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Lawrence S. Kubie, M.D. 1896–1973

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LAWRENCE S. KUBIE, M.D.
1896-1973

When the Yale Department of Psychiatry after World War II received the strong psychoanalytic stamp which it has maintained ever since, Lawrence S. Kubie became a familiar and impressive figure in the Medical School halls. Already a distinguished psychoanalyst with many published writings, the influence of his vigorous, colorful personality played a significant role in the lives of many young psychiatrists then in training. Those of us who were residents in those years were relatively unfamiliar with the extent of his work in New York and were inclined to look upon him as distinctly one of our own. We knew immediately that this rather elegant figure with his precise diction and scholarly attainments was through and through a clinician and one whom even those already committed to psychoanalytic psychiatry respected for his neurological knowledge as well as his psychological perceptiveness. For all his commitment to the medical profession and orientation, he made it plain at all times that he was a psychoanalyst, prepared when the inevitable controversies arose to enter the contest well armed with a knowledge of the personality that could rout the opposition. That he enjoyed the controversy was indeed evident, but the solid basis of his arguments was always impressive.

When Kubie was in charge of the staff conference there must have been many of us in training then who became aware for the first time of the empirical data on which the theories of the unconscious and the transference are based. Himself an acute listener, he readily conveyed to the attentive students around him something of his capacity for empathy, reached through the perception of details and their synthesis at a deeper level. He seemed to be everywhere at once in those days, and we learned later that this restless, enthusiastic investigator and therapist was almost constantly involved in teaching and speaking as well as in the practice of psychoanalysis. His personal interest in his students and residents added greatly to the impact of his teaching.

The extent of Kubie's interests and industry is indicated in a very approximate way by a glance at Grinstein's Index where

there are two hundred seventy-seven references under his name. They cover a scope of inquiry, opinion, definition, analysis over as broad a territory as even the most intrepid of exploring minds could traverse. Neurology, hypnosis, religion, symbolism, psychoanalytic education, and many other subjects occupied his attention and were communicated in a language which was always precise and clear. Sometimes he ventured into opinions where the more cautious would have remained silent: witness a brief paper in which he incidentally took Mozart to task for his repetitiousness, and another where he warned his readers that with physical immortality no longer an impossibility, it was necessary to take steps to prepare our minds for such a contingency.

Lawrence Kubie's most serious ventures—into the distortions in the symbolic process, for example—have had a lasting influence on the work of writers even remote from his own original concerns. Further, his program, formulated so many years ago, for medical psychological training not bound to a full medical education is at last under way.

If we attempt to grasp something of the spirit that Kubie consistently showed, one of the more striking evidences is a kind of psychoanalytic utopianism. He saw in the analysis of personality disorder an explanation of many, if not most, of the evils of human existence and he often expressed a kind of impatience with human willingness to put up with an unnecessary amount of discomfort and outright suffering. One gets the impression from Kubie that with a little more exercise, or if necessary a lot more, of our rational faculties, engaged with the full panoply of psychoanalytic knowledge in the arena of unconscious conflict, we could in not too long a time master these ills and bring about a better world.

His last paper, an expanded and revised version of The Drive to Become Both Sexes, will soon be published in the Quarterly. It is not so much a psychoanalytical paper as a philosophical testament, one in which he makes it clear that his thesis owes as much to his self-understanding as to his clinical experience and knowledge. Controversial to the end, he could still express himself in beautiful English that commands the attention even of readers who disagree with his thesis.

Dr. Kubie spent the last part of his professional life in Baltimore where, in 1921, he had received his M.D. degree at Johns Hopkins.

During these later years he was associated with the Johns Hopkins University and the University of Maryland Schools of Medicine, and the Sheppard and Enoch Pratt Hospital. In the past he had been President of the New York Psychoanalytic Society and the American Psychosomatic Society, and, in 1937, he was Secretary of the American Psychoanalytic Association.

Lawrence S. Kubie was one of our most vivid teachers and in many ways represented the best of the critical point of view in psychoanalysis.

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The Development and Distortions of Empathy

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THE DEVELOPMENT AND DISTORTIONS OF EMPATHY

BY THEODORE SHAPIRO, M.D. (NEW YORK)

> *When we witness any deep emotion, our sympathy is so strongly excited, that close observation is forgotten or rendered almost impossible; . . . our imagination is another and still more serious source of error; for if from the nature of the circumstance we expect to see any expression, we readily imagine its presence.*
>
> —CHARLES DARWIN (1872)

Psychoanalytic literature abounds with references to empathy: most authors advocate its use and decry its absence. Future candidates and colleagues are often evaluated by our estimates of their capacity for this somewhat vaguely defined but manifestly complex ego state. Greenson (1960) and Loewald (1970) have observed that we call upon empathy to help us interpret when we have difficulty in understanding our patients. Kohut (1959) and Fliess (1942), among others, have suggested that what distinguishes psychoanalysis from other sciences is the inclusion of empathy in its method.

It is not surprising that patients as well as analysts utilize empathic responses to evaluate and comprehend their human experiences. Nevertheless, psychoanalytic literature has neglected the patient's use of empathy, thereby omitting a source of data which might illuminate its meanings and variations. It may be that the analyst has defensively sought to consider empathy, with its altruistic aims, as his own exclusive tool. In itself, this attitude is unanalytic and inevitably leads to pro-

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tection of blind spots. A metapsychology of empathy should enable analysts to evaluate the possible distortions and flaws in this instrument which sometimes impede rather than aid in our understanding of it.

The present examination of the complex psychological structure of empathy and its possible distortion as a defense was prompted by a patient who talked about his empathic response to a friend.

After three years of analysis, the patient, then in his late thirties, decided to marry and repeatedly mentioned his intention to telephone a former woman friend to tell her of his plans since he knew, he said, how she would feel if she heard the news from someone else. What might be designated as his empathic knowledge was held with great certainty, but I wondered if his supposition about her reaction was accurate. Was the planned call really charitable? Since he had had an intimate relationship with her for four years, it was possible that his call informing her of his forthcoming marriage to someone else, might be taken as an act of hostility. She might interpret it as 'rubbing-it-in', as a narcissistic wish to know that she was still 'pining' for him, or as some other interactional maneuver.

Only after his delay in communicating with her and his reflection that he hoped she too might be planning to marry, did I confront him with his use of projection in the guise of empathic understanding. He had said he *knew* how she would feel if someone else told her of his marriage, because he himself would feel hurt if he had heard that she was to be married while he did not have another girl. What he felt to be empathic understanding had the defensive purpose of warding off his guilt for having occupied her time for so long without marrying her. He wished to mollify his conscience by assuming the responsibility of telling her himself. Nonetheless, his intention to call her showed genuine, although somewhat misguided, concern for the object. The defense could be seen not only as protective of egocentric concerns, but as adaptively object-centered, and

might even be empathic as he claimed. Clearly, the definition of empathy required clarification.

Following the interpretation that he was assuming he knew what this woman would feel because under similar circumstance he would be hurt, the patient was able to consider a broader range of possible responses that he had formerly omitted. He was no longer certain of his empathic understanding. Significantly, he also recalled a memory which he dated to age four. He remembered urinating in the toilet, purposely sitting rather than standing, as he wished to know how a woman (his mother) felt when she urinated. This act of imitation of the observed behavior of others, elicited in the context of the analysis of his 'empathy', suggested an important genetic link between *imitation* and later *empathy*.

This clinical observation provoked my curiosity and interest in exploring further the dynamic structure and genetic roots of empathy. Since we all once were or are analysands, studying our patients' empathic states should enable us to discover something about ourselves. In this study I shall attempt to show how distortions in empathy may arise and serve as a substructure for technical impediments, while its undistorted availability furthers better understanding.

DESCRIPTIVE DISTINCTIONS OF EMPATHY

Greenson (1967) suggests that 'empathy means to share, to experience the feelings of another human being. One partakes of the quality of feelings and not the quantity. Its motive in psychoanalysis is to give understanding; it is not used for vicarious pleasure' (p. 368). He further elaborates that intuition has relevance to ideas while empathy pertains to emotions and impulses. In an earlier paper, Greenson (1960) differentiates sympathy from empathy, pointing to the condolence, agreement, and pity necessary for sympathy. Olden (1953) suggests that 'empathy is the capacity of the subject instinctively and intuitively to feel as the object does. It is a process of the ego'

(p. 112). Schafer (1968) states that in 'the highest form of empathy [which he terms generative] the subject, so far as his own experience goes, feels that he is one with the object; he feels what the object feels; and yet, above all, out of self interest as well as interest in the object, he maintains his individuality and perspective at the same time' (p. 153).

These are but a few of the many definitions which stress the distance from the object and the quality of sameness of affect assumed by the individual who empathizes, regardless of the specific affect experienced (*cf.*, Loewald, 1970, and Jacobson, 1954, 1964). In this light some authors state that empathy is an affective experience while others regard it as an ego state; some more clearly differentiate ideation and affect. For example, Kohut (1959) suggests that empathy is 'vicarious introspection' (p. 459). The general thrust of these definitions seems to bypass a dynamic and structural analysis of empathy, yielding to a paraphrase of the phenomenal aspects of the process.

Specific dynamic structural and adaptive mechanisms operative in the experience of empathy can be considered within the context of the patient described above. In a spectrum of possible human experiences ranging from highly *egocentric* to highly socialized and *object-centered*, we may find various responses.

1. An individual may not acknowledge perceiving another's feelings.

2. Another's feelings may be perceived with or without understanding how the object could feel as he does.

3. An individual may perceive another's feelings, recognize that he feels or would feel similarly, and that a specific circumstance is the basis of the congruence of feelings.

4. An individual may recognize that he feels as another feels by observing him without awareness of a causative agent or circumstance other than a judgment that he and the object feel alike.

5. An individual is convinced that he feels the same as another regardless of the object's circumstance or expression.

Which of these experiences can we designate as empathic? Clearly the first and second are nonempathic responses. The first does not acknowledge perceiving the feeling state of another, while the second admits only to recognizing it. In neither instance is a similar state distinguished as the common experience of the individual and observer as well. The third instance provides distance from the object and clearly relates to the emergence of, or feeling toward, an external inciting event, such as shared mourning or religious rituals. Here we assume we belong to a community of human beings who are all subject to the same emotion in a given context by virtue of our humanness. This is clearly empathic, and is also 'normal' behavior, for it is based on the conviction that everyone will feel the same way under any given circumstance, and indeed, that most people do so.

Normative responses may not represent the best criteria for defining empathy, however, because they depend on 'usual' social experiences and practices. Psychoanalysts must be attuned to personal and individual situations, and there are occasions when the analyst is stimulated to develop 'imaginative empathy'. In the spectrum outlined, this would fall between the second and third categories: the analyst may not initially 'feel as his patient does', but he may reach empathic understanding by way of a conscious subjective construction. During this process he may review the patient's unique and sometimes alien experiences and achieve a reproduction of the emotional response in question. This activity tends to be somewhat mechanical and purposeful and therefore lacks some of the immediacy of the empathy described in the third category. It is closer to intellectual grasp than to a spontaneous emotional replay within the analyst.

Category four implies even more existential immediacy than category three. The observer claims no knowledge of the cause of the shared affective experience. However, if the experience is to be called empathic, one should consider Jacobson's (1954) distinction between 'like' and 'same' used to distinguish psy-

chotic object relations from nonpsychotic. While the boundaries between self and object may remain intact, the thrust of the feeling into consciousness reminds us of the intrusion of an obsessional idea. We may not desire the feeling and may not know from where it comes, but we are forced to recognize its immediate impact. In the sense that it is understood as another's feeling, it is also ego alien. The empathizer believes that the 'copied' emotion would vanish if the object were to alter his feeling. In that sense we are passive in the face of the affect, and if it disturbs us sufficiently to mobilize defenses against it, we may externalize it and deal with it in a manner similar to phobias or obsessions. We can avoid the person whose feelings so contaminate us, or ritualize our relationship to ward off the unpleasant affects generated. If the feelings are pleasant and unthreatening, they may be gradually adsorbed by the ego and cease being ego alien; they may then be interpreted as a form of sympathy, geniality, or even love. Whether any or all of these paths are taken will depend upon the individual's unique ego structure and his dynamic requirements for maintaining an adapted state. In hysterics, the passive submissive needs may dictate the empathic state while in the borderline personality, regressive states may affect the ego boundaries. In either of these instances the felt empathy may give way to ego threatening variants according to the vulnerability of the existing structures.

Category five tends toward the loss of boundaries between self and object, giving a conviction of merged experience. It is analogous to transitivism in the realm of ideas. The psychotic individual believes his thoughts are the common property of all people; ego boundaries are abrogated without regard for reality testing criteria. However, there are instances in which conviction may be temporarily strong, as in the case described earlier, or in the analyst whose a priori assumptions dictate his observations. These may be distinguished from the phenomena in category five because in the former reality testing is preserved. In their final judgments, observation of the external

world and self-correction determine their behavior, not mystical immediacy as in the case of the psychotic.

STRUCTURAL AND DYNAMIC CONSIDERATIONS OF EMPATHY

Traditionally empathy has been related to processes of identification. In this vein, Freud (1921) wrote, 'A path leads from identification by way of imitation to empathy . . .' (p. 110, n.). It seemed descriptively simple to suggest that the individual felt as the object did by virtue of some process by which the object's feeling state was reconstituted within the empathizer.

Fliess (1942) suggested that empathy was a 'trial identification' by which the analyst with 'psychological aptitude [puts] himself in [the patient's] shoes, and [obtains] in this way an inside knowledge that is almost firsthand' (p. 212). Greenson (1967) writes: 'The essential mechanism of empathy is a partial and temporary identification with the patient on the basis of a working model of the patient within the analyst, which he has constructed from his sum of experience with the patient' (p. 369). Only Greenson (1960) distinguishes sympathy from empathy and proposes that identification differs from empathy by virtue of its permanence, unconsciousness, and aim as a means of overcoming anxiety, guilt, or object loss. Kohut (1971) understands empathy as 'a mode of cognition which is specifically attuned to the perception of complex psychological configuration' (p. 300).

A modification of the identification theme is reflected in the insistence of some writers that merging or reconstitution of the mother-infant unity is the essential feature of the empathic state. Ferreira (1961) considers empathy 'a bridge function of the ego', analogous to an umbilical cord. Olden (1958) suggests that empathy is the 'end-product of sublimation from the early mother-infant unity', while Schafer (1959, 1968) has stated that merging is present in all forms of empathy but that the *generative* form, where productive synthetic interchange is possible, is

distinguished by the maintenance of the 'individual perspective of the empathizer at all times'.

These authors are impressed with the regressive anlage of empathic feelings; at the same time, in the mature adult they consider object distance of paramount importance. But how can we support both the idea of merging and object distance within a single function of the ego? To obviate this difficulty, Fliess (1942) wrote of a '*trial identification*' (p. 213). Schafer (1959) suggested that the 'identification remains segregated within the ego . . . it does not permanently modify its structure' (p. 357). By invoking merging as the origin of empathy, these authors must bypass the indicated relationship to the source by suggesting the relative isolation within the ego of the new 'identification'. This is suggestive of Kris's attempt to save regression from its former pathological connotation by noting its adaptive service to the ego.

In light of the foregoing, how does one consider my clinical vignette where the projective mechanism seemed to be more prominent than that of the identification?

The difficulty may stem in part from confusion surrounding the term 'identification'. Structurally we place it within the ego, and there is a tendency to view it as an autonomous function. It may function in the service of defense, however, and may then distort other ego functions such as perception and interfere with adaptation to reality. On the other hand, when we speak of projection we must clearly state that we usually ascribe a wish or feeling to another and deny it in ourselves. Novick and Kelly (1970) have described this as the projection of a drive. Writing about the promiscuous use of the term 'projection', they caution that externalizations of aspects of the self and animistic thinking, such as the child's capacity to generalize his experience, should be distinguished from the projection of drives proper. In the classical example of the paranoid projection, there is also a reversal of sign from 'I love' to 'I do not love' and then the projection 'he hates' and persecutes (*cf.*, Waelder, 1951).

In the case of empathy, I propose that the denial of the wish or emotion toward the object is absent and a feeling of unity is substituted. That is, instead of the change from 'I feel angry' to 'I don't feel angry, he does', the formula is, 'I feel angry in the same way he does'. Thus, both identification and projection share the same infantile matrix of nondifferentiation.

Freud's suggestion (1923) that object cathexis and identification are not distinguishable during the oral phase represents a similar observation about the undifferentiated function of the early mental apparatus. Only at a later point in development when inner and outer reality are better defined can we speak of identification and projection as discrete ego functions. If one had to postulate a clearcut stage when this becomes established, it might be after the 'me—not me' distinctions of the anal phase of development.

Because projection and identification emerge out of the same global infantile matrix, any defensive regression in ego state may elicit a mixed deployment of early forms of identification and projection. The appropriate distinction between the two is only apparent within a more differentiated ego with autonomously functioning reality testing that is not harassed by the need to defend. Thus, both identification and projection, or some intermediate stage where both are combined, may be instituted as regressive mechanisms to avoid castration anxiety as well as separation anxiety and helplessness.

While nondifferentiation may be the developmental basis for later empathy, the authors who espouse this as an explanation for empathy itself should enable us to understand how one human being knows another's feelings with such conviction that he uses a new word, 'empathy', to justify what may indeed be an error in judgment based on a requirement of defense. Indeed, it is an error in judgment which, if the other party agrees to it, leads to a re-enforcement of narcissism. That is to say, each time we share our empathic response with another and he verifies it, our sense of omnipotent vision is enhanced, lending veracity to the infantile merger which is used theoretically to

account for empathy in the first place. *(Cf.,* Beres [1968] for discussion of validation.) This seems a poor circle of reasoning in which to place trust.

The data presented by my patient may be instructive here. The day following the confrontation and interpretation of his 'empathic understanding', he began the hour by describing the humiliation and sense of weakness he had experienced when his fiancée berated him for a failing. He then contrasted his passivity with the active but shabby and demeaning way his father and grandfather had treated women; he hoped he would never be as cruel to women as they had been. He then revealed a sexually exciting fantasy of 'peeing on a girl', which he had experienced that day.

Early in life this patient had been exposed to women with whom he had identified and for whom he felt sorry when they were abused. When his anger was aroused by his fiancée's shabby treatment, he perhaps felt that to be 'manly' he must behave as his grandfather and father did; but his fear of assuming the paternal role blotted out his conscious fantasy of urinating on the female and enhanced the defensive identification with the female, as if to say, 'I am neither cruel like father nor am I competing with him. Indeed, I am just like you (the female); I feel as you feel. We are the same; we are both castrated'—or, as his fantasies revealed, bisexual.

The central role of castration anxiety in this patient's mental life demanded that all human beings be alike. At another point in the analysis, he reported a dream in which he presented his penis to a woman; he then described satisfaction in autofellatio. Thus he seemed to acknowledge his perception of the female's lack of a penis by giving his penis to her, but then he magically denied the need for the gift by retaining the penis: while he and she were the same, they were separate and alone but bisexually self-sufficient without the painful need for the other. His active fantasy of urinating on a woman, based on identification with the males in his early life, could not be easily maintained without lapsing into a passive identification

which he associated with femininity and bisexuality that both he and his fiancée shared.

A similar mechanism involving empathy as a defense was suggested by another patient, a young man in his twenties. His ambitious strivings were markedly restrained by an unrelenting superego. He came home one evening full of enthusiasm because his employer had complimented him and offered him a prized gift. However, on his arrival at his home he found his wife in a profoundly depressed mood, eager to tell him of her troubles. After a momentary surge of anger, which he quickly suppressed, he was as depressed as his wife. His perception of her mood led to a change in mood approximating his wife's appearance at the behest of his superego. His rationalization was that it would be inappropriate to be joyful when she was so depressed; it would not be considerate to be angry with her for he empathically understood her feelings; his ambitions and enthusiasm were petty; it was more important to be like his wife—if both are ineffective no one could accuse him of being competitive. Trying to cheer her with his good news would be self-centered. His conscience demanded equality even if it were at the expense of his success and the likelihood of his wife's sharing his success. Moreover, his mood change was immediate and associated with the wish to help her. Only in the analysis could the sequences of his reactions be understood.

In his early life enthusiastic ideas that he presented to his father were rejected in what he felt to be a deprecating manner; nothing he did, or wanted, was worthy. Similarly, with his wife he disparaged his own success and compared his needs with hers. He believed that her depression represented as profound a narcissistic hurt as he had suffered in the past with his father; that something within her was actively deprecating—as his father had been in the past. The patient's perception of his wife's mood was encroached upon by reminders of past personal hurts. The identity was clear, but he also used the perceived identity as a signal to suppress his own anger. He projected onto

his wife past feelings of narcissistic injury while suppressing the active identification with his father, which would have aroused his castration anxiety and caused him to berate her. Hence, rather than trying to cheer her, he felt he had to become as she was and as he had been as a child; it was better that they suffer together as equals.

In the conclusion of his paper (1960) on empathy, Greenson states that 'people with a tendency to depression make the best empathizers' (p. 424). In the cases described above, the threat of losing a current object could only be avoided by relinquishing of ambitious œdipal aims and yielding to passive depression. Thus, the empathic feeling was supported by at least two defensive organizations: the regressive pull toward a narcissistic object cathexis with projection onto a current object and the anxious defense against competitive identification with the castrating father. This suggests not only the defensive and conflictual origin of some empathic feelings but also that the identification/projection confusion may be solved only by genetic considerations.

GENETIC CONSIDERATIONS OF EMPATHY

Early hypotheses regarding the origins of mental life invoke, but sometimes slur over, the introjective-projective mechanisms. In 1915, Freud wrote: 'Consciousness makes each of us aware only of his own states of mind; that other people, too, possess a consciousness is an inference which we draw by analogy from their observable utterances and actions, in order to make this behaviour of theirs intelligible to us. . . . This inference (or this identification) was formerly extended by the ego to other human beings, to animals, plants, inanimate objects and to the world at large, and proved serviceable so long as their similarity to the individual ego was overwhelmingly great . . .' (p. 169).

This observation by Freud makes it possible to state our problem in terms of concern with *perception of* and *judgment about* another individual's feelings and thoughts. Thus, stress on ob-

ject distance is but one ego function to be considered; the second involves perception together with the observer's relationship to reality. Before the term 'empathy' came into the language, Freud placed the anlage for knowing the states of mind and feelings of others in a mixed deployment of autonomous ego functions and early tendencies toward animism. The latter perhaps represents an immature form of projection-identification.

While the pleasure-pain continuum certainly must dictate the earliest distinctions between inner and outer reality, it is still something of a mystery how an infant can project self-representations before he has introjected object representations; in other words, how projection can take place prior to the differentiation of self and object. Perhaps invoking the autonomy of perception, or its precursor, sensation, can provide a means of disengaging it from introjection and allow the introjective-projective continuum to fall within the province of the growing evaluative apparatus of the infant.

Recent hypotheses regarding initial fusion of self and object in an undifferentiated somato-psychic matrix are more helpful for our consideration of the origin of empathy as well as for identification and projection. Not only do they permit learning by way of perception and differentiation of functions in developmental sequence, but they are consonant with sensory-motor psychology in which the initial omnipotent egocentric operations gradually yield to the emergence of a separate, externally anchored representational reality independent of the infant's wishes, thoughts, and gestures. Moreover, if psychology truly begins with the first wish (Freud, 1900; Schur, 1966), our genetic theory demands that undifferentiated tension states become defined mentally by perceptual encounter with an external reality, in accord with a split continuum of pleasure and unpleasure (Schur, 1966). In this manner, representations of both the good and bad mother emerge and are then ultimately integrated into a unified object as the most mature form of object representation. Spitz (1957) suggests that even during

the second year, the child evaluates only in terms of 'for' or 'against' and is therefore incapable of empathy.[1]

The early internalizations, of necessity, depend upon multiple encounters with the perceptual qualities of the mother: her warmth, her visual appearance, her voice, etc. While at first these are globally fused in a coenesthetic 'buzzing blooming experience', and are heterologous like the individual frames of a film sequence, the integrative capacity of the central nervous system and its extension in psychology, the ego, fuses them into a psychic object which has permanence in form and stability over time. While we begin as fused and undifferentiated, we also 'take in' the object by way of our senses and in conjunction with drive-tension relief. These initially unique and idiosyncratic experiences then become socialized by categorization in a common language which is fed back to us and verified by adults. (*Cf.*, Grossman, 1967.)

Thus, from the beginning of life we postulate a double core of commonality among human beings. 1. A common neurological substrate with presumed specific integrative capacities and drive states which are modified by the physical environment. 2. A patterning of these states by the mothering person and the broader social environment which guarantees their continuity within the culture.

For example, in regard to the latter, ghetto children seen in large city hospitals are not capable of defining many emotional states, and the finer nuances of sadness, anger, or hurt go largely unnoticed. This does not suggest that their repertoire of affects is less full than those of middle-class children. It means only that the flexibility of response to affects is limited because the affects are categorized in a limited way, or may be used primarily as signals to action. Among infants and children from middle-class nuclear families, there are circumstances which also lead to variations in the capacity for empathic learn-

[1] Contrast this view with Sullivan's (1953) contention that empathy is the mechanism of anxiety arousal in infants, and Anna Freud's (1960) discussion of contagion of affects.

ing. For instance, a depressed mother who meets her child's needs with uniformly unenthusiastic behavior does not provide a model for mirroring a variety of emotional states. Similarly a child whose moods are invariably interpreted according to a pat definition may back off in disappointment and expect that he will not be correctly understood (Kohut, 1971). This same child may not know how to define his own state of feeling, and may experience undefined tension or boredom, and feel that he lacks understanding of others.

Thus, genetic investigation suggests that children learn to fuse and associate their inner tensions with specific experiences with parents. These then become structuralized psychological memories[2] which make future similar experiences more predictable. Such structures may be distorted at any time because of dynamic considerations due to phase and stage related anxieties. As a child begins to read another's facial expressions and body attitudes, he must bring them into coördination with his own growing repertoire of emotional states in order for empathy to emerge.

I would submit that there are very early experiences which seem to be forms of this process in states of 'becoming'. For example, Darwin (1872) suggested that infants respond to emotions in others almost from birth, explaining these as inborn species specific patterns. Regarding a six-month-old infant, he wrote: '. . . an innate feeling must have told him that the pretended crying of his nurse expressed grief; and this, through the instinct of sympathy, excited grief in him' (p. 358). Shall we assume grief because of a mask which coincides with an adult's external appearance? Imitation may be a better guess. Furer (1967) also has reminded us of mothers who indulge their own egos in the mutually satisfying game of pretending to cry and making the child the comforter. How much intervening and mediating psychological structure can be assumed from these behaviors depends upon other measures of ego development. We must

[2] *Cf.*, J. H. Smith (1970).

remember that turning the passive into the active is a primary human capacity, and Piaget (1947) suggests that the assimilation-accommodation cycle obtains from infancy to maturity. It is the functionally uniform route toward the repeated adaptations which results in development. Cognitive organization and psychic structure may change, however, and it is this differentiated route which marks the developmental progress from imitative precursors to maturely structured empathy.

A vignette involving a child of five, who was observed outside of analysis, illustrates the role of later imitation and perception in empathy. This five-year-old had kept his father awake during the night. At the breakfast table the father, tired and facing a long day, grimaced and moaned throughout breakfast. After the meal, the child said, 'I am sorry, Daddy, for keeping you awake'. The father reassured the child and left. Later the mother told the father that the boy, who had earlier watched his pained grimacing, seemed to grimace involuntarily during the morning, looking as pained and disgruntled as his father.

We do not know what this child felt, but clearly he had watched closely and may have feared that his father was angry; therefore, he apologized. But why the imitation? He followed his father's attitudes externally. In so far as he could, he recognized that they represented a feeling state demanding apology—whether he felt the same as father is not certain. How are we to know when the feelings are the same?

Because of our communication system we can sometimes verify our surmises. While we cannot claim to know another's feelings or consciousness perfectly, we call our feelings by names or guess their sameness by perceptual identity. Or, as in the instance mentioned, the child recognized the father's strained feelings, related them to a responsibility, remained vigilant, and attempted to discharge his anxiety by apologizing. This is an interpersonal solution but another is possible. If instead of, or in addition to, apologizing, the child had recognized his imitation or its representation as a reflection of

his father's pain, he might have obviated the anxiety of conscience by asserting a similar state within himself and suggested, 'I am blameless because we are the same', and indulged in empathic rationalization: 'I know how you feel because I feel the same'. This solution may subserve a number of dynamics which include alleviation of guilt, strengthening of identification, etc.

Thus, during the structuralization of experience with objects, individuals learn to designate inner states by identifying the external appearance of others with internally perceived affective experiences; in later life the interpretation of others' feeling states involves projection of established constellations of bound drives which are then verified by testing their congruence communally by the assent of others. However, in actual practice this process enables a potentially useful empathic response to miscarry and to be used to defend against anxiety. The individual, in effect, may say: 'I know how he feels; I feel it too', instead of, 'I am afraid because what he is feeling makes me aware of an unacceptable wish from the past, the expression of which will lead to separation or castration anxiety, or superego castigation'.

The cases presented above offer an example of this model of empathy as defense. If Loewald (1970) is correct in his assertion that what is internalized are not objects but interactions and relationships (p. 59), then each new perception of an interaction may activate an already structured psychic organization which, when raised to near consciousness, may trigger a resistive mechanism and/or an affect. The latter may coincide with a present situation only when it serves a defensive purpose or when there is a genuine recognition of present relevance.[3]

THERAPEUTIC IMPLICATIONS OF EMPATHY

The metapsychology and defensive use of empathy have importance for the conduct of therapy. The claim of empathy for defensive purpose is seen clinically when patients suggest that they know that the analyst will be hurt by what they may say.

[3] See, for instance, Arlow (1963) regarding the supervisory situation.

When vulnerability to narcissistic anxiety is projected onto the fantasied analyst, it can constitute the strongest resistance to self-knowledge. The tacit assumption that all minds are like the patient's mind underlies this defense. Kohut (1971) reminds us of the narcissistic patient who demands infinite empathy from the analyst because of his projected self-idealization.

Lesser degrees of disturbance in the maturation of empathy may interfere with analytic progress. Patients who have not grown up with a parent of the opposite sex may not have had the repeated verifying experiences to test congruence of feelings between the sexes. The transference of such individuals may be marked by fluctuations between over-idealization and profound disappointment in the analyst. Similarly in acute states of rage sustained to ward off frightening sexual feelings, some patients cannot empathize with their parents or spouses. Analytic progress suffers until more realistic perceptions can be established and interpretation of the dynamic function of the lack of empathy is acknowledged and understood. Profound fears of regressive merging or passive surrender may prevent patients from sharing feelings because of the vulnerability implied in the loss of self-object boundaries. For example, passive homosexual wishes or fantasies of oral surrender may be aroused when the analyst appears vulnerable himself because of a transient physical disability. The misapprehension of the analyst's need is based on the patient's past needs which, when reactivated, may give rise to resistive defenses that protect his fragile ego autonomy.

The analyst's empathic responses may also suffer distortion. Narcissistic smugness may find refuge in resorting to a claim of empathy. Moreover, assent to an interpretation from the patient may lead only to enhancement of the analyst's feelings of omnipotence. We are observers, and although we distill a patient's behavior through many channels of observations we must be cautious that claiming empathy as a rationale for our interventions is not just a mask for ignorance when empirical bases for understanding fail us. Sometimes we may count on the fact

that we share humanness with patients and therefore *know,* but the possibility of projection of our own affective reactions should be considered lest, in our certainty, we err. It is too easy to use the rationalization of 'much clinical experience' to bolster this certainty when tolerance of doubts and watchful waiting may be the better path.

The theoretical models of psychoanalysis also influence our understanding, and if we include empathy as one of our instruments, there is always the problem of keeping the resultant knowledge uncontaminated by the mark of the coding devices of our schemata. While it may not be possible to free any investigator of the bias of his vantage point, nevertheless there should be a continuous check on the instrument. Because empathy is so vulnerable to distortion for the dynamic reasons mentioned, it must be monitored. While the analyst may find it invaluable for his work, he should distrust it with vigilance and always be ready to modify his understanding of a patient as new data impinges on his senses. Freud's early error in judging his patient's tales of seduction as actual, is perhaps the best example of an observation that had to be modified in the face of new data. In that instance, interestingly enough, it was likely that Freud's early willingness to believe was superseded by empathic understanding as he learned of his own incestuous wishes which finally led him to the idea of psychic reality.

