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CLINICAL CONSEQUENCES OF CHRONIC PRIMAL SCENE EXPOSURE

BY WAYNE A. MYERS, M.D.

The author presents a phenomenological survey of the symptomatic, characterological, and transference manifestations observed in five male and five female patients who had spent the first three to twelve years of their lives in the parental bedroom. While chronic primal scene exposure is seen in these cases as not having produced any single specific psychopathological sequelae, certain sexual disturbances, split self-representation phenomena, etc., seem to have been primarily (though not solely) determined by these early exposures.

In the past fifteen years, I have treated ten patients who spent the first three to twelve years of their lives in the parental bedroom. It is reasonable to assume that under such circumstances exposures to the primal scene were actual events occurring on a continuing basis throughout both the preoedipal and the oedipal years. My sample consists of five men and five women, seven of whom were seen in analysis and three of whom were treated with intensive psychotherapy. The diagnoses included neurotic and character neurotic problems, narcissistic and borderline personality disorders, and there was a single female psychotic patient. Two of the patients were blacks raised in the ghettos of their respective cities, and the remaining eight were middle-class whites reared in urban settings.

In this phenomenological survey, I will delineate certain symptomatic, characterological, and transference manifestations which I have observed in these patients. My discussion will center on the twin questions of the pathogenicity of the primal scene per se and the specificity of sequelae of such exposures. In addition, I will present some clinical material illustrating both recall and reconstruction of the childhood primal scene exposures of two patients in my survey group. This material will facilitate a brief discussion of the problem of the recall, or the

lack thereof, of memories of actual childhood primal scene exposures in the treatment of adult patients.

SYMPTOMATIC AND CHARACTEROLOGICAL DISTURBANCES

Sexual Disturbances

All of the patients in this study exhibited serious sexual disturbances in their adult lives. Of the five males in the group, two presented initially in treatment as overt homosexuals. One of these two men experienced premature ejaculation in his sexual relations with men (see Case A, pp. 12-15). The second man, described in detail in a previous paper (Myers, 1973), had significant transvestite fantasies, most clearly delineated in an undistributed pornographic film he had directed. In the film the sexual adventures of a transvestite detective involved in solving a murder mystery in a bordello were graphically depicted. It should be mentioned here that his parents' pattern of "amusing" themselves by dressing the patient in women's clothing and filming him for subsequent home viewing was also contributory to his later transvestite fantasies. This is important to note, inasmuch as it underscores the multiple determinants of all of the symptomatic and characterological manifestations to be described in this paper. While I consider the chronic primal scene exposures to be of the utmost significance in the genesis of these phenomena, they were not the sole determining cause of any of the manifestations.

In addition to the transvestite fantasies just mentioned, the patient in Case A occasionally indulged in overt masochistic practices in which he allowed himself to be beaten by other men in order to achieve sexual gratification. In his sexual relationships with women, which often occurred in a *ménage à trois* setting involving another man, he frequently suffered from disturbances of potency. Beating fantasies were present in four of the five men included in this survey.

Four of the five males in the series experienced intermittent

or chronic episodes of depersonalization during sexual relations, accompanied by impotence, premature ejaculation, or ejaculatio retardata. In such episodes, they would perceive their genitals or other parts of their bodies as "numb," "dead," or "anesthetized." In addition, they would perceive themselves as being split into observing and participating portions. Their associations to this phenomenon were most frequently linked to conflicting wishes to be both observers and participants in the primal scene. In another paper (Myers, 1977), I have described how this splitting of self-representation allows such patients unconsciously to disavow the participating aspect of the self-representation from the conflict-ridden sexual and aggressive drive derivative wishes aroused during the sexual act.

Of the five women in the group, two had been involved in long-standing overt homosexual relationships earlier in their lives. The three other women had had frequent homosexual fantasies but no homosexual experiences. All five women presented in treatment with varying degrees of frigidity in heterosexual relations. Beating fantasies were either occasionally or chronically utilized by all five for the purpose of achieving orgasm, either in masturbation or in intercourse or in both situations. In only one of these women was the beating fantasy the exclusive means of achieving an orgasm in both masturbation and intercourse (Myers, 1979). Physical beatings for the purpose of achieving sexual gratification in reality were not sought out by any of the female patients, but "emotional beatings" represented the rule, rather than the exception, in their heterosexual object relationships. Three of the five women also experienced the phenomenon of depersonalization during intercourse.

While derivatives of the primal scene experiences figured prominently in the understanding of all of the patients' adult sexual difficulties, it can readily be seen that other factors (separate from what had transpired in the bedroom) were also of importance in the genesis of the problems observed. A prime example of this can be seen in the development of the trans-

vestite fantasies in the patient cited above. In essence, no single sexual disturbance could be said to be causally related *exclusively* to early primal scene exposure.

Split Self-Representation Phenomena

One interesting phenomenon found in the majority of my patients was the presence of fantasies, dreams, and symptoms in which there was a sense of a split within the self-representation. Arlow (1961, 1966) has described the relationship between early primal scene observation and later splitting phenomena in dreams and symptoms. In essence, this sense of splitting is tantamount to placing the patients in the dual roles of the observer and the observed.

As mentioned earlier, depersonalization was present in seven of the ten patients in the group. The relationship to the primal scene experiences became most apparent from associations to episodes of depersonalization that occurred during sexual intercourse. But the episodes of depersonalization were not limited to the sexual sphere. The sense of splitting in the depersonalization was viewed as involving an alteration of ego functions in the service of defense (Arlow, 1966). The anxiety defended against by such episodes seemed related to both preoedipal and oedipal conflicts which had become organized in masturbatory fantasies during the oedipal and latency periods and which gave rise to drive derivative wishes to be both participant and observer in the primal scene.

Related to the experience of depersonalization in two patients were dreams in which aspects of the self were seen in two different locations in the manifest content of the dreams, again the observer-observed roles. Similarly, mirror dreams were also present. Fantasies of being filmed (in other words, observed) and contrary fantasies of being an invisible observer of sexual and aggressive scenes while being protected from harm in some manner, such as being encased in an indestructible plastic bubble, were seen in a number of cases. The latter type of fantasy bears

a strong resemblance to the walls of denial described by Greenacre (1973) in patients who had experienced chronic primal scene exposure in childhood.

The split self-representation phenomena in my patients show contributions from a variety of sources. Historically, experiences of maternal deprivation and a lack of "mirroring" (Kohut, 1971) figured importantly in the backgrounds of all of the patients. Anxious fantasies concerning a threatened extinction of the sense of self were occasionally to frequently voiced by most of the patients in association to these splitting phenomena. In addition, having imaginary companions or fantasy twins in childhood has been described as developmentally related to split self-representational phenomena in the adult (Myers, 1976). In the memories and fantasies revealed by my patients during their analyses, however, the splitting manifestations were found to be organized *primarily* under schemata involving chronic primal scene experiences.

Sleep Disturbances

Eight of the ten patients in the group experienced chronic difficulties in falling asleep. In addition, frequent awakening secondary to anxiety dreams was present in all ten patients. The manifest content of the anxiety dreams often contained visual representations of people fighting or of people engaged in sexual activities, and the patients' associations to such dreams most often led back to the early primal scene exposures. Associated with the sleep disturbances were prominent fears of dying or of being awakened to witness frightening sights that combined the concepts of death and sex, such as murderous rapists or robbers in the bedrooms. Again, the patients' associations to these fears most frequently led us back to the primal scene exposures.

Seven of the eight patients who experienced difficulty in falling asleep often used alcohol or drugs, such as hypnotics and marijuana, in order to help them fall asleep. The drug-induced

changes in the state of consciousness were seen to parallel confusional states and alterations in the sense of reality which often arose in such patients during the recounting of material referable to the early primal scene exposures. Such confusional states were also present, however, in analytic sessions in which material concerning early surgical and anesthetic procedures was discussed.

It should be mentioned here that the family lives of many of the patients suffering from sleep disturbances had been marked by the presence of verbal and/or physical fights between the parents, which often occurred at bedtime. The fights thus became enmeshed in perception and memory, as Esman (1973) has suggested, in the child's interpretation of parental coitus as a murderous, sadistic act. While the manifestations described in this paper showed contributions from sources other than the primal scene exposures, these experiences served as the means of organizing the difficulties encountered in other spheres.

Learning Difficulties

Although all of the patients in this survey were intelligent individuals who had attained considerable educational and professional success before entering treatment, they all exhibited certain kinds of learning difficulties. Zetzel (see, Niederland, 1965), in reporting on two patients she analyzed who had undergone chronic primal scene exposures in childhood, speaks of chronic difficulties in passive learning situations. My patients showed problems in both passive and active learning situations. When they had to engage actively in the learning process, and most particularly when learning involved truly "looking at," that is, integrating and synthesizing information, they encountered difficulties.

A number of the patients had interrupted their graduate school studies prior to treatment because of problems in reading and concentration. As they began to work through and, thereby, to integrate the multiple levels of meaning implied in

the primal scene memory and affect schemata, they became able to engage actively in the learning process. At such times, they would spontaneously begin to read books in their chosen fields. Other patients were enabled to pursue hobbies centering on visual interests, such as photography, and still others became capable of passively looking at and enjoying sexual and aggressive content in films and television programs. Learning inhibitions were often manifested early in treatment by the appearance of pseudostupidity. This defense was also utilized by such patients in order to cope with anxieties aroused by material which did not stem from the primal scene exposures, such as experiences involving parental nudity or menstrual periods (often occurring in the bathroom, rather than in the bedroom). Once more the problems detailed here show other determinants in addition to early primal scene experiences, although the exposure to parental sexual acts was of paramount importance.

Repetition in Action

An action repeated by five patients in the group who were parents themselves involved the exposure of their own children to their sexual activities. This was not done, however, on a continuing basis by any of these patients. This single act, as noted in the protocols of the Kris Study Group (1969) which studied the primal scene, seemed derived from the patients' own early primal scene exposures. Obviously, however, the lack of parental consideration for the well-being of their children, evident in my patients' own early exposures, was not limited to the bedroom sphere alone. Hence even here, other determinants must also be postulated for this action, which repeated their childhood experiences.

As mentioned before, one male patient was repeatedly involved in *ménage à trois* sexual activities, and a second male patient (Case A) was intermittently involved in a similar type of activity. Another male patient, who had dreams and fantasies of being an observer of sexual activity while safely ensconced

in an indestructible plastic bubble, acted out this fantasy on a number of occasions by slowly driving his locked car late at night through a tawdry district of the city he lived in where he would be accosted by prostitutes offering a variety of sexual activities. In this situation, he would become aroused and yet feel protected from participation in the sexual acts he both feared and desired. Similarly, a young woman frequently allowed herself to be picked up by men in cars late at night. She would undergo sexual relations with them "in a fog," that is, in a depersonalized state. In so doing, she often thrust herself into highly dangerous situations from which she would manage miraculously to extricate herself. A number of other similar examples could also be enumerated. While associations to these actions most frequently led back to the primal scene exposures, the need to be involved in dangerous sexual and aggressive situations was also shown to have roots in occurrences which took place outside of the parental bedroom, such as early traumatic surgical procedures.

TRANSFERENCE MANIFESTATIONS

In this section, I will describe in somewhat schematic form the evolution of a sequence of transference manifestations which appeared in the treatment of the majority of the patients considered in this survey.

Only one of the ten patients exhibited a clearcut overidealization of the analyst of the kind that Greenacre (1966) described in a study of patients with chronic primal scene exposure. To this patient, I was a demigod of sorts, a being endowed with omniscient, omnipotent powers which I would confer upon him through the magical process of analysis. He listened to my interventions courteously in order to make certain that I would not leave him and would continue to pay strict attention to his productions. Whenever I attempted to question his overvaluation of me and the corresponding undervaluation of his father, he would respond with pseudostupidity or with confusion. It was

a matter of years before the second manifestation, to be described below, occurred in a clearcut form.

In other cases, the idealization was much more subtle. Those patients who had been in treatment before tended to denigrate their previous therapists. In contrast, I was seen as being more attuned to, and understanding of, their difficulties. Initially, their acceptance of my tentative reconstructions of the significance of primal scene exposures was on an intellectual basis, and such interpretations were often quickly forgotten and poorly integrated. But these interpretations seemed to serve as the basis for the patients' appreciation of my presumed superior understanding of them. In a general sense, the patients conveyed the idea that I was really listening to what they had to say and was able to integrate it for them in a manner which gave some sense of causality to the chaotic ideas and feelings they had experienced for much of their lives.

Although the next manifestation to be described became apparent to me only after the idealization mentioned above, I believe that it, too, was often present in some rudimentary form from the beginning of the treatment. I am referring to an extraordinary sensitivity on the part of these people to any noises or movements I might make during our sessions. These were invariably interpreted by the patients as a sign of lack of interest on my part, and they responded by becoming irritable and depressed. If I coughed or sneezed or interrupted them in order to try to clarify something which I had not heard distinctly, they would behave as though I had affronted them in some major way. I was told that I did not care about them, that they were only objects for my professional curiosity, mere "toys" to be picked up and abandoned by me in accordance with my whims. Associations to such ideas led to memories and reconstructions of narcissistic affronts suffered at the hands of the parents both inside and outside of the bedroom. The greatest impact upon the patients followed interpretations dealing with the idea that they must have felt abandoned, insignificant (par-

ticularly in comparing their childhood genitalia with that of their parents), and disregarded by their parents in the bedroom.

The five male patients in the group largely held their fathers responsible for such injustices. The resulting anger was projected onto the fathers, who were seen as sadistic individuals determined to interfere with the patients' real or fantasied closeness with their mothers. By this mechanism, which incidentally seems to me to be another determinant of the sadistic interpretation of parental coitus, the patients were able to undo (in fantasy) some of the painful feelings of being abandoned by their mothers during the original primal scenes and at other times as well. The female patients also perceived their fathers as sadistic and neglectful of them, although two of the women, whose mothers had been unable to offer significant nurturing to them in their childhood, saw the mothers as degraded and devalued.

Essentially what was being re-enacted in this later stage of the transference was a wishful fantasy of union with an idealized parental figure, much in the manner of the idealizing and mirroring transferences described by Kohut (1971). From the point of view of the patients' transference wishes, if the fantasy could be realized, the early narcissistic mortifications would be miraculously undone. While the transference wishes were usually expressed as a fantasy of symbiotic union, the majority of the narcissistic mortifications referred to had occurred at the oedipal level and could only be understood in the over-all context of the patients' associations. The interpretations I made, which went against the thrust of the transference wishes, often evoked denial or anger in the patients, who sought to ward off painful feelings of humiliation and a re-experiencing of the early narcissistic mortifications. The working through of such defensive transference manifestations was a long, arduous procedure. In the working through process, material emerged that was relevant to early separation experiences, parental fights, and maternal and paternal deprivations, and rejections. In the main, however, the primal scene experiences seemed to crystallize and organize the

data from these disparate sources into a sort of mnemonic shorthand which gave the data some semblance of coherence.

One other transference feature is of interest. All of the patients in the survey exhibited significant degrees of acting out behavior. Perhaps the most striking instances were in the film-making and *ménage à trois* activities of the patient mentioned before. With most of the patients, such acting out behavior often went on for long periods of time and led to dramatic frustrations of the therapeutic endeavors. These maneuvers frequently had to be understood as attempts to place the analyst in the position of the passive, helpless onlooker, unable to prevent the destructive actions that were being observed. Such a reversal of passivity into activity expressed the fantasy that the analyst would suffer the same experiences of humiliation and inadequacy which the patients had undergone throughout much of their early lives, most particularly during the years spent in the parental bedroom. The idea of patient and analyst sharing the same humiliating feelings was seen as another reflection of the wish for fusion with the mother on a superficial level, though on deeper analysis this was seen to screen off an oedipal wish for sexual relations with one or both parents, expressed in this instance in a regressive manner.

RECALL AND RECONSTRUCTION

Only three of the ten patients in this survey (two women and one man) had direct recall of the primal scene. In all three instances, only the sounds of parental intercourse were recalled (auditory rather than visual recall) and from a period no earlier than the age of five. In two patients, the recall was placed at a time after their removal from the bedroom, and in the third patient, it was dated at the very end of the stay in the bedroom. Two of the three patients blandly and spontaneously recounted the auditory recall during the earliest sessions of their treatment. The third patient did not recount such memories until a long period of analysis had transpired. One of the three pa-

tients with auditory recall and two of the other patients in my group spoke of a dim sense of having seen the parents engaged in intercourse, but there were no visual details of actual parental sexual acts, although many other remarkable details of the early bedroom arrangements were elicited. The clinical excerpts to follow will illustrate the manner in which such material arose during the course of the analyses of two of the patients.

Case A

Mr. A entered analysis at age forty, following a rejection by a homosexual lover. He complained of episodes of depersonalization in which his body and familiar people appeared "strange" to him, and he verbalized sensations of being split into observing and participating aspects of himself. The patient was the third youngest child in a large family, with opposite sex twins being born when he was five years old, at which time he was displaced from his position in the parental bedroom.

During the first year of the analysis, Mr. A recounted occasional memories of having observed his obese mother's buttocks and anus while she washed the floor. He also mentioned that when he was a child, she had taken him with her to see frightening films. Most of the material that emerged related to his feelings of humiliation and inadequacy in sexual encounters with men, when he experienced premature ejaculation in anal and intertriginous (between the thighs) intercourse. Such episodes invariably occurred during periods of separation from the analyst.

In the second year of the analysis, Mr. A spoke of needing me to be with him at all times and of his wish to suck on my penis and to incorporate my semen in order to bolster his feelings of masculinity. During this period, he invited for dinner a man and a woman to whom he was attracted. Both expected sexual approaches from him and when he failed to comply, they spent the night in his bed having intercourse while he remained in the next room, listening to their sexual noises and finding him-

self unable to fall asleep. He finally dozed off and dreamed of a hangman's noose descending through his body and cutting it into male and female halves. Feelings of depersonalization ensued. After a paucity of associations to the dream during our session that day, I inquired about his having listened to the other couple having intercourse. He became very anxious and spoke of my voice sounding "distant" and "unfamiliar." After the session, he masturbated with fantasies of performing fellatio on a man resembling me. Following this, he sought out a homosexual "pick-up" and again had premature ejaculation in anal intercourse. The next day, he spoke of having closed his eyes during the sexual act with the man and of having listened to his partner's rapid breathing. When I asked for further associations, he became angry with me for interrupting him and not listening to him.

In subsequent months, the patient occasionally revealed masturbatory fantasies centered on listening to the couple who had been in his apartment. Dreams of sexual involvement with one or both members of the couple were also mentioned. At this time, I became aware of how often he stood outside my office door before our sessions began. When I asked him about this, he spoke of wanting to hear what went on with my other patients, to see if they "got more" from me than he did. He wondered if I were having intercourse with men and women he found attractive. When I asked him about his interest in listening to sexual activities, he spoke of having heard his parents having intercourse after his removal from their bedroom. Although he tried to minimize the importance of such episodes, he was visibly upset by the memories. When I suggested that he might have masturbated as a child, while listening to his parents' lovemaking, he concurred, but spoke of wanting to shut his eyes to what I was saying. I pointed out that he had done just that in the homosexual encounter after the episode with the couple and that he again experienced feelings of depersonalization in which my voice in particular sounded "distant." He avoided my glance on leaving the session and upon

entering the next one. He became angry when I noted this avoidance; then he began to speak of fleeting attempts to visualize the sexual encounters between his parents when he was a child and of finding it hard to imagine how his father could penetrate his mother because of her obese buttocks and thighs (the two areas of his difficulty in relations with men).

Early in the third year of the analysis, after having seen a heterosexual pornographic film in the company of another man and woman who attracted him, he again spoke of his mother's taking him with her to frightening films. He mused on his mother's obesity and on listening to her heavy breathing in the dark theaters and became anxious and silent. He then revealed that he had sat next to the woman during the film he had just seen and had felt aroused by her. He had attempted to distract himself by concentrating his gaze on the male genitals on the screen but periodically would gaze at the female genitalia. He related having had feelings of "strangeness" in his body. Then he revealed that he had had a scrotal hernia in childhood, the descents of which had often made him question his sexuality. He had ashamedly hidden this problem from his family and had not had it surgically corrected until he was an adult. He recalled the earlier noose dream, related it to the hernial descent, and wondered if he had wished to replace his mother with his father in the early bedroom scenes. As he spoke of having observed how large his father's penis was when they had showered together, I commented that receiving his father's penis would have made him a man in fantasy (as he had wished for my penis to bolster his masculinity) and would have enabled him to have intercourse with his mother. He became frightened now but proceeded to relate the woman in the theatre to the mother of the past and the mutilated appearance of the female genitals on the screen to the "unnatural" appearance of his mother's genitals (which he had also observed as a child) because of the lack of a penis. In this and subsequent sessions, he felt convinced that he must have seen, as well as heard, the primal scene.

The organizing function of the primal scene memories can be

seen in this material as when recollections of parental nudity in the bathroom become enmeshed in memory with the bedroom scenes. We can also notice that the auditory recall of the primal scenes followed upon the analysis of the depersonalization and of the acting out. Most particularly, however, the interpretation of certain transference manifestations involving the modalities of hearing and vision laid the groundwork for the recall. Kris (1956) noted this when he said: "Interpretation . . . did not produce recall, but rather it established dynamic conditions under which recall became possible, conditions more similar to those which existed when the recalled scenes and events occurred" (p. 64).

Case B

Mr. B entered analysis at age forty during the breakup of his marriage and his involvement with a woman who reminded him of his mother. He had spent the first three years of his life in the parental bedroom and then had developed osteomyelitis, which necessitated frequent hospitalizations and surgical procedures on his affected leg between the ages of three and six.

During the first year of the analysis, Mr. B was intensely anxious on the couch, as it recalled the operating tables and beds of the hospital years. His ability to recall minute, previously unremembered details of the hospital era (generally in association to dreams about that time) was especially striking. Such dreams and memories came to be seen by us as gifts to me, which served to prevent my abandoning him, as the parents had appeared to do during his hospitalizations, and to keep me from harming (castrating) him, as he felt the doctors had in the past. As his memories of beds and of being attacked in them kept recurring, I asked for other recollections about beds and bedrooms, specifically referring to the early years in the parental bedroom. Mr. B was "amused" by my question but had few direct associations. Instead he again focused on a hospital scene in which he was kept alone in an isolation room and felt lonely

and sad as he saw his parents peering in at him through a glass window. I noted that this scene involved looking at and being looked at by the parents, but there was little response then to my observation.

Mr. B's relationship with his lover deteriorated and he experienced premature ejaculation and impotence with her and other women. Homosexual fears became prominent, and he felt humiliated at having to tell me of his "failures" as a man. The patient now remembered having been given enemas by nurses at a time when he was encased in a full body cast after a surgical procedure; these memories were accompanied by recollections of shame-provoking experiences of soiling. Such material frequently emerged after the patient had had a restless night and was reported during the session in a detailed, excited fashion. After long outpourings of such memories, the patient would often stop and speak of feeling confused about whether he had actually told me the details he had just recounted and about whether or not he really believed the veracity of the feelings he had just experienced. Memories and reconstructions grasped so clearly moments before seemed totally obliterated. I related the confusion to his feelings during the bewildering hospital years and interpreted it as a defense against the feelings of rage and humiliation he had experienced at that time. I further noted how these feelings had been re-experienced in the analysis in the context of having to reveal to me (to soil himself once more) the shame-provoking episodes of sexual failure. He concurred and likened his outpouring of dreams and memories to his having to "shit" for the nurses and to his earlier traumatic toilet training with his mother. He felt he had to give to me now (as he had done with others in the past) in order to keep my attention and not feel isolated and abandoned.

In the third year of the analysis, Mr. B resumed his relationship with his former lover in what he perceived to be a gesture of defiance toward me. He saw me as impotent and powerless to stop him. Their sexual interaction was marred, however, by his continuing problems with impotence; he often had to utilize

pornographic books and films in order to arouse himself. Enormous fights between them followed abortive sexual encounters, and these in turn were followed by dreams in which he would observe (or be observed by) other men having intercourse with his lover and in which he would attack them or be attacked by them. The dreams took place in dimly lit rooms and the men and his lover appeared very tall in such scenes. From his associations to such dreams and to specific sexual encounters with his lover, it became apparent that Mr. B was experiencing episodes of depersonalization during sexual activities (see, Myers [1977] for more details about this aspect of the case). His limp penis was associated to the osteomyelitic leg, and his feelings of being "drugged" and "glassy-eyed" were seen as being connected with early anesthetic and hospital experiences.

As I focused on the dim lighting and size distortions in his dreams, Mr. B mentioned long-standing anxieties experienced while seated in darkened theaters watching "larger than life" figures on the screen. He also spoke of having trouble really seeing and understanding what went on in the pornographic films he watched. When I attempted to relate this to things he saw in the parental bedroom that may have frightened him, he became angry at my interrupting him and began to re-experience the feelings of confusion described before. Following this session, however, he began to recall minute details of objects in the parental bedroom (all of which were corroborated by his parents). Painful feelings of isolation again emerged, as he spoke of having been abandoned by his mother during the sexual act, as she had abandoned him during the hospital years. He wondered if he had soiled himself in the bedroom in order to attract her attention and to avoid the crushing blow of having to recognize his mother's choosing his father over him. As we worked through such material, Mr. B spoke of having a dim sense of having seen his parents having intercourse, although he was unable to produce any concrete images to support this contention.

In this material, we are dealing with analytic reconstructions of the primal scene which gave the patient a firm sense of con-

viction of having witnessed parental intercourse (even to the point of imagining he could visualize it). The early material became fused with and confused by the traumatic hospitalizations and surgical procedures. This once more illustrates that the symptomatic, characterological, and transference manifestations encountered in these patients had determinants from other experiences in addition to the childhood primal scene.

DISCUSSION

Ever since Freud's (1914) reconstruction of the parental intercourse in the case of the Wolf Man, analysts have been entranced by the concept of the primal scene as trauma. Numerous references to it have appeared in the literature, and it has been used as a causal explanation for conditions ranging from hebephrenia to homosexuality. Until recently, few writers have questioned its fundamental pathogenicity, and little attention has been paid to possible differences in outcome, depending upon actual or fantasied exposures, single or multiple observations, or a variety of other factors which should have been considered.

Cross-cultural studies on the impact of the primal scene have led to apparently contradictory conclusions. Thus Róheim (1934) saw the primal scene as leading to repression of emotions in one study and to little effect on adult sexuality in another (1958). Similarly, Mead (1928) saw little effect on Samoan sexuality, whereas Boyer (1964) found the Apaches marred by their exposures. Devereux (1951), while espousing the idea of the primal scene as trauma, found Mohave children to be relatively untraumatized by repeated exposures to it.

The analytic references to actual, chronic primal scene exposure are limited in number. In her work, Greenacre has referred repeatedly to chronic exposure and has correlated such observations with disturbances in the development of the sense of identity (1958), with general body excitability (1960), and with walls of denial and a disturbance in the sense of reality (1973). She also saw evidence of trauma caused by chronic pri-

mal scene exposure in distortions of the analytic transference, such as the overidealization of the analyst and of the analytic process (1966). While I have seen the multiple features she has described in the patients in this series and would concur with her emphasis on primal scene exposure in their genesis, I must note again that such manifestations have other determinants besides the primal scene. I would also reiterate this statement with regard to her observations on acting out in the transference, although the following quotations from her work parallel the transference manifestations in my patients very closely. Greenacre (1963) noted:

> . . . these . . . primal scenes and . . . parental quarreling(s) create a temporary milieu in which the infant is both in and out of the affair. The fact that he frequently cannot get the attention of the parents at such times may produce a situation approximating abandonment. It would probably be inaccurate to consider this as evoking a feeling of definite humiliation in so young (preoedipal) a child. Yet this early state of helplessness and loss, combined with jealousy . . . is a forerunner . . . of special reactions to humiliations later in life (p. 707).

In another part of the article, she observed:

> It is my impression that the acting out is most forceful and persistent when the child has suffered humiliation in the traumatic episode, being forced from a desired active position to a seemingly devaluated passive one. When this situation is rearoused in the analysis, the acting out, representing an unconscious effort at regaining an active role, is usually carried out away from the analysis. The sense of humiliation which has originally promoted the repressions now comes into play in the transference and therapy and is experienced temporarily but acutely as a degradation (p. 699).

And finally, she commented:

> It [acting out] is sometimes openly and directly self-destructive, but it is always self-destructive if for no other reason than that it

> is clearly driven by a wish to delay or demolish the analysis and so achieve a negative therapeutic victory (p. 708).

I have commented several times in this paper on the sense of abandonment and the narcissistic mortifications suffered by my patients and the need for active mastery of the passively experienced traumas. While there were obviously contributions from experiences outside of the bedroom, the primal scene seemed to serve as the nodal point (Kris, 1956) of memory under which the various contributing episodes were schematized.

Zetzel (*cf.*, Niederland, 1965) saw chronic primal scene exposure as traumatic in the two patients she discussed. She noted:

> In both, specific neurotic defenses initiated in response to signal anxiety during the oedipal period had been influenced by repeated exposure to parental sexual relations. The premium on external phallic success in the man, and the defensive reinforcement of penis envy in the woman could be related to their perceptual experiences. In both, however, the impairment of the passive component of the learning process had a deeper meaning. Exposure to the primal scene had not only been defended against, in relation to oedipal or phallic fantasies, there had also been an extremely important regressive impairment of the pregenital one-to-one relationship with the mother or her surrogate. It was this impairment, in both cases, which had been most significant in its influence on the learning process and the capacity to regress in the service of the ego (pp. 628-629).

In commenting on the impairment of the relationship with the mother, Zetzel stressed an important facet of such cases, one which I will return to later.

The Wangh section of the Kris Study Group of the New York Psychoanalytic Institute studied the primal scene. In their unpublished protocols (1969), they noted:

> We considered many different symptoms as being directly or indirectly, alone or in combination, the possible outcome of conflicts arising from primal scene stimuli. For example, insomnia and sleep disturbances, exhibitionism and voyeurism,

> phobias of the dark, nightmares, oversensitivity to noise, beating fantasies . . . and more specific symptoms . . . such as equilibratory and motor disturbances. It is clear, however, that none of these can be considered specific for the primal scene. . . . Organized forms of character structure [also] are the result of many different dynamic constellations, including the primal scene . . . (Sec. IV, p. 2).

Although the Kris Study Group did not find specific symptomatic or characterological sequelae stemming from the primal scene, they found it hard to divorce the primal scene from the concept of trauma.

Esman (1973), in his review of the primal scene, offered similar views when he observed: "Evidence that observation of parental intercourse is per se traumatic to the child is not convincing; certainly, no specific pathological formation can be ascribed to it" (p. 76). Boyer (1977) described a patient with massive acting out and with sexual disturbances similar to those detailed earlier in this paper. This patient had also suffered repeated primal scene exposure. The clear inference in the paper is on the pathogenicity of the primal scene.

In a recent panel of the American Psychoanalytic Association on the pathogenicity of the primal scene (*cf.,* Isay, 1978), most of the speakers felt that it was not pathogenic per se. Blum, who chaired the panel, stated the tenor of the panel's feelings when he spoke of the primal scene as being conflictual, but not necessarily psychopathological (pathogenic). This is very much in keeping with Blum's views in his paper (1974) on the borderline childhood of the Wolf Man, in which he noted the multiplicity of factors which entered into the genesis of the Wolf Man's psychopathology.

From my own case material, it seems clear that the primal scene cannot be said to have any single, absolutely specific psychopathological outcome. I do, however, believe that chronic primal scene exposure within our cultural milieu is traumatic and pathogenic. The exact outcome of such exposures, however, depends on the interplay of many factors, perhaps best sum-

marized in the thoughts of the Kris Study Group (1969) as follows:

> . . . important considerations arise out of the circumstances for the child: his constitutional endowment, the development of his ego, the nature of his intelligence, the organization of predisposing anxiety, the existence of pathology at the time, his age, physiological and psychosexual development, the degree of ego and superego development, the nature of his defensive structure, the nature of his already existing fantasy life, the state of his object relations with his parents, and the question of who is seen or fantasied about—his parents or others, or one parent with another partner. What is then experienced by the child will be the consequence of the combination and interplay of all the external and internal factors (Sec. IV, p. 1).

One piece of evidence that seems to contradict the idea of the primal scene as trauma is that some of my patients (and Zetzel's, as well) did not develop overt symptoms until after they had been excluded from the bedroom. This need not dissuade us, however; more subtle manifestations may have already been evolving during the years in the bedroom (such as split self-representation phenomena) which did not require symptom formation until after the expulsion from the scene, at which time separation and castration anxiety may have reached new levels. I am in complete agreement with Zetzel and Greenacre regarding one important reason that chronic primal scene exposure is pathogenic in our cultural milieu: parents explicitly fail to protect their children from the effects of their sexual and aggressive attitudes displayed in the bedroom (and, of course, outside of the bedroom as well). Such disregard for the emerging individuality and phallic narcissism of children is most glaringly echoed in the transference manifestations that have been described in this paper and throughout the literature.

Whether the actual sight of parental sexual activities per se is pathogenic is much harder to establish with certainty. In considering the low percentage of recalls recorded in my patient group, we must recognize that severe denial and/or repression

does not necessarily imply that the primal scene, in and of itself, was traumatic. The memory schemata concerning the primal scene organize and subsume within them many other traumatic, pathogenic, and conflictual preoedipal and oedipal events, which might also require being defended against with denial and/or repression.

It is also difficult to determine why my patients had auditory rather than visual recall and why such recollections are dated toward the end of or after the period of exposure. It seems likely that such later recalls are screens for earlier ones: some distance in time and space may be necessary before the perceptions of parental sexual activities can be admitted to conscious registration. (Many factors may be related to this, such as ego development, state of psychosexual knowledge at the time, etc.) This would be in keeping with the distancing aspects of the depersonalizing defense and the split self-representation dreams and fantasies so common in such patients. With all of this, however, I believe that we must still consider the idea that direct visual stimulation is probably more traumatic than auditory excitation and may demand a greater degree of denial and/or repression. In support of this idea is a concept of C. Fisher's, referred to in the Kris Study Group Monograph on *Recollection and Reconstruction* (*cf.*, Fine, et al., 1971). Fisher suggested that certain kinds of visual stimuli may be so traumatic that the perceptions are repressed before conscious registration ever occurs; hence they are incapable of being directly recalled. I have no answer to this problem of visual versus auditory recall, although my impression remains that it is a traumatic experience to witness the primal scene on a chronic basis in our cultural milieu. Perhaps the answer is best deferred at this time.

SUMMARY

Material is presented from the cases of five male and five female patients who spent the first three to twelve years of their lives in the parental bedroom. Certain symptomatic and charac-

terological manifestations seen in these patients, such as sexual disturbances, learning inhibitions, defensive splitting of self-representation, and repetitions in action are described. In addition, there were particular transference manifestations in which attempts were made to actively master the passively experienced narcissistic traumata suffered during the preoedipal and oedipal years.

It is noted that chronic primal scene exposure is not absolutely specific in its sequelae. The problem of the pathogenicity per se of the primal scene is discussed. It is the author's contention that within our cultural milieu, chronic exposure—and the attendant lack of parental protection afforded the child's developing sense of individuality and phallic narcissism—is traumatic.

The issue of the paucity of actual recollections of the primal scene is raised. The three patients who recalled the primal scene placed the memory at a time after their removal from the parental bedroom, during their late oedipal and early latency years. Such recalls were auditory, as opposed to visual, and the possibility is considered that visual stimulation is more likely to be traumatic than auditory stimuli.

