opposite sex to the analyst, are felt keenly by the spouses of such patients, and are defended against by transference splits.

Such a conflict is clearly illustrated in the following vignette. A married patient, whose mother had protected her from a violent father, was interested in women's liberation and saw Freud as an archenemy. She regarded the analyst as an intermediary between herself and Freud. This protected the analysis for her, represented an element of maternal transference, but also served to maintain a paternal transference split between a dangerous father and a moderate one, and masked a masochistic erotic paternal transference.

SUMMARY

A blind spot may exist in our observations of clinic psychoanalyses. Since we have a number of motives for regarding them as we do private analyses, we may selectively omit observations of characteristic differences. As Windholz has indicated, the supervisor may be reluctant to discuss the patient's reactions to the analyst's student status for fear of humiliating the student, and the student and patient reluctant for other reasons. In addition, it is my observation that all three of them, and the entire pedagogical organization of the Institute as well, may wish to view the supervised analysis as a 'real' analysis and, consequently, de-emphasize those elements that make the analysis different from 'real' analysis. The patient is interested in having a 'real' analysis, the student in performing one, and the supervisor in teaching one.

One form of special clinic transference situation is described. A transference split occurs, involving the supervisor, which is related to the historical element of an important parent surrogate in childhood.

When the transference nature of such splits is recognized, they can be used in ordinary analytic fashion and will not be seen as impediments to analytic work.

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Fritz Schmidl

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PROBLEMS OF METHOD IN APPLIED PSYCHOANALYSIS

BY FRITZ SCHMIDL†

The origin of almost every idea and every concept in the field of psychoanalysis as a psychological theory and as a method of therapy can be traced back to the work of Sigmund Freud. This is also true of the idea and concepts known as 'applied psychoanalysis'.

According to Kris (1954), Freud first applied psychoanalytic concepts to problems outside psychoanalysis in a brief sketch about a short story by Conrad Ferdinand Meyer which he enclosed in a letter to Fliess, dated June 20, 1898. Freud remarked about the resemblance of the story to what he called the 'family romance', a feature which he frequently found in the fantasies produced by his patients. In The Interpretation of Dreams, we find his famous statements about Sophocles's Œdipus Rex and about Hamlet (Freud, 1900, pp. 261-266). In 1907, Freud published the monograph, Delusions and Dreams in Jensen's Gradiva in which he discussed Gradiva 'not as a phantasy but as a psychiatric study'. Three years later, in 1910, there appeared his essay on Leonardo da Vinci, with the subtitle, A Psychosexual Study of an Infantile Reminiscence. Afterwards came Totem and Taboo (1912 [1913]), The Moses of Michelangelo (1914), Group Psychology and the Analysis of the Ego (1921), Dostoevsky and Parricide (1928), and finally, Moses and Monotheism (1938). This list of Freud's contributions outside of psychoanalysis proper is not complete; it could be enlarged to include his more or less philosophical writings, such as The Future of an Illusion and Civilization and Its Discontents.

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When we consider the meaning and the value of Freud's writings on subjects of applied psychoanalysis, some thoughts come to mind. In almost every instance where Freud wrote about a subject outside of psychoanalysis proper, he made significant contributions to psychoanalysis itself. The brief sketch in his letter to Fliess about a story by Meyer can be seen as a forerunner of his paper on Family Romances, published in 1909. The paper on Gradiva contains interesting comments on the dreamwork; the monograph on Leonardo da Vinci deals with the problem of homosexuality; in Group Psychology and the Analysis of the Ego, Freud laid the foundation for the psychoanalysis of the ego; in Dostoevsky and Parricide, we find a discussion of the problem of affective versus organic epilepsy. While Freud's genius dealt with a tremendous multitude of human phenomena, the creation and the development of psychoanalysis remained his main interest.

In a letter to Ludwig Binswanger, Freud once said, 'I always felt that wilful independence and self-confidence as a matter of course are necessary conditions of what appears to be greatness . . .' (*cf.*, Schmidl, 1959). In all his writings Freud showed these qualities. In many respects he was a revolutionary, as he himself said in another letter to Binswanger. Many of his ideas were daring and unacceptable to most of his contemporaries. However, in his writings on applied psychoanalysis, Freud frequently showed restraint and modesty, particularly when he was not quite sure that his interpretations were accurate, or that they excluded other interpretations. For instance, he concluded his discussion of Hamlet in The Interpretation of Dreams with the sentence, 'all genuinely creative writings are the product of more than a single motive and . . . are open to more than a single interpretation' (p. 266). In the Leonardo study, Freud (1910) stated: 'if . . . we remain dissatisfied with the degree of certainty which we achieve, we shall have to console ourselves with the reflection that so many other studies of this great and enigmatic man have met with no better fate' (p. 85). Toward the end of his life, in the second prefatory

note to Moses and Monotheism, Freud (1938) made the humorous remark: 'To my critical sense this book . . . appears like a dancer balancing on the tip of one toe' (p. 58).

In contrast to Freud's modesty, there are examples of psychoanalytic interpretation being considered superior to any other interpretation. For instance, Jekels (1914), in a paper, The Turning Point in the Life of Napoleon I, stated: 'Historical research . . . should borrow from, or yield to, the methods employed by psycho-analysis which, more penetrative, can continue the task where other kinds of investigation fail' (p. 1). Sharpe (1929), discussing Jones's work on Hamlet, said: 'His essay . . . makes clear the unresolved œdipus conflict which is the fundamental problem in the play'. Barchilon and Kovel (1966), in a paper on Mark Twain's Huckleberry Finn, remarked: 'The message which the pre-Freudian novels and plays contained waited for ages before it could be decoded and formulated' (p. 812). These statements do not use Freud's restraint which, as mentioned above, left open the way for different interpretations.

Yet when one tries to evaluate the literature on applied psychoanalysis from the beginning to the present time, one feels that it has not been as productive and accepted as might be desired. Most contributions written by psychoanalysts are published in psychoanalytic journals, and seldom become known to the specialists in the fields concerned. In some areas, particularly those of literary criticism, authors who have an insufficient knowledge of psychoanalysis use its concepts in an erroneous or, at least, too superficial manner. In this paper I shall attempt to probe into some of the methodological problems.

In the beginning, the goal of applied psychoanalysis was to emphasize that literature, mythology, etc., could be demonstrated to confirm Freud's theories, notably that of the œdipus complex. In the Gradiva book Freud (1907) said at one point: 'When, from the year 1893 onwards, I plunged into investigations such as these of the origin of mental disturbances, it would certainly never have occurred to me to look for a con-

firmation of my findings in imaginative writings' (p. 54). In 1926, in The Question of Lay Analysis, Freud remarks to his imagined opponent, '. . . here again mythology may give you the courage to believe psycho-analysis' (p. 211). For the last few decades this goal of applied psychoanalysis has ceased to be of interest because of the more or less general acceptance of concepts such as the œdipus complex.

Now, most authors dealing with the application of psychoanalysis use it for the elucidation of problems with which anthropologists, historians, literary critics, and others are occupied. Their goal is to further and deepen knowledge and understanding in different fields of studies in the humanities.

However, there are other writers who use investigations of the life and works of great men for the furtherance of clinical understanding. The usefulness for the field of biography then becomes a by-product. A notable example of this type of applied psychoanalysis is Greenacre's (1955) book on Swift and Carroll. Closely related to the advance of clinical understanding is the area where psychoanalysts intend to understand problems which, without psychoanalytic insight, have remained unsolved, or erroneously or incompletely solved; here the question of interpretation is in the foreground. Every psychoanalyst knows that his work of interpretation in his contact with a patient is an arduous, time-consuming task. Listening to his patients, he watched for clues which might help him solve problems that at the onset had seemed enigmatic. But, as a rule, he is not satisfied with one clue; he continues until a number of clues cluster into a configuration—this may also be called a 'syndrome'—and he is convinced that a certain interpretation is plausible.

In applied psychoanalysis, the crucial problem is that the process of getting more and more information, and observing the reactions of a living patient, is obviously excluded. Freud's writing to Fliess about a story by Conrad Ferdinand Meyer is an example. The story deals with a seemingly incestuous relationship between brother and sister, but toward the end

the protagonists discover that there is no kinship between them. In his letter to Fliess, Freud said: 'There is no doubt that this is a defence against the writer's memory of an affair with his sister' (p. 256). Considered in isolation, this statement would mean that Freud had dared to infer from a story that a certain event happened in the writer's life, probably in his childhood. And one can argue that a story can never be more than a clue—a clue that might allow for a hunch but not for a convincing interpretation. So far as Freud's sketch is concerned, however, it had not been written for publication; it was a communication from one friend to another. When he wrote the letter, it is probable that Freud, as well as Fliess, was familiar with some biographical data about Meyer, particularly about the relationship between the author and his sister. Hence, it may be assumed that Freud's sketch reflected not only the story but also biographical data known to him and to Fliess.

Unfortunately, reliance on only one clue is frequently found in the literature of applied psychoanalysis. For instance, Eissler (1963), in his study of Goethe, discusses a letter written by the eighteen-year-old Goethe to his older friend, Behrisch. In the letter, Goethe wrote that he was upset about a gesture of his girl friend: he had observed her covering her eyes when she wanted to 'hide her blushes, her confusion from her mother'. 'This is what drives me mad. I am crazy, you think. . . . Advise me all around, and comfort me because of this matter.' In his discussion of this letter, Eissler considers it 'uncanny' and adds, 'There is one detail in the letter that permits—almost requires—the diagnosis of an acute paranoid psychotic episode'. The fact that Eissler takes Goethe's remark about this gesture seriously testifies to his astuteness of observation. But a diagnosis of a paranoid psychotic episode on the basis of one clue in a letter of an eighteen-year-old fails to convince clinicians. Historians of literature and biographers may be so disturbed by such an interpretation that they could fail to pay attention to the many important and substantiated interpretations made by Eissler in his book.

Interpretation on the basis of scant evidence may offer the experienced clinician some narcissistic satisfaction, and he may even draw some plausible conclusions from a word or a phrase used by a patient. However, in applied psychoanalysis the price is frequently too high. Those outside the field of psychoanalysis often use insufficiently substantiated interpretations as rationalizations in their resistance to psychoanalysis.

The question of the criteria for the correctness of an interpretation is certainly a difficult one. In an article on the problem of scientific validation in psychoanalytic interpretation which I published some years ago (Schmidl, 1955), I used as an example Freud's interpretation of the symptom of a patient, a thirty-year-old woman, who repeatedly and several times a day had to run from her room into the adjoining one, took up a certain position in this room, rang the bell for the maid, and gave her a trivial order or sent her away without an order. In analysis Freud discovered that this nonsensical action was closely related to an incident which had happened on the patient's wedding night. Freud (1917 [1916-1917]) concluded his remarks about this patient with the sentence: 'There could no longer be any doubt of the intimate connection between the scene on her wedding night and her present obsessional action . . .' (p. 262).

Using some ideas expressed by Siegfried Bernfeld, I arrived at the conclusion that the validity of a psychoanalytic interpretation depends on 'the fitting together of the gestalt of what has to be interpreted with the gestalt of the interpretation' (Schmidl, 1955, p. 112). I expressed the same point of view in Psychoanalysis and History (Schmidl, 1962).

Scant evidence and one-sidedness—problems encountered in the study of literature—are also problems in psychoanalysis applied to history. Some years ago Weissman (1958) published a paper, Why Booth Killed Lincoln: A Psychoanalytic Study of a Historical Tragedy. He proffered the interesting idea that the murderer, John Wilkes Booth, unconsciously identified Lincoln with his hated and envied famous brother, the actor

Edwin Booth. I discussed this paper in a psychoanalytic seminar to which we had invited a number of professors of history. They found the paper interesting but they could not accept its conclusions. While they did not consider themselves competent to confirm or refute the psychoanalytic interpretation, they knew a number of conscious reasons why John Wilkes Booth had joined the rebellion against Lincoln. It is only natural that in attempting to understand the murderer's motivation they preferred an explanation on the basis of known facts. To use Jekels's expression, it could be said that Weissman's interpretation is more 'penetrative', but it cannot be firmly established and documented.

In the area of psychoanalysis applied to history, there also exists the problem of studying a nation, or any group of people, as if they were individuals. Freud (1927) touched on this in a cautious manner when, in The Future of an Illusion, he said: 'In just the same way, one might assume, humanity as a whole, in its development through the ages, fell into states analogous to the neuroses' (p. 43). Yet he also expressed doubts about the use of such analogies. Alexander (1940) has taken a strong position against 'an uncritical application of the psychology of the individual to group phenomena'. He also has pointed out the danger of such procedures inasmuch as 'each party uses this theory for its own benefit'.

After many discussions, I must admit that it is hardly possible to draw a distinct line between what is considered a clue and what is considered a gestalt or a syndrome. Whoever desires a proof such as one expects in the so-called exact sciences will always find flaws, not only in psychoanalysis, but in the whole field of the humanities. A prominent American historian, H. Stuart Hughes (1964) said in his book, History as Art and as Science, 'For the historian as for the psychoanalyst, an interpretation ranks as satisfactory not by passing some formal scientific test but by conveying an inner conviction'.

Some psychoanalysts develop an 'inner conviction' on the basis of scant material, but fail to convey it to others. I think

that the writer in the field of applied psychoanalysis should be able to convince not only his psychoanalyst colleagues but also the specialists. As far as material is concerned, much will depend on the skill of the investigator and on his good luck in discovering meaningful facts. For example, the historian David Donald (1961)) in a biography of Charles Sumner, who played a considerable role during the Civil War, reports on his hero's friendship with the poet Longfellow. We learn first about a dream of Longfellow's in which the two men were in bed together and when Sumner mentioned 'a certain person's name, Longfellow fell on Sumner's neck and wept, exclaiming "I am very unhappy" '. Secondly, Donald reports that a letter in which Sumner congratulated Longfellow on his engagement ended in the sentence 'Now you have gone and nobody is left with whom I can have sweet sympathy. . . . What shall I do the long summer evenings?' Third, we read, furthermore, that 'the Longfellows . . . took pity on Sumner and invited him to accompany them on their wedding trip to the Catskills. He accepted and on the train read to the newlyweds Bossuet's funeral orations.' Any one of the three statements may be considered a clue, but the combination of all three creates the conviction that the relationship between the two friends must have been at least an intensive latent homosexual one.

It is obvious that the ability of an author of applied psychoanalysis to create an 'inner conviction' regarding the correctness of his interpretations is one of the crucial criteria of the value of his writings. But in many instances criticism of applied psychoanalysis is not based upon doubts about the validity of interpretations but on the stricture of *'reductionism'*. The anthropologist Geoffrey Gorer (1966), for instance, deplores the fact that psychoanalysts, in trying to show what the 'real' meaning of myths is, bypass the truth that 'myths are, or were, the religious beliefs and stories of people distant in space or time . . .'. Similar objections have been made by a number of literary critics. One of them, Brian A. Rowley (1958) remarked that it was 'the tendency of psychoanalytic criticism

to reduce literature to its lowest common factor, which usually turns out to be the œdipus complex'.

So far as anthropology is concerned, not all authors in this field are likely to agree with Gorer's criticism. It seems only natural that anthropologists look at the object of their studies from different angles. Some are interested in the diversity of ways in which human beings are living. To them the differences in space and time are essential. Others, however, are interested in the origins of culture, in those factors which human beings have had in common at all times. The outstanding psychoanalytic work dealing with these problems is, of course, Freud's (1912 [1913]) Totem and Taboo. If we remind ourselves of some facts in the history of this book we can see that what I consider the tragedy of applied psychoanalysis—namely, its relative isolation and poor acceptance by the other sciences—began with Totem and Taboo.

We learn from Jones (1955) that Freud wrote to Ferenczi on November 30, 1911: 'The Totem is a beastly business. I am reading thick books without being really interested in them since I already know the results; my instinct tells me that' (p. 352). On April 9, 1913, he wrote to Jones about his work on totemism: 'It is the most daring enterprise I have ever ventured. On religion, ethics and *quibusdem aliis*. God help me!' (p. 353). Three weeks later he wrote: 'I am writing Totem at present with the feeling that it is my greatest, best, perhaps my last good work. Inner confidence tells me that I am right' (p. 353). But about six weeks later, Freud wrote: 'I have reverted very much from my original high estimate of the work, and am on the whole critical of it' (p. 354). We learn from Jones that he and Ferenczi 'read the proofs together. . . . We suggested he had in his imagination lived through the experiences he described in his book, that his elation represented the excitement of killing and eating the father, and that his doubts were only the reaction' (p. 354). In the next paragraph Jones says, 'We seemed to have reassured Freud'.

It is most interesting that Freud never again mentioned

any doubts about the ideas expressed in Totem and Taboo. In the second preface to Moses and Monotheism, Freud said that the conviction in the correctness of the conclusions at which he had arrived in Totem and Taboo had 'only grown firmer'. About seventeen or eighteen years before Freud made this statement, a prominent American anthropologist, A. L. Kroeber (1920), had written a review of Totem and Taboo in which he voiced a number of serious objections but concluded with the sentence, 'Freud's point of view henceforth can never be ignored without stultification'. From a remark in Group Psychology and the Analysis of the Ego, we know that Freud had read Kroeber's criticism and that he had acknowledged the friendly spirit in which it had been written. Yet Freud did not deal with the details of the review; he only said that the ideas expressed in Totem and Taboo were 'only a hypothesis, like so many others with which archaeologists endeavor to lighten the darkness of prehistoric times' (Freud, 1921, p. 122).

We can assume that the reassurance coming from Jones and Ferenczi had made Freud almost immune to any criticism of Totem and Taboo to the end of his life. This can be considered an unfortunate influence of the master-disciple relationship on the development of applied psychoanalysis, of which Totem and Taboo is an important part. Freud was unwilling to go into a detailed scientific discussion with the anthropologists and chose to use his time and energy for other things more important to him, but it seems likely that Freud's lack of interest in a discussion with Kroeber has caused anthropologists to disregard psychoanalytic interpretations as merely speculative.

Gezá Róheim's work also deals with those phenomena which have been characteristic of mankind, not of one or the other nation, tribe, or group. In this area applied psychoanalysis shares methodological problems with anthropology; detailed and documented studies of phenomena occurring at a certain place at a certain time are not likely to explain what is common to all mankind. Inquiries into such problems will always be more speculative. In psychoanalysis proper the ego-psychological

inquiry into the problems of an individual, supplements the understanding of his id. In anthropology, cultural, economic, and similar problems would have to be considered in order to gain a fuller understanding of features of man living under certain conditions.

In order to understand the criticism of psychoanalysis applied to literature, we have to consider the different ways in which psychoanalysts have approached problems in the fields of literary criticism and biography. Some have tried to use biographical material for the understanding of a work of literature or art. Others have used works of art and literature for an understanding of the life and personality of an author or an artist. Psychoanalysis also has been used in order to 'analyze' a character in a play or a novel, i.e., to understand a character as if he were a patient.