But what of the empathy we all cherish, the kind of empathy which lets us work where all else fails (Knight, 1946), the generative empathy which Schafer (1959) analogizes to a creative process? This permits *comprehension* of another's predicament rather than simple *recognition.* With Schafer and others, I believe that we do indeed do some good work in analysis by the use of empathy, but each estimate of another's emotions, whether based on simple observation or empathy, must be subject to the same evaluative process. Self-knowledge aids in keeping the perceptions clear of contamination and the distance from the object optimal, but a feeling of certainty should never be an indicator of veracity.

Because the coöperation within the analysis does mimic the dyadic pairing in growing up, perhaps the self-correcting nature of the analytic process saves us from having to abandon empathy as a false god. We must desist only from viewing it as an autonomous tool which is free of conflict. Loewald's (1970) proposition that we internalize relationships and interactions might be extended to include the notion that there is a continuing incorporation of new emotional experiences in the course of analysis that serves as the medium for restructuralization. The transference is the medium for such relearning, but perhaps these cautionary notes will make it less likely that the analyst's anxiety will lead him to project his own past relationships and interactions onto the present in the name of empathy, to the detriment of understanding either himself or his patient.

SUMMARY

Psychoanalytic writers have devoted much of their attention to the importance of empathy as an adjunct to their work. While some have alluded to the sources of empathy in earlier developmental circumstances, little has been written regarding its dynamic structural and genetic substructure. The current exploration of empathy is drawn from the analysis of a patient whose empathic response seems to have had a defensive function and also pointed to genetic roots in imitation.

The defensive structure of some empathic responses is utilized to illuminate the structure, dynamics, and origins of empathy and the role of projection. Earlier undifferentiated forms of projection-identification as they occur in regressive states are postulated. The knowledge gained from the therapeutic observation and theoretical model is then applied to the therapeutic situation in order to show the distortions and pitfalls of the overzealous use of empathic states by patients and analysts alike.

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FANTASY AND IDENTIFICATION IN EMPATHY

BY DAVID BERES, M.D. AND JACOB A. ARLOW, M.D. (NEW YORK)

> *It is easy to cloathe Imaginary Beings with our own Thoughts & Feelings; but to send ourselves out of ourselves, to* think *ourselves in to the Thoughts & Feelings of Beings in circumstances wholly & strangely different from our own . . . and who has achieved it? Perhaps only Shakespere . . . a great Poet must be implicitè if not explicitè, a profound Metaphysician. He may not have it in logical coherence, in his Brain & Tongue; but he must have it by* Tact/*for all sounds, & forms of human nature he must have the* ear *of a wild Arab listening to the silent Desart, the eye of a North American Indian tracing the footsteps of an Enemy upon the Leaves that strew the Forest; the* Touch *of a Blind Man feeling the face of a darling Child.*
>
> —SAMUEL T. COLERIDGE (1802)

Empathy, which we consider of focal significance in our work as psychotherapists, is something that is too easily taken for granted. We expect a good therapist to be empathic and we search for this quality in the candidates whom we select for training in psychoanalysis. Criteria indicating the presence of empathic tendencies, however, are hard to define, and the literature does not make clear whether this quality is a given or whether it represents something which can be developed through training and personal analysis. Disturbances of empathy, on the other hand, are easier to detect, and consequently more has been written and discussed about them; they are frequently introduced in connection with countertransference difficulties during supervised work with candidates. This communication will limit itself to discussion of the nature of empathy and its mode of operation.

With the exception of material dealing with problems candidates demonstrate during training, precise and documented data concerning empathic phenomena are difficult to find in the literature. There are many reasons for this. Because empathic communication is so fundamental to our work and constitutes a welcome, if unconscious, adjunct to our technical procedures, we do not tend to wonder as much as we should how such an interaction comes about. Furthermore, the phenomenon is an old and familiar one, known to us from our daily experience outside the therapeutic situation. It is only within the therapeutic situation, however, that we exercise with disciplined attention the necessary consistent self-observation which illuminates the vicissitudes of empathy. This part of our experience has an æsthetic quality and is one we tend to regard and mistakenly believe to be beyond the realm of scientific analysis. Hence, it is easy for us to think of empathy as part of the art of therapy, imbricated into a mystique which has come to envelop probing into the unconscious mind of man.

There is another, even more important factor that accounts for the scarcity of documented reports on empathy. Such documentation has to be self-revealing, especially about the personal response of the therapist to his patient's productions. Very few of us have the courage to expose for public scrutiny the record of our inner processes, as Freud did in The Interpretation of Dreams.[1] It should be noted, also, that today the audience for such exposure is much larger, more sophisticated and highly skilled in the technique of psychoanalytic interpretation. Recording a few surface phenomena can be more revealing than they were in Freud's time.

The problem of how to enter into the mind of another person is an old and fundamental one. Freud (1915) spoke of the

[1] A notable exception is a recent communication by Miller (1972) in which with rigorous honesty he reports his reactions to falling asleep while listening to a patient. He ascribes this to a manifestation of his countertransference, the result of the simultaneous appearance in the therapist and the patient of an analogous unconscious fantasy.

difficulty of apprehending the conscious workings of another's mind. He well knew that consciousness made us aware only of ourselves but that by identification could be extended by the ego to others. 'But', he wrote, 'even where the original inclination to identification has withstood criticism—that is, when the "others" are our fellow-men—the assumption of a consciousness in them rests upon an inference and cannot share the immediate certainty which we have of our own consciousness' (p. 169). If this, indeed, is the difficulty encountered in understanding the conscious functioning of other minds, how much more difficult then is the task of grasping *unconscious* processes in the minds of others. In this task empathy and intuition play a basic role. And, in turn, they are buttressed by the analyst's conscious knowledge of psychic functioning and psychopathology.

In his advice on therapeutic technique, Freud (1915[1914]) recommends that the beginning analyst should not be too concerned with trying to master the patient's data in a cognitive fashion. The correct interpretation, he suggests, comes into the analyst's mind in the form of a free association. What Freud was actually describing is the fact that we rely heavily on the process of intuition, that is, on the immediate knowing or learning something without the conscious use of reasoning. As in any form of creative scientific work, the vast stores of information available to the investigator are organized into meaningful configurations outside of the scope of consciousness, and the results of this process are later brought into relationship in a rational, disciplined, and cognitive fashion with the data of observation. This does not mean that every association which comes to the mind of the therapist during his work constitutes an accurate interpretation of the data presented to him (*cf.,* A. Reich, 1961). Somewhere in the course of the introspective activity which the analyst exercises, he becomes aware of the end product of a highly complicated process which has been going on outside of the scope of consciousness. The awareness and the perception of this end product is the result

of intuition; the validation of the interpretation thus presented to the consciousness of the therapist is a further process upon which the analyst must then embark.

In order to illustrate the problems surrounding the utilization of empathy in clinical interpretation, the following data from a therapeutic session are introduced. From this data, it was possible to reconstruct the nature of the underlying, unconscious fantasy, and to examine to some extent the process by which this reconstruction became possible.

CLINICAL EXAMPLE

On his return from the long Thanksgiving holiday a patient reported:

> I am not so sure that I am glad to be back in treatment even though I did not enjoy my visit with my mother and father in the Midwest. I feel I just have to be free. My visit home was depressing. My mother hasn't changed a bit. She is as bossy, manipulative, and aggressive as always. My poor father. He says nothing. At least in the summertime he could retreat to the garden and work with flowers. But my mother watches over him like a hawk—a vulture—she has such a sharp tongue and a cruel mouth. You know, each time I see my father now, he seems to be getting smaller and smaller. Pretty soon, he will disappear and there will be nothing left of him. She does that to people. I always felt that she was hovering over me, ready to swoop down on me. She has me intimidated, just like my wife. I don't feel like getting involved, but when you are married, there isn't much you can do about it.
>
> I was furious this morning. When I came to get my car, I found that someone had parked in such a way that I was hemmed in. It took a long time and lots of work to get my car out. During the time I realized how anxious I was. The perspiration was pouring down the back of my neck.
>
> I feel restrained by the city. I need the open, fresh air. I have to breathe. I have to stretch my legs. I'm sorry I gave up that house in the country. Next week, I am going up to Massachusetts to look around for property. I have to get away from

this city. I really can't afford to buy another house now, but at least I'll feel better if I can look.

If only business were better, I could maneuver more easily. I hate this feeling of being stuck in an office from nine until five. My friend Bob has the right idea. He arranged for retirement and now he's free to come and go as he pleases. He travels; no officers, no board of directors to answer to. I love my work, but I can't stand the restrictions it imposes on me. But I am ambitious, so what can you do?

At this point, the therapist called attention to the recurrence in the material of the theme of being trapped and confined. The patient continued:

I do get symptoms of claustrophobia from time to time. They are mild, just a slight anxiety. I begin to feel that perspiring feeling at the back of my neck, and begin to have a sense of restlessness. It happens when the elevator stops between floors or when a train gets stuck between stations. I begin to worry how I'll get out. You know, I have the same feeling about starting an affair with Mrs. X. She wants the affair, and I guess I want it too. Getting involved is easy. It's getting uninvolved that concerns me. How do you get out of an affair once you are in it?

I am really chicken. It's a wonder I ever was able to have relations at all and to get married. No wonder I didn't have any intercourse until I was in my twenties. My mother was always after me. 'Be careful about getting involved with girls—they will get you into trouble. They will be after you for your money. If you have sexual relations you can pick up a disease. Be careful when you go into public toilets. You can get an infection, etc., etc.' She made it all sound dangerous. You could get hurt from this, you could get hurt from that. It reminds me of the time I saw two dogs having intercourse. They were stuck together and couldn't separate. The male dog was yelping and screaming in pain. I don't know how old I was then, maybe five or six, perhaps seven, but I was definitely a child, and I was frightened.

By the time the therapist communicated to the patient the simple observation that he seemed to be concerned about being hemmed in or confined, he had already concluded that the patient was suffering to some degree from claustrophobia. At this point, the existence of claustrophobia could be deduced in a rational way from clues presented in the material of the session. Although the idea of being confined had appeared in a few similar or parallel expressions and the theme repeated several times, claustrophobia was a new element in the treatment. The experience of anxiety was a factor common in all the elements mentioned.

While the data in this case corresponded to a pattern recognizable from clinical experience and reported in the literature, it is hard to say to what extent the therapist was aware of the configurations and interrelationships of the data at the times he was perceiving them. More often than not, in such instances, most therapists appreciate only in retrospect the rich and subtle interconnection of the inner logic of the material. For the most part, but by no means exclusively, the data is conceptualized outside of awareness. First, it is intuited, and then, it is rationalized. (The term 'rationalized' is used here in its strict sense, not as a form of defense.)

But there was another idea that presented itself to the therapist's inner perception. This was the idea that the patient was under the influence of an unconscious fantasy in which his penis would be trapped or injured if it entered a vagina, originally his mother's. A corollary of this notion was that the patient fantasied his whole body as his penis, and it, too, would be subject to the same danger that threatened his penis in the preceding fantasy. Concerning this insight, there was much less evidence than for the conclusion regarding claustrophobia. Yet certain clues, more subtle ones it is true, could be identified. The factor of contiguity was important. The material conveying the sense of anxiety about being confined followed immediately upon a train of thoughts dealing with his fearsome mother and her destructive, hawklike beak.

While the factor of contiguity is suggestive, it is not definitive. It is true, however, that in claustrophobia fantasies which unconsciously equate the fear of enclosure with the vagina are common. In addition, there was the earlier knowledge of this patient's sexual inhibitions which accurately fit into the configuration of the data suggested by the second fantasy.

In this clinical vignette, it should be noted that beyond the cognitive organization of the data there was an immediate, noncognitive sharing with the patient of a fantasy of which he was still unaware—namely, the fantasy of a *vagina dentata*. There can be no doubt that at this point technical knowledge and training were very important in organizing the data in the analyst's mind and helped to facilitate in concrete terms the formulation of the underlying unconscious fantasy.

How is it possible for the therapist to select and collate out of the myriad of observations available to him those necessary elements that he organizes as his insight into the patient's unconscious mental processes? Beyond the rational activities that may operate either within or outside of the scope of consciousness, a further element must enter. This element we call empathy.

IDENTIFICATION AND EMPATHY

The dictionary defines empathy as the projection of one's own personality into the personality of another in order to understand him better. This is essentially the usage of the term to which Kohut (1959) subscribes when he considers empathy 'vicarious introspection'. Greenson (1960) speaks of empathy as a form of 'emotional knowing', the experiencing of another's feelings, a special mode of perceiving. He considers empathy primarily a preconscious phenomenon to be distinguished from sympathy because it does not contain the elements of condolence, agreement, or pity. Definitions of empathy often include concepts concerning the genetic origin of the phenomenon. Loewald (1970) assumes that emphatic communication tends to approximate the kind of deep, mutual empathy

which we see in the mother-child relationship. Similarly, Burlingham (1967), H. Deutsch (1926) and others consider the infant's sensitive response to the mother's affective state as a manifestation of empathy. Perhaps the most extreme statement of this position is by Ferreira (1961) who sees empathy as rooted in the primary umbilical unity of the infant and the mother. A corollary of his view is the idea that empathy is primitive and archaic and gradually tapers off and decreases through the years. Such concepts which view empathy as recapitulating the early mother-child unity emphasize a merging of analyst and patient, of subject and object in the therapeutic interaction. Schafer (1968, p. 153) also speaks of infantile forms of empathy as being based on merging.

The literature contains many references to the importance of 'being with the patient' as a desirable technical approach. The fact is, for all its implication of human warmth, this may be detrimental to the therapeutic process. Brierley (1943) has made a useful distinction between thinking *with* the patient and thinking *about* the patient. Thinking with the patient is not necessarily empathy. Sometimes it may indicate counter-transference, projection, or a degree of identification with the patient that implies merging and can be detrimental to therapeutic work. This point has been emphasized particularly by A. Reich (1960).

There is general agreement that identification is indeed involved in empathy, but this form of identification must be separated from other forms. Empathy may play a role in feelings of sympathy or pity, but it is not identical to these feelings. There are two distinguishing features to empathy: one, it is a transient identification; second, the empathizer preserves his separateness from the object. It is hard to say just when the individual develops the capacity for empathy, but evidence indicates that it is not present in infancy: the essential component of empathy, which is lacking in the infant, is the capacity to separate self from nonself. Stable self- and object representations or the state of object constancy are not estab-

lished until later. In Mahler's (1968) terms, the infant has not completed the necessary process of separation-individuation. In addition, the capacity for empathy requires such functions as memory, thought, comprehension, and conceptualization. Only then can the cues that perception affords lead to empathy. Empathy consists of more than an immediate affective response; it requires considerable ego development. Accordingly, the capacity for empathy increases with age and experience, especially experiences of suffering.

While there is no question that the good mother empathizes with her infant, there is also a potential danger. Olden (1953) has described a pathological mother-child relationship which is essentially symbiotic and merging in nature and not empathic. When a child is hurt, for example, the empathic mother will react to his pain and anxiety but will maintain her separate existence as a mother; her identification with the child's pain and anxiety is evoked, but it is transient and serves to mobilize behavior appropriate to the emergency. The nonempathic mother, on the other hand, may narcissistically withdraw from the situation or so completely identify with the child that she suffers along with him to the point where she shares the child's helplessness. She merges with her child in identification; she suffers with the child and not about the child.

This is what Beres (1968a) emphasizes concerning the transient identification in empathy. Such identification implies only a temporary sense of oneness with the object, followed by a sense of separateness in order to appreciate that one has felt not only *with* the patient but *about* him. This point is important in evaluating the genetic precursors of the process of empathy mentioned above.

In general, narcissistic individuals have difficulty in empathizing because of their tendency to merge with the object for the purpose of narcissistic gratification and because of their inability to maintain a sense of separateness from the object. This is most apparent in the repetitive love relationships of certain narcissistic patients. They plunge into every

relationship with great emotional intensity. To be separated from the lover gives rise to intense anxiety. They are totally submissive and will accept humiliation and even physical abuse. At the same time, they make demands on the lover for attention and are intolerably possessive. As self and object are one in their fantasy, the love object has no real existence and serves only as a prop. Such individuals merge with a lover in identification; there is no separateness of self from the other.

SIGNAL AFFECT AND EMPATHY

So far we have emphasized two ideas concerning empathy: first, the sense of transient identification and second, the complementary sense of separateness. Several authors (e.g., Greenson, 1960; Racker, 1958; Little, 1951) have emphasized the sharing of the patient's affect in the process of empathy. The reaction of the empathizing therapist is a complex one, a mixture of affect and cognition. The affect experienced by the therapist we suggest is in the nature of a signal affect, a momentary identification with the patient which leads to the awareness, 'This is what my patient may be feeling'. It does not necessarily follow that the mood of the therapist duplicates what the patient is experiencing (*cf.*, A. Reich, 1960). The therapist need not be depressed when his patient is depressed, nor anxious when his patient is anxious. He knows what it feels like to be depressed or anxious, but after his momentary identification with the patient he avoids further participation in his affective state.

The affect which the therapist experiences may correspond precisely to the mood which the patient has sought to stimulate in him as, for example, the masochist who tries to evoke criticism and attack. Empathy in such instances consists of recognizing that this is precisely what the patient wishes to provoke in the analyst. The affect experienced is a signal affect alerting the therapist to the patient's motivation and fantasy. If the therapist does not recognize this, then empathy has failed and countertransference takes over.

The technical implications of these observations were succinctly stated by Little (1951) when she said: 'The analyst necessarily identifies with the patient, but there is for him an interval of time between himself and the experience which for the patient has the quality of immediacy—he knows it for past experience, while to the patient it is a present one. That makes it at that moment the patient's experience, not his, and if the analyst is experiencing it as a present thing he is interfering with the patient's growth and development' (p. 35).

FANTASY AND EMPATHY

The therapist's empathically sharing the patient's affective state, an affect which we regard as a signal affect, leads to the question of the significance of the signal. Clinical observations suggest that the signal portends the emergence of an unconscious fantasy, and that the quality of the affect is appropriate to the nature of that fantasy. This was suggested in the preceding clinical vignette and the material which follows makes the same point. In addition, however, it demonstrates the instant communication of an unconscious fantasy shared in common between therapist and patient.

A middle-aged professional man tormented by feelings of guilt and depression, demonstrated a rather typical masochistic character formation. Much of his problem centered around an unresolved feminine attitude and erotic longing for an uncle who had served as a father surrogate during his early years.

The patient was the youngest of three children and the only boy. When he was two years old his father left the family in Europe and came to the United States. The family was not reunited until the patient was ten years old. During the absence of his father the patient's uncle, his mother's younger brother, played the role of father surrogate. Illusions of grandeur concerning the missing father were soon displaced onto the young uncle: to the little boy, he became an idol—he was strong, self-reliant, gay, and always helpful. When the time

came for the family to join the father in the United States, the patient became depressed; he did not want to leave his uncle, with whom he had played and whose bed he had shared.

The patient found it difficult to reconcile himself to his father in the new country. He yearned for the uncle and tried to get his sisters to join him in saving money to bring the uncle to the United States, but the uncle had no intention of leaving Europe. The aggrandized image of his uncle from his childhood fell far short of reality. The uncle was a ne'er-do-well and lived primarily by his wits. However, this information, to which the patient was privy in his later years, had no effect upon the image of the uncle he retained. For example, when war broke out and the Nazis seized his home town, the patient was certain that his uncle would survive; his bravery and resourcefulness would see him through. In spite of the fact that no word had been heard from him for years, the patient was certain that his uncle must have outwitted the Nazis and found his way to Israel. Later, during his analysis, the patient went to Israel and learned his uncle's fate: he had been shot the first day the Germans occupied the village because of some foolhardy and defiant gesture.

One day, the patient began the analytic session by saying:

> Last night I had the following dream. I saw myself in a house with some cousin of mine in the country. It was not yet dark, but it was no longer light, and I seemed to be all alone in the house. My cousin was elsewhere; I could not see him. I called out 'Peter' and somebody, in a joking way, called back 'Joey'.

The therapist heard no more than this of the patient's material when suddenly he found himself having a vivid visual fantasy. He saw himself at a European airport, standing in the terminal. It was the kind of airport typical of many European cities: the passengers debark from the plane at some distance from the terminal and are brought in by bus. As the therapist was standing and waiting a bus approached the terminal.

Among the passengers, he recognized his father who had been dead for a number of years. Many thoughts came into his mind about this fantasy. As a matter of fact, the last time he had seen his father alive had indeed been at an airport except that the circumstances had been reversed; his father was waiting for him at the airport in New York upon his return from a visit to Europe. The visit had included a sentimental journey. The therapist had made a trip to his father's native land, and had, in fact, gone out of his way to visit the city where his father had spent his youth. It suddenly came to him that he was in a twilight zone between life and death, in that in-between land where it is possible for the living and the dead to be reunited.

The therapist's next thought was the patient's dream. The patient had been in a house in the country; it was not yet dark, but it was no longer light. The patient, too, was in the twilight zone, and the therapist realized immediately that the names Peter and Joey, which occurred in the dream, were actually anglicized forms of the names the patient and his uncle used to call each other. At this point, the therapist began to emerge from his intrusive visual fantasy and heard his patient speaking: 'Last night I was watching television. The show was "Twilight Zone" . . . '.

It was not hard to interpret the patient's dream. It expressed the wish to be reunited with his uncle. The dream was based upon the unconscious fantasy of reunion in a twilight area where the living and dead find each other once again. The patient and the therapist both had the same 'dream' and, with no immediate associations to the manifest content, an unconscious fantasy of the therapist's congruent with that of the patient's appeared in his mind. Without the benefit of associations to the dream, and before the process of intuition could become operative, the therapist had grasped the meaning of the patient's dream and responded with his own version of the identical unconscious fantasy. In truth, the therapist had created his own unconscious fantasy before he had any

conscious awareness of the meaning of the patient's dream.

Clearly, this empathic process by which the patient's fantasy stimulated the therapist's own had taken place entirely at an unconscious level. An identification between the two of them had been effected through this shared unconscious wish that led in turn to an almost identical fantasy in both their minds. What happened next, however, was a rupture of the sense of the momentary identification and the sudden awareness on the therapist's part that his inner experience, which seemed so personal and idiosyncratic, was in effect a commentary on the patient's material. The correct interpretation had come into the therapist's mind in the form of a fantasy. It then required a set of cognitive operations for him to be able to translate this fantasy into an interpretation. At this point, the identification was broken off and was replaced by an object relationship. Thinking and feeling *with* the patient was replaced, as Brierley (1943) and Beres (1968a) put it, by thinking *about* the patient.

SHIFTING IDENTIFICATION IN EMPATHY

Empathic understanding of the patient is much more complicated than simply the sharing of affects, presumably experienced by the patient at the time. Sometimes the process of identification in empathy goes through several phases and undergoes vicissitudes and transformations. This is illustrated in the following excerpt.

The main complaint of a patient in his middle thirties was pathological jealousy of one of his girlfriends. Although he had many transient love affairs, they did not seem to bother him. As the analysis proceeded, a pattern of hostile aggressiveness against women, expressed in these multiple affairs, became clear but the motive for this aggression was not clear. At least two possibilities had been suggested by the material but up until this time neither had seemed predominant. The first possibility was that the pattern of hostility toward women represented a displacement of his anger against his adulterous

mother; the second was that this sadism was used as a defense against his masochistic, passive, feminine identification.

During one session the patient described a date with one of his girlfriends. It was a long and somewhat startling record of one provocative statement after another. He took advantage of every feeling of inferiority or sense of insecurity that the girl exhibited in order to put her on the defensive. As this was only their second date, the girl tried her best to make a favorable impression; with each fresh assault by the patient, she tried a new tack which she hoped would make her seem agreeable and friendly, all to no avail. At one point in the conversation the young lady mentioned the fact that as a result of strenuous efforts she had recently lost quite a bit of weight. 'You're still too plump', the patient said. The woman responded, 'Oh I have pictures of myself some months ago. I was much plumper then.' 'I don't believe it', the patient said, to which the woman responded, 'Would you like me to show you the pictures?', and she rose to fetch them.

At this point in the session, the therapist had a quasi-visual image of this hapless young woman. He felt terribly sorry for her, and could practically see her with a small, wistful, desperate smile on her lips, trying to do everything to please this man and yet feeling that nothing would be of any help. He indeed felt very sorry for her. If empathic feelings had been aroused, the therapist's identification was completely with her and not with his patient.

The patient continued. He said, 'I was amazed to think that she would really get up and fetch those pictures for me. How foolish can anyone get? Why would she take my cruelty the way she did?' Beyond the triumph in the patient's voice, the therapist detected a note of remorse, a feeling of how terrible it must be to be in this young woman's position. At this point, the therapist had another empathic reaction, but with his patient. He recalled how, during his adolescence and on a few other occasions later in life, he had himself behaved in a similar way.

The therapist was struck by this two-phase experience of empathy; first, with the patient's feminine victim, and then, with the patient himself, especially with that aspect of the patient's productions which suggested an identification with his own victim. It made the therapist think immediately that the second possibility mentioned above—namely, that the patient's behavior constituted an aggressive defense against his own feminine masochistic wishes—was probably the more important element in his unconscious fantasy life at this time. But this was as far as he could go in trying to reconstruct the unconscious wish at that time.

Material elucidating the nature of the unconscious wish was not long in coming. In the next session, the patient recollected some feelings of sensitivity about having called the therapist's attention to the patient's dress. He then reported that he had had a restless night. Before falling asleep he had a fantasy of being on the couch in the office, getting very angry and feeling that he did not want to listen to the therapist any more. In his fantasy he got up, pointed a finger at the therapist, and began to shout: 'Now you listen here. There are some things that I want to tell you.' After reporting this fantasy, the patient laughed and said, 'I realize I had nothing to say. I don't understand what I was so angry about.'

He then reported a dream of being both a pursuing and a pursued person. The dream culminated in a struggle with a man at the edge of a brown, muddy pit. He was being very aggressive toward his adversary and tried to hit him, but could not quite do it. He woke from the dream in great fright, so much so that in regressive fashion he had to turn on the lights and go to the front door to make sure that it had been properly bolted to protect him against the possibility of intruders. His associations had to do with his fear that he might discover that he had homosexual trends, and with a number of recollections from his boyhood when he had placed himself in a sexually awkward and dangerous position with men; one of the men had fondled his buttocks.

This material confirmed the interpretation suggested by the therapist's double empathic response to the woman victim and to the patient, and, in effect, this double identification repeated the elaboration of the patient's conflict—first, the awareness of his defensive need to assault the woman, and second, the emergence of his own masochistic feminine wish. This would seem to be a clinical validation of the point made by H. Deutsch (1926) that in empathy the analyst may identify not only with the patient but with his objects as well.

NONVERBAL COMMUNICATION AND EMPATHY

There are other derivatives of unconscious fantasy activity, some of which find expression in the form of nonverbal communication, especially motor activity. From our knowledge of gesticulation, mimicry, and the dance, we know how emotion can be transmitted through an identification by way of the emotion we see in action (*cf.*, Fenichel, 1926). Jacobs (1973) has recently called attention to motor activity which analysts often engage in unconsciously during sessions. On investigation, he was able to determine that these constituted empathic responses to the patient's unconscious mental activity. There are colleagues who seek to penetrate the meaning of the patient's associations by repeating certain gestures or hand movements which they have observed in the patient. In this way, they feel that they can enter into his mood more easily and better understand the nature of his conflicts.

In a paper on noverbal communication in psychoanalysis, Arlow (1969c) observed that certain specific configurations of the fingers as they appear in photographs or in works of art are, in effect, motor metaphors through which the musculature in action captures and conveys important affective states. Gombrich (1972) discussed this point in connection with artistic representation of symbolic images. F. Deutsch (1947, 1952) reported similar observations in his studies of the posture patients assume on the analytic couch.

An example of empathy in nonverbal communication was reported by a patient. While in the kitchen his wife asked him to prepare the tuna fish for their son's sandwich, pointing out that the boy whom they both dearly loved liked to have the tuna fish chopped in a certain way. As he was preparing the food according to his wife's instructions, the patient was suddenly overwhelmed by a powerful feeling of the kind of affection that he felt his wife must have for their son. This emerged by way of his identification with her in the act of preparing the food. Through this identification he could understand not only her feelings but could be brought into closer awareness with his own very intense affectionate feelings of a maternal nature which he ordinarily warded off.

Also pertinent to this discussion is the analyst's empathic responses to the patient's silence, which may be an important clue to the mental content being suppressed or repressed during the periods of silence (Arlow, 1961). Blos, Jr. (1972) has also emphasized the communicative significance of the patient's silence and the importance of the analyst's feelings and reactions to the silent patient.

RESISTANCE AND EMPATHY

In addition to empathizing with the affective ideational and motor components of the patient's fantasies and conflicts, the therapist must be able to empathize with the patient's state of resistance. This has an important bearing on the timing and the wording of interpretation. Ferenczi (1928) emphasized this point when he stated that empathy is the precondition for tact. Ferenczi makes the further point that a proper empathic understanding and tact would dictate 'when one should keep silent and await further associations and at what point the further maintenance of silence would result only in causing the patient useless suffering'.

Shapiro (1974) draws attention to variations in the capacity of a patient to empathize with others in his environment. There is, further, one aspect of empathy that is frequently overlooked

in the therapeutic setting: the lack of empathy of the patient as his present self with his past self—a kind of discontinuity of identity which is occasioned by conflict and narcissistic influences. By resolving unconscious conflicts, psychoanalysis enables a patient to see himself in a continuum from his early life and to accept and tolerate hitherto repudiated aspects of himself. One result of treatment is the enriched capacity of the patient to empathize with himself.

Another aspect of the problem of empathy is the capacity of the individual to empathize with others whose experiences and background differ markedly from his own. This point has been raised in connection with the analyst's treatment of patients with different sex, race, social, and economic background. Except for the most extreme circumstances, the therapist, even as the artist, must have the capacity to empathize with the feelings and thoughts of others different from himself.

PERCEPTION AND FANTASY IN EMPATHY

In the clinical material cited above, we emphasized how the process of empathy reflects the awareness of the affective tone enveloping an emerging unconscious wish or fantasy. In previous communications Arlow (1969a, 1969b) attempted to define the relationships between persistent unconscious fantasy and perception and reality testing. He emphasized the reciprocal effects that unconscious fantasy and the data of sensory registration have upon each other. Unconscious fantasy activity establishes the mental set against which the data of sensory registration are selectively perceived, inhibited, disregarded, or transformed. Conversely, the data of perception have the power to reactivate or facilitate the emergence of unconscious fantasy activity. Sensory registrations outside the realm of consciousness can also affect the emergence of unconscious fantasy, and conscious fantasy activity may facilitate, alter, transform, or repress the registered sensory impressions even before they achieve mental representation in consciousness.

Clinical material obtained in the treatment situation may be examined from the vantage point of these principles. The sensory input, the analyst's perceptions, consists of the patient's productions. A measure of the analyst's empathic capacity lies in his ability to be stimulated by the patient's unconscious fantasy when the analyst himself is not yet aware of the existence or the nature of the patient's unconscious fantasy.

The process described above is basic in psychoanalytic experience. It furnishes, as we know from Freud (1908[1907]), Sachs (1942), Abraham (1935), Rank (1932), Kris (1952), Beres (1962), Arlow (1961b), and others, the fundamentals for the understanding of mythology, religion, group formation, and artistic experience from a psychoanalytic point of view. All of these shared experiences which hinge on the transmission of emotion have as one of their essential components the emergence of an unconscious fantasy that is shared in common (Sachs, 1942). In religious groups and in æsthetic experience, it is the leader or the poet who creates the frame of reference that evokes in his listeners, readers, or members of his audience unconscious fantasies which correspond to his own.