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ON THE CONCEPT AND CONSEQUENCES OF THE PRIMAL SCENE

BY HAROLD P. BLUM, M.D.

The concept of the primal scene is in need of redefinition and clarification. The primal scene is not identical with its regressive transformations or later derivatives. Because of the different implications for normal development and for psychopathology, the primal scene as a universal fantasy should be differentiated from the primal scene as real experience. The effects of exposure to the primal scene are considered in relation to the developmental level of the child, other problems in the parent-child relationship, and cultural attitudes.

The primal scene has been so intrinsic to clinical psychoanalysis and so salient in the development of psychoanalytic theory that it has become one of our basic concepts whose definition, developmental role, and clinical significance have usually been taken for granted. Our literature is replete with reports of primal scene disturbance; the pathogenicity of the primal scene has been invoked as a major determinant in virtually all forms of psychopathology—in neurosis with inhibition of learning and curiosity, in sexual dysfunction, in sleep disturbances, nightmares and night terror, etc.

Primal scene traumatization has been delineated in the etiology of the perversions, and disguised primal scenes can often be uncovered in perverse masturbation fantasies. Primal scene shock results in fixation and tendencies toward greater regression; thus preoedipal impulses and primitive ego defenses and functions, along with archaic superego reactions, have been commonly discerned in such cases. Primal scene shock, particularly if repeated, has been used to explain damage to ego devel-

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opment and object relations, the formation of sadomasochistic patterns, and the shifting or oscillation of identification, with instability in the sense of identity and in the personality organization. In fact, Esman (1973) wondered whether the primal scene, as a ubiquitous factor in the explanation of all forms of psychological disorders, explains everything—and nothing.

The concept of the primal scene has included both the fantasy and the actual experience, sometimes with no attempt to differentiate one from the other, and has been extended to the most varied derivatives and transformations. The configuration of the primal scene has represented not only the parents in the act of copulation but regressive and associated infantile meanings as well (Edelheit, 1971). The primal scene schema has encompassed secondary transformation in myth, crucifixion fantasies, etc. To refer to "the primal scene" without specifying the developmental levels involved, whether it was fantasied or real, whether there was single or repeated exposure, or whether remotely related derivatives are being considered may result in a conceptual confusion in which the primal scene may represent all things at any time. Its diffuse definition may also partially account for differences in the frequency and significance of the primal scene reported in the clinical material of different analysts. The expanded meaning and application of the concept has raised new questions concerning its definition and its relation to developmental phase and role, as well as its relation to trauma, personality disorder, sadomasochism, and sublimation.

To have a consensual definition of the primal scene, I believe that it should be differentiated from its precursors and derivatives. Historically and conceptually, the primal scene fantasy has been related to infantile neurosis and oedipal conflict. The primal scene fantasy of witnessing parental intercourse is a phallic-oedipal phenomenon which may have the most varied and disguised regressive or sublimated transformations. The phallic phase primal scene fantasy is not the oral triad or the fused dyad of symbiosis or the conjoint anal act of defilement or excretion. The primal scene should also not be confused with the negative

oedipus complex of the male and its regressive masochistic manifestations, although primal scene fantasy may have any or all of these regressive infantile interpretations. The child's ego immaturity and cognitive confusion can still be discerned in the oedipal child's distorted theories of sexual relations and reproduction. The young child does not have factual knowledge of sex and reproduction or the capacity to assimilate "the facts of life." If the primal scene is a dramatic representation of the oedipus complex and in a figurative sense is "the family romance," it is nevertheless not identical with the oedipus complex and all of its myriad derivatives. Just as the primal scene inevitably elicits reactions of rejection and exclusion or of intrusion, so there are serious problems on a theoretical level about what to include in the basic concept of the primal scene and its scope and boundaries.

The primal scene is oedipal drama at the point of highest intensity, the representation of passionate attachment and conflict between parents and child in the oedipal triangle. In the literal drama, the fantasy of the primal scene figures prominently in classic works, for example, *Oedipus Rex* and *Hamlet,* as well as in modern plays such as *Who's Afraid of Virginia Woolf?* and *Equus.* The drama and dance in form and content may be traced to the primal scene, with actors, audience, acts, action, and performance, as well as physical and psychological barriers between the actors and the audience. These barriers represent, of course, not only the door and walls of the bedroom but the prohibitions against participation in parental sexual activity, the universal taboo against incest. Typically, fear of looking (and listening) are linked to forbidden looking and punitive blindness or denial.

In Pirandello's *Six Characters in Search of an Author* (Kligerman, 1962; Wangh, 1976), the characters are stagestruck and, in association with the disguised primal scene, seek an author, a creator, like mighty Oedipus, who will answer the great riddles of life. Condensing the passions of the oedipus complex, the primal scene represents active and passive, male and female,

phallic and castrated, the bisexual combination of masculinity and femininity, and double identification in incestuous intercourse.

The primal scene is thus related not only to ancient fertility rites, but directly to the creation of the family. Primal scene curiosity leads to questions concerning pregnancy and birth and the origins of babies and parents. The confused child wonders, "Who does what, how, why, and to whom?" The young child misconstrues sex differences, sexual relations, impregnation, and birth, and conscious distortions often persist throughout childhood. Some primal scene fantasies refer to being present at the moment of creation of self and sibling. The primal scene is the quintessential oedipal drama; it thus represents the dramatic tension, conflicts, and questions of the oedipal child and, through displacement and condensation, may represent any oedipal derivative. Many derivatives of the primal scene occur right in the parental bed where so many children are allowed to rest or sleep, where games, study, and group reading occur, and often where the family watches television and practices playful togetherness. Other oedipal derivatives, such as the fantasy of castration or punishment in the act of intercourse, may be represented in primal scene imagery.

Freud's momentous leap from his patients' reports of parental sexual seduction to universal fantasies of incest led him to the oedipus complex. Yet his discussions of the primal scene are indicative of his continuing preoccupation with issues of early seduction and trauma and searching efforts to find the difference between fantasy and actual traumatic experience. Freud referred to the primal scene in both the Dora Case and in the *Three Essays*. Dora's dyspnea was related to her overhearing the primal scene, an experience which "may . . . have made the child's sexuality veer round and have replaced her inclination to masturbation by an inclination to anxiety" (1901, p. 80). In the *Three Essays* Freud noted that the primal scene is always overstimulating and that children will "inevitably regard the sexual act as a sort of ill treatment or act of subjugation: they

view it, that is, in a sadistic sense" (1905, p. 196). Freud was concerned about seduction trauma even after formulating the oedipus complex and the inevitable primal scene fantasy.

Two important questions related to the traumatic effect of the primal scene concern its proposed universal interpretation in sadomasochistic terms, and the difference between the primal scene as universal fantasy and the primal scene as an actual experience and observation: When do the fantasies develop, and what are the effects of actual overstimulation, genital exposure, and parental seduction?

Freud never overlooked either the difference or the interplay between reality and fantasy: he wrote of the influence of reality and of the shaping of children's theories concerning sexuality and in particular the primal scene. Referring to fragments of truth, Freud (1908) noted "the sex battle" that may actually precede the sexual act. He stated:

> In many marriages the wife does in fact recoil from her husband's embraces, which bring her no pleasure, but the risk of a fresh pregnancy. And so the child who is believed to be asleep (or who is pretending to be asleep) may receive an impression from his mother which he can only interpret as meaning that she is defending herself against an act of violence. At other times the whole marriage offers an observant child the spectacle of an unceasing quarrel, expressed in loud words and unfriendly gestures; so that he need not be surprised if the quarrel is carried on at night as well, and finally settled by the same method which he himself is accustomed to use in his relations with his brothers and sisters or playmates.
>
> Moreover, if the child discovers spots of blood in his mother's bed or on her underclothes, he regards it as a confirmation of his view (pp. 221-222).

Freud's remarks are crucial to contemporary psychoanalytic reconstruction and to an attempt to understand both the traumatic and the sadomasochistic interpretation of the primal scene and, conversely, the influence of sadomasochism on the primal scene and its interpretation and misinterpretation. (The primal

scene and sadomasochism are not equivalent or synonymous concepts. Sadomasochistic phenomena and masochistic character types have many other important determinants in addition to primal scene reactions.)

Greenacre (1967) defined trauma as an experience definitely unfavorable, noxious, or drastically injurious to development, and the primal scene has been related to all the categories of interference with development, with resultant fixation and tendencies toward developmental arrest, deviation, or disorganization. Primal scene trauma is not readily differentiated from other forms of parental exhibitionism and seduction. Exclusion from the primal scene may be associated with loneliness, rage, and feelings of rejection as well as masturbatory excitement and consolation. On the other hand, inclusion in the primal scene may be the equivalent of an incestuous perversion. While participation in actual primal scene experience is far more overstimulating and threatening to the ego, neither repeated exclusion nor inclusion in the primal scene may be readily described in terms of isolated experiences of shock.

As Anna Freud (1967) noted, trauma itself has lost its original and very specific meaning and has come to refer to almost any pathogenic event rather than to those instances in which the ego is overwhelmed. We may be in the same situation with respect to the primal scene and in our evaluation of its pathogenicity. As in the case of trauma, it is necessary to apportion pathogenic responsibility correctly to outside and inside forces and to determine whether and under what circumstances the primal scene is not necessarily pathogenic.

Esman (1973), in his thoughtful review of the primal scene concept, questioned the universality of the primal scene as a sadomasochistic experience and pointed out that the "fragments of truth" noted by Freud are often overlooked in clinical reports in which the primal scene is regarded as a primary pathogenic and traumatic factor. Considering the pathogenicity attributed to the primal scene, often regardless of the age or ego resources of the subject, Esman observed that parental seduc-

tion, violence, and brutality are not included as determinants in explanations of the sadomasochistic conception of the primal scene. The parents' actual behavior toward each other and toward the child is, in fact, of great importance in the child's interpretation of the primal scene and therefore in the formation and resolution of that particular child's oedipus complex.

As noted before, it becomes quite difficult to differentiate the primal scene as a specific experience—with its own determinants and consequences—from other experiences of parental abuse, perverse manipulation, and narcissistic exploitation of the child. The child's object relations and the parents' reaction to the child outside and inside the primal scene configuration contribute to the meaning of the primal scene and to the child's mode of defense and other ego responses to the instinctual stimulation.

Freud (1910) delineated the influence of the primal scene on sexual preference and object choice and the need of the child to disavow knowledge of parental intercourse in order to safeguard the idealization of the parents. We are reminded of the Biblical meaning of "knowing" and of the child's not "knowing," contrasting with the child's feeling of parental deception and infidelity in his or her exclusion from the primal scene. Defensive falsification by the child and the parents fosters fabrication and idealization and is related to fantasies of the virgin mother and the immaculate conception. Greenacre (1966) elaborated on this aspect of primal scene exposure in her paper on the overidealization of the analyst and analysis. Magical identification with the sexual partners may serve to master the overstimulation, while idealization of the sex organs, act, or partners may defend against fantasied injury to the self or object (Chasseguet-Smirgel, 1974). The devaluation and denigration of the sexual parents also occurs, often associated with feelings of betrayal and narcissistic rage.

Freud's (1914) most complete discussion of the primal scene is found in his case history of the Wolf Man. He described not only his conclusions about the primal scene but his doubts and

inner debate, his own conflicts and uncertainty concerning a variety of formulations. This profound and detailed reconstruction of a primal scene that had been experienced at eighteen months of age is probably the most famous reconstruction in psychoanalysis (Blum, 1974). The case did not result in the lifting of an infantile amnesia with the recovery of a childhood memory, but the reconstruction of the primal scene included the exact sexual activity of the parents as witnessed by the infant at eighteen months of age. The child was suffering from malaria and wakened to the primal scene disturbance with a bowel movement. In his reconstruction, Freud leaned heavily on the Wolf Man's nightmare at four years of age, which was itself a childhood memory that was analyzed in the Wolf Man's adult analysis. The wealth of data in the analysis confirmed the primal scene reconstructed from the Wolf Man's nightmare. Freud noted that the dream was another form of remembering and that reconstruction was, in this situation, equivalent to recollection.

Freud's astonishment at the implications of this preoedipal reconstruction of an almost preverbal phase of development led him in several different directions. He tried reconstruction to six months of age but rejected this developmental inference as impossible. Then he invoked the concept of phylogenetic memories which might require some sexual stimulation but could also be universal without any specific sexual experience. He also invoked the concept of deferred trauma in which the child's understanding of the primal scene and its traumatic consequences did not occur until the time of the nightmare on his fourth birthday.

Freud was here clearly concerned with what would now be called phase-specific effects of trauma, problems concerned with trauma at different levels of development. The Wolf Man's terrifying identification with a castrated mother in the primal scene was reconstructed forward to the oedipal phase. In this explanatory postulate, which was not the only one that Freud used, the effect of the primal scene at eighteen months, by virtue

of its activation at age four, was the same as if it had been a phase-specific recent experience. The Wolf Man's crippling neurosis, his bisexuality, his homosexual wishes for copulation with and impregnation by the father, his infantile fixations and characterological passivity, were all attributed in very large measure to the extraordinary traumatic effects of a single primal scene. The primal scene was originally experienced in the anal phase and in what we would today call the rapprochement phase of separation-individuation (Mahler, 1971), long before phallic phase-specific fantasies. Freud (1914, p. 103, n.) noted that he was considering the issue of "the part played by phantasies in symptom-formation and also the 'retrospective phantasying' of late impressions into childhood and their sexualization after the event."

Thus Freud again raised the question of primal scene fantasy versus primal scene exposure and acknowledged that the Wolf Man's view of the primal scene in terms of coitus *a tergo* was indicative not only of anal fixations, but also of his having observed animal copulation. While maintaining the fundamental importance of the primal scene in the Wolf Man's infantile neurosis and in his later symptoms and personality disorder, Freud was nevertheless inconclusive about fantasy versus reality (1914, p. 60). At one point he remarked that it was a matter of indifference whether the primal scene was a primal fantasy or reality in the Wolf Man's case (p. 120, n.).

The issue of primal fantasies and even of phylogenetic memories has been relegated to the far background of analytic consideration as much more has been learned of preoedipal development and the interplay of special sensitivities and infantile experience. However, Anna Freud (1951) observed children reared in wartime nurseries who appeared to act out coital fantasies and who had never had the opportunity to see their parents alone together or to observe adult sexual activity. The coital play of these children appears to be the expression of preformed instinctual attitudes (perhaps akin to Freud's "phylogenetic memories") which, for Anna Freud, indicated doubt

about analytic reconstruction of an actual infantile primal scene.

Anna Freud's (1951) observations of the telescoping effect of memory are most pertinent to the consideration of the shock trauma of a single primal scene experience. The formulation regarding a single preoedipal shock in the case of the Wolf Man now seems untenable when compared with the importance of such factors as the pathogenic patterns in the Wolf Man's earliest object relations and the effects of the life-threatening malarial illness. What is reported by a patient as a single event may be an event that has been repeated many times as a more or less typical experience; and shock traumata are overlaid with their aftermath (Kris, 1956). The anxiety, excitement, and guilt are elaborated in fantasy, and these fantasies themselves may be disguised and acquire new meanings during the course of development. Thus, the primal scene itself may become incorporated into a later screen memory; or the primal scene may *be* a screen memory. The differentiation of fantasy and reality becomes a complicated issue.

In the case of the Wolf Man, the timing involved in Freud's reconstruction of the primal scene, indicating a developmental disturbance at eighteen months, would be consistent with modern psychoanalytic knowledge of ego development and object relations and the later vulnerability to further trauma and regression. The later sexual seduction of the Wolf Man by his sister and primal scene experience were superimposed upon a personality organization which had not successfully negotiated pregenital phases and separation-individuation and which remained vulnerable to trauma and disruption of development (Greenacre, 1956, 1967).

More controversial than questions concerning the effects of the frequency and intensity of primal scene stimulation are issues surrounding the primal scene concept at different levels of development. Are primal scene fantasies of the preoedipal years and even of the preverbal period condensations derived from several levels of development? Preoedipal primal scene

exposure can best be evaluated if there was definitely no continued or later exposure. The primal scene may be a screen memory for other oedipal and preoedipal traumata or may be regressively represented and linked with preoedipal problems. Even when the child is given knowledge of the "facts of life" in the verbal and nonverbal behavior of the parents, does not such knowledge tend to be assimilated in terms of phase-dominant fantasies rather than of accurate comprehension? Children continue to fear castration and to have oral impregnation and phallic woman fantasies in the presence of educational efforts and enlightenment.

Although primal scene fantasy is associated with the oedipal phase, primal scene exposure may occur at any phase. Trauma may cause regression and reinstatement of previous phases, but it has also been hypothesized that it prematurely activates later phases of development. The effects of the primal scene must surely be quite different at different levels of development and quite different when the primal scene is an oedipal fantasy, or a phase-specific oedipal trauma, as compared to the primal scene at eighteen months of age during the anal phase and separation-individuation.

The effects of the primal scene as a phase-specific trauma or the primal scene experience as an out-of-phase form of overstimulation are still being debated. It is difficult to understand how the immature ego of the infant who has not yet completed and consolidated differentiation could comprehend the primal scene in terms of the perceptual and cognitive discriminations and judgment of later phases of development. As an out-of-phase stimulation, the primal scene may be fitted into the child's current phase-specific conflicts or may arrest and distort the developmental sequence. Phase disorganization may be followed by traumatic fixation and pathogenic effects on the developmental sequence. With our present greater understanding of preoedipal development, it seems to me that it is no longer necessary to postulate delayed response to trauma; by definition, trauma has immediate consequences for the overwhelmed ego. This does

not mean that trauma does not take on new meaning at new developmental phases or that subsequent events may not aggravate or ameliorate earlier disturbance. Preoedipal exposure to the primal scene occurs at a time of ego immaturity, with infantile modes of perception, cognition, and affectomotor response. Affectomotor communication is still important, although verbal language will become ascendant. The sexually involved parents are not likely to be empathic and concerned with the infant's needs. The possibility of contagion of excitement with traumatic overstimulation of the infant is significantly increased if the child's presence is important for the parents' excitement, and if the child's self-object differentiation is not fully consolidated and is vulnerable to regression. If ego boundaries are unstable, there is more likely to be primary identification and fusion fantasies.

Exposure to the primal scene at eighteen months of age could be understood as causing a disturbance of the rapprochement phase, with aggravation of rapprochement conflict and crisis tendencies. As we now know, children have begun to differentiate between the sexes by this time and to show the precursors of castration reactions (Galenson and Roiphe, 1976; Kleeman, 1976). However, castration anxiety would be fused with the crucial separation anxiety of this infantile period. The dominant danger situations described by Freud, the loss of the object and of the object's love, with parallel fears of loss of self and ego integration, represent the major threats. The primal scene would then be a relatively nonspecific trauma impeding separation-individuation, but it could also predispose the infant to anal fixation and to heightened castration anxiety and narcissistic injury.

In Western culture, the primal scene is perhaps most commonly experienced by preoedipal infants who are allowed to stay in the parents' bedroom until a later stage of development. Exposure of these infants to the primal scene may result in a generalized overstimulation and disturbance, which is associated with the parents' failure to protect the child, and in

developmental disturbance related to other dimensions of a disturbed parent-child relationship. The exposure may be primarily auditory-kinesthetic at night, but it can also involve visual shock and perceptual displacements. Where reality factors permit other arrangements, why do some parents keep the child in the room (bedroom and bathroom)? What is the parents' need for the child's presence? It appears that "primal scene exposure" has become an umbrella concept for various forms of pathological object relations, insufficient parental auxiliary ego functioning, and the sexual and aggressive abuse of children and their narcissistic exploitation by immature or deviant parents. Similarly, we sometimes fail to differentiate the effects of primal scene exposure from other disturbances which may interrupt or dislocate development, such as infantile physical illness, illness of the parent, object loss, or the birth of a sibling.

The primal scene, then, must be evaluated in terms of its actual effects at the time of the experience, the child's ego state and development, and the total psychic situation, including the reaction of the parents at the time and the influence of earlier and later developmental phases and experiences upon each other. The nature of the trauma also depends upon the degree of the child's ego immaturity, fantasy life, and ego strength, and the revival of old conflicts and traumata versus the capacity for meeting developmental challenge and mastery of trauma. It should be remembered, too, that "the primal scene" of exposure to parental intercourse is different from exposure to the intercourse of more distant relatives or strangers, or to seduction by siblings.

Besides the pathological consequences of the primal scene, Freud (1925) also commented upon its arousing, stimulating influence on the child's entire sexual development. The child's curiosity, affective development, and intellectual activity could be stimulated. The developmental role of childhood and adolescent masturbation with primal scene fantasy should be considered in relation to sex role rehearsal, consolidation of identification systems and sexual identity, preparation for adult

object choice and relationship, and motivation for parenthood. Fantasy may serve as trial action and as a means of experimental adaptation, as well as serving the usual function of defense and symbolic gratification. The universal fantasy of the primal scene could represent oedipal conflicts and solutions; the fantasy itself, in the context of age appropriate development and structure, is not necessarily a pathogenic influence. The child projects his or her own impulses onto the copulating parents or onto other dimensions of the parental relationship. The normal, expectable primal scene fantasies are created by the child and influenced by the actual relationships and unconscious communications of the parents. The fantasy will represent infantile gratifications on various levels and defend against dangers of castration, separation, etc., while castrating and separating the parents.

Today, I believe we are inclined to give much more weight to the organizing and disorganizing effects of real trauma and to attempt to differentiate between incestuous fantasies and actual seduction in primal scene exposure. The complexities of differentiation and multiple causes have clinical and theoretical implications. Cases of real trauma are much more likely to be associated with persistent tendencies toward acting out and traumatic repetition. Defenses such as denial, isolation, and splitting of representations may be more prominent and pervasive, especially in cases of multiple exposure and chronic overstimulation. There are often greater needs for control of situations and objects and greater interference with curiosity, learning, and memory. Derivatives of the primal scene trauma may be detected in the patient's recurrent dreams, symptoms, character disturbance, and altered ego states.

Even when children have been actively seductive rather than "accidentally" exposed, passive participants, they may elicit parental responses beyond their intent and control. With repeated exposure, the "split" between observer and participant, between the sexually degraded and the idealized asexual parent, may be defensively intensified. Active or passive collusion has usually

developed between all the partners. The ultimate clinical test of primal scene trauma is in the transference where the trauma may be revived and re-enacted in exquisite detail of sight, sound, action, etc., or it may be reconstructed from more remote clues and derivatives (Greenacre, 1956, 1967). Severe traumatization may be associated with massive denial and often with detachment, depersonalization, and perceptual disorder (Greenacre, 1973; Myers, 1973). The nature of the primal scene trauma has not been correlated with clinical differences in its retrieval via conscious recall, recovery from repression, or analytic reconstruction. The parents may oppose recall.

Trauma must be considered in terms broader than the single shock-like experience described in the case of the Wolf Man. The Wolf Man's immobility, helplessness, terror, and screaming were typical of shock trauma and probably condensed malaria attacks and other narcissistic assaults and preoedipal traumata, reactivated and reorganized in the oedipal primal scene. Fraiberg's (1952) description of multiple traumata in a two-and-a-half-year-old girl is pertinent to the overdetermination of primal scene disturbance. The child had seen her mother's sanitary napkin, had had sadomasochistic reactions to the previous birth of a sibling, had undergone genital examinations and a series of injections given by her pediatrician for an infection, and had engaged in genital play with another child. Witnessing her grandparents in intercourse when her parents were away was followed by wetting and by being punished by the grandparents. Her infantile fantasies were validated, distorting her sense of reality and precipitating her neurosis. One can imagine the difficulty in adult analysis many years later of sorting the various pathogenic influences, estimating their power and importance, and attempting reconstruction of the intrapsychic significance of the early events. It would be a major task, if not impossible, to unravel the later accretion and alteration of meanings and subsequent developmental impact.

The chronic strain of instinctual overstimulation and pathogenic patterning are emphasized in contemporary psychoanalyt-

ic studies. Particularly severe traumata, including the primal scene, may result in permanently altered or impaired ego functioning in the areas of reality and identity, affect storms, and persistent intrusion of primary process fantasy into conscious thought. Initial shock-like disorganizing effects may be followed by pathogenic organizing effects with various ego and superego impairments and tendencies to repeat the traumatic situation. Lack of parental controls and limits predisposes to later superego maldevelopment in the child.

The affects associated with primal scene exposure have great clinical importance and may be recalled or reconstructed. The overstimulated oedipal child is likely to feel passionate jealousy, betrayal, and rage, as well as guilt over forbidden gratification. Later reactions of exhibitionism, infidelity, vengefulness (Arlow, 1978), and special conditions of sexual arousal or aggression related to fears of exposure may derive from the highly charged childhood traumata and affect storms.

In evaluating the primal scene, the social setting is significant in that it influences the child-rearing practices and living arrangements of the family. What is the effect of primal scene exposure under cultural conditions which sanction the child's passive participation as spectator and in which the parental reaction is seemingly without anxiety or guilt? How do different cultures foster or inhibit the child's exposure to the primal scene, the channeling of the accompanying excitement and affective reactions, and what are the implications for the development of the child and of the culture? Where the primal scene is frequently encountered, the child witnesses the parents' repeated lack of injury and might surmise their gratification. Does this repetition serve mastery of the stimulation and associated dangerous fantasies? Is it true that the primal scene is never interpreted by the child as an act of love or pleasure (Esman, 1973)?

It has been proposed (e.g., by Mead, 1928) that repeated primal scene exposure under certain cultural conditions might foster and facilitate the child's sexual and social development

in the context of that particular culture. The culture would determine superego injunctions and values and ego-syntonic attitudes. Cultural and social patterns influence the channeling of the instinctual impulses, the modes of defense, and the forms of exhibitionism or modesty, privacy or intimacy; these in turn give meaning to the child's interpretation of the primal scene. Under favorable cultural and familial conditions, primal scene exposure might possibly act as a spur to curiosity and foster identification with the embracing parents. Learning might be encouraged through initiation into privileged adult activities. Many sublimations with primal scene content might have such a genetic determinant.

To my mind these hypothetical benefits are the "uses of adversity," the successful turning of passively endured trauma or turmoil into actively repeated and reorganized derivatives in the service of mastery. Ego mastery would have developmental consequences vastly different from those of traumatic fixation. However, that even excessive stress and distress may ultimately be utilized by the resourceful child for adaptive purposes or sublimation does not mean that excessive stress is beneficial or even harmless.

None of these adaptive possibilities contradict the ubiquity of cultural condemnation of incest and unconscious guilt over incestuous temptation. How is it possible to account for reports of lack of anxiety and guilt in connection with the activation of incestuous impulses when every culture demonstrates the universality of the oedipus complex with all its conflicts and with the taboo of incest? Is the excited child really not in conflict where culture and parents seem to sanction observation of the primal scene and parental nudity? Unconscious oedipal guilt is not only unavoidable, but intensified when there is actual primal scene experience. Similarly, parental permission to masturbate does not represent the whole of parental oedipal attitudes or obviate the child's guilt over incestuous fantasies linked to the primal scene. Does not the frustration of intense sexual arousal with an immature apparatus for the discharge of ten-

sions and with an inevitable inability to participate on an adult level in the primal scene tend to produce reactions of passionate jealousy and aggression? These issues are relevant to the question of the universal interpretation of the primal scene in terms of sadomasochism. The child's biological incapacity and exclusion from primal scene participation are related to inevitable oedipal disappointment, narcissistic injury, and hostile rivalry and jealousy. These reactions are enormously intensified if the child is included as a real participant in the primal scene, which becomes familial perversion rather than vicarious fantasy.

That the primal scene has no regular or predictable psychological consequences does not diminish the problems posed by such exposure or other overstimulation. While the actual primal scene is not inevitably pathogenic and may represent a telescoped screen memory for other traumata and patterns of strain, I believe that the traditional psychoanalytic formulation of its pathogenicity has essential validity. Primal scene exposure is not benign for the immature child, but an overstimulating, potentially pathogenic experience. The experience on an oedipal level is always unconsciously conflictual, guilt-provoking, and a focus for pathology. It need not necessarily result in overwhelming trauma or permanent developmental damage to be an adverse influence. Trauma is overdetermined, and children contend with many different traumatic experiences, noxious influences, and developmental challenges. The child with sufficient inner resources and parental support may be able to cope with crisis in degree. The child who is predisposed and vulnerable may succumb to the stress of repetitive overstimulation and lack of protection with severe psychological disturbance.

As noted before, parents who re-enact primal scenes are often disturbed in other ways and in other areas of parenthood. Freud's (1938) final incisive comments concerning the primal scene extended to interrelated influences and confirmed earlier views:

> Our attention is first attracted by the effects of certain influences which do not apply to all children, though they are common

> enough—such as the sexual abuse of children by adults, their seduction by other children (brothers or sisters) slightly their seniors, and, what we should not expect, their being deeply stirred by seeing or hearing at first hand sexual behaviour between adults (their parents) mostly at a time at which one would not have thought they could either be interested in or understand any such impressions, or be capable of remembering them later. It is easy to confirm the extent to which such experiences arouse a child's susceptibility and force his own sexual urges into certain channels from which they cannot afterwards depart (p. 187).

The primal scene tends to be re-enacted in life as on stage. Repeated between the generations of grandparents, parents, and children in direct, disguised, and regressed forms, the primal scene represents basic human passions and conflicts. The frequently injurious effects of primal scene exposure on character structure and ego development may not be manifest, but can be traced in clinical psychoanalysis. There are very cogent psychoanalytic explanations for why civilized people wear clothes and seek privacy for sexual and excretory functions. Civilized morality and social stability require that parent and child renounce each other as sexual partners.

SUMMARY

The concept of the primal scene is re-evaluated and differentiated from its derivatives and regressive transformations. Primal scene fantasy is universal and plays a normal developmental role in the child's oedipus complex and identifications. Exposure to the primal scene is potentially pathogenic and may constitute shock or strain trauma in the predisposed and vulnerable child. The single primal scene exposure is much less likely to be pathogenic than multiple experiences of overstimulation with lack of parental protection. The difficult differentiation of fantasy from the reality of witnessing the primal scene or from the reality of parental seduction is of theoretical and technical importance. The pathogenic effects of primal scene exposure

are overdetermined, may serve defensive screening functions, and are related to other problems of parental protection or abuse of the child.

The effects of primal scene exposure at different stages of development are related to the issue of phase-specific trauma or nonspecific overstimulation. Children react to the primal scene in terms of their fantasy life and current developmental conflicts. Even when there might appear to be cultural and parental sanction without conscious guilt, the child's active or passive participation in the primal scene is bound to be associated with unconscious conflict and guilt. The prohibition of incest is universal and a precondition for culture. When primal scene exposure cannot be mastered or sublimated, pathological consequences and derivatives are likely to be repeated and re-enacted.

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PROBLEMS IN THE ASSESSMENT OF ANALYZABILITY

BY JOAN B. ERLE, M.D. and DANIEL A. GOLDBERG, M.D.

As additional studies of assessment of analyzability have been reported, research has proven very difficult and provided little clarification. This paper reviews the literature, particularly of the last twenty-five years, from the viewpoint of identifying the nature of the problems in developing useful methods of study. Some approaches to these problems, which might provide increased understanding as well as a clearer definition of some inherent limitations, are discussed.

Analysts have been concerned with evaluating the appropriate use of psychoanalysis since Freud first began to publish his findings. Freud (1904) early described some of the conditions under which this method would be indicated. It would be suitable for a neurotic patient not accessible to less demanding forms of treatment: a reasonably educated person of reliable character, possessing a normal mental condition (nonpsychotic), sufficiently young to be educable and flexible, and free of any dangerous symptoms that would require speedy removal.

What seemed relatively straightforward at first became increasingly complicated. Different types of patients were to be considered, successes and failures explained, variations in technique retained or discarded. Increasing theoretical advances led to further clinical explorations which in turn provided other hypotheses in a sequence that has often been described in the literature. The "widening scope" (Stone, 1954) has spread still further, and the discussion of indications, suitability, assessment, and outcome has continued. Definitions and criteria have become more difficult to articulate clearly enough so that observations could be compared.

Issues related to the choice of candidates for psychoanalytic training and the selection of patients as supervised cases for students have also come up in this connection. Most recently,

issues of assessment have emerged as a major methodological question whenever peer review or insurance coverage of analytic treatment is discussed.

During the past twenty years the emphasis on assessment of analyzability has been reflected in the publication of an increasing number of studies and discussions. In ordinary clinical experience the analyst is likely to evaluate a patient as 1) a good analytic prospect; 2) one for whom analysis is not indicated; or 3) one about whom there is some degree of uncertainty. Analysts are accustomed to regarding the initial judgment as tentative, although training and experience provide a degree of confidence that analysis is the appropriate treatment to recommend. When research or teaching is the focus, however, such judgments must be made explicit and evaluated in a different manner. This has proven difficult, and efforts to do systematic research on the selection of patients, the analytic process, and outcome have been disappointing. Critical review of the literature on assessment reveals increasing complexity and considerable confusion about all aspects of the process. The formulation of testable hypotheses required for research has been difficult.

This paper considers the questions pertinent to the decision to undertake an analysis and the reasons these questions have not been answered. Part I is a critical examination of the issues related to assessment of analyzability as described in the literature, particularly during the last twenty-five years. We note that attempts to treat various types of problems through psychoanalysis are accompanied by discussions of the modifications required in such cases. When do such modifications so alter the method that it is inaccurate to call the treatment a psychoanalysis? These controversial issues underscore more fundamental questions which are also discussed in the literature: How and to what extent can we evaluate our patients reliably at initial consultation? A number of recent studies of assessment are reviewed, in which the authors discuss methodological problems that are not yet solved. Part II of this paper discusses some of the technical and theoretical aspects of the study of patient selec-

tion, treatment process, and outcome which make the study of assessment complex and difficult. Some approaches to clarifying these problems are suggested. Part III concludes with a discussion of methods which might supply data for testable hypotheses about suitability for analysis from initial selection to outcome. A second paper (Erle, 1979) will present the findings in a study of intake, assessment, and suitability of a group of patients whose treatment has ended, and a further discussion of the methodological problems.

I

REVIEW OF THE LITERATURE

Early approaches to the question of analyzability were quite general. In *Analysis Terminable and Interminable* Freud (1937) identified three factors important for the success or failure of analytic treatment: the influence of traumas, the relative strength of the instincts at any particular time, and the extent of such "alterations of the ego" as defenses and resistances. In *The Ego and The Mechanisms of Defence,* Anna Freud (1936) estimated analytic prognosis according to the type of anxiety serving as the motive for defense. In particular, she noted that when the defense is derived from the patients' dread of the strength of their own instincts, the outlook for analysis is unfavorable.

In the next two decades the psychoanalytic method was applied increasingly to a range of problems characterized as "a widening scope" (Stone, 1954). The heightened interest in just how far the limits of psychoanalysis might be pushed and what problems might result was focused on in papers by Eissler (1953), A. Freud (1954), Glover (1954), and Stone (1954).

In discussing the effect of ego structure on analytic technique, Eissler (1953) described the "basic model of psychoanalysis" as that in which the analyst's activity is limited to interpretation (and occasional question). He then referred to situations in which the basic model is insufficient. The example given was

the phobic patient, for whom interpretation often gave way to advice or command that the patient enter the phobic situation. Such a maneuver Eissler called a "parameter" of a technique, a technical deviation of minimum degree, whose effect on the transference must never surpass that which can "be abolished by interpretation." He added that the boundaries marking irreparable effects on the transference remain to be defined.