Jones (1949), in Hamlet and Œdipus, has criticized the 'fashionable' view 'that every work should be judged "purely on its merits" '. According to him, 'the critical procedure cannot halt at the work of art itself: to isolate this from the creator is to impose artificial limits to our understanding of it'. No doubt, any information regarding a connection between a specific life experience of an author and a specific creation can be interesting. But, the fate of Freud's and Jones's ideas about such a connection in the case of Hamlet can serve as a good example for the difficulties one may encounter in such an effort. In The Interpretation of Dreams, Freud remarked about the temporal coincidence of the death of Shakespeare's father and the writing of the play. As is known, Freud had called the death of the father the most significant event in a man's life. Freud did not contend that the information about either the time of the death of Shakespeare's father or about the time when Hamlet was written was firmly established. Jones elaborated on Freud's idea; he called it 'a greatly inspired guess'. About thirty years after Freud had published The Interpretation of Dreams, a book written by a historian of literature convinced him that the works attributed to Shakes-

peare had been written by the Earl of Oxford. Freud mentioned his doubts in a footnote to the respective passage in the eighth edition of The Interpretation of Dreams but did not change the text. Today Shakespearean scholars, on the basis of newly found documents, are reasonably sure that it was Shakespeare who wrote the plays, but they have considerable doubts as to the time when Hamlet was written.

To the problem of accurate biographical information another—a more intrinsic problem—has to be added. From biography we can learn about a certain life experience of a poet, writer, or artist. There may be a more or less obvious connection between this experience and a work of literature or art. But the private experience of the author will always be only a part, and often a rather insignificant part, of the work. Literary critics often say that the creative writer or artist deals with the 'human condition'. This is a very complex affair, never limited to one aspect only. The artist or writer also gives his work a certain form. Only in an artistic form is his creation experienced as a work of literature or art.

These problems may be exemplified by reference to Goethe's The Sorrows of Werther. The student of Goethe's life and work learns that two events preceded Goethe's writing the Werther novel: he had fallen in love with Lotte Buff, a girl engaged to another man, and he had learned about the suicide of an acquaintance, young Jerusalem, who had killed himself after he had fallen in love with a married woman. Goethe's relationship to Lotte Buff was one of many more or less serious love affairs of the poet, who did not marry until he was fifty-seven years old. According to the biographers Goethe left Wetzlar, the town where he had met Lotte, abruptly, leaving a note to her fiancé in which he enclosed a goodbye note for Lotte. Lotte, in a letter to an aunt of the poet, complained about his poor behavior. Jerusalem was not a close friend of Goethe's and it was not known to what extent his suicide had been due to his unhappy love. Yet these experiences stimulated the conception of The Sorrows of Werther, one of the most successful

works in the literature of the Western world. Goethe's private experience can be compared with the grain of sand which stimulates the growth of a beautiful pearl. The novel is complex in its content, original and impressive in its form. Literary historians see it as a link in the chain of the development of the Western novel. Historians of culture tell us how the novel expressed ideas of the time when it was written, also its influence on contemporary life. We know that it became the nucleus for an epidemic of suicides. The passage about the last meeting of Werther and Lotte, when Werther reads to her some of the sentimental poems attributed to Ossian, is in its form almost more a work of operatic music than of descriptive literature.

To repeat, all this does not invalidate an interest in the poet's life experience which became a stimulus for his creative work, but we have to admit that the psychological understanding of the life experience is rather secondary. Jones's statement that 'to isolate the work from the creator is to impose artificial limits to our understanding of it' is not incorrect, but he overrates the importance of the study of a germinal life experience for the understanding of a work.

In Hamlet and Œdipus Jones also made the statement, 'I propose to pretend that Hamlet was a living person'. This is in line with Freud's comment in the Gradiva story 'as a psychiatric study'. Psychoanalytic writers have followed this trend. It seems worthwhile to examine the merits and the shortcomings of such a procedure. Some works of literature are, to a great extent, psychological studies. From recent literature I would like to use as an example Saul Bellow's (1956) short novel, Seize the Day. It deals with the relationship of an unsuccessful man in his forties to his old father, a retired physician who, although he seems quite wealthy, refuses to give the son financial help. Daniel Weiss (1965), a literary critic, has written a 'psychoanalytic study' about this work. Weiss, who apparently has a thorough knowledge and a good understanding of psychoanalysis, explains the character of the hero and his relationship to his old father in psychoanalytic terms, freely using not only

the writings of Freud, but also more recent psychoanalytic literature. Yet, he does not pretend to 'analyze' Tommy Wilhelm, the hero. He discusses the relationship between father and son not only in psychoanalytic terms, but also in terms of literary tradition where any conflict ends in an 'atonement' and where a 'posthumous reconciliation [is] more formative of a religious belief than a real human relationship'. In this way Weiss discusses the work from the point of view of its psychological content, from that of literary tradition, and he also touches upon some ideas regarding the formation of religious feelings.

The question arises: What significance is to be attributed to a consistent psychological development of a character in literature? There can hardly be any doubt about the fact that psychoanalysis is the method of choice to determine whether or not a character is described in a consistent manner. The same critic, Daniel Weiss (1962), says in a book on D. H. Lawrence, 'psychological criticism should constitute a bureau of tragic or comic weights and measures, testing in the work of art for the organic, psychologically valid material'. This statement is quite different from the statement in Barchilon and Kovel's paper in which the authors suggest that psychoanalysis should 'decode' literature, i.e., find its 'real meaning'.

In Huckleberry Finn, Barchilon and Kovel (1966) 'analyze' the hero. They do not even mention the question of whether Mark Twain intended to portray Huck Finn as a real human being. Well-known literary critics see Huck Finn not as a boy, but as 'the servant of the river god' (Lionel Trilling, 1948), or as 'a myth' (Leslie A. Fiedler, 1960). Efforts to 'analyze' a fictional person are interesting and show a great deal of psychoanalytic sophistication on the part of their authors, but they indicate that the psychoanalyst is one-sided in his appreciation of art and literature. Freud (1914) openly admitted his preferential interest in psychological content when he wrote in his monograph, The Moses of Michelangelo: 'I have often observed that the subject-matter of works of art has a stronger

attraction for me than their formal and technical qualities, though to the artist their value lies first and foremost in these latter' (p. 211). Freud admits not only his one-sidedness, but also states distinctly that the artist tends to see his work in a different light. He does not pretend that he 'decodes' the work of the artist or writer. Psychoanalysis could only offer a definite and exclusive criticism if an author would only intend to write a psychological study: whether or not, however, such a study would be considered a work of literature is a question. As far as I know, there has been only one instance when literary men saw in psychological studies works of literature—in the case of Freud's writings, when he was awarded the Goethe prize for literature.

As a rule, works of literature are likely to have some psychological content, but they offer more than that. For this reason Wellek and Warren (1956), two eminent literary critics, in their Theory of Literature state: '. . . psychological truth is a naturalistic standard without universal validity'.

Where the life of a creative writer is examined and where the works are used as additional biographical material, difficulties such as those mentioned above do not exist. There are many examples of interesting and well-documented biographies in which psychoanalytic understanding of the work of a writer or artist is used. Greenacre's (1955) study of Swift and Carroll belongs to this group; also from the more recent literature, Meyer's (1967) Joseph Conrad, A Psychoanalytic Biography. Such studies are not only interesting as biographies but they also further the clinical understanding of the creative artist.

Where psychoanalysis has been applied to art, the problems are similar to those encountered in literature. Gombrich (1954), in a paper Psycho-Analysis and the History of Art, has dealt with this subject. He has criticized the emphasis on the private experience of the artist pointing out that a work of art has to be appreciated in the context of æsthetics rather than that of psychology. As far as the creative process is concerned, one must refer to the work of Kris (1952). I think, however, that the

study of the creative process as such belongs more to the field of psychoanalysis proper than to that of applied psychoanalysis.

SUMMARY

To paraphrase Kroeber, contributions of the psychoanalytic approach to the content of literature, art, history, and the behavioral sciences 'henceforth can never be ignored without stultification', despite methodological errors made by individual psychoanalysts.

It is to be hoped that scholars in different fields of the humanities who have psychoanalytic training will be able to close the gap between their respective fields and applied psychoanalysis.

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Michel J. De Wolf

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COMMENTS ON FREUD AND KRONOS

BY MICHEL J. DE WOLF (BELGIUM)

In a recent article in The American Journal of Psychiatry, J. M. Schneck wrote that Freud's reference to the castration of Kronos by his son Zeus in Splitting of the Ego in the Process of Defence does not correspond to the usual version of the myth. For instance, according to Grant (1964) and Graves (1955), Uranus was castrated by his son Kronos; Kronos did not suffer the same fate from his son Zeus. Schneck suggests two possible reasons for Freud's 'error': that he had access only to a version of the myth different from the major accounts relied on today and in past centuries, or that in this unfinished, posthumously published paper, Freud relied on his memory, which deceived him. 'A special desire and effort to reinforce his [theoretical] views [on the role of castration fear] could have led to his false recollection of mythology' (Schneck, 1968, p. 693). Some light may be shed on the problem and on Schneck's suggested explanations when one considers Freud's entire work.

It is clear that Freud's 'false recollection' cannot be attributed to the unfinished state of the posthumous article or to Freud's failing memory at the age of eighty-two. For as far back as 1900 we find Freud (1900-1901) asserting twice in The Interpretation of Dreams that Zeus castrated his father, Kronos.

> . . . mythology and legend from the primaeval ages of human society gives an unpleasing picture of the father's despotic power and of the ruthlessness with which he made use of it. Kronos devoured his children, just as the wild boar devours the sow's litter; while Zeus emasculated his father and made himself ruler in his place (p. 256).

> . . . The material for them was provided by a recollection from mythology. The sickle was the one with which Zeus castrated his father; the scythe and the picture of the old peasant represented Kronos, the violent old man who devoured his children and on whom Zeus took such unfilial vengeance (p. 619).

From the Université de Louvain, Centre de psychologie clinique et différentielle, Louvain.

It is surprising to note that Freud (1901) himself was the first to criticize this statement one year later in The Psychopathology of Everyday Life.

> . . . I state[d] that Zeus emasculated his father Kronos and dethroned him. I was, however, erroneously carrying this atrocity a generation forward; according to Greek mythology it was Kronos who committed it on his father Uranus (p. 218).

Freud went on to give a psychoanalytical interpretation of his error.

> It is to the influence of the memory of . . . [my] brother that I attribute my error in advancing by a generation the mythological atrocities of the Greek pantheon. One of my brother's admonitions lingered long in my memory. 'One thing', he had said to me, 'that you must not forget is that as far as the conduct of your life is concerned you really belong not to the second but to the third generation in relation to your father.' Our father had married again in later life and was therefore much older than his children by his second marriage. I made the error already described at the exact point in the book at which I was discussing filial piety (p. 220).

Freud's interpretation of his error seems, indeed, superficial. But we will here pass over such problems between Freud and his father as the castration threat probably implied by the symbolic content of the myth of Kronos.

A moment later, however, Freud (1901) in a footnote minimizes or denies that he erred.

> This was not a complete error. The Orphic version of the myth makes Zeus repeat the process of emasculation on his father Kronos. (See Roscher's *Lexicon of Mythology*.) [*Cf.*, footnote 2, p. 198.] (p. 218, n. 1).

We see that in 1901 Freud was aware that the castration of Kronos by Zeus could be challenged. He thus anticipated, and answered, Dr. Schneck's questions. Perhaps Freud was too confident of the value of the *Ausführliches Lexikon der griechischen und römischen Mythologie* published in Leipzig by W. H. Roscher (1884-1937). He thought both accounts could be maintained: Kronos's castration of his father Uranus, and Zeus's castration of *his* father Kronos. According to Roscher's Lexicon the castration was repeated. Each son castrated his father. We can hardly reproach Freud with having been too confident in Roscher's work; Van der Leyen, a scholar of Munich, who probably acquainted

Freud with Roscher's works before drawing Roscher's attention to Freud's research,[1] was thoroughly reliable.

Freud (1900-1901) slightly modified his position by a footnote added to the second edition of The Interpretation of Dreams in 1909.

> Or so he [Zeus] is reported to have done according to some myths. According to others, emasculation was only carried out by Kronos on his father Uranus (p. 256, n. 2).

Freud (1926b) returned to the problem in The Question of Lay Analysis and presented the double version of the myth.

> And here again mythology may give you the courage to believe psychoanalysis. The same Kronos who swallowed his children also emasculated his father Uranus, and was afterwards himself emasculated in revenge by his son Zeus, who had been rescued through his mother's cunning (pp. 211-212).

Finally, in the paragraph cited by Schneck, which Freud left unfinished in Splitting of the Ego in the Process of Defence, we find a last reference in which Freud returned to his original account that he justified in 1901.

> At this point it is impossible to forget a primitive fragment of Greek mythology which tells how Kronos, the old Father God, swallowed his children and sought to swallow his youngest son Zeus like the rest, and how Zeus was saved by the craft of his mother and later on castrated his father (p. 278).

Why did Freud, in this last version, limit himself to the castration of Kronos by Zeus? Probably because he wanted to stress the character of Kronos. Kronos exhibited the two processes that Freud wished to illustrate: regression to an oral phase (fear of being eaten by the father[2]) and castration according to the law of retaliation. Freud's will to re-enforce his clinical and theoretical views about castration cannot be asserted. He had, of course, discussed the topic many times before: first implicitly in 1900 with the allusion to Kronos in The Interpretation of Dreams, then explicitly in 1908 in On The Sexual Theories of Children. He had done so convincingly and brilliantly, as in his analysis of Little Hans (1909) and of the infantile neurosis of the Wolf-man (1918

[1] See letter dated May 7, 1902, Warburg Institute, London University.

[2] Two other brief allusions of Freud to Kronos refer to this aspect of the devouring father. *Cf.*, Freud (1913, 1926a).

[1914]). And, he adduced other myths, legends, and customs (for example, Attis and Cybele, the blindness of Œdipus, and circumcision among certain tribes) as indices of the universality and importance of the idea of castration,—an idea he hardly needed to defend when he made his last allusion to Kronos in 1938.

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Aaron Esman

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BOOK REVIEWS

PROBLEMS OF PSYCHOANALYTIC TRAINING, DIAGNOSIS, AND THE TECHNIQUE OF THERAPY. 1966-1970. THE WRITINGS OF ANNA FREUD, VOL. VII. New York: International Universities Press, Inc., 1971. 312 pp.

With the publication of this volume, Anna Freud's collected works are brought virtually up to date. It is, by and large, a set of occasional pieces, composed over the past five years, some major, some minor, but all imbued with the harmony, richness of invention, and cadence that have characterized her work throughout her long and richly creative life.

The scope of these contributions—some reprinted, others newly published here—ranges from profoundly important reflections on crucial psychoanalytic and child development issues to rather transient mourning tributes and salutatory prefaces. Through most of them, however, certain leitmotifs appear that seem to serve as unifying principles drawing together this somewhat disparate collection. In several cases these reflect a return to old themes, reworked and reconsidered; in others the themes are new, but represent the development of motifs stated earlier but never fully exploited.

An instance of the latter is the paper, Problems of Termination in Child Analysis, a subject never before considered in the literature. Warning against premature termination, Miss Freud nonetheless discourages excessive therapeutic zeal with her admonition that 'no successful conflict solution on one [developmental] level can act as safeguard and immunization against the conflicts and difficulties in store for the individual in the future'. Further, she emphasizes here, as she does repeatedly throughout the volume, that child analysis is above all a therapy for neurotic conflict, and that the analyst who aims through analytic means alone to undo the effects of early precœdipal disturbances is more than likely to be doomed to frustration or to interminable efforts. Still another new venture is Miss Freud's consideration of the relative merits of residential versus foster care, in which her clarity of thought and her ability to cut to the heart of questions yield a concise and systematic set of criteria for the use of the various modes of surrogate care for children.

These same qualities of mind appear repeatedly in Miss Freud's

reprises of old subjects as well. Thus in her 1968 paper, Indications and Contraindications for Child Analysis, she returns to a topic she first assayed in 1945, but with a deepened appreciation of the complexities of early development and a clearer grasp of the differential diagnostic problems that underlie the decisions at issue. A further variation on this theme is elaborated in the magnificent essay, The Symptomatology of Childhood, in which she ventures what she modestly describes as a 'preliminary attempt at classification' but which is, in fact, a brilliantly concise formulation of the problem—and an elegant solution—of the nosology of childhood psychopathology, based on developmental constructs.

It is in the papers on training, however, that Miss Freud most fully strikes out in new directions. One gets the sense that it is this area that has most occupied her concern in her later years. In The Ideal Psychoanalytic Institute: A Utopia, she sets forth the design of a scheme for training based, as is her own center, on full-time attendance. There would be an emphasis on self-motivated study of theory, with constant cross-fertilization regarding clinical applications through the development of clinical work groups on all levels and with all types of patients. Students would be systematically trained, not only in clinical practice but in the recording and analysis of data and in the clarification of theoretical concepts. Analysts thus schooled and selected from varied backgrounds with somewhat less than the current concern for weeding out heretical thinkers and eccentrics, might, she suggests, contribute to the long-awaited revitalization of psychoanalytic thought.

This review can only hint at the fertility of this collection, which includes reflections on the relationship between psychoanalysis and the law, on the current state and problems of psychoanalysis, and other timely issues. It is true that one is occasionally brought up short by an overcategorical generalization, a somewhat archaic formulation, a metapsychological statement perhaps too firmly anchored in outmoded terminology. But these are minor details that do not in any substantial way vitiate the impact of Miss Freud's youthful air of tireless inquiry, the diamond-like sharpness of her language, and the openness of her spirit. These papers form a backdrop to her revolutionary Vienna Congress paper on aggression, not included here but yielding further evidence that, in the autumn of her life, she is perhaps the youngest of us all.

AARON ESMAN (NEW YORK)

RECOLLECTION AND RECONSTRUCTION; RECONSTRUCTION IN PSYCHOANALYSIS. (Monograph IV of the Kris Study Group of the New York Psychoanalytic Institute.) Edited by Bernard D. Fine, M.D., Edward D. Joseph, M.D., and Herbert F. Waldhorn, M.D. New York: International Universities Press, Inc., 1971. 128 pp.

Monograph IV really comprises two interrelated monographs on reconstruction, based on the work of analytic study groups under the chairmanship of Rudolph Loewenstein. The first section is reported by Edward Joseph and Burness Moore, the second section by Jerome Ennis. The reports are meritorious in being both laconic and erudite. The discussions are on a high level of analytic thinking and sophistication, and are balanced with varied clinical material and illustrations. After a brief review of the literature, there is lucid consideration of a gamut of topics including the definition of reconstruction, the technique and effects of reconstruction, its relationship to memory and recall, the metapsychology of the process of reconstruction for both analyst and patient, the sense of conviction, the validity of reconstruction, and the roles of fantasy and reality as determinants of a reconstruction.

The scope and breadth of these topics are of great importance to both psychoanalytic theory and clinical practice. It would be impossible in one monograph to elucidate fully all these themes and to reconstruct the stimulation, challenge, and group synthetic function. There are brief but profound debates: for instance, over the importance of discrete traumatic organizing experiences in development versus the modification, patterning, and secondary elaborations to which genetic events are subjected. The reconstruction of a childhood event and situation, with its intrapsychic meaning and ramifications, would most often be gradual, tentative, and aimed at multiple developmental areas. The reviewer would also agree that it is important to distinguish between real trauma and fantasies. To reconstruct accurately such trauma and the links between pathogenic experience and subsequent psychopathology is a formidable analytic task. The problems of reconstruction of the 'shock' event versus the pathological pattern are left unresolved, for the reader's reflection. The spectrum of developmental disturbance between traumatic fixation

and its complex aftermath are among the many research issues which are explicitly or implicitly raised. Variant views among the group participants sharpen the focus on problems left for further deliberation and exploration. This is parallel to reconstruction itself, which establishes a cohesive past and present, restores connection, and provides the opportunity for further growth of understanding.