In previous studies on the analogy between æsthetic experience and the psychoanalytic experience, Beres (1957, 1968b) has demonstrated the parallel between the therapist and the patient on the one hand and the poet and the audience on the other. The devices which make poetry and enable the poet to transmit to others the emotion he experiences are the same ones which make the patient's material assume configurations that transmit meaning and emotion to the therapist, making empathy possible. Contiguity, repetition, symbolism, allusion, contrast, and, above all, metaphor (*cf.*, Sharpe, 1935, 1940; Arlow, 1969b) are the most important of these devices. In addition to the consciously experienced fantasies, what the poet presents to the audience are derivative expressions of fantasies of which he is completely unaware. These derivative expressions are congruent with the unconscious fantasies that

members of the audience share in common with him. The universally shared early biological experiences of mankind form the basis of universal fantasies, facilitating empathic communication between person and person, and person and groups. Thus poet and audience respond to similar but not necessarily identical unconscious fantasies, though neither of them is aware of the infantile, instinctual fantasy roots of his emotions. Only the process of analysis can bring these fantasies into consciousness. The interaction between audience and poet, like the interaction between patient and therapist, is an empathic one based upon the communicability of unconscious fantasy. Psychotherapy and art both serve to place a distance between the individual and his unconscious conflicts, a distance from which he can contemplate with comfort derivatives of his unconscious fantasies. In art, for reasons of defense, the experience remains at the level of derivative expressions of unconscious fantasy. In analysis, on the other hand, one seeks to overcome the defenses and reconstruct the unconscious fantasies in order to alter their persistent intrusiveness and destructive effect on the individual's functioning.

INTUITION AND EMPATHY

There is an important relationship between intuition and empathy. Neither intuition nor empathy are mystical phenomena based on some kind of innate capacity to comprehend or experience. When the therapist appears to arrive intuitively at an understanding of his patient he is actually becoming aware of the end product of a series of mental operations carried on outside the scope of consciousness. Intuition, however, differs from empathy. Empathy involves identification, although transient, with a mental activity of another person. Intuition does not involve identification; it is an immediate apprehension of an idea, a thought, or a fantasy. Empathy furnishes the clue which alerts the therapist to the emergence of the correct interpretation. The intuitive understanding of the therapist follows his empathic response.

The therapeutic situation requires that empathy and intuition go on to interpretation and insight; otherwise, we would have no more than a mutuality of experience—for the patient a transference experience and for the therapist a countertransference experience.

The final step in our discussion of empathy is the issue of validation. Greenson (1960) says that when the therapist's associations precede or coincide with a patient's, this confirms that the therapist is on the right track. While we agree with the statement, we would add that this phenomenon is suggestive but not necessarily confirmatory. Both the empathic and the intuitive responses which arise in the mind of the therapist have to be subjected to disciplined validation. The technical implications of these observations have been considered in detail by A. Reich (1960). Empathy is an essential tool in psychoanalytic work. It facilitates the emergence of intuition and leads by way of interpretation to insight.

SUMMARY

This communication considers the clinical and theoretical aspects of empathy, emphasizing the role of identification and the distinction between the self and the nonself. We have stressed how empathy is mediated by the communication of unconscious fantasy shared by the patient and the analyst. The cues for this communication are both verbal and nonverbal: they emanate from words, gestures, and behavior.

The empathic process which is central to the psychotherapeutic relationship between patient and therapist is also a basic element in all human interaction and finds its highest social expression in the shared æsthetic experience of the artist and his audience, as well as in religion and other group phenomena.

From the theoretical point of view it is necessary to consider the relation of empathy to identification, projection, and

countertransference, as well as the distinction between self and objects.

Empathy serves as a signal affect and leads to intuition. These are not mystical, innate phenomena and demand disciplined clinical validation.

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COMMENTS ON TEACHING PSYCHOANALYTIC PSYCHOTHERAPY IN A RESIDENCY TRAINING PROGRAM

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INTRODUCTION

In a previous communication, the authors (1972) described their experience in a pilot project on teaching psychoanalytic psychology of adolescence to residents. The project consisted of a continuous case conference, jointly chaired by the authors, for a mixed group of third-year residents in adult psychiatry and second-year residents in child psychiatry. It was found that there was a 'definite need for clarification of the methodology of individual psychotherapy and the principles of analytic psychology, both to differentiate this approach to treatment from others in the training program, and to clarify conceptual levels within an analytic frame of reference'. It was further noted that as an interphase between childhood and adulthood, adolescence is 'an excellent meeting ground where the principles and assumptions of child and adult dynamic psychiatry can be critically examined and tested' (p. 205).

One of the most interesting findings of the previous investigation was the observation that certain aspects of the deliberations in the conference paralleled some of the characteristics of adolescence itself. 'There was a great temptation [by the residents] to view the adolescent in a psychosocial or interpersonal frame of reference, thus bypassing intrapsychic factors. It was fascinating to realize how this attitude mirrored the adolescent's own view of his life' (p. 206). This parallelism between the therapeutic process and the educational process will be explored further in this communication since it has an important bearing on the means by which a psychoanalytic

viewpoint can be meaningfully conveyed to residents in the training program.

The format chosen was that of a continuous case conference. This provided greater assurance that any discussion of methodology would be closely tied to an actual clinical problem. This approach also capitalized on the residents' high interest in clinical data. The method employed was to stimulate the residents to respond to the accounts of the treatment sessions as they attempted to understand the patient from a dynamic point of view. These responses were then used as 'clinical data' to explore and delineate the underlying assumptions of a psychoanalytic approach to the patient. Rather than working from a preconceived agenda or lecture approach, the authors found it preferable to stay within the framework of the problems as conceptualized by the residents. When an issue relating to underlying methodologic principles emerged, no attempt was made to be didactically exhaustive. Instead the emphasis was placed on stimulating the group to become more aware of their own often implicit assumptions regarding treatment and to have a better appreciation of the rationale of an analytic approach to clinical data.

This method of teaching, therefore, has much in common with the therapeutic process. Both are open-ended and both avoid undue influence on the direction to be taken. Just as a therapist resists the temptation to deflect the patient's thoughts onto lines which are of interest to him alone, the authors tried to operate within the area of interest indicated by the residents' responses. The continuous case conference has built into it, therefore, the same openness that obtains in analytic therapy. This similarity may have facilitated the emergence of the parallelisms which became apparent and would appear advantageous in any attempt to convey the psychoanalytic point of view in a residency training program.

This communication will report on further experience with the pilot program. First, some of the conference proceedings will be used as 'clinical data' to illustrate the teaching method

being employed. Second, particular events in the conference that occurred toward the end of the academic year will be examined in some detail for the light they shed on the extent to which the educational process can be considered as parallel to the therapeutic process and how this might be employed to mutual advantage in both teaching and therapy.

A 'CLINICAL' EXAMPLE

The patient whose treatment was being followed was a sixteen-year-old girl. She reported to her therapist that she had asked her boyfriend if it was all right if she went out with someone else. She was not anxious to accept the date but felt that she could not turn the young man down lest she hurt his feelings. Her boyfriend was vague in his response but became upset and sulky for several days after the date. She was both upset and puzzled by his reaction, feeling that she had done the right thing by asking beforehand.

The residents were asked their opinions and understanding of the situation with particular reference to making a response to the patient's rather direct plea for help with her dilemma of how to 'square things' with her boyfriend. The responses were varied with several concurring that the patient's behavior was quite 'bitchy' and that the proper intervention would be to inform her of this fact. In keeping with the idea of exploring assumptions which underlie the approach to the therapeutic process, the authors directed the group's attention to this intervention to examine the implications. The avowed aim of the intervention was claimed to be that of helping the patient focus her attention on her behavior so that she could better understand herself. The implication was that if she could see that she had in fact upset her boyfriend, she would be better able to prevent herself from doing the same the next time. This approach was felt to be in keeping with an insight-oriented therapy.

Some of the residents offered quite a different opinion: the patient was to be taken at her word that she was trying to be

'nice' and that she therefore should be supported in her struggle to stand up to her unreasonable boyfriend. This raised the interesting question as to which of these quite opposite views of the situation might be correct. How could that be decided?

Those who felt she was being 'bitchy' inferred this wish from the result of her behavior. Those who considered her 'nice' accepted her intentions and felt the boyfriend was the unreasonable one. It was pointed out that both groups had evolved an intervention after first arriving at a value judgment about the patient's behavior. Evidently, in becoming an arbiter of the patient's actions, the therapist assumes an additional burden, for the efficacy of his treatment will depend on his ability to evaluate whether the patient behaved appropriately or not. Also, why should the patient accept the therapist's opinion, especially if it were at variance with her own view? In such a case what would prevent the therapist from being drawn into an adversary position with the patient? Since adversary encounters with parents were this patient's usual life experience, what would therapy have to offer beyond further argumentation with another adult?

By discussing the situation in this way, the authors were able to make the residents aware of the consequences of taking sides in a current dispute in the patient's life. Actually, in confronting her with her supposed 'bitchiness' the therapist would in effect be admonishing the patient to stop what she is doing with the implied threat of his disapproval. Therefore, rather than an analytically-oriented therapy which was ostensibly being followed, this approach would really comprise a covert form of suggestion. The therapist's authority coupled with the patient's desire to please would be harnessed to induce behavioral modification. In a similar way, by agreeing with the patient, the therapist would be really re-enforcing behavior of which he is tacitly approving. Neither approach would lead to further self-understanding or insight.

By contrast, the psychoanalytic method does not require the therapist to make a prior value judgment about the pa-

tient's actions. She need be considered neither 'bitchy' nor 'nice'; rather it could be observed that her intention of not hurting anyone had not been fulfilled. There was actually something paradoxical about this situation, since as she construed it, no matter what she did she was in danger of hurting someone: either the boyfriend or the young man who asked her out. This kind of 'no win' situation is a prime indicator of a possible internal conflict where contrary wishes or motives exist and where only one side of the conflict may be conscious and accessible. This patient could therefore be described as being compelled by unconscious forces over which she has no control to behave in a certain way despite the unwished for consequences.

This search for inner contradictions in the patient's thinking and behavior is a keystone to the psychoanalytic approach. As Waelder (1960) aptly put it, the psychoanalyst 'is constantly surveying the field to discover inconsistencies in the patient's thoughts or actions. Wherever he discovers any sign of them he will examine the point more closely and present any evidence of inconsistency to the patient. He is thus trying to bring contradictions into the open in order to discover, or to see more clearly, the inner conflicts which they may indicate. In this way he is trying to open the area of conflict more widely and clearly, with a view to discovering possible unconscious elements, ultimately to help the patient "make peace with himself"' (p. 220).

NEUTRALITY AND EMPATHY

In addition to highlighting the essential concern for internal conflict and alertness to the possibility of powerful unconscious motives behind the patient's behavior, this vignette served to underscore for the residents another important facet of psychoanalytic therapy: the neutral position of the therapist. The real meaning of this often misunderstood term is that the therapist's most useful vantage point is equidistant from the various intrapsychic agencies and the external world which

are in conflict. His job is to help delineate these conflicts, to help the patient become aware of the various dynamic forces at odds within himself, so that he can better understand the purposes these various forces serve (Waelder, 1930). It would appear that this attitude of neutrality would give the therapist the best opportunity to assess the internal affairs in the mind of his patient and thereby offer a kind of help available nowhere else.

By adopting a neutral standpoint, the therapist, in concert with his patient, can examine the situation to determine what is keeping her locked into such self-defeating behavior. What needed to be pointed out to this young woman was the insolubility of her life situation as she construed it. No matter what course of action she followed, she felt she would hurt someone. This, indeed, was a repetitive problem, as her history showed. At an earlier point she had become pregnant through a similar inability to say 'no' for fear of hurting someone. The aim of this intervention would be to 'open the area of conflict more widely and clearly'. This could not be accomplished by taking sides in the problem she presented.

In this way the authors were able to depict the advantages of the psychoanalytic approach by a convincing clinical demonstration of the merits and constructive possibilities of therapeutic neutrality in its proper sense. This permitted comparison with other treatment modalities which require active involvement of the therapist with the aim of influencing the direction of the patient's life rather than helping the patient 'make peace with himself'.

An examination of the means by which such an understanding of the patient's conflicts in her life situation could be achieved led to a brief consideration of the role of empathy. It was noted how the residents determined that the patient wanted to hurt her boyfriend. This was inferred from the results—namely, the boyfriend was hurt—an inference that was achieved by an identification with the boyfriend. In his place the residents would have felt as he did. However, where

should the therapist's identification be? In terms of understanding the patient and appreciating the complexities of his feelings and motivations, the therapist must identify with his patient. This aspect of the therapeutic process has been described as making a transient empathic identification (Kohut, 1959; Reich, 1960). With this patient, the empathic function of the residents had been deflected to the boyfriend, preventing them from seeing her life situation from her point of view. More will be said later about this deflection of the therapist's function away from his patient.

What the authors tried to convey in the discussion of the treatment sessions was that the medium through which a truly dynamic therapy operates is the patient's impressions as they are filtered through his own psyche. Distortions which are revealed are seen as serving some unconscious purpose, and attention is drawn to the distortion for what clues it may have to offer about the unconscious. They are means to an end and are utilized cumulatively much as an experienced tracker can examine a trail for footprints, bent branches, scratches, etc., and build up an image of who has passed by, how many, what kind, and when. Thus, through a close examination of one piece of clinical material from the fabric of this young woman's therapy, many of the important ingredients of the psychoanalytic point of view could be highlighted and clarified. The operations of a dynamic unconscious in the patient's life revealed itself in the paradoxes and contradictions of her actions as surface manifestations of an internal struggle. Understanding the nature of these intrapsychic conflicts was furthered by the dual process of introspection on the part of the patient and of empathic identification by the therapist who remains a neutral but compassionate observer whom the patient can take as a model.

The aim of the discussions in the conference was akin to the therapeutic goal with the patient; namely, to heighten the awareness of the dynamic forces operating in the context of the therapy situation. The residents, through these dis-

cussions, were often made aware of contradictions and paradoxes in their own approach. This stimulated them to think through the assumptions by which they acted, helping them to develop a consistent and viable rationale in their therapy. This made possible the detection of the intrusion of such alien motives as the need to protect, guide, or otherwise direct the patient's life when this was not an avowed purpose of the treatment. To the extent to which the therapist was able to modify his approach and his attitude, the therapeutic course could be altered.

PARALLELS BETWEEN THE CONFERENCE AND THE THERAPY

One of the most fascinating aspects of the conference concerned interaction processes among the participants which developed *pari passu* with the case under discussion. The patient, who had once become pregnant, was intelligent, perceptive, quite verbal, and articulate. She appeared to be suffering mainly from neurotic difficulties in which she was always the victim or scapegoat; for example, when she was pregnant her boyfriend was completely shielded from any responsibility since he was not even told. Even though she was being seen once a week she managed to maintain some continuity between the interviews. For quite a while she appeared content just to have someone who would listen to her without moralizing. Gradually, some resistance began to appear in the form of pauses and searching glances at the therapist for some response. Her associations at the time were complaints about her boyfriend's taciturn behavior and her difficulty in knowing what to say; she expressed annoyance that he put the onus on her to maintain the conversation. However, the relationship was also intensifying due to his demands for sexual relations. She described spending the night with him on a vacation trip. At first she begged off sleeping with him because of a painful sunburn and went to her own room, but she could not stand this and came back some time later to spend

the night. Thus, she repeated once again the pattern of taking a masochistic path in her life, ostensibly to avoid the greater pain of having to hurt someone. In response to the patient's mounting tension in the sessions and evident inability to avoid self-defeating behavior, the therapist indicated to the conference that he felt impelled to do something for the patient to forestall a crisis. He asked for help from the group about what he should do.

Various viewpoints were expressed centering on the apparent need to do something to relieve the patient's anxiety. There seemed to be a consensus that something should and could be done; otherwise, the therapist's anxiety about what to do would remain unrelieved. The residents were diverted from empathizing with the patient because they now empathized with the therapist. Yet no one had any specific suggestions that held up under scrutiny. It became apparent that the group was then expecting the authors, as leaders of the conference, to come up with the 'right' thing to do. One of the residents jokingly commented, 'After all some of us graduate in a few weeks so there won't be much time to tell us all we need to know'.

By this time the conference had been running for nine months and a consistent feeling of congeniality and informality prevailed. The atmosphere was nonthreatening and it appeared that everyone felt free to be candid in his remarks. The authors, sensing the mounting pressure on them to come up with an answer to the therapist's dilemma, directed the situation back to the conference, commenting on the implications: 1, that as the avowed experts who were running the conference we should and presumably did know what to do; 2, that as novices struggling for a time and failing to come up with the 'right answer' themselves, the residents were justified in expecting to be told by the 'experts' what was correct.

There was an air of incredulity as the authors explained that they had not known themselves what to do, and were not withholding an answer for 'didactic purposes'. It was

explained that, contrary to the residents' belief that their own ideas were being discarded as wrong, the authors' own thoughts were influenced and stimulated by the cumulative observations; that whatever opinions were being expressed had been arrived at by a process of mutual feedback and not produced ex cathedra.

As an example, it was pointed out that one of the author's initial comments was an elaboration of a note he had made as he listened to the material. The jotting was 'the pearl in the oyster', which was a shorthand reference to the patient's apparent theory about how therapy works. She had begun the session in question by asserting, 'I think I know what's wrong with me. I lack confidence.' Then there seemed to be a feeling of disappointment on her part when this revelation did not appear to help in any way. This was as far as the initial comment was developed at the time. One of the residents then had contributed his own observation that the patient's subsequent remarks concerned her belief that there was something physically wrong with her. She had lamented that she did not feel that she could be a dancer, nor was she smart enough to be a doctor. He felt this could derive from some unconscious castration anxiety because of a feeling of physical inferiority. It was pointed out to the group how this shed light on the meaning of the patient's disappointment about her new idea that she lacked confidence. This could now also be seen as a derivative of her castration complex: it was as if she were saying, 'No matter what I find out, no matter what I do, nothing will help me since it is due to my inherent inferiority of being born a girl'. Even if the castration complex hypothesis proved to be false, it seemed likely that her insoluble problems derived from some unconscious conflict. Thus, she could not be reassured nor argued out of her pessimism. Her disappointment in therapy therefore was not to be taken at face value. It was a communication about the reasons for her feelings of worthlessness which helped explain why she

could justifiably demand that the therapist tell her what to do. As she was a female, she was incapable of figuring out anything for herself.

It is interesting to note that both the patient and the resident shared the same point of view about therapy. The patient had the idea that if she could find out some one basic thing, she might be cured. She was becoming impatient with the therapist for his failure to tell her what she needed to know; she saw him as the expert who would tell her what she could not possibly find out for herself. Most of the residents were in accord with this view in the sense that they tacitly accepted the role attributed to them by their patients—namely, that they were supposed to know what was wrong. As they saw it, their function as therapists was not to tell the patient directly, but first to ask the 'right' questions that would hopefully lead the patient to the 'answer'. The difficulty in the case of the adolescent girl was that the therapist was made to feel very uncomfortable as he really did not know what to say or do, and, in his mounting discomfort and frustration, turned to the conference for help. Essentially, then, he was repeating with the conference what the patient was doing with him. He assumed that the participants, particularly the authors as experts, would know what to do and would relieve him of his dilemma by telling him.

When all of this was brought out in the conference, it led to a very interesting discussion by the residents about their general assumptions regarding the residency training process itself. Some commented that there were teachers who taught by the 'Guess what I'm thinking' method. In this situation, the resident takes a chance by exposing his own ideas in the hope that he might be 'right' about the patient because he guessed what the instructor was thinking. Some residents were candid enough to reveal that they tailored their comments to fit the particular predilections and interests of various instructors. They were being diverted from evaluating the

patient by this kind of teaching method to an examination and evaluation of the instructor. Once again the empathic identification process had gone astray.

There were other teaching experiences in which direct questions aimed at siphoning off the expertise of the instructor were deflected by the response, 'What do you think?'. The purpose here was for the resident to try first with his own ideas and thereby ultimately earn the 'right' answer which was there all along but not so easily obtained, at least without working for it. This was exactly the same as the adolescent girl's 'theory' of how treatment worked. The group came to realize that they had felt in the conference what the patient herself was experiencing because the presenter did to them what the patient did to him. This could be understood both as an expression of the patient's masochistic way of trying to be considered 'deserving', and as a consequence of the therapist's assumptions about his role. He felt he should know the 'right' thing to do and became anxious when he found that he did not. His assumptions remained unchallenged as he displaced the problem to the conference with the belief that if he did not know, then surely the experts would know.

By bringing these latent assumptions to the surface, the authors were able to break the vicious cycle in which both the patient and the residents were caught. The parallelism between the treatment situation and the conference thus provided an experience for the residents which helped them make an empathic identification with the patient. Their own approach had led them to identify not with the patient but with those on whom she focused her demands.

The difficulty experienced by this therapist may have significance for the teaching of psychotherapy as well as for other aspects of the training program in psychiatry. The psychiatric resident, by virtue of his position as novice or student, is actually in a position of great narcissistic vulnerability, since he has to learn his skill while practicing it without the watchful eye of his instructor to keep him out of trouble. The instructor

is available only after the fact, during supervision or, in an even more trying situation, before his peers in a clinical conference. In comparison with other aspects of medical training this situation would appear to be specific to learning the technique of psychotherapy. It is the authors' belief that this pressure on the residents leads to an undue readiness on their part to believe that there is a 'right way' to do things, a 'revealed truth' to which they in time will be given access. The belief that their mentors have this knowledge is re-enforced since it holds out the hope of a solution—that through the training program their ignorance can be transformed into expertise provided they are diligent and hard working.

In turn, teachers and supervisors can become seduced, unwittingly or otherwise, into accepting the mantle of expertise which is so readily being conferred. Being looked up to in this fashion, as the one who always 'knows what is going on in the patient', becomes one of the gratifications of teaching which is not so easily acknowledged. The psychoanalyst as a teacher is particularly vulnerable in this regard. In his clinical work, he must systematically abstain from exercising his own authority. Instead of telling his patient what to do, he must help him to understand himself and then let the patient make his own decisions, for better or for worse. If teaching has to provide him with an outlet for any frustrated need to assert his authority, then the analyst will be more easily seduced into acting as the omniscient teacher.

In this manner the training process can be subverted into a mechanism by which the resident's narcissistic vulnerability is assuaged in an illusory way. The wish for omniscience is first projected onto the teacher with whom the residents become identified. As students they see themselves as sharing and partaking of his knowledge. Then, by fulfilling the requirements of the training program, the resident expects that he will have earned the right to the 'truth'. So long as this perversion of training continues to operate silently, a sequence of events is set into motion with results as inevitable as they

are unfortunate. First, disappointment in the training appears, followed by a disillusionment with the process of therapy itself. This disillusionment is rationalized by espousal of an eclecticism about theories and methods of treatment which renders unimportant the need for a precise methodology in setting up and maintaining a psychodynamic treatment situation in which conflict can be exposed and interpreted.

It was quite a surprise to learn that the residents were of the opinion that the authors appeared never to disagree. They had evidently drawn this conclusion, despite contrary evidence, in order to re-enforce their need to believe that there was some special expertise which in due time could be transmitted to them. When this was interpreted they could then recall that there were many initial disagreements about the clinical material that were resolved by the mutual feedback of the seminar discussion process. Certainly the greater experience on the part of the authors might have contributed to their formulations having more appeal, but the residents failed to appreciate that the authors relied on their agreement about methodology to enable them to resolve differences of opinion about the meaning of the patient's material. By examining the flow of associations the more accurate explanation could be found.

It was extremely helpful, therefore, to examine the implications of the parallels between the therapy situation and the conferences. Both the patient and the therapist were each in the position of saying to an imagined authority, 'Tell me what to do'. However, the real task for both the therapist and the patient is to examine the assumptions by which they find themselves in that position; namely, subordinated to a supposed expert to whom they have attributed such omniscience. This would appear to be a valuable way for the patient to examine and learn more about the way in which she functions to her disadvantage; similarly, the therapist's being more clearly aware of the assumptions by which he

functions would enable him to set more realistic limits as to what he expects of himself. Taken a step further, this would also hold for the conference leader or teacher who espouses a psychoanalytic point of view about the therapeutic process. Like the therapist, he too must guard against the temptation to be seduced and have his own vanity gratified by the willingness of others to look up to him.

At the last session one of the residents, in describing his reaction to what had been going on, told an old joke which had great impact on the group. It seems a very rich man, having both fame and fortune, felt unfulfilled because he did not know the meaning of life. He travelled the world seeking out wise men, statesmen, philosophers, trying to get an answer to this question. His travels finally brought him to a Tibetan plateau where lived an old guru, reputedly the wisest man in the world. With great difficulty, he gained access to this guru and posed his question: 'What is the meaning of life?' The old man replied, 'Life is a fountain'. The rich man became annoyed. 'Do you mean to say I've come thousands of miles across the face of the earth to have you tell me that life is a fountain?' At which the guru looked up and said, 'Do you mean it isn't?'

THE PSYCHOTHERAPIST AND THE MEDICAL MODEL

One of the other assumptions which surfaced as a result of this discussion with the residents concerned their belief in the continuity of their role as physicians and as psychotherapists. In their previous medical training they had assimilated the role-model of 'healer', the expert who is equipped to diagnose the patient by applying skills in detecting what is wrong and drawing on special knowledge to formulate and carry out the appropriate treatment. Closer examination revealed that this model was not applicable to the context of a psychotherapy which aims at dealing with the influence

of unconscious factors in mental life. The meaning of having a problem and needing treatment is significantly different in a purely medical and in a psychotherapy situation.

With regard to physical illness, the physician can utilize the Socratic method and arrive at a diagnosis by asking questions and by physically examining the patient. Likewise he can apply treatment in the form of surgery, medication, or change in the patient's activity or diet. The role of the patient is essentially one of passive compliance and submission to the authority of the doctor. In return the patient expects to be healed as the doctor performs his expert service. This doctor-patient configuration evolves from and draws its emotional strength from the parent-child relationship. The parents are viewed necessarily as omnipotent and omniscient figures to offset the child's realistic helplessness. With illness, the adult's real helplessness is superimposed on and re-enforced by this infantile prototype. The transference to the doctor is to the benign powerful parent who will 'make it all better'. In the medical model the physician utilizes the patient's transference to enhance his authority and to induce compliance to what he thinks is best.

In analytic psychotherapy a critical examination of these ideas and feelings to separate the anachronistic infantile components becomes an integral part of the treatment process. Both the medical patient and the psychiatric patient are prone to the same regressive magical expectations to be listened to, cared for, and cured. In psychotherapy these transference expectations and attitudes must become grist for the mill, since the aim of this form of treatment is ultimately to enhance the patient's autonomy, his capacity for mature decision making, and his willingness to take responsibility for his own life. To accomplish this, he must be able to free himself from modes of thought and action which are only appropriate to childhood. For example, a competent physician was treating a woman with episodic anorexia among other difficulties. He rightfully helped her to assert herself with her husband whose

approach consisted of nagging his wife about her poor food intake. At the same time, the physician would question her himself at the end of each session about what she had been eating. Left at this point, her therapy would be interminable. Dependence on the therapist, even if fostered unwittingly as in the above example, must itself come under scrutiny.

THE THERAPEUTIC CONTRACT

These critical differences in the doctor-patient relationship in medicine and psychotherapy lead to significant variation in the therapeutic contract.

In the psychotherapy model, the patient is not looked upon as merely a passive producer of raw data under the direction of the physician's expert questions. The patient must understand that he has two functions to perform: to be an active participant and to be an observer of his own mental processes. The therapist adopts a parallel stance, being both a neutral observer and a participant by virtue of his empathic identification with the patient. This was discussed earlier in connection with the advantages of maintaining a neutral position in therapy.

The therapist must also function as a 'teacher', unlike any the patient ever knew in the past. Instead of teaching content known to the teacher and unknown to the student, he helps the patient learn to examine his own mental processes and to detect the operation of unconscious tendencies. This is performed using the data produced by the patient and is continued until the patient can develop this capacity for himself. In this way the therapist presents himself as a model for the patient, encouraging him to identify transiently with his way of looking at the patient's conflicts.

In addition, the therapist provides the patient with information which he has no other means of acquiring; for example, drawing the patient's attention to phenomena that might otherwise seem innocuous or trivial, such as comments he makes coming to or leaving his appointment, or to the way

he handles his financial obligation for therapy. In this latter sense the therapist does have expertise: a general knowledge of how the mind functions and the knowledge of how to set up and maintain a proper therapeutic situation for the exploration of the patient's mental life.

However, the patient's demands for help exceed the limits for this kind of expertise. What the patient demands, as exemplified in the vignette of the adolescent girl, is an answer to such questions as 'What is wrong with me?' or 'What can be done to make it better?'. These questions aim at magical assurance about the future. What the patient has to be helped to understand is that the therapist's actual expertise refers only to his ability to help the patient understand the relationship his own past bears to his present life.

Part of the discussion of the therapeutic contract which was stimulated by the patient we have discussed concerned the nature and source of her demands. On the surface her expectation for magical relief as a result of subordinating herself to the doctor's authority was a built-in part of the definition of the medical doctor-patient relationship. From a psychoanalytic viewpoint, it is easy to see that such a relationship must also draw its strength from the phenomenon of transference, as has been indicated. In a dynamic psychotherapy these tendencies are naturally expected, but instead of being utilized to strengthen the physician's position of influence over the patient, the expectations are themselves made the object of a systematic study. In psychoanalysis, transference manifestations are allowed and encouraged to unfold to the fullest extent; they are then analyzed as a prime source for reconstruction of the genetic roots of the patient's illness. In less extensive analytic therapies, transference manifestations are also explored, but with more emphasis on using them to understand the patient's attitudes and expectations and the unintended consequences of his behavior. As already noted, the analytic therapist looks for paradoxes and contradictions as clues to the presence of intrapsychic conflict and these

are most easily discerned as they occur in the interaction with the therapist.

For example, it could have been pointed out to the young woman that her complaints about her boyfriend's silence which made her feel responsible for conversation possibly referred in a veiled way to similar feelings about the therapy. The therapist's expertise allows him to recognize this connection and enables him to draw attention to something of which the patient is unaware. She could be told that it was probably difficult for her to complain directly to the doctor about the treatment, and therefore the same complaints were deflected onto the situation with the boyfriend. In this way the therapist demonstrates, rather than claims, that his feelings are not hurt and that he considers it a legitimate topic for discussion.

Also, the patient could be encouraged to explore and articulate exactly what she wanted from the doctor. This could bring into focus her inappropriate ascription to the therapist of powers that he does not have or claim. The subtle self-denigration behind portraying herself as helpless and needy could be brought to light in this manner. Through this kind of heightened awareness she might become cognizant of doing the same elsewhere, as in the hour which she opened by explaining that her problem was that she lacked confidence and then went on to indicate by her associations that she felt both physically and mentally incompetent. She could be neither a dancer nor a doctor. Thus, a process could be initiated by which she could begin to examine more critically the sources of her poor image of herself coupled with her willingness to overestimate others, particularly men. The hypothesis that her behavior is part of her castration complex could only be established by the patient through her own associations and memories. It is understandable at this juncture in therapy that the patient might misconstrue the hypothesis as an established conviction of the therapist to which the patient must submit. If opposition to this interpretation developed it might

mean the hypothesis is wrong or that the patient is unable to accept it. Rather than exploiting the patient's irrational need to overestimate the abilities of the therapist while denigrating her own capacities, it would be better to suspend judgment while relying on the treatment process to confirm or deny the hypothesis.

Through this speculative formulation as to the way in which this patient might have been handled, the role of the therapist has been exemplified. First, he drew attention to a possibly important transference area which was being defensively distorted by displacement onto an outside situation. He then functioned as a model demonstrating to the patient how to look at the phenomenon in question and helped her to do so. In this way he is working toward his own obsolescence, having initiated hopefully a process of self-examination which the patient can begin to carry out autonomously. Indeed, the criterion of greatest import for deciding on termination of treatment will be assessment of the patient's ability to carry on by herself.

RECOMMENDATIONS

In accordance with the preliminary findings of the pilot program on the teaching of psychoanalytic psychology of adolescents, the authors recommend that training in the fundamentals of psychoanalytic psychotherapy in a residency program should be anchored in a conference based on clinical material. The observation that a parallelism develops between the conference and the therapy should be utilized as a guide in the structuring of the program. Experience with a continuous case seminar as set up by the authors would suggest that the conference should be organized in a fashion analogous to treatment. This does *not* mean that the residents are to be viewed as patients. The object of the program would *not* be to effect some therapeutic change in the emotional life of the participants. Emotionally based interferences with the capacity

to conduct psychotherapy must remain the private concern of the resident.

A proper exploitation of the observed analogies between teaching and therapy would be as follows:

1. The methodology of the seminar should be made very explicit in the sense that it should be clearly explained to the residents at the beginning how the conference is to operate. In particular, the emphasis, as with the patient, should be placed on the importance of their own mental processes as they listen to the clinical material, utilizing the fiction that they are the therapist listening to the patient for the first time. Thus the 'clinical data' of the conference would consist of the accumulated 'associations' of the participants. While it is no revelation that the analytic therapist must use his own mind as an instrument in the treatment process, it may be somewhat novel to displace this idea from the couch to the conference table.