Such a command to the phobic patient raises a question: Can the effects on the transference relationship be "abolished," even though the patient's reactions and associated fantasies, affects, impulses, and memories may be understood? The analyst in such examples becomes a "real" as opposed to a "transference" object to the extent that he intervenes in any way other than by interpretation to effect change in the patient. The analyst, moreover, has told the patient to act rather than having interpreted the patient's resistance to further analytic work. Some might argue that this is an inevitable limitation of psychoanalytic technique with certain patients, but in that case the analytic process has been significantly and substantially altered; the patient is being treated as if he or she is not analyzable.

Stone (1954), referring to the expansion of psychoanalysis after the Second World War to include virtually every psychological illness, wondered where analysis left off and psychotherapy began. He used the term "modified psychoanalysis" to cover the deviations from standard technique and wrote:

> If . . . the essential structure and relationship of analysis have been brought about, if a full-blown transference neurosis has emerged, if the patient has been able to achieve distance from it, if it has been brought into effective relation with the infantile situation, if favorable changes in the ego have occurred as a result of interpretation and working through, if the transference has been dissolved or reduced to the maximum possible degree, I would say that the patient has been analyzed (p. 576).

Stone noted, however, that to achieve such goals, an analysis may be modified by the introduction of "any number and

degree of parameters" necessary to meet special conditions. He took exception to Eissler's criterion that a parameter must terminate before the analysis terminates:

> The practical value of retention of this maneuver as consistent with true analytic work outweighs the ideal requirement. . . . There are very sick personalities who, to the very end of analytic experience, may require occasional and subtle or minimal emotional or technical concessions from the analyst, in the same sense that they will carry with them . . . vestiges of ego defects or modifications, which, while not completely undone, are . . . vastly improved (p. 576).

Stone's discussion raises further questions about the nature of the transference effects of certain technical maneuvers and the possibility of "analyzing" them. But his paper does illustrate a persistently knotty issue: the differentiation between therapeutic benefit and psychoanalytic process. The discussions by Eissler and Stone mark the start of an inquiry into which modifications of the basic model are consistent with an acceptable concept of analysis. When is a modification only different from the "ideal" and when does the process become fundamentally altered?

Glover (1954) noted that modifications of standard analytic technique would depend on "how widely the analyst casts his therapeutic net," and continued:

> It can, however, be fairly claimed that provided the usual techniques of association, interpretation and transference analysis are followed whenever possible, such modifications as are entailed by the clinical necessities of the case or by the need to safeguard such of the patient's interests as he is for the time incapable of safeguarding, can justifiably be called psychoanalysis (p. 409).

Suitability or "accessibility" to analysis was determined according to diagnostic groups.

Anna Freud (1954) asked whether standard technical considerations are sufficient for the analysis of character disorders and

perversions and wondered about legitimate technical means for keeping anxiety at an optimum level for treatment. She reported her experience in applying to two homosexual patients the same technical device: that they postpone pathological gratification in order to bring the ensuing anxiety into the treatment situation. Noting sharply differing results, she remarked, "Similar or even identical symptomatology may be based on very different psychopathology, and it is the latter, not the former, which decides how a case should be dealt with from the technical angle" (p. 51).

These earlier papers, then, deal in a general way with questions of suitability, indications, and technique. As the "therapeutic net" is cast more widely, issues become increasingly complex. Symptoms or diagnosis are used to determine technical devices as well as analyzability. When a term refers to different things in different patients, such a complex end-product of data collection as the "assessment of analyzability" may be murky indeed.

Since these papers appeared, there has been a burgeoning of literature on the subject of analyzability which demonstrates the lack of consensus in approach. The papers might be divided into those which are discussions of issues of assessment from a technical and theoretical point of view and those which report specific patient groups studied according to certain criteria. The order of presentation here is essentially chronological; more recent literature has tended predominantly toward reporting on specific groups of patients in relation to assessment of suitability, course of treatment, and outcome. This review focuses on those publications which we deem particularly relevant for documentation of the problems in developing methods of assessing analyzability.

At a panel on Criteria for Analyzability in 1959 (*cf.*, Guttman, 1960), all of the panel members referred to the uncertainties, difficulties, and variability in assessing analyzability at the time of initial consultation. Most proposed approaching this through increasingly adequate methodology, including clear

definition, increasing experience, and better theoretical understanding. Aaron Karush spoke of developing methods which would make "consistent early prognosis of analyzability . . . feasible" (p. 149). During the discussion, Rudolph Loewenstein suggested the possibility of some insurmountable limitation of judgment at the outset. Some patients may become analyzable through the process of analysis itself. He described patients whose neurosis is related to obtaining revenge. This is difficult to overcome; until it has proved possible to analyze that problem, it is uncertain whether analytic work can proceed. Heinz Lichtenstein asked whether a definitive initial assessment can be made when there are so many intervening variables and suggested probabilistic theories as more fruitful than a cause-and-effect model. Since they deal with the individual, analysts must accept a considerable degree of unpredictability.

In her summary of the panel Elizabeth Zetzel remarked, "While it is extremely likely that many analysts present would make similar evaluations and predictions with respect to certain patients, it is equally certain that they would advance different reasons for doing so" (*cf.*, Guttman, 1960, p. 150). This observation, made many times before and since, has not received the careful analysis it warrants. What might explain the different lines of reasoning by which a similar conclusion is reached? If a patient is seen by several interviewers, somewhat different material may emerge in each interview. Various interviewers may use somewhat different criteria and organize the data in varying ways. The reasons given may not reflect all of the conscious and unconscious considerations entering into the decision. These factors are recurrent sources of confusion unless explicitly identified and systematically studied.

In 1960, Waldhorn published an expanded version of his contribution to this panel. In a comprehensive review of the literature, he noted the absence of an "integrated discussion" of the "technical problems of assessing analyzability and the related theoretical problems of establishing specific criteria" (p. 478). With few exceptions, he found references to criteria or suit-

ability tangential or inferred from other issues under discussion. Approaches to assessing analyzability range from "clinical hints" (for example, Freud [1911-1915] in the *Papers on Technique*) to complex technical and theoretical discussions of the impact of certain character types, implications of the vicissitudes of development, and significance of functions of the ego (Anna Freud, 1936). Other approaches, such as those of Stone (1954) and Glover (1954), were also described by Waldhorn (1960). His survey concluded that "there does not appear to be any widespread agreement on [the] precise meaning [of such factors] or [on their] proper application in clinical situations" (p. 487).

Waldhorn proposed an approach through identifying the demands made on the patient by the analytic treatment: What psychic resources must be available, and how are these psychic elements to be evaluated? He noted the complexity of such an evaluation. Few of the factors provide an invariable contraindication. Many are subtle and variable, and much that is crucial may not be available until treatment is initiated; others may emerge very late or even at the end of analysis (see also, Waldhorn, 1967).

Some of the issues involved in assessing suitability for analysis were discussed in 1960 by Knapp, et al., in a report of "a preliminary study of the selective criteria, the way in which they were being applied, and the degree of resulting success" in a group of treatment center cases. For supervised analysis, they sought patients with "classical symptomatic neurosis." Other criteria for acceptance, such as ego strength and motivation, were less explicit. A random group of these patients was selected for further study after they had completed a year of their supervised analysis. There was some evidence in this study for the importance of factors which have previously been recognized through clinical judgment or intuition, or derived from theoretical propositions. These include motivation, frustration tolerance, capacity for object relations, and the need for more careful definition of healthy forces in the personality. Also noted was the relevance of the experience and attributes of the analyst and

of the raters. This was the first of a number of such studies in the literature that have attempted an evaluation of initial assessment of treatment center patients from the protocols at application and have compared this to follow-up data obtained from the analyst or supervisor.

A study reported by Feldman (1968) highlights two problems in the evaluation of studies of assessments of analyzability. The first is dissimilar criteria for measuring results. The second is the lack of data on the treatment results of graduate analysts with which the results of student analyses may be compared. Actually such a comparison would be essential not only to a study of outcome but to the evaluation of any aspect of assessment.

Feldman reported the results of the analysis of all cases selected by the Intake Committee of the Clinic of the Southern California Psychoanalytic Institute. He noted at some length the methodological problems raised by lack of criteria and definition, limited information, confusion about the goal of treatment (e.g., "worthiness," "interestingness," "teaching value," as well as "potential for improvement through analysis"), and lack of criteria for judging improvement. A list of eight factors which contributed to an inadequate evaluation by the committee in one or more cases included four factors related to the patient's withholding information or presenting in a misleading manner. The remaining categories reflected errors or difficulty in reaching agreement by the committee. Comparing the 64% of cases reported as having "good" or "very good" results at the time of review (one hundred sixty to over one thousand hours of treatment, averaging three to four hundred hours; ninety-nine cases; rated by the researchers) with the 48% in the Boston series (Knapp, et al., 1960) and with 25% of first control cases reported to the American Psychoanalytic Association (Robbins, 1965), Feldman noted the dissimilar criteria for good result. It is also clear that there is no standard of comparison for the distribution of treatment results in other groups of cases where analytic treatment is attempted. There are, for example, no studies in the literature on results in cases treated by experienced analysts or

in private practice except for some of the patients included in the series of the Topeka Psychotherapy Project (Kernberg, et al., 1972).

In a more detailed study, "Bases for Judgment of Analyzability," Lower, et al. (1972) attempted to determine how practicing analysts decide on analyzability. They also studied the similarities and differences in the way that twenty-seven analysts (the practicing analysts who did the interviews) and a five-member intake committee arrived at their evaluation of suitability for supervised analyses. They were judging "potential for improvement through psychoanalysis" with the emphasis on "positive outcome predictors." The screening analysts recommended that twenty-eight of a group of forty patients be accepted; the committee, after reviewing the data supplied by the screening analysts, accepted sixteen of the twenty-eight. The more frequent acceptances by the screening analysts were attributed to their being "more subjective" than the committee, that is, more influenced by favorable impressions in their contacts with the patients. The committee responded more often to data the authors regarded as more suitable for objective demonstration: oedipal pathology, good social adaptation, good work performance, ego strength, mature motivation.

Three years later a follow-up study of eighteen cases accepted by the committee (Huxster, et al., 1975) reported that fifteen had been suitable for analysis, although six of these were suitable only for advanced or able candidates; three were termed unsuitable. The authors themselves identify a major problem in their assessments:

> It is not the existence of "oedipal pathology" in an applicant that makes for his being a good prospective analytic patient (or, for that matter, "preoedipal pathology" that makes him not analyzable) (pp. 94-95).
>
> We would now say that . . . many developmental attributes (ego functions) must have been attained, regardless of the psychopathological condition, the symptom complex, the level of psychosexual development at which inner conflict occurs, or the

> defenses involved in conflict resolution. Most basic among these functions are the capacities for object constancy, for differentiation of self and object representation, and for tolerance of frustration, anxiety, and depression—attributes necessary for a stable therapeutic alliance to exist as a background against which transference phenomena may be recognized and analyzed (pp. 100-101).

It will be of interest to hear whether a subsequent series is more satisfactorily chosen since ego functions can be as difficult to evaluate in initial interviews as the structure and dynamics of what are apparently oedipal conflicts. The authors note that such attributes cannot be adequately assessed without a trial analysis and state that "there must be pitfalls to each approach" (Lower, et al., 1972, p. 618).

In each of the contributions we have discussed so far the difficulties in making reliable initial evaluations are acknowledged. All refer to inadequate methods, particularly criteria not clearly defined or validated, and the limitations of the data available. The problems in overcoming these shortcomings are not studied systematically, however, and the obstacles are often viewed as likely to yield to improved methods. We think it would be more accurate to say that such attributes as ego functions and oedipal pathology often *cannot* be adequately assessed at the onset and that we must study more systematically when and why they cannot be, how this situation might be improved, and what may remain as a limitation of initial assessments.

Over the next several years even more complicated, multifactorial studies were reported. They exemplify the increasing difficulty in identifying reliable criteria or bases of judgment when the study method becomes so complex. An elaborate metapsychological assessment profile was developed by Greenspan and Cullander (1973) to allow comparison of the same patient initially and at various points of the analysis as well as comparisons to other patients. Their method uses a more or less conventional narrative report of the clinical interview and a twelve-item profile on which each item can be rated along a seven-point

range with a separate three-point specification of the rater's confidence in his ratings. This study does not adequately deal with problems of clarity of definition of attributes, consensual understanding, and basis of judgment. The clinical example included allows readers to check their own impressions against those of the authors in relation to evaluation of the patient and the usefulness of these scales. The authors comment that "although the final criterion for analyzability is the analysis itself, we are required in our daily practice to make the determination of analyzability within the limits of one or several interviews" (p. 303). In our view, the requirement would be more appropriately defined as the need to determine whether an analysis should be *undertaken* and then to evaluate subsequently as treatment continues.

In a study titled "Assessment and Follow-Up in Psychoanalysis," Schlessinger and Robbins (1974) developed another rating system based on data from various specific points in the supervised analytic treatment. Material was submitted about the onset, point of decision to terminate, termination, and follow-up. Ratings were made according to sixteen categories of psychic functioning, such as object constancy, tolerance of frustration and anxiety, and "defense transference." Again, definition and evidence of reliability of the criteria are not specified. Similar problems are posed by a recent paper on psychoanalytic process by Graff and Luborsky (1977).

The active interest in Boston in predictive factors and assessment is reflected in another group of papers published in 1975. Sashin, et al., attempted to assess the usefulness of specific factors by rating one hundred five items from the data supplied in the report of initial evaluation interviews. There were one hundred eighty-three patients accepted for supervised psychoanalytic treatment through the Boston Psychoanalytic Institute between 1959 and 1966; each patient had terminated treatment. The outcome groups were classified according to the nature of the termination: Group 1—by mutual consent; Group 2—prematurely by the patient; Group 3—prematurely by the analyst;

Group 4—analysis became interminable. The groups were examined on over-all change and certain specific scales. The groups did not show significant differences at onset on those scales.

The discussion of the findings is particularly illustrative of the difficulties in reliably assessing such factors at onset. Some items were discarded as not discriminatory, but many, including the factors usually subsumed under "ego strength," found too little inter-rater agreement. There was a similar problem with "psychological-mindedness" and some items dealing with interpersonal relationships. No significant differences in motivation could be identified among one hundred twenty-two patients. Of fifteen predictor items found useful in distinguishing Group 1 from at least one other group, thirteen were part of the clinical history, such as family history and the presence of severe obsessional symptoms. The two exceptions, concerning relationships with other people, are not described in detail, but might require a judgment by the interviewer. In other words, the items found distinctive were regarded as matters of historical *fact;* all items (with the possible exception of two) which required *judgment* had to be discarded. These historical factors, such as severe deprivation, a frightened and passive father, a father or mother with poor work history, are largely negative ones to which clinicians are generally sensitive. Further information would be needed to demonstrate their usefulness as predictors. For example, as the analysis progresses, emerging data often requires revision of the initial reports, as in the recall of the repressed positive aspects of the relationships with parents or an entirely different version of an important event.

The authors discussed the limitations of incomplete and variable records and of retrospective information. They suggested that such a study would be stronger with outcome information from other sources, better records, perhaps including psychological testing, data about the analyst, and other pertinent items. They hope "to turn the often vague, subjective assessment procedure into a clearly understood, easily communicated scientific

process" (p. 358). Whether that improved process would be likely to overcome other limitations of the initial evaluation situation will be discussed below.

Using patients from the Boston Institute Treatment Center, Kantrowitz, Singer and Knapp (1975) presented another method for a prospective study of suitability: psychological testing. A review of past contributions noted such advantages as: indirect approach, relative standardization with easier comparison, survey of total ego function through a battery of tests, and the observation that in some hands psychological testing is a more accurate prognostic tool than interviews.

Four global aspects of psychological functioning were selected for study: reality testing, level and quality of object relations, affect availability and tolerance, and motivation for therapy. Terms were carefully defined and a detailed rating scale was developed. The authors emphasize the complexity and difficulty of these assessments. For example, the tests assessed current functioning and might not illuminate questions of regression. The testers, too, made "subjective" favorable assessments of certain patients.[1] The evaluation of motivation is apparently a classic difficulty in the current use of psychological testing since the opportunity to assess certain strengths, historical factors, and choices made by the patient is lacking. Affect was the most troublesome aspect to evaluate, with difficulty in discriminating between availability and tolerance of affect. The authors anticipated that the deeper, more refined and subtle data revealed during the analysis would permit better identification of the crucial determinants of analyzability. It might also, we may add, further clarify the limitations of predictions.

The most detailed study of patients treated with psychotherapy or psychoanalysis is the Topeka Psychotherapy Project. Since the authors (Kernberg, et al., 1972) studied a population already selected, the criteria for choice of treatment recom-

[1] It is interesting how rarely anyone notes or questions subjectively *unfavorable* distortions, although there may be an example of this in the case of a woman mathematician reported by Greenspan and Cullander (1973).

mended were not developed as part of the study. The process of the treatment was studied as well as degree of improvement along a particular scale. For the purposes of this discussion we will note their correlation of improvement with good initial ego strength, high initial quality of interpersonal relationships, high initial anxiety tolerance, and high initial motivation. Data was reported on patients screened by the same clinic staff and not accepted for analysis but instead referred for various types of psychotherapy.

This study provides information on some of the issues we have raised concerning the limits of evaluation. It is very common in the other studies we have quoted to discover that motivation has been overestimated. In this study, a group of psychotherapy patients did not score highly for initial motivation, but improved nevertheless. The authors comment:

> It may be that this issue [evaluation of motivation] can only be settled by studying motivation factors during an initial, stress-inducing part of the treatment, of a sufficiently long time to be able to assess this complex factor, and after a sufficiently short time not to contaminate one's assessment by knowledge of the outcome (Kernberg, et al., 1972, p. 172).

A. Appelbaum (1972) described another study based on the same data highlighting the methodological problems in such a complex field.

Although it is not uncommon in clinical discussions to hear reference to the patient who proves to be more suitable for analysis than had been anticipated, the unduly pessimistic evaluation is rarely referred to in any of these studies.

A last group of papers directs our attention to some other specific factors which require further study and clarification. These include the extraneous factors introduced in the selection for supervised cases, the vagueness in criteria of outcome (which is often proposed as a measure of correctness of initial assessment), and a number of issues relating to clarity and definition of terms.

Problems pertinent to selection for analysis by a candidate under supervision have recently been explored by Lazar (1976). This issue is highlighted by his example of supervising analysts initially recommending patients to the clinic and subsequently rejecting these same patients as unsuitable when they were assigned to candidates under their supervision. He writes:

> It is possible that the experienced analyst, functioning as a consultant, may at times be evaluating the patient on the basis of his own analytic skill rather than in terms of suitability for a candidate (p. 420).

An attempt is made to provide student analysts with cases that will provide an optimal learning experience in conducting a psychoanalysis. This brings up another facet of assessment: analyzable by whom? Whatever the significance of such a distinction, clearly reports in the literature based on treatment center studies may be expected to reflect some criteria different from those of more experienced analysts. Lazar reminds us, echoing Knapp, et al. (1960), that patients analyzable in one analytic situation may not be analyzable in another. The age, sex, experience, interest, and personality of the analyst are other variables. Some of these may be systematically explored more easily than others.

Lazar's paper, however, reflects another problem in the literature: the masking of the larger issue of analyzability behind a seemingly lesser technical or clinical point. He described four cases, of which three might well be considered unsuitable for analysis by anyone, not just by candidates. The issue in such cases may not be what Lazar calls "the magnitude of the potential technical problems" requiring the greater experience of graduate practitioners, but instead the question of analyzability under *any* circumstances.

A similar dilemma arises from the paper by Oremland, et al. (1975), one of the few follow-up studies on patients in analysis (*cf.*, Kernberg, et al., 1972; Klein, 1960; Norman, et al., 1976; Pfeffer, 1959; Schlessinger and Robbins, 1974). Oremland's

study focused on the vagueness surrounding the concept of completed analysis. Using the term "successful" to indicate analyses in which both patient and analyst agree on the therapeutic benefits and the decision to terminate, the authors cited two cases to illustrate that such therapeutic success may be technically and significantly incomplete. Large areas of important transference material were unanalyzed, with residual effects in the subsequent life of each patient. In one case a young married woman withheld material on her marriage, unprepared for the consequences should she decide to leave her husband on whom she was dependent. Hidden in this reality "resistance" was a significant transference fantasy that was enacted rather than analyzed by both patient and analyst. The authors noted that the analyst had no awareness of the withholding of the hidden transference fantasy. The second patient also withheld material, the authors again citing unresolved areas of the transference only partially recognized by the treating analyst.

These cases raise questions regarding the definition of a completed analysis and about the difference between analyzability and therapeutic benefit. Moreover, as in Lazar's cases, we might question whether they were ever analyzable. Put another way, did the incomplete analyses reflect the patients' unsuitability? Does such withholding, for example, point to features of the patient's personality which might render him or her unanalyzable in any case? This does not mean that therapeutic benefit is impossible. The special technical problems and limitations presented by such situations have been noted in patients with negative therapeutic reactions and masochistic personalities and in individuals with an intense wish for revenge.

Further difficulties spring from other inconsistencies in the use of the concept of "analysis" in various reviews and case reports. Tyson and Sandler (1971) called attention to the variability in the use of terms. Calling for sharper distinctions between "indications," "suitability," and "analyzability," they noted that the concept of "indications," based, as in Glover's work, on symptoms and diagnosis, is contrasted with the more specific, individual assessment of "suitability," the "presence or

absence of those qualities which would make it more likely that psychoanalysis could be of help" (p. 215). Regarding "analyzability," they remarked:

> It is possible that part of the attraction of the term lies precisely in the fact that it obscures the vital distinction between whether the analyst understands the patient and whether the patient can benefit from the analytic procedure (p. 218).

Limentani (1972) emphasized, but did not clarify, the distinction between "suitability" and "analyzability."

A variety of techniques have been included under the heading of psychoanalysis, resulting in vagueness and confusion about its definition. Kernberg (1975), in discussing treatment of borderline conditions, took care to point out that the techniques advocated reflect sufficient departure from the standard concept of intervention by interpretation alone to call for the use of the term "modified psychoanalysis," meaning an intensive psychoanalytic psychotherapy approaching, but not technically identical to, psychoanalysis.

Fleming (1975), writing on object constancy in the analysis of adults, described such a variation. She asked:

> Is it possible that the structural changes we hope for from the psychoanalytic experience can be facilitated by responses from the analyst other than interpretation in the usual sense of the term? My experiences in trying to understand the clinical phenomena that commonly appear in the course of psychoanalytic therapy have led me more and more insistently in this direction. The object need in many adults reproduces in many ways the functional relationship between mother and child—the diatrophic feeling, without which the analytic process meets with difficulty (p. 749).

Fleming illustrated this in her accompanying case report. A pattern developed in which the male patient would sit for a minute or two on the edge of the couch at the end of an hour, "looking me in the eye. Intuitively at first, I returned his gaze and made a comment or two. Occasionally, this exchange lasted for a couple of minutes." This "was understood as an intensified

regressive need for symbiosis. I simply responded to the need without making an interpretation" (p. 755).

We are not disputing the therapeutic benefits of such an approach in appropriate patients. However, we emphasize the associated blurring of the line between analysis and psychotherapy, when observed behavior is not analyzed. This blurring is crucial to the issues of analyzability, completed analysis, therapeutic benefit, and results. As one example, an analyst who shared Fleming's approach might call such a patient "analyzable" (and even contribute to a study of analyzability) without making such techniques explicit, while a more traditional analyst might label the patient unsuitable for analysis (and also contribute to the literature on analyzability), urging instead psychotherapy or "modified" analysis.

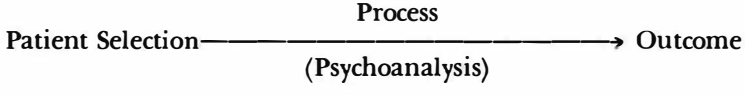
In a recent extensive review of the literature on analyzability since 1954, Bachrach and Leaff (1979) discussed the failure of investigators to indicate the evidence for their conclusions, adding, "It is therefore difficult to be fully cognizant of the nature of the populations referred to, selection, biases, and the extent to which one investigation may be said to truly replicate another."

Thus it is clear that the study of assessment has been impeded by a lack of consensus on approach and definition. This may be attributed in part to the failure to make clear statements of the terms being used, but the issues seem far more complicated. In the next section we shall explore some pertinent aspects of the evaluation situation, the analytic treatment and the methods available for study.

II

DISCUSSION

The situation we are examining might be schematically summarized as follows:



Study of this interaction requires careful definition and understanding of each of these three elements. Many papers, addressed to a wide range of clinical and theoretical topics, have touched on various facets of these issues. We will note some of these approaches and present our suggestions for more effective study of these questions.

Definition

The lack of definition of terms is a basic problem. Certainly, to the extent that terms are employed differently, investigators may be reporting different types of patients, processes, or treatments. It seems logical to begin with the definition of "psychoanalysis." Luborsky and Spence (1971), in a review of quantitative research in psychoanalytic therapy, noted that "it usually means an intensive treatment—three to five years of four or five sessions a week, in which the patient reclines and tries to say whatever comes to mind (free association), while the analyst responds interpretively with particular emphasis on the concepts of transference and defense" (p. 410). Other definitions refer more specifically to process, resistance, unconscious mental functioning, and infantile roots of neurosis (Eidelberg, 1968; Moore and Fine, 1968; Rycroft, 1968) or to transference neurosis and therapeutic alliance (Manual of Psychiatric Peer Review, 1976; Rangell, 1968). Brenner (1976) does not define psychoanalysis in terms of technique or elements of the process. He speaks in terms of the "analytic attitude, i.e., to attempt to understand the nature and origins of the psychic conflicts that underlie a patient's thoughts, feelings and behavior" (p. 132).

Whatever the significance of these differences in emphasis, it is surprising how often the treatment under consideration in studies of analyzability is not defined, or so vaguely defined that it is impossible to determine what specific treatment process was undertaken. Eissler (1963) stated:

> The classical technique is a subtle instrument; in almost all instances of psychoanalytic writings not enough details are

> published to make it clear whether it was actually used properly (p. 448).

For example, the technical issues cited in our review of the work of Eissler (1953), Fleming (1975), Kernberg (1975) and Stone (1954) are either not mentioned in studies of analyzability, or sufficient information is not supplied to permit adequate evaluation.

What appear to be minor differences in technique or "style" can often be traced back to an important difference in definition of the psychoanalytic process. It is conceivable that analysts might agree on basic concepts yet disagree about specific technical points. In a study group, two senior training analysts disagreed on whether it was appropriate to read the published book of an analysand. Should the analyst limit himself to data emerging in the consulting room? Is it appropriate to seek information about the patient from sources outside the analytic session?

We regard precise definition of the analytic technique or its modifications as central to the study of the questions of analyzability. For discussion and research it is necessary to identify the intermediate steps between basic concepts and observable phenomena. Ideally the study should specify observable phenomena which are regarded as consistent with that definition. There are differences of opinion about certain pertinent aspects of this question, on both theoretical and clinical levels. For a given study, however, precise specifications should be provided to permit evaluation of the nature of the treatment as well as patient selection and outcome.

The need for definition and specification would also apply to other aspects of the analytic process, such as transference neurosis, therapeutic alliance, and free association. The transference neurosis, for instance, is a complicated matter. Questions have recently been raised not only about its definition, but also about whether the shift in recent years from well-defined symptom neurosis to more diffuse character pathology in clinical practice meets its counterpart in a more diffuse, less well-defined

transference neurosis, more difficult to work with. In relation to outcome, what happens to the transference neurosis in analysis? Is it "resolved" (Schlessinger and Robbins, 1975)? Freud (1937), in *Analysis Terminable and Interminable*, pointed out that conflicts are never actually "resolved," but rather the balance of instinct and ego is changed so that after analysis increased drive derivatives are tolerated by a strengthened ego. Pfeffer (1959) has noted the ease with which transference residues are reactivated in follow-up interviews after completed analyses and questions "the degree and nature of the resolution of the transference." A clear definition of transference neurosis and its observable correlates would be imperative in any work describing the course of one or many analyses.

The term analyzability should be made equally explicit. In our view, the term should be limited to treatment potential: Is the patient treatable by psychoanalysis? In other words, will the psychic conflicts of the patient be modifiable through a treatment process which revolves around recognition, understanding, and eventual interpretation of those conflicts as they emerge in the analytic situation? The analytic process is distinguished by the analyst's unvarying commitment to the understanding and interpretation of the material which is revealed progressively through the patient's associations. Such concepts as "transference neurosis," "free association," "therapeutic alliance," "resistance," and "defense" refer to aspects of this process. Thus, Fleming's (1975) case would differ from this view of the analytic process in that certain behavior of the patient was not analyzed and interpreted.

Sometimes an analysis is attempted, but the analytic process does not develop. The failure may reflect the patient's unsuitability or other factors. Such a patient may obtain marked therapeutic benefit, with the use of some analytic methods and concepts, but such a treatment can be distinguished from a psychoanalysis. It is essential that the issues of therapeutic benefit and analyzability be separated, particularly if we are to avoid circularity.

The Selection of Patients

The major source of information on which the recommendation for analysis is usually based is the evaluation or consultation interview. What sort of perspective does the interview situation provide? What are the specific methodological problems related to this manner of obtaining data?

First, there is the material which is initially accessible to the patient. We are all aware of the great variation among patients in the nature and extent of the history that they can impart in initial interviews. Sometimes, detailed, sophisticated, consciously "frank" and "honest" presentations can be more obscuring than revelatory of historical details. Patients vary enormously in their capacity as observers of themselves and others. Moreover, their capacity for self-awareness may be affected in specific ways, such as in hysterics and obsessive patients. Much of the material presented in the consultation interview is descriptive reporting, and in the absence of associations and the uniquely specific information obtained in the analytic process, our conclusions about dynamic formulations may be substantially speculative. Such processes as repression, amnesia, and conscious withholding may influence material in imperceptible—even if expectable—ways. Some of the greatest difficulties may surround judgments of strength and the balance of pathological and nonpathological factors, with such limited information. For example, it may prove crucial to analyzability whether a specific traumatic experience occurred in relationship to a particular developmental phase or whether it was only secondarily related to it. Similarly, it may be difficult to evaluate whether the impairment of an ego function is explained by its involvement in conflict or in a more severe developmental distortion. The "pseudostupid" or nonpsychologically-minded patient may be more than adequately competent when a conflict about curiosity has been uncovered and is being worked through. S. Applebaum (1973) has given a detailed description of such a case.

It is often said that adequate or noteworthy functioning in

other life situations has prognostic value. So far, this has not been clearly supported, partly because the evaluation of a patient's report that he or she has succeeded or failed can be difficult. Further, the correlation of the attributes required for success in school or work and suitability for analysis is far from simple. One of the most familiar examples of this is the evaluation of applicants with very positive recommendations for analytic training. Such individuals may have done very well in their schooling and work but are found to have unanalyzable pathology.

Second, given the limitations of the data available to the patient, how does the interview situation affect its presentation? Again, motivation and honesty are difficult to evaluate when a patient wishes to impress, please, placate, submit to, or discourage the analyst. The need to avoid shame, humiliation, anxiety, and guilt can also affect presentation. Character traits of rigidity or plasticity may be intensified. The reaction to the specific analyst, whether as a transference manifestation or "reality," also may affect the material presented. Certain individuals are particularly handicapped in an unfamiliar situation; this may be understood later and be no substantial obstacle in treatment. The analyst attempts to alter the flow of the material as little as possible. The spontaneous sequence of the patient's thoughts, including noticeable omissions, is part of the data. The analyst does not attempt to expand the inquiry during the consultation, except to clarify some issue. He requires only sufficient material for making the decision of whether an analysis should be attempted. Because of the importance of allowing material to unfold in the context of the analytic situation, the analyst usually prefers not to pursue a systematic history according to some preconceived outline.

There are some further methodological issues in the evaluation which reflect the *analyst's* strengths and limitations. Professional competence, experience, and sensitivity provide a framework. The analyst's own psychoanalysis is expected to enlarge awareness of his or her own conflicts, in order to diminish their

effects on work with patients. Nonetheless, the analyst's reactions may include such responses as marked attraction or aversion to the patient, or other conscious or unconscious phenomena often subsumed under the heading of countertransference. There can also be complexities in the *analyst's* motivation: the wish to do (or avoid) analytic work, therapeutic zeal, time free to be filled, rescue fantasies.

The question of an implicit value judgment about analysis deserves separate mention. Patient or analyst may be unduly influenced by such a value judgment in deciding on treatment. There are many references in the literature—e.g., Knapp, et al. (1960), Stone (1954), Waldhorn (1960)—to the high value placed on analytic treatment especially in the health professions and in certain social groups. The recommendation for analysis may be thought to reflect an encouraging view of a potential candidate's future, a mark of status or favor, a reassuring assessment of the extent of an individual's pathology or, in the more unsophisticated patient, a frightening reflection of "how sick I am." If the analyst highly values analytic treatment either as reflecting a more favorable outlook for the patient ("worthwhile") or because the analyst's own value as a therapist is greater if he or she is doing more analytic work, this may influence the recommendation or the labeling of a particular treatment as an analysis when it differs from the analyst's usual criteria in significant respects. Two aspects of the problems this may create are the difficulties for the unsuitable patient and the conclusion by the analyst or others, when such treatments fail, that analysis is not an effective treatment or requires substantial modification from the classical method. This introduces a lack of clarity about the initial recommendation for analysis.

Finally, we might add here the decisions which are familiar to analysts as "if there is *any* hope for this patient it would be through an analysis." Such a recommendation may be made, for example, when a patient seems capable of self-understanding, motivated by considerable suffering, and experiences his or her symptoms as alien even though there are substantial questions

about ego defects, affective disorder, age, or other limiting factors.

We have noted these aspects of the evaluation situation not because they are unfamiliar or altogether insurmountable, but because their systematic description might provide some perspective on the enormous complexity of the decision and the nature of the analyst's task. In 1956, Sargent described such problems when presenting the "Rationale" of the Topeka Study. She wrote of clinicians using their clinical judgment as the instrument with which they work, as have many others in different contexts. She noted such characteristics of the instrument as the clinician's habit of making "more or less" judgments, being "most certain of judgments made within a context" (p. 230), and clinical judgments coming "in ordinary practice wrapped in qualifications. Tables of either-or choice, unqualified and unelaborated, are misleading" (p. 230). Sargent regards this "instrument" as "impos[ing] limitations and offer-[ing] certain advantages, but within it the basic requirements of science are unaltered" (p. 231).

The development of clear criteria for assessing analyzability has been particularly difficult. In clinical work the analyst arrives at a working decision which may be revised subsequently. Reported studies, however, deal with treatment center populations which present evaluation and treatment issues differing from those of private patients (Erle, 1979). Even given comparable standards for analyzability (see, Lazar, 1976), the clinic programs usually attempt earlier and more accurate prognostic decisions than are necessary in private practice. Thus, the clinic determination is generally made on the basis of less information and less time.

Which criteria are important in predicting analyzability? Numerous papers, many reviewed above, address this question. Some authors emphasize fewer criteria of broader perspective, while others cite more numerous, less extensive categories. Bachrach and Leaff (1979), in their review of this literature, list three hundred ninety individual but widely overlapping items

which different authors thought important to assess in predicting analyzability. This compendium makes clear the variation in transposing patient qualities to the rating scale or the printed page. For example, the tolerance of unpleasant affects is subdivided in the literature into four "different" categories.