Monograph IV forthrightly presents the difficulties that lie in the spiraling process of analytic conceptualization and the limitations of our knowledge. There are numerous enigmas of screening, repetition, and ego integration, particularly in relation to the precœdipal and preverbal period. An occasional superfluity of formulation may be a side effect of analytic group process.

On the whole, Monograph IV of the Kris Study Group is a fertile contribution which deserves careful reading and contemplation by all psychoanalysts and students of our science.

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

DEPENDENCE IN MAN. A PSYCHOANALYTIC STUDY. By Henri Parens, M.D. and Leon J. Saul, M.D. (Foreword by Margaret S. Mahler, M.D.) New York: International Universities Press, Inc., 1971. 261 pp.

Parens and Saul have written a very thoughtful book about a complex topic. The book is divided into three parts: a study of Freud's writings, theoretical considerations, and clinical considerations. Dependence is recognized as one of the significant human conditions, observed and formulated more clearly in the earlier years of life. Terms such as 'dependence in man' or 'object relations' refer to so many multiple variables and to so many changes through a lifetime that a book on such issues may easily suffer because it cannot be sufficiently outlined in all its details. As psychic structure becomes more and more complex, aspects of dependence are then coördinated with structure formation and its theoretical propositions. It seems that one cannot address oneself to dependence in man as if this were a 'unit of behavior'; instead one must define the variables as they emerge during development.

It is the more surprising how well the authors fare—in the review of Freud's writings on this subject and in the discussion of

the theoretical propositions which address themselves to dependence. The literature review linked to this topic has been done with great care and provides a highly stimulating experience in the evolvement of psychoanalytic theory through Freud's writing as well as in his particular concern with aspects of dependence. Similarly excellent are the theoretical considerations that deal with the genesis of psychologic dependence, 'inner sustainment', the process of internalization, the achievement of object constancy, and a section which outlines the coördinates of dependence.

One can see from these outlines the artful dissection of the topic from a metapsychological point of view. The authors lean on psychoanalytic theory but, not surprisingly, refer to ethology and other fields in order to bring data to bear on the definition and clarification of the broad range of function of dependence. In doing so, they evolve their own point of view by reviving earlier propositions from psychoanalytic theory.

As one examines dependence, one can be led to the biological concomitants of those psychic forces which reach out for the object—that is to say, to the 'biological demand' on psychic life, and thus one can speak about the link between the drives and the biological matrix. Ethologists refer to the term 'bond'; Bowlby referred to the capacity for attachment. The authors find it advisable to return to Freud's original two currents of the libido—the sensual and the affectional libido. Both are an expression of the libidinal drive under the auspices of the ego and of self-preservation. Furthermore, they refer to these under the heading of 'need'. On these concepts the authors organize the chapters and headings and the discussion of clinical and theoretical issues. In addition they propose, as they have done in earlier papers, the concept of inner sustainment and explore its usefulness within the context of dependence.

The authors found it necessary to divide libidinal strivings into two parts when they examined various aspects of dependence as seen through the several modalities of perception. Thus they do not refer here just to modes of channelization of libidinal strivings or areas of stimulation which then, in turn, affect the drive function; they propose two qualities of the libidinal strivings. These are derived from the earlier history of psychoanalysis when instincts and part-instincts were in the foreground of considerations.

Referring frequently to Mahler's work on separation-individuation, and accepting Anna Freud's line from dependence to independence and the achievement of self-reliance, the authors are led to the task of understanding the interplay between dependence, interdependence, and independence. There are new data from early infant observation which permit an outlining of emerging ego function and early dependence.

The third section, Some Clinical Aspects of Dependence, highlights the difficulties of applying theoretical formulations of dependence to clinical work. Here the authors make reference to those clinical manifestations seen during analysis. The examples are presented in vignette form. A page or two on such topics as Dependence Reactions, Dependence and Character Disorders, Fear of Loss of Father's Love Reactive to Competition with Him, and so forth, are only reminders of the clinical implications of the first two chapters. Thus one gains the impression that after an outline of the many facets of dependence in those chapters, the clinical vignette oversimplifies the manifestations of dependence.

This is a challenging book. It approaches many clinical and theoretical data from a vantage point different from that usually pursued. The historical review, which is more a study of the literature, is particularly informative and will be very useful to those who are interested in psychoanalytic child development and child observation. The theoretical discussion will, similarly, be of great interest. It brings into focus many concepts around the central issue, dependence in man.

PETER B. NEUBAUER (NEW YORK)

TALENT AND GENIUS. The Fictitious Case of Tausk contra Freud. By K. R. Eissler. Chicago: Quadrangle Books, Inc., 1971. 403 pp.

Eissler's subtitle, The Fictitious Case of Tausk contra Freud, is a reference to Paul Roazen's thesis in Brother Animal[1] that the brilliant pioneer, Victor Tausk, best known for his paper on the 'influencing machine',[2] was driven to suicide in 1919 at least in part by the indifference if not outright hostility of Freud to his troubled

[1] *Cf.*, review of Roazen, Paul: *Brother Animal. The Story of Freud and Tausk*, This QUARTERLY, XXXIX, 1970, pp. 631-633.

[2] *Cf.*, Tausk, Victor: *On the Origin of the 'Influencing Machine' in Schizophrenia*, This QUARTERLY, II, 1933, pp. 519-556.

and troublesome disciple. Few informed readers will fail to recognize obvious tendentiousness in Roazen's presentation of the facts and the inferences drawn from them. Eissler has most adequately corrected these.

Yet there is also an excess of zeal, as though a strained hypothesis must somehow be balanced by a strained antithesis. As Eissler himself puts it: 'I can imagine some book reviewer suggesting that the Roazen book was not good enough, to begin with, for such a serious and passionate rebuttal in book-length form. . . . it might be stated that you have stacked your argument for Freud, as it now stands, against a poor adversary' (p. 3).

The tone is suggested by these lines in a work which, nearly twice the length of the original, might well be called The Case of Eissler against Roazen. It is all the more unfortunate that an analytic atmosphere could not be maintained, for out of conflict arises the forgotten outlines of one of the most fascinating, creative, and tragic figures in analytic history. From the depths of a Kafka-esque personality, Tausk added his concepts of identity, ego boundaries, and self-feeling to the insights provided by psychoanalysis. Freud was self-disciplined and for him the ego was a system functioning in relation to reality; for the æsthetically sensitive Tausk, it was a subjective experience which complemented this objectivity. The relationship between the two men, which Eissler seeks to encompass in terms of a confrontation between genius and talent, was further accentuated by a generation gap (twenty-three years) and the inevitable contrasts between the world-famous leader and a permanently rebellious follower who was incapable of either leadership or independence.

These contrasts reciprocally illuminate both the characters of the principals and the milieu in which they moved, but this does not make them polar opposites as Roazen assumes, nor does it justify the detachment with which Eissler asserts that 'from the historical viewpoint, one can see that the small group that had gathered around Freud had one chief contribution to make. It can be stated without exaggeration, when viewed retrospectively, that its historical function was to provide Freud with that background of participating discussion and stimulation that he needed to maintain his creativity at its maximal power'—a function that should have been performed with 'tact' (pp. 37-38).

It might well be understandable that Tausk in particular was not disposed to view his historical function with such humility, nor to comport himself with the required tact. (His sons were named Marius and Victor Hugo after other champions of freedom.) He remained intensely loyal to Freud, but his voice was among the first—perhaps *the* first—to warn against mechanization and estrangement between the sharers of the analytic compact. His own works, written with considerable literary merit, were most characteristic when combining analytic insight with sympathy toward social protest, as in choosing a time of war to champion publicly the cause of deserters from the army of the Hapsburg monarchy, and to declare that it was the war profiteers who should be prosecuted.[3]

Not the least of the gains consequent to the re-emergence of Tausk from the background of genius is the increasing evidence that a most interesting self-analysis, not devoid of historical significance, is emerging from beneath the façade of his 'case histories'. To this Eissler now adds the hitherto relatively insignificant article, Ibsen the Druggist.[4]

MARK KANZER (NEW YORK)

DER MENSCH UND SEIN ES: BRIEFE, AUFSAETZE BIOGRAFISCHES (Man and His Id: Letters, Essays and Autobiographical Notes). By Georg Groddeck. Wiesbaden: Limes Verlag, 1970. 464 pp.

Georg Groddeck died in 1934 but his books are still being published in German and in English. His place in the history of psychoanalysis is assured by Freud's recognition of him in his adoption of Groddeck's term, 'the it', known in analytic terminology as 'the id'. Now a new book has been edited which includes, first, the correspondence between Groddeck and Freud from 1917 through 1934. Only a few of these letters have been published before and it is a pleasure to have them all available. There are also letters to his brother, his wife, and to his friend, Sandor Ferenczi.

The second section of the book is devoted to Groddeck's articles which appeared regularly in a journal he published for the use of his hospitalized patients. The last third of the book contains

[3] *Cf.*, Tausk, Victor: *On the Psychology of the War Deserter*, This QUARTERLY, XXXVIII, 1969, pp. 354-381.

[4] Tausk, Victor: *Ibsen the Druggist*, This QUARTERLY, III, 1934, pp. 137-141.

Groddeck's memoirs, a short essay by Ernst Simmel for Groddeck's sixtieth birthday, and a few reprints of reports about treatment with him by friends, patients, and colleagues.

The Freud-Groddeck correspondence gives special insights into the personality and development of Freud. For instance, one of his letters (April 17, 1921) contains a remarkable sketch of the relationship between ego, id, and superego, a sketch revealing interesting differences from his final formulation in The Ego and the Id. It is also refreshing to see the spirit in which Freud describes his enjoyment of the first analytic novel ever written, *Der Seelensucher,* which, incidentally, has never been translated.[1]

The correspondence started in 1917 after Groddeck had made himself totally unacceptable as a physician serving in the German army and was sent home, probably as a menace to military discipline. At this point he wrote a long letter to Freud intended as a kind of apology for having condemned psychoanalysis in public and in print without having studied it. Freud reacted with joyful surprise and received this pioneer of psychosomatic disease into the rank and file of analysts. Freud always showed a remarkable tolerance for this wild, demonic man, the sort of person he usually found offensive, and from whom he ordinarily kept his distance. In one letter Freud congratulated Groddeck on his marriage to a woman with whom he had lived for years. Freud confessed that he was a Victorian, lived as such, and had never felt at ease with a man who came to a psychoanalytic convention with his mistress! There are also several analytic and interpretative letters, including one in which Freud comments on Groddeck's provocative masochism and his split transference: he noted that Groddeck was affectionately devoted to him, but hostile in his ambivalence toward everyone else. Often Freud wrote like a mother to a hurt child.

Freud was anxious to bring Groddeck together with Ferenczi and when this finally was arranged, the two men became great and good friends for the rest of their lives. Ferenczi spent many vacations in Groddeck's sanitorium where he met visiting analysts such as Ernst Simmel, Karen Horney, and Frieda Fromm-Reich-

[1] For further information about this book, see, The Life and Work of Georg Groddeck, The Symbol Seeker, Chapter VII, in: *The Voice of the Symbol* by Martin Grotjahn. Los Angeles: Mara Publishers, 1972.

mann. Through all the years it was Groddeck's desire to get closer to Freud, perhaps even to get him to come to the sanitorium for a while, a fate that Freud skilfully sidestepped. It was Groddeck's intense desire to return some joy of life to Freud, who had once rescued him when he was in the depth of a depression. However, the men drifted apart: Groddeck into the wildness of his often poetic interpretations, and Freud into the darkness of his physical suffering.

It is of course not quite fair to review this book by discussing only the letters of Freud, since the rest of the book is of interest too. The autobiography is truly analytic and the articles reprinted are significant in demonstrating Groddeck's intuition. They are stimulating, at times upsetting, but always poetic and filled with the love of beauty and truth. We can only hope that this material will become available in English. The letters especially are unique in showing Freud in the role of tolerant friend, an open-minded reader of a friend's creative production. It is also refreshing to witness Groddeck's analytic enthusiasm, his courage, his originality, and his love of life.

MARTIN GROTJAHN (BEVERLY HILLS, CALIF.)

THE DOUBLE. A PSYCHOANALYTIC STUDY. By Otto Rank. Translated and edited, with an Introduction by Harry Tucker, Jr. Chapel Hill: The University of North Carolina Press, 1971. 88 pp.

Otto Rank's *Der Doppelgänger,* a psychoanalytic classic published in 1914 and amplified in 1925, has finally been translated into English. We can now enjoy this paper which we have known chiefly from Freud's reference to it in The Uncanny (1919). A monumental study in applied analysis, a remarkable contribution to and elucidation of narcissism, it first appeared in the same year as On Narcissism: An Introduction.

The bulk of the book consists of the amassing of literary tales and anthropological data regarding doubles. Rank introduces us to a film, The Student of Prague, in which a man surrenders his mirror image to a daemonic antagonist with whom he completes a Faustian pact. His reflection returns to haunt him until the hero's shooting his double results in his own death. In other novels and stories the double is a shadow or a person identical with the hero,

who plagues the main character. Summaries of many myths, tales, and superstitious beliefs help to clarify the meaning of the double. The author presents anthropological data demonstrating that souls in addition to reflections and shadows fall into this category. In one chapter Rank shows that many of the romantic authors who wrote about doubles were personally besieged by uncanny fantasies regarding such phenomena.

In a final section Rank integrates his findings in a theoretical exposition. Emphasizing narcissism, he states that the double can represent the self, persons equivalent to the self, or aspects of the self. As an alter ego the double can be loved. However, narcissism being a dangerous interference in object love, hatred and revulsion may be used as defenses against it. The double can also be a reassurance against, as well as a representation of, death. As such, following Freud's study, The Theme of the Three Caskets (1913), it 'finds its deepest foundation in the relationship with the mother' (p. 70). In addition the double can stand for the father or the brother, to whom one is narcissistically attached.

These formulations, which I have incompletely summarized, are excellent. The reader must place Rank's contribution in theoretical and historical perspective, a task not fully performed by the editor. Although this brief review is no place for an expanded historical survey, a few words are in order. In 1914 the framework for psychoanalytic thinking was the first instinct theory in which drives were classified as sexual and self-preservative. The topographical point of view led one to see conflict as between the conscious and the unconscious. Rank uses the term *ego,* as was customary, to refer to a variety of concepts including the self, the conscious part of the personality, and a still poorly defined aspect of the personality which performed defensive functions. The term *self-representation* was yet to be invented and hence could not be used to provide a clarifying definition of narcissism as libidinal cathexis of the self or self-representation.

Part of the joy in reading this book is to reconsider Rank's formulations in the light of present knowledge. A certain amount of translation is necessary. As I have indicated, 'self' must often be substituted for 'ego'. In addition the reader will be reminded of the enriching work of Lewin, Mahler, Jacobson, and Kohut, to mention but a few of the contributors to the psychoanalytic liter-

ature on narcissism. Applying Lewin's findings on the oral triad, he will note that the fear and revulsion of the double can result from the anxiety regarding fusion with and being eaten by the precedipal mother. Such fears are often regressive expressions of dread of castration. And in wondering why the double may represent the self and mother, he will recall that the self- and object-representations of the symbiotic phase are poorly differentiated, making the love for the mother narcissistic.

I offer these few formulations to put The Double in perspective and to indicate the pleasure the reader will have in applying our present knowledge to the wealth of data and theory that Rank provides.

JULES GLENN (GREAT NECK, N. Y.)

EVIL IN MAN: THE ANATOMY OF HATE AND VIOLENCE. By Gustav Bychowski, M.D. New York: Grune & Stratton, Inc., 1968. 98 pp.

In these times of polarization, it requires more than the ordinary measure of courage to feel strongly about the issues of the day and, at the same time, to be able to stand apart sufficiently to observe and to try to understand the origin and meanings of the passions racking the body politic. Even more than courage and concern are needed; a broad perspective of history, of human motivation, and group interaction is essential. This is exactly what the author has undertaken in a pithy, cogent, and moving monograph, Evil in Man. Combining his reflections as a citizen and psychoanalyst, Bychowski strikes a fair balance between what psychoanalysis has learned about aggression in the individual and in the group and what history and sociology can teach.

The author searches out the vicissitudes of aggression from instances of individual psychopathology, to motorcycle gangs, national prejudices, riots, and war. He places the data in the context of the philosophic, scientific, and religious tradition of our society. While he is mindful of the complexities of the problem, he dares to cut through the cultural rationalizations and to confront the reader with the truth of man's and society's corruptibility and weakness. He does a particular service when he emphasizes how anxiety and fear lead to hatred and destruction in the individual and the mass.

Bychowski concludes on a note of cautious optimism. He feels that our present knowledge of human behavior has reached a stage where we should be able to apply it to the practical conduct of human affairs. In this direction he offers a number of suggestions, ranging from sociopolitical changes to principles of education. Most of these suggestions have been put forth earlier, in other ways, but when brought together in this context, they can be appreciated as a program integrated by a consistent rationale.

JACOB A. ARLOW (NEW YORK)

FREUD AND PHILOSOPHY. AN ESSAY ON INTERPRETATION. By Paul Ricoeur. New Haven: Yale University Press, 1970. 573 pp.

Sigmund Freud wrote in a letter to Fliess, ' . . . I secretly nurse the hope of arriving by the same route (i.e., medicine) at my original objective, philosophy. For that was my original ambition before I knew what I was intended to do in the world.'[1] Yet freudians have attacked and disclaimed philosophy, and philosophers have challenged the scientific basis for psychoanalysis. What are the complex interrelationships between these two overlapping fields? Does freudianism contain an implicit philosophical point of view far more complex than the limited psychic determinism, in spite of Freud's disclaimer of a psychoanalytic *Weltanschauung*?

Paul Ricoeur, a French religious philosopher who has not been analyzed nor practiced analysis, has written an important book, a stimulating tour de force that allows us to envisage both the psychoanalytic body of knowledge and the psychoanalytic movement in a broad perspective within the framework of its links to culture, history, and the evolution of Western intellectual thought. In the course of his book, he makes many observations on what he believes comprises the psychoanalytic ethic and philosophy.

The author is clearly not a narrow polemicist. In keeping with an ancient philosophical tradition, he challenges Freud to a textual, epistemological debate, only occasionally straying from the content of psychoanalysis as elaborated in Freud's complete works. Ricoeur respects the brilliance and innovativeness of his antagonist, and the debate forms an intriguing dialectical discourse

[1] Freud: *The Origins of Psychoanalysis. Letters to Wilhelm Fliess, Drafts and Notes: 1887-1902*. New York: Basic Books, Inc., p. 141.

that reaches a climax in the third section of the book with a synthesis of Cartesian, Husserlian, Hegelian, and freudian thinking. Semantics, symbolic logic, mythology, world literature, the various philosophies of science, symbolism, religion, and history are familiar terrain for the author. Thus he can serve as our guide on a journey that covers a vast and complex territory. Ironically though, the middle section of the book, A Reading of Freud, is a clear though necessarily selective summary of the evolution of Freud's thinking from the Project onward, and is a good review.