2. It should be understood that the aim of the conference would be to heighten the residents' own awareness of the often implicit but unrecognized assumptions behind their therapeutic orientation and interventions.

For example, one resident expressed the view that it was necessary very early in the treatment of an adolescent boy to ask questions of the patient about his life. The purpose, beyond accumulating information, was to manifest an interest in the patient to foster a therapeutic alliance. It was feared that to be silent might create anxiety which would prevent the patient from expressing himself freely. From an analytic point of view it would be of more interest to see what resistances did, in fact, arise rather than try to prevent him. If the patient blocked and expressed the idea that the therapist's silence meant to him that the doctor was not interested, this could be explored profitably after the real meaning of the silence was explained—namely, that the therapist did not know enough about the patient at the time to know what questions to ask; he was being silent in order to give the patient a chance to express himself.

3. It is to be expected that some difficulties in presenting the patient's material will occur. Care must be taken to safeguard the narcissism of the therapist-presenter. It has proved fruitful to look upon these difficulties of the presenter as analogous to resistances in therapy. For example, the therapist asked at the beginning of one seminar whether he should go directly to the material or raise some particular issues and questions. He was becoming very uncomfortable and wanted some immediate help as to what to do about the patient's demands for help. His 'resistance' manifested itself in his desire to bypass presenting the clinical material and have his questions answered directly. As with this example, the authors have regularly observed that a careful scrutiny of the material provides an essential understanding of the case and the immediate problem, even though the reason for desiring to delete it is not always ascertained.

These difficulties, therefore, should be approached in the same way as one views resistances in therapy; namely, as a form of communication indicating that trouble has been encountered in the patient's ability to be candid. The content of the resistance will itself be a disguised expression of the reason why the difficulty has arisen (*cf.*, Waelder, 1960, p. 181).

4. If, indeed, the parallelism between the conference and the treatment proves to be a general phenomenon, this form of teaching can also facilitate the capacity in the residents for empathic identification with the patient. As noted, their identifications are sometimes deflected away from the patient by the teaching method itself.

5. The possibility that processes in the conference might be a valuable barometer of the interaction between the therapist and patient should be further evaluated. Such repetitions have been noted in individual supervision in the relationship between the supervisor and the psychoanalytic candidate. In this context they have been considered a reflection of a countertransference problem for the therapist, which he repeats with his supervisor. While this potential is not discounted, it is suggested that the phenomenon has implications and usefulness in teaching psychoanalytic psychotherapy beyond serving as a barometer for countertransference intrusions.

6. The therapeutic contract between doctor and patient in psychotherapy is significantly different from that which exists in general medicine: in the former the relationship between doctor and patient itself becomes an object of scrutiny and the patient's expectations that being a passive recipient will lead to cure must be challenged. Similarly the residents' expectations to be provided with expertise obtained in a passive learning experience, need to be challenged and altered. As has been indicated, the authors had to be vigilant to resist the demands of the residents to be told 'the right thing to do'.

After listening to an account of a therapeutic session it is the usual practice to elicit comments about the material. It is common then for the instructor to offer his own formulation after the rest of the group has commented. This is often welcomed by the group for the wrong reasons. Since the instructor is more experienced, his formulations will perhaps be more complete, more polished, and thus more convincing. This places other points of view at a disadvantage and there will be a general tendency to view the instructor's hypothesis as 'correct' and that of members of the group as 'incorrect'. In this way facility in formulating dynamics has been allowed to become a criterion for establishing validity of clinical generalizations. The instructor must be aware of this tendency since it bypasses the really valuable aspects of the conference as a learning experience. It places the students in the position of being in competition, both with each other and the instructor, to see who is 'right'. It takes the residents' attention away from the scrutiny of their own way of processing the clinical data by which they can begin to examine their own assumptions. As soon as 'the answer' is given by the 'expert', there is a natural tendency on the part of the residents to turn off their own efforts. When this happens, learning stops.

While there is validity in the assumption that the teacher knows more, it behooves the analytically oriented instructor to be restrained in proffering content information. Doing this to excess will only re-enforce the student's belief that he can be taught psychotherapy, when actually he must come to realize that he can only be helped to learn how to do it. This can be facilitated, for example, by indicating from the outset

that participants should be willing to reveal the reasons why they are asking a particular question. The discussion can then more easily focus on the assumptions which led to the question.

7. The problems imposed on the conference leaders by this method of teaching are formidable and require discussion.

In the first report on the pilot project (Sachs and Shapiro, 1972), it was stated: 'The heterogeneity of the group and the lack of a consistent approach to the patient combined to place great stress on the conference leader. The demands of critically examining treatment methodology were eased by being shared' (p. 205). Further experience with the method has served to emphasize that dual chairmanship of the conference is not only felicitous but absolutely essential. The pressure exerted by the residents to make the conference leaders conform to their wishes to be given all-purpose rules and to be told what to do has already been cited and discussed. The temptation to supply specific answers and be drawn into fulfilling the role of the admired expert is diminished when each conference leader acts as a restraining influence on the other.

In addition, the authors found it necessary to spend an equivalent amount of time after each session discussing what had taken place. This extra burden of time and effort was necessary in order to keep abreast of the complex developments in the conference; namely, the interaction of the group as well as the developments in the case with which these interactions were also enmeshed. The authors were faced also with the need to scrutinize their own responses. Without spending this extra time in 'mutual supervision' and without a common prior basis of understanding between the conference leaders, this approach would have failed. Setting up such a program therefore represents a difficult challenge. Still, if properly carried out it can be an exciting and extremely rewarding experience.

SUMMARY

It has been described how the therapist's need for omnipotence was threatened by his patient's demands for guidance. His inability to satisfy these demands made him feel inadequate, and he transferred this same problem to the case conference, placing

pressure on the group to help him by telling him what to do for the patient. The conference then began to parallel the therapy and the interactions in the group were examined. This helped the group to empathize with the patient and to recognize that her demands probably stemmed from her feeling of inferiority due to her castration complex.

The parallel demands by the residents for help from the authors was itself a reflection of the difficulties in the educational process. The medical model by which they had been trained led to the expectation that they could be told what to do in the same way that the psychotherapy patient expects to be helped by submitting to the authority of the doctor. Although it suffices for the medical doctor to manipulate his patient's willingness to transfer onto him the role of the all-powerful parent, this cannot be done either in the practice or in the teaching of analytic therapy. Both the patient's and the resident's dignity must be maintained; infantile modes of subordination and wishing to be told what to do must themselves become the objects of dispassionate scrutiny as maladaptive archaic forms of behavior.

Pursuit of the observed analogy between the educational process and the therapeutic process has enabled the authors to formulate recommendations for a particular kind of clinical conference designed to exploit the similarities. The method holds promise as a means of conveying the psychoanalytic point of view in a residency program. It also can be used to provide some psychological perspective on teaching methods in use in training psychiatric residents.

This point of view cannot be taught in a residency training program solely by lectures or by reading. It is the authors' contention that it can best be conveyed as an experience. Just as the most convincing demonstration for the patient is his own therapy, the clinical case conference as described in this paper can provide a meaningful experiential basis for the residents in their attempt to understand the essentials of analytic psychotherapy. It provides a setting in which more than content about

such ideas as the œdipus complex can be transmitted because the conference itself demonstrates the special process of communication which must develop between doctor and patient. This approach to teaching actually represents an application of the psychoanalytic viewpoint in the same way that analytic therapy is but one application of psychoanalytic psychology.

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UNCONSCIOUS VERSUS POTENTIAL AFFECTS

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Psychoanalysts have long been familiar with the importance of affects of which the individual is unaware. In a previous paper I attempted to distinguish between two different modes in which such affects may exert their behavioral effects: as *unconscious* or as *potential* affects (Pulver, 1971). This distinction, I hasten to say, is not original. Freud (1905 [1901]) first suggested it in the Dora case:

> The disgust which Dora felt on that occasion did not become a permanent symptom, and even at the time of the treatment was only, as it were, potentially present (p. 29).

Schafer (1964) makes the point quite explicitly in his article on clinical aspects of affect:

> . . . . the affect may be present but warded off by defense and thus remain unconscious or exist only as an unconscious potential or readiness for that affect (p. 277).

Eissler (1953) also makes the differentiation, emphasizing its clinical importance:

> Evidently it is necessary to differentiate between a situation where the unconscious parts of the ego are free of an emotion and the repressed impulse is completely relegated to the repressed part of the id, and one where emotions are not fully unfolded within the ego but are present within the unconscious area of the ego. I believe that in most clinical situations the analyst automatically differentiates between these two situations. Usually when it is said that a certain impulse or wish cannot be interpreted to the patient because it is not yet close enough to the surface, the metapsychological description would be: the emotions corresponding to the respective wish or impulse have not yet formed in the unconscious parts of the

> ego and the derivatives of the repressed impulse from which we arrived at an interpretation are limited to ideational representations only (pp. 201-202).

As Eissler points out, in clinical situations we draw the line automatically. In theoretical discussions, however, the distinction is usually ignored. Unconscious and potential affects tend to be considered as a uniform group and designated by various, often interchangeable names, such as unconscious affect, latent affect, predisposition to affect, and affect readiness (Fenichel, 1945). The aim of this paper is to differentiate explicitly between *unconscious* and *potential* affects and to describe the theoretical relevance of the distinction in some detail.

DIFFERENTIATION OF UNCONSCIOUS AND POTENTIAL AFFECTS

Stated simply, *unconscious affects* exist in an activated or aroused state outside of awareness.[1] They may be either preconscious or dynamically unconscious. They are 'activated' because they exist experientially in a dynamically active state; that is, they have an effect upon motor or psychic activity at the moment under consideration. *Potential affects,* on the other hand, may arise from a dispositional state in which the affect is not aroused and active, but is 'more ready than usual' to be so. We might better speak of affective potential than potential affects were it not that our primary interest is in the affect and the motivational effects of its readiness to be aroused. Unconscious affects, then, are items of mental *content,* whereas potential affects, strictly speaking, are not affects at all, but *structural* dispositions to produce affects.

THEORETICAL RELEVANCE OF THE DISTINCTION

Affect theory is often markedly clarified by distinguishing between unconscious and potential affects, particularly in the understanding of specific processes involved in affect vicissitudes. To illustrate this, I have chosen a limited but important

[1] 'Unconscious' is used here in its descriptive sense.

area of clinical theory: defenses against affect, several of which were described by Fenichel.

1. *Postponement of Affects*

Fenichel (1945) defines postponement of affects as a '. . . temporal displacement, resulting simply in a later appearance of the affect reaction . . . '. He gives postponement of rage as an initial example: 'Rage can obviously be endured without discharge for a short period, but for a short period only; then it must be released no matter against whom' (p. 162). He does not make it clear whether he is referring to situations in which the patient is unaware of his rage, but such situations are well known to the practitioner. For example, a patient of mine took quite obvious umbrage to an interpretation about his desires to possess.[2] While revealing his pique in his tone and his behavior, he was quite unable to recognize it consciously; it was an unconscious affect. That evening he got into an explosive argument with a creditor who had called an overdue bill to his attention. This patient's postponement of rage seems best conceptualized as the arousal of an affect accompanied by only partial expression, and a complete repression of its awareness until a later time when it was displaced onto a different object, toward whom it was both noticed and expressed.

Fenichel's second example, the postponement of anxiety, deals with a very different process, one in which the anxiety (more properly, fear) is best considered as a potential affect rather than an unconscious one.

> Pfister investigated the reaction of the ego to acute mortal danger and repeatedly found an absence of fear during the period of acute danger, but a subsequent appearance of intense fear when the danger was past (p. 162).

While I question the implied universality of this, such situations do occur and most of us have experienced them. In such

[2] In a later session, he revealed that he felt that I was delicately stating that he was a thief at heart.

situations, we do not defend against awareness of fear; rather, we defend against the arousal of the unconscious affect of fear, which remains potential. As Schur (1953) points out, the arousal of fear is a complex process involving such ego functions as the perception of the situation in which the individual finds himself, the evaluation of the situation as potentially dangerous, the judgment that the danger cannot with certainty be avoided, and the recognition of the consequences of the danger. If any of these steps do not take place, either because time does not allow it, or because the attention necessary is pre-empted by the need for action, or because they are actively inhibited, the affect will not be aroused. Later, completion of the process results in the subsequent appearance of intense fear which Pfister described.

It is easy to see that Fenichel's examples of postponement of the rage and postponement of anxiety involved very different psychic processes. Postponement of affect in general can take place in many different ways, and distinguishing between unconscious and potential affect is helpful in delineating the specific processes involved.

2. *Reaction Formations against Affect*

A commonplace manifestation of this defense is seen in the overly kind, compassionate, and solicitous individual who is reacting against, among other things, his anger at the objects in his environment. Recently Sandler (1972) mentioned that at Hampstead these individuals are divided into two types, characterized as 'sugar' and 'saccharine'. While all reaction formers can be irritating, the 'sugar' type is much less so. Their kindness has a quality of sincerity in it, as the label implies. Their anger, in fact, is largely potential.[3]

Let us assume that the anger in one such person is apt to be aroused when he perceives another as an enemy. He keeps this anger in a potential state by seeing others as friends.

[3] One must assume there is some degree of aroused unconscious anger to warrant calling them 'reaction formers'.

He re-enforces this perception by treating them with 'super-friendliness'. He is defending, not against *aroused* affect, but against the *arousal* of the affect. In contrast, 'saccharine' reaction formers are much more annoying. They are quite unaware of their anger, but one feels that it is both present and active, as indeed it is. Their anger is unconscious, not potential. It is aroused, and they are defending against becoming aware of it by emphasizing the presence of its opposite: feelings of kindness and good will. The distinction between unconscious and potential affect in this situation again helps to clarify the dynamic mechanisms involved.

3. *Defenses against Guilt Feelings*

Fenichel (1945) writes: 'There is a group of defenses against affect that deserve special attention because of their clinical importance: the defenses against guilt feelings' (pp. 164-165).[4] He describes a number of these defenses, implying but not clearly stating the distinction between unconscious and potential guilt. By making the distinction overt, we can better understand the process. In patients with unconscious guilt, the affective aspects of guilt are aroused but not conscious. They feel guilty and, although not aware of the feeling, they wish to get rid of it. They may attempt this by seeking punishment (as do 'criminals from a sense of guilt'), or they may instead look for forgiveness, for 'love'. On the other hand, the guilt may be projected and seen as belonging to someone else, or dealt with in a number of other ways. In patients with potential guilt, the affective aspects of the guilt are not immediately active but easily aroused. Since these patients attempt to avoid situations which might activate guilt, their usual complaint is some kind of inhibition.

A clinical example illustrates that these defenses may occur in combination, although one or the other may pre-

[4] Fenichel refers only to the affective aspects of guilt. Guilt is, of course, a phenomenon having complex ideational components as well.

dominate at any particular moment. A young man had entered analysis with three main complaints. First, he felt unable to decide on and pursue a career, to 'make something of himself'. Second, whenever he undertook any venture to which he attached importance, he invariably failed, although he was quite competent in areas which he viewed as inconsequential. Lastly, he was bothered by 'attacks', acute spells of loneliness, anxiety, and nausea. During his analysis, it became clear that all of these problems were related to guilt aroused by the possibility of successful competition with his father. This guilt existed in three different modes: *potential, unconscious,* and *conscious.* Most of the time the guilt was *potential,* and his efforts to keep it so contributed to his inability to make something of himself. He strenuously avoided situations which would arouse it from its state of potentiality. Since his father was a successful business man most of these situations involved the pursuit of vocational accomplishment through competitive activities. The inhibition, however, was not complete. He did engage in some competitive activities, and unconscious guilt was aroused. His defensive efforts were then devoted to keeping the guilt and all of its ideational connections from consciousness. During one period, for instance, he became interested in karate and actively engaged in a course of instruction that would result in a certification of skill. He was not aware of the guilt this stirred up, but its presence was obvious in a dream of this period.

> I was in jail scheduled to be hanged in the morning; I don't know why.

Every success in karate was followed by failure in some other area of his life. As the time for certification approached, the guilt became stronger and threatened to break through into consciousness; he felt 'on the edge of an attack'. On the day of the examination for certification, the guilt became conscious and he suffered from a full-blown incapacitating attack. When, after much anguish, he decided that the whole thing was not

worth the effort, he canceled the test and his symptoms disappeared. This young man used inhibitions to prevent the arousal of guilt (i.e., to keep it potential). When such defenses were unsuccessful and the affect was activated (as 'unconscious' guilt), further defenses were used to keep the aroused affect from awareness. The interplay of potential, unconscious, and conscious guilt in this case is clear.

This fluctuation of potential and unconscious affect can also been seen in Freud's (1916) example of those 'wrecked by success'. He described a young woman:

> She was of good birth and well brought-up, but as quite a young girl she could not restrain her zest for life; she ran away from home and roved about the world in search of adventures, till she made the acquaintance of an artist who could appreciate her feminine charms but could also divine, in spite of what she had fallen into, the finer qualities she possessed. He took her to live with him, and she proved a faithful companion to him, and seemed only to need social rehabilitation to achieve complete happiness. After many years of life together, he succeeded in getting his family reconciled to her, and was then prepared to make her his legal wife. At that moment she began to go to pieces. She neglected the house of which she was now about to become the rightful mistress, imagined herself persecuted by his relatives, who wanted to take her into the family, debarred her lover, through her senseless jealousy, from all social intercourse, hindered him in his artistic work, and soon succumbed to an incurable mental illness (pp. 316-317).

Her guilt was initially potential. It was 'more ready than usual' to be aroused, but she avoided this as long as she remained in a state of social disgrace. The imminence of social rehabilitation aroused guilt, which was kept unconscious by a variety of mechanisms.

SUMMARY

Affects of which the individual is unaware may exert their behavioral effect in two different modes, as *unconscious affects*

or as *potential affects.* Unconscious affects are those which exist in an activated state outside of awareness. Potential affects are those which may arise from a dispositional state of the individual in which the affect is not aroused and active but is 'more ready than usual' to be so. Unconscious affects are items of mental content; as such, they are in the realm of subjective experience. Potential affects, on the other hand, are, strictly speaking, not affects at all but *structural dispositions* to produce affects and, as structures, they are not in the realm of subjective experience. The relevance of this distinction is illustrated with some examples of defense against affects.

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The Impostor: Aspects of His Development

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THE IMPOSTOR: ASPECTS OF HIS DEVELOPMENT

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INTRODUCTION

The impostor is a person who assumes a false name or identity for the purpose of deceiving others; he is a type of pathological liar who hopes to gain some advantage from his deception. Unlike the show-off or poseur who fails to deceive people and leaves them chiefly impressed with his pretentiousness, the impostor succeeds at least for a while in charming his audience into believing his deceptions. His role playing differs from more normal forms of pretending and acting a part, which are forms of mastery or play, because it involves driven, repetitious behavior that stems from unresolved, pathological inner conflicts. The driven quality of this behavior is similar to that found in other forms of impulsive behavior, sometimes rather loosely called acting out. However, imposturous acts are not acting out in the more specific sense of re-enactments that serve to prevent the painful recall of repressed scenes from childhood. The impostor also may or may not be a confidence man, swindler, or psychopath engaged in antisocial or criminal acts.

Although there are only a small number of documented cases of impostors in the psychoanalytic literature, such individuals are by no means rare. Newspaper articles regularly describe impostors who have been discovered filling responsible positions in public affairs, teaching, and medicine. Those who have studied impostors often comment on how many can be observed once one has become aware of their existence (*cf.*, Deutsch, 1955, p. 503). Furthermore, many people have

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assumed the role of imposture at certain times in their lives. Travelers may adopt false names in cities far from home; the 'gay' life of the homosexual is filled with unusual costumes, assumed names, and other deceptions. But true impostors lead a life that does not bring them to analysis unless they are in trouble. If they do come for help, it soon appears that their characters make them unanalyzable and often untreatable. Their dishonesty and superficiality, their poor tolerance of frustration, their tendency toward action, and their deep underlying pathology tend to nullify any attempts to help them.

REVIEW OF THE LITERATURE

The earliest clinical paper on the impostor is Abraham's (1925) report of a few brief encounters with a remarkable impostor who had an almost unbelievable ability to seduce and charm people for his own purposes. Abraham believed this impostor's extreme need for narcissistic self-enhancement and his hostility toward society were the result of œdipal disappointments: he was an unwanted child whose mother did not love him.

Thirty years later, Deutsch (1955) reported the first actual analytic treatment of an impostor. Her more detailed study considered the patient's pathological narcissism which she traced back to a severe narcissistic disappointment suffered when, as a young boy, the impostor had seen his idealized father become a pathetic invalid. Deutsch also described the patient's passivity and his infantile character, the result of extreme overindulgence during infancy and childhood, but did not relate these character traits, which may have been a source of inferiority feelings, to his need for compensatory narcissistic self-enhancement.

In 1958, Greenacre published two papers in which she drew a more complete and far-reaching picture of the impostor's mental functioning and development. She emphasized three sets of symptom constellations: First, the persistence, due to unresolved œdipal conflicts, of family romance fantasies which

are acted out in the imposturous roles; second, the impostor's disturbed sense of reality and of his own identity—as if two identities are warring within him, the sharply focused imposturous role and the crude, poorly knit identity from which it emerged; and third, the impostor's defective superego, which lacks any principles requiring him to use reality testing.

In explaining the development of the personality of the impostor, Greenacre (1958a) proceeds from the assumption that his central problem is that of identity which she ascribes to a particular pattern of development: a too-close relationship with an ambivalent, possessive mother that prevents the child from forming a clear sense of his separate self, and an absent or ineffectual father with whom the child cannot identify. A further result of the parental imbalance is that the child supersedes his father even though he is maturationally incapable of filling the role. This causes '*an intensification of infantile narcissism*' and makes the œdipal conflict 'sharp and insoluble' (p. 369, italics added), so that in his impostures he must repeatedly kill the father or steal his penis to cover his own deeper feelings of helplessness and incompleteness.

While Greenacre's chief emphasis is on the impostor's identity problems, she also comments on his pathological narcissism. She notes the impostor's small penis syndrome and his need to appear as a 'great lover', and relates this need to feelings of inadequacy due to trying to assume a manly role too early in life. Greenacre suggests that an earlier cause of the impostor's narcissistic problem is the mother's admiration of the two to three-year-old child's heightened use of mimicry and gestures in imitating adult behavior. At this age the child becomes extremely responsive to his own visual image as reflected in the eyes of his mother, an image used to conceal his feeling of being defective.

Regarding superego development, Greenacre is rather brief, stating that the impostor, presumably because of his failure to resolve œdipal conflicts, has no strong principles which would require him to use reality testing and that he lacks

normally introjected ego ideals. Further insight into the superego of the impostor is provided by Zavitzianos (1967) in a case report of a juvenile delinquent who occasionally impersonated the dress and manners of women she admired. His patient's mother actively encouraged the girl's delinquent behavior.

There are other papers on the impostor (Aarons, 1959; Zac, 1964; DuPont, 1970), as well as a novel (Mann, 1955), which elaborate or develop themes that are implied or dealt with briefly in Greenacre's studies. However, this review of the literature is not intended to present the views of all authors on the subject nor does it consider the far larger literature on pathological lying, delinquency, and narcissism.

The purpose of this paper is to report the ongoing psychoanalytic treatment of an impostor that has lasted for over four years. While the patient is a typical impostor who shows many features described by other authors, I will focus particularly on the patient's narcissistic quest for various ideals of perfection or omnipotence, the childhood factors causing his narcissistic disturbance, the role of his parents in encouraging his superego defects and his development as an impostor, and finally, his relationship to his audience which in many ways mirrors his childhood relationship to his parents.

CLINICAL CASE

Teddy, or as he jokingly called himself, 'The Great Teddy', was twenty-three years old when he entered analysis, ostensibly concerned because he had 'flunked out' of college again. He presented himself as a young man looking for answers in travel, mysticism, and marijuana. But he soon turned out to be quite a different person.

He was not handsome but his appearance was striking due to his large eyes, thick, curly black hair, a confident smile and lively expression. He loved clothes and on different days would appear in different costumes. One day he was a typical college student in faded bell-bottom blue jeans, work shirt,

and sandals; the next day he was a dashing young businessman in a stylishly 'mod' suit; and the following day he was a playboy in riding clothes. With each change of clothes he seemed to change character for he wore clothes with a special style all his own. I later found that he paid great attention to the smallest details of his appearance: he might leave one sleeve rolled up so as to appear absent-minded, or wear an unusual wristwatch or sunglasses to attract special interest. But the total effect never appeared studied nor did it show any signs of the effort he had made. He appeared quite natural, as if with each change of clothes he became someone else.

When he was wearing the 'right clothes' Teddy could believe in himself and could hope that others would also believe in the image he was projecting. He knew just how a young doctor or artist would dress and act, and he once told me that he would like to 'do me over' since he felt sure he knew better than I how an analyst should look. He had his hair done by a hairdresser at least once a week, wore tanning lotion, and went to a health studio for workouts and rubdowns. His aim was to be 'a beautiful boy' and to look 'just perfect', especially if he were going to be in the company of his mother who always wanted him to look his best for 'show-off purposes'. While he never appeared effeminate, he admitted he felt like a woman, spending so much time and effort on his dress and hair. If he did not feel properly 'turned out', he became depressed and hated to go out or be seen until he was 'fixed up'.

When he spoke, he used such expressions as 'really' or 'honestly' or 'I'll be honest with you' in an attempt to appear sincere. Later, as he found that in using these phrases he was revealing his essential dishonesty and wish to deceive, he was embarrassed to find that it was difficult to stop saying 'really' or 'honestly'; he was unsure whether he was trying to convince the other person or himself. His manners were most pleasant and agreeable. In all disagreements he made sure he understood the other person's view, and he was willing to forgive faults in everyone. In addition to his accepting and tolerant

nature, he was full of interesting stories about himself, his family, and friends. He told of working on a kibbutz, riding camels in the desert, meeting famous people in Europe and in the Caribbean islands, and conquering many beautiful girls.

In describing his adventures around the world, he admitted that he often assumed a false identity, saying that he did this to impress people. I later found that this urge was so strong that he might stop at an accident on the freeway and, if he saw that no one was seriously injured, pretend to be a doctor. He would look things over, reassure the victims in a professional manner, and go on his way feeling satisfied with himself. He said he felt big and important when he represented himself to others as a doctor, lawyer, or author, and told people that his father was a director of I.B.M. and his mother a beautiful, talented artist. Many of the grandiose roles he chose and the elevation of his parents' status appeared to involve typical family romance fantasies.

One August while I was on vacation, Teddy decided to go on a trip to California with a girl he casually knew. While traveling they stayed at a large resort hotel where he met a world-famous tennis player who was employed at the hotel. Teddy reported:

> I could sense that he was a guy who acted assured but underneath he was very unsure of himself. He had this façade that works with the public, but I wanted to get behind it because I felt that if I did he would open up to me. He is a terrific tennis player which is impressive. I wanted something to impress him too so I told him I was a young doctor, starting out. He believed me, although to tell the truth he wasn't too impressed, but he did begin to like me and trust me. He started to confide in me and he really has got problems—money problems and other problems. I became like a special friend of his and not just a guest at the hotel. He even gave me two tennis lessons for free. It's hard to explain how I did it; you would have to see me. It's the way I *carry* myself. I'm so friendly. I played with all the kids there and they all knew

> my name. When I talked to the pro I could feel how he felt, and I knew what he wanted to hear from me, so I said it, and soon he trusted me. I know he believed I was a doctor and came from a fantastic family. In fact, I almost believed it myself.

In his associations to this episode, Teddy revealed that he had noticed that I wore a tennis racket tiepin and figured that I was a tennis player. He hoped to impress or even daunt me by his friendship with such a great player. Also, he had enjoyed playing my role by befriending the pro and becoming an analyst who listened to the pro's troubles. Further, Teddy enjoyed a feeling of superiority at fooling the pro and discovering that he was such a 'screwed up' guy.

Thus, in his imposture, Teddy had become a 'big shot', assuming a phallic masculine role for both me and the pro, and at the same time enjoying the pleasure of castrating the pro who now appeared weak and defective. This he did by 'zeroing in' on the pro's weak spot, his need to talk about money, and on my interest in tennis. After reporting this experience, Teddy was obviously intensely sensitive to whether I appeared frightened, angry, or pleased.

As he described this and other episodes, it was possible to study his affects and his ego functions as he played out his imposturous roles. Teddy felt alert and elated while playing a part because he believed he was smart, strong, attractive, capable, rich, and accomplished. When he could not maintain his belief that he could fulfil these idealized qualities, he would suffer painful affects associated with feelings of shame, worthlessness, inadequacy, and narcissistic mortification. To avoid the pain and possible depression that might ensue, he lived out his role, using particular defense mechanisms to prevent the intrusion of unpleasant realities. Among these were *denial*: 'When I imagine I will do something, like paint a picture, I really can't believe that I couldn't be another Picasso'; *rationalization*: 'It doesn't matter if I'm pretending; everyone is a bit of a phony'; and *splitting*: 'If I tell someone

that I'm a lawyer, I forget about what I really am and I have no feeling of guilt at the time'. These defenses allowed unconscious self-representations to emerge and to be acted out without any conflict with reality-oriented ego functions.

Schafer (1968) has spoken of the suspension of the reflective self-representation in describing how one can lose oneself in a daydream of being someone else and yet not lose one's general sense of reality. This Teddy did, particularly by suspending his sense of reality about his own self-representation. Furthermore, with the aid of his audience, he acted out what others only imagined. Of course, in achieving his goal, Teddy required an audience which was insecure, ambivalent, and in need of the reassurance provided by the omnipotent image or ego ideal that Teddy provided. His sensitivity to the art of illusion, particularly his ability to discover what his audience was ready, indeed eager, to believe, distinguished him from the ordinary braggart or poseur who offends his audience by his obviousness and insensitivity to their feelings. On the other hand, despite his acute awareness of signs that his audience was ready to believe his deception, Teddy by the use of denial could be quite unaware of the occasions when certain people saw through his deceptions. Although at times he could be a minor swindler, he was not a 'confidence man'; his strongest motivation was to achieve the self-satisfaction he felt when *he* believed in his own role; he was only occasionally or secondarily interested in swindling people out of their money, either for profit or deeper hostile motives.

Despite his lack of education and training, Teddy could always find a job, but holding it was a different matter. He once was hired as a substitute teacher in a public school. At first the children loved him because he charmed them, played records for them, took them on outings, and even arranged a puppet show for them. As time went on, however, he became restless and bored with the job, and managed to get himself fired. After this failure he returned as usual to his parents who, Teddy told me, would 'fuss' a little but then would be

all too ready to believe his lies and excuses and, after a while, to help him along on his next adventure. His parents, like his other audiences, were always eager to believe in him.

Teddy was the youngest of four children. He described his father as a self-made man, a super-salesman, who had risen to an executive position in a fairly large business. When his children were young, he had been away from home much of the time. He was active in his fraternal organization, had been president of his congregation, and was a dynamic conversationalist who could talk with anyone on any subject. If his father was engaged in an argument and realized he was wrong, he would quickly shift sides. He was a man of contrasts and mood changes. When the family was entertaining, he played the part of the great host; at other times he would go into the kitchen and wash the dishes. He spoke sentimentally about his love for his family and for people in general, but he was a shrewd, aggressive businessman.

Teddy admired his father's success but admitted that he often exaggerated his position and worth in the hope that people would believe the family to be millionaires. Gradually Teddy came to acknowledge that there were many things about his father of which he was ashamed: his shallow sentimentality, his 'phony' glibness, his weakness in the home where the mother 'ruled the roost', and his willingness to be the chief victim of Teddy's aggression as he always seemed to end up paying for Teddy's hare-brained schemes and extravagances. Teddy chose to ignore that his father looked upon him with contempt; after each failure, Teddy became a scapegoat upon whom his father could vent anger for the behavior he had encouraged. Behind Teddy's 'idealization' of his father was his identification with his ability as a 'great salesman' and his hostile, competitive, castrative impulses against his father.

Early in the analysis, Teddy pictured his mother as a 'perfect person', an angel, a beautiful woman who reigned at home and among friends like a beloved, bountiful queen surrounded

by happy subjects. She was a peacemaker, a comforter, and an example of virtue; her only fault, Teddy said, was her unselfishness which allowed other people to take advantage of her.