In view of these problems, what would be the requirements for useful criteria and their validation in a research situation? Once again, a criterion must be capable of clear definition with specified, observable correlates. Its relevance must be demonstrable. Suitability for accurate observation would include the item's being clearly discernible and permitting a significant level of consensus. It should also allow correlation with subsequent observations during the analysis, particularly to evaluate prediction. Psychological testing has been cited as having advantages in these respects; it also requires skillful administration and interpretation. For example, in connection with the Topeka Psychotherapy Project, Kernberg (1977) discussed the difficulty of using such test batteries in formal research and the crucial importance of the clinical sophistication of the psychologist.

The consultation interview may seem to be an unstructured situation without systematic inquiry according to a specific outline or inventory. Actually, like the psychoanalytic situation, it provides a standard framework, a specific tool which facilitates the emergence of complex material in a manner that does not distort connections or obscure spontaneous omissions (*cf.*, Freud, 1911-1915; Glover, 1954; Rosen, 1958; Stone, 1954). During the consultation analysts behave in a consistent and deliberate manner: they are quietly receptive, allowing the patient's spontaneous presentation to unfold, noting difficulties, and intervening only if necessary to clarify, facilitate, or explore. The patient's response to the situation is noted as part of the material. More precise methods of evaluating this data need to be developed; it is a tool which could be further studied and used with greater skill. In these respects it is comparable to the sophisticated, nonpsychometric psychological testing situation

(for example, Rorschach) which is standardized in a different fashion with access to certain data. In both settings we also have to take into account subjective responses of the evaluator.

Particular attention must be paid to developing approaches to complex factors. The concept of "objective terms" (*cf.,* Lower, et al., 1972) implies that certain data can be clearly defined and free from subjective distortion. Such "objectivity" is suitable only for relatively simple items, such as demographic data (age, sex, profession, etc.) or certain items of behavior. Sashin, et al. (1975) found such factors were not of value in prediction. As more complex constructs (ego strength, affects, nature of relationships) are involved, it becomes more difficult to reach consistency or agreement in definition or application. We have to take into account that subjective responses of the rater may lead to significant distortion.

Translating raw data into judgments, first about the patient's personality, and then further into decisions about analyzability, is quite complex. Zetzel (*cf.,* Guttman, 1960) noted that senior clinicians tended to agree on analyzability but not on how they arrived at such a judgment. Knapp, et al. (1960) found that when impressionistic judgments were replaced with explicitly stated criteria, patterns of judging in evaluations were not significantly altered. Such findings reveal the gap between raw data and evaluation result, even when the decision may be both accurate and reliable. We need to understand and to improve the process of evaluation. It would be useful to analyze what operations are carried out by the more successful judges and to formulate testable hypotheses about those methods.

Outcome

Finally, in order to measure which factors are important for evaluating analyzability during initial consultation, there must be consideration of outcome of treatment. Lofgren (1960) discussed difficulties in using the concept, "results," in evaluating psychiatric treatment.

> Let us note as our first difficulty that different people when talking about "results" use different frames of reference, and thus actually are discussing different things. If the various frames of reference are covert, as they usually are, the discussants are apt to believe that because they are using the same *word* they are giving it identical meaning content (p. 95).

He also noted a further complication: in psychiatric conditions, "results" cannot be unequivocally explicated or defined as a rule. This opens the way to controversy over which criteria might define results in psychotherapies (symptomatic improvement, therapist or patient ratings, conflict resolution, mutual agreement to terminate, as examples).

Studies to date have selected simplistic criteria, giving little explicit definition. Moreover, there may be wide disparity in outcome ratings when the *same* treatment is rated by patient, therapist, and research judges (Harty and Horwitz, 1976). The report by Oremland, et al. (1975) on the incompleteness of "satisfactory" analyses highlights the dilemma. Pfeffer (1961), in exploring a method for follow-up of completed analyses, gives considerable detail documenting the patient's improvement at several clinical levels: both patient's and analyst's opinions, decreased symptomatology, change in masochistic character structure, with new, more mature relationships, as well as changed relations with old objects and change in ego and superego structure. The description of the case and several follow-up interviews include evidence of transference residues and the brief recurrence of original symptoms. The detail in this report, or in Dewald's (1972) extended case history, facilitates the reader's own judgment. However, such data would need to be systematized to be useful for the purposes of further investigation.

We have been unable to find studies which cover all phases: selection, prediction, analysis, and outcome. Predictive studies thus far have not extended into the phase of completed analysis, while outcome studies have been retrospective. Some reports have compared "predictive" ratings with outcome (e.g., Knapp, et al., 1960; Sashin, et al., 1975), but in these cases the predictions were made retrospectively in blind examinations of data

from patients already chosen and in analysis. More complete and comprehensive data do not always lead to better understanding. Unless meaningful hypotheses can be developed for exploration of significant questions, the volume of data—especially in so prolonged and complex a process as an analysis—may swamp the investigation. It is clear in certain specific areas, however, that studies which do not include the entire process may be misleading. For example, a stated interval may be chosen as sufficient to assess suitability, sometimes as short as a year or eighteen months (Hildebrand and Rayner, 1971; Knapp, et al., 1960; Weber, et al., 1974). It is also reported that patients who remain in treatment many years terminate unsatisfactorily or are found to be unanalyzable or "interminable" (Sashin, et al., 1975). Obviously, they cannot be identified in the less complete study. Similarly, a patient whose analyzability is in doubt due to a marked tendency to negative therapeutic reaction would require evaluation at termination for adequate assessment. Even then, some follow-up might be useful.

Problems pertinent to prediction based on evaluation studies have been described above (*cf.*, Kantrowitz, et al., 1975; Lower, et al., 1972; and the preceding section of this paper). Pitfalls of prediction in a longitudinal study have been described by Marianne Kris (1957) in relation to work with mothers and their young children. Errors in prediction appeared to arise from several sources, such as the paucity and nonanalytic nature of data on which predictions were based, the complexity of the mother-child interaction, and the failure to utilize fully and properly all the available information. Kris noted moreover, that often the significance of earlier observations could not be appreciated by even the most careful investigators until later in a clinical course.

III

CONCLUSIONS

When one is involved in the issues of studying assessment, there is a temptation toward subjectivity and nihilism, partly

because the issues are so complex and partly because some of the work done seems to confound rather than clarify the issue. There may be an irreducible level of uncertainty inherent in such a situation, but we would stress the importance of further attempts to elucidate these problems.

Collecting data and being precise at the time of initial evaluation is inherently difficult. These difficulties are increased by lack of specification or agreement on what constitutes an analytic treatment, variability in usage of terms, insufficient validation of criteria, data which are limited in extent and skewed by the method of collection or presentation. We have made suggestions for reducing the confusion: accurate definition, widely-based studies as well as individual cases, prospective studies, studies which include data of the treatment as it unfolds and its outcome. Beyond this, however, there remains a crucial question: Can we confidently predict the establishment of an analytic process—can we say "This patient is analyzable"? The guidelines we follow in deciding to initiate an analysis in a particular instance are clinically useful. However, if we attempt to study assessment, a different method of proceeding is required which would permit investigation of the many aspects of the process that can only be clarified during the analysis.

Experienced analysts with varying points of view on many theoretical and clinical issues have repeatedly referred to the problem of understanding clinical material. Bak (1970) noted that no matter how careful the initial investigation, the true picture of the patient's suitability will evolve only during analysis. In recognition of the shortcomings of such predictions, Bak suggested consideration of a flexible period, within which a decision would be made about "whether the analysis will be productive enough to warrant its continuation" (p. 10). He recommended early discontinuation or a shift to another form of treatment in unproductive cases.

Even during ongoing analysis the meaning of clinical material is often uncertain. In his discussion of the analysis of

affects, Schafer (1964) warned that a formidable problem is "not to jump to conclusions," and continued:

> Clinical and personal experience teaches us to expect certain types of feelings in certain situations. The fact that they are expressed does not prove they are genuinely felt; the fact that they are absent does not mean that they are there but hidden; the fact that they are conveyed histrionically or in an offhand manner does not mean they are entirely artificial. The distinctions are not always easy to make. As analysts we wait and wonder, sometimes aloud, and give ourselves and our patients time and opportunity to make sure. In practice, we spend much of our time this way (p. 277).

Arlow (1977) emphasized this need for precision; he urged moving beyond apparently obvious meanings of expressed or described affects and linking them with specific unconscious fantasies. Brenner (1976) also cautioned the analyst against taking at face value such material as symptoms, suicidal thoughts, object loss, "realistic" or "normal" behavior, fantasies, hobbies, or other interests. Before such material can be regarded as understood, it must be approached with a consistent analytic attitude aimed at defining the nature and extent of the contributing psychic conflict.

Clearly, then, we often confront a situation where the analyst does not know. In other connections, the analyst's awareness that he or she does not know or understand is widely regarded as an essential signpost in identifying the emergence of some significant material in the patient's associations. Uncertainty must be an even greater limitation of initial assessment.

Are we then suggesting that one "just begin and see what happens?" We are proposing, rather, that the basis of the decision would be specified and, should an analytic process *not* be established, the analyst would then note: 1) the nature of the treatment process that had occurred; 2) the point at which the treatment was modified and in what ways; 3) what further therapy seemed appropriate and why. The reasons for such failure to develop an analytic process might range, for example, from an

early massive regression or the inability to tolerate the frustration of the analytic situation to more subtle issues appearing in the form of a stalemate. Similarly, for such a research purpose, the analyst would specify the evidence that an analytic process had developed. A process of such complexity demands ongoing evaluation throughout.

At this point, we are again aware of methodological issues. As noted above, a particular definition of psychoanalysis and the analytic process would be required in a study. Further, it would be necessary to decide how the patient's involvement in that process could be observed and evaluated. If the patient is not involved, how could one discriminate between the unsuitability of the patient and the inadequate use of the technique or the limitations of psychoanalysis? At the end of treatment, does the process seem to have gone to completion satisfactorily or might there be limitations? These limitations might be understood in terms of factors in the patient, the technique, a result of the process (e.g., the development of severe negative therapeutic reactions or regression with the emergence of paranoid fears), or the skills of the analyst. In practice, evaluation of each of these is limited by a number of considerations in addition to complexity. We are concerned about intrusions into the analytic work, whether they involve evaluations, testing situations, concerns about confidentiality, or the influence of research interests. There may be obvious drawbacks, as well as potential benefits, in such a systematic analysis of data. The data can be obtained only from the analyst and, indirectly, from the patient. Consequently, it cannot be verified directly, and it has been extremely difficult to develop reliable means of evaluating it indirectly.

Detailed individual case studies are required for clarifying some of these issues, but studies of groups of cases—particularly those treated by graduate analysts—are needed. How often is an analytic process established? What is the therapeutic benefit in patients who are analyzed? Are there problems in continuing the treatment of those who do not become involved in an analy-

sis? As far as possible, patients for supervised analysis are chosen for their suitability for that purpose. How do graduate analysts deal with more complex cases in which there are uncertainties about the modifiability of pathology or character structure? Can we better understand and identify patients who do not develop and conclude a classical analytic treatment? Do some of the failures of which we are aware in clinical practice or published reports reflect the limitations of prediction? That some analytic treatments are only partially successful or fail does not mean they should not be attempted or could be predicted.

The work we are proposing should supply more adequate data for testable hypotheses about assessment of analyzability throughout the process—from selection to outcome. In such a complex situation we may be limited to certain kinds of understanding; it may not be possible to go beyond a certain point. Within that, however, we may be able to construct a framework which is clear and consistent and which allows replicable results (including similar limitations). We may also be able to understand and document the bases for persistent and irreducible uncertainty so that the question of assessment can be approached in some way that allows for clear communication and the development of further studies.

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Mental Transitional Spheres

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MENTAL TRANSITIONAL SPHERES

BY ISIDOR SILBERMANN, M.D.

The human being may be considered to have mental transitional spheres in which the sifting, transforming, intensifying, and inhibiting of stimuli are initiated. Stimuli essential to the development of the psychic apparatus are converted in the mental transitional spheres into a form that will enable them to exert the appropriate influence on the ego. Optimal ego development cannot take place without the proper functioning of these spheres. Thus, the mental transitional spheres are essential for the development of psychic functions and defenses.

The problem of "space" has occupied many investigators during the past number of years (*cf.*, Erikson, 1940; Green, 1975; Winnicott, 1967, 1974). In this paper I intend to demonstrate that the "transitional space or sphere" is not merely a theoretical construct but an innate, i.e., biologically determined, phenomenon in man and animal, which is extensively affected and shaped by external experiences. In this respect I differ from Winnicott (1967), who states that the area of transitional phenomena is not biologically determined but is instead "determined by *life experiences*. . ." (p. 371). He speaks of the area of transitional phenomena, "of the potential space between the subjective object and the object as objectively perceived, between the me-extensions and the not-me" as really existing space filled with a multitude of functions. He also states, "In order to study the play and then the cultural life of the individual one must study the fate of the potential space. . ." (p. 371). Further, he feels that this transitional space is "sacred to the individual" and that the "exploitation of this area leads to a pathological condition in which the individual is cluttered up with persecutory elements of which he has no means of ridding himself" (p. 372).

Anything alive is delineated by a "functional transitional system and area," an active buffer zone which, besides serving as

a perimeter, attends to many functions, among which are connection, communication, transformation, and exchange. The observations of many ethologists *(cf.,* Ardrey, 1966; Lorenz, 1971) as well as biochemists (particularly Nachmansohn, 1974) support this proposition.

I propose to start this study by considering the surface of the body. The skin seems to be our most exterior transitional system. The next step will take us to the space or sphere that surrounds us, which may be considered as an extension of the skin's transitional system. By a series of steps, we progress from the transitional sphere surrounding the body to parallel concepts of transitional psychological spheres.

We must approach the complexity of the mind with caution if we are not to fall into the trap of oversimplification, particularly since the translation of the abstract depends upon simplification. Our inability to grasp abstractions without demonstrable signs forces us to use various means—for instance, language—for communication. Often it seems nearly impossible to find accurate descriptive terms for the translation of abstractions, and symbols and metaphors must be called upon to help.

Since we cannot think without images, we have to pour our ideas into molds. Their quintessence, however, is most difficult to capture. This gap can be filled only by the imaginative intelligence of the observer. The crucial essence of the void, of that which is, but seems not to be, of that which fills the empty space, is beautifully expressed by Lao-tzu (c. 500 B.C.):

> Thirty spokes by joining in the hub
> Their empty spaces in between
> Make the wheel.
> Clay molded into form becomes a pitcher
> By the void inside of it.
> The empty spaces of windows, doors,
> And those between the walls
> Make the house.
> Thus by using that which is,

For that which seems not to be,
Man is greatly helped.

An interesting parallel to Lao-tzu is found in Heidegger (1971):

> Sides and bottom, of which the jug consists and by which it stands, are not really what does the holding. But if the holding is done by the jug's void, then the potter who forms sides and bottom on his wheel does not, strictly speaking, make the jug. He only shapes the clay. No—he shapes the void. . . . From start to finish the potter takes hold of the impalpable void and brings it forth as the container in the shape of a containing vessel (p. 169).

THE SKIN

The skin, with its many sensory receptors, is not an inert boundary, but a functional system, essential for existence, orientation, and communication and for the exchange of stimuli between the inner and outer worlds, between inner and outer realities. Stimuli are received by the skin, worked on, transformed, muted or enhanced, accepted or rejected.

Besides being a stimulus barrier, the skin serves many other functions, such as respiration, heat exchange, and protecting against radiation and infections. Our emotions are expressed through the skin, as when we pale, blush, get angry or excited. In addition, illness may be heralded by changes of skin coloration, as in anemia, plethora, and jaundice. Our skin perspires, lubricates, and is possessed of personal lines and individual fingerprints. From it also emanate smells.

By way of analogy, Nachmansohn (1974) and others have shown that the excitable cell membrane is not a simple retaining wall, but a dynamic system, a "chemical factory" where interchanges of metabolic products continually occur. Accordingly, the membrane is the functional transitional system of the cell reaching beyond its visible boundaries. Continuing the analogy, one might say that our skin is not the end of our body

but extends its transitional functions into the space surrounding us. Every living substance, then, could be viewed as surrounded by a functional transitional sphere.

TERRITORIALITY

Ethologists have described what Ardrey (1966) calls the "territorial imperative," the instinct of certain wild animals to delineate and guard a particular territory they consider their own. An invisible line marks its boundaries, and no other male animal of the same species is permitted to trespass. Should an intruder cross the border line, he will meet a ferocious defender and have to fight for his life.

It is tempting to think that the territory of animals is an extension into space, larger or smaller, of the vitally important transitional sphere of the skin. An inborn respect for this "space" seems to exist among animals of the same species. This can be observed in seagulls who, in following a ship, perform breathtaking acrobatics, rise and sweep down, twist and turn "miraculously" without ever colliding. It can be seen in ducks who, swimming in measured formation, keep their distances from each other and, even when they return from a dive, do not bump into one another. Many more examples could be added.

Since man's place in the animal kingdom is clearly established, it is not surprising that some of his behavior patterns resemble those of animals. Since I suggested above that an animal's need for an extended transitional sphere shows itself in the territorial imperative, I now propose that in humans, we find a similar need for territoriality, although in the latter case this need is starkly reduced and weakened.

Such transitional space seems essential for our sense of security and stability. Dr. George Harell (1976) called to my attention that in the streets of Hong Kong, as crowded and confused as the human traffic is, people rarely bump into one another. Everyone seems to appreciate the invisible space surrounding the other, and with skill and grace they avoid invad-

ing that personal sphere. The anthropologist E. Hall (1969), following the lead of H. Hediger, calls this the "personal distance" which non-contact animals maintain between themselves. Hall further reports that all non-contact animals must maintain a minimal "critical space," without which survival is impossible. Another investigator, John Christian, found that enhanced closeness puts these animals under enormous pressure, resulting in stress symptoms and metabolic disturbances, through the hyperproduction of adrenalin (*cf.*, Hall, 1969).

The "Hediger bubble," which surrounds animal and man in different degrees, is, according to Hall (1969), determined largely by thermal and olfactory emanations. Speaking about the "territory," he says, "It is in every sense of the word an extension of the organism which is marked by visual, vocal and olfactory signs" (p. 103). "It is a mistaken notion," he continues, "that man's boundary begins and ends with the skin. . . . Man is surrounded by a series of expanding and contracting fields" (p. 115).

Hall quotes W. H. Auden who speaks poetically to this problem:

> Some thirty inches from my nose
> The frontier of my Person goes,
> And all the untilled air between
> Is private pagus or demesne (p. 113).

To a greater or lesser extent, all human beings desire privacy and a little space of their own. People erect fences around their territory or property. The English consider their homes their castles. Markers announce boundaries of counties and countries which are to be respected and often cannot be crossed without special permission. People go to war to defend the borders of their land.

Hardly anyone likes to be touched without implicit permission. Many people respond negatively under such circumstances. Not many people like to be squeezed into narrow spaces. Some are not just physically discomforted; they feel strangled or op-

pressed, their anxiety mounts, and they fear collapse. Various expressions, such as "keeping another person at arm's length" or "don't get too close to me" or "don't crowd me in," all represent an attitude of "respect my privacy; do not intrude upon my surrounding transitional territory."[1]

If we turn to pathology, we find people who avoid closed spaces such as subways, theaters, and airplanes. They cannot tolerate the limitations of the *Lebensraum* or vital space. They feel deprived of their mobility. It does not need to be stressed that these phobias are multidetermined; here, however, I emphasize the factor of territoriality.

There are some people who, when driven by strong sexual desire, strive for the closest possible contact with those they love. In the sexual embrace they try to eliminate even the smallest space separating them. In certain people, however, all this changes dramatically with orgasm. Such individuals, as if shocked out of their self-abandonment and aware of the loss of their "private space," become disturbed by the consciousness of the closeness of the partner, feel threatened, and tear themselves away. Closeness can no longer be tolerated, and they seek to recapture the "lost buffer zone."

The behavior of certain patients who cling to their self-imposed prisons, refusing to leave their *Lebensraum* and struggling with vehemence to defend their space, may be interpreted as a form of territoriality. A psychotic twenty-five-year-old woman exiled herself to a small room stacked with shelves full of food and books for more than ten years. Nobody, except her mother, was admitted, and she came only occasionally to provide new supplies and remove her daughter's waste products. I was allowed to speak to this woman through a small gap in the door. I could not cross the threshold because, as she said, I might take away her "living and breathing space" and leave her "denuded

[1] In Thomas Mann's "Doctor Faustus" (1947), the protagonist Adrian is portrayed as a *noli me tangere*, as the "three-spaces-off" type whose distaste for too close physical presence of people is just as marked as his abhorrence of the mutual invasion of the "nebulous encircling corona."

of the protection surrounding" her. Without that protection, she believed she would collapse and die.

Society punishes criminal offenders by reducing the dimension of their space, their "private territory." We put them behind bars in small cells and even in dark and solitary confinement. This powerful cutting off of their transitional and vital space has a crippling effect, often beyond our expectations. Enslavement and crowding in ghettos also deprive people of the vital free exchange with the world around them. Stimuli can no longer travel in both directions. The space necessary for emotional development is eliminated, and as a result, the evolution and development of mental representations is seriously impaired.

THE MIND

In primitive animals the nervous system is a simple apparatus for sensory perceptions and motor reflexes. In contrast, the human brain has evolved into a system of great refinement with a large number of functions. In the evolution from homo erectus to homo sapiens, more and more specialization occurred, more intricate connections between the different dynamic functional systems were established, and the arch between perception and action became a manifold interpolation of "locks," as it were, agencies of inhibitions, diversions, and transformations. In comparison to man, animals have sharper sense organs, but human beings, through the greater development of the brain, have acquired an organ that can enlarge, refine, elaborate, and channel their relatively weakened sensory perceptions, an organ that computes and anticipates.

The mind is not a physical or corporeal entity, but a functional system which is related to the physiology of the brain. It has no physical boundaries, nor does it have an assigned location in the brain. The mind is never static; it is not cast into a rigid form; it is in perpetual flux, always at work. Only with death does all mental activity cease. Body and mind are closely linked

by the mental representations of all our experiences, experiences within our body as well as in the external world.

After a certain stage of development of the function of cognition, what is external is considered real and objective; what is internal is considered subjective and changeable. Mental representations are not static copies of imprints; they change with the steadily growing flow of inner communications and develop into formations of their own, with various tones, forms, and subjective modulations. These mental representations may expand or shrink considerably. Mental representations of the perceptions of our inner and outer worlds are greatly influenced by our emotions, which may cause various distortions, misrepresentations, and misconceptions (*cf.*, Silbermann, 1973).

In order to grasp the complex interrelationships of the various functions that constitute the abstract concept of mind, we find it convenient to fall back upon models which can be visualized. Following Freud, we imagine the mind as a formal organization and attempt to structure and compartmentalize it into units with different functions—ego, id, and superego. Freud described the id as a seething cauldron of emotions. Contradictions abound, and systematization is alien to its very nature. The ego is conceptualized as being distinct from the id and as having many functions, such as thinking, synthesis, fragmentation, an elaborate defense system, etc. In its domain, order, consistent regulation of function, and striving for balance hold sway. Again, for the purpose of visualization we introduce terms such as ego boundaries, fusion, defusion, and displacement. We speak of the separation of ego and superego, as if we were dealing with physical entities kept apart by a membrane-like border. In the same spirit, we speak of mental representations as if they were physical deposits or mirror images, and we are tempted to look for their actual location in the mind. Being aware that the mind is not a physical organ but a system of functions, we may conjecture that the *mental* representations of the physical transitional sphere form agencies which function in a way similar to that of their matrix without being physical structures.

MENTAL TRANSITIONAL SPHERES

In a previous communication (Silbermann, 1961) I proposed that the boundaries of the ego as well as those of the various ego functions, should not be considered as rigid encapsulating structures, but should be thought of as interconnecting "elastic links." These interconnecting channels make it possible for the various ego functions to adjust and readjust in keeping with the constant dynamic flux of the system. I propose now to expand the concept of "links."

The hypothesis that transitional spheres exist in and around all living things necessarily leads to the assumption that these functional, existentially essential spheres have their mental representations. While the physical transitional sphere that extends beyond the human body has been reduced in extent, its mental representation, as do all mental representations, tends not to shrink but to grow. Accordingly, instead of "links," I propose the term "mental transitional spheres." The latter seem interpolated between the functional units, as well as between their subfunctions, and represent dynamic systems—for instance, for the purpose of connection, transmission and communication. Is it possible that the unconscious part of the ego may be considered as such a transitional sphere? These interpolated working systems determine the functioning of the mind. They act not only as transmitters for stimuli but also as barriers against such transmission. In these spheres, the drives begin to be transformed, tamed, neutralized, diminished, or intensified. Contradictory elements and opposites which exist side by side in the id are prepared for proper order, arrangement, and alignment. Viewed this way, the mental transitional spheres operate not only as passageways, but as active functional systems as well. In effect, the functional zones surrounding all the systems of the mind may be imagined as something comparable to the membranes of living cells. They are not rigid, independent, interpolated structures between units; rather, they are border zones of the id, of the ego and its subfunctions, and of the superego,

while still remaining a part of the id, ego, or superego, as the case may be.

In a mind which is free from disabling conflicts, the channels of communication are open, enabling a constant exchange of stimuli, and the functional border spheres of the various structures are not restricted by pathological defenses. Through these transitional spheres, there proceeds a flow of communication, albeit one that is guarded and scrutinized. This flow can be impeded or even arrested by many factors, such as genetic flaws, childhood trauma, and fixations. Pathological influences of this nature disturb the proper functioning of the mental transitional spheres, interfering with, for example, the neutralization of drives, which may result in faulty ego development.

The mental transitional zones, like their physical counterparts, are not acquired, but are an innate system with the nuclei of many functions which, in the course of development, become widened, refined, and enriched by a constant influx of stimuli. The establishment of proper communications and the expansion of object relations depend on the state of these functions in the mental transitional sphere.

As the child grows away from the symbiotic relationship with the mother, the range of object cathexes is widened, and, under propitious circumstances, enhances constantly the number of mental representations and thus the domain of the ego. The healthy child is not excessively cautious; he is curious about the world and tests reality with his sensory capacities open for stimulation. He constantly looks for new experiences and, as the range of his mental representations increases, so does his knowledge. If the operation of the mental transitional spheres is impaired, curiosity will not be properly channeled into a search for information. This applies to information about the object world as well as to insight into one's inner motivations. People with disturbances in this area tend to look for external reasons for their inner discord, which leads to projection and to attempts to find simple magical solutions for their inner ills.[2]

[2] For the pleasure-ego the external world is divided into a part that is pleasurable, which it has incorporated into itself, and a remainder that is extraneous

If the mental transitional spheres are adversely affected in their formative stages—for instance, by early childhood trauma or by genetic flaws—different pathology may result: a) they may not develop their dynamic functions appropriately; or b) they may gel and become fixed at an early stage of development and, accordingly, inhibit further transformation of function. On the basis of these two types of developmental vicissitudes, I have been able to delineate two types of psychopathology.

In the first instance, there are those patients who are unable to regulate, to sift, to inhibit the inflow and outflow of stimuli; their organizing and defensive functions are inefficient. They seem to be characterized by a kind of nonchalance, a lack of scrutiny, as if everything that happens is permitted and runs like sand through their fingers. Activities and functions are at a low point and seemingly without reason. These patients seem to be diffuse and without cohesion. They seem to have no aim or purpose, no inner constraints or incentives; they seem to lack vitality and substance.

On the other hand, there is the second category of patients, who, by contrast, seem to be fixed or hardened, as if their personalities were encased in armor. Unlike the first type of patients, these patients seem to close off channels of communication. They seem to be unyielding, wanting to keep everything within themselves and for themselves. While patients of the first type seem to squander whatever they manage to possess, those of the second type seek to hold on to and enlarge their possessions.

The first type is inconsistent, unhappy, and desperate about his drifting, nebulous quality; the second type seems like a rock, steady, seemingly self-possessed and self-confident. He becomes upset only if he feels that his "fortifications" are threatened. The first type considers himself never right. As a matter of fact, he does not know what is right and what is wrong. The second type considers his balance perfect and gets disturbed only when he feels his equilibrium is assaulted. While the first type tries to

to it. It has separated off a part of its own self which it projects into the external world which it experiences as hostile (Freud, 1915).

reach security by symbiotic fusion with other people who might furnish him with cohesion and strength, the second, "frozen" type tries to maintain his solidity by avoiding exchange of communication or influence by others.

Two illustrative case reports follow. They will not be described in the usual way. While they may be considered borderline patients, I will not try to fit them into the diagnostic category of severe narcissistic character disorders, nor will I stress the fear of or the wish for castration, or the deep-seated ideas of persecution, the enormous penis envy, and the overwhelming fear of loss of virginity. The material will be presented from the point of view of demonstrating the crippling distortion of the patients' thinking and object relations which results from the impairment of the functioning of the mental transitional spheres in these instances, due to lack of adequate stimulation and the failure of the environment to facilitate maturation.

CASE A

This case will be used to illustrate the type of patient who is unable to regulate or to inhibit appropriately the flow of stimuli through the mental transitional spheres. These are the patients in whom everything seems to be diffuse, dissolved, and without cohesion.

Mrs. A, a young married Englishwoman of twenty-four, sought psychoanalysis on account of depressive moods that at times led to feelings of utter despair. She complained of feelings of depersonalization and derealization. The patient felt that she could not form her own thoughts or manage her emotions, which were getting out of control. She complained of feeling denuded, without a protective shield, and lacking in inner cohesion. During her adolescence she had tried to shed her "wishy-washy" personality with the help of alcohol, drugs, and incessant smoking. When she became an addict, she realized that these avenues of escape had failed her. She felt hopeless and depressed. This was her mood when she began treatment.

Mrs. A was an only child, brought up by a nanny whom she

described as having attended her like a "sleepwalking robot." Her mother was undemonstrative, unloving, and withdrawn: she never kissed or hugged her daughter, never took her in her arms or spoke loving words to her. There was no visible exchange of affection between her parents. She described her childhood as "an icy wind constantly blowing around me." Mrs. A's father was a busy man who nevertheless tried to be attentive and loving toward her. She remarked that he tiptoed around her mother as if he feared that any wrong step might lead to a catastrophe.

At school she was a good pupil, learned easily, and soon climbed to the top of her class. It was not long, however, before trouble started with teachers and fellow students because she felt unaccepted and unwanted. Although she was surrounded by admiring boys, she distrusted their praise. Her mirror, she said, told her something quite different. She felt that her body was ugly, that it was a torso which had been "atomized" when she was a child and since then had consisted of "innumerable little fragments which never fitted together." She stated, "I am a heap of shards which cannot be put together and mended into a whole." In spite of all this, she was a brilliant young woman who at times spoke in cohesive, poetic, colorful sequences. At other times, however, her language mirrored her inner turmoil: sentences broke apart, and it was hard to follow her train of thought.

Mrs. A craved a man who, through his strength and deep love, would put her together, give her form and substance, who would unite the fragments of her being and make her able to communicate with the world around her. She searched frantically for this "loving healer." This led her, from the age of sixteen on, to engage in numerous sexual relationships until, at the age of twenty-one, she believed she had finally found the man of her fantasies. Soon after her marriage, however, she discovered that she had been mistaken. Her husband failed her in all respects, and she became more bewildered than ever. Desperately she started to cling to him, hoping thereby to force a relationship

that would supply the magical substance she needed for her salvation. During sexual relations she felt as if some mysterious power were entering her, but eventually even frequent love-making could not make her feel better. Since she felt somewhat alive during orgasm, she attempted to recapture the experience through compulsive masturbation.

Because she was intelligent and had already undergone some psychotherapy, she was familiar with such terms as oedipus complex and castration fear. Although she believed that she had accepted all these motivations, she returned over and over again to the topic of faulty, confusing, missing identifications, flaws in her psychic development, delayed or arrested maturation. She requested that we look for the "missing links," the "mysterious nebulous substance" which holds everything together. She would ask, "Why can't I love anybody, not even my own child?" She answered herself, "Unfortunately, I have become so dependent on the love of others that I cannot function. As I am impoverished myself, how can I give to anyone?"

Although she hated herself and reproached herself severely, she nonetheless felt apathetic and indifferent to what was happening. This was finally expressed in a pattern of impulsive masturbation, promiscuity, homosexuality, drinking, and drug abuse. She needed the stimulation of these experiences, she said, in order to stay alive, "to expel that terrifying inner cold." Fortunately, she realized that all this activity did nothing to lessen her mounting misery. This enabled her to maintain the therapeutic alliance in the face of many stormy upheavals.

After some time she was able to stop the drinking, the drug abuse, and the sexual escapades. She thought of forming a "drifters anonymous" club. She gathered around her women whom she characterized as "social drifters," women who complained that they felt empty and who expected a man to supply them with borrowed strength. The goal of the practices she instituted for this group was to bring order into the lives of these women by making them less dependent on men. Thus, one of the women who, at a given time, felt strong and secure,

was designated their leader. The other members of the group were encouraged to identify with her: they assumed her first name, copied her manners and her attire, the way she spoke, and even sometimes shared her husband. If the leading member of the group felt drained by the responsibility, another member would take her place, and so on. The members of the group grew very close to each other. They arranged parties and went to concerts and theaters together, thereby beginning to "circulate" in the outside world. Gradually they assumed a greater number of responsibilities.

This group experience had a calming as well as a stimulating effect on the patient. She became more productive and constructive in the analysis, facing problems which, until that time, she had not dared to consider. She was able to dissolve her marriage and ultimately went to work, while arranging at the same time for the proper care of her child. After the termination of her therapy I lost contact with the patient. However, I later learned indirectly that she had remained quite well for some years.

I had accepted this seemingly hopeless case because I felt there was some basis of health from which one could proceed. The intensity of Mrs. A's suffering and her awareness of her inner chaos helped to establish the therapeutic alliance. Nevertheless, because of her weak ego, it was necessary from time to time to encourage her to continue. Her problem seemed to center on the unstable and flimsy nature of her early object relations, which had reduced communication with the world about her to a minimum. The therapeutic goal, as I conceived it, was to vitalize the dormant roots of her functional transitional spheres that serve communication and that also regulate, inhibit, or exclude stimuli that are potentially disruptive. Ultimately, the functioning of the transitional spheres developed to the point where new stimuli could be communicated between all the functioning units and the mental systems, the id, ego, and superego. As defenses worked more adequately, the personality could develop more favorably. Object cathexes became more stable, resulting in a new sensitivity of the patient to her

own self, a decrease in her isolation, and a reduction of her anxieties and distrust. She felt that under her eyes, her "torso grew into a full gestalt."

CASE B

This case is presented to illustrate the second type of patient, the kind of patient who seems steady, self-possessed, and self-confident, whose character structure is founded on an effort to maintain stability and solidity by avoiding communication with or influence by others.

While I was still in Vienna, I was consulted by a young aristocratic woman who came to my office accompanied by two ladies-in-waiting. The patient, Mrs. B, was elegantly dressed and richly jeweled. She wore white leather gloves on which diamond rings glittered. Her posture was erect and her speech reserved. Neither the elegance of her dress nor the richness of her jewelry could reduce the feeling of coldness that seemed to radiate from her. She explained that she had no reason to see me but that she had come at the insistence of her husband who felt she needed psychiatric help. With unflagging composure she said, "He thinks I am sexually cold." She considered herself completely normal, the perfect woman and wife.