Ricoeur's book represents a stage in the development of a comprehensive religious philosophy in a man who is intellectually intrigued by history, the unconscious, science, and reason, but also by phenomenological[2] and religious thought. In the course of his introspective reasoning, Ricoeur intrigues us with a panoramic view of freudian metapsychology. He has the capacity to take the essence from complex ideas and express it in amazingly succinct forms. The reader cannot help but enter into his own dialectical debate with the author.

There is an interesting section on Freud's Project, which is discussed within the framework of the state of science during the nineteenth century. Freud's determinism at that time was anatomical and mechanistic, resulting in an attempt, as Ricoeur points out, to crowd a mass of clinical facts into a limited framework. Freud later moved toward placing energy on a higher abstract level, i.e., libido; biologically based concepts, such as the constancy principle, then moved on to higher levels of meaning. As the book unfolds and the 'neuron' dissolves, the libido concept is joined by eros. The repetition compulsion and death instinct appear and Ricoeur muses, 'Having reached this ultimate phase of metapsychology, one may then wonder whether the Freudian theory has restored the *Naturphilosophie,* which the school of Helmholtz endeavored to overthrow, and Goethe's *Weltanschauung* which the young Freud admired so much. If so, then Freud will have brought to pass the prophecy he made about himself, to return to philosophy by way of medicine and psychology.'

Much of Ricoeur's book is an attempt on a rational philosophical and psychological level to correlate and interrelate hermeneu-

[2] Phenomenology is used in its philosophical, not psychiatric sense.

tic (interpretive) concepts such as 'apparent meaning and hidden meaning, symptoms and fantasy, and ideas, with economic concepts such as cathexis, displacement, substitution, projection and internalization. . . . We have seen that the specificity of the analytic discourse ultimately lies in the relation between instinct as the primary energy concept and instinctual representatives as the primary hermeneutic concept; such discourse unites the two universes of force and meaning in a semantics of desire.' The author tries to show the uniqueness of the psychoanalytic situation which operates in the field of desire as it moves into speech, where a 'story' is told that must be deciphered.

The metapsychological papers are reviewed, evaluated, and discussed, and fascinating critiques are made of many of Freud's ideas that, to Ricoeur, present conceptual difficulties. He covers in some depth the theories of psychic representation, narcissism, identification, instinct, sublimation, the reality principle, object choice, and negation (with its rich philosophical associations).

Ricoeur discusses the use of the analogies between dreams, neuroses, art, and religion, and points to the weaknesses of Freud's æsthetic and cultural essays. He criticizes the equation of religion and neurosis and notes that for Freud art seems to have been exempt from a reductionistic explanation. The limitations of attempts to explain art and religion by content alone are discussed (though of course this failing is seen less frequently in the writings of ego psychology). He stresses the 'looking backward in dreams' while the work of art 'goes ahead of the artist'; Ricoeur does not see this conflict as unresolvable. 'Could it be that the true meaning of sublimation is to promote new meanings by mobilizing old energies initially invested in archaic figures?'

In his appraisal of Eros, Thanatos, and Ananke, Ricoeur shows how the epistemological level of the reality principle changes from one linked with the pleasure principle to that approximating a 'quasi-mythical force' after the introduction of the death instinct. He feels a philosophical meaning is attached by Freud to reality. On that level the attainment of reality becomes linked with the attainment of pleasure wherever possible, resignation to the inevitable vale of suffering, resignation to the sacrifice of illusion and consolation, adjustment to a world shorn of God, the Father, and submission to the twin gods of Logos and Ananke.

The current cultural trends in the young, especially the movement toward action or withdrawal, the thirst for psychedelic and mystical experience, and even more recently, the phenomenon of religious revival cannot be seen exclusively as regression and escape from reality. The gods, Logos and Ananke (Reason and Necessity), are not worshipped in an age of anxiety, alienation, and apocalyptic fear. Ricoeur's book enables the reader to reflect on the interrelationships between the levels of the psychoanalytic situation, the reality principle, and the pleasure principle, the more philosophical level of Eros and Thanatos, and their expression in cultural trends; at the same time one can appreciate their precursors in the development of Freud, the man. In this context Freud is seen as a philosophical negator of philosophy, as religiously attacking religion while entertaining such nearly transcendent, mythopoetic concepts as Eros and Thanatos.

Psychoanalysts may find the author's views on the current debate between behaviorists or operationalists and the freudians one of the most interesting aspects of the book. Ricoeur 'accepts' the premise of these psychological schools that psychoanalysis is not an observational science, although ultimately he turns the attack into a defense of analysis. 'Psychology is an observational science dealing with the facts of behavior; psychoanalysis is an exegetical (interpretive) science dealing with the relationships of meaning between substitute objects and the primordial (and lost) instinctual objects. The two disciplines diverge from the very beginning, at the level of the initial notion of fact and of inference from facts.' For the analyst, behavior is not a 'dependent variable observable from without, but is rather the expression of the change of meaning of the subject's history as [it is] revealed in the analytical situation'. Ricoeur quotes Hartmann who said, 'A considerable part of the psychoanalytic work can be described as the use of "signs" '. In this sense one speaks of the psychoanalytic method as a method of interpretation. Ricoeur points out that work with the symbol, signal, and expressive signs might 'break through the epistemological framework taken from the experimental sciences of nature'.

Many psychoanalysts will disagree with Ricoeur. I offer a few of my own observations at this point. It is important to differentiate between the observation of nonverbal behavior and obser-

vation of the verbal productions of the patient. The latter is divided into two categories: 1, the observation of the *form* of the verbalization which is at the same epistemological level as the observation of nonverbal behavior, and 2, the registration in the analyst's mind of the *meaning* of what is said. These functions can be illustrated, for example, by listening to someone speak in a foreign language that has been learned by the listener. The tone, form, timing, etc., stand out. However, once the language has been understood, interpretation and registration of meaning intervene and any 'facts' that are ascertained about the past or the unconscious are no longer observed facts but are 'interpreted' facts on another level of knowledge. Interpretation here is used in its receptive semantic sense, and is linked to the analyst's capacity to 'observe' meaning.

A value of the analyst being analyzed that has been noted is that his *analytic instrument* can become a *scientific instrument* of observation. Hopefully, analysis will never eliminate the semantic levels of our thinking; hence the analytic situation, as it applies to utilizing the *meaning* of the patient's story, consists of two people both utilizing their signifying, symbolic processes and their interpretive skills. The analyst's own analysis reduces the error or bias in interpretation, but does not change its semantic nature. In this sense the analytic situation is one that transcends the observational sciences as well as the experimental sciences. However, it is not relegated by Ricoeur to speculation, or even to art, and retains its special links to science, but to an interpretive science.

In this important conflictual area, I do not feel that Ricoeur either misunderstands or is inimical to the psychoanalytic situation, but rather is a defender of its unique qualities. He sees it as a dyadic dialogue, a relationship predominantly in the realm of the verbal sphere where interpretive and creative work is done. Ricoeur wonders whether attempts to force it into the cubbyhole of a strict observational science will not dissipate some of its uniqueness. Of course, it should be stated that modern clinical analysis is frequently sprinkled with modifications that may require evaluation on a different epistemological level.

Ricoeur follows the not infrequently traveled road of observers of the psychoanalytic scene by noting a greater resemblance of psychoanalysis to the theory of historical motivation than to that of nat-

ural explanation. He feels the validity of interpretation made in psychoanalysis is subject to the same kind of questions as the validity of a historical or exegetical interpretation.

With the growth of ego psychology, a more overt recognition of the actuality of the therapeutic alliance, and the acceptance of a greater number of 'borderline' patients into adult analysis, there is increasing realization that we are not only in an area of meaning or insight, but that there are developmental tasks to be redone. We now see more preœdipal difficulties, structural weaknesses, and developmental lags in our patients (and, retrospectively, in Freud's original patients). Surely between Ricoeur's exegetical concept of analysis and, for instance, Franz Alexander's 'corrective emotional experience'—or a purely interactional and developmental view of the analytic situation—lies a middle ground. However, Ricoeur's evaluations in depth about the hermeneutic aspects of psychoanalysis can only be valuable to it.

From another standpoint the anachronistic nature of the book is frustrating, and a great deal of energy must be spent in extrapolating its ideas into present clinical work. Also, many of Ricoeur's criticisms of Freud's theory have already been made within the movement itself, some of them even having become more or less institutionalized. Ricoeur's concern about the reductionism, pessimism, and the disillusioning qualities of freudian psychoanalysis must be taken in this light. However, the implications of the effect of this aspect of the freudian ethic, at least in the general culture, cannot be ignored after reading this book.

Psychoanalysis as a body of knowledge is based on a philosophy of psychic determinism, but clinically it is ultimately interested in intrapsychic reality and a sense of conviction about such; hence it is subjectivistic in its clinical orientation and sees the danger of reality itself in a reconstruction that is devoid of affects. Ricoeur stresses the solipsistic aspect of topographic-economic theory from the standpoint of the language and form of the metapsychology that deals with the object as an internal representation. Meanwhile the interpersonal (or, in Hegelian terms, intersubjective) qualities of the patient's childhood, present relationships, and the transference are not encompassed in the language of the model. It is helpful to be aware of the manner in which the metapsychology itself can affect our own clinical language and

our perception of the clinical situation. Ricoeur's book stimulates this self-evaluation through the doorway of language.

The last, most innovative, and most difficult section of the book is entitled Dialectic. Here Ricoeur logically discusses the many sides of his inner debate between a 'demystifying' freudian hermeneutics and one which restores meaning, between regression and progression, between a psychological archeology and a teleology, and, importantly, between the abstract and the concrete. ('The concrete is the final conquest of thought.') Ricoeur undertakes a discussion of the complex interrelationships of Husserlian phenomenology, Hegelian dialectics, semantics, and psychoanalysis in order to develop and synthesize a philosophy of reflection with the introspective but intersubjective (interpersonal) analytic dialogue. In other terms, can there be a synthesis between the intrapsychic experiences of the reflective philosopher and the reflection taking place in the analyst within the framework of the dyadic dialogue? A complex task! Ricoeur ingeniously attempts to do what seems impossible: to show the related areas between phenomenological ideas and freudian topographic and structural thinking. He entertains a view that all the great philosophies 'contain the same things but in a different order'; but nevertheless he is a militant antieclectic, directing his scepticism at the neo-Freudian schools.

The psychology of phenomenology to Ricoeur, surprisingly, implies the presence of the not perceived, an unconscious, or more specifically, a preconscious. The limits of phenomenology in the realm of ideation are pointed out. Ricoeur feels that the analytic situation provides an area to study this further.

The author notes the freudian stress on the past and sees it as 'a revelation of the archaic, a manifestation of the ever prior'. The true stress in a freudian philosophy, he believes, is on the anterior, a psychic archeology. It attempts 'the restoration of the old in the features of the new'. This is contrasted with the *spirit* and its posteriority and futurity. The defect of a system of symbols which have only past reductive determinants is pointed out, leading to Ricoeur's regarding symbols as ambiguous or, in freudian terms, multiply determined. He shows this in his view of art symbols: '. . . in the work of art the emphasis is on disclosure; thus works of art tend to be prospective symbols of man's personal synthesis

and of man's future and not merely a regressive symptom of the artist's unresolved conflicts'. He feels symbols show progressive and regressive forces in a united framework, that these are inseparable, that disclosure and disguise are fused, and cause and motive are dialectically raised to advance meaning.

Ricoeur shares with modern freudian ego psychology its scholarliness, its interest in the healthy side of the personality, its humanism, its fascination with creativity, its preoccupation with multiple determinants, its own building momentum against reductionism and simplistic behaviorism and operationalism, and its thrust toward a general psychology. His book lives somewhere in the broad interface between psychoanalysis and religious philosophy. His attempts to make sweeping syntheses of Hegelian, Husserlian, and freudian thinking demand respect as we follow the writings of this introspective man who is clearly in the same tradition that led Freud to greatness. I can only feel that Freud would have regarded this critique as a challenge and a tribute.

SIMON A. GROLNICK (BROOKLYN, N. Y.)

THE PSYCHOANALYTIC INTERPRETATION OF HISTORY. Edited by Benjamin B. Wolman. New York: Basic Books, Inc., 1971. 240 pp.

This volume is composed of seven essays by prominent psychoanalysts, historians, and psychologists. The spirit of this compilation is conveyed in William Langer's introduction. As in his inaugural presidential address to the American Historical Association some fifteen years ago, Langer emphasizes the importance of coöperative efforts between historians and modern psychologists. His influence in this direction upon the younger generation of historians has been most effective and fruitful.

An outstanding example of the mastery of psychoanalytic knowledge by a historian is the superb psychobiographical essay by Peter Lowenberg on Theodore Herzl. Lowenberg displays his full armamentarium as an experienced research historian and a highly integrated student of psychoanalytic dynamics and technique. This results in an unusual portrait in depth of Herzl and a penetrating psychological study of his role as the founder of Zionism. There are also two interesting studies of Stalin and Hitler by Gustav Bychowski and R. G. L. Waite, respectively. Bychowski's

keen sophistication as a psychoanalyst and Waite's expertise on Nazism are clearly reflected in their studies.

The first half of the book contains four essays on the interpretation of history by Robert Waelder, Robert Lifton, Ronald Grimsley, and Benjamin Wolman. These essays reflect the personal interest of their authors in given areas of history and psychoanalysis more than a unifying approach to the psychoanalytic interpretation of history. Waelder's essay on psychoanalysis and history stresses the importance of mixed motives in human motivation. This is an extension and an elaboration of Waelder's early important contribution to psychoanalysis on the principle of multiple functioning, made during a later period in his life when his interest had turned to psychoanalysis and its relation to historiography. With equal emphasis on the importance of group psychology in this field of investigation, Waelder illustrates his formulations with an array of examples that include the Austrian revolution in 1918 and the revival of the popularity of the British monarchy.

If Waelder's literary style can be described as being in the tradition of gracious Viennese café analysis, one might consider Lifton's essay on Protean man to be crisp literary neo-American academic ego analysis. Lifton creates a fascinating psychological reconstruction of contemporary man with his 'capacity for polymorphous versatility', his attitude of 'the end of ideology', and his integration of his inner sense of absurdity. This is followed by Grimsley's erudite essay, Psychoanalysis and Literary Criticism, which is unfortunately completely out of bounds in this book on history and psychoanalysis.

Wolman, who served as editor for this volume, has written a judicious essay on sense and nonsense in history. His emphatic statement that there are no laws of history other than those laws which underlie human behavior becomes the ultimate justification for this and future studies on the psychoanalytic interpretation of history.

† PHILIP WEISSMAN (NEW YORK)

GEORGE III AND THE MAD BUSINESS. By Ida Macalpine and Richard Hunter. New York: Pantheon Books, 1969. 407 pp.

No easy task confronts the psychoanalytically trained reviewer of this study of America's last king and 'Psychiatry's most famous

patient', which contains within its pages a spectrum of attributes ranging from medical brilliance to psychiatric bumbling. The latter is all the more remarkable since the work is a product of the same writers who not long ago brought out a sophisticated and informed renewed inquiry into another celebrated psychiatric case: Senatspräsident Daniel Paul Schreber. Still earlier the senior author published a paper on transference that continues to enjoy a high reputation in the psychoanalytic literature. Yet paradoxically it is precisely within the scope of the authors' psychoanalytic expertise as manifested in these two works in particular that the present study falls down.

As chroniclers of medical history they are superb: from the point of view of pathography George III and the Mad Business is an undeniable tour de force. Armed with a long catalogue of painstakingly assembled data, interspersed with plausible hunches, the authors bring forward persuasive evidence that the mental illness of the King was a manifestation, not of a manic-depressive illness, as has been commonly assumed, but of a hereditary metabolic disorder, porphyria. With the taut logic of a well-knit mystery story the drama of the King's recurring ailments is unfolded; point by point the similarities are tracked down between his malady and the known course of acute intermittent porphyria, and finally, in the best tradition of a British thriller, the clincher is provided by a tinted telltale clue—during certain phases of His Majesty's illness, his urine was colored red.

But this engrossing essay is not limited to the illness of King George. As a Mendelian dominant trait whose appearance may be expected in roughly half the offspring of afflicted individuals, evidence of porphyria has been sought by the authors among his ancestors, his collaterals, and his descendants. The results of their investigation are indeed impressive, for beginning with Mary Queen of Scots they offer highly suggestive evidence that in varying degrees of severity, porphyria, like hemophilia, has been an affliction of royalty, affecting not only the House of Hanover but the Stuarts, the Tudors, and the rulers of Prussia.

That a cold in the head impaired Napoleon's judgment at Borodino is questionable, but if the thesis of Drs. Macalpine and Hunter is valid there is every reason to ascribe to porphyria an important influence on the course of British and European history.

For here was a disease that struck down royal personages with such frightening rapidity that more than once there was suspicion of foul play. Not only was the sixty-year-long reign of George III periodically interrupted by the physical and mental ravages of his malady; the very succession to his throne was similarly determined. One week before his death on January 29, 1820, his son Edward, Duke of Kent and father of Victoria, suddenly died; on January 28, the day before the Prince of Wales would become George IV, he was stricken with so severe an attack that his life was despaired of. It was indeed the death in childbirth in 1817 of George IV's daughter, the Princess Charlotte, another apparent victim of porphyria, that was responsible for the accession of Victoria to the throne of England, for Charlotte's child, a male, was born dead after a prolonged confinement.

Although it is hardly possible today to accept as proven the correctness of the authors' diagnoses of illnesses occurring more than a hundred years before the initial description of porphyria, it cannot be denied that their arguments are strongly persuasive and no less beguiling. What further implications they have drawn from their conclusions, however, are far from satisfactory.

Most arresting is the unavoidable impression that the authors have advanced the diagnosis of the King's porphyria in the manner of a polemic, designed, it would appear, to vindicate his reputation and clear him of the seeming stigma of an endogenous psychosis. To this end they stoutly deny the generally held opinion that he was mentally sick during his bouts of physical illness in his early adult life, explaining that belief in these 'legendary mental breakdowns' has been essential for the theory that the King suffered from a manic-depressive psychosis. On the contrary they insist that he became deranged for the first time at the age of fifty and that in the ensuing twenty-three years the duration of his derangement added up to less than six months.

Now while there is no disputing the desirability of correcting historical or medical error, not infrequently there is a contentious note in their presentation that would appear rather inappropriate in a scientific inquiry. When they state that they have striven to correct 'the fanciful picture of a weak and neurotic personality, prone to "mental breakdowns" ', it is difficult to avoid the impression that they have been influenced by personal feelings toward

their subject, much as if they were rushing furiously to the defense of a maligned member of the family. Perhaps it is this quasi countertransference element that is responsible for the failure of their portrait of the King to come to life, for in the heat of their passionate concern to establish an 'organic' diagnosis the authors have focused on the patient rather than the person, thereby losing sight of those human qualities in their subject, who became ill, both physically and mentally, under circumstances which a more detached observer might endow with pathogenic significance. In such matters the authors display little interest. Having established their diagnosis fairly conclusively, they seem to feel as if psychodynamic formulations do not apply—either to the sphere of physical illness in general or to organic mental illness in particular. Yet despite the fact that it is a hereditary condition, acute intermittent porphyria, like epilepsy, asthma, and many other psychosomatic illnesses, is a recurring and sporadic disorder interspersed with periods of complete well-being. Hence an adequate clinical study of the disease should include a search for those influences that are known to precipitate outbreaks of its symptomatology: toxins, drugs, alcohol, and, by no means the least important, psychologic factors.