As the analysis progressed, however, Teddy began to present a different picture of his mother, one that stirred up resentment in him. He described her as a controlling woman who needed to infantilize her children to keep them close and dependent upon her. He hated her for treating him like a baby but was afraid of her angry silences if he showed any sign of rebellion. She was obsessed with appearances and always wanted Teddy to 'look perfect'. Teddy was remarkably attuned to her reactions and could sense immediately if she felt proud because he looked 'perfect' or irritated because he made a poor showing. Teddy also recognized that her approval made him feel safe and worthwhile, while her disapproval made him nervous and anxious. But he was unaware for some time of her superficiality and lack of concern with real issues. Only later in treatment did he see that she was more worried about his long hair than about his unfitness for school, work, or marriage. Teddy also noted that when he pretended to be a doctor or lawyer, he was choosing roles which would have delighted his mother. Thus, in his concern for appearances and in his choice of roles, Teddy was acting as a phallic object for his mother.

Beyond his wish to please his mother by being an impostor, Teddy also revealed aspects of his imposturous behavior that were similar to his mother's behavior. When he was a child she had been charming and seductive with him, and even when he was an adult she continued to flirt with him and flatter him. His imposturous seduction of his audience was in part an identification with the aggressor-mother. He also described his mother as trying to please people and make them happy by saying what they wanted to hear without much concern for the truth, just as Teddy did in his imposturous behavior. Finally, in his impostures, he was able to make fools of his audience and thus discharge some of the repressed hos-

tility he felt toward his mother. Teddy, by making her the victim of his pathological lying, enjoyed castrating the vain, controlling, seductive, phallic mother with whom he identified.

Teddy's three older siblings were married but remained dependent on their parents for money, admiration, and love. Only the oldest sister had achieved some degree of independence from the parents. A brother was a reformed 'cheater' who barely managed to get through professional school; another sister was a childish woman who was having trouble being a wife and mother. The whole family took great pride in their image. They were active in social causes, gave parties for people they scarcely knew, and supported poor relatives, all in the shared fantasy that they would appear to be a warm, generous, wonderful family. In this sense the entire family, if not impostors, were hypocrites. But Teddy was the one who was most devoted to creating an image and the one who had accomplished the least in reality.

Through his childhood memories as well as what his family had told him and through the transference, it was possible to reconstruct certain influences which seem to have determined his need for omnipotence.

During his earliest years, Teddy's family lived in a house which was always full of friends and relatives, visiting, talking, arguing. In this stimulating atmosphere, Teddy was the baby; he was spoiled, pampered, and treated like a toy. He was also exposed to the overstimulation of sleeping in a different bed almost every night, seeing the adults undress, bathe, and use the toilet, and of often sharing his bath with his father. Teddy was excitable and hyperactive, always needing attention and developing little self-control or tolerance of frustration. His overactivity often led to mischief for which he was spanked. In this atmosphere, he became painfully aware of his smallness; he was especially ashamed of the smallness of his penis as compared to his father's.

When he started school and compared himself with other children his own age, he found he could not behave as they

did: he was too restless to be educable; he bit his nails; occasionally he was a bedwetter and sometimes when he became excited he soiled his pants. In the analysis it became clear that much of Teddy's need to appear capable, mature, and accomplished was an attempt to cover his painful knowledge of his ego weaknesses.

Another source of his quest for omnipotence lay in Teddy's intense castration anxiety. His strong attachment to his mother, as well as his wish to please her by showing off, has already been noted. From the age of two or three he had been keenly attuned to his mother's great interest in his image and appearance, and he had tried to please her. As his father was away much of the time, Teddy was frequently his mother's companion and felt protective of her. During his childhood, Teddy often wondered about his parents' sexual relationship. Since his father bragged about having been inexperienced until he married and seemed proud that he was not ruled by sexual needs, Teddy decided that his father was unable to satisfy his mother and that she preferred Teddy to her husband.

At age five, at the peak of his œdipal attachment to his mother, Teddy had a tonsillectomy. Before going to the hospital, the mother promised the frightened boy that she would not leave him alone. Once they were there, she told him she had to go get her purse and left the room; before she returned Teddy was taken to surgery. Teddy said his mother often lied 'so people shouldn't worry', a habit he soon picked up himself. The point here, however, is that the surgery greatly intensified the castration anxiety he already felt as a result of his overly close œdipal relationship to his mother. Evidences of castration anxiety appeared in a series of 'bloody' dreams during his childhood which reappeared periodically when he was in analysis. After the surgery, Teddy became a confirmed coward: he would do anything to avoid a fight, he was terrified of injuries, and could not stand the sight of blood. Because of his castration anxiety, he attempted in his impostures to appear strong, clever, and invulnerable.

Teddy clearly recalled his childhood fears of being injured or hurt, castration fears which were closely associated with his confusion about sexual identity. When taking a bath with him, his father had a habit of tucking his genitals between his legs so that they could not be seen by Teddy. This added to the boy's confusion about appearance and reality: genitals could disappear and reappear. As a child he, too, would tuck his genitals between his legs and enjoy 'being a girl'. As he grew older, Teddy also frequently assumed feminine roles in which he identified with his mother, cooking and caring for the house—roles which defended him against fears associated with a more masculine role. At other times he would act like a 'little man' in attempting to fulfil a phallic role for mother and also to overcome his feeling that his penis was small and defective. These defensive shifts between masculine and feminine roles continued through his adult life.

In summary, Teddy's need to assume grandiose roles or to be omnipotent appeared to stem from a number of sources: his painful feelings of smallness and helplessness in a family of older children and adults which made him wish to be large and important; his painful awareness of his lack of self-control and intolerance of frustration which made him wish to be mature and responsible; his painful castration anxiety which made him wish to be strong and brave; and finally, his painful inner knowledge of a strong feminine identification which made him wish to be manly and virile.

Overlaid upon his wish to be omnipotent was another factor in his becoming an impostor: the direct encouragement of role playing by his parents, especially his mother. When Teddy was seven years old his mother took him to a stage show. As the show started his mother suggested that he go up on the stage. He at first demurred but then walked up onto the stage, where one of the comedians asked his name and age. Teddy was frightened but, wanting to appear bigger and older, gave his brother's name and said he was ten years old. His mother was pleased that he was so cute on the stage and said

nothing about his lying. Teddy recalled thinking how easy it was to lie and please everyone. From the time of this first imposture, he was always eager to talk to adults and, with no concern for the truth, would adopt any role that might please or impress other people.

Teddy's school career was a farce. When his mother left him on his first day of kindergarten, he ran away from school and had to be brought back. Shortly after he started school, his mother began to work as a nursery school teacher. Teddy became jealous and resentful; at every opportunity he faked illness and left school. He stole money from his mother's purse, using the money to eat lunch at restaurants and to impress the other children. He felt he had to lie and steal to compensate for his lack of friends, his smallness and weakness. Although he had no real friends, there was one boy he would bring home to feed; he enjoyed playing a motherly role, cooking and taking care of the boy. During grade school, his parents got tutors for him because he was not interested in learning. He got through school by cheating on examinations, getting help from classmates, and ingratiating himself with his teachers.

He recalled that during these school years his father, who was 'crazy' about him, would take him on business calls and show him off to friends and associates. As Teddy could always charm the adults, he began to really believe that everyone liked him and that he had 'a million friends'. His mother also admired him, forgave all his faults and failures in school and his outrageous use of money. When he was in high school he had over forty sweaters in his closet, all arranged according to color. While he was making no effort and performing dismally at school, he was given attention, praise, and many rewards.

Teddy's real impostures began when he left high school. He went from college to college, picking up a few credits and then dropping out to travel or pursue poorly planned business schemes. He managed to be admitted to a third-rate

law school in another city, where he lived in a paneled apartment filled with books. There he would discuss legal problems with fellow-students but never attended classes. He failed all his subjects in his first year and was asked to leave. It was after this and several more failures at colleges that he finally came for analysis.

ASPECTS OF THE TREATMENT AND TRANSFERENCE

During the first year of analysis, Teddy was seen five times a week, on the couch. From the start I began to analyze his need to appear great and to be admired. I pointed out that the reason he assumed roles in which he appeared wealthy, charming, and accomplished was in order to avoid the painful affects which would emerge if he saw that the opposite were true—namely, that in reality he was not the person, or people, represented as his ego ideals or ideal self-representations. I explained to him how he used the defenses of rationalization, denial, and splitting when he was lying or playing an impostorous role. I told him that in his lies and impostures his audience played an essential role: while they might be victims of his frauds, they were necessary so that he, himself, could temporarily believe in his deceptions. Gradually it became clear that while much of his behavior had been encouraged by his parents, his imposturous behavior also represented identifications with varying aspects of his parents' behavior. For instance, in being an impostor he was giving people what they wanted, thus identifying with his all-giving mother; in lying and assuming a flashy role, he was identifying with ideals of 'appearing good' which she had represented; and in being a charming deceiver, he was identifying with his father's changing roles and his abilities as a 'super-salesman'. With these interpretations came a deepening of the analysis.

What has been described above is an overview of the analysis in terms of general therapeutic goals: the interpretation of the patient's defenses against the painful affects associated

with narcissistic injuries as well as the anxieties associated with forbidden libidinal and aggressive drive fantasies. With this background, certain episodes, fantasies, and conflicts that occurred during the analysis are of interest.

A few months after the analysis had begun, there were signs of emerging transference feelings and fantasies. From the start, Teddy made every effort to be charming and interesting. He was pleased with my attention to him and showed in many indirect ways that he respected me and that he and I shared a rare sense of understanding and rapport. While other patients, preoccupied with their inner concerns, scarcely noticed the color of the room or the couch, Teddy noted every detail of my appearance and my office and tried to read into each detail some 'secret knowledge' about me, my tastes, and my private life. This he did in an unobtrusive, flattering way. The meaning of his behavior became increasingly clear because during that time Teddy was reading and describing to me the writings of Anaïs Nin whose famous Diary (1966) describes her life among the artists and intellectuals of Paris before World War II. Nin had seduced her first analyst, an event she describes in some detail in her diary. Later she became deeply involved with Otto Rank and became his assistant.

Nin was fascinated by impostors. In one of her novels, A Spy in the House of Love (1968), she starts the book with a scene in which her heroine, a typical impostor leading a double life, cannot sleep and makes a random phone call to a man who says he is a lie detector. This passage greatly impressed Teddy; he admired Nin's amazing insight into the minds of people like him and identified with both the author and her heroine. He imagined how they felt, and also how it felt for Nin to seduce the analyst and then become an assistant, an analyst herself. This imagined role, Teddy said, reminded him of his pleasure when as a boy he went on business calls as 'Daddy's little

helper'. It also explained his motivation in being such a seductive patient for it became clear that he already felt superior to the analyst in many ways. I discovered this later when he told me that from the start he had decided that I probably came from a poor family and had spent my life plodding and cramming to become a doctor. He felt sure I knew little of life and its pleasures, and he interpreted my interest in him as a sure sign that I was secretly thrilled to have such a fascinating, wealthy patient. He also believed that after a short time he would have me and psychoanalysis 'figured out' and would leave having learned a few tricks. In this fantasy, Teddy had appropriated the analyst's phallus and power for himself.

His associations with regard to Anaïs Nin also involved another transference fantasy: he would be like Nin's fictional heroine who was discovered by the lie detector-analyst. Here Teddy would play a penitent role before the relentless analyst-father. But in this role he also revealed a healthier motivation: his wish to have his lies detected and to have an honest relationship with the analyst.

In these transference fantasies, Teddy represented himself as a woman. The underlying feminine self-representations were in marked contrast to the strongly masculine roles he assumed in his impostures; it appeared that the imposturous roles defended him from the painful conscious recognition of the intensity and importance of these feminine self-representations. Of course, his feminine identifications were a defense against competitive feelings, which emerged fleetingly later in the analysis. For instance, for a while Teddy thought of going to medical school and eventually becoming an analyst; he wondered if I could tolerate the competition. His dreams at this time were full of injuries, blood, and other barely disguised representations of castration. Thus it was possible to observe the rough outline of a triple layering of defensive positions, each with its own fantasied gratifications and dangers and each bearing a relationship to the others.

As Teddy continued his efforts to seduce and to castrate me, he also began to experience me increasingly as a superego figure. He thought of me many times each day. How would I behave in certain situations? What would I think of a certain act? He began to wish he could get me out of his mind for these were not simply thoughts about me: I was beginning to exist in his mind as a highly idealized figure. He became more and more curious about my personal life, my home, and my children, and then developed the wish that I were his father, for then he would not have problems and could be a real man. Although he professed to idealize me as a perfect man and father and began to give lip service to values such as honesty and dependability, it became apparent that this was chiefly a new way Teddy had found to flatter and please me by being a good patient. Even though his behavior had scarcely changed and he had not yet suffered any deep guilt or remorse, he acted as if he were a changed man and as if I were the finest analyst imaginable for having helped him so greatly. He let me know how often he praised me to his friends. In effect, he was playing an impostorous role of 'the good patient'.

All the while, the chief characteristic of the transference appeared in his continual lying to me. He 'forgot to mention it' when he lost his job as a teacher. He told me he was taking a college course but later admitted he had not registered for the course. When he was in a poorly planned business venture, he concealed the fact that funds were mislaid and the bookkeeping was less than adequate; he said they had an accountant when in fact they did not. When, after some time, he told me the truth he was very sensitive to my reaction. Was I angry? Did I enjoy looking down on him? He lied particularly in telling me his feelings about me and the analysis. He was eager to make me feel that I really understood him and was helping him to change. He avoided any criticisms of me because he was sure I wanted only to hear good things about myself.

As we explored his lying to me, Teddy revealed through associations that he was reliving in the transference his lying rela-

tionship with his parents. He was offering me an opportunity to condone his lies, support his self-deception, and enjoy his self-idealization, as well as his idealization of me, in order to form with him a narcissistic 'mutual admiration society'. Furthermore, when he finally admitted his lies, he expected me to be angry with him, as his father usually was, but then to soon forgive him, accept his regrets and statements that he had learned his lesson, and encourage him to go on to some new unrealistic adventure.

Lying to me and the need to keep my interest and attention constituted a central transference resistance, one of the main obstacles to cure. To the degree that Teddy reacted to me as he had to his parents, the analysis became a narcissistic alliance in which he devoted himself to his own gratification and what he imagined to be his analyst-parents' narcissistic needs; at the same time, he could castrate the analyst and destroy any hope of health for himself.

In addition to his need to involve me in a corrupt but flattering narcissistic alliance, Teddy also went through periods of superficially identifying with me, particularly with aspects of my character and behavior which he felt had some value in projecting an impressive image. He adopted some of my manners of speaking, he spoke for a while of going to medical school and becoming an analyst, he began to play tennis, and he took an interest in art, particularly in the work of Magritte since he had seen a Magritte etching on the wall of my office. I pointed out to him that he was now using me as a model to practice playing the role of an imposturous analyst, sportsman, and art lover just as earlier he had adopted aspects of his parents' personalities as the material from which he constructed his imposturous character.

After a year or more of analysis, my interpretations began to have some effect. Although he was not experiencing any conscious anxiety, Teddy began to tire of playing the impostor, even though when he stopped his role playing he often felt empty and had nothing to say to people. He was becoming

ashamed of his old way of life and gave up marijuana, obtained a job, enrolled in a college course, and, for the first time, learned something and received a good grade. He found that when he was working and leading a healthier life he felt better, initially because he was seeking my approval but later because he began to experience some fleeting self-approval. As his behavior improved, Teddy also was able to express some of the hostility which until now had appeared chiefly in his dreams.

An example of his emerging anger was seen in an incident while he was riding in a cab. The driver boasted that he cheated the cab company, that he was really a law student and only a part-time driver. As the cabby continued to talk, Teddy realized that the man knew nothing about law school and was an impostor. Teddy reported that he felt enraged with the man for lying and trying to impress him, and that his first impulse was to report him. But he then realized that his anger was inappropriate and was due to his own self-hatred. Using denial and projection, he avoided self-criticism and directed his harsh self-judgment against the cabby.

Teddy was not only becoming aware of anger against himself, but began to express anger toward his parents. He now saw them as false, hypocritical, and, even worse, as encouraging his problems by accepting his lies and supporting his impostures. His parents, in turn, were displeased with the changes in him. So, as the analysis progressed, Teddy was increasingly torn between two conflicting forces: the influence of the analysis and the influence of his parents.

During the second year of analysis, Teddy got a new roommate, a student who was a 'ladies' man' and a bit of a swindler himself. At the time, Teddy was disinterested in sex: he felt his earlier exploits with women had been 'just to impress someone'. He had no direct homosexual contact with his roommate, but he enjoyed watching him go about nude and was fascinated by his descriptions of his sex life. Teddy did the cooking, cleaned the apartment, and played a womanly role; he said he enjoyed this role and 'mothering' his roommate.

Time was spent on analyzing Teddy's feminine self-representations and his latent homosexuality. As a result of these interpretations, he moved, began to live alone, and found a girlfriend with whom he had a moderately satisfactory sexual relationship. There were occasional episodes of impotence during which he recalled, while in bed with his girlfriend, the vivid memory of seeing his mother nude and particularly of seeing her black pubic hair. Much of his pleasure in sex was in controlling his partner's reactions and bringing her to orgasm.

At this point in the analysis there has been some improvement in Teddy. To some extent he has given up acting as an impostor; he realizes how grandiose and unrealistic his goals have been; he has developed some identification with me and with the analytic process which hopefully may become consolidated in the form of healthier ego identifications; and, finally, he has become somewhat less passive and feminine. But the improvement has been limited and slow in coming. And his progress has been counterbalanced by the continual reenforcement of his old way of life by his parents as well as his girlfriend. There have been a few interruptions and changes in the frequency of visits due to his unstable financial position which depends on whether or not he has a job or how much money he can get from his father. For the past year, however, he has been working and coming to analysis five times a week. But Teddy remains an infantile, passive, narcissistic character caught somewhere between severe illness, which he can no longer deny, and the beginning of a healthier life.

DISCUSSION

In describing Teddy's imposturous behavior we must not overlook the possibility of important differences that may exist between him and other impostors, particularly the more severely ill impostors who never come for treatment and who form a rather heterogeneous diagnostic group ranging from hysterical multiple personalities to psychotic delusional identifications.

Still, while acknowledging the hazards of generalizing too far on the basis of one case, I feel that we can see many ways in which Teddy fits the pattern of impostors described in the literature. For instance, his need for narcissistic self-enhancement to defend him from feelings of being empty, worthless, and defective; his unresolved œdipal conflicts which caused him to falsify his identity and parentage in acting out hypercathected family romance fantasies; his passivity and other regressive character traits; his disturbed sense of self-identity, incapacity for normal object relationships and other ego defects, particularly the reliance on pathological defenses; and, finally, his faulty superego function that resulted in his feeling little shame or guilt about his antisocial behavior.

What makes Teddy notable, among the impostors who have been described in any detail, is the importance of his unconscious feminine self-representations. For him there was a feminine aspect to being an impostor. When he stressed that he was making people happy by giving them what they wanted, he was being like his 'unselfish, giving mother' who cared only about other people's needs but who was also totally concerned with her image and who was able to manipulate and control people in her own seductive way. But for the most part, the imposturous roles Teddy chose to enact were not feminine roles. Rather he chose roles in which he appeared as a 'big man' from a wealthy family, playing out family romance fantasies which were intended to resolve positive œdipal conflicts. However, these imposturous masculine roles defended him from the painful acknowledgment of his underlying femininity which emerged when he gave up being an impostor.

These feminine self-representations appeared in his childhood memories of caring for other boys and later in his pleasure in keeping house, pleasing, and controlling his roommate so that he could enjoy an identification with his roommate's impressive phallic presence. The same impulses appeared in the transference when he began to express his pleasure in my company

and in the virtues he attributed to me. He bragged about me to his friends and felt enhanced by associating with me. In these attitudes he was expressing an underlying homosexual fantasy which has been described by Nunberg (1938) and Anna Freud (1950): by contact with a strong, masculine man, the homosexual hopes to gain magically the phallic omnipotence which he feels he lacks or has forsaken. Nunberg makes it clear that the homosexual is not simply seeking to gain strength from the man but to insinuate himself into his good graces in order to *rob* him of his potency or castrate him (p. 158). In Teddy's case the fantasy of castration appeared most clearly in his interest in Anaïs Nin which revealed his wish to seduce me, rob me of my potency as an analyst, and leave me discredited as Nin had done with her analysts.

However, if we attempt to generalize about the impostor from our knowledge of Teddy's case, it may be useful to leave the content of his unconscious self-representations and fantasies and focus instead on his essential pathology from a structural point of view, where the impostor's central defects appear largely in the area of his narcissism or regulation of his self-esteem. I shall not review here the many contributions on this subject (e.g., A. Reich, 1953, 1960; Jacobson, 1964) but will rely on the recent formulations of Sandler and Joffe (1969) and Sandler, et al. (1963). Following these concepts, the impostor appears as a type of narcissistic character who has unrealistic, grandiose ego ideals, or, more properly, idealized self-representations, that he must attain if he is to achieve a basic feeling of well-being. Since the impostor is prey to severe anxieties and painful states of awareness of his own defects and weaknesses, and since his defective ego lacks the ability to delay, postpone, plan ahead, and tolerate frustration, he is ill-equipped realistically to attain these idealized goals and must resort to pathological means to convince himself that he has achieved them. As already noted with regard to Teddy, these include the use of denial, rationalization, and splitting, as well as considerable talents for acting

and mimicry in order to deceive his audience, so essential in reflecting back to him the sense of reality he needs if he is to believe his own deception.

If the impostor fails to convince himself that he has achieved his goals, he suffers painful affects, such as shame or humiliation which may be subsumed under the heading of narcissistic injuries or mortifications. Furthermore, if he gives up his imposturous behavior but cannot learn to tolerate delay and frustration, modify his grandiose goals and develop more realistic goals, and work toward some real life achievements, he becomes seriously depressed. Understandably, the impostor who enters analysis hopes that it will be another means of achieving his grandiose ideals. Schmideberg (1933) describes the difficulty in treating patients who idealize psychoanalysis and hope it will make them perfect or omnipotent but then lose interest when they are faced with giving up their unrealistic goals. She also notes that it is a sign of progress if the patient's ideas of a cure and his goals in general become more realistic. Her observations apply very well to Teddy.

In considering the factors that caused Teddy to become an impostor, I was led by the reconstruction of his development through memories and the transference to emphasize his general disturbance in regulation of self-esteem. As noted, Teddy's need to appear great and omnipotent stemmed from a number of painful self-representations related to memories of weakness, smallness, helplessness, as well as to his knowledge of his ego defects, hi :ntense castration anxiety, and his need to conceal his strong feminine and homosexual fantasies. These areas of narcissistic vulnerability formed a soil in which his pathology flourished. Other factors were the excessive amount of attention he received as a young child, the early use of pathological defenses because of his profound ego defects, and finally his considerable talents as an actor, liar, and practical psychologist.

But I should like to go further in considering the development of Teddy's particular type of narcissistic disturbance since I feel that this constitutes a central structural defect in the

impostor. In particular, I should like to stress the effect of *both* parents, rather than the mother who has been stressed by other authors, in causing the impostor's magnified ideals, corrupt superego, pathological defense mechanisms, and disturbed object relationships. Teddy's case seems to me to show how this influence was exerted not only in the preœdipal period but during latency and even later.

Both parents unconsciously wanted or needed Teddy to be an impostor and enforced his becoming one. Teddy provided innumerable examples showing how his parents continually encouraged his grandiose lying and fakery, while discouraging healthier values and behavior. They were similar to the parents of delinquents described by Johnson (1949) who created superego lacunae in their children and encouraged delinquent behavior because of their own poorly integrated unconscious wishes (*cf.* also, Johnson and Szurek, 1952; Szurek, 1942). The children provided vicarious gratification for the parents and also played the role of family scapegoats, allowing other family members to direct their anger against them. In Teddy's case, it was especially clear how his father, and at times his siblings, despised him for the very traits they encouraged in him.

While Johnson's formulations about delinquents apply in a general way to Teddy's development, and perhaps to the development of other impostors, there are important differences. In the first place, one cannot state simply that Teddy had 'superego lacunae'. His defect was more complex. His parents, out of their own narcissistic fixation, instilled in him a number of highly overidealized self-representations that became the core of his grandiose, unattainable ego ideals. At the same time they condoned his dishonesty and use of pathological defense mechanisms. Further, they provided the external evidence of the reality of his deceptions and thus became the models for his later audiences. Thus, if he could fool others, Teddy could achieve a feeling of self-satisfaction, as if for a job well done. His parents instilled rather severe superego attitudes in him as well. When he had an audience to take the place of his

parents and support him in his impostures, he could feel the self-satisfaction of fulfilling his ideal. When he had no audience, however, he became prey to the reproaches of his superego and felt a degree of shame and guilt.

Zinner and Shapiro (1972), who like Johnson worked with both parents and children, describe parents who project onto their children aspects of their own unconscious wishes, fantasies, and self-representations, thus affecting both their own and their children's behavior. Their descriptions, like Johnson's, are similar to my description of Teddy's parents. But Teddy's parents not only encouraged him to become an impostor; they also provided characteristics for him to identify with, particularly his mother's lying and her interest in superficial appearances and his father's abilities as a glib talker. It should be repeated that being an impostor was Teddy's way of relating to his parents by giving them the lies and pretenses they wanted. In this way he gained their love and avoided rejection, setting a pattern which determined all his later object relationships.

The picture of how his parents encouraged him to become an impostor emerged most clearly in the transference. As indicated earlier, Teddy was trying to create with me the same atmosphere of mutual admiration that he had with his parents. He also used me as a model for role playing. Only when I failed to play his parents' roles, did he begin to modify his usual defenses, question his grandiose self-representations, and internalize new, more realistic ideals based on his image of me and of the analytic process.

Other impostors have had parents who showed the same vicarious pleasure in the impostor's role playing and the same easy acceptance of his lying. One of the few childhood memories that Ferdinand Demara, 'the great impostor', told to his biographer, Crichton (1959), reveals how a father can encourage his son to become an impostor. At a party for Demara's fourth birthday, his newly rich father demanded that the servants henceforth call the little boy, *Mister* Demara. Each servant stepped forward, bowed, and said, 'Happy birthday, Mister Demara!'. The boy

assumed a royal posture, took four roses from a vase, and gave each servant a rose. His act became a family legend which, with each retelling, encouraged the boy to continue his role playing.

There is also evidence that many impostors were reared to relate to their audiences in the same warm, giving way that Teddy did. Newspapers regularly report that when some impostor has been exposed, a number of citizens come forward to say that he should not be condemned, that he is a fine, giving person whom everyone loves. The impostor is not a cold, unrelated 'as if' or schizoid character. On the contrary, it is his warmth, unusual relatedness, and devotion to the feelings of others that make him such an appealing character. We are all brightened and entertained by him until we find he is a sham, a sick person, a child pretending to be something he is not and fooling people who really want to be fooled. Our observations of Teddy no doubt pertain to most impostors: the audience plays the part of the parents who had wanted to be fooled, who had encouraged the deception and imposture.

Finally, it should be noted that there are certain individuals who are eager to serve as the impostor's audience. From Teddy's description of those who were taken in by his deceptions, a picture emerges of people who themselves are suffering from problems of low self-esteem. Olden (1941), in her paper on the narcissistic personality, describes a woman who could love only someone whom she could idealize. Olden says of her patient: 'Although she had given up her own omnipotence, she still had preserved a belief in omnipotence in general. She looked for omnipotent people' (p. 353). Such a person would be a perfect counterpart to an impostor like Teddy whose main motivation is to assume an omnipotent role. The relationship of audience to impostor is much like Freud's (1921) description of the relationship between a group of followers and its charismatic leader. The leader functions as the ego ideal, or idealized object representation, for the group just as Teddy functioned as the ego ideal of his audience and earlier as an idealized phallic object for his mother.

Such a relationship has important implications for the therapy of impostors. Johnson found that she could achieve cures only in cases where the delinquency was mild and the parents were able to change so that they no longer encouraged the antisocial acts of the child. I have already mentioned factors within the impostor that make it difficult for him to give up his pathology and attempt to lead a healthier life. To these inner factors opposing a cure must now be added the strong external or reality factor of his audience, like his parents, encouraging him to be an impostor. While in Teddy's case the struggle for health is still going on, it is easy to see why in most cases the prognosis for the impostor is so poor.

SUMMARY

The case of an impostor who has been in analysis for over four years is reported, with special emphasis on his narcissism, disturbed object relations, and superego development.

The patient's need to appear in grandiose roles is an attempt to overcome narcissistic problems of low self-esteem, the sources of which are painful knowledge of his own ego defects, intense castration anxiety, and concern about feminine identifications and homosexual fantasies.

Other factors that play a part in the patient's character are his considerable talents as an actor and mime, and his use of particular defense mechanisms—denial, rationalization, and splitting. In addition, his parents stimulated his imposturous behavior by encouraging his showing off and lying, thus fostering the development of his grandiose ideals and corrupt though harsh superego.

The parents also provided models for some of his impostures, and his relationship with them later became the pattern for his relationship with his audience, as well as with the analyst in the transference.

The importance of the audience for the impostor is discussed. The type of person who joins the impostor's audience is one who has given up his own omnipotence and hopes to achieve mag-

ically feelings of safety and worth by contact with an omnipotent person. The audience is a suitable counterpart for the impostor whose assumed roles function to fulfil his own grandiose ideals.

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The Meaning of 'Nothing'

Samuel Abrams

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THE MEANING OF 'NOTHING'

I. A NOTE ON 'NOTHING'

BY SAMUEL ABRAMS, M.D. (NEW YORK)

A few years ago, Lewin (1948) suggested that during free association the use of the term 'nothing' refers to the female genital. More specifically, its use refers to the concept of the female genital from the vantage point of the centrality of the penis in the phallic phase. One of my analysands offered an opportunity to study a bit of the ontogeny of this 'nothing'.

While making a deprecatory evaluation of her chores as a 'typical housewife', this patient remarked that such a critical assessment was a common 'flatitude', thus condensing 'flatus' and 'platitude'. She reacted to her slip with laughter and concomitantly recognized an urge to pass flatus. This called to mind frequent feelings of disappointment when she merely passed gas while attempting to move her bowels. Feces were worth her efforts and had merited praise in earlier times, but flatus was 'nothing'. A certain trait of character was suddenly illuminated. In weighing abstract principles against concrete issues, invariably she had leaned toward the latter. This was a derivative of her infantile judgment about the relative worth of flatus and feces respectively: principles were 'nothing' compared with matter, such as money. Her recognition of this helped overcome a resistance to free association, based on the related misunderstanding that organized material was more valuable than spontaneous ideas and feelings.

Somewhat earlier in the analysis, she had described feeling like a 'nothing' herself when separated from whomever currently represented the image of the omnipotent precœdipal mother with which she was transiently in a regressive symbiotic attachment. Subsequently data derived from attitudes about her 'nothing' genital and her penis envy, of which the flatus-feces and mother-infant issues were regressive equivalents, were to appear in abundance. This amplified and extended the study of her characterological bias concerning abstract versus concrete goals and questions.

Clinically, therefore, differing presenting developmental phases determined differing meanings: 'Everything' was the omnipotent mother, the valued feces, and the envied penis, while 'Nothing' was the helplessness of separateness, flatus, and the absent phallus.

II. MORE ABOUT THE MEANING OF 'NOTHING'

BY LEONARD SHENGOLD, M.D. (NEW YORK)

Abrams amplifies Lewin's remark (1948) that 'nothing' refers to the female genital and suggests that 'nothing' has meanings which change with developmental stages. His patient contrasted her 'nothing' ('helplessness of separateness, flatus, and the absent phallus') with 'everything' ('the omnipotent mother, the valued feces, and the envied penis').

I wish to illustrate another meaning of 'nothing' and of 'nothing' as contrasted with 'everything': the all-or-nothing system of values of the early narcissistic period. The material is from *King Lear.*

'Nothing' is a word that resounds through *Lear,* and much more could be said about its use in the play than is presented here. 'Nothing' appears initially in the first scene. Lear, in the narcissistic dotage of 'second childhood', is giving away his kingdom and his substance to his daughters and yet expects somehow to retain his power. He demands that his children flatter him and promise him gifts and care. He wants to be *the* favorite child, and expects most from his favorite daughter, Cordelia. The two older daughters praise and promise fulsomely; Cordelia, who is about to be married to the King of France, responds differently.