She had spent all her childhood on a huge country estate where her parents employed many peasants and workers. She was always surrounded by a large staff of attendants who never dared to find any fault with her. As a young woman, she was always surrounded by a swarm of admirers from whom she received unending adulation. Since she was tutored at home, she had no children to play with, "because it would have been déclassé to mingle with the children of servants and the like." Only during puberty when she started to travel did she become acquainted with the "other world," but not before she had been warned beforehand to be on her guard against the avarice of other people, people who would want to take things from her, to rob her of her virginity, etc. One parental formula imprinted itself deeply on her mind: "Taking is gain, giving is loss." She

was taught to enlarge her riches, to gather in, not to squander or be generous or even charitable; in brief, she was taught to be stingy and greedy. With this kind of indoctrination, she became restrained and her attachment to people tenuous; instead of getting involved with people she kept herself aloof as if she were suspended above everyone.

She married a rich merchant who indulged her and bought a palatial home staffed with servants. He tried to re-create the luxurious life the patient had enjoyed when she was growing up. She remained aloof, however, and did not permit him to get physically close, or even to touch or pet her. His patience finally reached its end, and he suggested divorce. This came to the patient as a surprise. She was thunderstruck; she believed that she had been a good wife and a perfect hostess. After all, she kept their palace in excellent condition and had, as a matter of fact, by her apt financial suggestions, enabled her husband to enhance their fortune considerably. As a result of her husband's threat, she decided to "give him her body." This acquiescence, however, was subject to many conditions: for instance, she must be touched as little as possible, her breast must not be petted or her nightgown removed, the lights must remain on. She felt that only by being "totally absent" from the experience would she be saved. She determined to deny what was happening to her physically. During intercourse she would eat sandwiches or fruit, and sometimes she tried to read a book. After this had gone on for several weeks, her husband insisted that she seek psychiatric help.

Mrs. B told her story with a kind of "virginal innocence," reflecting a deep conviction that there was nothing wrong with her since she had the God-given right to keep what belonged to her and to use her body as she pleased. I must have shown some surprise because her cold composure changed, and her face took on a tense expression. She said, "Everybody wants me to give and give. But I was brought up from early childhood on not to give but only to receive." Then she asked me, "Did you ever think what would happen to me if I gave myself totally to my

husband? Touching already frightens me, terrifies me unbearably; under threat I had to permit him to enter my body but neither he nor anyone else on this earth will ever get my soul." She added, "My privacy belongs to me. I need some space for myself. He tries to steal it from me, and if I did not absent myself mentally I would also lose my mind." Her face became frightened and bitter, and her final statement was brief and determined: "I'm all right. I feel well. If only my husband would change, our life would be happy and good." That was the last I heard from her.

She was convinced that her "inner power" would be drained off and that she would be left totally impoverished if she gave anything away and if she permitted anyone to enter the "private sphere" she considered essential for her existence. Only if she closed all her openings and rejected the influx of endangering stimuli could she maintain her balance and strength. She was unaware of her massive defenses against imagined threats and her self-imposed avoidance of involvement with the world around her. She felt no inner disharmony, no conflicts, as long as no external demands disturbed her equilibrium.

Patients of this type, in their coldness and reserve, maintain a distance around them, separating them from other people. Free communication is reduced to a minimum. It is as if their system of exchange has lost its fluidity. In my view these phenomena reflect the fixation or hardening of the functioning of the transitional mental spheres, which leads to an interference with the free flow of stimuli and with inner communication.

If the transitional spheres can develop normally, the quality of their inborn functions increases and consequently the ego's territory enlarges. Such normal transitional spheres enable cathexes to pass from the ego to certain object representations without pathological censoring, sifting, or muting. They do not reduce the growing number of object cathexes, and they admit external stimuli without pathological scrutiny, distortion, or defenses. The relative freedom thus established further strengthens and expands the ego's activities.

If, for pathological reasons, these transitional spheres do not develop and their dynamic functions do not unfold properly, the cathexis of object representations suffers and the handling of incoming and outgoing stimuli will be defective. In patients in whom the functioning of these spheres is not fully developed, as in the case of Mrs. A, few stable object cathexes can be effected and these will lack the necessary flexibility.

On the other hand, in the patients of the second kind, the functioning of the transitional spheres has *almost* reached the stage of mature operation, but because of untoward influences, the functions have changed their activity in a pathological way. As a result, the investment of object representations with libidinal and aggressive cathexes and appropriate identifications is defective. Libidinal ties are strained, and stimulation from the object world is cautiously received or, at times, rejected altogether. The ego is weakened, and mental development is slow. These pathological influences interfere with the child's normal curiosity which, instead of growing and expanding into a search for knowledge and for the subtleties of meaning and values, remains arrested and superficial. While the normal child seeks to investigate things from all possible perspectives, this "frozen type" casts only a hasty and suspicious glance at the world about him and quickly rejects any connection between it and him.

In the first type the functioning of the mental transitional spheres has not yet been firmly established. By way of contrast, the second type, although somewhat more mature, seems to be arrested at a sluggish level of functioning, leading eventually to a kind of frozen equilibrium of function. Superficially viewed, the first type does not seem to have a firm hold on reality; the second type seems rigidly tied to conventional modes of perception and practical, realistic considerations. The functioning of the transitional spheres is dynamic and vulnerable to disequilibrium. In addition, it requires a steady and reliable set of stimulating experiences emanating from favorable relations with other people. Only through this latter influence can the

human mind reach its highest achievement—creative self-stimulation.

Expressed in metapsychological terms, in those patients in whom the mental transitional spheres fail to function appropriately, the normal conflicts and problems of early childhood are aggravated. Serious obstacles to growth ensue. Furthermore, regression and pathological fixations are more likely to occur. Sublimation is faulty and may even fail. One of the eventualities of this process may be a failure of neutralization of the drive energy, resulting in the impoverishment of the ego because of the diminution of the energy available to it. Affective and cognitive development is impaired, leading to a tendency toward acting out. Disruption of the ego's function of defense causes an interference of communication between id, ego, and superego.

The instinctive watchfulness of the animal, its guarding of its territory, appears in the human being as anticipation, attention, and preparedness against dangers. This anticipation is part of the defensive function starting in the mental transitional border sphere.[3] Patients of the second type with dysfunctional mental transitional spheres also show a highly increased watchfulness, but they are mostly obsessed with erroneous anticipation of dangers. They react to imaginary dangers by erecting powerful defenses and often hopelessly attempt to fight the aggression that exists only in their fantasy.

SUMMARY

The thesis developed in this paper is that in all living systems there are transitional zones of functioning, both physical and psychological, that control and modulate the constant flow of stimuli and the exchange of communication. Since everything that happens inside and outside of the body has its mental representation, the mind may be considered to have what we might

[3] "A special function was instituted which had periodically to search the external world, in order that its data might be familiar already if an urgent internal need should arise—the function of *attention*. Its activity meets the sense-impressions half way, instead of awaiting their appearance" (Freud, 1911, p. 220).

call "mental transitional spheres" between the structural units and their functions. These spheres are functional systems in which sifting, transforming, intensifying, or inhibiting the stimuli are initiated. They are also the spheres where drives start to undergo the process of being brought under control, discharged, or neutralized. Thus we assume that the stimuli which are essential for the development of the psychic apparatus are transformed in the mental transitional spheres into a form which will enable them to exert the appropriate influence on the ego. Without the functioning of these spheres, proper ego development does not take place. The appropriate ordering and integration of stimuli is an essential preparatory action which takes place in the transitional spheres. Homeostasis is maintained through the proper scanning, censoring, inhibiting, and rejecting of derivatives of the drives, all of which is the function of the mental transitional spheres.

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CHANCE, AMBIGUITY, AND PSYCHOLOGICAL MINDEDNESS

BY DAVID S. WERMAN, M.D.

The inability to believe in chance occurrences and an intolerance of ambiguity in the external world are often the outward manifestations of poor psychological mindedness. Such attitudes are frequently accompanied by beliefs in the occult and the mystical. It is suggested that these factors be considered when an individual is being evaluated for analytic treatment.

The crucial interest that psychoanalysts have in the psychological mindedness of their patients has led some analysts to a relative neglect of the patients' views of the external world, of which their attitudes toward chance and ambiguity are two significant aspects. Since the inward regard and the outward are opposite sides of the same coin, distortions in one are apt to be reflected in the other.

Freud wrote briefly about chance, distinguishing between "internal (psychical) accidental events" and "external (real) chance" (1901, p. 257). He observed that superstitious people deny the effect of mental processes on their actions and parapraxes but believe such processes exert an influence on external events. Subsequently he wrote, "A fair amount of intellectual education is a prerequisite for believing in chance; primitive people and uneducated ones, and no doubt children as well, are able to assign a ground for everything that happens. Perhaps originally it was a reason on animistic grounds" (Freud, 1932, p. 122). In a birthday congratulation to his son he once more mentioned chance, noting that ". . . not all things in life go according to merit, [hence] let me express the wish that luck will continue to remain faithful to you" (*cf.*, E. Freud, 1960, p. 338).

A belief in external chance does not imply a negation of causality but rather relates to an awareness of the relative un-

predictability of certain events, to one's ignorance of their precise causes, and to one's lack of control over them. Poincaré (1908) used the example of a roulette wheel to illustrate the nature of chance: whether the needle stops at red or black depends upon the initial impulse the wheel is given. Neither muscular sense nor even the most delicate instruments can distinguish the difference between neighboring impulses.

Ambiguity relates primarily to meaning and is defined in two different ways: the first relates to imprecision, uncertainty, or vagueness of meaning; the second concerns the presence of two or more meanings. In the latter sense it is analogous to the overdetermination of mental events and consequently characterizes many of the cultural derivatives of psyche. In contrast to the merely obscure, ambiguity in the second sense seems to be intrinsic to great works of art (Kris, 1952) which communicate and interact on several psychical levels. Arlow (1969a) has observed that "situations of perceptual ambiguity facilitate the foisting of elements of the life of fantasy upon data of perception" (p. 8). He further pointed out that the very "lack of specificity" in a work of art tends to "stimulate a wider range of unconscious fantasy activity" (p. 8). In an opposite manner, the trivial and the sentimental in art generally prove to be single-minded and unambiguous.

Chance and ambiguity (in both its meanings) may evoke anxiety by depriving the subject of a purposeful activity aimed at some control over an event which is perceived as dangerous. This situation is analogous to the anxiety evoked during therapy when resistance is diminished and hitherto repressed ideas move closer to consciousness. It should also be pointed out that in a quite contrary manner, ambiguity may support repression and limit anxiety: in dreams, for example, threatening material may be veiled from consciousness by condensation with other ideas or images forming an ambiguous and therefore tolerable composite.

The ability to believe in chance and to tolerate ambiguity are consequences of the development of secondary process thinking

and may be regarded as specialized aspects of reality testing. Reality testing itself is a slow, developmental process. As Arlow (1969b) summarized it, "In addition to the maturation of the essential ego apparatuses, the vicissitudes of development are very important" (p. 28). We see ". . . the development of reality testing as a gradual evolution in the child from an attitude toward the world which is self-centered, pleasure seeking, animistic, and magical, to a later capacity to differentiate between inner fantasy and objective reality" (p. 29). Hartmann (1956), in particular, laid special stress on the life-long task of learning to differentiate subjective and objective elements in our perception of reality. In addition, Arlow (1969b) has shown how unconscious fantasies impinge upon and may critically distort one's images of the past and one's perceptions of the present.

The problem of causality, viewed primarily as a consequence of the human being's projection of internal perceptions, was conceptualized by Rado (1932). The thrust of his contribution was a critique of a mechanistic, pre-Heisenbergian determinism that was unable to integrate the newer contributions from natural science, in which fortuitous events loom so importantly. Determinism, he observed, has never freed itself from its earlier animistic impress: ". . . our whole scientific conception of the universe, based as it is on research, is a legitimate derivative of the animistic system of thought. Moreover, we should be ever mindful of the fact that the materialistic sovereignty of natural science obtains only for our consciousness; in the unconscious animistic thinking indeed holds unlimited sway" (p. 699).

Nunberg (1956) attributed man's "need for causality" to the synthetic function of the ego. Although not an instinctual drive, it had, he believed, the "compelling force of an instinct." "The seeking for connections in a chain of events in which the last link is determined by the first seems to be at the root of causal thinking" (p. 151). Rationalization is thus an illusory causality which, like the secondary elaboration of the dream, "reconciles contrasts which are too sharp, fills in gaps and gives the appearance of plausibility to illogical mental processes. . ." (p. 151).

The ego's work of unifying, connecting, and breaking down contradictions may be further overextended, as in the psychotic patient, where delusions bridge the lacunae in consciousness. Nunberg added that "the younger, the less logical, the more primitive or the sicker a person is, the more easily will he find 'causes' " (p. 151).

It thus appears that problems in dealing with causality, and consequently with chance and ambiguity, arise from distortions in the development of reality testing, probably reflecting crucial animistic vestiges. A somewhat differing point of view has been suggested by Coltrera (1978), who noted that the tolerance of ambiguity and chance are "as much determined by nonconflictual autonomous ego gifts as they are by . . . conflictual determinants." This intriguing hypothesis seems, however, to present problems of verification.

As previously mentioned, the belief that one can control external events by one's thoughts is observable among many people. Indeed, magical thinking may occur in virtually all individuals when they find themselves in a perilous situation and realize they possess no effective means of dealing with it. If fight or flight is useless, an individual may enter a state of depressive withdrawal, experience feelings of derealization or depersonalization, or regressively attempt to control the situation magically. Freud (1901) described some of his "bungled acts" when, for example, his accidental destruction of a valuable object represented a sacrificial offering given to protect one of his children who was seriously ill.

Examples of difficulties with chance and ambiguity are commonly encountered in clinical practice. A female patient in analysis had an early spontaneous abortion. Her obstetrician outlined the usual causes of miscarriage, but was unable to establish the etiology of the one she had just undergone. She felt intensely guilty and was convinced that her miscarriage was caused by a weight she had lifted the week before the bleeding had begun. Her evident intolerance of the ambiguous situation was subsequently seen to be related to an induced abortion she

had had performed several years before her marriage. Her inability to accept the unknowable thus served as a resistance against dealing with the earlier guilt-ridden event.

A student in psychotherapy, applying to a professional school, was told that despite his superior qualifications his chances of being accepted were only one out of four because of the large number of similarly qualified applicants. Not surprisingly, he became anxious during the weeks he waited for a decision. He soon began to have complicated fantasies, however, which "mathematically proved" that he would be selected. He also found himself making pacts with God that he would abandon his extramarital relationship if he would be accepted. As in the case of the former patient, his magical formulas not only served to deal with an uncontrollable, unpredictable situation, but also reflected a particular intrapsychic conflict.

During an extended evaluation to determine whether a young woman, who had applied for analytic treatment, was actually capable of introspection, she reported several dreams whose manifest content disturbed her and whose latent content, relating to incestuous wishes, was close to awareness. The patient was dissatisfied because the doctor did not explain (away) the dreams. It became apparent that her mounting anxiety impelled her to seek explanations of her dreams that would repress the emerging material. When no "explanations" were forthcoming, the patient supplied her own, characterizing her dreams as "precognitive." She related that she had had many such dreams in the past and described how they had foretold the future. In this way she effectively closed the door to the past. Although this patient demonstrated a number of characteristics that would make her an appropriate patient for analysis, her lack of introspectiveness, as shown above by her intolerance of uncertain material, was further evidenced by a generally alloplastic view of her psychological problems and an adamant refusal to talk about subjects which she decreed to be "off limits." Along with the other patients described she demonstrated a marked predilection to regress to the level of magical

thinking when confronted with uncontrollable, potentially dangerous material.

In contrast to the preceding patient is the case of a thirty-five-year-old woman who was accepted for analysis. She had sought treatment because of a work inhibition, marital disturbances, and a poor self-concept. During the initial hours of evaluation, although she freely described her belief in astrology and an interest in various religious sects, for the most part she identified her difficulties as stemming from her own behavior, recognizing that she used these magical means in a defensive way. During the years of her analysis there were several occasions when she utilized magical behavior and thinking as a resistance; each time, however, the therapeutic alliance was sufficiently sturdy for her to work through these evasions from the analytic process. Most probably this woman will fall back on magical defenses at critical times when she feels out of control, but these will be infrequent and less urgent.

Perhaps the most dramatic preoccupation with chance is seen in gamblers. Although gambling has multiple determinants, in many gamblers one finds an isolation of ideas which permits them to reject the laws of probability despite their erudite understanding of those very laws. This allows the gambler not only to avoid a realistic appraisal of the chance event, but also to deny those unconscious and preconscious aspects of his behavior that impel him into believing that he can surmount odds that are often overwhelmingly against him. Luck, always maternally personified, will gratify all his wishes. In a case vignette, Fenichel (1945) observed, "A passionate gambler in the lotteries behaved as if it were assured and inevitable that one day he would win the Grand Prize" (p. 372).

The gambler, in his denial of the known probabilities of an event so that he can expect the odds to operate in his favor, is the mirror image of the individual who is completely unable to accept luck. In both situations there is a denial of the actual nature of chance in conjunction with the use of magical thoughts to control the event. It is therefore not surprising that

gamblers are well known for their use of the paraphernalia of magic—rituals, signs, amulets, etc. Like the patients previously mentioned, compulsive gamblers use the denial of chance as a means of dealing with unconscious conflicts. Thus, through gambling, they simultaneously succeed in distorting both internal and external reality.

The matter of magical thinking and determinism (or, more properly, overdeterminism) not only has significant clinical implications but social overtones as well. Some observers have claimed that during the past twenty-five years there has been a significant increase in mysticism, irrationalism, and anti-intellectualism. In specific individuals this propensity for magical thinking and behavior can be seen to represent specifically an intolerance of ambiguity and chance and a concurrent rejection of psychic determinism. It has been suggested that the history of philosophy as well as popular attitudes demonstrate a cyclic pattern in which a society swings from a relatively Dionysian world view, characterized by experiential, body-directed, supernatural, and mystical concerns, to an Apollonian posture marked by naturalism, rationalism, and logic. Perhaps the contemporary rejection of rationalism represents yet another normal oscillation; it is, however, paradoxical that these attitudes thrive in an era of unprecedented scientific achievement. Freud's comment that "intellectual education is a prerequisite for believing in chance" implies only that such education is necessary but not in itself sufficient to develop a rationalistic outlook. It is not uncommon today to find individuals with higher education who reject rationalism, chance, and ambiguity in many areas of their lives and demand and discover the "answers" to all their questions in a wide variety of faiths ranging from astrology to oriental mysticism.

Perhaps the very successes of science and technology have thrown into relief not only our ignorance but our growing concern, often dread, over the destructive monsters that science is creating which appear to be progressively eluding human control. In this light, science itself is commonly regarded as synony-

mous with anti-humanism. Furthermore, scientific developments in many areas have led to heightened expectations, with the inevitable result that some people are embittered because their physical and emotional illnesses, as well as their problems of everyday life, are not quickly and painlessly eliminated. Such utopian expectations cannot fail to engender disappointment, frustration, and pessimism. Those individuals who are unable to accept the ambiguity of the unknown are led to denigrate science and the reality it studies. They repulse the mysterious and embrace the mystical.

Such regression may be partial and limited to times of stress or to particularly conflictual areas in the lives of individuals who at other times may be reasonably capable of introspection. In others, magical thinking widely pervades their mental functioning, and if they are in psychotherapy, this cognitive mode will constitute a powerful resistance. Although even prominent magical thinking may not in itself be a contraindication to psychoanalytic therapy, its presence represents an unfavorable factor unless there is reasonable evidence that the patient will be able to form a therapeutic alliance. Accordingly, the evaluation of patients for analysis or psychoanalytically-oriented psychotherapy may be enhanced by assessing not only their capacity for introspection, but also by determining their view of the external world. Assessment of patients' ability to believe in chance occurrences and their tolerance of ambiguity may be a useful adjunct in evaluating the extent to which they rely on magical thinking.

SUMMARY

The inability to believe in chance occurrences, along with an intolerance of ambiguity in the external world, are often the outward manifestations of difficulty with introspection. Case vignettes are presented to demonstrate how magical thinking and behavior, directed to the outside world, also serve to defend against intrapsychic conflict.

The contemporary vogue of anti-intellectualism and mysticism is seen as a sociocultural expression of individual magical thinking. Those who are strongly pervaded by these attitudes are apt to show poor psychological mindedness. It is suggested that information about a patient's ability to accept external chance and ambiguity may be important in the evaluation of the patient for analytic treatment.

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Psychoanalysis and the History of the Individual. By Hans W. Loewald, M.D. New Haven and London: Yale University Press, 1978. 77 pp.

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BOOK REVIEWS

PSYCHOANALYSIS AND THE HISTORY OF THE INDIVIDUAL. By Hans W. Loewald, M.D. New Haven and London: Yale University Press, 1978. 77 pp.

At a time in psychoanalytic history when serious thinkers wonder whether the theoretical lode which can still come from free associations may not be coming to an end, it is reassuring and refreshing to read these reflections of a psychoanalytic lifetime by Hans Loewald. Not only does Loewald still extract new and compelling ideas from the psychoanalytic process, but he does so with its most routine method and goal, the genetic historical reconstruction of the past. The exercise of thought through which he leads his reader reminds one that Freud also did not "discover"; he saw differently what was always there. Only a small amount of the profuse literature in the mental sciences continues to do this to a significant degree and in a helpful way. This is such a book.

The first of a new series, "The Freud Lectures at Yale," the book consists of three lectures: on man as moral agent, on transference and love, and on psychoanalysis and religious experience. Historicity and temporality are the themes which bind the three together. While each starts from a different point of origin, they all dip back to a common substrate: "To appropriate, to own up to, one's own history is the task of psychoanalysis as a therapeutic endeavor" (p. 20). The psychoanalytic process aims to develop the capacity in human beings to "appropriate" (the word is used a number of times and comes to have an affective meaning idiosyncratic to Loewald) their past, make it part of their living present, and use it effectively to direct their thrust into the future. Although it is said a bit differently here and is pithily true, this is hardly a new formulation of the psychoanalytic aim. Yet it is said with a grace and with a theoretical and therapeutic blend that imbues it with a distinct flavor and impact of its own. It is characteristic of Loewald's creative stamp that he can hold in his hand a ubiquitous truth, turn it around for us in his mind's eye, and have us see a new plane, or facet, or savor a new relationship between its elements. The potential for continuing psychoanalytic understanding seems to be limited

not so much by the contents of free associations as by the capacity of the analyst to sift them for new views and insights.

Under each subject he treats, Loewald has us see a commonly experienced datum in an extra dimension. A theme repeatedly stressed is the need to maintain a reciprocal interaction between ego and id in both directions, not one; the id influences the ego as much as the reverse. Unconscious products, repressed drives, even traumatic memories are brought to consciousness, he points out, not to be "deplored and undone—even if this were possible" (p. 21), but to be transformed and reworked, to be made more meaningful and creative in our ongoing lives. From many poignant observations in treatment and in life, Loewald is moved to amend Freud's "where id was, there ego shall be" to "where ego is, there id shall come into being again to renew the life of the ego and of reason" (p. 16).

The book is full of such thoughtful epigrams. "There is no one-way street from id to ego. Not only do irrational forces overtake us again and again; in trying to lose them we would be lost" (p. 22). If they are in danger of being unavailable in fact, the enduring quest of psychoanalysis is to find the way back to them. Modern trends in art and literature and the interests and activities of the younger generation point the way to a renewed vigor and vitality in our culture precisely because of a new evaluation of the irrational unconscious "leading toward a less rigid, less frozen and more humane rationality" (p. 15).

There is a constant dynamic interplay between the two levels of mental processes. Each stratum can be overemphasized and be given exclusive domain, with characteristic psychopathology at either pole. There can be a madness of rationality as well as of irrationality, Loewald points out in a main thrust of the book, which he demonstrates in each of the areas upon which he enlarges. The corrective for this false quest for perfection and dominance of the intellect and reason is an open intrapsychic channel to the instinctual, less differentiated, and more unrestricted unconscious.

This central theme is applied in turn to the subject of each lecture: to the goal of psychoanalysis (man as moral agent), to love and its manifestations in the transference, to religion and other mystical experiences of life. On the subject of religion and the religious experience, Loewald again surprises us, showing us the other side of the usual coin of psychoanalytic explanation. To complement

what he regards as a one-sided attitude of psychoanalysis toward religion engendered by the dominating influence of Freud's views on the subject, Loewald points out that religious experiences are as capable of evolving as mature forms of functioning and expression as any other mental phenomena of life, "no less than human love, for example" (p. 72). Although Freud did much to clarify the irrational sources of religious belief, he failed to give proper emphasis to the ways in which unconscious mentation feeds into the higher ego organization in this sphere as in all others. As Loewald puts it, "One does not have to be a mystic to remain open to the mysteries of life" (p. 25). Religious experience is not always a defense against repressed sexuality; both can stem from deep common sources, and both can be equally defended against. Both can be final psychic products on an equal plane, stemming from the same unconscious reservoir and primary narcissism and culminating in the higher consciousness of a responsible individual life.

Sublimation, Loewald goes on, one of the most obscure and vague concepts in psychoanalysis, is similarly subject to the fallacy of reductionism. Loewald goes beyond the rote formulation that sublimation represents a successful defense against unacceptable impulses, a formulation that indirectly or even explicitly emphasizes the "lowly" origins of the creative product. There is a thin but perceptible line, he says, between sublimation as a defense and sublimation as "a genuine appropriation, the responsive interplay between id and ego" (p. 76). The same instinctual vital forces go into creativity and sexuality. The sublimated product can represent a valid outcome from both levels of mentation rather than a sham or pretention because one is serving as a defense against the other.

Many other large subjects of interest in psychoanalysis today are touched upon in Loewald's observations which cannot be adequately followed up here. To the current intensely argued problem of the interrelated lines of development of narcissism and object love, Loewald brings clarity and consistency. Out of the original primary narcissism of the fused mother-child unit come both self-love and object love. These stages, as well as the object love of the succeeding oedipal phase, persist in all subsequent stages of life, an observation which, by serendipity, can be applied with profit to current theoretical and practical controversies. The internalization which results in superego development "can be described as a narcissistic trans-

formation of object relations" (p. 45). And normal separations and the process of mourning also involve "narcissistic transformations of object relations."

"The range and richness of human life is directly proportional to the mutual responsiveness" between primitive and later developmental stages of mentation (p. 61). A most original elaboration by Loewald in this regard is on the subject of time. On a par with the distinction between external and internal, "a basic differentiation in the unfolding of mental life [is] that of temporal modes" (p. 61). Treating in psychoanalytic terms a subject hitherto reserved for philosophical discourse, Loewald differentiates everlastingness, or time unlimited that has no beginning or end, from eternity, in which time does not apply, is abolished, or never existed. The latter Loewald correlates with the earliest stage of development, in which experiences do not take place "in time" and in which past, present, and future do not yet exist. "The articulation of experience in terms of temporal modes ushers in the beginning of higher, secondary forms of mentation" (p. 63). Something of the earlier feeling is recaptured in certain pathological states throughout life, those of a mystical, ecstatic, exceptionally intense nature. "The temporal attributes of experience fall away; only a 'now,' outside time, remains" (p. 64). Ideas of everlasting life after death derive from secondary process mentation and are not the whole truth. More likely there are "intimations of eternity" (p. 69) that are largely ignored in Western thought which is dominated by a narrow scientism. This deeply disturbing challenge to the human being's rational life may derive from the earliest oceanic feelings.

Near the end of these essays, Loewald reflects with modesty and caution that his discourse on matters of religion and eternity may be due to his age. But they are ideas which he has had for many years; they are entertained by many younger people, and perhaps his present status or age has merely given him the courage to put these ideas into print. There is more than is or can be known, he concludes, and we should be open to it all.

A discussion as bold and imaginative as this cannot fail to induce some questions and a few quibbles. First, it is worth pointing out that when Loewald talks of man as a moral agent, he is not, as the title of one lecture might suggest, referring to superego functioning or moral conflicts, but to man's evolving into a civilized being. Be-

coming responsible and moral means developing a mature ego. Second, another adventitious observation is that although Loewald strives at the beginning for a less technical language in addressing an interdisciplinary humanistic audience, the language he eventually uses and which still serves him best includes the same dynamic and structural terms—id, ego, and superego—that are used in discussions among analysts; and from this language his meanings flow freely to this wider audience. An attempt, in fact, to substitute a new term "conscient" (a "knowing together") (p. 13) for "preconscious," given and explained for good reason, is still not very convincing or compelling, nor does it last effectively throughout the volume.

The main word of caution, however, is stimulated by the very persuasiveness and imaginative evocativeness of Loewald's approach and style. I would recommend that the reader keep a conservative stand in regard to the valid place of some long-held theoretical views even as these are being supplemented and enriched. For example, in spite of what Loewald points out about the one-sidedness of older views on sublimation and religion, such views are also distinctly correct and are at least as contributory as his present emendations of them can be. Religion in many of its aspects can still be a mass psychosis. Sublimation can be and is, in many specific instances, an outcome of a distortion and creative channeling of unacceptable impulses. A state of existence free of the limiting borders of time or space has been a mental construct of human beings ever since they became aware of their finiteness and helplessness. Speculations, imaginations, hypotheses, or fantasies about such an existential condition can well be looked at from all possible (and even some impossible) directions. But all of these can or should also be subject to scientific scrutiny, not done narrowly, but from as wide a scope as possible. Loewald's suggestion to link this cognitive-affective psychic product with an oceanic timeless state of infancy is such an attempt based on the psychoanalytic genetic point of view.

In these days when the theory and practice of many proliferating therapies extend squarely into the realm of the irrational, it is necessary, even as we follow Loewald in a greater appreciation of the permanent role of the unconscious and early affective states, not to lose our selves and operate from an unstable platform ourselves. Jung, among the original analysts, did so, as Loewald points out.

Many of the therapies of recent years espouse the irrational rather than treat it. Psychoanalysis has historically not been part of such a move. While aiming to understand and, indeed, make available the derivatives of the instinctual drives, its base and source of understanding is in the rational ego. Treatment of the primary process is by the secondary, and while rationality can be overdone and become a defense or a symptom, as Loewald so successfully and so regularly points out, it can also not be done without. These thoughts, to my mind, balance the boldness of this book.

Loewald embodies the complete psychoanalyst, the clinician guided by theory, the theoretician who applies his understanding to clinical psychoanalysis, the empathic therapist who synthesizes the science and art of analysis, and the researcher always alert to advance the frontiers of our knowledge by what he divines from the conduct of many analyses. To achieve the aims of Mark and Viva Kanzer in establishing these new Freud Lectures, a more worthy first lecturer could not have been chosen, nor the series begun more auspiciously.

LEO RANGELL (LOS ANGELES)

THE PATIENT AND THE ANALYST. THE BASIS OF THE PSYCHOANALYTIC PROCESS. By Joseph Sandler, Christopher Dare, and Alex Holder. New York: International Universities Press, Inc., 1973. 150 pp.

The implicit bold premise of the title of this book is elaborated into a provocative and, in my mind, quite valid thesis. The authors argue that the analyst and the patient form a contained system whose psychodynamic balances define both the operational and epistemological conditions of the psychoanalytic situation. Within this situation the analyst must be as reflectively aware of his reactions as he is of his interventions, in the same sense that patients are asked to be reflectively aware and introspectively curious about their verbal and nonverbal associations during the hour. In this view countertransference transcends its usual sense of a neurotic transference resistance on the part of the analyst to the patient, to become a darker shadow of empathy in the service of the work of the analysis proper (pp. 61-71).

Invoking the spirit of Wittgenstein, the authors develop their arguments from a proper English positivist commitment to visit

language reform on the veritable babble of psychoanalytic language and concepts all about us (pp. 11-13). Few would argue the development of such positivist critique according to historical principles. "The clinical concepts used to describe, explain and understand the psychoanalytic treatment process have arisen at different points in the history of psychoanalysis. Terms which derived their original meaning in the context of one phase have been carried over into later phases . . ." (p. 21). We can do no less than judge this book by the terms of its most praiseworthy methodological commitments.

The history of any empirical idea, such as psychoanalysis, is really the history of its defining empirical dialogues. The authors have chosen for their historical model David Rapaport's 1959 systematizing attempt (pp. 13-20) in which four phases are defined: the first phase coincides with Freud's prepsychoanalytic theory (1881-1897); the second phase is the development of psychoanalysis proper (1897-1923); the third phase encompasses the development of Freud's ego psychology (1923-1937); and the fourth phase is the development of modern ego psychology after Freud (1937-).

To attempt a systematizing approach to the processes, devices, and management of the psychoanalytic situation implicitly assumes a quest whose success may be judged by the nobility of its failure. This book and the bold premise of its title begs the old nagging question of whether the psychoanalytic process can be discursively limned or whether its precepts are better "learned" as a verbal tradition in the spoken dialogues of the supervisory relationship. In this question Freud's own experience in the matter is worth recalling.

As late as the Salzburg Congress of 1908, Freud believed he could reduce the teaching of psychoanalytic technique to a formal synthesis, which he would call *A General Account of the Psychoanalytic Technique*. He worked on the project fitfully for two years, giving up the attempt at synthesis after some fifty pages, proposing instead to develop the "general account" as a group of six technical essays. In his 1910 paper on "wild psychoanalysis," Freud took a strong and never to be changed stand against a pedagogy of psychoanalysis. Insisting that technique could not be learned didactically from books, he advanced the operational notion of psychoanalytic training, stating that clinical competence could be acquired only in a preceptorship with those who had themselves mastered the psychoanalytic method. Freud's basic rejection of a psychoanalysis learned

from some hornbook of technique was in itself a beginning appreciation of the open nature of his own cognitive style, with its tendency toward incomplete dialectic formulations which fend off premature synthetic closures. The *Papers on Technique,* written between 1911 and 1915, should be thought of as the empirical summary statements of a radically innovative mind. As such, they represent the "fitting in" of serial hypotheses derived from a linked series of empirical questions posed during the largely clinical time bridging the two high-water marks of Freud's metapsychological thinking, Chapter VII of *The Interpretation of Dreams* and the *Papers on Metapsychology.*

While it is true that the principles of technique as we essentially know them today derive from the *Papers on Technique* (1911-1915), those essays were contemporaneous in time and in empirical assumptions with the *Papers on Metapsychology* (1915-1917). As such, they cannot be treated as isolated empirical ideas, as the authors do (p. 22), removed, as it were, from the structuralist premises of those same *Papers on Metapsychology.*

This leads to my most serious quarrel with the book, for although the authors cite David Rapaport on the history of psychoanalysis as an empirical idea, they arbitrarily ignore the structuralist premises of his historical approach. Rapaport's special emphasis is on the pervasiveness of structure in psychical functioning. An intimation of what is to follow is contained in the seemingly straightforward statement that they, the authors, believe "it is convenient to divide the history of psychoanalysis into a number of phases (after Rapaport, 1959)" (p. 13). But Rapaport very clearly spoke of "the four phases of the development of ego psychology," clearly invoking the third (1923-1937) and the fourth (1937-) phases, whereas the authors seem to believe that "much current psychoanalytic thinking, particularly that part related to the clinical situation, is still firmly rooted in the second phase of psychoanalysis" (p. 20). The authors go on: "During the second phase, which lasted until 1923, the basic psychoanalytic treatment setting, and the clinical concepts related to it, were developed. Although major theoretical changes occurred during the third and fourth phases of psychoanalysis, the 'classical' psychoanalytic treatment situation has remained essentially that of the second phase. By the time Freud came to write the 'technical' papers on psychoanalysis [1911-1915] the technique had been for-

malized" (p. 22). For all intents and purposes, the authors seem to have pre-empted the empirical history of psychoanalysis after 1923.