While there is no evidence that the King's illnesses were precipitated by physical agents—he was apparently abstemious of alcohol—there are ample indications from the authors' own voluminous data that his attacks occurred consistently during periods of unusual stress and mental suffering, most commonly associated with his intimate relationships and characteristically involved with problems of separation and loss. His mental illness of 1810 offers a particularly clear example.

On the 25th of October his family gathered around him to celebrate the fiftieth anniversary of his accession. The party was marred, however, less by the fact that the King was virtually blind than by the circumstance that his youngest and favorite daughter, the Princess Amelia, was on her death bed. It was soon apparent to those about him that his old malady had returned: he displayed a 'great and increasing agitation of the mind', severe insomnia, incessant talking, and confusion. When he became 'extremely violent' it was necessary to put him in a strait jacket. Then he began to improve and by the 11th of November he started to

inquire about his condition. 'Only now', write the authors, 'could he comprehend the death of the Princess Amelia on 2 November, although attempts had been made before to convey it to him'. Restraints were removed on the following day, but on the night of the 16th, after he had attempted to go through his dead daughter's effects he suffered a severe relapse. Even his own physician recognized that the illness had 'come on from the anxiety of his mind upon the illness of his daughter'.

It is asserted that the King was very possessive of his daughters, allegedly forbidding them to marry before the age of thirty. When Amelia sought his permission to marry in 1808 at the age of twenty-five he is said to have withheld it. Subsequently she was stricken with a grave illness, confessed to her father her wickedness—it is said she had contracted a morganatic marriage—and gave him a ring containing a lock of her hair, begging him never to forget her. Under the circumstances it is hardly remarkable that he suffered a renewed outbreak of his illness as she lay dying, nor that in the course of that illness, during which his loss was denied, he fancied he could recall from the dead anyone he chose and make them of any age.

This was not the first time that the King had asserted his power of recalling the dead. During his severe illness of 1788 he claimed that his youngest son, Octavius, who had died four years before after a smallpox inoculation, had been reborn. His behavior at this time is arresting: 'He had got a pillow case round his head, and the pillow in bed with him, which he called Prince Octavius who he said was to be new born this day'. Surely this sounds like a male pregnancy or parturition fantasy, just like those the authors described in their Schreber article. 'Some patients', they reported, 'had symptoms reminiscent of the couvade, a custom in which archaic pregnancy fantasies in the male are also expressed in physical symptoms'. Yet although they had no difficulty in recognizing such fantasies in their patients and in Schreber, they apparently saw nothing of the sort in King George, or in other members of the House of Hanover for that matter. Indeed although some writers believed that the abdominal pains suffered by his son, the Duke of Kent, when his wife was pregnant (with Victoria), were a manifestation of the couvade, Macalpine and Hunter dismiss it out of hand: 'Thus, because the medical significance of his ab-

dominal colic [porphyria, presumably] was not appreciated, it was endowed with psychological significance'. It is not surprising to note that in the course of their vehement, and quite possibly valid, insistence that the King was not mentally deranged during his illnesses of 1762 and 1765, they failed to attach any significance to the fact that on both occasions the Queen was in a very advanced state of pregnancy. It would appear as if Macalpine and Hunter have excluded from their understanding of King George III anything that was reminiscent of Daniel Schreber.

Further indications that the authors hold that the establishment of an 'organic' diagnosis eliminates the validity, or the necessity, of psychodynamic formulations are found in their discussions of the King's marital fortunes. During his 1788 illness the King asserted that all marriages would soon be dissolved by Acts of Parliament. That this notion applied to his own marriage in particular seems plain, for coupled with this delusion were 'phantoms' concerning Elizabeth, Countess of Pembroke, with whom the King had fallen in love at eighteen, but whom he had been prevented from marrying. Once again it would appear that his psychosis served as the vehicle for the fulfilment of wishes and the means of denying an unpalatable reality, for it was during that illness and in subsequent attacks that he claimed he was married to Elizabeth, toasted her as his wife, and referred to her as Queen Esther and himself as Ahasuerus. Despite the authors' knowledge of these ravings, despite their repeated allusions to a progressive estrangement between the King and his wife, despite the King's decision in 1804 to live apart from the Queen, and despite his threats to take a mistress, the writers persist in minimizing all of it; on virtually the last page of the book they allude to the King's 'satisfactory married life'. They remind the reader that Elizabeth was a grandmother over fifty years of age, and Lady of the Bedchamber to the Queen, when he called her his 'wife'. 'She therefore belonged to his everyday environment, had done so for years and continued to do so. It is well to remember this', they continue, 'because his preoccupation with his relation to her came to play an *unwholesome part* in later studies of the illness' (Italics added). Indeed they reject out of hand that such fancies possess any significance. 'To such absurdities may historic figures be reduced when the mutterings of a delirious mind deranged by an intoxicated brain are interpreted

as wish-fulfilments and as revealing the conflicts responsible for the illness. The fundamental fallacy of the psychological approach [is that] the effects of the illness were mistaken for its cause.' Who can fail to marvel at such feats of denial, whereby the most elementary principles of dynamic psychiatry have been drowned in a pool of ruby-colored urine!

In his essay on Leonardo da Vinci, Freud warned the future biographer against the temptation of idealizing his subject in order to gratify an infantile fantasy, alluding in particular to a revival of a childhood concept of the author's father. From the foregoing it would seem that there are grounds for suspecting that this caution is particularly relevant to the work at hand—the study of an English king by two English psychoanalysts who, hampered it would seem by unrecognized attitudes toward their subject, have fallen somewhat short in bestowing upon an undeniably fascinating work their greatest potential.

BERNARD C. MEYER (NEW YORK)

AFTER GREAT PAIN. The Inner Life of Emily Dickinson. By John Cody, M.D. Cambridge: Harvard University Press, 1971. 538 pp.

Psychoanalytic biography has been chronically beset by the inverted pyramid effect: a bewildering variety of manifestations at the surface, all resting on a few etiological molecules. To be sure, some molecules are more important than others, and as in embryonic development, influences at critical phases of mental development have consequences out of proportion to their apparent magnitude. The trouble is that often too many consequences flow from too few recognizable influences, and the principle of overdetermination has to be invoked on faith. The crux of the difficulty has been exposed frequently; books cannot talk back, as patients can, and reconstructions of the unconscious memories of authors cannot be scrutinized in the light of present memories and affects.

John Cody, a psychiatrist, in this very engaging and massively researched psychoanalytic biography of Emily Dickinson, reminds his readers of the biographer's advantages over the analyst working with the living patient. His subject's life is over, and it is a whole

life that comes under observation. In the case of the writer, especially the poet, we work with a source of exceptional richness of expression. This is undeniable if the biographer's intention is limited to discovering the unconscious elements in the writings, and therefore in the writer. Trouble comes when the biographer approaches these findings psychogenetically, looking for historical events from which these unconscious consequences followed. Inevitably then he must lapse into that form of language which could be called the 'conjectural conditional', represented by the repeated use of 'might' and 'possibly' and 'probably' and 'must have been'. The biographer has to fill in the lacunae of history with 'traumatic events', resembling psychoanalytic reconstructions, but, unlike them, untestable.

These general strictures notwithstanding, I believe the reader will see the poems of Emily Dickinson in greater depth after following Dr. Cody in this long journey into the unconscious mind of the poet, through the inferno of despair in which she lived. He has, it seems, three purposes in making this journey: first, to write a pathography; second, to attempt a psychoanalytic literary study of some of the poems; third, to study the psychology of creativity. The whole work, however, is dependent upon the pathography.

Many before Dr. Cody, suspected that the poet-recluse had a psychotic phase, but on the evidence of the poems themselves, in addition to the letters and some hitherto unpublished family sources and scant objective data, the author infers an episode that can be dated definitely and its nature described, though not without speculation. Its prodromata are specified, and also its apparently spontaneous cure, as well as the great influence of the experience on the poet's creative life.

Analysis of some of the poems reveals specific unconscious themes, provided that one accepts the methodological assumptions. Translation of symbols, for example, which the analyst performs so sparingly in actual analysis, becomes indispensable in the absence of immediately pertinent associative material. A detailed analysis of the obscure but highly evocative poem 'My life had stood—a loaded gun' depends on the application of traditional psychoanalytic interpretations of such images as 'gun', 'woods', 'doe', 'mountains', 'thumb'. The effort is worth while,

because Dr. Cody moves freely about the poem, like any literary critic, in search of the internal connections of the symbols, and he emerges with an over-all interpretation that can be taken seriously.

The question of creativity is most problematic. Dr. Cody seems to believe that his analysis of Emily Dickinson through the available data demonstrates that she wrote *because* of her early childhood traumas. Her mother was probably a severe depressive, and it is not a wild conjecture to suppose that her capacity for mothering was limited. Nor are the inferences from the poet's writings themselves improbable. The difficulty is that we really do not know much about the actual relations between mother and daughter, and, of greater importance, no amount of this kind of information could by its nature instruct us on the question at hand: how did she become a poet?

Like many others, the author obscures the difference between creativity and content. Psychoanalysis of literary works can penetrate deeply into the unconscious intentions of the literary content (by which I do not mean anything separate from the form of the work) but it tells us nothing about the fact of creativity. Some analysts, notably Kris, Erikson, and Greenacre (whose work is not discussed by Dr. Cody), have entered into finer descriptions of the antecedent conditions of the creative process with regard to both genetic and epigenetic elements, and also the alterations in the ego states involved. The creative function itself has not been explained, and cannot be explained by the analysis of content. Perhaps it is not incumbent on psychoanalysis to provide an explanation.

STANLEY A. LEAVY (NEW HAVEN, CONN.)

THE PSYCHOPATHOLOGY OF ADOLESCENCE. Edited by Joseph Zubin, Ph.D. and Alfred M. Freedman, M.D. New York: Grune & Stratton, Inc., 1970. 342 pp.

This book contains the Proceedings of the Fifty-Ninth Annual Meeting of the American Psychopathological Association. Seventeen papers were presented, including a Presidential Address and a Paul H. Hoch Award Lecture. Although distinguished workers have contributed, the articles in general appear to be remarkably

ordinary. For the psychoanalyst, at least, the almost exclusive emphasis on phenomenology and social psychiatry is boring and frustrating; the frequent reliance on questionnaire and statistical research is distressing. The format too is a bit puzzling. The address of Kenneth Clark, the Paul Hoch Award Lecturer, is not found until page 203. The Presidential Address, an erudite and somewhat polemical discussion of the problems of scientific communication, is also buried in the body of the book. Following most of the articles are discussions which must have frustrated the discussants as much as they do the reader. They are so brief it appears that real discussion was either impossible or very superficial. In general then, the book suffers from the problems of most published proceedings of meetings. Too often the articles are written for oral presentation to live audiences and not as publishable material; and the material itself is frequently not original, but rather summaries of, or addenda to, previously presented work.

Several of the articles, however, do present new thinking, the most notable being John Money's Hormonal and Genetic Extremes at Puberty and Kenneth Keniston's Postadolescence (Youth) and Historical Change. The first is an interesting contribution to the problems of interplay between constitutional (genetic) make-up and environmental opportunity and expectation. Money himself acknowledges that psychological exploration in depth of the personality structure and the psychopathology of the reported cases would be highly desirable. Lacking this, he is able to make only phenomenological distinctions.

Keniston's hypothesis is probably already well known. He postulates on the basis of his description of a very small and selective number of young adults that there is not only a newly occurring variation in individual behavior related to cultural and social factors, but that this is the reflection of a fundamental difference in psychological structure. We infer that he not only postulates a developmental phase between adolescence and adulthood, but one that is clearly distinguishable on economic and structural grounds, that is, in terms of metapsychology. Observed psychosocially, his subjects may be neither adult nor adolescent. In terms of intrapsychic organization, however, including the degree of consolidation of self, ego ideals, superego, and the imbricating relationships

between them, they might best be described as being adolescents in process. With our increasing understanding of the development of the self-organization and the place in it of ego ideals, the psychoanalytic concept of genitality as an indication of the 'maturity' of the intrapsychic structures retains its validity. In other words, the operations of the self and object systems may be mature and 'adult', while the externally judged behavior will seem to follow narcissistic inclinations rather than expected, object oriented (i.e., socially predetermined) directions. Arbitrary descriptions according to cultural and social modes of relating to objects can be useful and valid, but do not reflect accurately their developmental significance in the intrapsychic structure.

Another concern has to do with the postulation of a new phase. I do not doubt that a fourteen year old appears to be different from a twenty-four year old, but I wonder if every step along the developmental scale, which must perforce be an ever-changing one, progressive or regressive, can usefully be called a different *phase*. The desire for simplicity should not blind us to manifest truth, however unpalatable, but neither should we indulge in psychologic *furor taxonomicus* which has been especially characteristic of students of adolescence. The difference between a twenty-five-year-old married man with a job with General Motors and an unmarried man in the Peace Corps may be more obvious than actual, i.e., the manifest behavior is a final common pathway of many forces, including societal availability, differing values, and cultural pressures. This is obvious. Not so obvious, but more enduring and significant to the final personality outcome are the intrapsychic modes of stimulus assimilation, tension reduction, and structure maintenance. I suggest that unless we are satisfied with the truly reductionistic theories based on social observation, then we must make systematic observations using the psychoanalytic method to distinguish one phase from another. This has been done, but not as regards 'Youth' as far as I can tell.

Throughout this book, the psychoanalyst will long for the kind of verification he is accustomed to looking for, that stemming from the exploration in depth of the individual which can only be achieved through the psychoanalytic method.

ROBERT KOHRMAN (CHICAGO)

ADOLESCENT PSYCHIATRY. Volume I, Developmental and Clinical Studies. Edited by Sherman C. Feinstein, Peter L. Giovacchini, and Arthur A. Miller. New York: Basic Books, Inc., New York, 1971. 552 pp.

The reasons for an increasing interest in adolescence as a developmental phase are expressed succinctly in the preface to this book, a volume sponsored by the American Society for Adolescent Psychiatry: 'As a clinical challenge adolescence demands the utilization of specialized techniques. . . . As a period of life adolescence may be of great importance in the general understanding of development and psychopathology. Beyond the individual, adolescence is also a social phenomenon. The adolescent needs to be understood for his influence on values and social institutions.' What emerges is a series of articles written by professionals whose knowledge is firmly based on experience.

The volume is divided into five sections: General Considerations, Developmental Stages in Adolescence, Effects of Early Object Relations on Adolescent Character Structure, Training in Adolescent Psychiatry, and Psychotherapy of Adolescence. Each section begins with an introduction that gives a brief summary of the papers and an overview of the thinking that went into the formation of the section. These vignettes have more than introductory value—they also spell out the specific nature of the problems of adolescence. Adolescent Psychiatry is not a textbook, but a good sampling of work being done in the field. Hence the reader will find exploratory, thought-provoking literature which stimulates the formation of new ideas.

The opening chapter, an essay by Peter Blos, The Generation Gap: Fact and Fiction, sets the theme for the volume. By clarifying the difference in the function and size of the generational conflict in a given individual—distancing as opposed to individuation and differentiation—he demonstrates the need to relate existing knowledge of the psychology of the adolescent to his social behavior. Blos separates fact from fiction, serious investigation from idle speculation.

The rest of the volume presents a wide range of theoretical and clinical points of view on such subjects as drugs, normal and pathological development, diagnosis, and therapy. There are dif-

ferences in the depth and style of the articles. They are, however, written by individuals with experience and knowledge, who offer points of view requiring thoughtful reflection. A few papers have appeared in print earlier, but they are relevant to the aim of the book and bear re-examination. For instance, a study on normal adolescents, published in 1962, still provides valuable insight into individuals with whom one is currently familiar. A scholarly paper on LSD differentiates the uses from the abuses of the drug and dispels common misconceptions.

Because adolescents are unique, one can easily forget that they were once children and are about to become adults. Workers in the field of early childhood will find food for thought in an article that traces the etiology of some current adolescent syndromes to child-rearing practices. Another article views *youth* as a developmental stage connected with the history of society. Developmental psychology is also accepted in the section on the effects of early object relations on character structure. Chapters in this section for the most part are documented with clinical case material, enabling the reader to judge the authors' formulations on such theoretical concepts as the effects of the impact of the maternal introject on fantasy productions, sexual development, superego structure, and the function of the stimulus barrier.

Extensive use of clinical material and case reports also characterizes the section on psychotherapy. The controversial idea that the therapeutic task with adolescents requires special techniques and innovations as differentiated from treatment of children and adults, is amply illustrated in this section. Cases of severely disturbed adolescents are used to illustrate modified individual and group psychotherapy in outpatient and residential settings. Those who are confronted with the severely disturbed will profit greatly from the readings and acquire a good overview of the work being done with this difficult segment of the adolescent population.

Adolescent Psychiatry will give professionals working with adolescents a sense of proportion regarding the magnitude of the problems of adolescence and will provide connecting links between the theories and knowledge of adolescence and other stages of development. It is highly recommended not only to psychiatrists, psychoanalysts, social workers, educators, and others working

with adolescents, but to those working with children and young adults.

CARL P. ADATTO (NEW ORLEANS)

TROUBLED CHILDREN IN A TROUBLED WORLD. By Edith Buxbaum. New York: International Universities Press, Inc., 1970. 341 pp.

The reader who is enticed by the title of this book may be surprised to find that it is a collection of heterogeneous papers. He may also find the author's opening remarks in the Foreword misleading. She says, 'This collection of papers is made up of old and new papers. Some of the old papers have been revised [the book jacket says "extensively revised"] and for the purpose of continuity, rewritten to a certain extent. They represent my experiences and development in the areas of child analysis and education.'

There are only two new papers, Activity and Aggression in Children and Problems of Kibbutz Children. Fourteen old papers, published between 1935 and 1966, make up most of the book and only minor editorial changes of phrasing and organization have been made in most of them. There are some cross references to clinical cases and to certain concepts developed by the author (e.g., the effect of interferences in the practicing stages of learning a new activity). There is a brief Foreword and a detailed Index but no further supplementary material has been introduced into the collection. About half of the old papers originally appeared in psychoanalytic, and half in psychiatric and other publications concerning children. In this volume they are arranged, without regard to chronology or to the originally intended reader, into three overlapping sections: I, Theoretical Considerations (seven papers); II, Clinical Case Illustrations (five papers); III, Psychoanalysis and Education (four papers).

In the final paper, Three Great Psychoanalytic Educators, the author has written a personal note. 'I had the good fortune of being acquainted with and learning from Bernfeld, Aichhorn, and Anna Freud. I might add that knowing them had a decisive influence on my choice of career' (p. 307). That Dr. Buxbaum's career spans the development of child analysis from its origins to the present day is the *raison d'être* for this collection. But the reader, recogniz-

ing this fact and anticipating classical contributions and historical perspectives, may feel disappointed.

The papers are written with clarity and common sense and the author is at her best in accounts of her own clinical work. Hair Pulling and Fetishism (1960), the most recent and the most significant clinical paper, is an analysis of a hitherto unexplored symptom presented in an interesting account of the treatment of two little girls.