> *Lear*: . . . Now, our joy,
> Although our last, not least; to whose young love
> The vines of France and milk of Burgundy
> Strive to be interess'd; what can you say to draw
> A third more opulent than your sisters? Speak.
> *Cordelia:* Nothing, my lord.
> *Lear*: Nothing?
> *Cordelia*: Nothing.
> *Lear*: Nothing will come of nothing: speak again.
> *Cordelia*: Unhappy that I am, I cannot heave
> My heart into my mouth: I love your majesty
> According to my bond; no more nor less. (I: i: 82-93)

Cordelia expresses her disgust in oral imagery and rejects the false promise of the preferred gifts. She has far more to give than her two selfish sisters. Her 'nothing' means 'not everything'. She speaks for the reality principle, one might say. She sees that the

infantile Lear wants the unattainable—like Narcissus. He wants to give away and still to keep. He demands that the tie between the parent and child be primary—a symbiotic bond that would put him before her husband. His daughter will be his nurse, his perfect mother—full of milk. Of Cordelia, Lear says:

> I lov'd her most, and thought to set my rest
> On her kind nursery. (I: i: 123-124)

If we accept Lewin's interpretation of 'nothing' as a reference to the female genitals, this confrontation scene between parent and child full of repeated 'nothings' can be viewed on one level as a portrayal of a child who wants milk and sexual gratification from the mother and is presented with 'nothing'—the castrated genital. The 'nothing' response to the female genitals of course involves fear and denigration.

Since Cordelia has not fulfilled his needs, Lear hates and disowns her. He has demanded the omnipotent good mother; her 'everything' is needed in part because he must neutralize the destructive fury to which he is so subject. According to my speculations, he would need comfort for his fear of castration as well as his fear of overstimulation. The cannibalistic intensity of his rage (*King Lear* is replete with cannibalistic imagery) is evident in his banishment of Cordelia. Lear says:

> Here I disclaim all my paternal care,
> Propinquity and property of blood,
> And as a stranger to my heart and me
> Hold thee from this for ever. *The barbarous Scythian,*
> *Or he that makes his generation messes* [eats his parent or offspring]
> *To gorge his appetite,* shall to my *bosom*
> Be as well neighbour'd, pitied, and reliev'd,
> As thou my sometime daughter. (I: i: 113-119, italics added)

In the earliest stages of the development of object love, the mother who does not fulfil the infant's needs invokes a terrible and terrifying rage which is then projected upon her—thus it is Cordelia whom Lear depicts as the cannibal. She has withheld the words full of narcissistic promise that he required—an oral gift signifying the breast that offers 'everything'. If Lear cannot have his everything, Cordelia is nothing to him and he negates her existence. The 'everything-or-nothing' value system of the early narcissistic

period of development is not compatible with the tolerance of tension, or with love. The internalization of the parent is yet to be accomplished.

Lear in turn is rejected, robbed and cast out by his false older daughters. He has, the Fool tells him: '. . . madest thy daughters thy mothers; for . . . thou gavest them the rod and puttest down thine own breeches . . .' (I: iv: 170-172). The daughters have been given the power to castrate him. On the heath, in his madness, he sees half-naked 'Poor Tom' and himself as castrated by daughters; again 'nothing' is sounded.

> *Lear:* . . . nothing could have subdu'd nature
> To such a lowness, but his unkind daughters. (III: iv: 67-69)

In his adversity Lear learns the Fool's lesson:

> *Fool:* . . . now thou art an O without a figure. I am better
> than thou art now; I am a fool; thou art nothing. (II: iv: 191-193)

In the storm Lear sees that man is nothing to destructive Nature. He is 'unaccommodated man . . . a poor, bare, forked animal . . .' (III: iv: 105-106). He has lost his kingdom but learns what it is to be a man—the terror and wonder of what lies between 'everything' and 'nothing'.

In his suffering Lear learns to value the love of and for Cordelia. Having lost her he now knows she is infinitely precious. Even if stripped of everything, and in prison, one can be happy if one is loved and loves. To Cordelia he says:

> We two alone will sing like birds i' the cage. (V: iii: 9)

Perhaps the most moving lines in the play constitute Lear's lament for the dead Cordelia. He has attained a full sense of what it is to love—and thus can feel its loss as a man and not as an infant. Lear says to Cordelia's corpse:

> . . . Thou'lt come no more,
> Never, never, never, never, never! (V: iii: 308-309)

The five iterations of 'nothing' in the first scene, full of destructive rage and denial, have been transmuted by love and acceptance into the five iterations of 'never' in the last scene.

The repeated 'never' hammers home the poignancy and terror of irreversible loss which evokes castration as one unconscious

meaning of death; and, returning to the meaning Lewin attributes to 'nothing', castration anxiety is one reaction to the sight of the female genitals by the child. The image and metaphor of 'blindness', so important in *King Lear*, would affect the viewer in part by the putting out of the eyes being unconsciously equated with castration, specifically in relation to incest (Œdipus's blindness) and to forbidden seeing (the primal scene and the sight of the mother's genitals). Lear's figurative blindness is based on his selfish narcissistic values. Like Œdipus he learns to see only by suffering adversity and after renouncing his omnipotence—his kingdom.

The importance of 'seeing' and 'looking' is underlined by Lear's enigmatic last words which finish the 'never' speech. He is describing Cordelia whose body he is holding in his arms:

> Do you see this? Look on her, look, her lips,
> Look there, look there! [Dies]. (V: iii: 311-312)

It may be that part of the effect of these lines, whose meaning has been much debated, has to do with their reference to the female genitals ('lips') and the fantasy of accepting the female genitals that can be unconsciously communicated. The terrifying castrated and castrating 'nothing' has been transformed by the power of love to the precious and the wonderful.

The male infant must learn to love women through the mother, and then she must be given up. Her love teaches him to love. This is all one has to calm the storm of destruction in Nature without and in human nature within. The good mother, like Cordelia, gives the child his due, does not promise everything, and lets him go. By being able to sustain the loss of his kingdom, his Eden, the child can give up the all-or-nothing values for those that make him human.

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BOOK REVIEWS

CLINICIAN AND THERAPIST. SELECTED PAPERS OF ROBERT P. KNIGHT. Edited by Stuart C. Miller. New York: Basic Books, Inc., 1972. 322 pp.

This book contains seventeen of Knight's most significant papers written between 1937 and 1953. Also included are Knight's comments at seventeen clinical conferences held at the Austen Riggs Center between 1947 and 1965. There are, in addition, a complete bibliography of Knight's writings, an introduction by Margaret Brenman-Gibson, a charming and insightful By Way of a Memoir by Erik H. Erikson, and, finally, a very unassuming preface by Stuart C. Miller. The clinical conference discussions, especially, reveal the clarity of Knight's diagnostic acumen and his flexible therapeutic approach, while the formal papers contain his original contributions to the understanding and modified psychoanalytic treatment of chronic alcoholism, the borderline states, and the schizophrenias.

The first and last papers are of enduring historical interest. The former is a delightful account of Knight's visit to Freud in Vienna in 1937; the latter is Knight's address as outgoing President of the American Psychoanalytic Association in 1953. This valedictory presentation, The Present Status of Organized Psychoanalysis in the United States, is a condensed but vivid account of the evolution of psychoanalysis in the United States from the time, in 1911, when anyone with an interest in psychoanalysis could join the American Psychoanalytic Association to the emergence of that body after World War II as a complex, centralized organization with numerous functions including the regulation of psychoanalytic training and, in effect, the certification of graduates of its affiliated institutes. Knight was active in the Association's administrative affairs for fifteen years (1938-1953), the years of its most rapid growth and stormy evolution.

It is sometimes difficult to determine the genesis of psychoanalytic ideas. Knight's paper on the analysis of a minister indicates his early awareness of anniversary reactions. It also sets the stage for the dictum that an analyst does not lightly interfere

with matters of faith. The papers on chronic alcoholism contain many references to technical modifications now taken for granted in the treatment of borderline and psychotic patients as well as to what is currently discussed as the 'real relationship', the therapeutic alliance, and so on. Knight early and repeatedly stressed recognition of countertransference and other feelings toward patients, and he taught that no case report is complete without a record of what the therapist did, thought, felt, and said.

Erik Erikson states that the staff meetings at Riggs, under Knight, were the best he has known. It must be added that these were transported from Topeka. There, too, Knight was a major force together with the Menningers, Rapaport, Tidd, Reider, Lewy, Grotjahn, and various others through several 'generations'. Knight apparently never abandoned the very extensive (and costly) medical, psychological, and psychiatric diagnostic workup and its presentation for discussion by a full staff. At the Menninger Clinic, at Riggs and a few other places, this has been one of the most exciting and effective learning experiences in the annals of American psychiatry and of inestimable value for the beginning psychoanalyst. In this volume, Knight's Remarks at Clinical Conferences gives some of the flavor of these symposia.

Many of Knight's papers are classics, but are not thereby dated. Those included here can be read today with profit. Even colleagues who recall when Knight's ideas were being formulated may discover here for the first time how they emerged crystalized in staff conferences as recently as 1965. Beyond this, as Margaret Brenman-Gibson suggests in somewhat different words, these papers comprise a reaffirmation of the enduring importance of psychoanalytic psychology, progressively developed and flexibly applied, as well as a powerful statement of a humanistic model—as contrasted to mechanical ones—of human personality and individual lives.

DOUGLASS W. ORR (LA JOLLA, CALIF.)

TACTICS AND TECHNIQUES IN PSYCHOANALYTIC THERAPY. Edited by Peter L. Giovacchini. New York: Science House, Inc., 1972. 754 pp.

This large volume is a collection of papers by fifteen authors. There is much repetition and certain sections are somewhat tedious

to read; I feel the book could have appeared with fewer pages without sacrificing any of the richness of the material.

The title implies that the book will deal with the art and science of psychoanalytic technique. In fact, however, the authors focus on only one sector of psychoanalytic technique: the treatment of patients with severe ego-superego deformities and pathology. Giovacchini seems to feel that most analysts today are not aware of the widening scope of psychoanalysis; that many analysts do not attempt to analyze nonneurotic patients. It has been my experience, however, that most analysts feel that many severely ill patients *can* be analyzed successfully, while they know that some neurotic patients prove to be unanalyzable.

The weakness of the book is that the authors do not clearly define the problems and criteria for analyzability and they do not concern themselves seriously with attempting to understand and conceptualize the differences between the psychoanalytic situation and process and the psychotherapeutic one. It may be that the differences are blurred because many of the contributors do not believe that there are any significant differences between psychoanalysis and psychoanalytically-oriented psychotherapy. An important task for psychoanalytic educators is, I think, to clarify these differences in the course of analytic training. The tactics and techniques that have to be used at times with very ill patients have to be considered from the base line of classical analytic technique and with knowledge of the complexity and subtlety of ego psychology.

Analytic educators have an important responsibility and task: to assign supervised cases for our beginning candidates that unfold—of course with the help of a good technique—in a classical manner. Only with this learning experience are candidates able to move on to successfully treat patients where parameters have to be used, or to know when only analytically-oriented psychotherapy is appropriate.

The authors, among whom our English colleagues are well represented, present many interesting vignettes and some excellent discussions of fusion and symbiotic problems, and they discuss a number of intriguing transference manifestations, especially of the narcissistic type. The book does show how several analysts work and think. We do need more of this.

I would recommend the book to students of psychoanalysis and to their teachers to read, study, and most of all, to discuss.

STANLEY S. WEISS (DENVER)

ESQUISSE D'UNE THÉORIE ÉTIOPATHOGÉNIQUE UNIFIÉE DES SCHIZOPHRÉNIES (Outline of a Unified Etiopathogenic Theory of the Schizophrenias). By Ernest Abelin. Bern: Hans Huber, 1971. 274 pp.

Ernest Abelin's book is the outgrowth of a thesis written some ten years ago in the early years of the author's training and, as he modestly reminds us, with limited clinical data and time.

Starting with a moderately detailed cross sectional history of the interaction between a sixteen-year-old psychotic child and the other members of his family (parents and a schizoid younger brother), Abelin attempts to formulate the case on the basis of a few clinical interviews and subsequent follow-up of the case at a distance. A number of other psychotic children and families are alluded to, but in lesser depth.

In the most original portion of the book, the author sets himself the ambitious task of using his clinical formulations as a starting point on which to build a far-reaching, unified theory of schizophrenia in childhood, combining genetic, constitutional, familial, and developmental points of view along with references to Piaget's theory of sensory motor development and Spitz's theory of the organizers. This erudite, highly condensed, abstract piece of work requires very careful reading to grasp the vast pyramid of knowledge that Abelin erects for our benefit. Also included is a thorough review of the literature through 1965. In order to facilitate our task, a summary is included at the start of each chapter.

In a well written introduction, Abelin spells out some of the more obvious pitfalls of his over-all approach: the drawbacks of excessive speculation and the considerable difficulty in anchoring wide ranging theory building on rather limited clinical data. To be sure, his formulations are not inconsistent with his new data, but there is a certain danger in believing that one has 'explained' or understood the clinical facts rather than translated them into another more abstract but not necessarily more enriching language.

The main value of Abelin's theory, in my opinion, is that he has supplied many hypotheses that could lend themselves to experimental validation. His most creative efforts center on the central place he allocates to Spitz's 'organizers' in locating specific fixation points and breakdown in structure formation leading to the development of psychosis. He tries to formulate the intricate interrelated network between structure, function, and further growth.

Over the last decade, our clinical understanding has been enriched by the work of Mahler and the longitudinal studies of major centers such as Yale. Perhaps Abelin can be encouraged to expand his work further and to attempt to apply his formulations to the currently available detailed clinical histories.

FRANCIS BAUDRY (NEW YORK)

THE MIND OF ADOLF HITLER. The Secret Wartime Report. By Walter C. Langer. New York: Basic Books, Inc., 1972. 269 pp.

The Mind of Adolf Hitler originated as a report prepared by Walter C. Langer during World War II at the behest of the Office of Strategic Services. The report, which was held secret for over a quarter of a century after Hitler's death, appears significant on three counts: because of its value to the historian; because it was a 'first' for this country's intelligence services; and because of the official recognition of psychoanalysis the assignment implied.

Is Hitler's personality so vivid to me because I lived through Nazism, or was it re-evoked by the vividness of Langer's report? *Führer* to sixty-seven million Germans, Hitler overshadowed in his apocalyptic ruthlessness both his models—Mussolini and Stalin.

It is to the credit of General Donovan—'Wild Bill' Donovan, head of the Office of Strategic Services—that he was prepared to recognize the possibility of Hitler's being mad, and that he was willing to ask a psychoanalyst to help in trying to understand him.[1] Donovan was impatient with the blindness of politicians and strategists who neglected psychological inquiry into the characteristics of the enemy.

[1] Dr. Langer, in his Introduction, describes a research project of potentially broad scope for psychoanalysis, which Donovan had initiated even before the Hitler assignment. This was a psychological evaluation of the reluctance of American youth to join the Armed Forces and take part in the war already being fought in Europe.

'What we need', Donovan said to Langer, 'is a realistic appraisal of the German situation. If Hitler is running the show, what kind of a person is he? What are his ambitions? How does he appear to the German people? What is he like with his associates? What is his background? And most of all, we want to know as much as possible about his psychological make-up—the things that make him tick. In addition, we ought to know what he might do if things begin to go against him.' It is to these naked, straightforward questions that Langer, as we can see from his chapter headings, tried to give answers.

Langer describes the methods of inquiry which he and his analytic colleagues pursued.[2] As a base line for their study the assumption was made that Hitler belonged in the diagnostic category of a neurotic psychopath. During the course of preparing the report, other possible classifications were suggested but, as Professor Waite so rightly states in his Afterword, the contribution to understanding made by way of these general psychiatric diagnostic terms is minimal. What is significant is that an attempt was made to grasp psychoanalytically the genetics and dynamics of Hitler's personality. All available biographical materials were studied from a psychoanalytic point of view and all available persons who had any direct contact with Hitler were interviewed, among them for instance, the ex-Nazi Otto Strasser; Richard Wagner's granddaughter, the daughter of Hitler's motherly friend Winifred Wagner; and the Jewish doctor, Eduard Bloch, who had treated Hitler's mother. Above all, Hitler's *Mein Kampf* (My Struggle), the bible of Nazism, was put under psychoanalytic scrutiny.

There are unfortunate repetitions of the same material in Parts I through V. However, since the report was written for psychologically and, particularly, psychoanalytically unsophisticated readers, such repetitions—each one from a different perspective—were probably necessary to overcome their resistance and to persuade them of the validity of the arguments. Part VI, which

[2] Langer omits the names of these co-workers. To explain this, he states in the Introduction that he was quite abruptly commanded to meet a firm deadline only a month away. He therefore had to abandon the collaborative effort and complete the final report on his own. The pressure of time 'unfortunately precluded any possibility of submitting the manuscript to the collaborators for their approval or disapproval'.

predicts Hitler's probable behavior when things go against him, is remarkable for the accuracy of its foresight.

As their point of departure, Langer and his colleagues took a statement Hitler made on the occasion of the reoccupation of the Rhineland: 'I follow my course with the precision and security of a sleepwalker'. This was 'an unusual statement for the undisputed leader of sixty-seven million people to make in the midst of an international crisis'. They were also struck by another statement Hitler made. To Schuschnigg, the Austrian Chancellor, he said: 'Do you realize that you are in the presence of the greatest German of all times?'[3] Indeed, Hitler thought of himself as the greatest warlord, the supreme judge, the greatest architect, etc. These ideas of grandeur, so unself-consciously proclaimed, raised at least two questions: How did they come about? And how was it that so many Germans, and even non-Germans, came to believe in this new Messiah?

What were the biographical facts that Langer and his colleageus had to work with? Hitler was born in Austria in 1889. His mother was the third wife of a man twenty-three years older than she, which thus placed Adolf more in the position of a grandchild to his father. He also had a half brother, Alois, seven years older, and a half sister, Angela, six years older. Hitler's father was a retired customs official, irascible, violent, often drunk, and overly impressed with the dignity of his uniform. When Adolf was five years old, a younger brother (Edmund) was born, who died when Adolf was eleven. The mother is described by her Jewish doctor as extremely neat and submissive. (Her photograph gives one an eerie sense of schizoid absentia.)

Adolf did quite well in his elementary school studies, but from the age of eleven on, his social and educational functioning was uneven: he failed in school, was moved from school to school, was

[3] In this connection, Bromberg notes that 'Klara Hitler was very fearful for the life of her fourth child, Adolf, since the three children born before had all died . . . . in this situation we have one of the foundations for Hitler's oft-repeated idea that he was chosen by fate above all others to be followed and obeyed by the German people. The other side of this coin was his frequent preoccupation with thoughts and expectation of imminent death' (*cf.*, Bromberg, Norbert: *Hitler's Character and Its Development: Further Observations*. American Imago, XXVIII, 1971, pp. 289-303).

expelled, and finally, in May 1906, he failed the entrance examination to the Academy of Art in Vienna. Langer sees this dysfunction as related to a deep disturbance caused by the death of the younger brother. Bromberg,[4] however, stressed the importance of the findings of Russian pathologists who examined Hitler's corpse. In the course of the autopsy they discovered what they held to be a congenital monorchism. Bromberg argues that the 'striking change [that] became manifest in [Hitler's] behavior'—he was described by one of his teachers during this period as 'lacking in self-discipline, being notoriously cantankerous, willful, arrogant and irascible'—'corresponds remarkably to that reported by Blos in his study of cryptorchism in boys of about the same age'.[5]

When Adolf was thirteen, his father died suddenly as he was returning from the tavern. Then, some two or three years later, his mother was found to be suffering from cancer, which brought about her death in 1907 when Adolf was eighteen. According to Langer and to Hitler's own description in *Mein Kampf*, after his mother's death, Hitler lived a life of degradation in Vienna, mostly unemployed and occasionally even reduced to begging. Recent investigations undertaken by Werner Maser,[6] however, show that Hitler was by no means as poor as he had pictured himself.[7] It does seem, though, that at some point during those years Hitler did spend a couple of nights in a flophouse.[8] Hanisch, his companion in that period, upon whose report Langer relied a good deal, claims it was during that time in Vienna that, when he was not withdrawn in moody brooding, Hitler began to expound on German nationalism, Austrian deterioration, and anti-Semitism to anyone who would listen. While Langer described Hitler's 'flight to Munich' as a 'flight into health', Maser states that at the time of his move to Munich in 1913, Hitler was in fact a draft

[4] *Op. cit.*, p. 292.

[5] *Ibid.*

[6] *Cf.*, Maser, Werner: *Adolf Hitler, Legende, Mythos, Wirklichkeit.* Munich and Esslingen, 1971.

[7] *Cf.*, Werner Maser in his series of articles on Hitler, *Selbstzeugnisse Adolf Hitlers*, Der Spiegel, 27 Jahrgang Nos. 14-24, April 2-June 24, 1973.

[8] 'Hitler was fibbing and bragging when he later wrote in *Mein Kampf:* "Need and hard reality forced me to come to a quick decision. The scant paternal means had, for the most part, been exhausted by my mother's severe illness." ' (Maser, *op. cit.*, No. 14, April 2, 1973, p. 54. See also, p. 58).

dodger. The Austrian police, with the coöperation of the Munich police, finally caught up with him. When at last he 'presented' himself in Salzburg in February 1914, he managed to get himself adjudged 'totally unfit for military service'.[9]

In contrast with his evasion of military service in Austria was his behavior as soon as World War I was declared. He rushed to join a Bavarian regiment, becoming the neatest of soldiers, who strove to impress and please his officers, even offering to act as their valet. Such behavior made him the butt of the jokes of his comrades, from whom he kept himself apart. Hospitalized in October 1916 for a minor wound, he was soon begging to be returned to the front. In October 1918 he was exposed to mustard gas and was again hospitalized in a state of functional blindness and muteness. Langer comments: 'When he became fully aware of Germany's defeat, he reacted in a typically hysterical manner'.[10] From this state he recovered according to Langer, with the conviction that he must become the savior of Germany and rehabilitate her, raped as she had been by International Jewry, betrayed and stabbed in the back by the Socialists.[11]

After the war, Hitler stayed on in the Army Reserve and, when his speech-making abilities came to the attention of his superiors, was assigned to special propaganda work. The *Putsch* of 1923, which he provoked, was followed by imprisonment in the Landesberg. Here he wrote *Mein Kampf*.

The inferences made from Langer's psychoanalytic examination of *Mein Kampf* provide an illumination of Hitler's personality,

[9] *Cf.*, Maser, *op. cit.*, No. 15, April 9, 1973.

[10] Maser, however, states categorically that the documentation for the fact that the 'blinding was a consequence of the enemy gas bombardment near La Montagne' is unassailable. He also mentions Hitler's own account of this episode, written three years later, in 1921. Hitler, who in 1918 still believed in a future as an artist, suffered great mental anguish and, 'faced (as he wrote) with the fear of permanent blindness, for a moment' lost his head (Maser, *op. cit.*, p. 145).

[11] Henry Lowenfeld points out that the socialist parties, having committed the revolutionary deed of removing the Kaiser but being unable to set up a leader of their own, fell victim to a sense of guilt when they failed to approach a realization of their theoretical plans, and were thus themselves unconsciously prepared to accept the Nazi epithet of 'traitor' (*cf., On the Psychology of Fascism,* published 1935, in Czech, and quoted by Wangh in *National Socialism and the Genocide of the Jews,* Int. J. Psa., XLV, 1964, pp. 386-395).

his fantasies, and conflicts. The basic psychoanalytic assumption is that Hitler's way of externalizing inner and intrafamilial conflicts is by displacement from the personal to the communal sphere. Thus the mother violated by the drunken father, presumably perceived by the three-year-old boy, becomes Germania raped by the hideous Jew. When Germany was defeated, Langer writes, 'to him it was as if his mother was again the victim of a sexual assault. This time it was the November Criminals and the Jews who were guilty of the foul deed, and he promptly transferred his repressed hate to these perpetrators.'

Some of the evidence that Langer submits allows for dynamic hypotheses other than those he offers. For instance, he writes of Hitler's sojourn in Vienna after the death of his mother: 'He seemed to enjoy being dirty and even filthy in his appearance and personal cleanliness. This can mean only one thing from a psychological point of view, namely, that his perversion was in the process of maturation and was finding gratification in a more or less symbolic form.' (The perversion to which Langer alludes was Hitler's known demand to be humiliated and kicked by women, and the deduction Langer made from this and other data, that he also had the wish to be defecated and urinated on by them.) Pursuing this hypothesis, Langer says: 'The fact of the matter is that he probably derived great masochistic satisfaction from his miserable life in Vienna, and it was not until his perversion became full blown and he realized its implications that he fled to Munich in 1913'.

However, we must remember that those years in Vienna followed immediately after his mother's death. Hitler may then, failing in the mourning process, have been in danger of a psychotic identification with a masochistic, castrating,[12] and *dead* mother. The complex sexual perversion which Langer infers may have developed as an avenue for recovery from the ultimately suicidal identification. Through it castration is denied, life is restored to the dead by incorporation, and, through the self-degradation, guilt is expiated.

How suicidal was Hitler throughout his life? It is known that he constantly used his own possible suicide to get his way, and Langer,

[12] Bromberg (*op. cit.*, p. 293) quotes Blos, who points out that in cases of cryptorchism 'the perpetrator of the body damage is in the child's mind identified with the mother'.

noting his wish for immortality, saw this as a deep preoccupation with death,[13] and correctly predicted his ultimate suicide in 'apocalyptic glory'. It is also striking that four of the women with whom he was involved to varying degrees attempted suicide (Susi Liptauer, Unity Mitford, Martha Dodd, Maria Reister).[14] The suicide of a fifth, Renata Mueller, was actually successful as, of course, was that of Eva Braun, who died with Hitler. The cause of death—whether by suicide or murder—of Hitler's niece and probable mistress, Geli Raubal, was never determined.

At many points in his fact gathering, Langer points up Hitler's identification with his mother and his search for a strong father. In the light of this, his assumption of the role of a speech-making politician—like his beer-cellar-frequenting, haranguing, drunken father—might have been for a time life saving. To rush into uniform and to become in this way a man like his father continued this suicide-postponing identification. Yet, of course, by choosing to go to war, he exposed himself to being killed. And, in fact, death in a *Götterdämmerung* was his ultimate aim.

Historical philosophers have an age-old discussion over the question of who is responsible for the march of human history, a leader or those who choose to follow him. Langer is well aware of this debate and of the crucial question it raises in relation to Hitler and the Germans: Why was this 'crazy' man's oratory so effective and why did the displacement of his personal unconscious needs onto the political state so inflame the minds of the German multitudes? Was it perhaps that he perceived their unconscious needs and that these were similar to his own?[15]

Let us first consider Hitler's close associates, his companions in the 1923 *Putsch*. They and many others of their generation shared with Hitler a glorification of the uniform and a psychotic-like need to deny the defeat of World War I. They maintained with him that

[13] *Cf.*, Bromberg, *op. cit.*

[14] *Cf.*, Maser, *op. cit.*, No. 17, April 23, 1973, p. 150.

[15] Speaking of Hitler the speech maker, in the years 1920 to 1923, Maser says: 'In fact this man, who understood how to exploit with such mastery the aggressions and fears of German postwar society, and to politicize the wishful images of a spiritually and intellectually disoriented middle class, had appeared on the scene without a concrete program. What he called a "world view" was only a sponge that sucked up what Hitler's environment thought and felt' (*op. cit.*, No. 16, April 16, 1973, p. 169).

had it not been for the 'stab in the back' and Jews like Rathenau, there would have been no defeat. Putting themselves into uniform and marching through the street, hand on belt buckle, they followed Hitler, gathering to them all like-minded ex-soldiers and other, younger men who had 'just missed' the war. The same need to deny defeat was also felt in much wider circles. It showed up in the education of the next generation, those born shortly before or during the war. (For this reader, the teaching of German history ended with the victories at Tannenberg in 1914. What followed was passed over lightly. Finally, the booklet containing the Weimar constitution—the constitution under which we were then living—was handed to us without much comment.) This was the generation which, as I have described elsewhere,[16] flocked to the S.S. and the S.A. They had been sensitized in their childhood during World War I, and for them the Great Depression—by which Germany was more severely hit than any other European country—coincided with the normal crisis of stepping into manhood. For them the future looked bleak indeed. This dark outlook opened the way to a retreat to childhood ideals based on fantasies of soldiering, revenge, and victory. These common ideals found their echo in the political ideology of Hitler, and their libidinal expression in deification of him.

In his report, Langer brilliantly describes the interaction between Hitler and the masses he addressed. On the platform Hitler is nervous and begins by stammering, as though he were unsure of the wishes of the masses before him. Then, sensing these wishes like a fine seismograph, he swings into action and pours out a 'steady stream of filth . . . until both he and the audiences are in a frenzy'.[17] Langer comments that 'the steady stream of filth he spreads on the heads of his "feminine" audience, is the reverse of his masochistic perversion that finds gratification in having women pour their "filth" on him'.

[16] *Cf.*, Wangh, Martin: *National Socialism and the Genocide of the Jews: A Psycho-Analytic Study of a Historical Event,* Int. J. Psa., XLV, 1964, pp. 386-395 and *A Psychogenetic Factor in the Recurrence of War*, Int. J. Psa., XLIX, 1968, pp. 319-323.

[17] As early as 1919, a Munich professor, Karl Alexander von Müller, who heard Hitler talking to a small group of soldiers and students, described the relations between him and his audience: 'I had the strange feeling that their excitement was his creation and that simultaneously it, in turn, gave him his voice'. Quoted by Maser (*op. cit.*, No. 16, April 23, 1973, p. 158).

Was Hitler's behavior, including what is symbolized by the self-degrading, self-punitive perversion, then also reflective of the psychic disposition of at least a large portion of his audiences? If, speculatively, we were to say with Langer that Hitler expiates in this fashion his guilt over death wishes against his mother, did not his youthful followers suffer from a similar psychological constellation? Longing for an absent soldier father, whom they had also wished dead, they suffered intensified death wishes against him because of his defeat. They too had developed considerable rage against their lonely, seductive, and punitive mothers who betrayed them when the fathers returned. Furthermore, such murderous wishes, disappointment, and rage were in many instances re-enforced by oral sadistic and passive fantasies developed during the famine of 1917-1919. This whole complex of feelings was reawakened in the 1930's, at the time of the economic depression. The guilt for the hatred involved was once more--as in childhood—warded off by splitting: father and mother, *Führer* and fatherland were idealized, while all hate and deprecation were expressed in the diabolization of the Jew. For a more extensive discussion of the psychological processes at issue, see my paper, National Socialism and the Genocide of the Jews.[18]

Since the end of the war, historian Robert Waite,[19] who has worked in close collaboration with our colleague, Norbert Bromberg, has immersed himself deeply in the study of Hitler's personality. In his Afterword to Langer's book, Waite discusses the neurotic aspects of Hitler's personality, the understanding he himself had gained from Langer's insights, and the 'limitations of the traditional approaches'. However, for all his appreciation of Langer's efforts and his recognition of the 'irrational and unconscious urges' that helped to shape Hitler's life, Waite does feel the lack of an adequate description of the historic setting and of the ideas that led to the ideology of the Nazi movement.

[18] *Cf.*, Wangh, *op. cit.*, 1964.

[19] Robert G. L. Waite, Brown Professor of History and Chairman of the Department of History at Williams College, Williamstown, Mass. His publications on the subject include Adolf Hitler's Anti-Semitism: A Study in History and Psychoanalysis, in *The Psychoanalytic Interpretation of History,* edited by Benjamin B. Wolman, New York: Basic Books, Inc., 1971 and *Adolf Hitler's Guilt Feelings,* Journal of Interdisciplinary History, I, 1971, pp. 229-249.

Despite its deficiencies, Langer's report is significant because it shows the value a psychoanalytic inquiry can have for political science and history. In the Preface to the report, the dean of American historians, William L. Langer, Walter Langer's brother, pleads for interdisciplinary exchange between historians and psychoanalysts. It is with pleasure that this reviewer recalls the privilege of having participated with both Professor William Langer and Professor Waite in just such an interdisciplinary effort, the colloquium on the Alternation of War and Peace, at recent meetings of the American Psychoanalytic Association.

Researchers in psychohistory will be stimulated and perhaps encouraged by Dr. Langer's Secret Wartime Report. The possibility of a total holocaust with which mankind now lives makes the study of man's drive for war a most urgent task.