While the authors quote historical scripture according to David Rapaport, they tend to live according to the older and more apocryphal gospel of Kurt Eissler, citing the latter's "basic model of psychoanalysis" as the arbiter of the operational conditions and management of the psychoanalytic situation (pp. 22-23). The subsequent chapters, marvels of parsimony in themselves, all refer back to the operational conditions imposed by that basic model: the treatment alliance, transference, special forms of transference, countertransference, resistance, the negative therapeutic reaction, acting out, interpretation and insight, and working through.

Although it is true that the principles of technique as we essentially know them can be dated to about 1913 (really to the five "papers on technique" published between 1911 and 1915), it faults the critical sense of psychoanalysis as a viable empirical idea arbitrarily to restrict it to the empirical contexts of the second phase (1897-1923), in which they were formulated. To recall those contexts: it was a time in which economic theory had gained ascendancy over the topographic in the "metapsychological papers," with all emphasis now being laid upon the instinctual aim and the drive object defined as a function of that aim. Accordingly, the working through of resistances was conceived as a microabreaction. Interest was still more or less centered on the contents of the unconscious. Therapeutic intention was little changed from Freud's first description of his psychoanalytic method in 1904, namely, that repression was to be undone and that the dynamic task of the interpretation was to raise significant unconscious contents to consciousness. Even then, however, intimations of the structural concerns of a later ego psychology were already "in the air," with resistances beginning to be meaningfully related to the forces that bring about repression. The method still operationally honored the two dominant processes of the cathartic period, abreaction and remembering. Essentially, these are the empirical contexts of the second phase, contexts which the authors' argument would move forward to the empirical conditions of the principles of psychoanalytic technique in our own time. In my mind, to do this not only seriously compromises the sense of psychoanalysis as an empirical idea, but also blocks access to the wider methodological resources of later historical phases.

Most serious, to restrict the principles of technique to the empirical conditions of the second phase is to place them outside of what Anna Freud has called the "rise of the transference," which took place for the most part in the third and fourth phases. It is of central importance that the "papers on technique" were arranged in an ascending gyre around the idea of a working transference neurosis. Thus, the "technical papers" represent the first stage in the "rise of the transference," shifting emphasis from a reconstruction of a meaningful past through free association and dream interpretation to a recovery of that determinant past in the regressive recall of transference acts and modes. The "rise of the transference" is an empirical function of the discoveries of the third phase. Among the historical forces which shaped this critical turn in psychoanalytic practice and theory may be cited the shift of interest from the id to the ego and the widening of instinct theory to include aggression. Also contributing was a shift of interest after 1926 from the singular causative role of the phallic-oedipal phase in neurosis to one emphasizing preoedipal events, especially those of the oral period and its central mother-child unit.

The omission of this last in the authors' considerations has ended in a near exclusion of developmental constructs in the book. This seems to reflect an apparent bias of the English school in general against developmental approaches. It is a bias that tacks quite close to polemic when by inference the authors seem to be casting out the developmental approach to acting out (i.e., Greenacre, Fenichel) (pp. 99-100). The authors also reject a general psychology approach to the problem (e.g., that of Helene Deutsch), with its contained developmental constructs (pp. 100-101). Parenthetically, are they not implicitly rejecting their avowed commitment to Rapaport's historical model, with its specific contained historical argument for psychoanalysis as a general psychology?

As empirical evidences mount from child and adult analyses—on occasion, in serial analyses with the same patient from childhood into adolescence and then as an adult—one becomes ever more impressed that the transference neurosis is very much developmentally determined, its character and focus changing throughout the life-cycle according to phase-specific developmental events and conflict resolutions, and their subsequent internalizations.

To say that the concept of resistance has changed little from the

time of Freud's frustrating experience with the Wolf Man, save for a more extensive description of its forms (p. 78), and to give a comprehensive list of resistances in support of such argument (pp. 80-81), is to miss the methodological advantages and technical sophistication granted to interpretation by the widened metapsychological points of view of a modern ego psychology. To cite but one example, the technical implications of an excellent discussion of the negative therapeutic reaction (pp. 84-93) are greatly foreshortened by an absence of structural and developmental points of view. In its most serious form, the negative therapeutic reaction represents a trenchant negative transference in a masochistic character. The technical problem is how to convert it into a *working* negative transference neurosis. The tactful management and eventual working through of this most serious transference resistance requires, in my mind, an appreciation of how the conjoined flawed development in those patients—of aggression, of the superego which remains primitive and utilizes pathological self-esteem mechanisms, of adaptation, and of self and object constancy—can be recovered and worked through in the ongoing narcissistic modes of the transference. The authors, on the other hand, turn, in this matter, to Karen Horney (pp. 88-89), whose construction seems to me to be irrelevant to psychoanalysis insofar as it is made apart from both drive and dynamic considerations.

The trouble with an adversary critique is that it more often than not ends sounding like an unrelieved litany of exception and complaint. Apart from my basic disagreement with the authors' notion of the historic nature and direction of psychoanalysis as an empirical idea, there is much that I like in the book. It contains many masterful, integrated presentations of often disparate ideas, nowhere better seen than in the two splendid last chapters on the dependent relationships among insight, confrontation, clarification, interpretation, and working through.

This is not a book for all seasons and all people. Nor was it meant to be: "The overall purpose of the present work can be regarded as an attempt to facilitate communication, not only within the realm of clinical psychoanalysis itself, but also where situations other than the classical psychoanalytic treatment situation (e.g., psychotherapy and some forms of casework) need to be conceptualized in appropriate psychodynamic terms. . . . This need is all the greater in

view of the increasing emphasis being placed on training in psychotherapy as part of general psychiatric education" (p. 12).

JOSEPH T. COLTRERA (BROOKLYN, N.Y.)

THE MEANING OF ILLNESS. SELECTED PSYCHOANALYTIC WRITINGS INCLUDING HIS CORRESPONDENCE WITH SIGMUND FREUD. By Georg Groddeck. Edited by Lore Schacht. New York: International Universities Press, Inc., 1977. 270 pp.

"I arrived at my . . . views not by studying neuroses but by observing complaints that are commonly called organic," wrote Georg Groddeck in May 1917 in a letter asking Sigmund Freud for permission to count himself a psychoanalyst. Freud responded affirmatively: ". . . you are a splendid analyst who has understood forever the essential aspects of the matter. The discovery that transference and resistance are the most important aspects of treatment turns a person irretrievably into a member of the wild army. No matter if he calls the unconscious 'It' " (p. 36). Thus began that remarkable relationship between the "wild analyst," as Groddeck began to call himself, and Freud, whom he revered as his "most respected teacher and dearly beloved human being."

The present volume contains two kinds of writings, many of which are of interest to contemporary psychoanalysts. First, there is a correspondence with Freud spanning the years from 1917 to 1934, the year of Groddeck's death; second, there are selections from Groddeck's scientific works. The whole is ably edited and introduced by Lore Schacht.

The correspondence contains forty-four letters by Groddeck (some of which are co-authored by his wife) and thirty-six letters by Sigmund Freud. Groddeck proves himself to be a brilliant and, at times, original thinker. His great admiration for Freud, whose approval he constantly solicited, seems not to have dissuaded him from stating his own divergent views modestly but with the forcefulness born of conviction. Freud, for his part, accepted the younger man's contributions with kindly encouragement but with increasing skepticism. He chided Groddeck for not having overcome his "trivial ambition of claiming originality and priority" and for being a monistic philosopher who "discards all the beautiful differences in nature in favor of the temptation offered by unity" (p. 38). In spite of mis-

givings, especially about Groddeck's mysticism, Freud welcomed the heretic to the pages of the psychoanalytic journals which published many of Groddeck's articles.

Excerpts from Groddeck's *opus* constitute the bulk of this volume and reveal a gifted physician who combined great sensitivity and curiosity with a speculative bent. His grand conception of the unconscious, the It, sees it not just as the motivator of psychological phenomena but as the impetus behind all human thought, action, behavior, illness or health. Doing away with the mind-body dualism which informed contemporary scientific thought, Groddeck studied organic illness as a manifestation of the mysterious It. He speculated that although the It cannot be fathomed in its depth, it endows illness with meaning. Human beings are lived by the It or by the symbols through which the It permeates life.

Thus Groddeck, like Ferenczi, stimulated interest in psychosomatics. Freud concurred with this aspect of Groddeck's views and wrote him "that the [Freudian] unconscious act exerts an intensive, decisive influence on somatic processes such as conscious acts never do" (p. 37). Freud also liked Groddeck's novel *Der Wanzentöter* (*The Bedbug Killer*) and compared it to one of his favorites, "that model of all humorous novels, *Don Quixote*." However, Freud thought "a less whimsical title might help its publication," and it was later published under the title *The Seeker of Souls*.

Groddeck was fearful about losing Freud's approval when mentioning another book he was hatching that still had a lot of mysticism and fantasy in it. Freud reassured him with: "I am myself a heretic who has not yet become a fanatic. I cannot stand fanatics, people who are capable of taking their narrow-mindedness seriously" (p. 56). Freud was also very conciliatory with Groddeck regarding the latter's expansive claims: "I understand very well why the unconscious is not enough to make you consider the It dispensable. I feel the same. Yet I have a special talent for being satisfied with the fragmentary" (p. 58). Freud states the scientific issue clearly: "I do not, of course, recognize my civilized, bourgeois, demystified id in your It. Yet you know that mine derived from yours" (p. 93).

Psychoanalysts have been less interested in Groddeck's ideas than in his warm support for Freud. Groddeck's mysterious and almost transcendental unconscious, his idiosyncratic theory of symbolism, his pan-psychologism that based itself on his observations of physi-

cally ill patients rather than on data obtained during psychoanalytic treatment of neurotics—all these intermixed with praise for Freud and his psychoanalysis—sound friendly but strange to analytic ears. Groddeck belongs to that group of contemporaries of Freud who developed parallel theories, partly out of their own creativity, partly as a result of being sparked by the incredibly stimulating ideas emanating from Freud. Some, like Adler, Jung, Rank, Reich, and others, drifted away from the mainstream of psychoanalysis. Groddeck was never close enough to the mainstream to need to assert his individuality by making an issue of his differences with Freud. For his part, Freud never swallowed any of Groddeck's mysticism for the sake of their friendship, as he had with Fliess and with Jung. Consequently, Freud never had to undergo the kind of traumatic disillusionment with Groddeck that so painfully tore his friendship with some of his other early colleagues.

Georg Groddeck deserves recognition as a true pioneer and original contributor in the history of psychoanalysis. The present volume can be read with profit and pleasure.

ERNEST S. WOLF (CHICAGO)

FREUD AND THE DILEMMAS OF PSYCHOLOGY. By Marie Jahoda. New York: Basic Books, Inc., 1977. 186 pp.

From the days when Wundt and Freud were providing the originative impulse for their respective disciplines, the areas of experimental and clinical psychology and the field of psychoanalysis have gone their separate ways and have created few opportunities to fashion meaningful dialogues. There have, of course, been exceptions: one can think immediately of such outstanding figures as David Rapaport, the late George Klein, Robert Holt, Roy Schafer, and others. Beyond these creative few, however, the tendency of the empirical sciences of behavior to go their own way has remained the rule while psychoanalysis has tended to concern itself more or less exclusively with its basic clinical preoccupations. The dialogue remains pitifully thin and trivial, basically antithetical, and even at times hostile.

This book, by an outstanding English psychologist who has a firm grasp on psychoanalytic concepts and their meaning, provides a tidy account of the development of Freud's thinking as he struggled in his own way with some of the basic dilemmas that presented them-

selves to him in his clinical practice. These dilemmas, in fact, present themselves to any inquiring scientific mind that seeks to enter into the exploration of the human mind and its functioning. Jahoda demonstrates in many different contexts that Freud was making a valiant effort to be as scientific as he could in an area where the scientific grasp of the phenomena was uneasy and riddled with ambiguities.

Such an attempt, being the product of a limited human mind, must have its inadequacies, its deficiencies and obscurities; to deny these qualities to Freud's thinking would at the same time deny him his humanity and his position as a scientist. Certainly Freud himself was exquisitely aware of these limitations. At many points in the development of his thought he cautioned his listeners and readers that the theory was, after all, only a construction, a scaffolding that could be easily torn down and reconstructed in some other fashion that might more conveniently or suitably account for the data. Freud's continuing insistence on the validity of clinical data as the firm, solid, empirical bedrock of psychoanalysis was a repeated theme, even as his acknowledgment of the hypothetical, questionable, and alterable status of his metapsychology remained a predominant characteristic of his thought.[1]

On the other side of the fence, modern psychology is both a human and a scientific undertaking and therefore has its own inherent limitations and difficulties. Comparing Freudian psychoanalysis and contemporary psychology on a number of points, Jahoda concludes that the latter has succeeded no better than psychoanalysis in addressing or resolving the dilemmas of the study of the human mind and human behavior. In Jahoda's words, "Psychoanalysts, psychologists and even natural scientists arrive inevitably face to face with the great riddles which, as scientists, they lack the competence to solve. Within a much more modest frame of mind, a psychologist will not mistake Freud's world-view for part of his science" (p. 161).

In sum then, this is a succinct, compact, wise little book. It will not teach either psychoanalysts or their psychological colleagues very much that they do not know already, but it will put the questions and issues in a much more balanced frame of reference. Along the

[1] *Cf.*, Meissner, W. W.: *Freud's Methodology*. J. Amer. Psa. Assn., XIX, 1971, pp. 265-309.

way there are some very good expositions of Freud's thinking and some rather apt discussions of touchy and difficult theoretical issues. Particularly noteworthy are the discussions of metapsychology and of validation. This is a book that should be read by anyone interested in psychological discovery, and it can be warmly recommended as a stimulating and thought-provoking book for students of other, nonpsychoanalytic persuasions.

W W. MEISSNER (CAMBRIDGE, MASS.)

FROM OEDIPUS TO MOSES. FREUD'S JEWISH IDENTITY. By Marthe Robert. Translated by Ralph Manheim. Garden City, N.Y.: Anchor/Doubleday, 1976. 229 pp.

In the opening sentence of this book we are told that "the intimate relationship between psychoanalysis and the 'Jewish spirit' is so obvious that few of those who refer to it stop to define the 'Jewish spirit'. . . ." Expanding on this assertion, the author proposes to examine the "secret roots" of Freud's "coolness to specific contents of Judaism" and thus to explain "how it came about that psychoanalysis, though profoundly marked by its Jewish origin, has something essential to say about mankind in general" (p. 7).

At this point the reviewer suspects that most Psychoanalytic Quarterly readers may decide to read no further. This approach is all too reminiscent of Jung, the Nazi outlook, and the misreading of both psychoanalysis and the Kabbala by Bakan.[1] Robert's arguments, however, are more subtle; her style is persuasive and she is not alone among contemporary critics holding such views.[2]

The author's first witness is Franz Kafka who wrote to Franz Werfel in 1922, "It is no pleasure to busy oneself with psychoanalysis and I keep as far away from it as possible." So much for Kafka's attitude toward psychoanalysis. The sentence of Kafka that Robert uses as a starting point for her book is found in a letter to Max Brod: ". . . the father complex from which more than one Jew draws his spiritual nourishment relates not to the innocent father but to the father's Judaism. What most of those who began to write

[1] *Cf.*, Bakan, D.: *Sigmund Freud and the Jewish Mystical Tradition.* Princeton: Van Nostrand, 1958.

[2] *Cf.*, Cuddihy, J. M.: *The Ordeal of Civility. Freud, Marx, Lévi-Strauss, and the Jewish Struggle with Modernity.* New York: Basic Books, 1974. Reviewed in This QUARTERLY, XLVII, 1978, pp. 149-150.

in German wanted was to break with Judaism, generally with the vague approval of their fathers (this vagueness is the revolting part of it). That is what they wanted, but their hind legs were bogged down in their fathers' Judaism, and their front legs could find no new ground. The resulting despair was their inspiration" (p. 9).

The author believes that the greatest achievement of psychoanalysis, which she sees as a Jewish science, albeit a heretical one, was to build a new bridge for assimilating the Jews into the Gentile world. Psychoanalysis accomplished this by breaking radically with the religious and philosophical traditions of the West, thus finding the first genuine ground upon which Jews and non-Jews could meet.

The "secret roots" of Freud's character the author finds in a desperate and unscrupulous ambition. The main obstacle to the goals that Freud sought was Jacob Freud, his father who, according to the author, was still in his ways and appearance very much the orthodox Eastern Jew. Supporting evidence for this analysis of Freud's character is derived from the "Irma Dream" and the other dreams that Freud reported in *The Interpretation of Dreams*. The author interprets Freud's derealization experience on the Acropolis as the expression of conflict between his love for Greece and the ancestral enmity between Athens and Jerusalem.

Freud's feeling before Michelangelo's statue of Moses she interprets as a hallucination: "He really expected it [the Moses statue] to spring to its feet" (p. 124). Freud's life seems to her a long quest for a glorified father to replace the debased Jacob. Hence Freud's insistence that Shakespeare must have been an aristocrat and Moses a royal follower of Akhenaten.

In spite of her wide reading and writing about psychoanalysis there are serious gaps in the author's understanding. She naïvely believes that in his self-analysis of dreams Freud shows himself to be possessed by an abnormal hatred of his father. She fails to understand that dreams are distorted psychological magnifying glasses. Moreover, she seems ignorant of Schur's analysis of the "Irma Dream" which threw an entirely new light on Freud's supposed ambition.[3]

[3] *Cf.*, Schur, M.: Some Additional "Day Residues" of "The Specimen Dream of Psychoanalysis." In: *Psychoanalysis—A General Psychology. Essays in Honor of Heinz Hartmann*. Edited by R. M. Loewenstein, et al. New York: International Universities Press, Inc., 1966, pp. 45-85.

Robert also misunderstands Freud's capacity to let the statue of Moses exert its fascination upon him. What Freud intended as a metaphor for an inner experience she sees as a psychotic hallucination. Had Freud been subject to hallucinations, his own biography and the history of psychoanalysis would, of necessity, have taken a different turn.

The author's understanding of the Jewish culture Freud absorbed in his home is also incomplete. Had she examined the pictures of Jacob Freud published by Jones (see also the front picture in Standard Edition, Volume XX), she would have noted that during Freud's childhood, Jacob's appearance was no longer that of an orthodox Jew. Jacob's Hebrew dedication in the Bible he gave to his son for his thirty-fifth birthday is not, as I have shown elsewhere, a sign of orthodoxy, but is rather in the style of a typical document of the Hebrew enlightenment.[4]

Finally, the author fails to differentiate between the psychology of the discoverer and the significance of his discovery. Freud himself believed that being a Jew and standing outside of the "compact majority" was helpful, if not essential, for the discovery of psychoanalysis. But like any other genuinely creative discovery, psychoanalysis has to be evaluated independent of its author's biography. The biography of its originator is relevant to his discovery only when it can be shown to distort or limit the validity of the discovery itself. The author of this book does not make such a demonstration convincingly.

MARTIN S. BERGMANN (NEW YORK)

STYLE, CHARACTER, AND LANGUAGE. By Victor H. Rosen, M.D. Edited by Samuel Atkin, M.D. and Milton E. Jucovy, M.D. New York: Jason Aronson, 1977. 394 pp.

The appearance of this posthumous book by one of the most erudite, witty, and thoughtful psychoanalytic authors of recent years has been warmly anticipated by his many admirers. Those who were hoping that Victor Rosen might have left a body of publishable work at his death in 1973 will be disappointed in this volume: in spite of the ambitious title, it actually consists of a selection of

[4] *Cf.*, Bergmann, M. S.: *Moses and the Evolution of Freud's Jewish Identity.* Israel Annals of Psychiatry and Related Disciplines, XIV, 1976, pp. 3-26.

Rosen's published productions, spanning the years from 1953 to 1974. In addition, there are commentaries about the man and his work by each of the co-editors as well as by one of Rosen's eminent students, Theodore Shapiro. As one should expect, his friends and colleagues remember him with affection and hold his contributions in the highest esteem.

Rosen's work was generally published in the major psychoanalytic journals, and regular readers of this literature will not discover new facets of his work in this collection. The task of reviewing the book therefore amounts to an assessment of the cumulative impact of the scientific activity of one creative personality in the field. I feel some diffidence about reviewing a man's work on the basis of a specific collection of his writings torn out of context. For instance, Rosen was extraordinarily active as a panelist at meetings of the American and International Psychoanalytic Associations; thus many of his papers were written for particular occasions. In fulfilling these expository functions, he wrote elegantly and knowledgeably, but without much concern over repetition, and it is doubtful that he would have chosen to publish so many of these pieces simultaneously, as do the editors of this volume. His scientific interests were focused on a series of discrete problems, and these are roughly summarized in the title of this volume. The actual range of these fourteen papers crosses these arbitrary boundaries, however; Rosen's subject matter was not confined to these themes.

Victor Rosen was a product of the extraordinary intellectual ferment that projected the New York Psychoanalytic Institute into the forefront of the analytic community after the death of Freud. His first creative endeavors followed in the footsteps of the triumvirate which had conquered America for "ego psychology." More specifically, he was primarily influenced by Ernst Kris, who had been his analyst and the leader of a research group studying gifted adolescents that Rosen later joined. The earliest papers in this volume are two reports, based on the analysis of a young mathematician, that tackle the question of his creativity in the face of his deficiencies in reading and writing skills. In making his psychoanalytic debut in this area, Rosen was ambitious; although the case is fascinating, by contemporary standards his formulations are unconvincing and these two papers do not represent Rosen at his best.

The first indication of Rosen's mature originality occurred in his

contribution to a 1957 Panel on the theory of thinking, where he questioned the assumption that the capacity for abstraction develops as a result of a process of delibidinization. This paper was a harbinger of Rosen's subsequent interest in the sequelae of early developmental vicissitudes. Almost a decade was to pass, however, before he found his own voice, for Rosen's work through the mid-1960's continued to be heavily influenced by his former teachers, whose concepts he sometimes overused. For instance, I would challenge Rosen's assumption (in a 1964 paper on artistic talent and character style) that the transference re-enactments he observed in the analysis of a late adolescent had any significant bearing on the latter's talent. One might even question whether this material adequately explains the patient's specific character configuration.

In more general terms, this group of papers suffers from a propensity to "explanation" by classifying discrete, primarily autonomous functions (to use Hartmann's conceptual schema) and by describing them as subject to the vicissitudes of intrapsychic conflicts and their resolution. At the same time, Rosen's definition of the ego was so broad that it loses specificity and relevance. Attempts to explain psychoanalytic observations on the basis of presumed "ego pathology" are limited by their circularity; and worse, in my view, they substitute meaningless labels for the precise descriptions of behavior they are intended to illuminate.

Rosen's major achievement as a theoretician consisted of his realization that ego psychology would remain empty of meaning unless operational referents were found for postulated variations in ego functioning. I assume that he turned to the study of communication within the psychoanalytic setting in an effort to find such referents. In my judgment, this work has great value largely because it transcends the boundaries of Hartmann's concept of the ego as the "organ of adaptation." Detailed study of verbal and paraverbal communication reveals that language cannot be categorized as an "ego function"; on the contrary, in terms of the tripartite model of the mind, these capacities partake of the qualities Freud ascribed to id and superego, as well as ego. By 1967, Rosen had therefore begun to write about disturbances in communication in terms of developmental pathology.

Theodore Shapiro has pointed out that Rosen's work did not actually concern itself with those aspects of language that interest

the contemporary linguist. Nonetheless, his principal papers (Chapters 4, 5, 6, and 10 in this volume) brought a significant body of knowledge from that discipline to the attention of the psychoanalytic community. Perhaps most important in this regard was Rosen's repeatedly emphasizing that Freud's assumption that the roots of thinking consist of imagery was in error. He stressed the importance of preverbal thinking and of preintellectual speech in regressive deteriorations of language and attempted to develop a typology of "semantic dislocations" encountered in analytic practice. In Rosen's posthumous paper of 1974 (edited by Shapiro), he provided a parallel classification of the analyst's verbal interventions. In his Presidential Address to the American Psychoanalytic Association (published in 1967), Rosen even succeeded in bringing difficulties in encoding and decoding meanings into the realm of behavior capable of psychoanalytic understanding.

In his last years, Rosen was pursuing a line of research of unquestionable importance for psychoanalysis, bringing the resources of a first-rate intellect and unusual capacities for sustained effort to this task. But the collection of his completed reports in this volume also serves to remind us, painfully, that his death kept him from fully achieving his goals.

JOHN E. GEDO (CHICAGO)

CHILD ABUSE AND NEGLECT: THE FAMILY AND THE COMMUNITY. Edited by Ray E. Helfer and C. Henry Kempe. Cambridge, Mass.: Ballinger Publishing Co., 1976. 438 pp.

Assisted by thirty-two co-authors, Helfer and Kempe have produced their third major work. It is a fitting sequel to *The Battered Child* (1968 and 1974) and *Helping the Battered Child and His Family* (1972), both also published by Ballinger. The editors' stated purpose was to provide theoretical and technical help for the thousands of workers from many disciplines who have been entering the field in recent years. They have accomplished this goal admirably in the present volume.

The term *the battered child* has been dropped in favor of the more inclusive *child abuse and neglect*. "The problem is clearly not just one of physical battering. Save for the children who are killed

or endure permanent brain damage (and these remain a prime concern), the most devastating aspect of abuse and neglect is the permanent adverse effects on the developmental process and the child's emotional well-being" (p. xix).[1] Most of the contributions focus on developmental issues, either explicitly or implicitly. An important example: In discussions of family-oriented therapy the authors stress the value of thorough medical and psychologic evaluation of every sibling, not just the referred victim and the parents; for, very frequently, medical illness, psychopathology and/or signs of abuse and neglect among the siblings are revealed. In fact, a nonabused sibling may reveal more serious developmental arrest and distortion than the beaten child. The gross implications of these findings for prevention and early treatment of disease and developmental disorders are obvious; the book elucidates them in compelling detail.

Although the contributions vary in quality, almost all are highly informative and stimulating, and the editorial work is exemplary. The book is divided into six sections: 1) Dysfunction in Family Interaction; 2) Assessing Family Pathology; 3) Family Oriented Therapy; 4) The Community; 5) The Family and the Law, and 6) Early Recognition and Prevention of Potential Problems with Family Interaction.

I will comment briefly on several of the most interesting articles. The title and selection headings might give the impression that individual psychology is neglected. This is not the case. In the opening chapter, "Violence within the Family," Brandt Steele presents the complex biological, psychological, social, and cultural determinants. As he and others have done previously, he confronts us with the inevitable conclusion that abused and neglected children tend to become abusing and neglecting parents (if they develop sufficiently to become parents).

There are two excellent chapters on sexual abuse: "Sexual Exploitation" by Marshall D. Schecter and Leo Roberge, and "Humanistic Treatment of Father-Daughter Incest" by Henry Giarretto.

Family hospitalization has been a striking innovation in family-oriented treatment. This approach is now used at about a dozen

[1] A conservative estimate of the prevalence of abuse and neglect in the United States is one per cent of the child population; about two thousand are killed every year.

centers. A very successful example is succinctly described in "Residential Therapy—A Place of Safety" by Margaret A. Lynch and Christopher Ounsted who developed their program at the Park Hospital for Children in Oxford, England. A multidisciplinary team (including legal experts) makes a comprehensive assessment of each family. "In treatable cases medical treatment, practical help, and the initiation of ongoing psychotherapy makes it possible for these troubled families to be rehabilitated without prolonged separations" (p. 206).

Several contributions are extraordinarily helpful in very practical ways. The most noteworthy is "The Community-Based Child Abuse and Neglect Program" by Ray E. Helfer and Rebecca Schmidt. These authors provide lucid, detailed guidelines for establishing and maintaining such programs.

I recommend this book to experts as well as novices working in the field of child abuse and neglect.

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

EVALUATION OF PSYCHOLOGICAL THERAPIES: PSYCHOTHERAPIES, BEHAVIOR THERAPIES, DRUG THERAPIES, AND THEIR INTERACTIONS. Edited by Robert L. Spitzer and Donald F. Klein. Baltimore and London: The Johns Hopkins University Press, 1976. 314 pp.

Viewing this volume from the vantage point of a psychoanalyst, I have a distinctly mixed reaction. On the face of it, this is a well-edited, carefully thought-out group of papers and discussions—a series of scholarly presentations. The papers reflect the dedicated efforts of researchers to test experimentally the effectiveness of a wide range of therapeutic modalities. As a means of scanning these endeavors and obtaining a sense of their accomplishments and unresolved dilemmas, the book is an unusually clear and comprehensive contribution.

It is disquieting, however, to realize that this research, even when it approaches the level of the appraisal of psychoanalytic therapy found in Kernberg's and Robbins's presentations based on the Menninger Foundation Psychotherapy Research Project, is still in a very primitive state of development and utilizes remarkably naïve measures of change. These investigations are, on the whole, simplistic and superficial; they do not begin to work with the complex vari-

ables considered by most analysts as measures of inner structural change.[1] These factors, of course, leave psychoanalysis open to criticisms of relative ineffectiveness and lack of superiority in comparison with many other forms of treatment. There is, for the moment, little data available to counter such claims.

Nonetheless, this book and these facts do indeed reflect the prevailing conditions in therapy outcome research at this time. Let the psychoanalyst beware, and let him regard this volume as a stimulus for more extensive and careful research into the evaluation of the results of psychoanalytic treatment. The contributors to this symposium would, I believe, welcome such investigations and reconceptualization, and would, I am certain, offer many new and fascinating perspectives in return.

ROBERT J. LANGS (NEW YORK)

TOYS AND REASONS. STAGES IN THE RITUALIZATION OF EXPERIENCE. By Erik H. Erikson. New York: W. W. Norton & Co., Inc., 1977. 182 pp.

Erik Erikson's latest book is a slim volume conceived for the 1972 Godkin Lectures at Harvard and originally more descriptively titled, *Play, Vision and Deception*. Drawing extensively on two previously published papers, one on play, the other on rituals and pseudospeciation, the author shifts his emphasis to both play and shared vision gone awry. He shifts also to the political stage, the world theatre of war and international confrontation.

Recapitulating his original and creative attempt to define and preserve the meaning of play in human development, Erikson provides a perspective which integrates the meaning of play fairly successfully with the rituals of each culture, subculture, and family by emphasizing the child's need to come to terms with dread and "regain belief in a utopian promise." The author postulates an ontogeny of ritual in the life cycle on the borderline between playfulness and routine on the one hand, and between the individual and society on the other, which leads developmentally to the adult need for a shared vision.

The familiar but well-written short chapters on play and vision

[1] *Cf.*, Dewald, P. A.: *The Clinical Assessment of Structural Change*. J. Amer. Psa. Assn., XX, 1972, pp. 302-324.

in the young introduce, in the microsphere, the pathology and deviations from true play and are followed by the focus on the deviations and pretenses of adults. Loss of spontaneity and its replacement by a striving for the *appearance* of looseness and joy is seen in the pressured use of drugs and alcohol. "Playing with" others as toys both dehumanizes and expresses aggression, while "playing at" roles becomes self-deluding and self-perpetuating in scenarios which are felt to be real by their participants. Recognition of the aggressive and deceptive uses of play is connected to Watergate, which exemplifies not only the breakdown of the rituals of government and politics but also, by implication, the loss of the shared vision of the adult.

Pseudo-speciation, which was only one aspect of Erikson's previous paper on the development of ritual and the individual character, occupies a more central position in this book in order to explain the moral catastrophe of My Lai. The sense of "rightness" in what one does is the supportive, structure-providing aspect of culture which demands, preconsciously at least, an awareness of and perjorative rejection of all other alternative solutions and rituals. Internal conflict is diminished by alienation from these alternatives and by the subsequent shameful derogation of that part of the self associated with those threatening wishes.

Increasing sensitivity to and exploration of destructiveness in people is a subtheme of this book. Erikson reiterates that the historical need of human beings to define their "own kind" as a pseudo-species, and thus to free obliterative hostility for "others" with different rituals, is no longer tolerable in an age of nuclear and mass warfare. Stagnation, the counterpart of generativity, is developed as a specific phase of rejection and suppression of whatever seems to threaten one's subspecies or value system. Conceptually it can encompass groups within the wider community, who appear to belong to a lower species. Rage at the young who threaten the repressions and sacrifices of the establishment is emphasized; its counterpart, according to Erikson, can be seen in My Lai where over four hundred and fifty men, women, and children, who had become defined as "others" or not human, were massacred by those very young.

The attempt to use the theory of ritualization to explain the pseudo-speciation of the "others" and at the same time to describe the attack as "an acute de-ritualization of military training" lessens the cogency of the original argument. My Lai is proffered as an

example of the deadliness which takes over when gamesmanship goes out of the "adult scenarios." Erikson deliberately separates My Lai from possibly comparable events of previous wars, such as the American Civil War and the Holocaust. No historical evidence is used to support this differentiation from the multitude of previous failures of our national vision, of our gamesmanship and ritualization of war, or legal justice, whether on the Missouri frontier, at Andersonville, or later with Sacco and Vanzetti, the Scottsboro boys, or the Hollywood Ten.

Despite the overwhelming argument Erikson builds up for the roles of ritual and of "splitting" in the maintenance of personal and community stability in each culture, he now warns that these are too costly for the larger world community to bear. He then links the two aspects of human self-destructiveness, one derived from pseudospeciation and one resulting from loss of the capacity for true play, each bringing concomitant danger to the human species. His lack of complete success in this endeavor should not distract us from the courage and creativity involved both in approaching these issues and in providing significant insight.

JUDITH S. SCHACHTER (PITTSBURGH)

THE DEADLY INNOCENTS. PORTRAITS OF CHILDREN WHO KILL. By Muriel Gardiner. New York: Basic Books, Inc., 1976. 190 pp.

Muriel Gardiner is well-known in the world of psychoanalysis, not only as a clinician, but also for her indefatigable support as a therapist and friend to the Wolf-Man. Through her invaluable stimulation he was able to write his memoirs[1] some thirty years after his analysis with Freud. Now Dr. Gardiner has written a book about "children who kill": ten case histories of young criminals that the author gathered in her years of working in schools, mental institutions, and houses of correction and detention.

A brief review can only suggest the spirit of these tragic stories, which are written with Dr. Gardiner's characteristic warmth and empathy. She demonstrates that these violent crimes are directly traceable to a disturbed family life. Two adolescent girls from broken homes illustrate her point.

[1] *Cf.*, Gardiner, M., Editor: *The Wolf-Man*. By the Wolf-Man. New York: Basic Books, Inc., 1971. Reviewed in This QUARTERLY, XLI, 1972, pp. 268-269.

Marilyn's father served a life term in prison; her mother and the mother's lover had no use for the children. At fifteen Marilyn fell in love with an ex-convict on parole. Together they daydreamed of a new life in a new country. Marilyn, with the blindness and boldness of young love, took it upon herself to provide the needed cash. Her first attempt, the theft of a mailbag, was a failure, and she planned to take money from an old man, known to reward young girls with money for their services. When he tried to molest her, she stabbed him. Fortunately, he survived. In the correction center Marilyn adjusted well to the orderly life after she learned that her lover had saved his own skin by fleeing the country without ever asking for her.