The section on theoretical considerations includes papers on psychosexual development, separation and identity, aggression, psychotherapy and psychoanalysis of children, and an original contribution, The Parents' Role in the Etiology of Learning Disturbances (1964). The final section contains three papers on groups in childhood and adolescence. One of these, a new paper, Problems of Kibbutz Children, is an outgrowth of the author's experiences as a consultant at a kibbutz child guidance clinic.

Individual papers in this book will appeal to selected readers. But put together as a new book, the papers do not make a collection that will sustain the interest of either the analyst, the child psychiatrist, or the educator.

MARJORIE MC DONALD (CLEVELAND)

SEMIOTIC APPROACHES TO PSYCHIATRY. By Harley C. Shands, M.D. The Hague: Mouton & Co., 1970. 412 pp.

The first striking point to notice about Shands is the breadth of his knowledge. This is apparent in the references to his essay, Creativity and Success: Bartlett's Remembering; a paper from Science; an interview with Duchamps, the painter; a quotation from T. S. Eliot; Festinger's Theory of Cognitive Dissonance; Francis Galton's early paper on free association; Kuhn's Structure of Scientific Revolution; Piaget's Origin of Intelligence in Childhood; and a paper of his own on the complementarity principle in psychiatry. Psychoanalysis, art, history of science—all are discussed and the paper begins with a quotation from Emily Dickinson. In other papers, he shows an acquaintance with Whitehead, with Mary Brazier and George Miller. His heroes—to judge from the most frequently cited authors—include such names as Bartlett, Cannon, Descartes, Dewey, Einstein, Freud, James, McLuhan, Pav-

lov, Piaget, Sherrington, Whorf, Wigner, and Wordsworth.

Shands describes himself as a physician turned amateur philosopher, cites Locke for comparison (he also began as a physician), and is steadfast in his determination to make psychiatry a branch of natural philosophy and remove it from the hard sciences. He is particularly interested in the communicative process and believes that 'human beings are primarily occupants of a universe of meaning rather than of a universe of physical being' (p. 9).

What conclusions has he reached? To begin with, he is inclined to doubt that the outside world exists in the form we usually assume. In a solipsistic outburst stronger than is currently fashionable, he worries at length over the nature of the outside world and feels that reality must be based primarily in the mind. Because the world of objects is much less palpable than we tend to assume, the true reality for all of us is the world of ideas, conveyed primarily through language and conceptualized by Shands largely in terms of information theory. This point of view emphasizes that psychiatric problems are largely problems of communication; that changes in the object world are much less threatening than changes in verbal content; and that dynamic psychiatric issues come down, in the long run, to problems of language use.

Some of his most distinctive papers deal with the impact of words on the organism—for example, the consequence to the patient of discovering that he has cancer when informed by the physician, as compared to his observation that he has a lump on his skin. The first piece of information, because it is conveyed by symbols, is, says Shands, much more telling than the second. This argument has interesting implications, but it is fairly easy to think of natural events which are just as threatening as something conveyed by language (an earthquake, for example, or a hurricane). Another paper discusses the difference in language structure in patients who prove to be suitable and unsuitable for psychotherapy. Here Shands would have been more convincing if he were more systematic and had followed up his original assumptions with a larger sample of cases. In a third paper, he tries to relate schizophrenia and information theory, leaning heavily on Shakow's view that schizophrenia is, to an important degree, a fear of novelty (and hence, in the language of the trade, a fear of information).

Beguiling as most of this is, it is Shands's breadth of interests, the very quality which makes him so readable, that is frequently his undoing. Working with such a large canvas, he fails to come to grips with the core issues of the problems he chooses to discuss and is prone to toss off a provocative idea as a definitive statement. While it is true, for example, that some psychiatric problems involve the communicative process, it is too sweeping to say 'psychiatric disorders are simple [sic] disorders of communicative method . . .' (p. 15). Similarly, it is somewhat rash to state without qualification that such habits as biting one's nails or twisting a lock of hair are 'overt manifestations of programmed instructions' (p. 11). They may *seem* that way at first glance, and such observations would make engaging jump-off points for a more deliberate examination of the problem. But unfortunately, the more systematic examination rarely appears because Shands is attracted by a similar pattern in another field of scholarship and does not work through the details in any one context.

The big danger in this kind of discipline hopping is that appearances are deceiving. The computer and the brain have obvious similarities, for example, but we are gradually coming to learn that they also contain large differences and that one is a misleading model for the other. An ambiguous concept from one discipline may seem similar to a linguistically comparable concept from another, but the ideas represented by the two concepts may be quite different and possibly antagonistic. Only a detailed study of each set of concepts would reveal these discrepancies; they cannot be seen by remaining at the conceptual level. Working with a broad brush, Shands gives us a dazzling series of aphorisms that may or may not prove true. In future papers, one hopes he will turn to the task of putting them more systematically to the test.

DONALD P. SPENCE (NEW YORK)

LOSS AND GRIEF: PSYCHOLOGICAL MANAGEMENT IN MEDICAL PRACTICE. Edited by Bernard Schoenberg, Arthur C. Carr, David Peretz, and Austin H. Kutscher. New York: Columbia University Press, 1970. 398 pp.

It is stated on the jacket that 'the purpose of this book is to define concepts and practices for professionals of all kinds who

are called upon to handle matters relating to loss and grief. It also deals with the matter of loss of biological function and the psychological aspects of death with respect to the patient, the family, and particularly children. The book is unique, and its twenty-four contributors include, among others, psychiatrists, physicians, clergy, dentists, and psychologists.'

The authors and editors succeed remarkably well, producing a book that can be recommended to any physician and paramedical professional, and to psychoanalysts teaching in medical schools, hospitals, seminaries, etc. Most of the contributions are of high quality, some too brief. It can serve too as a model of expressing psychoanalytic concepts in simple terms.

The papers are arranged in five sections: Psychological Concepts Central to Loss and Grief, Loss and Grief in Childhood, Reaction to and Management of Partial Loss, The Dying Patient, and Humanistic and Biologic Concepts Regarding Loss and Grief. One of the most interesting chapters is The Hospital Chaplain Looks at Grief by Robert B. Reeves, Jr. In discussing his hospital experiences, Reeves states:

> The deceptions and disguises by which people try to disown or keep feelings of grief to themselves are often rudely penetrated by the life-and-death thrust of crisis in a hospital. A chaplain is likely to see in a raw state the things that people usually deal with only under wraps. Patients, their families, and members of hospital staff alike, tend to feel embarrassed by grief, and the more religious they suppose themselves to be the guiltier they become. Even the nonreligious tend to be embarrassed and apologetic. Maintaining control seems to be an obsession.
>
> Instances are encountered daily. Members of a dying patient's family gathered at his bedside and in spite of themselves broke down in anguish. Immediately, nurses in ill-concealed annoyance rushed to herd them into the visitors' room, and with a resentful sigh the doctor ordered medication to quiet the prospective widow. Granted, a hospital corridor is not the ideal place to hold a wake, and an outburst of this sort does present a problem in management, yet the staff disapproval seemed far beyond the requirements for maintaining decency and order. . . .
>
> Frequently, these anticipatory grief feelings find other outlets through complaints about such matters as food, nursing care, side effects of medication, noise, etc. If these complaints are heard out, the patient may begin to realize that he can trust the listener and allow his true thoughts and feelings to be known. When this occurs, it is almost always with apology, frequently with a deep sense of failure and guilt.
>
> Hints of anticipatory grief may appear in the form of bewilderment at

what is happening to him. He may say to the chaplain, 'I can't understand why. . . . I have faith, but sometimes I wonder. . . .' Or, in answer to inquiry of how things are going, he may say, 'Oh . . . they say I'm doing fine. . . .' Such hints are a thin disguise for feelings about impending death. If one continues listening, the feelings are likely to well up and spill over, usually with tears and almost always with self-reproach.

Sometimes, however, the patient's denial seems so complete that one might assume he was going to a picnic instead of to the operating room or the grave. It is often maintained that to break down the denial in such a 'brittle' patient would result in his falling apart. I have often taken that risk when there was enough time to help the patient work through his grief, and irreparable damage has never resulted. The confession of failure and guilt for 'lack of faith' has sometimes been tortuous, but it usually allows the alleviation of the intense inner pressure of grief.

This book should make us more optimistic about the possibilities of wider diffusion of psychoanalytic knowledge among students, physicians, and other professional workers.

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

LANGUAGE AND PSYCHODYNAMIC APPRAISAL. A Development of the Word Association Method. By J. D. Sutherland and H. S. Gill. London: Research Publication Services Ltd., 1970. 144 pp.

This volume attempts a pragmatic application of Fairbairn's object relations theory (as developed by Guntrip and practiced at the Tavistock Clinic) to a revised form of Jung's word association test. The procedure is considered an aid to the screening of clinic applicants. Subjects are required to respond *in the form of a sentence* to a standardized set of stimulus words 'chosen to emphasize the various roles in the main range of human relationships and their associated affects' (for example, 'friends', 'work', 'father', 'guilty', 'patient', 'fail', 'satisfied', etc.). Responses are then interpreted in their formal as well as their semantic aspects (grammar and syntax as well as meaning). The power of the test is illustrated by a statistical comparison of test results with independent clinical evaluation of the same subjects. The succinct insights afforded are impressive and should inspire further study.

Object relations theory, as presented here, seems to owe a good deal to Melanie Klein. Of course, oppositions and alternations are clinical commonplaces and are accessible to other than Kleinian

interpretation (e.g., double identifications in unconscious primal scene fantasies). In spite of the generality of the title, the relation between language structure and psychic structure and function is hardly touched upon, and the developments of the last half century in linguistics are simply ignored. However, the authors' intent is, after all, psychological and clinical rather than linguistic and theoretical, and their book should be regarded as a modest guide to the administration of a potentially useful test.

HENRY EDELHEIT (NEW YORK)

NUMBER WORDS AND NUMBER SYMBOLS. A CULTURAL HISTORY OF NUMBERS. By Karl Menninger. (Translated by Paul Broneer from the revised German edition.) Cambridge, Mass.: The M.I.T. Press, 1969. 480 pp.

Karl Menninger (1898-1963) was a German mathematician who established a unique reputation in German-speaking countries as a scholarly popularizer of mathematics and the history of mathematics. The English translation[1] of his works is winning him a growing reputation in this country.

Number Words and Number Symbols is his crowning achievement. It is a masterpiece and the translation by Broneer is superb. The book is unreservedly recommended to the psychoanalyst with more than a casual interest in linguistics, philology, mathematics, or cultural anthropology. Menninger traces the origins and developments of number sequence and number language, and written numerals and computation. He ranges widely and incisively, historically and geographically, crossing interdisciplinary boundaries effortlessly. His writing is a model of painstaking scholarship, presented in a most engaging style without a trace of pedantry.

Optimal use is made of almost three hundred illustrations aligned with or placed within the text. The format for integrating illustrations and text is excellent. Lucid comparative tables also enhance the factual and theoretical presentations.

It is impossible to select a brief example from the riches in this

[1] Menninger's first book went through ten German editions. English translation by E. V. F. Primrose: *Calculator's Cunning. The Art of Quick Reckoning.* New York: Basic Books, Inc., 1964.

book that would do justice to the whole, but here is one from the fascinating chapter, Hidden Number Words:

> The *Kümmelblättchen*, 'caraway leaf', is actually a foreign loan, although it looks very German. It refers to a game played by card sharpers, in which three of the cards are covered. But where is the 'three" hidden in this word—in the *kümmel*? Yes, because this is not a true German root, but a misunderstood assimilation of *gimel*, the third letter of the Hebrew alphabet, which we met earlier (p. 121). The Hebrews, like the Greeks, used their letters as numerals, so that *alef* was 1, *bē* 2, and *gimel* 3.

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

A HISTORY OF SCIENTIFIC PSYCHOLOGY. ITS ORIGINS AND PHILOSOPHICAL BACKGROUNDS. By D. B. Klein. New York: Basic Books, Inc., 1970. 907 pp.

The stated purpose of this book is to survey the long history of psychology's efforts to achieve scientific status from its origins as mental philosophy and to present the philosophic backgrounds from which scientific psychology emerged. The result of this undertaking is a work of such scholarly breadth and penetrating inquiry that we are carried along into all of the fascinating details of man's age-old struggle to discern the nature of the universe and of his existence in it, and to fathom the riddle of his mind and consciousness. Almost encyclopedic in character, there is a wealth of information provided here and a masterful perspective on the background of many of the questions that still confront the mental sciences.

The author recognizes that history represents selective perception, that the historian's viewpoint determines the selection and interpretation of material, and that history as well as psychology requires an idiographic (individually determined) even more than a nomothetic (natural-law-determined) approach. In this connection it is pointed out that William James took a dim view of 'brass-instrument psychology', and that the issues he raised highlight the unresolved questions stemming from psychology's philosophic heritage. It is one or another of James's six basic questions that determines for the author the assigning of historical significance: 1, How is mind related to its physiological substrate? 2, Are objective techniques adequate to deal with subjective life? 3, How are experiences and impulses integrated into personality?

4, How can we reconcile determinism and volition? 5, Why are the laws of association inadequate to account for mental organization? 6, How is it that despite careful behavioral analysis, the uniqueness of each person remains unexplained?

There are four basic headings under which the author organizes a vast array of data. Part One deals with the general questions of the place of psychology in the history of science and of the foundations of science in philosophy. Part Two covers Grecian and medieval backgrounds. Part Three, Historical Significance and Psychology's Key Problems, elaborates on the six basic questions and proceeds historically by taking up William James and some contemporaries to provide a broader understanding of psychology's postmedieval philosophic background, as detailed in Part Four, From the Renaissance to the Modern Period.

It is difficult in a brief review to convey even a small part of what this book abounds in, namely, a correlation of the views of thinkers throughout the ages, showing the roots of certain key concepts and their subsequent development by others. Thus the pre-Socratic concern with physical nature in contrast with Aristotle's emphasis on the mental is traced as a theme through the Middle Ages and Renaissance, (in the development from an interest in the practical to a focus on the abstract, as larger political units and the improved communication of printing evolved), thence to the nineteenth century study of man as a person rather than an organism. In this context, we are reminded of the central role of the rationalist-empiricist controversy of philosophy and its latter day revival in the nature-nurture problem of modern psychology.

The strength of this book lies in its skillful portrayal of the development, the working, and reworking of fundamental ideas from ancient to modern times. An example is Plato's anticipating of Freud with regard to man's tripartite structure, Eros as a force, the emergence of the unconscious in dreams, and the principle of integration by higher forces, with later contributions by Leibnitz, Herbart, Schopenhauer, Spinoza, and Hebbel. Another illustration: the importance of Aristotle is indicated in a survey of his empirical and genetic viewpoint which influenced all later thinkers. His concept of entelechy, of cause and intentionalism, was later reflected by Hobbes on motion and process as key concepts; by

Locke on the importance of both sensations and reflections; by Brentano on intentional inexistence, developed further in Freud's motivational psychology. The author traces Aristotle's phenomenology (pertinent to later schools of psychology); his associationism (reflected in British associationism); his sensitivity to whole-part relationship (gestalt viewpoint); and his notion of things defined by their working and power (functional, Adlerian, and social psychology).

The chapters on the medieval period include descriptions of the contributions of Plotinus, St. Augustine, Roger Bacon, Francis Bacon, St. Thomas Aquinas, and Maimonides. Klein delineates their influence on later thinkers on such issues as mind-body relationship, subjectivism, infantile experience, will, memory, time, experience, perception, realism, nominalism, scientific method and critical scholarship, dualism, appetitive and reasoning faculties, and faculty psychology.

A good deal of space is devoted to William James and his great service in keeping open the basic questions and promoting eclecticism. We are given a thorough account of his approach to the mind-body problem, to epiphenomenalism versus idealism where he decided in favor of pluralism rather than monism or dualism, and to psychophysical parallelism. We learn of his influence on the problem of positivism (doing) versus subjectivism (feeling). He proposed an integrative move toward a liberating positivism, developed further by later relativists and phenomenalists (in contrast to Comte's restricting positivism and that of the behaviorists and operationists later). There are, in addition, elaborations of his distinction between self (realization of personal objectives) and ego (evaluation of outcome as success or failure); and of his position in the free will-determinism controversy, in which he argued in favor of a contingent determinism based on motivational factors, with a relative or truncated freedom. In the course of discussing each question, the evolving positions of various schools of thought in modern psychology are further elaborated.

The chapters on the Renaissance and modern period contain many excellent analyses of the outstanding philosopher-psychologists and of their historical influence. There are details on the role of Hobbes in paving the way for British empiricism, and in pioneering contributions to what eventually became the fields of

developmental, social, and behavioristic psychology. The implications of Descartes's rationalist approach are perceptively discussed in light of his influence not only on contemporaries but on later behavior and cognitive theorists and, in fact, on all who advanced theories based on innate qualities, including Jung's racial archetypes and Freud's phylogenetic inheritance. Locke is dealt with in a particularly impressive chapter describing his application of the empirical method to a vast array of psychological questions, hence his position as founding father of British empiricism and of later experimental psychology. Spinoza is also given lengthy consideration, especially his hormic psychology which contributed to an understanding of emotions and mental health, tying in with MacDougall's later concept of intrinsic teleology. The rationalism of Leibnitz is traced from its Platonic base to its influence on the formulation of a tripartite division (affect, cognition, conation), showing the sequence of those who enlarged on this viewpoint: Wolff, Tetens, Kant, Hume, Wundt, and Freud.

Equally impressive expositions are offered on Kant, Berkeley, Hume, Hartley, Reid (as well as others of the Scottish school), and the Mills, in rounding out the philosophic background of psychology. Chapters on the works of Herbart, Lotze, Bain, and Wundt carry the book to completion. Only a sample can be given here to indicate the kind of data included in this comprehensive history.

Herbart is given special attention: in particular, reference is made to his anticipation of and influence on Freud with regard to the concepts of conflict, inhibition, repression, and unconscious ideation. Lotze is also cited in this connection, with respect to his ideas about local signs as unconscious cues leading to a theory of the unconscious based on implicit judgments. Next, there is a consideration of the work of Bain, who advanced the physiological basis for psychology, represented the culmination of British associationism, with contiguity and similarity as the key principles, was the first to deal with the psychology of emotional expression (along with Darwin), and introduced such terms as 'tender emotion' and 'trial and error learning' (anticipating Thorndike's law of effect). Finally, extensive coverage is given to Wundt as the founder of experimental psychology. In the latter's ideas on psychical causation, voluntarism, structuralism, empiricism, tri-

dimensional theory of feeling, laws of relation and laws of development, he was indebted to John Stuart Mill for the concept of experimental psychology, to Weber and Fechner for techniques for measuring sensory impressions, to Müller and Helmholtz for laboratory apparatus, to Leibnitz for the concept of psychophysical parallelism, to Herbart for that of apperception and to Lotze for the doctrine of local signs; and with all others to Plato, Descartes, Spinoza, Locke, Hume, Kant, and the other philosophers. As Wundt put it, *'Wir Sind Alle Epigonen'*, we are all heirs to the ideas of preceding generations of thinkers.