MARTIN WANGH (NEW YORK)

THE SCOPE OF CHILD ANALYSIS. By Victor Smirnoff. New York: International Universities Press, Inc., 1971. 233 pp.

Although the author states that his book was not written for psychoanalysts, but for all those interested in the 'human sciences', his comprehensive approach and delineation of the theories and practices of child analysis will be particularly helpful to students of psychoanalysis. It will also serve as a useful basic textbook for psychoanalytic candidates.

Originally published in French in 1966, the book has been completely revised and brought up to date by the author for this English translation by Stephen Corrin. M. Masud R. Khan observes in the foreword that 'too often analysts writing in one language disregard the researches in other countries'. This translation provides the English reader with a hitherto unavailable bridge to this European study.

The book is organized into eight sections: Definition; The Scope of Child Analysis; Basic Concepts; Infantile Sexuality; Object Relations; Analytic Practice; Indications for Child Analysis; and The Parents. The first two chapters offer basic definitions of psychoanalysis as a therapeutic discipline and general psychology and attempt to demonstrate the scope of child analysis. So many studies, approaches, and divergent views are presented in such condensed form that some confusion may occur concerning both the range and

usefulness of psychoanalysis. Fortunately, many of the issues are clarified in the chapters that follow.

Thus the subsequent sections present a comprehensive outline of classical freudian theory and clear descriptions of some of the divergent views. The chapter on object relations covers the work of many researchers, including Freud, E. Kris, Spitz, Piaget, Hartmann, Melanie Klein, Anna Freud, Winnicott, Mahler, and others.

Perhaps the most valuable contributions are the descriptions and comparisons of the two major schools of child analysis: that of Anna Freud and that of Melanie Klein. The summary of Melanie Klein's views on unconscious fantasies in the constitution of the object is admirable for its clarity and should be particularly helpful to the student in understanding the theoretical basis for the techniques used by Mrs. Klein and her followers. The special meanings of Kleinian terms such as paranoid-schizoid position, depressive position, and projective identification are clearly presented. In addition, some criticisms of Kleinian theory (Glover and Lebovici) are included. The discussion of Kleinian technique in terms of approach, use of play, and the role of fantasy are also helpful. Smirnoff deals with the cloudy area of criteria for termination of child analysis primarily by introducing thoughtful questions without proposing specific answers to them.

Though the comparison of techniques of the Anna Freud and Melanie Klein schools reveals an understanding of both, some of the author's conclusions raise questions for this reviewer. For example, Smirnoff states that the differences between Miss Freud's and Mrs. Klein's opinions are defined most clearly on the subject of transference. To state this is to disregard some recent works by members of the Anna Freud school such as S. Fraiberg and M. Harley. In addition, Smirnoff fails to distinguish between transference reactions and transference neuroses, and seems to relegate to positions of secondary importance the analysis of defenses, the effect of structural theory on therapy, and rules of evidence that would be considered so essential by members of the Anna Freud school.

Comparison of the two major schools continues in relation to indications for analysis and the role of parents. The significant differences summarized in these sections stress Anna Freud's examination of structural elements and discussions of pathology as the basis for decisions about the usefulness of analysis. Miss Freud's

school maintains that real relationships with parents must be taken into account not only in evaluating and recommending the type of treatment, but throughout the course of analysis. The child analyst, unlike the analyst of adults, is faced with the parents from the onset of treatment and the total family situation must be considered throughout the analysis. The Kleinian school, on the other hand, regards the fantasy life of the child as the basic determinant and cause of neurosis. In considering indications for treatment, Mrs. Klein and her followers disregard almost all reference to the child's conflict with 'real parents'. Since the present parental relationship is of secondary importance to the fantasied relationship in the child's imagination, Kleinians regard the role of real parents as less important in the treatment than the role of imaginary introjected parents.

Smirnoff's goal, as expressed in his concluding remarks, is to establish an essential unity between child and adult psychoanalysis. However, this work does not convince the reader that such a unity exists. This failure may be due to the condensing of such a large body of knowledge and theory into one volume. Though it is made clear that the child analyst may use the same theoretical framework as the adult analyst, this volume nevertheless reveals the significant differences in methodology which suggest that child and adult analysis are essentially separate forms of psychoanalytic discipline. In addition, Smirnoff fails to justify his proposition that every analyst should have the experience of analyzing a child, for he does not resolve the problem of whether every analyst is capable of working with children. The author does, however, succeed in presenting an introduction to the subject of child analysis which should encourage and help the reader to pursue his own investigations further. This is a scholarly work that will add to the knowledge and understanding of all serious students of analysis.

JOHN J. FRANCIS (WASHINGTON, D.C.)

CHILDHOOD PSYCHOPATHOLOGY. AN ANTHOLOGY OF BASIC READINGS. Edited by Saul I. Harrison and John F. McDermott. New York: International Universities Press, Inc., 1972. 903 pp.

This bountiful volume is divided into nine parts, with a large section on development and several that address themselves to various

emotional disorders, including sections on learning disabilities, mental retardation, and brain dysfunction. The editors have selected fifty-five different papers representing almost as many contributors. The wide range of interest of the editors is expressed by their inclusion of historical papers which were milestones in child psychiatry with those representing the advances of recent years.

Psychoanalysts will be interested to note that the first paper in the book, The Innate and the Experiential in Child Development, is by John D. Benjamin. Freud's paper, The Etiological Significance of Sexual Life, Hartmann, Kris, and Loewenstein's Comments on the Formation of Psychic Structure, Anna Freud's The Concept of Developmental Lines and her paper, The Role of Bodily Illness in the Mental Life of Children, are included. In addition, papers by Spitz, Bowlby, Levy, Fraiberg, and Adelson indicate the scope of the volume. The editors have collected those writings that they feel are essential for teaching on the undergraduate, graduate, and postgraduate levels; and they present the volume as a reference book. Surely all those who are engaged in teaching will find it useful, as will those who like to have a convenient reference book.

Such an anthology cannot be reviewed in detail, nor would it be advisable to compare one's own preferences among papers on particular subjects with those the editors have selected. As I began to read through this nine hundred and three page book, I felt it would have been advisable for the publishers to have divided it into at least two volumes. In spite of its awkwardness, this large volume is a most welcome publication; its readers will find themselves immediately absorbed in the familiar papers and in those pertaining to their present interests. The classic papers in child psychiatry to be reread in this work are: Leo Kanner's Early Infantile Autism, Lauretta Bender's Childhood Schizophrenia, Jean Piaget's The Relation of Affectivity to Intelligence in the Mental Development of the Child, Peter Blos's Puberty and Adolescence, Margaret Mahler's On Child Psychosis and Schizophrenia: Autistic and Symbiotic Infantile Psychoses, Fritz Redl's Ego Disturbances, and E. James Anthony's An Experimental Approach to the Psychopathology of Childhood: Encopresis. The authors speak from different theoretical and clinical points of view, but it is apparent that the contribution of child analysis to the field of child psychiatry is outstanding.

The editors offer an introductory commentary with each paper.

It is their purpose to help the student gain perspective by 'placing the paper in proper context'. Moreover, they wish to formulate those issues which need further clarification and 'to guide the student who wishes to pursue a subject beyond the confines of this volume'. These commentaries are scholarly and an excellent aid to the student as well as to those who teach in the field of childhood psychopathology. The reviewer finds this anthology praiseworthy and to be recommended to students, researchers, and practitioners.

PETER B. NEUBAUER (NEW YORK)

CHILD STUDIES THROUGH FANTASY. Cognitive-Affective Patterns in Development. By Rosalind Gould, Ph.D. New York: Quadrangle Books, 1972. 292 pp.

Every now and then one reads a book about young children which evokes a feeling of delightful discovery. My first reading of Isaacs, Erikson, Anna Freud, Mahler, and Piaget, for instance, not only enhanced my understanding of my own experiences with children but encouraged me to go back and re-examine those experiences. This book impresses me in much the same way.

The author uses protocols of fantasy play observations of three-to-five-year-old nursery school children. She complements this with a review of the observations of Piaget and some reports on young children in a Head Start program. She describes consistencies in cognitive-affective patterns of development as well as sex, individual, and group differences. Her self-appointed task is to show that protocols of this kind can be used for the study of the interrelationship of affective and cognitive capacity in ongoing development. In addition, she explores structure formation, the organization of schemata within the ego and superego, and ego and superego functions which evolve *pari passu*. She pays particular attention to this evolution as it relates to aggression in both its positive and negative aspects. The development of the moral sense in young children takes up the latter part of the book and includes many different topics ranging from narcissistic issues to the importance of the first year of life and a critique of Piaget's hypotheses.

Certain key concepts are immediately stated and defined. A young child develops a 'sense of entitlement' and a 'wish to please'. These act as affective organizers. They derive from the child's experience

of having his demands and needs readily and consistently met. There is a 'core self–self image' which is precipitated by a child's early impulse-life experiences. Along with this there is the organization of the child's body image. Self-representations in these protocols are expressed in terms of 'direct I' versus 'distance-from-self' statements and play. There are three major types of identification, one or the other of which can consistently characterize a particular child. The child might identify primarily with the provider or protector, with the victim, or with the aggressor. The capacity to distinguish between 'pretend' and real dangers is a developmental achievement. This function, when impaired, can be described as including a state of fluctuating certainty. Children develop consistencies in their 'limited versus global' self-condemnation in regard to their thoughts, feelings, and activities. Limited self-condemnation is a developmental milestone which lends shape to an emerging benign superego, to superego constancy, and to a sense of health in alliance with superego introjects. There is emphasis on the reciprocal influences of the child's inner and outer worlds in his selection and understanding of his experiences. Throughout the book, the reader is made aware of the processes involved in individualization and internalization of conflict.

Concerning superego development, the author convincingly discusses the potential early formation of superego schemata in terms of protective, and not merely 'harsh' internalization. To be sure, the sources of the aggressive investment of superego systems play an important part in her scheme. Among them she includes actual parental aggressions, the child's projection of his own feelings, and his self-critical capacity. Children whose experiences enable them to identify strongly with the provider and to develop a wish to please out of these experiences are more likely to develop superego schema of a protective caste. The wish to please is primordial, as is the tendency toward establishing causal linkages in the ordering of experiences. These two tendencies are important factors in the development of the child's moral sense. The author's discussion of the primordial tendency toward causal linkages is only one example in many of the way she interrelates cognitive development and affective development. This discussion, which includes many testable hypotheses, seems well and closely reasoned. The entire book, in fact, contains many hypotheses that invite further investigation.

They are clearly stated and specific enough to be tested without great difficulty. Obviously, one way of doing so would be to replicate her own techniques relating to nursery school protocols with different groups. It seems to me that these protocols, although based on manifest content, will prove to provide verifiable leads about a child's inner processes.

A quote from the portrait of a child whose prominent identifications are 'with the provider' may demonstrate the kind of statements and hypotheses that should be subject to continued research:

> He is a child who (1) is more likely to have developed distance forms of defense (by age 3) against his aggressive impulses, which represent a developmental advance over direct 'I' forms, and are also more effective, more productive, as a mode of defense; (2) is least likely to experience fluctuating certainty in comparable circumstances; (3) exhibits more reliable aggressive-drive controls in reality (related to superego constancy), or is more responsive to this ideal; (4) demonstrates more capacity for empathy, remorse and felicitous efforts toward 'reunion'; (5) is more likely to express a limited than global type of self-condemnation; and (6) in his fantasy expressions reflects a greater freedom to utilize his aggressive energies for creative elaborations of his underlying conflicts (pp. 267-268).

This is not an easy book to read, not because the literary style is muddled but because the wealth of observations, ideas, and suggestions on these pages require such close attention.

JOSEPH AFTERMAN (SAN FRANCISCO)

BEREAVEMENT: STUDIES OF GRIEF IN ADULT LIFE. By Colin Murray Parkes. New York: International Universities Press, Inc., 1972. 233 pp.

Colin Murray Parkes has written a welcome addition to the literature on the nature of the process the individual passes through when a loved person dies. Using Bowlby's 'protest-despair-detachment' model of the normal mourning process, Parkes provides a wealth of clinical material and statistical data on a psychiatrically normal and on a psychiatrically disturbed group of mourners. He deals with such issues as the factors that lead to a normal mourning reaction and those that seem responsible for atypical, disturbed responses; the role of medication and physical symptoms in mourning; the relationship of mourning to physiological changes; and how the

type of relationship between the mourner and the deceased person determines the nature of the grief experience.

Many of the phenomena characteristic of mourning pointed out by previous investigators are cited by Parkes, such as idealization of the dead person, identification with him, and denial of the reality of the loss. Parkes draws parallels between elements of the mourning process and such processes as the alarm reaction and traumatic neuroses. He points out that the major distinguishing factors in disturbed mourners are delayed or prolonged grief, feelings of guilt, and self-reproach.

Parkes's work is a continuation of and enlargment upon the earlier contributions of Freud, Bowlby, Pollock, Lindemann, Barnacle, Anderson, Lehrman, Schmale, Moriarity, and Marris. It is one of the few book-length studies of the subject and should be required reading for students of grief and mourning.

JILL MENES MILLER (BROOKLYN, N.Y.)

CLINICAL SUPERVISION OF THE PSYCHIATRIC RESIDENT. By Daniel B. Schuster, M.D., John J. Sandt, M.D., and Otto F. Thaler, M.D. New York: Brunner/Mazel, Inc., 1972. 334 pp.

During the last twenty years many talented psychoanalysts have dedicated considerable time and energy to supervising psychiatric residents in the psychotherapeutic work with outpatients. The high quality of this supervision has inspired many qualified residents to apply to and be accepted by psychoanalytic institutes. A good supervisory experience focused on long-term therapy with neurotic and borderline outpatients will convince the psychologically oriented resident of the validity of unconscious conflicts and of the way transference and countertransference reactions influence the psychotherapeutic process; it will whet his appetite for the kind of in-depth understanding of these issues that comes from training in psychoanalysis. Particularly now, when the funding of psychiatric residency training programs has been shut off by a shortsighted federal administration and residents are offered a barrage of therapeutic approaches that ignore depth psychology, it is essential that those committed to psychoanalysis reaffirm the crucial part that long-term supervision of psychotherapy should play in the teaching of psychiatric residents.

Schuster, Sandt, and Thaler are obviously so committed and reaffirm this commitment in their scholarly treatise on the clinical supervision of psychiatry residents. Reading between the lines, one gains the impression that they have carved out with considerable persistence a piece of the turf of the Rochester Residency Training Program for outpatient supervision and have defended it with unwavering vigilance against the claims of competing interests. The residents in this program spend six months in their second year working with outpatients in some depth and have the opportunity to discuss their work with experienced supervisors. The structure of a residency training program is as much dictated by financial and service needs as it is by the philosophy of those who direct it, but a six-month period is at best a barely adequate apprenticeship for beginning to acquire the highly complex skills needed by a psychotherapist. It is true that many talented psychotherapists have had even less training and, of course, if a resident subsequently undertakes training in psychoanalysis he will be in a position to develop his potential both as analyst and therapist. But there are many residents who require several years of learning what they can and cannot do with a psychodynamically oriented approach in an outpatient setting to convince them that there is much to be gained by applying to a psychoanalytic institute.

The largest portion of this book is devoted to a thorough and helpful review of the divergent approaches toward supervision of psychiatric residents suggested in recent years. One of the most important questions raised is how far supervision should be directed toward calling to the therapist's attention his own difficulty in working with his patient and in his exchanging information with his supervisor. Ekstein and Wallerstein advocate helping the resident with his 'learning problems' and with his 'problem in learning'; that is, they point out countertransference reactions to the patient and transference responses to the supervisor when these reactions interfere with the psychotherapeutic and the learning situations, although they do not interpret the neurotic basis of these problems. Tarachow, on the other hand, believed that supervisory activity should be confined to a 'patient-centered focus' and that the supervisor should use the resident's transference to him only by 'displaying himself as a model'. The authors of this book discuss these divergent views as well as a number of other pertinent issues

in a very thoughtful and sensitive manner and are quite successful in avoiding a dogmatic tone.

The book's weakness stems not from the authors' lack of experience or skills, both of which are obviously extensive, but from the state of the art of itself. Supervision is in fact too much of an art. Outside of Fleming's and Benedek's outstanding contributions to psychoanalytic supervision, there have been few attempts to delineate the supervisory process in a systematic way that might enhance diagnostic and procedural issues. Ekstein and Wallerstein's categories of 'learning problems' and 'problems in learning' are useful but speak only in a general manner to the many options confronting the supervisor of psychotherapy. The lack of focus of the discussion in the last section of this book, in which the authors offer transcribed interchanges among themselves and with their equally experienced colleagues about supervisory problems, brings home this absence of a sophisticated conceptual approach to supervision. It is essential that experienced supervisors of psychiatric residents dedicate themselves to developing an approach that will highlight the pertinent supervisory options, delineate the criteria by which supervisory choices are made, and clarify the cues that will inform them whether or not their choice was the correct one.

PAUL G. MYERSON (BOSTON)

MODERN PSYCHIATRY AND CLINICAL RESEARCH. Essays in Honor of Roy R. Grinker, Sr. Edited by Daniel Offer and Daniel X. Freedman. New York: Basic Books, Inc., 1972. 320 pp.

This volume, a *festschrift* prepared by the students, collaborators, and colleagues of Dr. Roy R. Grinker, Sr. and edited by Dr. Daniel Offer, the Associate Director of the Michael Reese Psychiatric and Psychosomatic Institute, and Dr. Daniel X. Freedman, the Chairman of the University of Chicago, Pritzker School of Medicine, Department of Psychiatry, honors Grinker on the occasion of his seventieth birthday for his many clinical, theoretical, research, and training contributions. The thirteen chapters in this book begin with an essay by Talcott Parsons, Field Theory and System Theory: With Special Reference to the Relations between Psychobiological and Social Systems. This area, one of Grinker's main interests, was the focus of a conference on A Unified Theory of Human

Behavior. Grinker chaired the conference and was later the editor of its published proceedings. In the volume being reviewed, Grinker's former students, John P. Spiegel, David A. Hamburg, Donald Oken, Seymour Levine, and Melvin Sabshin, each contribute chapters bearing on their present work or on the reassessment of Grinker's earlier research. Other behavioral scientists present essays that illuminate research works and concerns of Grinker: Marvin Stein writes on psychosomatic medicine, Brewster Smith discusses normality, Robert Wallerstein essays a presentation on transactional psychotherapy, Aaron Beck presents a synthesis of the phenomena of depression, and David Shakow describes the Worcester State Hospital research on schizophrenia. Jarud Dyrud, a colleague of Grinker's at the University of Chicago, addresses himself to The Treatment of the Borderline Syndrome.

The last chapter, written by the editors and Mrs. Judith L. Offer, is a succinct, stimulating and excellent overview of The Psychiatrist as Researcher. These three writers have also done an excellent job in summarizing, organizing, and ordering in the first appendix the research undertaken by Grinker. The second appendix, presenting Roy R. Grinker, Sr.'s curriculum vitae and bibliography, is an impressive record of this internationally known physician, neurologist, psychiatrist, and psychoanalyst. Grinker is still actively involved in administrative, educational, and investigative work. We undoubtedly will read of his future work; although the volume is impressive, it is not the 'last word'.

GEORGE H. POLLOCK (CHICAGO)

RACISM AND PSYCHIATRY. By Alexander Thomas, M.D. and Samuel Sillen, Ph.D. New York: Brunner/Mazel, Inc., 1972. 176 pp.

Thomas and Sillen have attempted an important, worthy task: to document the evidence of racial bias in research investigators, psychodynamic formulations, sexual myths about Blacks, criteria for patient selection in the delivery of mental health services, epidemiologic surveys, and the assessment of psychopathologic deficits consequent to oppression. I learned much from the authors about the political manipulations in the United States Government Census of 1840, the history of the origin of the word 'miscegenation', the historical context of the Jensen assertions about

genetically determined intellectual inferiority of Blacks, the pervasive denial of black resilience, and exaggerated reports of black 'deficits'.

Unfortunately, the authors are not equipped for one major portion of the task they set themselves, an evaluation of methodology in applied psychoanalysis. They are convinced not only that certain analysts are blinded by covert racist attitudes, but that psychoanalysis as a science has offered nothing very valuable to the study of racial prejudice and probably never will. They base this conclusion on assumptions which reflect their ignorance of some basic aspects of psychoanalysis.

For example, they cite a 1914 paper by Lind surveying the manifest content of the dreams of one hundred Negroes, in which Lind concluded that since these were dreams of simple wish-fulfilment such as Freud had described in children, then Negroes clearly had childlike minds. It may very well be that Lind's racist attitudes were a major element in his publishing such a study, but the authors do not question whether associations were utilized for the 'analysis' of these dreams. This lack of basic psychoanalytic knowledge is reflected in their definition of transference: 'The term transference is used by psychiatrists to designate the irrational and inappropriate attitudes that a patient may develop toward the therapist' (p. 144). Consequently in their quite accurate criticism of the conclusions of some more complex, modern psychoanalytic studies, the authors seem unable to discern the difference between racist attitudes, applied psychoanalysis, and if I may suggest a term, misapplied psychoanalysis. For example, a study by Doris M. Hunter and Charlotte G. Babcock comparing the psychology of a group of black people with the vicissitudes of the symbiotic phase postulated by Mahler is offered as an example of covert racism. My own reading suggests not racism, but conceptual confusion and methodologic error.

The authors are correct to criticize these studies. But instead of asking what valid methodologic criteria *could* be devised to enhance the psychoanalytic contributions to the future study of racism, they have concluded that racial oppression is simply a manifestation of white exploitation of Blacks on a mostly conscious basis. They are convinced that psychoanalysis is too 'pathology and individual-oriented' and that to postulate unconscious

determinants of the propagation of racism is only to absolve racists of full 'responsibility' for their racist behavior. They state, for example, that '. . . Black liberation becomes contingent on emancipation from the id' (p. 106).

The prevailing impression conveyed to me by this book was that an effort was made to present the *appearance* of scientific objectivity toward psychoanalysis. The exclusion of quite basic psychoanalytic references is telling. For example, the authors have ignored basic psychoanalytic work on prejudice by Freud, Loewenstein, Spitz, Róheim, and others. They express concern that white therapists may ignore a black patient's realistic complaints. They do not mention Greenson's excellent discussion of this problem concerning one of his own black patients, but they did manage to locate an article by L. L. Brown entitled Psychoanalysis versus the Negro People in a periodical called Masses and Mainstream. They describe as 'trenchant' the paper by a sociologist who correctly described the 'domineering black mother' as a stereotype, but who went on to say that this stereotype is part of a 'divide and conquer strategy . . . it has been functional for the white ruling class, through its ideologic apparatus, to create internal antagonisms between black men and women to divide them and to ward off effective attacks on the external system of white racism' (p. 96).

In their preface the authors allude with unintended irony to well rationalized prejudice on the part of certain behavioral scientists who 'may even feel that their concepts further the struggle against racism'. They say their concern is with scientific validity and social consequences. In actuality, they are more concerned with the latter. They erroneously believe they have essentially understood the complex and profoundly important problem of racism and they wish us simply to rid ourselves of it. Now.

DALE BOESKY (DETROIT)

ADVANCES IN PSYCHOSOMATIC MEDICINE, VOLUME 6: DUODENAL ULCER. Edited by H. Weiner. Basel: S. Karger, 1971. 200 pp.

'Ulcer in man is probably *the* classic example of a psychosomatic disease.' This is the opening sentence of a remarkable volume of essays organized by Herbert Weiner, the Editor-in-Chief of the

journal, Psychosomatic Medicine. Two chapters are long, distinguished, and undoubtedly definitive: Induced Gastric Lesions in Animals by Robert Ader and Observations on Man by Joel Yager and Weiner. Additional chapters by D. State, Manfred Pflanz, Muller-Wieland, and F. W. Ossenberg and John C. Nemiah, although shorter and perhaps less distinctive, are of an excellent quality. Pflanz's contribution parallels a recent challenging review by Susser[1] and takes a different point of view. Pflanz's bibliography (two hundred twenty-nine references) is likely to be the superior one. Short discussion sections included in the book serve the purpose of review and criticism for longer chapters.

John Mason chooses to use his space for a provocative discussion of psychosomatic research. George Engel and Howard Spiro are gently critical in a chapter on medical and psychiatric management. A 'summarizing review' by Franz Reichsman (pp. 195-200) serves to balance apparently critical comments made elsewhere. In a charming, brilliant account he points out the pioneering contributions of Franz Alexander and Arthur Mirsky and their effect on subsequent developments in psychosomatic research and theory.

Readers of this journal and/or anyone contemplating writing about duodenal ulcer from a psychoanalytic, psychiatric, or psychophysiologic view are advised to focus their attention on the heart of the book: Chapter Two—Observations in Man with Remarks on Pathogenesis by Yager and Weiner. Fifty-eight pages in length, it is, in an excellent, dense way, 'compact'. An enormous and diverse literature (two hundred forty-four references) is covered with erudition and precision. While initially the article may give an impression of faultfinding and nihilism, after several readings it seemed to me that important issues are handled fairly, with sharp intellectual comprehension. The bibliography is clearly the best available. Especially interesting are discussions of the work of Alexander, Mirsky, the Chicago Institute, Avery Weisman, Margaret Thaler Singer, Sidney E. Cleveland and Seymour Fisher.

Concerning Chapters One and Two, John Mason states:

> I read these two truly authoritative reviews on peptic ulcer research with admiration and pleasure. They provide not only thorough coverage of

[1] *Cf.*, Susser, Mervyn W.: *Causes of Peptic Ulcer. A Selective Epidemiologic Review.* J. Chron. Dis., XX, 1967, pp. 435-456.

> the field, but are keenly critical and interpretative, particularly with regard to the much-needed emphasis on methodological and tactical approaches. The authors also emphasize the general value of peptic ulcer research as a model in the psychosomatic field, in that it provides unusually extensive experience with both animal and human approaches. Many of the problems encountered and the lessons learned in peptic ulcer research almost certainly should apply in a general way to research in many other psychosomatic disorders (p. 99).

And Reichsman comments:

> It is clear that the contributors to the volume recognize that the etiology and pathogenesis of duodenal ulcer disease are influenced by the interaction of multiple factors. While assigning different degrees of importance to them, the writers stress the role of the following factors: genic, peripheral physiologic-biochemical, neural, social and psychological processes.
>
> In Chapters 1 and 2 of this volume, by Yager and Weiner and by Ader, respectively, much of the extensive literature concerning etiology and pathogenesis in man and animals has been admirably pulled together and conceptualized (p. 195).

Pepsinogen studies are mentioned by nearly every author and are discussed in great detail several times. (Yager and Weiner's account is the best.) Although the book was published in 1971, nearly all of the data quoted concerning pepsinogen in the blood and urine, while of classic importance, is now in 1973 suddenly 'out of date'. Recent discoveries of a variety of pepsinogens in animals and man having different electrophoretic and pH-optima characteristics[2] force a reconsideration of interpretations made on data drawn in the 1940's and 1950's. Recent ongoing and projected explorations in Samloff's laboratory, descended in part from the studies of Arthur Mirsky, his associates, and others inspired by their work, should produce data that will clarify issues Weiner sees needing more definitive study. For example, the absence of pepsinogen '5' from the urine of fourteen per cent of an apparently healthy population underscores the importance of genetic factors in gastric secretion and indicates one mode of inheritance of such factors.

For students of duodenal ulcer the entire volume is worth a careful reading.

MARTIN L. PILOT (WESTPORT, CONN.)

[2] *Cf.*, Samloff, I. Michael: *Slow Moving Protease and the Seven Pepsinogens,* Gastroenterology, LVII, 1969, pp. 659-669; and *Pepsinogens, Pepsins and Pepsin Inhibitors, ibid.*, LX, 1971, pp. 586-604.

ADVANCES IN PSYCHOSOMATIC MEDICINE, VOL. 7. HUNGER AND SATIETY IN HEALTH AND DISEASE. Edited by F. Reichsman. Basel: S. Karger, 1972. 336 pp.

Hunger and Satiety in Health and Disease exhibits both the advantages and disadvantages of books that are collections of papers by various authors. On the positive side, it brings together a series of experimental studies which reflect a broadening of the approach to weight regulation. The chapters dealing with genetic, hypothalamic, extrahypothalamic, and peripheral factors agree in emphasizing the great complexity of the neural regulation: that practically every part of the brain is involved in food regulation in one way or another; that the exclusive emphasis on the hypothalamus is in need of revision; and that the differentiation between 'metabolic' and 'regulatory' obsesity needs to be modified. They also reflect that the old dichotomy between the innate and the experiential is no longer tenable and that learning experiences have a modifying influence on physiological factors. However, progress has not yet led to an integration of the various findings into an internally consistent hypothesis.

The section on disturbances in food intake provides evidence that the subdivision of obesity into different subgroups, postulated by clinicians,[1] has an organic correlate in the morphology of the adipose tissue. For instance, hyperplastic obesity shows an increase of the fat cell number, while hypertrophic obesity is correlated with an increase of the fat cell size. The selection of the clinical papers has confined itself to authors with traditional views of the disorders, with an interesting chapter demonstrating that severe weight loss may be an expression of a variety of conditions, not only of anorexia nervosa. Treatment recommendations range from behavior modification, which is described as the superior method for the treatment of obesity, to traditional psychoanalysis for anorexia nervosa, although J. C. Nemiah states that 'the universal value and appropriateness of psychotherapy aimed at uncovering and resolving conflicts is, I believe, open to question'.

[1] *Cf.*, Bruch, Hilde: *Eating Disorders: Obesity, Anorexia Nervosa and the Person Within*, New York: Basic Books, Inc., 1973; Cioffi, L. A. and Speranza, A.: Physiological and Psychological Components of the Body Weight Control System in the Obese. In: *Bibliotheca 'Nutritio et Dieta', No. 17*, edited by J. C. Somogyi. Basel: S. Karger, 1972, pp. 154-176.

This book, like many other interdisciplinary efforts, suffers from the bias and restricted vision of what Kubie has called 'organophobic psychologists' and 'psychophobic organicists'.[2] The latter attitude is dominant and openly expressed in Mayer's concluding General Discussion, where he describes himself correctly as 'without any recognized qualification to enter the psychiatric realm' but then proceeds to demolish as irrelevant the thoughtful observations of several clinicians and also of more open-minded experimentalists. 'Unusual behavior' is acknowledged only as expressing some organic or genetic defect, or as a response to societal pressures. Even the delusional body in anorexia is 'explained' in this simplistic fashion, and careful observations on disturbed family relationships, etc., are dismissed as 'unconvincing'.

The book as a whole falls disappointingly short of what might have been of significant help to psychoanalysts.

HILDE BRUCH (HOUSTON, TEXAS)

LSD: PERSONALITY AND EXPERIENCE. By Harriet Linton Barr, Ph.D.; Robert J. Langs, M.D.; Robert R. Holt, Ph.D.; Leo Goldberger, Ph.D.; George S. Klein, Ph.D. New York: John Wiley & Sons, Inc, 1972. 247 pp.

This book is a carefully documented presentation of the relationship between pre-existing personality types and the altered states of consciousness induced by the administration of LSD.

A group of male actors varying considerably in intelligence, socioeconomic background, and personality patterns was selected for the experimental study. All subjects were carefully screened to eliminate gross psychoses and were studied by means of personal interviews, a detailed questionnaire, and a wide battery of psychometric tests including projective studies, human figure drawings, etc. Then, LSD was administered to one group of subjects, and a placebo to a control group.

The psychological data were carefully assessed and categorized into six LSD reaction types. Formal characteristics of the manner of thinking, the content and form of ideation, affective changes, modalities related to perception and nature of experiencing, con-

[2] *Cf.*, Kubie, L. S.: *Problems of Multidisciplinary Conferences, Research Teams, and Journals.* Perspec. Bio. Med., XIII, Spring 1970, pp. 405-427.

trols, identities and degree of self-awareness, and psychological and somatic symptoms were among the variables studied and tabulated. The results indicated a change in the dimensions of cognition and state of consciousness for every subject receiving LSD.

The six groups categorized differed considerably in respect to drive, defense, and adaptive functioning. These varied from gross manifestations of an altered state through a series of 'specific variants of grossly altered functioning to a minimal shift in the organismic state'. For example, in the color-form test, the results indicate a primitivization of perceptual functioning in drug-altered states. In the study of earliest memory recall, partial regression appeared in certain subjects, and in some subjects this led to the recall of previously unreported, earlier, and more drive-dominated memories.