Gloria, another girl from a broken home, had found refuge at her grandmother's house. But her peaceful life there became unbearable when an uncle and his wife, both alcoholics with violent tempers, moved in. They wanted to get Gloria out of the house, because they were afraid that the grandmother would leave her house and her money to Gloria, her favored grandchild. One day, dangling a butcher knife in front of Gloria, they threatened to kill her. In her terror and fury she got hold of a rifle that was in the house, and when they threatened her again she shot and killed the uncle. In the reformatory she, too, adjusted well to the orderly life. Eventually, she was able to become a loving wife and mother. Her kind grandmother's love had endowed her with the resources for growth.

The two adolescents who arouse the strongest feeling of pity are the ones who committed the most inhuman crimes. Peter had never received any love from his mother. Although his stepfather loved him and his younger sisters adored him, he was forever craving his mother's love. The mother and infant son had been the only survivors of a happy and distinguished family from a small European country. Her parents, her brother, and her young husband were all victims of the destruction of her country. With all her strength she tried to repress and deny her horrible memories and to have a new life with her new husband and children in a new world. But Peter's existence constantly reminded her of the brutal past. The fatal hour came when Peter, on furlough from the Marines, asked his mother for some of his savings in order to go out with a girlfriend. She refused his request in her usual belittling way. He happened to have a hammer in his hand and, overcome with rage, he killed her with

one stroke. When his beloved little twin sisters rushed in, he killed them with the same hammer. After the deed he went to the police. He has tried to commit suicide, and all attempts to help him have failed.

Rose had been a sickly, nervous, unwanted child for whom the parents had no love, in contrast to a much younger son whom they adored. Rose spent most of her childhood in hospitals and institutions. In spite of these handicaps she passed a college entrance examination, hoping by these efforts to gain her parents' love and respect at last. They brushed her off, however, like an annoying insect, and paid no attention to her. After this final rejection she could think only of revenge. She killed their adored son with a bronze statuette and went to the police. In prison she was in a state of amnesia for a long time. Later, when encouraged by psychiatrists and social workers to recapture the event, she became psychotic and never recovered.

Although Dr. Gardiner has not written a psychoanalytic study, her compellingly written book is a valuable reminder of the power of destructive drives and affects in the child who is deprived of maternal love in the first years of life. The lack of control in moments of hurt, so decisive in these cases, may be due to the still undeveloped ego of those early years. Patients who come to analysts are usually protected by their neuroses from such violent actions. Their murderous impulses of jealousy and envy remain fantasies, but the often underestimated repressed urges for revenge may continue to rule their lives.

YELA LOWENFELD (NEW YORK)

THE LIFE OF THE SELF. TOWARD A NEW PSYCHOLOGY. By Robert Jay Lifton. New York: Simon & Schuster, 1976. 190 pp.

This work is, in a sense, a spiritual sequel to the late Ernest Becker's *The Denial of Death*.[1] Its central thesis is that those who confront death, either the organic fact of it or the deeply felt idea of it, and who survive the confrontation can serve as guides—as creative survivors—to those who have not yet done so. But to survive the confrontation, it is necessary to avoid taking refuge in "psychic numb-

[1] Becker, E.: *The Denial of Death*. New York: The Free Press; London: Collier Macmillan, 1973. Reviewed in This QUARTERLY, XLIV, 1975, pp. 487-488.

ing," which Lifton sees both as the central fact in psychopathology and as a replacement term for repression.

The psychically numb live a "death-in-life," refusing, as Lifton quotes Otto Rank, to "accept the loan (life) in order to avoid paying the debt (death)" (p. 42). Lifton suggests that those who choose life in the form of ever-ready renewal and the capacity for change—such as his Protean Man—can transcend the mere fact of bodily death and survive through the symbolic immortality of their ideas. According to Lifton, Freud would qualify here (the psychoanalytic movement being his symbolic immortality), as well as Mao Tse-Tung, and Lifton himself, who writes, "the controlling image in my work is that of death and the continuity of life" (p. 61). The reader may wonder just what comfort can be taken in the idea of the compelling quality of the durable belief, when the ideas of Freud, Mao, and others can be seen undergoing such radical transformation. If I understand Lifton, the real durability of one's ideas is not as necessary as one's believing they are durable at the time of one's death. The important quality is the belief itself, and if an idea can no longer support its immortal purpose, it is time to shift to another.

Lifton recognizes that there is a "darker side" to the "multiplicity of possibilities . . . in the Protean style. Anxiety around diffuseness can in turn contribute to the kind of quest for certainty we now see so widely expressed in fundamentalist religious sects and various totalistic spiritual movements" (p. 141). This is true in the field of psychotherapy as well, where there is a rapid proliferation of new "schools," some identified by only a single practitioner. In this era of the charismatic therapist and in the atmosphere of today's rapid turn-over of beliefs, those who promise quick, inexpensive, and certain change may well have taken the competitive edge away from psychoanalysis.

Lifton is not surprised by this turn of events; indeed he argues that the time for a change is long past. He wonders "why classical psychoanalytic theory has generally prevailed . . . [against deviationist writers] . . . even when the revisions seemed to improve the theory and put it more in touch with recent thought" (p. 16). In Kuhn's terms we are already at that plateau phase he calls normal science and ready for a paradigmatic shift. For Lifton the shift comes in apocalyptic language; we must speak of a "mutation in

cultural evolution" in response to an increasing awareness of "our ability to eliminate the human race . . . and short of extinction, . . . [to] alter human form, whether genetically or through organ exchange or mind influence" (p. 137).

With Protean flexibility Lifton describes his book as neither psychoanalytic dogma nor heresy, but rather as intended to "weave together the threads of heresy" toward "the new consciousness struggling to take shape" (pp. 13, 18). He argues that now, as never before, our increasing technological capacity to implement the discharge of old instincts has brought us face to face with death and discontinuity. With the death of god and the attendant promise of immortality, it has now fallen to the psychologists to become our secular priests.

For Freud, being trained in medicine and the hard realities of nineteenth century physiology meant an inexorable confrontation with science, which he once described as demanding the most complete renunciation of the pleasure principle of which our minds are capable. Here Freud meant to include the narcissistic blow dealt us all by psychoanalytic science, with its recognition of the extraordinary power our wishes have to create our beliefs. Lifton was also trained as a physician, but he believes that Freud's concept of the repetition compulsion kept Freud from seeing anything "new under the sun" and made him tend to view "collective change . . . as illusion" (pp. 103, 105). Lifton feels that we can remain truly alive only by remaining open to the diversity of new beliefs which our minds are capable of creating, shifting, and changing according to the requirements of our time. The reader may find that it is once again a question of just how anchored we think our psychic lives remain in an immutable biology when confronted with the transforming power of our geometrically expanding cultural evolution.

Lifton's argument in favor of the latter is based largely on what he sees as the possibilities for new symbolizations to effect change in psychic structure, especially their power to continue to do so throughout the life-cycle, thus diminishing the importance of what we learn in the earliest years of our lives. This is a bedrock problem for psychoanalysis and has been since its beginning. What *is* change? How shall we define it? Substitution of one symptom for another seems hardly worth our psychoanalytic effort; we have already surrendered those historically early therapeutic claims to the behaviorists. Psy-

choanalysts continue to seek out the early-formed unconscious fantasies which—once raised to the level of adult consciousness—can strengthen the ego to deal not with the new psychology of the new self, but with the relentless persistence with which the old familial self reasserts its sometimes pernicious and always enduring power. Lifton's book, on the other hand, questions the extent of the hold these early symbolizations have on our later development. Are infantile sexuality, the incest taboo, the oedipus complex, etc., determining facts or mere transitory fantasies? And how much of a fact *is* a fantasy? Is it still as true now—with the technological world booming in on us—as it was when Freud discovered psychoanalysis, that psychical reality is of more importance than material reality? Philip Rieff has pointed out that the battle to remain orthodox is always lost; Lifton, unlike Rieff, sees no loss here. Orthodoxy is just another variant of psychic numbness, one that comes with the safety of an encrusted familiarity. The questions raised by Lifton's book are precisely: When is change heretical illusion, and when is orthodoxy a numbing dogma?

This issue has of late become more complex to decide. Proliferating life-styles reflect so many behavioral surfaces that it is harder to see clearly between the pieces of the kaleidoscope to the core structures below, and there may be fewer who are willing to undergo the painstaking work of a psychoanalysis to seek themselves out with our newly old-fashioned procedures. Protean Man is on the move, and he brings his theories and his therapies with him.

One of the most important aspects of Lifton's book is its serious inquiry into questions that are today being raised by a wide variety of practitioners and authors, some of them hardly more than pamphleteers whose tracts contain in their titles alone the promise of a new man ready for a change to any season. But Lifton's book is not a simplistic sermon, nor is it primarily a "clinical" book; with the exception of his description of the personal anguish he felt as he participated in "rap-groups" of Vietnam veterans, by whom he felt legitimately accused of having lent himself to the "counterfeit moral universe . . . in Vietnam," his "clinical" examples are drawn from literature. This is in keeping with his notion that it is the "formative process," the creative act, which is the human being's highest achievement, the truest demonstration of the life of the self.

It is all the more revealing, then, to look at the message Lifton's

literary/clinical examples offer. Caligula, from Camus, kills because "there's only one way of getting even with the gods; all that's needed is to be as cruel as they" (p. 117); Warren Miller, in his novel *Looking for the General,* tells us that "madness is not only an expectation but a duty" (p. 121); Norman Mailer's Rojack murders his wife in an effort to overcome his own fear of extinction, an act Lifton sees as attempting to "reassert his mastery over death" (p. 128).

Although chosen for their extremity, these examples and others not here named tell a profoundly disturbing tale. Lifton calls his book *The Life of the Self,* and yet I find it most profoundly about the inability to accept the idea of death. This disturbing tale is poignantly summarized by another of Lifton's "creative survivors," the pathetic dwarf Oskar Matzerath from Gunter Grass's *The Tin Drum*. Lifton describes how Oskar's memories have taken on immortal qualities, including "the secret parts of a few women and young girls, my own pecker, the plastic watering can of the boy Jesus . . ., my drumsticks from my third birthday on . . ., my umbilical cord, as I sat playing with it. . . ." And then Lifton says, in clear appreciation of Oskar, "The journey is precarious, replete with disaster, but it is exuberant, open, and (here is the hope) endless" (p 127). The author refers to these examples as the literature of survival; to this reviewer they are the literature of the denial of death.

MICHAEL BELDOCH (NEW YORK)

ANTI-JUDAISM. A PSYCHOHISTORY. By Ernest A. Rappaport, M.D. Chicago: Perspective Press, 1975. 312 pp.

Rappaport, born and educated in Vienna, was a survivor of the infamous concentration camp, Buchenwald. He died in 1974, the year before this profoundly personal work was published.

In the book, he speaks of anti-Judaism as both a particularly virulent form of individual hatred and as a social disease which demands a collective mobilization of all societal agencies to combat it. This statement indicates what the content of the book confirms: it is not clear what audience the author is addressing. His psychoanalytic colleagues may be the wrong group to exhort in order to mobilize all societal agencies to combat anti-Judaism. On the other hand, nonanalysts who might further such a mobilization will cer-

tainly find many of the interpretations speculative, and probably would demand further elaboration of most of the clinical and theoretical concepts. The communication of psychoanalytic ideas to a lay audience of activists interested in social issues is no easy task at best.

Certainly, the task is not made easier by the inept editing of the book. The constant use of the term *already,* for example, doubtless as an equivalent of the German *schon,* is unidiomatic and could easily have been avoided. A skillful editor could also have eliminated many passages which do not further the argument of the book and therefore constitute distracting digressions. It is regrettable that these relatively minor matters interfere with a more effective presentation of the bold, central position taken by the author.

Rappaport attempts to demonstrate that the anti-Jew is a paranoid schizophrenic who needs his delusions of persecution: the belief that he is selected as the object of injustice gives him an unconscious sense of superiority. (Rappaport's view was also held by Fenichel.) The author believes that the anguish of the anti-Jew is "caused by his futile resistance against a sick, irrational behavior pattern which he introjected in the early years of his childhood when he was exposed without protection to the unmitigated influence of his environment, parents and educators" (p. i). Among these influences, a major one is Christianity. Confronted daily with the crucifix, which Rappaport calls the tree of death, the Christian is unable to deal effectively with the anxiety surrounding death. Instead, he develops a Christophobia accompanied by compulsions, delusions, and doubts. The resulting disbelief in the divinity of Jesus is then projected onto the Jews as habitual disbelievers. This projection, Rappaport says, is facilitated by the myth of the Hebrews, the forbears of the Jews, that deals with a people and its disobedience to its single God. The reasoning that is alleged to follow from this is that the "hero of the single anti-Jewish legend must also be a God and therefore not accepted by the Jews."

Hence the presence of anti-Judaism as a chronic endemic social disease. Under certain economic, political, or other social conditions, it may assume epidemic proportions and represent a mass psychosis, as Ernst Simmel called it. The further danger of such outbreaks of epidemic anti-Judaism, according to Rappaport, is that they are followed by more generalized killing, as was the case during the Crusades and World War II. Thus, the problem is one that concerns not only the Jew and the anti-Jew, but everyone.

The phenomenon of anti-Judaism, the author believes, can be "diagnosed and analytically studied in the single case, the individual anti-Jew." He attempts to demonstrate this hypothesis by examining the lives of a number of historically important figures whom he considers such anti-Jews. These include St. Paul, St. Augustine, Martin Luther, Hitler, and Stalin.

Not everyone would agree that all these men were paranoid schizophrenics. This reviewer is not in agreement so far as Hitler is concerned and is on record as considering that tyrant as having had a narcissistic personality that functioned on the borderline personality end of the spectrum, with paranoid trends. Although the papers elaborating this concept[1] appeared well before the publication of Rappaport's book, there is no mention of them nor of the excellent studies of another colleague, Martin Wangh.[2]

These are minor caveats, however, that should not distract us from the real merits of the work. Rappaport reveals an encyclopedic grasp of the history of the Jews and their endless tribulations at the hands of the anti-Jews. He presents his discussion of the personalities of the anti-Jews well, and though many of his psychoanalytic interpretations are rather speculative, they are interesting and arresting. The work makes a valuable contribution to our understanding of a complex phenomenon. It is sad that its author did not live to see its publication.

NORMAN BROMBERG (TARRYTOWN, N.Y.)

THE REVOLUTIONARY ASCETIC. EVOLUTION OF A POLITICAL TYPE. By Bruce Mazlish. New York: Basic Books, Inc., 1976. 261 pp.

The Revolutionary Ascetic is Professor Bruce Mazlish's third major attempt at psychoanalytically-informed historical exegesis. The first, *In Search of Nixon,* was straight psychobiography, clear in focus, but limited by the lack of data about Nixon's formative years. The second, *James and John Stewart Mill,* benefited from access to considerable biographical data about both father and son, as well as

[1] *Cf.,* Bromberg, N.: *Hitler's Character and Development: Further Observations.* Amer. Imago, XXVIII, 1971, pp. 289-303; *Hitler's Childhood.* Int. Rev. Psa., I, 1974, pp. 227-244.

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

information about their interaction. In that work, however, his extrapolations from the psychobiographical findings to broader historical trends, including speculations about the shape of the industrial revolution and the rise of nineteenth century liberalism, are less convincing. In his third book Mazlish's focus is primarily psychohistorical rather than psychobiographical; although Emerson's dictum about the understanding of man leading to the understanding of events is an appealing and perhaps theoretically incontrovertible principle, Mazlish's attempt to explain the revolutionary process by generalizing about the personalities of those who make revolutions requires great logical leaps to achieve credulity.

The historical theses of the book are: 1) that asceticism is a central dynamic of the two major modern revolutions, namely, the Russian and the Chinese; 2) that there is a link between revolution and puritanism; and 3) that there is a developmental line from a) religious asceticism to b) worldly asceticism to c) nineteenth century capitalism and industrialization to d) the revolutionary ideologies which transformed the Chinese and Russian societies in the twentieth century. Mazlish defines a "revolutionary ascetism" that links Mao's and Lenin's applications of Marxism to nineteenth century liberalism and utilitarianism. He makes the point, which I think is well taken, that both the Chinese and Russian revolutions were essentially modernizing upheavals in which fostering industrialization was at least as important as eliminating an oppressive regime. The most recent events in China—their new constitution, for example, which stresses the importance of the promotion of technology and scientific thought—clearly reflect this order of priorities.

Professor Mazlish's psychological theses are that "ascetics" make revolutions and that the revolutionary ascetic is an ideal personality type to which modern revolutionaries will partially correspond. However, here one may ask: Do ascetics make revolution, or does successful revolutionary activity require a certain amount of self-denial and self-discipline as well as a singular sense of purpose and devotion to a cause? In other words: Is there a trivial connection which might hold true as well for reactionary or counter-revolutionary leaders as it might for revolutionary ones?

According to Professor Mazlish the revolutionary ascetic has two major characteristics: first, he abhors "wine, women and song," and second, he has "few libidinal ties" and is therefore able to "deny the

normal bonds of friendship feeling and affections and [to] eliminate all human consideration in the name of devotion to the revolution" (p. 6). Drawing from Freud's *Group Psychology and the Analysis of the Ego,* Mazlish develops the thesis that the revolutionary leader has displaced his libido from individuals onto an abstraction, namely revolution. Mazlish uses his case studies of Lenin and Mao to establish this thesis, but in both instances he is handicapped by the relative paucity of childhood developmental data, autobiographical material, etc.

Unfortunately, Mazlish's approach to the data that he does have is often superficial and facile. For example, he makes much of Lenin's relationship with his mentor Plekhanov. Mazlish finds it significant that Lenin began to sign his articles in Iskra with the pseudonym "Lenin" directly after he broke with Plekhanov over policy. Mazlish says, "the Ulyanov given to sentiment has been replaced by the hard, unloving, unyielding Lenin" (p. 116). We are now in the presence of the prototypic leader "with few libidinal ties." Mazlish fails to consider the alternative that Lenin's pseudonym was taken from the River Lena possibly in emulation of Plekhanov who took his pseudonym "Volgan" from the name of the River Volga. Thus Mazlish has not proven his conclusion that the name change signaled a significant break in Lenin's capacity for libidinal investment.

Solzhenitsyn's portrait of Lenin in his *Lenin in Zurich* has a very moving account of Lenin's subsequent relationship with his mistress Inessa, which, although partially fictionalized, rings true. It establishes convincingly that even after his break with Plekhanov there was nothing strikingly deficient in Lenin's capacity to relate to people. The important issue is how to account for Lenin's success. Mazlish links it to his personality; this reviewer attributes it to his genius as a theoretician. Within the realm of personality, Mazlish focuses on asceticism and constricted object relations, but fails to give due weight to Lenin's opportunism and his consummate skill as a politician in small group meetings which, on the face of it, would seem more directly related to his success.

Similar objections could be made to Mazlish's inferences about Mao. Since he had three wives and several children who seemed, at least from Snow's account, to have meant a great deal to him, Mao probably did not lack objects. His reputation as a singer and dancer is evidence against asceticism. More important, he probably suc-

ceeded as a revolutionary because he was able to adapt his Marxist ideology to the particular Chinese situation, and especially to the role of the peasants. Through all the years of the war against the Nationalists, his policy of keeping the Red Army honest and paying peasants for supplies instead of taking them by force helped win the peasants to his side. He made the long march into the most successful propaganda road show in history. Mao's mastery of public relations seems to have contributed more to his success than his putative asceticism or his hypothetical deficiency of libidinal ties.

In summary, *The Revolutionary Ascetic,* although at times lively and interesting, is not convincing as historical or psychological argument. It can be faulted for being based on inadequate data and for a lack of logical rigor which limit its value for historians and psychoanalysts.

ARNOLD D. RICHARDS (NEW YORK)

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ABSTRACTS

Revue Française de Psychanalyse. XXXVIII, 1974.

Dream, Illusion, and Knowledge. René Diatkine. Pp. 779-820.

Diatkine is concerned with the function of the dream in mental life. Some theorists attempt to move the dream out of any save a historically privileged place in psychoanalysis. In this view, the dream is simply one in a series of mental events, distinguished only by its relative diminution of censorship and by a special mode of elaboration. Any special quality of dreaming as a process would be due merely to a quantitative difference in primary and secondary process contributions. Diatkine opposes this view of dreaming and believes that dreams have a special place and a particular quality that permits contact with elements which otherwise have to be reconstructed. He is thus opposed to the view of Serge Viderman, who argued, in *The Construction of Analytic Space,* that the unconscious fantasies reached therapeutically through dreams are a product of the analytic situation and constructed out of it. Diatkine is also critical of Lewin and Isakower on the manifest content of the dream. He views their efforts, and especially the more fanciful theses of Garma, as re-emergences of Rankian-type hypotheses about very early primitive reminiscences. In addition, Diatkine is critical of the neurophysiological studies on dreaming, because of the problematic identification of experimental dreams with dreams from ordinary life and during the course of an analysis.

Dreams as Unity and Continuity of Psychic Life. José Rallo Romero; Maria Teresa Ruiz de Bascones; Carolina Zamora de Pellicer. Pp. 821-962.

This lengthy report consists of an excellent review of the literature on dreams and dreaming. The authors begin with a perceptive summary of Freud's various writings on the dream, the dream process, and the place of the dream in therapy. They then review recent clinical and laboratory studies on the dream and the relation of this experimental work to the psychoanalytic theory of dreaming. They are particularly concerned with recent work on the neurophysiological aspects of dreaming. The report is of value to American readers for its extensive bibliography and summaries of French and Spanish research on the dream. One of the authors' main themes is that the laboratory studies on dreaming have provided criticisms against Freud's theory of dreams applicable only on certain limited issues. In the main, Freud's theory of dreams has been corroborated by such studies, in particular with respect to the dynamic unconscious, the continuity of psychical life in the production of dreams, the richness of the actual dream life in comparison with recalled dreams, and the equilibrium between instinctual forces and countercathexes during the night. They emphasize that forgotten dreams are different from repressed dreams in that the dream which has accomplished its mission (hallucinatory gratification and the continuation of sleep) is forgotten. There follow the comments of participants at the conference

at which the report was presented. Three of the most important contributions are abstracted.

Metaprimary Process and the Dream. Pierre Luquet. Pp. 963-968.

Luquet suggests that the dream has a different status of organization and a different level of organization from the primary process mechanisms which support it. Dreams seek to resolve object-relationship problems in a narcissistic mode, for example. This and other aspects of the dream, such as the role of censorship, lead us to question the old dualism of primary and secondary processes. The dream seems to belong to an intermediate psychical system between primary and secondary process, which Luquet would call "metaprimary." This system is constructed on the basis of preconscious functioning. The metaprimary mode of thought uses language, but indirectly and in its own peculiar fashion, markedly different from the secondary process role of thought and language.

The Child of the Night. Jean Bergeret. Pp. 969-984.

Bergeret emphasizes Freud's comments in 1932 on the strangeness of the dream when perceived upon waking. The dreamer when awake regards the "child of the night" as an uncanny and strange product of primitive fantasies. Bergeret is interested in what is behind the more recent and largely oedipal derivatives which may make up the façade of a dream. What is the primitive or primary unconscious? Bergeret argues that the primary unconscious is constituted by instinctual representatives which have never been conscious and consequently cannot be translated into images, while the secondary unconscious is made up of representations which were once conscious and then repressed. A dream is supplied by two sources, the secondary unconscious and the primary unconscious. The latter, which some have regarded as fanciful, mythical, or phylogenetic, is nonetheless theoretically indispensable. Perhaps it is made up of some type of mnemic traces which are not imaginal but which are nonetheless perceptible.

Dream, Fetishism, Space and Time. Jean Guillaumin. Pp. 1007-1040.

Guillaumin sees in the dream a function similar to that of the fetish, in that the dream attempts to make up for a narcissistic threat of loss and separation involved in change, particularly in somatic change. He examines the fetishistic use of the dream in therapy and the seduction of the analyst by it. The Dora case is reviewed with the suggestion that Freud's enthusiastic interest in Dora's dreams may have contributed to his difficulties with the case. Guillaumin attributes the capacity of the dream to assume the function of a fetish to its singular and uncanny position in waking life and to its visual and representational aspects. An emphasis on the visual is also characteristic of the fetish. The specific transformation involved in the dream is the change of the experience of time (and changes through time) into spatial experiences. Guillaumin correlates this hypothesis with some themes developed by Lewin. A fetish has precisely the function of denying the limitations and narcissistic threat of castration. The dream similarly attempts

to deal with fundamental aspects of change, for example, separation, individuation, sexualization. Following Guillaumin's paper, there are reports on workshops on various clinical aspects of the dream, psychosis and dreams, and the relationship of dreams to art and creativity.

EMMETT WILSON, JR.

International Journal of Psychoanalytic Psychotherapy. V, 1976.

Ego Functioning during Paranoid Depression. M. Gerard Fromm. Pp. 11-37.

A patient's psychotic decompensation during treatment is described in detail. The author points to a regression in ego functioning: in the affective sphere, "fragmentation" occurs, permitting various emotions to be expressed while defending against synthesis of a malignant delusional system. In the cognitive sphere, "dedifferentiation" is characterized by loss of the capacity to make distinctions. The patient's regression was touched off by an unconscious perception of the therapist's countertransference feelings, and some of the patient's symptoms caricatured what he believed the therapist to be expressing.

Psychoanalytic Contributions to the Relationship between Dreams and Psychosis—A Critical Survey. John Frosch. Pp. 39-63.

Dream formation and psychosis are related but not identical. The nature of the anxiety represented in a dream is an important indication of psychopathology. Fear of dissolution of the ego (not defined further in this article) has a grave prognostic meaning when it appears in dreams. Inability to distinguish dream from reality upon awakening is also an ominous sign. Many investigators believe that dreams can presage psychotic decompensations. Such dreams can be viewed as emergences of overwhelming instinctual urges or as last ditch efforts to reconfirm the fantasy nature of disturbing thoughts. Sometimes the manifest content of a preceding dream is incorporated into a delusion. Dreams can give information about the dreamer's psychopathology only when they are examined in context.

The Mirror Transference in the Psychoanalytic Psychotherapy of Alcoholism: A Case Report. James Gustafson. Pp. 65-85.

An alcoholic man was seen in outpatient psychotherapy for one year with considerable symptomatic relief. Balint's concept of the "basic fault" and Kohut's "mirror transference" were helpful in understanding the patient's addiction and determining the therapeutic stance. Improvement was due to an unanalyzed mutually idealizing relationship with the therapist. The patient's resistances to forming such a relationship are discussed, as are several countertransference reactions which temporarily obscured these resistances from the therapist's view.

Psychotherapeutic Schema Based on the Paranoid Process. W. W. Meissner. Pp. 87-113.

In paranoia an organization of introjects is reprojected into the environment. The psychotherapy of paranoia must gently and gradually bring the patient's attention back to his internal world. Typically, this is done by first carefully defining the projective system, testing it against reality, and then clarifying its origin. Subsequently, analysis of the process of introjection and the renunciation of and mourning for infantile attachments can be accomplished.

The Self as a Transitional Object: Its Relationship to Narcissism and Homosexuality. Joseph M. Natterson. Pp. 131-143.

In each of three cases presented, narcissistic imbalance and homosexual trends in a male patient were felt to be particularly prominent. Psychodynamic formulations are based on the idea that aspects of the self can be split off and formed into an imaginery object, which is then used to alleviate anxiety.

Transitional Phenomena and Therapeutic Symbiosis. Harold F. Searles. Pp. 146-203.

Searles sets out to examine as comprehensively as possible the relevance of the concept of transitional phenomena to an understanding of the therapeutic process. He reviews his own prior work and the literature in general in considerable detail, taking up a variety of ways in which symptoms, fantasies, and therapeutic instruments can function as transitional phenomena for therapist, patient, or both. Searles's focus, as always, includes emphatic attention to countertransference experiences. Most of the clinical examples refer to work with psychotic patients but the points made are meant to apply to the psychotherapy of any disorder. Searles identifies transitional phenomena in therapy as subspecies of the more general phenomenon of "therapeutic symbiosis," which he has defined and explored in previous writings. In his view, many therapists are reluctant to appreciate the extent to which their patients experience them—and therefore influence them to experience themselves—as "nonhuman." The concept of the transitional phenomenon may be an attempt at particularism that avoids a more threatening experience.

Object Choice and Actual Bisexuality. A. Limentani. Pp. 205-217.

The author stresses the distinction between patients who require overt sexual experiences with partners of each sex (actual bisexuality) and those who have vivid conscious fantasies of such activity. Actual bisexuals act out an oscillation between object attachment and narcissistic object choice. Beneath this apparent wish to maintain a libidinal tie with both parents lies an inability to resolve ambivalence toward an unavailable mother. Attachment gives rise to the danger of unmanageable instinctual urges, producing a narcissistic regression and object choice. This regression involves the danger of psychotic withdrawal and ends in a desperate return to the object of "attachment." The author encourages psycho-

analytic therapy for actual bisexuality, but warns that psychosis or destructive acting out may occur, especially as one or the other of the patient's customary alternatives becomes less available.

Transvestism: A Disorder of the Sense of Self. Lionel Ovesey and Ethel Person. Pp. 219-235.

On the basis of histories obtained from a large sample of transvestite men, the authors observe that cross-dressing usually becomes increasingly dissociated from conscious sexual excitement. They conclude that transvestism is primarily an effort to avoid separation anxiety. Feminine clothes are worn to enact a fusion with the pregenital mother. The defensive function of submission to ward off castration anxiety is seen as a secondary purpose of cross-dressing. Contrary to Stoller's reports, the authors find that transvestism has usually not been initiated or encouraged by a parent.

Empathy and Intuition in Becoming a Psychiatrist: A Case Study. Ronald J. Blank. Pp. 237-253.

On Becoming a Psychiatrist: Discussion of "Empathy and Intuition in Becoming a Psychiatrist" by Ronald J. Blank. Robert Langs. Pp. 255-279.

The experience of being a novice therapist intensely involved for the first time in trying to understand and help a patient is recounted in detail by Blank. Using Blank's narrative as an illustration, Langs considers various motivations for selecting psychiatry as a career and discusses how they can function as assets or liabilities to learning. Projective and introjective identifications with the patient stem from the therapist's efforts to seek specific gratifications and defensive postures. This can lead to the shutting off of particular material from the patient, fear of interpretation, or institution of unanalyzed modifications of the methods of treatment. "So-called empathic experiences" may function as rationalizations for these errors. It is necessary to include a mechanism for validation of hypotheses as part of therapeutic technique and to remember that patients' remarks may refer to real observations of the therapist as well as to transference fantasies. A brief response by Blank is appended to this article.

Toward a General Concept of the Therapeutic Process. Paul A. Dewald. Pp. 253-299.

A taxonomic classification of over 30 types of psychotherapy is offered, using 10 "factors" that describe determinants of the therapeutic process according to psychoanalytic clinical theory.

The Misalliance Diversion in Freud's Case Histories: The Dora Case. Donald Langs. Pp. 301-317.

The "framework" for analysis is defined. Changes in this framework lead to "misalliances" which interfere with analytic work. Freud's communications with Dora's father, his interest in infantile sexuality, and his use of a possession of his

own to make a point to Dora are identified as three disruptions of the framework for analysis. These and other errors led to Dora's inability to distinguish Freud from important transference figures and contributed to her flight from analysis.

Psychotherapists' Passivity—A Major Training Problem. Gerald Roskin and Charles J. Rabiner. Pp. 319-332.

It is not uncommon for neophyte therapists to manage various anxieties and impulses of their own by becoming inactive. Inactivity may correspond to the trainees' misconception of correct technique while actually harming the treatment.

Related Issues in Childbearing and Work: Two Clinical Studies of Professional Women. Rosemary Marshall Balsam. Pp. 333-348.

Aspirations and conflicts expressed in the professional careers of two women seen in psychotherapy were found in each instance to parallel the aims and problems involved for them in bearing children. The two cases, one of an artist and the other of a scientist, are compared and contrasted.

The Ellsberg Psychoanalytic Situation. Victor Bernal y del Rio. Pp. 349-368.

By means of a mailed questionnaire, a survey was made on how frequently analysands referred to the burglary of Daniel Ellsberg's psychoanalyst's office. That 62.25% of analysts surveyed responded, and that of the respondents 69.33% voluntarily identified themselves, is in itself an unexpected and significant result. It was found that only 13% of 5,074 analysands referred in any way to the burglary. Of these an overwhelming majority were patients of a proportionately small number of analysts. The author discusses his findings in terms of the role played by "perimeter events" in analysis. He raises the question of scotomatization on the part of some analysts, patients or both.

Conservatism and Liberalism: A Psychoanalytic Examination of Political Belief. J. Alexis Burland. Pp. 369-394.

Political conservatism is based on the premise that man's instincts are destructive and must be brought under control, which is a psychological orientation as opposed to the social orientation of liberalism, a political philosphy based on optimism about man's capacities and criticism of the imperfect world of man's creation. Three case illustrations are given in which the patient's intrapsychic organization was expressed in his or her political views.

Symbiosis and Intimacy. Peter Giovacchini. Pp. 413-436.

Long-lasting intimate relationships are based on the projection of valued parts of the self upon the loved one, with whom a pleasurable fusion is achieved. Both partners are found to have identical character structures. The capacity to form such relationships is founded in an undisturbed symbiotic phase of development.

Psychological Unevenness in the Academically Successful Student. Thomas O. Ogden. Pp. 437-447.

Pathologic character formations of various kinds can be organized around academic success. In a group of such patients, doing well at school was found to be a continuation of attending to the needs of a mother who used her child narcissistically. Often the mothers were depressed and turned to the child for solace, ignoring the child's needs. Sensitivity to nuances of the therapist's mood and efforts to please dominate the patient's participation in treatment, resulting in countertransference hazards. The work of Winnicott and Khan helps conceptualize the developmental difficulties experienced by the patients.

Intersecting Languages in Psychoanalysis and Philosophy. Louis Agosta. Pp. 507-533.

Interpretative reconstruction is a method in psychoanalytic clinical work permitting psychoanalysis to be compared and contrasted with both philosophy and the physical sciences. Interpretative reconstruction links metapsychology, which attempts to explain, with clinical method, which aims at understanding for therapeutic purposes.

A Cross-Cultural Test of the Freudian Theory of Circumcision. Michio Kitahara. Pp. 535-546.

A survey of 111 primitive societies reveals that circumcision rites occur more commonly in cultures where the son sleeps in the mother's bed as a child and the father sleeps in a separate hut. This evidence is taken to support Freud's suggestion that circumcision symbolizes the feared oedipal castration; the evidence is inconclusive, however, as it bears upon Bettelheim's idea that circumcision arises from men's envy of the vagina.

Sartre's Contribution to the Understanding of Narcissism. David B. Klass and William Offenkrantz. Pp. 547-565.

The philosophical system described in Sartre's *Being and Nothingness* explicates the experience of the protagonist of his novel *Nausea*. Sartre offers a theory of narcissism which may be compared and contrasted with those expounded by Kohut and Kernberg.

Notes from the Couch: From Psychoanalysis to Psychotherapy. A Review of the Literature. W. W. Meissner. Pp. 567-582.

The relation of psychotherapy to psychoanalysis is discussed via a critical review of books by Tarachow, Dewald, Saul, Paul, Langs, Bruch, and Balsam. The role of suggestion in psychotherapy, the importance and character of the concept of patient-therapist alliance, and the place of focus on reality factors in the treatment are among the themes used to evaluate the views of each author.

OWEN RENIK

American Journal of Psychiatry. CXXXV, 1978.

The following abstracts appeared in the American Journal of Psychiatry and are reprinted with the permission of the publisher.

Maladaptive Cognitive Structures in Depression. Maria Kovacs and Aaron T. Beck. Pp. 525-533.