There is relatively little that one can find to criticize in a work of such dimensions. Although the point is made several times that 'armchair psychology' (philosophical and clinical observation) is as valid as the experimental, there is perhaps some defensiveness in the reiteration, and implicitly a downgrading of the scientific status of clinical research. There is the impression that a full accounting must be given to the experimentalist, and at times a rather gratuitous criticism of the position of some psychoanalysts, such as those who take Freud as an authority no matter what; or again, those who apply the principle of determinism indiscriminately. The mistrust of psychoanalysis by academic psychology is, in fact, in accord with a longstanding tradition which the author acknowledges and documents at various points. For example, he describes the early opposition to Freud as exemplified by Titchener's rebuff, the critique by Woodworth, and Boring's failure to mention Freud in his 1929 first edition, though Boring corrected this by 1950 and recognized Freud as one of the 'four very great men in psychology's history', and in fact 'the greatest originator of all'. Incidentally, of the four only William James is considered at length, perhaps since he was the 'only one actively identified with the field of psychology'. Darwin and Helmholtz are not given adequate coverage, and though some of Freud's basic concepts are traced in terms of historical antecedents, there is no systematic dealing with psychoanalytic psychology.

The discussion of such questions as 'did Plato influence Freud?', or 'was Freud indebted to Herbart?' tends to challenge Freud's disavowal of such influences. Though the author acknowledges that Freud worked out the implications and carried the theory of the unconscious further than any of his predecessors, he does not

seem to be fully convinced of some distinctions that should properly be taken as crucial. Thus, he takes exception to the statement by Kris that Herbart's concept of conflict was mechanistic whereas Freud's was dynamic. In so doing, he refers to Ernest Jones's attributing to Herbart's concept of the unconscious the label of a dynamic one. Yet, if one reads the context of Jones's quotation, Herbart's concept is described as an ideational unconscious. Herbart's concept of repression is a far cry from Freud's theory of the role of instinctual drives, and of the influence of fear, shame, and guilt in his early formulations and of signal anxiety in his later contributions.

One additional point worth noting is the author's uncritical inclusion of some views which should by now be recognized as quite inadequate. For example, the position of O. H. Mowrer, particularly regarding psychotherapy, is given special consideration. That his views do not deserve such serious consideration has been indicated by Rapaport[1] in his critique of Mowrer's work.

Such reservations are in no way intended to detract from the over-all estimate that this book has great value. As an illustration of its current relevance, we might consider such a question as that of the balance between early life experience and innate drive, which is obviously a crucial one in any kind of model making. Sandler and Joffe,[2] who recently offered a basic psychoanalytic model, take cognizance of this problem and make reference to the Kantian distinction between the noumenal and the phenomenal. Recent object relation theories raise similar questions. Thus it is evident that in our present-day theorizing we are still occupied with many of the issues noted in earlier philosophical discourse. As mentioned above, Aristotelian entelechy and his concept of final cause had special influence on Brentano, whose act psychology with its transcendent intentionalism found echoes in the motivational psychology of Freud. British empiricism and associationism, though also drawing on Aristotelian principle, took another direction in advancing the thesis of experience as opposed to inherent endowment, thereby reviving the old rationalist-empiricist contro-

[1] *Cf.*, Gill, Merton M., Editor: *The Collected Papers of David Rapaport.* New York: Basic Books, Inc., 1967.

[2] *Cf.*, Sandler, Joseph and Joffe, Walter G.: *Towards a Basic Psychoanalytic Model.* Int. J. Psa., L, 1969, pp. 79-90.

versy. Current psychoanalytic ego psychology, and particularly some of its offshoots like object relations theory, may be tending toward a shift away from the transcendent motivational principle implicit in drive theory, back toward the empiricism which places superordinate emphasis on the experiential. If we are to maintain a balanced perspective in our formulations, an enlightened historical background is essential. Toward this goal D. B. Klein's A History of Scientific Psychology offers us an inspired, exciting, and thoroughly outstanding contribution.

DANIEL S. JAFFE (WASHINGTON, D. C.)

TESTING FREUDIAN CONCEPTS. AN EXPERIMENTAL SOCIAL APPROACH. By Irving Sarnoff. New York: Springer Publishing Co., Inc., 1971. 276 pp.

The thesis of this book is that freudian concepts (psychoanalytic theory) are essentially a collection of scientifically unproven hypotheses. For this author hypotheses can be considered valid only if successfully subjected to the ultimate empirical proof—*the experiment*—in which predictions about phenomena are shown to come true as the result of carefully controlled manipulations made upon phenomena said to represent the original concept. In addition, other experimenters following the same protocol should be able to repeat the results. Sarnoff's view is that Freud's ideas were primarily arrived at by an inductive approach and, to a great extent, derive their popularity and acceptance as the result of his exceptional writing ability and the emotional power of his concepts. He disputes Freud's contention that only those who have experienced a psychoanalysis are in a position to judge its truth. Furthermore, by contrast with the experimental approach, the author considers the clinical situation as a series of uncontrolled experiments.

The book is devoted to a description and analysis of the methodological difficulties in applying the experimental method to psychoanalytic concepts. The author proposes various solutions to these problems. He proposes a particular experimental model—the interactive design—in which a fixed personality trait (nonmanipulated independent variable) said to reflect a particular concept is placed in a situation presumed, by inference from the

concept, to contain an element which should interact with the original personality trait. This element (manipulated independent variable) is varied quantitatively and another psychological manifestation (dependent variable) predicted to be effected by this interaction is measured. For example, in an interaction between the 'trait' of castration conflict and differing degrees of heterosexual arousal, the various predicted outcomes in levels of anxiety and phobic ideation are measured. The methodological issues studied are problems of measurement of the variables, the ethical and moral aspects of manipulating people to produce effects, problems of checks and controls, experimenter effects, and problems related to the deceptions required to conceal the purpose of the experiments from the subjects. In addition, the author has a particular interest in including a social manifestation of a psychoanalytic concept as part of his experimental design.

The book's main values to a psychoanalyst relatively untrained in this sort of methodology are: first, a sharpening of awareness and thinking about methodological problems; and, second, a sharpening of his recognition of the methodological and experimental aspects of the psychoanalytic clinical situation. Essentially, many of the experiments referred to are daily problems of clinical judgment, formulation, and evaluation of cases. The difference is that in this book they are posed in the language of the experimental psychologist.

My criticisms of the book are, first of all, that the author does not discuss pros and cons of his central thesis that conceptual validation by the experimental method is the ultimate form of scientific proof for psychological concepts. He does briefly refer to a paper of G. Klein that deals with another point of view. Secondly, what he presents seems to me to be a methodological ideal under the guise of specific recommendations for procedure. In actuality the methodological approaches he suggests are fraught with all the ambiguities, uncontrollable aspects, and tautologies, such as the use of 'unproven' concepts to prove other concepts, which he considers to be the shortcomings of the clinical 'experimental' situation. In my judgment the clinical situation has more built-in controls over these methodological pitfalls than the author's approach. These potential controls are: 1, a relatively standardized and explored context—the analytic situation; 2, a standardized 'form' of

measurement—free association; 3, the analyst's broad knowledge of theory; 4, the analyst's deep knowledge of the subject (patient); 5, his knowledge of the effects of his manipulations (interventions); 6, naturalness as opposed to deception and artificiality in the manipulations of the environment (life situations, interpretations); 7, a procedure which encourages reliability of reporting in the subject (resistance analysis, working alliance); and 8, self-knowledge in the experimenter (analyst) as gained from personal analysis. These 'controls', too, represent an ideal but, on balance, one more attainable than the ones presented by the author. The main advantages of the experimental situation he defines lie in the possibility of controlled dosage of the manipulated effects, use of large numbers of people at the same time in an experiment, and the possibility of repeatability through the standardization of stimuli. On the other hand, in the experiments reported, basic concepts are not directly studied, but rather presumed derivatives of them. In addition, the measurements of variables used are usually based on symbolic interpretations of data which in turn are based on psychoanalytic concepts that are 'unproven' in the author's sense. Essentially, as in the clinical situation, clinical levels of data are used to 'validate' deeper concepts. I do not believe that psychoanalytic concepts can be 'proven' or 'disproven' by this form of experimental approach.

LAWRENCE CHALFIN (NEW YORK)

THE ORIGINS OF ALCHEMY IN GRAECO-ROMAN EGYPT. By Jack Lindsay. New York: Barnes & Noble, Inc., 1970. 452 pp.

This book is a sequel to several scholarly works Lindsay has written on Graeco-Roman Egypt. It is for the reader already knowledgeable about classical antiquity, mythology, and the history of science. The first nine chapters are too difficult for the casual reader. Because it contains much of psychoanalytic interest, a valuable bibliography, and an exceptionally useful index, the volume should not be overlooked as a reference work by psychoanalytic libraries.

Lindsay performs a masterful job of historical analysis, delineating the multiple philosophic and cultural determinants of alchemic theory and practice. He is generally weak on the psychologic and symbolic determinants. However, in the chapter, Womb

Furnace and Vase, he finally comes to grips with something of psychologic significance; namely, the linkage of sexual conflict with alchemic secrecy. The psychoanalytic reader can make his own interpretations of the abundant material supplied by Lindsay throughout the book.

Noteworthy too are fascinating chapters on Maria the Jewess, the inventor of the alembic and probably the first professional alchemist, and Kleopatra, the alchemist.

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

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Journal of Nervous and Mental Disease. CLIII, 1971.

Harold R. Galef

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ABSTRACTS

Journal of Nervous and Mental Disease. CLIII, 1971.

Multiple Fallacies in the Concept of Schizophrenia. Lawrence S. Kubie. Pp. 331-342.

This is an important paper that deals with current nosological practices applied to all forms of psychiatric disorders, not just schizophrenia as the title implies. After a historical perspective, Kubie presents a striking picture of the clinical and research difficulties that are produced not only by outdated Kraepelinian classification, but by our supposedly more sophisticated diagnostic nomenclature. Mental illness, like physical disorders, is viewed by Kubie as an ongoing process: a neurotic potential, an evolving neurotic process, the precipitating out of a neurotic state, the variegated distortions that, in turn, are produced by the symptoms themselves, and lastly, the possibility of a psychotic process supervening from an insoluble impasse.

Kubie feels that while it is possible and justifiable to characterize an individual moment of behavior as normal, neurotic, or psychotic, the application of the same terms to a whole individual or to an entire life is never permissible. Our nosology confuses the distinction between the severity of a neurosis as a process of illness and the degree of 'sickness' of the life it produces. A summary cannot do justice to the richness of the amalgam Kubie has created from the older concepts of others and newer ideas of his own.

HAROLD R. GALEF

Bulletin of the Menninger Clinic. XXXV, 1971.

Cultural Aspects of Transference and Countertransference. Gertrude R. Ticho. Pp. 313-334.

Basing this paper on her analytic experience in three different countries, Dr. Ticho discusses a variety of problems that arise when analyst and analysand have different cultural backgrounds. Analysts, she suggests, are the target of their patients' stereotypic ideas. Cultural stereotypes include, for instance, the view that 'North Americans are industrious and conscientious, South Americans are sexually promiscuous and unreliable', attitudes that constitute projections of ambivalence toward cultural values. Stereotypes can determine the patient's choice of therapist and provide a vehicle for the expression of resistances and transference manifestations. When patient and analyst share a common cultural background, the analyst is more liable to overlook or take for granted certain potentially symptomatic behaviors; for example, some South American analysts do not question their compatriots' lateness to appointments. The double-edged aspect of work with patients whose cultural background differs from the analyst's is emphasized. The analyst can, on the one hand, bring fresh viewpoints to, and be creatively stimulated by, the confrontation. On the other hand, when working in an unfamiliar cultural setting, the analyst can be prone

to a degree of culture shock that may, in turn, undermine technical skills. The latter situation is candidly illustrated by Dr. Ticho in a case where her lack of familiarity with prevailing cultural practices contributed to temporary impairment of technical skills and to regressive countertransference reactions. Culture shock and its mastery, she believes, are necessary preconditions to one's assimilation into a new culture.

ELLEN ROTHCHILD

American Imago. XXVIII, 1971.

The Symbolic Process: A Colloquium. Theodore Shapiro, Reporter. Pp. 195-215.

This colloquium, sponsored by the American Psychoanalytic Association, was held December 11, 1969. Victor Rosen, the chairman, felt the linguistic definition of a symbol, as an arbitrary representational stand-in for something else, had replaced the former psychoanalytic usage that more clearly corresponded to the idea of the sign, which is related by simile. Tom Bever, a professor of linguistics, asserted there were built-in developmental regularities that account for the apparently arbitrary relationships between a sound pattern (word) and its referent from a different sense organ, e.g., vision; this idea of an organizational rule was carried over to language itself in the belief that humans intuitively have such rules available to generate adequate grammatical sentences. Bernard Kaplan, a professor of psychology, disagreed with Bever, claiming that representation in a medium other than that of the percept is arbitrary. Kaplan also cautioned against carrying over to human psychology the conclusions reached in the study of lower animals, since the organization of behavior, not the comparability of particular responses, is the central issue.

Jerrold Katz, a professor of humanities working in the area of linguistic theory, philosophy of language, and semantics, held that the capacity for structuralization of sentences so that understanding is made possible by the composite functioning of their parts is categorically present in the human mental apparatus.

Jonas Langer, a professor of psychology, sketched the role of symbolization in cognitive development. The ontogenesis of symbolic activity, he stated, is necessary for the transformation of sensorimotor, practical logic into the first forms of intuitive logic. Symbolization is central to the construction of the concrete, actual, and conventional cognition of the physical and social environment of the human being between the ages of two and eleven; it is less important, perhaps disruptive, to formal logical reasoning from adolescence on. These claims are consistent with the discoveries of the 'imageless thought school' which holds that advanced reasoning appears transparent and not embodied in a symbolic medium.

Steven Marcus, a professor of English, showed that Wordsworth's writings are rich in speculation regarding the sources and operations of symbolic representation in poetry. One point, derived from The Preludes, was that the infantile synesthesias, consisting of drinking with the eyes and soul, indicated a priority of nonlinguistic sources for poetry. For most, the separation of mother and

infant damages the immediacy of imagery in all sense organs; those who retain the gift are the poets.

Leo Steinberg, an art historian, took the position that nothing in art is without meaning; that there is purpose in every gesture of a statue. He thus put himself in opposition to the formalists, who declare art is opaque and not translatable, and also to the archivists, who concede meaning but demand rigorous documentation. Steinberg argued his position with references to a late Pietà by Michelangelo and to a painting from the Sistine. It would have been more instructive had he applied his theory to a strict formalistic artist such as Albers.

Othello: The Justice of It Pleases. M. D. Faber. Pp. 228-246.

Faber argues that Othello's strangling of Desdemona has the significance of oral retaliation against his mother, who had rejected him originally, and against Desdemona, who, he believed, had betrayed him. Faber explains Iago's suggestion for the murder method as a part of his identification with Desdemona, an expression of his passive homosexual disposition: he was excited by the fantasy of a physical attack and counseled against poisoning, a less stimulating anticipation.

JOSEPH WILLIAM SLAP

Journal of Psycholinguistic Research. I, 1971.

The introductory statement in this new and promising journal indicates that it will give priority to articles on various aspects of psycholinguistics, 'broadly defined'. Included will be: 1, studies of the communicative process; 2, the social and anthropological aspects of communication; 3, the development of speech and language; 4, the semantic aspects of communication; 5, the biological foundations of communication; 6, the psychopathological aspects of the communicative process; and 7, educational psycholinguistics. Theoretical papers as well as the results of experimental studies will be considered for publication.

Of Language, Knowledge, Apes and Brains. Eric Lenneberg. Pp. 1-29.

In this theoretical paper Lenneberg asserts that man's ability to use language as a species specific function is due more to general deep-seated cognitive characteristics than to a specific ability for vocal auditory exchange of thought. He argues that man's ability for mathematical thinking arises from the same cognitive sources as language. 'For every mathematical notion there is a homologous one in the sphere of language.' Lenneberg illustrates certain formal similarities in the structure of mathematics (especially arithmetic) and language. A comparison of animal communication with man's language is not possible without an intimate knowledge of the nature of the structure of human languages. Both language and arithmetic are processes of relations that combine into integrating systems. Although the ontogenetic characteristics of these integrating systems are known, we do not know what the homologous phylogenetic systems are. 'By characterizing language and arithmetic simultaneously, it is also possible

to sharpen the questions that the student of language should put to the neurophysiologist concerning differences in human and other mammalian brain processes.'

Theories of Language Acquisition. Harold J. Vetter and Richard W. Howell. Pp. 31-64.

The authors present a theoretical review of the changing concepts concerning the child's acquisition of language. Prior to Chomsky's concepts of 'generative grammar', theoretical approaches to language development relied heavily upon operant conditioning models. Current studies suggest that the child constructs his language on the basis of a primitive evolving grammar that is partly programmed at the time he is ready to learn to speak. Vetter and Howell attempt to trace the development of vocalization from prelinguistic stages to the first clearly discernible language behavior and the stages that intervene before the child approximates adult speech. The most challenging problem for developmental linguistics is the discovery of the processes that enable the speaker to go from meaning to sound, and the listener from sound to meaning. The authors attempt to answer the question of what constitutes an adequate theory of language ontogenesis. They suggest that such a theory will have to be congruent with theories of cognitive development and will have to take into account disparities of various forms between 'language competence' and 'language performance'.

The Comprehension of Rate-Incremented Aural Coding. Murray S. Miron and Eric Bronn. Pp. 65-76.

This is a highly technical study of 'orientation of efficiency' of aural coding by the application of certain distortions in the message speed of delivery. Implications for listening strategies and speech apperception are drawn.

Methods for Quantifying On-Off Speech Patterns under Delayed Auditory Feedback. Stephen Breskin; Louis J. Gerstman; Joseph Jaffe. Pp. 89-98.

Studies of the effects of delayed auditory feedback on the disruption of speech patterns have been of interest to both psycholinguists and clinicians. This paper is difficult for readers to assess unless they are familiar with analog and digital computer methods. The authors conclude that 'independent correlates of subject task and environmental variables would be required to determine the usefulness of their measures' (i.e., for the study of speech patterns).

Symbolism and Reality. Peter Fingesten. Pp. 99-112.

As far as semiotic (theory of signs) conventions are concerned, the author uses the term 'symbol' in an idiosyncratic sense. This paper presents 'an alternate view of the history and significance of symbol to Freud and Jung'. Fingesten believes that 'creative spurts of mankind require a partial or total rejection of previously existing symbolic systems'.

Piagetian Measures of Cognitive Development for Children up to Age Two. Albert Mehrobian and Martin Williams. Pp. 113-126.

An interesting but limited study suggests that a child's cognitive skills during the first two years of life, particularly in regard to nonverbal representational abilities, not only precede but enhance language acquisition. This is contrary to the assumptions of some linguists and in support of Piaget's findings.

VICTOR H. ROSEN

Archives of General Psychiatry. XXV, 1971.

A Study of Encounter Group Casualties. Irvin D. Yalom and Morton Lieberman. Pp. 16-29.

Eighteen encounter groups directed by apostles of different ideological schools were investigated by the authors. All group members were Stanford University undergraduates. They completed a questionnaire before beginning, after each meeting, at the end of the group experience, and six months after completion. Groups met for thirty hours. There was no pregroup screening of members.