LSD did not produce a regression to more primitive cognitive organizations or lead to the emergence of primary process in every subject studied. Both the degree and nature of the specific regressions were strongly related to the specific personality types. Therefore, this aspect of the work tended to corroborate many of our analytic postulates.

Among the many conclusions reached, only a small sample can be listed here. First, the authors stressed several decisive contradictions of classical analytic theory. For example, although LSD did interfere with the working of cognitive controlling structures, the amount of direct drive derivatives that emerged did not change as significantly as would be expected. Second, it was concluded that LSD is capable of markedly altering thresholds of sexual and aggressive drives, and in some, thresholds were actually raised. Third, it is of special interest that anxiety is not a universal effect of the drug; that in some subjects the emergence of new ideas was the result of a weakening of repression, and that one effect of the prolonged abuse of psychedelic drugs is great passivity influencing the ability to will, to make effort, and to take active control over one's life. Fourth, regression did not occur uniformly 'across ego functions or across the various cognitive functions', and appears to be directly related to pre-existent ego structures such as defenses. Fifth, LSD has potent influences on many physiological functions and these in turn affect psychological structures. Thus, there is a marked interrelationship between the physiological, somatic and psychological effects of the drug.

The book, based on data carefully obtained and evaluated, is well done. It represents a further step forward in our capacity to bridge the tantalizing gap between psyche and soma.

JULIAN L. STAMM (SCARSDALE, N.Y.)

CHANGING FRONTIERS IN THE SCIENCE OF PSYCHOTHERAPY. By Allen E. Bergin and Hans H. Strupp. Chicago: Aldine-Atherton, Inc., 1972. 468 pp.

The authors report on a survey project sponsored by the NIMH on the current status of research in psychotherapy. They specifically limit themselves to individual psychotherapy for neurotic and characterological problems and to three therapeutic models: behavior modification, client-centered therapy, and psychoanalysis. Their extensive review of the literature on research in the therapeutic process and critiques of this review by nine consultants were previously published in the International Journal of Psychiatry in 1969.

The major part of the current work is a chronological account of personal interviews by the authors of some twenty-five different workers throughout the country in the field of research in psychotherapy. Each interview is followed by a critical evaluation by one of the authors, and, throughout the entire sequence, are interspersed various working papers and correspondence related to their project and to the general status of research in the field. As a result one can sense the evolution in their thinking and the gradual modification of some of their plans and ideas as the project unfolded.

The book also makes clear the enormous complexities of scientific work in this research area, and illustrates how some of the workers in the field attempt to simplify them. Issues such as clinical relevance versus scientific rigor, natural therapeutic process as currently practiced versus an experimental paradigm which can be more effectively controlled, statistical elegance versus natural complexity, etc., are repeatedly emphasized. There are frequent discussions of the issues involved in patient variables, therapist variables, and multiple attempts to establish common factors in the therapeutic process relatable to different theoretical approaches. There are also attempts to focus on the problem of theoretical technique vis-à-vis the personality and personal characteristics of the therapist and the various nonspecific aspects of the therapeutic

process. The authors began with the hope of fostering collaborative efforts across theoretical lines, and ended with the realization that effective collaboration among theoreticians of different backgrounds is not yet possible or potentially fruitful.

With a few notable exceptions, throughout much of the book psychoanalysis is heavily criticized both as a theory of the mind and as a therapeutic process. Many of the people interviewed dismiss it as cumbersome, or outdated, or ineffective. Yet throughout the book there is little distinction made between psychoanalysis and psychoanalytically oriented dynamic psychotherapy. The majority of interviewers are from academic psychology and only four of the interviews were held with workers actively identified with psychoanalysis today, although Szasz and Colby are also included.

Unfortunately the style and layout of the book results in much repetitiveness. But this fact also permits the reader to observe the evolving ideas of the authors. This book is not likely to have strong interest for the practicing psychoanalyst, but for anyone whose interest lies in research in the field of the therapeutic process, whether in analysis or elsewhere, it is an important volume for study and reference.

PAUL A. DEWALD (ST. LOUIS)

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M. Donald Coleman

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ABSTRACTS

Israel Annals of Psychiatry. X, 1972.

On the Creative Spells of a Young Scientist. L. Sonnenfeld-Schiller. Pp. 123-136.

Describing the creative activities of a young scientist, the author observes that they begin with regressive moves in which the thinking entails much conflict-laden material. However, the creative mode dominates and is carried out by 'non-regressive movements'. Sonnenfeld-Schiller elaborates this idea in his concept of the nature of the 'igniting sparks', which consist of one from 'above' (the actual scientific realm) and one from 'below' (the infantile wish). Why this process results in true creativity rather than in some form of neurotic stalemate remains unanswered.

Psychoanalytic Observations on Creativity. L. Grinberg. Pp. 137-146.

The author postulates the existence of 'creative potentiality': an innate capacity for the evolution and manipulation of the primary process while connections with reality are maintained. Several other mechanisms based on this paradigm are described. Grinberg suggests that creative processes be seen not only as 'regression in the service of the ego' but also as 'primary process progression towards the ego'.

A Consideration of Some Problems of the Terminal Phase of Analysis in a Parent-Loss Case. Nathan Simon. Pp. 149-163.

Clinical material is used to illustrate two important aspects of the termination process. The first is its relationship to mourning. The author distinguishes between real loss and the neurotic perception of the transference, and believes that the analyst should acknowledge both. The second is that during the termination phase the analyst should recognize elements of the postanalytic mourning experience and help the patient become aware of the future work of handling the loss.

Psychoanalytic Considerations of Fertility and Sexuality in Contraception. George H. Pollock. Pp. 203-228.

In a wide-ranging study that includes a scholarly historical survey of his subject, the author contends that there is a need to distinguish castration and mutilation anxiety from anxiety about fertility. The latter is an adolescent addition to the infantile œdipal conflict and may fuse with it. However, its chief concern is the loss of the procreative function as opposed to the organ detachment or damage of the earlier conflict. Unfortunately, the clinical material in this paper does not clearly illustrate the theoretical distinctions which, nevertheless, remain convincing categories.

Historical Perspectives on the Development of Psychoanalytic Psychotherapy. Robert Marcus. Pp. 289-304.

Much of this article is devoted to the author's views on the distinction between psychoanalysis and psychotherapy. He states that a trusting, nondefensive relationship is necessary for successful analysis; since this does not 'develop' in the majority of patients with neurotic and character disorders, formal analysis is not possible. There is no mention of the analysis of defenses. Psychotherapy, he states, cannot expect to reach the unconscious in any meaningful way; we should therefore give up the notion of interpretations in psychotherapy and make wider use of advice, guidance, and counseling. This approach, Marcus feels, would be more honest and more respectful of the patient than 'interpretations' that are designed to manipulate or to deal with unconscious wishes in a way that mythologizes rather than uncovers them.

Toilet Training by Multiple Caretakers: Enuresis Among Kibbutz Children. Mordecai Kaufmann. Pp. 341-364.

Thirteen hundred seventy-six kibbutz children were included in this study to determine the frequency, duration, and outcome of enuresis. The author reports that very few comparable studies of other children throughout the world can be found. The available literature indicates that in Western cultures the average incidence of enuresis is ten to fifteen percent between ages four to seven years, and eight to twelve percent between seven to eleven years. For kibbutz children aged four to five, thirty-one percent have not yet completed bladder training, and of those between four and seven years of age, twenty-six percent are enuretic—about twice the rate for other children. By ages nine to twelve, however, the ratio is reversed, and by ages twelve to fifteen, the percentage of enuresis in other children is four times that of kibbutz children. The author explains the larger incidence of early enuresis in kibbutz children as due to child-rearing practices that separate toilet training from the intensity of winning or losing maternal love. Further, since the emotional significance of toilet training is relatively reduced, there is less chance of the child using it later as an expression of family conflict. This theory is supported by the relative infrequency of regressive enuresis in the kibbutz child.

M. DONALD COLEMAN

Psychoanalytic Review. LIX, 1972.

A Psychoanalytic Interpretation of Shamanism. Robert F. Kraus. Pp. 19-32.

The scant available literature suggests that the shaman is a 'highly sensitive, affective, emotionally responsive man' who responds to minor environmental stimuli by regression to primary process thinking and perception. In the seance, deep-seated tribal anxieties and wishes are expressed in a dreamlike group trance in which the shaman symbolizes his people. From this a collective dreamlike solution emerges.

The Adolescent Suicides of Romeo and Juliet. M. D. Faber. Pp. 169-180.

Faber views Romeo and Juliet as a play about failed adolescent rebellion. The narcissism (self-love and prideful hatred of others) of the Montagues and Capulets opposes and frustrates their impulse-ridden children in such a manner the children do not recognize its source. Hence they cannot meaningfully rebel.

The Mother: Image and Reality. W. N. Evans. Pp. 183-198.

The tendency to blame neurosis on inadequate mothering originates in the denial of the loss of the sense of omnipotence experienced at birth and from the idealization designed to preserve this omnipotence. Ferenczi, Freud, and Alexander all recognized that reality breeds anger because it contradicts the belief in self-sufficiency resulting from prenatal blissful experience. The mother then becomes the scapegoat.

The Development of Ego Autonomy. Ernst A. Ticho. Pp. 217-233.

Superego development is reviewed and illustrated. Early and global internalizations are succeeded by selective identifications. The need for social support of the superego diminishes, the moral directives become more abstract, and drive qualities reflected in narcissistic perfectionistic ego ideals become less pronounced.

Xerostomia: The Dry Mouth Syndrome. Ralph B. Little. Pp. 235-243.

Xerostomia occurred in a patient who had been hospitalized with somatic delusions and cancer phobia when she undertook extensive dental repair work. The symptom receded when ambivalent oral wishes in relation to her father's and mother's (fantasy) phallus were uncovered. Little suggests that the dry mouth, which made swallowing impossible, reflected the wish to incorporate as well as the defense against that wish.

Two Principles of Reparative Regression: Self-Traumatization and Self-Provocation. Joel Shor. Pp. 259-279.

The 'primary illusion' is an experience in which the subject's aims are identical to those of the environment. In adult love and in certain transference regressions this illusion reappears to some extent, together with unresolved infantile wishes specific to a given patient. The wish to recapture the illusory past is joined with a wish to repair early trauma by provoking situations similar to those in which narcissistic injury took place in the past. In analysis parameters such as encouraging the expression of feelings of hate, dependence, and nausea may need to be introduced to allow the appearance of traumatic cores of precœdipal character fixations. The provocative, self-traumatizing elements consequent to frustration of the wish to realize the 'primary illusion' can thus be identified.

From the Keystone of Comedy to the Last of the Clowns. Ernest A. Rappaport. Pp. 333-345.

Rappaport describes some of the historic personal sources of the humor of Sennett and Chaplin—their photographic tricks, changes of pace and rhythm, and some of the many symbolic meanings of the costumes, situations, and actions in their films. Chaplin's humor asserts a grandiose superiority to and independence of the dangers and restrictions of reality. Perhaps the sense of resignation and apathy in current films reflects social dangers too imminent to be laughed away.

Unconscious Processes in Relation to the Environmental Crisis. Harold F. Searles. Pp. 361-373.

Current world dangers—for example, pollution of the oceans, overpopulation, and disposal of atomic wastes—unconsciously threaten the phallic position (we may have to give up our cars), and stimulate depression (the magnitude of the problem), and paranoia (our dependence on inanimate technology). Other aspects of the current situation also militate against an effective approach to these world problems.

The Therapeutic Community in Private Practice. Herbert J. Freudenberger. Pp. 376-388.

Freudenberger uses a 'therapeutic community' to treat 'emotionally starved' addicted, alcoholic, and schizoid patients. These patients meet in groups for three-hour sessions with and without the therapist, and with the therapist individually. To the extent that they feel able to participate, they do. The therapist and the group members act as parents, teachers, and friends to each other and interpret transference, dream, and genetic elements. The benefits of group and community are combined to overcome the ill effects of the inadequate or destructive family milieu.

Psychoanalysis and History: Problems and Applications. Joseph A. Dowling. Pp. 433-449.

American reform movements have shared a millenialistic air. Populism, for example, looked back to an agrarian Eden in looking forward to social reforms. The belief in a lost paradise and the wish to re-create it, which are applied in efforts to deal with objective problems of the day, derive from subjective experiences of satisfaction in early childhood.

ERNEST KAFKA

Journal of Youth and Adolescence. I, 1972.

Adolescent Thinking à la Piaget: The Formal Stage. Everett Dulit. Pp. 281-301.

The results of the author's studies qualify the conclusions of Piaget and Inhelder which demonstrated formal-stage thinking to be the rule in adolescence.

Two of the formal-stage experiments of Piaget and Inhelder were replicated with groups of average adolescents and adults and groups of gifted adolescents. Only twenty to thirty-five percent of the average population functioned at the fully formal level, while seventy-five percent of a group of scientifically gifted older adolescent boys achieved full formal level functioning. Thus formal-stage thinking appeared more ideal than typical, a potential only partially attained by most.

The Relationship of the Vampire Legend to Schizophrenia. Lawrence Kayton. Pp. 303-314.

With the use of clinical vignettes, Kayton relates the experience, behavior, and psychodynamics of the schizophrenic to the history of the vampire legends. The vampire, usually a young suicide, partakes of another life in an oral sadistic way, then merges with his victim who in turn becomes a vampire. This plot is suggestive of the schizophrenic's fear of his intense, aggressive, devouring oral needs and his fear of fusion. The author speculates about the origin of the vampire myths. Do they represent a projection of the family's guilt over actual oral deprivation, or a conscious knowledge of the suicide's psychodynamics? Concern is expressed about the recent resurgence of interest in the occult, particularly among the young. Perhaps this reflects severe psychopathological pressures in our society.

Drug Use and Level of Anxiety among College Students. Michael Wogan and James P. Elliott. Pp. 325-331.

Basing their conclusions on a statistical survey of one hundred and thirty-eight college students who participated in the study as part of the requirements for an introductory psychology course, the authors disclaim the hypothesis that drug users are more anxiety prone than nonusers. On the contrary, they support those who have found drug users to be less anxious, more adventuresome, and less conventional. The abstracter hopes that these conclusions will be subjected to more detailed psychoanalytic investigation; they leave the impression that drug use is a sign of mental health.

Fantasies about the Fetus in Wanted and Unwanted Pregnancies. Edward C. Senay and Susan Wexler. Pp. 333-337.

Fantasies during pregnancy appear to reflect the mother's emotional investment in her child. This study is based on interviews with a group of women requesting therapeutic abortion and a group who wished to carry their babies to term. The authors conclude that women who wish to abort uniformly inhibit their fantasies. Although aware of the obvious limitations of their study, Senay and Wexler suggest an interesting hypothesis for further research.

Dimensions of Adolescent Self-Images. Stuart T. Hauser and Roger L. Shapiro. Pp. 339-353.

This is one of a series of articles in which the authors propose to investigate self-image processes within both the normal and the psychiatric adolescent patient population. Using techniques derived from information theory, they studied the degree of polarization of various self-images, i.e., between current self-images, maternal, paternal, dream (idealized) images, and temporal self-images. The tentative findings suggest that normal late adolescent boys tend to polarize their paternal and maternal idealizations and that adolescent patients tend to polarize their dream idealizations.

MARION G. HART

Psychiatric Quarterly. XLVI, 1972.

Some Thoughts about Patients Who Run Away from Residential Treatment and the Staff They Leave Behind. Edwin Z. Levy. Pp 1-21.

The many factors that contribute to or precipitate the running away of young patients are described dynamically in terms of the patients' intrapsychic conflicts, the situation at the residence, and the attitude of the staff. Running away is not necessarily a manifestation of pathology, 'sick behavior', or 'acting out'. It is sometimes adaptive, an escape from closeness, often a 'running to' or an assertion of independence. In one case it heralded the beginning of a therapeutic alliance when the patient volunteered to return. Group dynamics are also important, particularly when there is an epidemic of runaway behavior or when youngsters run away in pairs.

The author distinguishes between treatment needs and developmental needs, which are not always compatible. The response of the staff to runaway behavior is examined in the light of the psychiatrist's fear of abandonment and the mobilization of aggression within himself. This paper will be of particular interest to analysts because the problems examined pertain also to nonresidential analytic patients who flee from (or to) in the course of their treatment.

Fatherhood and Mental Illness: A Review and New Material. Roy B. Lacoursiere. Pp. 109-122.

This paper describes patients whose mental illness manifests itself in association with becoming a father. Besides such factors as dependency on the wife (mother) and resentment of the intruder, the following sources of anxiety are discussed: 1, guilt associated with aggressive impulses toward the wife and baby, which reactivates earlier aggressive feelings toward the patient's own mother, father, or sibling; 2, pregnancy envy, particularly in psychotic males who have believed they were pregnant; 3, reactivation of the œdipus complex in men whose sense of maleness is poorly developed, the denial of fatherhood being the defense in some cases against the incestuous crime; 4, deep unconscious concerns regarding masculinity and the consequences of potency in patients who

have strong death wishes toward the father and fears of castration; and 5, identification with the baby.

An interesting summary of the couvade ritual is presented along with current manifestations of the 'couvade syndrome'. Men who experience one or more of the symptoms of pregnancy are attempting to resolve their ambivalence and envy through identification with the pregnant wife. Psychiatric illness in the father may contribute to postpartum problems in the mother as well. The battered child syndrome is not uncommonly the result of aggression toward the mother turned on the child.

VIVIAN FROMBERG

Revista Uruguaya de Psicoanálisis. XII, 1970.

The King of the Forest: A Case of Anxiety Hysteria. Oswaldo Francheri. Pp. 331-358.

A woman's analysis showed that her phobia of moving from one place to another represented a failure of defensive maneuvers to keep unacceptable wishes dissociated. She protected herself against castration anxiety and against a homicidal regression as well. The author describes aspects of his patient's eating phobia as being in accord with Rado's concept of 'alimentary orgasm'; everything she ate had prominent symbolic representations. Her promiscuity was a means of denying and at the same time revealing her basic fear of women (mother figures). This was a constant reminder of her defeat in the œdipal rivalry.

A Part of a Dream Communication in the Analysis of a Female Patient: The Search for a Love Object by Way of the Theatre and Dreams. J. Carlos Plá. Pp. 359-401.

This is a detailed account of an analytic session; it is long but rewarding. The author considers the analytic process as a co-thinking. This concept aided him in understanding his patient's psychosis as reflecting common unconscious conflicts.

GABRIEL DE LA VEGA

Revista Uruguaya de Psicoanálisis. XIII, 1971-1972.

Obsessive Mechanisms Operating in the Restitution of a Schizophrenic Ego. Hector Garbarino. Pp. 5-16.

Garbarino reports on four years of analysis of a schizophrenic girl. Initially very regressed, with the establishment of a psychotic transference, the child showed marked improvement. The change coincided with her dramatizing the primal scene and her attempting to usurp the role of the analyst's wife. The vicissitudes of the patient's obsessive-compulsive defenses in the treatment are emphasized in evaluating the improved ego functioning.

GABRIEL DE LA VEGA

Revista de Psicoanálisis. XXIX, 1972.

Technique of Supervision in Child Analysis. Arminda Aberastury. Pp. 5-34.

Aberastury describes six types of experience as fundamental for supervision in child analysis. 1, Studying the history given by the parents and attempting to predict the course of the first interview with the child; or 2, studying the first interview with the child before studying the history given by the parents. 3, Comparing the first interview with the parents and the first hour with the child with the data derived from subsequent sessions in the analysis of the child. 4, Performing what Aberastury calls 'style exercises' to find better ways for the analyst to interpret the material. 5, Attempting to 'translate' the adult language to the child's level and vice-versa, including a tentative approach as to what words the analyst will use in interpreting material produced by the child. 6, Having an essential knowledge of normal child development as contrasted with the pathological.

GABRIEL DE LA VEGA

Revista del Hospital Psiquiátrico de la Habana. Special Supplement, 1972.

Round Table Discussion of Homosexuality. Pp. 1-50.

The participants in this discussion were Dr. Maria Elena Solé, Dr. Magaly Casell, Dr. Noemi Perez Valdes, Dr. Gerardo Nogüeira, Dr. Bartolome Arce, and Dr. Edmundo Gutierrez-Agramonte. The discussants reviewed the literature on the subject, stressing freudian theory which they felt had afforded them a different way of dealing with male homosexuals who are chiefly referred by the courts. When a case is referred to a psychiatrist or to a hospital, thorough psychiatric study and psychological testing are carried out. If the study results in a prediction that the offender is likely to resume his homosexual acts—especially the seducing of young boys—he is given the choice of going to a homosexual colony or receiving outpatient psychiatric treatment until it is reasonably certain he will restrain his advances toward minors. The homosexual colony is not a penal colony in the usual sense of the word. The members of the colony work for wages. Psychiatric services are available to them but many refuse treatment. The offender remains in the colony, however, until the psychiatrists decide he is ready to leave.

GABRIEL DE LA VEGA

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Meetings of the New York Psychoanalytic Society

Ernest Hartmann

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NOTES

MEETINGS OF THE NEW YORK PSYCHOANALYTIC SOCIETY

June 6, 1972. PANEL ON THE ROLE OF PSYCHOANALYSIS IN PSYCHIATRIC EDUCATION. Morton Reiser, M.D., Chairman.

Dr. Reiser specified some areas for possible consideration in the discussion. 1, The relative importance of psychoanalysis in general psychiatric training. 2, Goals of incorporating psychoanalysis into residency as well as medical school and non-house training. 3, Administrative issues which might arise between separate administrations. 4, Evaluation of efficiency and effect of such training.

Dr. Marvin Stein spoke of the comprehensive functions performed by psychiatrists today in which links with various agencies and community groups appear to overshadow direct patient contact or care. He felt that psychoanalytic theory is important and essential in all training programs. Further, because of the current shortened hospital stay of patients, it is essential for residents to understand ego psychology and to evaluate ego functioning. He pointed out that individual psychoanalytically oriented psychotherapy, as well as milieu, group, and family therapy, utilize psychoanalytic concepts and techniques. As the clinical role of a psychiatrist is primary, training must include contributions of psychoanalysis, neurophysiology, neurochemistry, biology, sociology, and clinical psychiatry.

Dr. Milton Horowitz spoke of the analyst's role in the education of psychiatric residents in relation to data gathering, particularly in history taking. In psychoanalysis the critical life events provide a valuable perspective which then provides a framework for the understanding of character and certain symptoms, and gives renewed impetus to a tradition of medicine—the complete and accurate anamnesis with the hallmark of exquisite observation and description. This may contribute to spontaneous interpretation of the data by the patient and may strengthen certain other ego functions.

Dr. Lawrence Kolb described the unique situation at Columbia in which the psychoanalytic institute is within a large university and medical center residency training program, as well as a medical school and undergraduate school; also the psychoanalytic faculty is actively engaged in teaching courses at Columbia College and its graduate school. The frequent negative attitudes toward psychoanalysis, particularly among incoming medical students who had majored in psychology and sociology in college, are dealt with by arranging meetings with patients, resulting in a 'rearousal of interest in things human'. At present all entering medical students are brought into clinical seminar teaching by way of patient contact; there is less reliance on formal lectures.

Dr. David Berenson, a psychiatric resident at Albert Einstein, commented that today's residents, many of whom are in therapy or personal analysis, wonder why they should go to analytic institutes. They speak of the different analytic schools of thought and wonder if group and behavior therapists are not the 'exciting people'. Dr. Reiser commented that not everyone ought to be a psychoanalyst. However, he would encourage any psychiatric resident to have a

personal analysis if he intends to seriously use his mental apparatus as an instrument for gathering data and treating patients, but he would advise such residents to go into full institute training only if they wish to become expert in technique. Dr. Stein said the issue was not psychoanalysis but the psychiatric residency training programs as such.

Dr. William Frosch warned against presenting residents and medical students with pseudo-observations and premature abstractions; although psychoanalytic theory is basic, it must flow out of experimental work with patients. Specifically he felt that analysts could teach medical students certain attitudes that future physicians might bring to patients as well as theoretical ideas, particularly the significance of child development in determining adult behavior. In planning programs for residents, he said the initial experience with patients should be focused on a one-to-one relationship; too early experiences with groups or behavior therapy is destructive to the 'listening attitude' necessary to the development of exquisite observation.

In conclusion, Dr. Reiser emphasized that analytic theory is the best we have at this time to explain individual behavior. Each panel member felt that analysts themselves were the best qualified to teach in the specific areas noted.

ERNEST HARTMANN

October 17, 1972. THE RELEVANCE OF RECENT PSYCHOANALYTIC CHILD DEVELOPMENT RESEARCH FOR THE PRACTICE OF CLINICAL PSYCHIATRY. Edgar L. Lipton, M.D.

Dr. Lipton focused on three topics. First, the effects on personality of early physical malformations. Defects themselves are not necessarily pathogenic but the environment and the attitude of the mothering figure are crucial. Reality testing, coping with aggression, and character formation are subject to derangement. The psychiatrist must be alert to the patient's narcissistic sensitivities and keep the disability out of the treatment. When the problem is frankly explored, improvement and clarification of the self-concept results. Second, the effects of maternal deprivation and institutionalization. Here the author emphasized the importance of Spitz's work but cited evidence that not all maternal deprivation produces irreversible damage. The quality of the antecedent mother-child relationship, the adequacy of substitute care, and the constitutional endowment of the child must also be considered.

Finally, the author cited the work of Mahler and her co-workers as an example of how child observation has enriched our appreciation of the earliest mother-infant bonds. He discussed the implications of the symbiotic metaphor in the evolving, ever-changing, need-satisfying dyad. Failure of the necessary mutual cuing results in psychotic patterning in which the infant cannot use the mother to acquire a sense of reality. It is from the vicissitudes of the symbiotic relationship that the 'as if' personality, certain borderline cases, and severe narcissistic disturbances can have their roots; indeed, psychoses of adolescence and adulthood can be traced to a faulty early symbiotic relationship. Mahler's therapeutic approach gives the child another opportunity to progress through previously missed or unsatisfactory phases of development, with the aim of developing better object relationships and a firmer sense of identity. Therapy

with borderline adults can be aided by keeping in mind the process of separation-individuation and using our understanding of it to help foster a working therapeutic alliance. The development of basic trust by such patients is interfered with by their 'autistic character'. Too great a symbiotic bond with the mother can make therapy frightening: an engulfing experience. One must always work within the mobilized transference neurosis, trying to stay as close as possible to a psychoanalytic model of psychotherapy.

DISCUSSION: Dr. Frank Curran spoke of physical malformation and its effect on personality, and offered clinical examples from his experience with adolescent and latency children. Serious physical defects in children hospitalized for emotional difficulties are frequent and remedying them aids their psychological status. Schilder's work on body image and his own research projects demonstrate the conscious denial of dissatisfaction with one's own physical defects. Dr. Curran emphasized the need to provide particular supervision for children of psychotics.

Dr. Alexander Thomas pointed out the disparities between retrospective studies and child development observations. He stressed the importance of evaluating all aspects of the motivation for and effect of working mothers on their children's development. Maternal deprivation must no longer be a catch-all descriptive term; precise definition is needed. Dr. Thomas extended Mahler's concept of separation-individuation throughout all of adult life and suggested that it is a 'much more all-encompassing and dynamic framework than formulations which center on the development and resolution of the œdipus complex', which might be considered one specific aspect of the separation-individuation process. He emphasized that 'intrinsic behavioral deviations in the child' are as important as disturbances in the mother.

ALLAN J. WALTZMAN

MEETING OF THE PSYCHOANALYTIC ASSOCIATION OF NEW YORK

October 16, 1972. THE CONCEPT OF EROTIZED TRANSFERENCE. Harold P. Blum, M.D.

The concept of erotized transference may be differentiated from the relatively universal erotic transference. Freud defined erotized transference in terms of a repetition of childhood drives and called it a resistance. After describing the characteristics of erotized transference, Dr. Blum noted that it is not limited to patients with impaired object relations or to any diagnostic category and that a poor prognosis is not invariably implied since the regression may be partial and reversible.

The genetic factors of erotized transference were explored. They include instinctual overstimulation and usually intense masturbatory conflicts. The parents show contradictory behavior by being 'proper' on the surface and at the same time overstimulating and seductive. The confused and traumatically overstimulated child is overwhelmed by masturbatory excitation which, together with parental denial, contributes to the altered sense of reality in the analytic

situation. The analyst becomes not only the loved and idealized parent but also the hostile seducer. The patient may consume love but cannot reciprocate. The more severe cases display ego impairment and primary preœdipal problems, often including conflicts of separation and symbiosis. The malignant form of erotized transference is erotomania. The erotization frequently marks a misguided attempt to master past trauma and consequent distrust.

Erotized transference is associated with magical expectations and manipulative tendencies. Analysis may be sought for reunion with a lost idealized object or for reward, rescue, or cure by love. Analyzability depends upon personality structure and capacity for ego growth. The analytic situation in itself cannot originate an erotized transference but a countertransference response in which the analyst 'enjoys' the 'love addiction' of the patient can anchor the erotized transference and the situation becomes intractable. In Dr. Blum's patients the erotized transference was amenable to analytic resolution because their reality testing was not overwhelmed and the situation was not ego-syntonic in depth.

DISCUSSION: Dr. Robert A. Savitt agreed with Dr. Blum's description of the erotized transference but felt that two other aspects should be considered: the pre-analytic erotized transference which is manifested in the life style of some patients, and the silent erotized transference in which the erotic feelings are masked by hostility and deprecation of the analyst, or by indifference to him. Dr. Savitt presented two cases to illustrate these aspects of erotized transference. While he agreed that it can occur in many different types of patients, he would enlarge the concept to include these two aspects. He suggested that Dr. Blum's concept might be termed a 'classical erotized transference' and that his additional examples might be termed 'atypical erotized transference'.

Dr. Jerome Silverman agreed with Dr. Blum's re-emphasis of the significance of the ego in the clinical manifestations and analyzability of erotized transference. However, he found the current usage of the term 'erotized transference' semantically confusing and prejudicial; he proposed use of the term 'instinctualized transference' which can represent either erotized or aggressivized transference, or both. He suggested that erotized transference states have the same quality of closeness to the ego and superego, to intrasystemic conflict, and to development as the transference neurosis has been considered to have to the id and to symptom-formation. He doubts that erotized transference can occur without important pregenital fixations; it functions not only as a revival of an infantile incestuous fixation but also as a revival of an altered sense of reality connected with early severe trauma. It can function as a defense against destruction of the object or as an attempt at restitution of a lost object through obsessive preoccupation with the analyst. A differentiation must be made between the universal erotic transference and an unanalyzable transference psychosis.

In conclusion, Dr. Blum stated that transference is traditionally defined by its manifest content. He did not object to the term 'instinctualized transference' but felt that it is crucial to distinguish between ego regression and early developmental arrest. The prognosis is good if there is a reversible regression and poor if there is a developmental arrest.

RITA W. CLARK

The Annual Meeting of THE AMERICAN PSYCHOANALYTIC ASSOCIATION will be held at the Denver Hilton, Denver, Colorado, May 1-5, 1974.

The Annual Meeting of the AMERICAN ORTHOPSYCHIATRIC ASSOCIATION will be held April 8-12, 1974, in San Francisco, California. For further information write: American Orthopsychiatric Association, 1775 Broadway, New York, N. Y. 10019.

PSYCHOTHERAPY, a new journal published in English and in Croatian, has been launched by the Psychotherapeutic School of the Mental Health Centre, Zagreb Medical School, Yugoslavia. The sponsors of the journal are the staff members of the Mental Health Centre, all of whom are psychoanalytically oriented. The editor-in-chief is D. Blažević; international members of the Editorial Board are R. Battegay, Basel, E. Jacobson, New York, Th. Freeman, Antrim, S. Lebovici, Paris, W. Solms, Vienna, H. Thomä, Ulm, and G. Gerö, New York.

The first GERMAN ASSOCIATION OF PSYCHOSOMATIC MEDICINE (*Deutsche Gesellschaft für Psychosomatische Medizin*) was founded in June 1973, and Dr. Günter Ammon, Berlin, elected president. All workers in the field of psychosomatic medicine are invited to apply for membership in the Association at 1 Berlin 28, Hattenheimer Strasse 4.

A National Conference on Evaluation in Alcohol, Drug Abuse and Mental Health, sponsored by the National Institute of Mental Health and organized by the Division of Community Psychiatry, State University of New York at Buffalo, will be held in Washington, D. C., April 1-4, 1974. For further information write: Berna Koren, 462 Grider Street, Buffalo, N. Y. 14215.

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