According to the cognitive view, the individual's negative and distorted thinking is the basic psychological problem in the depressive syndrome. The distorted cognitions are supported by maladaptive cognitive schemata, which involve immature "either-or" rules of conduct or inflexible and unattainable self-expectations. These schemata are probably acquired early in development and, if uncritically carried into adulthood, serve to predispose the individual to depression. Since these schemata are long-term identifiable psychological patterns that influence attitude and behavioral responses, they may constitute a cognitive dimension of the depression-prone individual's personality. The authors discuss the treatment implications of the cognitive approach to depression.

Use of the Extended Family in the Treatment of Multiple Personality. Edward W. Beal. Pp. 539-542.

The author describes a patient with the diagnosis of multiple personality who was treated by several therapists with different theoretical perspectives, including psychoanalysis and family systems theory. The latter approaches to the patient's illness are compared, a new methodology of treatment is reported, and the impact of different ways of thinking about the patient is discussed.

Obesity and Psychoanalysis. Colleen Rand and Albert J. Stunkard. Pp. 547-551.

Seventy-two psychoanalysts collected information on 84 obese patients and on a control sample of 63 of their patients of normal weight. Despite the fact that obesity was the chief complaint of only 6% of the obese patients, weight losses after 42 months of psychoanalytic treatment compared favorably with those after traditional medical efforts: 47% of the obese psychoanalytic patients lost more than 9 kilograms and 19% lost more than 18 kilograms. There was also a striking decrease in the percentage of obese patients suffering from body image disparagement—from 44% to 12%, an unexpectedly good result for this chronic and intractable disorder.

Self-Destructive Behavior in Battered Children. Arthur H. Green. Pp. 579-582.

Fifty-nine physically abused children demonstrated a significantly higher incidence of self-destructive behavior than two control groups of nonabused children, one neglected and one normal. The self-destructive behavior, including suicide attempts and self-mutilation, was potentiated by interrelated variables operating in the abused child and the child's environment. Often enhanced by the ego deficits and impaired impulse control of the abused children, this behavior

seemed to represent a learned pattern originating in early traumatic experiences with hostile primary objects.

The "Relief Effect": A Sociobiological Model for Neurotic Distress and Large-Group Therapy. Marc Galanter. Pp. 588-591.

The author discusses the new discipline of sociobiology. He develops the hypothesis that relief of neurotic distress may be associated with experiencing social affiliation and presents data that demonstrate a decline in neurotic symptom intensity in individuals who joined a cohesive religious sect. Anthropological and ethological evidence for the adaptive value of this "relief effect" provides a basis for the evolution of this trait. The author proposes a corresponding model for psychotherapy in large groups.

Day Hospital Treatment of Borderline Patients: A Clinical Perspective. Martin J. Pildis; Gary J. Soverow; Carl Salzman; June G. Wolf. Pp. 594-596.

The authors suggest that day hospitalization can provide a useful therapeutic framework for patients with borderline personality organization without creating the ego regression often seen in such patients during 24-hour hospitalization. The lack of room and board facilities and of contact with patients who need 24-hour hospitalization plus the maintenance of contact with the people in the patient's nonhospital life facilitate treatment in this setting.

Natural History of Male Psychological Health: VI. Correlates of Successful Marriage and Fatherhood. George E. Vaillant. Pp. 653-659.

The author examines the relationship between quality of object relations and health on the basis of data from a prospective 35-year follow-up of 95 men selected for health. Judges blind to other data made independent ratings of physical health at 52, childhood environment, psychopathology, and maturity of defenses. These ratings were highly correlated with independent ratings of high school social adjustment, adult friendship patterns, marital satisfaction, and outcome of children. The author speculates that the capacity for object relations may be a relatively stable dimension of adult personality—a continuum that stretches from mature, generative mental health to schizophrenia.

Mid-Adult Development and Psychopathology. Stefan P. Stein; Stephen Holzman; T. Byram Karasu; Edward S. Charles. Pp. 676-681.

The authors studied a group of 193 psychiatric outpatients with varying diagnoses and a comparison group of 136 nonpatients across nine measures: sense of self; feelings about marriage, sex, career, and leisure time; relationship to parents, friends, and children; and sense of time passing. They found significant differences between the groups at specific ages in the areas of sense of self, feelings about career and sex, and relationships to parents, children, and friends. They discuss these results with a view toward identifying and elucidating normal and pathological factors in the adult life cycle.

Drug Use by the Polysurgical Patient. Richard A. Devaul; Richard C. W. Hall; Louis A. Faillace. Pp. 682-685.

The authors compared the drug use of 23 patients with 5 or more major surgeries (mean number of surgeries = 9.8) with that of a matched control group (mean number of surgeries = 1). Total drug use of the polysurgical patients was 3.7 times greater than that of the controls and involved naroctics, analgesics, barbiturates, and minor tranquilizers. The authors describe the characteristics of polysurgical patients, one of which is chronic pain, and propose a treatment plan that involves psychological intervention for the patient and his or her family.

Sexual Identity of 37 Children Raised by Homosexual or Transsexual Parents. Richard Green. Pp. 692-697.

The author reports on 37 children who are being raised by female homosexuals or by parents who have changed sex (transsexuals): 21 by female homosexuals, 7 by male-to-female transsexuals, and 9 by female-to-male transsexuals. The children range in age from 3 to 20 years (mean = 9.3) and have lived in the sexually atypical households for 1-16 years (mean = 4.9). Thirty-six of the children report or recall childhood toy, game, clothing, and peer group preferences that are typical for their sex. The 13 older children who report erotic fantasies or overt sexual behaviors are all heterosexually oriented.

Pathological Tolerance. Emil R. Pinta. Pp. 698-701.

Pathological tolerance is a symptom that occurs in a stable triadic relationship with certain characteristics, including the sharing of a sexual partner. The term refers to inappropriate acceptance of the triangular relationship by the member of the primary dyad who is of the same sex as the "triadic addition." The author suggests that the intrapsychic and interpersonal dynamics of pathological tolerance are identical with those of pathological jealousy and include the reenactment of earlier conflictual relationships through symbolic representation, expression of homoerotic drives, and a variety of interpersonal patterns. He presents three case reports and recommendations for treatment.

The Paradoxical Underutilization of Partial Hospitalization. Edward B. Fink; Richard Longabaugh; Robert Stout. Pp. 713-716.

Partial hospitalization continues to be underutilized even though its clinical effectiveness for a variety of psychiatric patients has been demonstrated. The authors investigated the potential economic advantage of partial hospitalization by comparing matched groups of day hospital patients and inpatients who had comparable symptoms and prognoses on admissions. They present one-year follow-up data documenting the comparability of the study groups on clinical outcome measures and the cost advantages favoring the partial hospitalization group. They discuss possible causes of the paradoxical underutilization of the clinically effective and lower-cost partial hospitalization, which include institu-

tional factors, patients' clinical characteristics, family resistance, and clinician bias.

Attitudes toward Issues in Psychiatry among Third-Year Residents: A Brief Survey. William Coryell and Richard D. Wetzel. Pp. 732-735.

The authors surveyed 378 third-year psychiatric residents on their attitudes toward psychiatric training, forms of psychotherapy, and the medical model; their treatment preferences for 4 given psychiatric disorders; and their career plans. Correlation coefficients and analysis of variance indicated clustering of attitudes along a dynamic-biological continuum, with medical education and experience with drug therapy rated highest of the training aspects and with personal analysis or psychotherapy, training in psychoanalysis, and research rated lowest.

Symptom Passing in a Transvestite Father and Three Sons. David W. Krueger. Pp. 739-742.

Three sons of a transvestite father engaged in cross-dressing beginning in early adolescence. The literature suggests that observation may play a role in determining the specificity of the symptoms of conflicted sexual identity. These cases of transvestism in offspring are unusual in that the father played an important role in symptom choice and modeling. It is hoped that in future studies of transvestism the father will be examined in a more intensive way as a figure with whom an active identification process may evolve.

Israel Annals of Psychiatry and Related Disciplines. XIII, 1975.

The following abstracts appeared in Israel Annals and are published with the permission of the journal.

Jewish Concentration Camp Survivors in Norway. L. Eitinger. Pp. 321-334.

The article gives a brief description of the deportation and imprisonment in German concentration camps of the Norwegian Jews during World War II. Of the 760 who were deported, only 24 survived. Thirteen of these were refugees to Norway from Central Europe. At the end of the observation period (31 December 1974), 6 of these were dead, 2 were untraced, and 5 were living in Norway. The author was able to follow the lives of the other 11 Norwegian-born Jews during their imprisonment and during the entire thirty-year period since their release. In spite of the excessive stress they were exposed to during their stay in the camps, they have managed better than the average non-Jewish Norwegian concentration camp survivors. It is concluded that the close-knit milieu and the active acceptance and help of the small Jewish community in Norway have contributed to this. The practical and theoretical implications of this conclusion are discussed.

Israel Annals of Psychiatry and Related Disciplines. XIV, 1976.

Obsessive Psychosis. Justification for a Separate Clinical Entity. S. Robinson; H. Z. Winnik; A. A. Weiss. Pp. 39-48.

This paper is based on a follow-up of 36 cases, extending over several years. Obsessive psychosis is defined here as an illness of long duration characterized by remissions, which may be either spontaneous or induced by treatment, when the patients are free from their symptoms. The remissions may extend over months and even over years; however, in the majority of cases a relapse may be expected. The ability to form obsessive symptoms appears to be the factor counteracting the disintegration of personality. As to differentiating this illness from schizophrenia, the emotional life of patients suffering from obsessive psychosis is not shallow and there is no intellectual impairment even in cases of long standing. Unlike schizophrenics, patients with obsessive psychosis do not suffer from hallucinations or loosening of associations.

Toward Obliterating Sex-Role Dichotomy: An Alternative Conception. Michaela Lifschitz. Pp. 73-82.

The author feels that distinction between parents is useful for the child's process of perceptual differentiation, which may eventually lead to individual integration (identity). Nevertheless, each parental figure is to be viewed in terms of complementary diverse human constructs or interests which are not necessarily linked to differentiated sex role characteristics. A model is offered in which father and mother are bipolarized at an optimal distance from each other, which enables a cooperative relationship between them and enough freedom of movement for their children to experiment with different approaches to life and to reduce fear and dependency.

Selected Remarks on Morality and Will in Adolescent Development. J. Zellermayer. Pp. 98-110.

The moral turmoil of adolescence and the intense preoccupation of adolescents with morality and will have not received the necessary attention. The meanings of the terms, morality and will, and their relation to the self system and to value systems are discussed. The moral dilemma of adolescence is seen as a clash between a strong need for self-assertion and an equally strong commitment to values, both of which normally emerge during this period. Recognition of the normal clash between self-assertion and value-rooted self-approval may facilitate the task of the educator and the therapist to help in the resolution of the moral dilemma to which adolescents are exposed.

Some Problems in Psychoanalytically-Oriented Psychotherapy with Young Male Adolescents. Eliezer Ilan. Pp. 132-144.

Problems in the psychoanalytically-oriented treatment of young male adolescents are discussed. Treatment vignettes of three youngsters illustrate the diffi-

culties but also the necessity of interpreting the decisive role of the parent-child relationship to adolescents who deny the importance of the parents. The author shows how the defense of intellectualization can be used to enhance the therapeutic alliance and how transference interpretation can be used to mitigate homosexual panic. Sexual problems are dealt with according to the religious-cultural milieu of the youngster. Although the Israeli sociocultural milieu gives specific coloring to problems past and present, family relations are the main universal etiological factors.

Requests for Abortions—A Psychiatrist's View. Roberto Mester. Pp. 294-299.

A high percentage of therapeutic abortions in Israel are performed after psychiatric recommendation. To decide on the need for abortion on psychiatric grounds is often a difficult problem-solving situation due to the interplay of the conscious and unconscious psychological forces of the woman requesting the abortion and of the examining psychiatrist. This article attempts to analyze these forces.

Perversions: Some Observations. J. Moussaieff Masson. Pp. 354-361.

Perversions are not entities that subsist autonomously. They are variations of neurotic behavior with their own histories. Their origin should be sought in childhood and cannot be divorced from parental behavior. The often maligned theory of seduction may yet turn out to be deeply implicated in the development of perversions.

Psychiatrica Fennica (Finnish Psychiatry). 1977.

Aspects of Anxiety in Transitional Society in Coastal Tanzania. Anja Forssén and Marja-Liisa Swantz. Pp. 15-19.

Anxiety is a signal produced by the ego when it perceives the danger of becoming overwhelmed. Social institutions play an important part in the individual ego's self-regulatory systems. Accounts are given of the anxiety observed in Tanzanians recently deprived of their traditional rituals, particularly adolescents who do not undergo rites of initiation. Independently tested girls who had recently undergone such a rite showed striking similarity in their Rorschach responses.

On the Foundations of Family Therapy—A Clinical and Psychoanalytic View. Yrjö Alanen. Pp. 155-166.

Various conceptualizations of the relation between individual psychopathology and family dynamics are summarized. Objectives of and indications for family treatment are given. This brief review article is lucid and thoughtful in covering a subject which is so often approached with misguided clinical thinking.

On Patient-Therapist Interaction as a Specific Diagnostic Tool with Suicidal Patients. Heinz Henseler. Pp. 181-187.

The therapist's assumption that the suicidal patient has an underlying narcissistic conflict, usually not conscious, brings unexpected clarity to the immediate reasons for the self-destructive urge and leads to a successful therapeutic approach. Disappointment in a partner often figures centrally in the precipitating circumstances. In the author's experience with suicidal patients, a time-limited treatment with emphasis on what is experienced as an acute situational difficulty is indicated, rather than long term therapy.

OWEN RENIK

The British Journal of Psychiatry. CXXXI, 1977.

The Children of Psychiatric Patients: Clinical Findings. S. F. Cooper, et al. Pp. 283-301.

The children and spouses of 26 consecutive patients referred to the outpatient department for psychotherapy were studied. The referred patients had a variety of psychological disorders with the majority being neurotic disorders, endogenous depression, and personality disorders. There were 42 school-age children representing the offspring of the 26 adult psychiatric patients. Psychiatric disorders were found in 45% of the children and 26% of the control group. The discussion centers around the psychiatric disorders of the children reflecting pathological marital discord in the parents.

Outcome in Psychotherapy Evaluated by Independent Judges. Sidney Bloch, et al. Pp. 410-414.

Twenty-seven patients were evaluated by independent judges to determine the outcome of psychotherapy. The judges were "blind" as to the exact form and duration of therapy the patient had received. All the judges viewed videotapes of clinical interviews, including tapes of the patients before therapy had actually started and again after eight months of therapy. Agreement between the judges' rating was low, both for the severity of the clinical state and for its outcome.

The British Journal of Psychiatry. CXXXII, 1978.

Prognostic Factors in the Assessment of Male Transsexuals for Sex Reassignment. Jan Walinder, et al. Pp. 16-20.

The authors examined a group of five male transsexuals who had undergone sexual reassignment and who were unhappy or repentent and compared this group of "unfavorable results" with a group of nine patients who had a favorable outcome. They derived a group of factors which could be considered prior to surgery that would serve as indicators of poor prognoses. The major factors were: (1) an unstable personality, (2) criminality, (3) inadequate support from family,

(4) inadequate self-support (inability to hold a job), (5) inappropriate physical build (heavy bone structure, large hands, athletic muscle development, coarse features and profuse body hair), (6) heterosexual experience indicating the subject had at some time achieved full coitus. An additional major factor that was present in those who had an unfavorable outcome involved the age at the time of the request for intervention—the older the patient at the time of intervention, the more unfavorable the outcome. Other factors that have been mentioned by these authors as well as by others is the poor prognosis in those patients who have had a psychotic reaction or those who have mental retardation, alcoholism, and/or drug addiction.

MICHAEL D. GOLDFIELD

The Journal of Psychiatry and Law. V, 1977.

The following abstracts from the Journal of Psychiatry and Law are published with the permission of the journal.

Prolixin Decanoate: Big Brother by Injection? Thomas K. Zander. Pp. 55-75.

This article examines the psychiatric research and legal doctrine concerning the psychotropic drug prolixin decanoate. Prolixin is a unique drug because, once it is injected into a person, its effects last from two to four weeks. Some courts are now considering the circumstances under which this drug should be forced upon an involuntarily committed individual. The article concludes that because of (a) the shortcomings of psychiatric research on prolixin and (b) the adverse effects of the drug, courts should consider prolixin to be an experimental treatment modality—like psychosurgery—when deciding whether it should be forcibly administered to an involuntarily committed individual.

Custody by Agreement: Child Psychiatrist as Child Advocate. Robert A. Solow and Paul L. Adams. Pp. 77-100.

The authors offer a new plan to help not only the large numbers of children involved in their parents' divorces, but all the participants in divorce and custody disagreements. This plan stresses psychiatric values above legal ones and involves the fuller participation of child psychiatrists in being advocates for the welfare of the child. The paper presents the historical context for custody rights as well as currently emerging concepts and practices. A review of the child psychiatrist's role as an objective expert and as an expert witness is given and also a brief review of what is helpful to children whose parents divorce. The authors' nonadversarial model for determining child custody is proffered with a consideration of the benefits of an agreed judgment on child custody.

Discretion and the Law: A Psycholegal Overview. C. G. Schoenfeld. Pp. 101-131.

Numerous examples of the clearly excessive discretionary powers that now saturate the American legal system are discussed. The dangers that these discretionary powers pose are explored with the aid of psychoanalytic findings, par-

ticularly those concerning man's moral faculty or superego. These psychoanalytic concepts are also employed in an effort to determine how such discretionary powers might be limited or structured so that the United States remains, as much as possible, a government of laws and not of men.

Mental Health Expert Testimony: Current Problems. Norman G. Poythress, Jr. Pp. 201-227.

In spite of the increasing utilization of mental health professionals as expert witnesses in the courts, neither the people in the mental health professions nor those in the legal profession find the present state of affairs concerning expert testimony to be satisfactory. This paper extensively reviews the literature which points to the problems with both the mental health and the legal personnel who play major roles in mental health litigation. Also reviewed are the various proposals for change that have been suggested to date.

The Legal and Social Significance of Aftercare Systems: A Review and Analysis. John J. Ensminger and Patrick Reilly. Pp. 229-291.

There have been several findings in the research on aftercare which have significance for courts and legislatures faced with choices involving planning and implementation of mental health systems. Both the older and newer methods of community mental health care delivery are analyzed. There appear to be cogent reasons for emphasizing the provision of aftercare facilities to poverty communities. Certain reasons for failures in aftercare treatment are identified. An analysis of the literature on aftercare indicates that there are certain elements important for the effective functioning of an aftercare system.

The Dangerousness of Patients Released from Maximum Security: A Replication. Manfred Pruesse and Vernon L. Quinsey. Pp. 293-299.

Two hundred six male patients discharged from a maximum security psychiatric institution were followed up for a 37-49 month period. Failures were defined as men with new convictions or a readmission to the security hospital. 46% of the sample failed, usually through the commission of minor property offenses, and 17% of the total committed at least one violent offense against persons. As in earlier studies of patients discharged from this hospital, younger personality-disordered patients were more likely to fail. They were also more likely to commit a violent offense than the older nonpersonality-disordered patients.

Group Psychotherapy: Privileged Communication and Confidentiality. Ralph Slovenko. Pp. 405-466.

Do privileged communication and confidentiality prevail in group psychotherapy? This paper, based on interviews with several group therapists and an interview with a group, indicates that therapists are far more concerned about confidentiality than are members of the group. Be that as it may, therapists fear

that one celebrated case, should it arise, would create a great deal of anxiety about group therapy. There are circumstances and pressures that foster the maintenance of confidentiality, but if group therapists have doubts, can the group members long be without doubt themselves?

Crisis in Confidentiality, Ethics and Legality for a Psychiatrist. Richard G. Rappaport. Pp. 467-498.

A patient in individual and group psychotherapy protests the exposure to the group of information told only to his psychiatrist in confidence. A formal complaint by the patient to an ethics committee, with threat of a malpractice suit, highlights the absence of a legal mental health code for guidance. Correspondence and committee hearings are the forum for a heated debate of the issues of confidentiality, patient rights, and responsibility of the therapist. The predicament of the therapist in the hands of a committee of peers unprepared for their role becomes a trauma itself.

Journal of the History of the Behavioral Sciences. XIV, 1978.

The following abstracts from the Journal of the History of the Behavioral Sciences are reprinted with the permission of the publisher.

Gestalt Psychology and Gestalt Therapy. Mary Henle. Pp. 23-32.

This paper examines the relation between Gestalt psychology and Gestalt therapy, as presented in the writings of Fritz Perls, who claims that his perspective derives from Gestalt psychology. Intellectual traditions, philosophical assumptions, and specific theories and concepts are considered. It is concluded that the two approaches have nothing in common.

Psychotherapy in the Third Reich: A Research Note. Geoffrey Cocks. Pp. 33-36.

This study seeks to examine and illuminate some aspects of the history of psychotherapy in Germany during the twentieth century. The specific focus encompasses the profession's development between the two world wars and, within that time frame, centers on the National Socialist era. Psychotherapy existed for a long time on the margins of the academic medical establishment, accused by the holders of the powerful nosological tradition in German psychiatry of romantic and unscientific "dilettantism," on the one hand, and of a materialistic "dismemberment of the soul," on the other. The internal chaos of the Nazi state and the precedence taken by mobilization over reform allowed the growth of psychotherapy from the status of a method to that of a profession.

An American Analyst in Vienna during the Anschluss, 1936-1938. Walter C. Langer and Sanford Gifford. Pp. 37-54.

Two letters of Dr. Walter C. Langer give an animated, informal picture of (1) his experiences as a young American psychologist in training at the Vienna

Psychoanalytic Institute during its last years before the Nazi occupation, (2) the clandestine activities of Dr. Langer and other foreign students in helping Austrian friends and colleagues to escape after the *Anschluss* in March 1938, and (3) his recollections of earlier years as a clinical psychologist, child analyst, and director of a residential school for disturbed boys. Dr. Langer's experiences are presented and discussed in relation to an important early phase in the development of American psychoanalysis, when full training could only be obtained in European institutes. His position as an analyst, a nonphysician, on returing to this country, where the American tradition of "medical orthodoxy" prevailed, prompts some reflections on the past and present status of lay analysis.

The Structure of Psychological Revolutions. Allan R. Buss. Pp. 57-64.

Four major revolutions within psychology (i.e., the behavioristic, cognitive, psychoanalytic, and humanistic) are briefly examined in an attempt to unearth their formal structures. The view put forth is that it is a transformation of the subject-object relation—an insight gleaned by an application of Ludwig Feuerbach's transformative method—which underlies major paradigmatic shifts within psychology. It is noted that psychological revolutions based upon a transformation of the subject-object relation could go on indefinitely in a vicious, circular manner. Thus, a revolution to end revolutions is called for (a dialectical revolution) in order to liberate psychologists from partialist, encapsulated, or limiting views of the subject-object relation.

The Philosophical Development of the Conception of Psychology in Germany, 1780-1850. David E. Leary. Pp. 113-121.

Although it is generally acknowledged that the modern science of psychology was produced in the mid-nineteenth century by the cross-fertilization of philosophy and physiology, few historians have tried to specify the exact role of philosophers in the evolution of modern psychology. The purpose of this article is to identify one important line of development from within early nineteenth-century German philosophy toward the conception of psychology as an independent, experimental, and mathematical science. The thesis it proposes is that Immanuel Kant's criticism of the psychological tradition and his articulation of a specific philosophy of science provided the negative and positive foundations upon which Jakob Friedrich Fries, Johann Friedrich Herbart, and Friedrich Eduard Beneke developed the conceptualization of scientific psychology.

Demonology and the Rise of Science: An Example of the Misperception of Historical Data. Irving Kirsch. Pp. 149-157.

Many writers have inaccurately attributed the rise of demonology and the witch-hunts to the Middle Ages and have associated the decline of these activities with the Renaissance and the period of the scientific revolution (1500-1700). An examination of medieval Church proclamations indicates that during the early part of the Middle Ages, the Church denied the reality of witchcraft and

was relatively tolerant toward alleged or self-proclaimed witches. More credulous views were developed during the Renaissance, and the height of the witch mania did not occur until the mid-seventeenth century. This misperception of the data is seen as related to a more general "Whig" myth concerning the historical relationship between science and superstition.

Treatment of the Mentally Ill in Medieval and Early Modern England: A Reappraisal. Richard Neugebauer. Pp. 158-169.

Conventional histories of psychiatry depict the medieval and early modern period as dominated by demonological ideas about mental illness and treatment of the insane as cruel and inhumane. English legal records from the thirteenth to the seventeenth century, generated by the Crown's jurisdiction over the mentally disabled, produce a radically different picture. When royal officials examined allegedly disturbed persons before local juries, they measured mental status with common sense criteria based on psychological and physiological notions of etiology. For established cases of disability, the Crown appointed supervised guardians. In the course of these centuries, the responsibility of guardians for the care and protection of the disabled underwent increasing expansion. The records of this jurisdiction exist largely in manuscript form, a documentary source which psychiatric historians have been slow to appreciate. These records cast doubt on printed sources and on the validity of restricting historical research to published materials.

From "Race Psychology" to "Studies in Prejudice": Some Observations on the Thematic Reversal in Social Psychology. Franz Samelson. Pp. 265-278.

In 1920, most psychologists believed in the existence of mental differences between races; by 1940, they were searching for the sources of "irrational prejudice." In a few decades, a dramatic reversal of the dominant paradigm for the study of groups and group relations had occurred. Although this shift can be seen as a victory of objective-empirical research, there were other contributing factors: passage of the Immigration Restriction Law of 1924, which shifted the political problem from justification of differential exclusion to conflict resolution in this country; the influx of ethnics into the originally rather lily-white profession of psychology; the Great Depression and the leftward shift among psychologists; and finally, the need to unite the country against a dangerous enemy proclaiming racial superiority.

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Meetings of the Psychoanalytic Association of New York

Howard K. Welsh & Melvin Stanger

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NOTES

We would like to take this opportunity to express our gratitude to colleagues other than our Editors who have reviewed a number of papers submitted to us during the past year. Our thanks go to Dr. Sander M. Abend, Dr. William A. Binstock, Dr. Herbert J. Goldings, Dr. Eugene Halpert, and Dr. Ernst Ticho for their invaluable help.

MEETINGS OF THE PSYCHOANALYTIC ASSOCIATION OF NEW YORK

October 24, 1977. KASPAR HAUSER AND SOUL MURDER. Leonard Shengold, M.D.

Defining soul murder as the purposeful destruction, by deprivation or overstimulation, of the essential human qualities of the growing child (referring to the sense of reality and identity and the capacity for thought and emotion), Dr. Shengold cited the celebrated story of Kaspar Hauser to illuminate this phenomenon. He pointed to relevant portions of our understanding of ego development and object relations theory which tend to make different aspects of this bizarre story credible. The discrepancy between advances in ego development and instinctual development was discussed in terms of the features of the substitute mothering involved, which permitted advance through Mahler's "practicing subphase" but failure of "rapprochement." The resultant superego developments and related obsessional characteristics were climaxed by Kaspar Hauser's characterologic regression after his later traumas. Dr. Shengold connected these observations with the dehumanization and de-individuation that threaten our culture today and which, through authoritarianism and the breakdown of the nuclear family, result in an increasing number of patients whose conflicts are based on what others have done to them.

DISCUSSION: Dr. Eugene H. Kaplan questioned the reliability of the accounts on which many of the author's observations are based and suggested that other studies of different types of child abuse, including well-intended deprivational treatments, would be more instructive to study. Dr. Melvin Stanger offered some clinical material which he felt supported the author's findings concerning the development of defensive splitting and the reliance on a good object to help cope with murderous rage against parents guilty of overstimulation. Dr. Austin Silber emphasized the significance of Hauser's ego development being dissociated from the instinctual arrest, which he felt demonstrated the expansibility of the ego as compared to the drives. In response, Dr. Shengold defended the value of applied psychoanalytic studies and pointed out that the concept of soul murder was a dramatic concept rather than a clinical one, highlighting the impact of parental traumatization.

HOWARD K. WELSH

November 21, 1977. BRAINWASHING, LOVE, PASSIONATE BELIEF: A STUDY OF IDEALIZATION. Alan J. Eisnitz, M.D.

Dr. Eisnitz suggested that idealization plays several roles in brainwashing, love, and passionate belief. In the state of loving, the love object is idealized. With passionate belief, a particular cause or ideal affirms idealized values. In brainwashing, victims are pressured to accept ideals which may be antithetical to their own. These phenomena underscore the value of studying the development of idealization within the process of ego development and maturation. The foundations of the process of idealization are established during the preoedipal and oedipal phases, but the process undergoes a revival during adolescence, with subsequent reoccurrences during later steps in individual development. When the oedipus complex is not successfully resolved, the necessary identifications cannot occur, and external object relations must be available to a large extent to stabilize the cathexis of the self-representation. Just as object relations progress from the requirement for actual gratification by the object to the object's presence as a potential gratifier and, finally, to the acceptance of the object's absence, so, too, in the earlier stages of idealization, the ideals must be closely connected with the actual object or self qualities, although later ideals may become more abstract and depersonified. During periods of stress, however, these paths of development may be reversed, and the actual presence of an idealized external object may again become necessary. New ideals may then replace previously internalized values.

Stressing self-representation as the keystone in these developmental processes, Dr. Eisnitz noted that serious conflicts threaten the stability of the self-representation, and defensive measures involving the reappearance or strengthening of a neurotic symptom, or the revival of narcissistic features in object relationships, may follow. This will then result in a tendency toward reversal of the paths of internalization already described. Such conflicts may easily arise in instances involving love, brainwashing, and passionate belief. Persons in love may suffer both object loss and narcissistic mortification when they feel they are not loved. This narcissistic vulnerability and diminished stability of the self-representation predisposes toward a degree of regression, and when the internalization of ego-superego systems is reversed, the external object assumes an increased importance and tends to become further idealized. Object choice then serves the purpose of restoring stability to the self-representation; "as if" patients, for example, markedly overidealize their love objects. Idealization is also a normal component of the love relationship in that the idealized object is genetically linked with idealized aspects of the parents and narcissistic attitudes toward the self.

Brainwashing involves disturbances in reality testing, memory, and idealization as a result of the attack upon the values of the victim. This leads to a shift in the direction of the value system of the inquisitors. The various methods used impair perception and induce confusion. Humiliations revive old narcissistic conflicts and old areas of vulnerability and thus interfere with the maintenance of a stable self-representation. For example, constant accusations blended with demands for confession result in the revivial of important levels of unconscious guilt. The failure of the idealized objects to protect and rescue leads to intense

feelings of rage at the abandonment, with more guilt. When captors then seduce by offering strength and libidinal gratification, the victims tend to identify with their "saviors" and to incorporate (their) new ideals. People with mature personalities may have firmly held beliefs, while others may develop intense enthusiasms and beliefs which they abandon with ease or cling to with fervor and fanaticism. A passionately held belief may represent an externalized and idealized aspect of the self-representation or idealized qualities of past objects, while a passionate hatred may represent unacceptable or undesirable aspects of the self-representation, a "negative" ideal.

DISCUSSION: Dr. Nathaniel Ross spoke of preoedipal phenomena, such as splitting, which result in the inevitable misrepresentation of the whole mother, serving as a kind of way station en route to object constancy and normal postoedipal ambivalence. The brainwasher reactivates an early mode of object-relatedness in which intensified ambivalence ultimately gives way to the even earlier state of splitting. The good and bad representations of object and self which emerge depend upon the fixations originally present in the victim's early development, with particular reference to the subphases of separation-individuation. Many of our youth today, deprived of consistent love and a set of workable, realistic, and worthy values which could be elevated to the status of ideals, succumb to simplistic philosophies offering them the sharp division between "good and bad" characteristics of a subphase of infantile development. The associated regressed affects result in altered states of consciousness and a surrendering of their capacity for rational thinking. Vulnerable to authoritarian forces resembling those of earliest infancy, they become enmeshed in a symbiotic web in which partial fusion with those forces destroys their identity. Dr. Richard Yazmajian suggested that there is a reverberating and reciprocal relationship between object idealization and ego and self-representation development. This facilitates the development of aim inhibited object love as a love relationship develops. The narcissistic vulnerability inherent in falling in love and staying in love relates to the difficulties encountered in analyzing patients with marked narcissistic problems who require painstaking and lengthy treatment in order to be able to take the "risk" inherent in adult loving. The formation of a stable self-representation is indeed dependent upon resolution of oedipal conflicts, but these conflicts can be successfully resolved only in the crystallizing matrix of an adult love relationship. Dr. Otto Sperling offered several clinical vignettes illustrating ego regressions with deidealization of previously idealized values and beliefs, with internalization and idealization of substitute values of a kind which were previously either abhorrent or foreign to the individual concerned.

MELVIN STANGER

The 31st INTERNATIONAL PSYCHO-ANALYTICAL CONGRESS will be held July 20-August 3, 1979, at the Waldorf Astoria, New York.

The 56th Annual Meeting of THE AMERICAN ORTHOPSYCHIATRIC ASSOCIATION will be held March 31-April 4, 1979, at the Washington Hilton Hotel, Washington, D.C.

The Tenth Annual MARGARET S. MAHLER SYMPOSIUM will be held in Philadelphia on May 19, 1979. The subject of the symposium will be *Constructive Contribution of Aggressive Endowment in Personality Development*. For further information, contact: Judy Myers, Medical College of Pennsylvania, Department of Psychiatry, 3300 Henry Ave., Philadelphia, Pa. 19129.

The SAN FRANCISCO PSYCHOANALYTIC INSTITUTE has announced the inception of two annual Harold S. Rosenberg Memorial Prizes of $500.00 each for original papers on child analysis. One prize will be offered for a paper from a candidate in child analytic training at any recognized training center; the second will be offered to any graduate child analyst. The prizes have been established in memory of Harold S. Rosenberg by his family to encourage those who are interested in psychoanalysis as a research and clinical tool for the study and treatment of children. A committee of five child analysts will judge the papers on the basis of clinical relevance and theoretical significance. Papers submitted for this year should be postmarked no later than April 30, 1979. For further information, contact: Jules M. Weiss, M.D., San Francisco Psychoanalytic Institute, 2420 Sutter St., San Francisco, Calif. 94115.

The 29th LINDAU PSYCHOTHERAPY WEEKS CONGRESS will be held April 23-May 5, 1979, in Lindau, Germany. For further information, write: The Secretary, Orlandostr. 8/IV, D-8000 Munich 2, Germany.

The FOUNDATIONS' FUND FOR RESEARCH IN PSYCHIATRY is again offering a limited program of support for scholars on sabbatical leave in order to further their research and contribute to the knowledge of psychiatric diagnosis, treatment, and preventive measures. The sabbatical must be spent away from the home institution at an internationally recognized institution. Applications must be received no later than May 1st of the year preceding the proposed sabbatical, and applicants must be United States or Canadian citizens or permanent residents of the United States or Canada. For further information, contact: Foundations' Fund for Research in Psychiatry, 100 York Street, New Haven, Conn. 06511.

Each year the NEW YORK CONSULTATION AND REFERRAL SERVICE FOR PSYCHOTHERAPY sponsors a series of lectures in psychology by distinguished contributors. The talks, given at the Carnegie International Building, are on contemporary issues in psychology that are of interest to both professional and layman. For further information, contact: Dr. Harvey Kaplan, New York Consultation and Referral Service for Psychotherapy, 130 West 57 Street, New York, N.Y. 10019.