Yalom and Lieberman categorize as a casuality any individual who experienced an enduring (judged eight months after the group experience) negative outcome caused by participating in the group. Of the various methods for identifying casualties, the most reliable was peer evaluation: all members were asked, 'Did anyone get hurt in your group?'. The frequency and severity of psychological distress varied considerably among the eighteen groups. Of two hundred and nine undergraduates, one hundred and seventy completed the group experience. Of these, sixteen were considered casualties. It was found particularly stressful to have a leader whose style is characterized by charisma, aggressive stimulation, and who focuses on the individual in an authoritarian manner. This leader style was related to forty-four per cent of the casualties. Individuals who over-invest their hopes of salvation through encounter groups are especially vulnerable when they interact with leaders who believe that they can offer deliverance. The authors compare the encounter technologies and given data about positive gains for many group members.

Ambiguity for Individuation. John S. Kafka. Pp. 232-239.

Kafka offers a critique and a reformulation of the double-bind theory. Clinical observations are drawn upon to illustrate the relative lack of ambiguity in the patient's life during the phase of individuation. The author links parents' fear and intolerance of ambiguity with the child's inability to integrate paradoxes. This is contrasted with the double-bind theory which assumes a superabundance of paradoxical communications. Although the essay works within the context of descriptive, 'etiological' concepts, the psychoanalyst interested in intrapsychic structures of the separation-individuation phase will find this paper of interest and value.

Longitudinal Sleep Study of Hypomania. Joseph Mendels and David R. Hawkins. Pp. 274-277.

The authors studied sleep patterns of one hypomanic patient for seventeen of twenty-five consecutive nights. The patient was a forty-five-year-old salesman with a history of recurrent manic episodes. For several weeks prior to the sleep study, the patient had been developing a documented manic episode. He was not taking drugs and was not hospitalized. There was a marked reduction in actual sleep time and in slow-wave (stage 4) sleep, a slight reduction in stage 1 (REM) sleep, and an increase in time spent awake and drowsy. These findings were strikingly similar to the sleep patterns of patients suffering from psychotic depressive illness.

Alcoholism in Women. Myron Belfer, et al. Pp. 540-544.

Forty-four women were studied, thirty-four of them alcoholics and ten of them nonalcoholic wives of alcoholic husbands. Some measures used in this study were the Taylor Manifest Anxiety Scale, the 'D' scale of the MMPI, and the California Personality Inventory. Over fifty per cent of the alcoholic women, sixty-seven per cent of the menstruating women, and forty-six per cent of the nonmenstruating women related their drinking to their menstrual cycles and, overwhelmingly, to the premenstruum as a key time.

DONALD J. COLEMAN

International Journal of Psychiatry. IX, 1970-1971.

With this volume The International Journal of Psychiatry became a hardcover biennial. (Subsequently, however, it was announced that it will continue as a quarterly.) The following is a brief summary of, and commentary on, the issues raised in Volume IX.

In the past fifteen years there has been a dilution, deterioration, and fragmentation of professional standards in the practice of psychiatry and the training of psychiatrists. These developments have been accompanied by diminishing interest in psychoanalytic training among psychiatric residents who have been exposed to powerful seductions. 1, The blandishments of financial grants and instant careers in community mental health, teaching, and private practice; to be effective, these blandishments require antipsychoanalytic and other rationalizations. 2, The regressive trends of the revolutionary turmoil throughout the world that negate the value of history and scholarship, and enshrine adolescent omnipotence. (The abstracter is not saying the revolutionary turmoil is all bad, nor is he pessimistic about it in general.) Regardless of cause, it is obvious that psychiatry today is in a state of agitation, with every psychiatrist encouraged to do his own 'thing'. Jason Aronson, the editor, calls this 'an identity crisis in psychiatry'.

Aronson is to be congratulated for producing an attractive, useful reference work, a guide for the perplexed who seek clarification on such subjects as behavior therapy, sensitivity training, community mental health, and sex reas-

signment. Leaders of sixteen subspecialties, movements, or philosophies in psychiatry were invited to contribute review articles in their respective fields. Each article is critically evaluated by several other experts in the field. While the contributions vary greatly in quality of thought and writing, the discussions are frequently instructive and spirited. The editing is excellent.

The best contribution is the final one by Lawrence S. Kubie: The Retreat from Patients. This article is an incisive and compassionate statement of the needs of psychiatrists in training and how their training falls short of meeting these needs. Most psychoanalysts will subscribe to Kubie's appraisal.

H. ROBERT BLANK

International Journal of Group Psychotherapy. XX, 1970.

Group Therapy and the Small Group Field: An Encounter. Morris Parloff. Pp. 267-302.

Initially intended as a means to study small group processes at the Tavistock Institute in London, and as an educational device to emphasize the experiential basis of learning, the small group encounter process has developed into a method of studying interactions between group and institution, groups in institutions, and institutions with each other. The small encounter group's ill-defined techniques, broadly and somewhat indiscriminately applied, have produced results regarded by some as antidotes to social ills and by others as a debasement of group psychotherapy and a subversion of the basic tenets of our culture.

The aim of such groups is less the amelioration of suffering and overcoming of disability than it is the achievement of new experiences and sensations. To this end some ten to fifteen persons talk, meditate, fantasize, touch, embrace, dance with, and strip each other. Little or no attempt is made to screen out prospective participants. The outcome of such participation may extend from transitory titillation to permanent conversion. Many take part who could be usefully treated by psychotherapy and, indeed, serious decompensation can result.

Although the small group movement is expanding, the question remains: what are its effects? That a small group experience enhances organization efficiency has neither been proved nor disproved; neither has the claim that it enhances interpersonal skill. Rogers stated that three-fourths of eighty-two participants questioned reported a helpful, positive experience, but Stoller has said that only twenty per cent achieved the gains they wished, while two per cent spoke of actual harm. The percentage of those who suffer breakdowns during or after such encounters varies enormously according to different authorities. At the Menninger School of Psychiatry, three out of eleven residents were adversely affected. However, intense emotional stress occurring in the members may be valued by some as evidence of an active response and therefore desirable.

The uninhibited expression of feelings in the groups results not only in occasional physical injury, but humiliation and embarrassment as well. Also,

on returning to his habitual environment, the participant may confront marital tensions previously ignored, while overlooking the fact that skills in communication should include the assessment of the recipient's ability to receive the communication. The small group advocates believe that communication, if not drastically truthful, direct, and spontaneous, is hypocritical. The encounter group experience is described as an elective cosmetic operation that may result in a new self-concept and may induce the individual to make permanent changes that are not desirable. After one encounter, individuals may become addicted, moving from group to group in an attempt to regain the impact of sensation and feeling they found there.

The analytically oriented group therapist notes clues to the members' underlying motives in their group behavior; the encounter group leader notes group-shared motivations and conflicts. The author believes that the latter's techniques may be of use to the analytically minded in increasing suggestibility and emotional contagion, i.e., 'therapeutic regression'.

The Challenge to Group Psychotherapy Created by a Society in Flux. Emanuel Hallowitz. Pp. 423-433.

Recent civic explosions have impelled the author to ask: 'Do our clinical efforts merely help people to adjust to a sick society? Has our preoccupation with the inner turmoil of our patients made us neglect social forces that produce or at least exacerbate pathology? Are our therapeutic efforts too often geared to the upper levels of society, ignoring the multitudes crippled and thwarted by economic and social conditions?' Ethnic groups on the fringes of society, denied opportunities for self-fulfilment, endure much suffering. Traditional psychotherapy is irrelevant to their troubles; consequently as patients, they are demanding, suspicious, hostile, or—conversely—apathetic, hopeless, or overly dependent. Work with the poor demands a reassessment of our treatment goals; such work has been started in mental health centers. According to the author, not only people, but institutions should be changed.

Sager has pointed out that many therapists feel alienated when working with the poor who are the victims of repression and discrimination. The desperate inability of an individual to extricate himself from a crushing environment and the terrible realities of his existence make us feel impotent. Such a feeling alienates the therapist from his patient whom, consciously or not, he blames for his disquiet. This discomfort may be manifested by avoidance or overidentification, evidenced by benevolence and patronizing or infantalizing patterns, and is related to the therapist's own unresolved problems with authority. Countertransferences in this particular area have not been generally examined. The author recommends that therapists conscientiously set aside time for introspection. Here group participation can reveal to the therapist unsuspected attitudes, biases, guilts, value systems, intervention models, and goals. The indigenous nonprofessional can help bridge the gap between the client's culture and that of the therapist, interpret the therapist to the client, and show the therapist how he may be unwittingly offending the client. There is a great need for more commitment by therapists in this area.

Individuation through Group Psychotherapy. Edrita Fried. Pp. 450-459.

All psychotherapy aims at enabling patients to achieve independence and identity. In a group, members develop emotionally to achieve distance from the leader and fight off their primitive desires to identify with him through submission and fusion. They must learn to love as reasonable and autonomous beings. A therapy group, appropriately conducted, achieves this. After anxieties have been understood and shed, good peer feelings arise.

In therapeutic groups, new members go through a phase of concern about being accepted. (Exceptions are schizophrenics, who behave like hermits.) Next, the relationship to the group resembles a mother-child symbiosis in which members begin to resent a lack of understanding and to challenge each other. This is the start of the struggle for individuation, usually accompanied by a show of hostility. Finally, the acceptance is shown by the development of coöperation and peer feelings. Hostility at this point is directed primarily toward the therapist. The countertransference of the therapist is the deciding factor in the group's being able to move from the aggressive individuation phase into the coöperative individuation phase. The therapist must realize that in the life of a group, every patient-follower at some time must become a rebel.

GERALDINE PEDERSON-KRAG

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Meeting of the New York Psychoanalytic Society

Ernest Kafka

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NOTES

MEETING OF THE NEW YORK PSYCHOANALYTIC SOCIETY

May 11, 1971. Panel on LATE ADOLESCENCE: PSYCHOANALYTIC CONSIDERATIONS. A Tribute to the Work and Influence of Dr. Elisabeth Geleerd. Chairman: Peter Blos, Sr., Ph.D.

Dr. Blos noted that Geleerd's work, much of which has become an integral part of psychoanalysis, was firmly rooted in clinical observation. Late adolescence, the subject of the meeting, can be seen from the perspective of work with both adults and children. In late adolescence, the gradual consolidation of the personality takes place, and the adult neurosis is organized and structured wherever an insoluble infantile precondition is found. This thesis is illustrated by material from analytic work with late adolescents.

Dr. Charles Feigelson, in An Identity Conflict and Drugs, presented the case of an adolescent who began his analysis at age eighteen. During the early part of his treatment, he spoke of his involvement with his stepmother whom the father had married shortly after the patient's mother had abandoned the family. The stepmother had two children of her own; the patient assumed a passive, masochistic, ingratiating stance with her. The transference attitude then changed and was concerned with his relationship to his father and difficulties in forming a masculine identity—problems of career choice, forming a relationship with a girl, and dealing with the father. Smoking marijuana served as a passive pregenital and homosexual gratification, as a suppressor of guilt over sexual impulses, and as a self-destructive gratification of anger. It became clear that when he was faced with issues of career choice and heterosexuality, the pressure to resolve the negative œdipal identification increased. In middle adolescence, while going back and forth from negative to positive œdipal identifications, he had defenses, especially track running, that enabled him to cope. Without the sublimation of track running, without peer relationships, and with the increased pressure to assume a 'masculine' identity, he began to smoke marijuana, most heavily when passive feminine wishes were activated. Smoking not only reduced the tension but gratified him. Also, it was an effort to split the positive and negative œdipal constellation. It is hoped that further analysis of the early pathological identifications will enable the patient to resolve this identity problem of late adolescence.

Dr. Robert J. Kabcenell, in Defense and Dream in Psychoanalysis, illustrated that adolescence can be divided into an early period when bodily and mental changes focus attention on the body, especially the genitalia, while defenses are inflexible and weak, a middle phase with numerous defensive trials, and an end phase in which particular defenses have been chosen and are consistently used in a less all-embracing way. He reported the case of a girl who began her analysis at age sixteen, at which time she was withdrawn, anorexic, depressed, and showed a restricted, stereotyped imagination. Shortly before she entered

treatment, she began a relationship with a boy; during sexual intercourse she felt strange and anesthetic. Her reduced body sensations and her restricted fantasy life were illustrated in a dream: she was alone in a tower in a sunless, empty landscape; a minstrel sang a song and scaled the tower; she was uncertain whether to defend herself or to allow him to reach her. The literary quality of the dream, her inability to associate, and the impoverishment of imagination paralleled her anorexia, her anesthesia, and her depression. Four years later, in another dream, she was lying in bed, beckoned to her boyfriend who came over; she touched his erect penis and it ejaculated fluid like rain; she hid under the covers but was inundated. The patient was now aware of her own sexual excitement, was able to associate to the dream, and analyze it over a period of several days. Negation and counterphobic acting out were now more prominent; although she was now generally freer, she remained sexually anesthetic. However, in a manner characteristic of adolescent development, the earlier extensive inhibitions and denial were now modified.

Dr. Felicia Landau, in her paper titled 'I Shouldn't Have to Work': A Syndrome in Girls in Late Adolescence, described a passive attitude in late teenage girls who expect to have their difficulties solved for them in life and in treatment. This appears to reflect a narcissistic fragility with fears of failing and not being loved. It may be encouraged by a narcissistic, anally fixated mother who helps to create an image of her own omnipotence and the child's incompetence; the child then controls her aggressive rebelliousness through passivity. The attachment of a nineteen-year-old girl to her mother was related to her feeling, 'I am all alone'. Another girl described interference by her parents in all her activities and the resulting feeling that nothing she did counted. Regression in adolescence can bring about activation of infantile ego ideals and archaic superego attitudes, and, in turn, enhance narcissistic vulnerability.

Dr. Maurice S. Nadelman, in A Pathological Consolidation in Late Adolescence, presented the case of a nineteen-and-a-half-year-old girl who entered analysis because of vaginal itching which had begun after her first sexual intercourse a year earlier. She revealed feelings of being taken advantage of by the boy, and resentment and devaluation of the analyst as a clinic doctor, a student, and a Jew. She felt that if she could meet a young 'WASP' this would help resolve her difficulties with family, teachers, and other authorities who were responsible for her many social problems. The fact that she was an only girl, with three younger brothers, appeared to foster her need to deny her femininity. During an infantile illness of a brother, she had felt abandoned by her parents and wished to be cared for by a 'WASP' woman who would replace her 'WASP' mother. A contributing factor in her selection of men friends was her need for distance from her Jewish father; she identified circumcision with castration and felt herself to be castrated. Fantasies of prostitution and of being tortured were partially understood in terms of sexual wishes and defenses. The initial 'consolidation' gradually gave way as the patient became more aware of the nature of her problems.

Dr. Martin S. Willick, in The Search for Identification, stated that in adoles-

cence a stable sense of self has not yet been achieved. Anxiety and conflict over sexual identity, and the loosening of ties to parents, intensifies confusion about identity, which can sometimes be ameliorated through the formation of a transient identification. A patient who entered analysis at nineteen because of confused feelings about himself, lack of direction in his life, and mood swings, had a close attachment to his mother. In college a close relationship with another boy, who subsequently committed suicide, stimulated powerful homosexual and aggressive wishes and fears. Soon after beginning treatment, he began to emulate the analyst, became involved in his studies, and felt more settled. The 'identification' served to defend against femininity and was an aspect of this adolescent's personality consolidation.

Dr. Blos suggested that analysis of late adolescents may be distinguished from that of adults by the adolescent's urgent need to find sexual identity and to resolve œdipal conflicts.

ERNEST KAFKA

MEETING OF THE PSYCHOANALYTIC ASSOCIATION OF NEW YORK

May 17, 1971. THE DEHUMANIZATION OF PSYCHOANALYSIS (Annual Freud Lecture). Jacob A. Arlow, M.D.

Dr. Arlow stressed the æsthetic qualities of psychoanalysis and its closeness to human experience and conflict. Because of this æsthetic sensitivity, writers and artists have been among the first to appreciate the relevance of psychoanalysis as the most human of all the psychologies. Psychoanalysis is a scientific psychology with a methodology uniquely its own, studying man not as an artificial specimen divorced from past and present but as an individual in the setting of his constant conflict within himself and with the world. In Arlow's opinion, the psychoanalytic situation—namely, the special technical device of psychoanalytic therapy and investigation—was Freud's greatest contribution. It provided a standard method of operation and, therefore, the beginning of a scientific discipline, which takes advantage of the unique human qualities of man and permits understanding of deeper, universal aspects of the human condition. From analytic data based on psychic determinism and dynamics, one can infer such derivative concepts as intrapsychic conflict, the operation of the unconscious, the genetic approach, and the persistence of infantile fantasies. When the analytic process is proceeding favorably, the communication between analyst and analysand takes on the quality of an æsthetic experience. As in art, in analytic therapy communication reaches its most human expression: the transmission of emotion. The patient's productions are given meaning through the creative effort of the analyst's interpretation.

Dr. Arlow divides the interpretive process into two phases: the first is æsthetic and intuitive; the second is cognitive. To validate his intuitive and empathic understanding of the patient, the analyst must turn to the data of the analytic situation: clinical observations which provide the basis for our claim

of psychoanalysis as a science. Empathic and intuitive understanding of the patient must be fused with a cognitive understanding of the data.

In recent years, there has been some tendency to move away from the essential and uniquely human features of the psychoanalytic situation: a retreating from the methodology, however subtle or disguised it may be. There has been a decreasing number of contributions in the literature reflecting the stream of association and the dynamic interplay of forces in the transference that demonstrate the reverberating effect of the patient's unconscious fantasies and conflicts. Without this material, such contributions cannot be considered psychoanalytic data. There are other trends in the literature in which the data of the analytic situation are abandoned and the patient's experience is conceptualized in ways that disregard the elemental conflicts of the human condition. The analytic process then becomes short-circuited and the patient becomes dehumanized. First, there is the tendency to resort to phylogenetic metaphors to illustrate some feature of mental function, and to treat these analogies as though they were identities. Second, there is the tendency to treat physiological disturbances and psychological trauma as though they were interchangeable. Third, there is the attempt to reconstruct from within the psychoanalytic situation the earliest preverbal experiences of the infant in the third year of life. A final and most important area where dehumanization of psychoanalysis may be observed is in the misuse of metapsychology.

Dr. Arlow concluded by calling for a proper regard for the methodology of psychoanalysis so that the level of our scientific discourse can be improved and the specifically human quality of psychoanalysis can be maintained.

RICHARD C. SIMONS

The 1972 Fall Meeting of THE AMERICAN PSYCHOANALYTIC ASSOCIATION will be held November 30-December 3, 1972, at the Waldorf Astoria Hotel, New York City.

At the Annual Meeting of THE AMERICAN PSYCHOANALYTIC ASSOCIATION in April 1972, the following officers were installed: President: Edward D. Joseph, M.D.; President-Elect: Burness E. Moore, M.D.; Secretary: Stanley Goodman, M.D.; Treasurer: Alex H. Kaplan, M.D.; Councilors-at Large: Calvin F. Settlage, M.D. and Sylvan Keiser, M.D.

The INSTITUTE FOR PSYCHOANALYTIC TRAINING AND RESEARCH, INC., of New York, has established an annual Edmund Weil Memorial Lecture.

The Thirtieth Annual Meeting of the AMERICAN PSYCHOSOMATIC SOCIETY, will be held April 6-8, 1973, in Denver Colorado.